

CY 2026 Michigan  
Trauma Registry

DATA  
DICTIONARY

State of Michigan Systems of Care  
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ADA Compliant Version

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## About this Data Dictionary

The primary purpose of this data dictionary is to assist Michigan trauma registrars in reporting trauma cases to the Michigan Trauma Registry, which serves as a repository of injured patients. If a registrar has questions that cannot be answered in this data dictionary or other resources cited within, please contact [statetraumaregistrar@michigan.gov](mailto:statetraumaregistrar@michigan.gov).

This is the 2026 edition of the dictionary and incorporates changes in requirements from the National Trauma Data Bank (NTDS), state elements, and any changes in data entry resulting from updates by the state trauma registry vendor. The data dictionary also contains TQIP and MTQIP elements as currently provided by these entities. This dictionary does not include TQIP or MTQIP measures for processes of care required by Level I and II participating centers. Not applicable, not known / not recorded are detailed in the edit checks.

The state of Michigan receives authority to collect and analyze trauma system data to evaluate the delivery of adult and pediatric trauma care, develop injury prevention strategies for all ages, and provide resources for research and education from Michigan Administrative Rule 10 of 325.134. Rule 10 indicates the department shall coordinate data collected by the trauma care facilities and emergency medical service providers. The department shall develop and publish a data submission manual that specifies the following:

- (a) Data elements and definitions. The standards that are incorporated by reference pursuant to R 325.133(1)(a), and all of the following:
  - (i) Definitions of what constitutes a reportable trauma case and directs all hospitals to submit data to the department on a quarterly basis determined by the department.

The purpose of the State of Michigan Systems of Care Trauma Networks is to reduce death and disability resulting from traumatic injury. The data in the trauma registry is used for performance improvement activities at the state, regional and local level. Registrars must enter patients meeting inclusion criteria but may enter additional patients to assist in hospital trauma program and/or regional performance improvement. Registrars will need to utilize this data dictionary in addition to ICD-10 resources to accurately complete fields.

This document is created, updated, and maintained by the state of Michigan Bureau of Emergency Preparedness, EMS, and Systems of Care. Updated versions of this document may be released throughout a calendar year; however, the inclusion criteria and required data elements will only be updated on an annual basis.

## **Introduction**

### Michigan Trauma Reporting Requirements

## 2026 Inclusion Criteria

Applicable to patients admitted: January 1, 2026, to December 31, 2026.

A trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria below. Level I, II, III, and IV trauma centers will submit data from their trauma registries for all patients meeting these criteria.\*

### Glossary for Flow Chart:

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

International Classification of Diseases, Tenth Revision (ICD-10-CM):

S00-S99 with 7th character modifiers of A, B, or C only. (Injuries to specific body parts – initial encounter)

T07 (Unspecified multiple injuries)

T14 (Injury of unspecified body regions)

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

Excluding the following isolated injuries (ICD-10-CM):

S00 (Superficial injuries of the head)

S10 (Superficial injuries of the neck)

S20 (Superficial injuries of the thorax)

S30 (Superficial injuries of the abdomen, pelvis, lower back, and external genitals)

S40 (Superficial injuries of shoulder and upper arm)

S50 (Superficial injuries of elbow and forearm)

S60 (Superficial injuries of wrist, hand, and fingers)

S70 (Superficial injuries of hip and thigh)

S80 (Superficial injuries of knee and lower leg)

S90 (Superficial injuries of ankle, foot, and toes)

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

### AND

Must include **one** of the following in addition to the first two criteria :

Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);

### OR

Patient transfer from one acute care hospital\*\* to another acute care hospital:

**OR**

Patients transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice);

**OR**

Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);

**OR**

Patients who were an in-patient admission and/or observed;

\* In-house traumatic injuries sustained after initial ED/hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

\*\*Acute care hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). Standalone EDs are included. "CMS Data Navigator Glossary of Terms"

[https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav\\_Glossary\\_Alpha.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf)

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

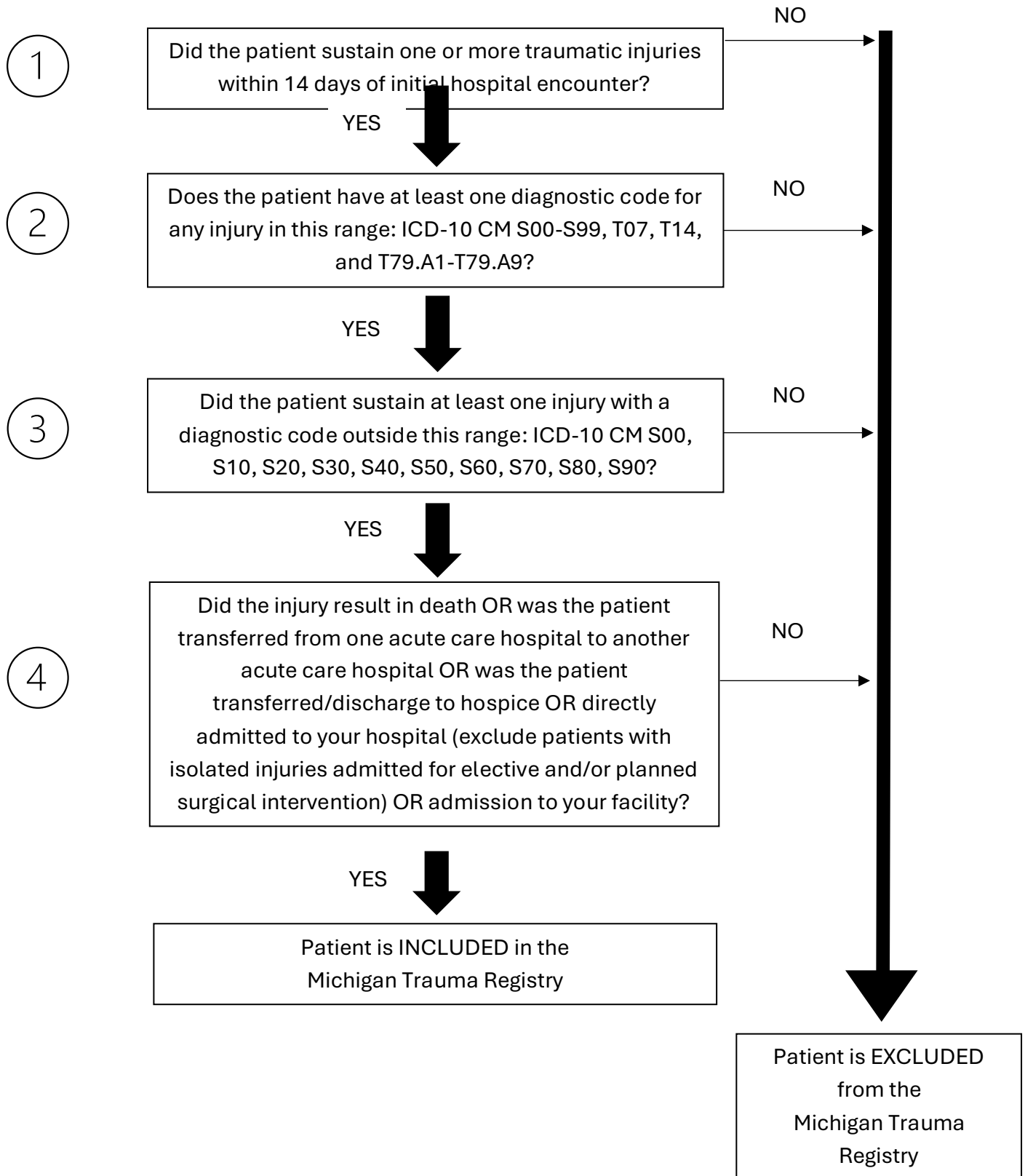
Trauma team activation where the patient is found to have no qualifying injuries and is discharged home from the emergency department

Drownings

Hangings, strangulations, or asphyxiation

Isolated burn injuries

## 2026 Inclusion Criteria Flowchart



## Example Inclusion Scenarios

A 31-year-old female arrives to your emergency department via their friend's private vehicle. The patient states she fell down an unknown number of stairs earlier today, landing on her arm. Her arm has an obvious proximal deformity. The trauma team is not activated. Radiology shows fractures to the left clavicle and humerus. Your facility does not have orthopedic services available today, so you advise the patient she will need to be transferred to another local facility where the appropriate interventions can be performed. A cast and sling are placed to protect the injured area. The receiving facility eventually agrees to accept this patient, and after a two-hour length of stay, the patient's friend picks them up and drives them to the receiving acute care center.

**This patient does meet inclusion criteria. The patient has a qualifying traumatic injury and was transferred from one acute care hospital to another acute care hospital.**

Your emergency department receives a radio report from local EMS stating they are bringing a 28-year-old male with a stab wound to the upper left abdominal quadrant. A chest seal has been placed and needle chest decompression was performed with air return. Your facility's highest trauma team activation is called 10 minutes prior to patient arrival. The patient arrives with a SBP of 80 and is tachycardic at 150bpm. The patient is diagnosed with a grade 4 spleen laceration and a pneumothorax. After one hour in the ER, the patient is taken to the operating room and eventually is admitted to the ICU. Total facility length of stay is four days.

**This patient does meet inclusion criteria. The patient has qualifying traumatic injuries and has one additional criterion met (admission for the care of his traumatic injuries).**

A 30-year-old male pedestrian was struck when crossing the street by a sedan travelling approximately 10 miles per hour. The patient was not thrown and did not lose consciousness but presented to local EMS with shortness of breath and tenderness in his pelvic region. The radio report from the transporting unit meets your facility's criteria to page a level two trauma team, your hospital's lower-level activation. Patient arrives to your ER and assessment reveals minor road rash to his anterior pelvic region and bilateral bruising to the thighs. Radiology reveals no additional injury. The patient's final diagnosis is minor abrasions to the anterior hips and bilateral contusions to his thighs. After nearly 3.5 hours in the ER, the patient is discharged home without services.

**This patient does not meet inclusion criteria. However, if you are placing your trauma activations in software to utilize for over/under triage, program analysis, and pre-review questionnaire, you may use the registry for activations.**

A 13-year-old male patient is brought to the ER by his coach after the patient fell face first into the boards during a hockey practice. The patient's parents couldn't be reached, and the coach didn't find it necessary to call EMS. The patient does not remember the accident, but is complaining of neck pain, a broken tooth, and a headache. The coach isn't clear whether the patient was unconscious after the fall, but he does state the patient didn't move for "a few seconds" after hitting the boards. A level two trauma team activation is called as a precaution and all team members respond within their required timelines. Consultation with the receiving pediatric center recommends transport to their facility by EMS for further evaluation. To prevent a delay in transfer, the MD at your facility elects not to perform radiological studies. After a 64-minute stay in your ER, the patient is transferred to the receiving pediatric trauma center by ground ambulance. Your facility's diagnosis is a broken tooth, strained neck ligaments, and a concussion with a loss of consciousness less than one minute.

**This patient does meet inclusion criteria. The patient has a qualifying injury and has one additional criterion being transfer to another acute care center via ground ambulance.**

A 94-year-old female presents via private vehicle with a persisting headache and bruising on her extremities. She is brought into your ER through triage. The patient states she hasn't had a recent injury, is not on blood thinners, and just feels "tired." There is no trauma team activation. The patient's son, who drove her to your facility, states the patient has been having issues with her gait and strength. He states that he believes the patient's metoprolol is causing her to become unsteady after standing. Initial exam shows bruising at multiple stages of healing on her extremities. There are some small lacerations on her palm, just next to her thumbs that appear to be almost completely healed. Upon further interview, the patient states she has been falling more frequently, and her last fall was three weeks ago. She describes the fall as a "slip, where I just went to my hands and knees." The patient's son was able to help her back up, and place cold packs on the patient's hands for treatment. This is her first hospital encounter to treat these injuries. The remainder of the workup is unremarkable for any injury or illness. The patient receives a medication review and is referred to a physical therapy program. The son is also advised on how to prevent falls in the patient's home. The patient is discharged home from the ER.

**This patient does not meet criteria. While the lacerations on her hand may constitute a qualifying injury, the injuries were sustained over 14 days prior to this hospital encounter.**

## Null Values

These values are to be used as the null values:

Not Applicable (NA): Applies when the information requested was not applicable at the time of the patient care event. For example, the common null value “NA” is reported in the data element *Other Transport Mode* if a patient had a single mode of transport.

Not Known/Not Recorded (NK/NR), Not Documented, Unknown are interchangeable: Applies when the information is unknown (to the patient, family, health care provider) or not recorded at the time of the patient care event. For example, the common value “NK/NR” is reported in the data element *Injury Incident Date* if it was documented as “Unknown” in the patient medical record. Another example, the common null value “NK/NR” is reported when documentation was expected, but none was provided, i.e. *Initial ED/Hospital Temperature* was not documented in the patient medical record.

References to other databases:

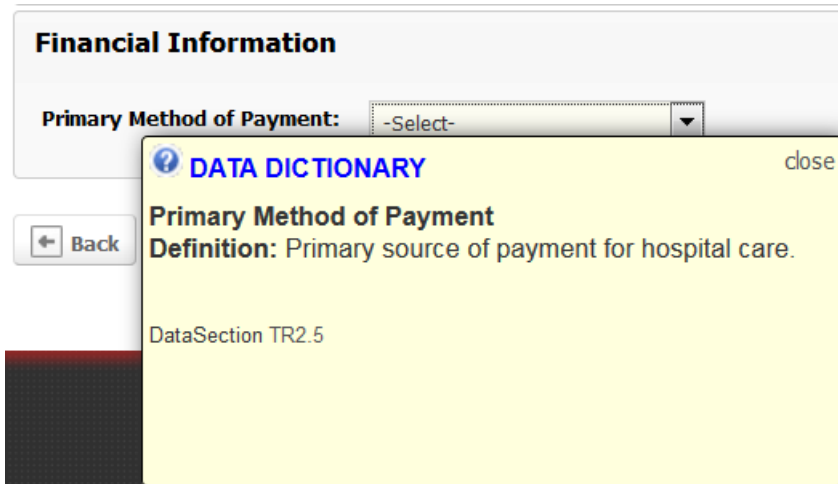
National Center for Statistics and Analysis (NCSA), NHTSA; US Department of Transportation  
ICD-10-CM—the International Classification of Diseases, Tenth Revision

## Dictionary Element Legend

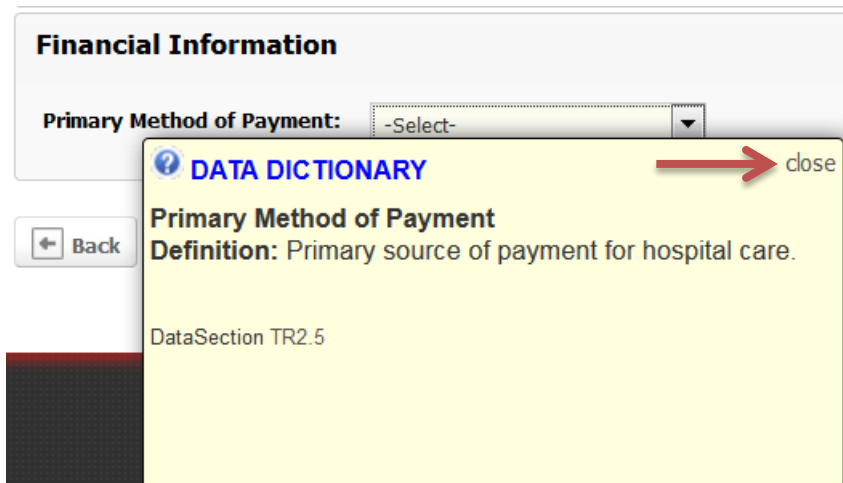
All definitions contained in this data dictionary are available on various data entry forms within the Michigan Trauma Registry. If a data element does not have a definition, please notify the state of Michigan Trauma Registrar at [statetraumaregistrar@michigan.gov](mailto:statetraumaregistrar@michigan.gov).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

Enter the data entry form and locate your desired data element

Select the title of the data element



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



This data dictionary contains required fields for 2026 diagnoses. The data items on the following pages are listed by category. Each data item description contains:



Will appear if the element is required by the State of Michigan



Will appear if the element is required by the NTDS



Will appear if the element is required for upload by 3<sup>rd</sup> parties



Will appear if the element is optional for all incidents

### [Tab Location, Element Number, Element Title Description](#)

The general meaning of the data element.

### [Element Values](#)

Lists all available values for data element entry. The order in which these fields appear do not necessarily correspond with data import mappings.

### [Additional Information](#)

Instructions for reporting the data element.

### [Data Source Hierarchy Guide](#)

Sources where information can be obtained in the medical record.

### [Associated Edit Checks \(NTDS\)](#)

If the element is NTDS required, the associated validation rules will be displayed here.

## **SECTION A**

### National Trauma Data Bank (NTDS) Elements

## NTDS Demographic Information



## Demographics TR1.20 – Patient’s Home Zip/Postal Code

### Definition

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

### Field Values

Relevant value for data element

### Additional Information

Can be stored as a 5- or 9-digit code (XXXXX-XXXX) for US or can be stored in the postal code format of the applicable country.

May require adherence to HIPAA regulations.

If *Patient’s Home ZIP/Postal Code* is “Not Applicable”, report data element: *Alternate Home Residence*.

If *Patient’s Home ZIP/Postal Code* is “Not Known/Not Recorded”, report: *Patient’s Home Country*, *Patient’s Home State* (US only), *Patient’s Home County* (US only) and *Patient’s Home City* (US only).

If *Patient’s Home ZIP/Postal Code* is reported, must also report *Patient’s Home Country*.

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
0001	1	Invalid value
0002	2	Field cannot be blank
0040	1	Single Entry Max exceeded



## Demographics TR1.19 – Patient’s Home Country

### Description

The country where the patient resides.

### Element Values

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

### Additional Information

Selections are made from a dropdown menu.

Values are two-character FIPS codes representing the country (for example, US).

If *Patient’s Home Country* is not US, then the null value “Not Applicable” is reported for: *Patient’s Home State*, *Patient’s Home County*, and *Patient’s Home City*.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
0101	1	Invalid value
0102	2	Element cannot be blank
0104	2	Element cannot be “Not Applicable”
0105	2	Element cannot be “Not Known/Not Recorded” when <i>Patient’s Home ZIP/Postal Code</i> is any response other than “Not Applicable” or “Not Known/Not Recorded”
0140	1	Single Entry Max exceeded



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

### Description

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

### Element Values

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

### Additional Information

Only reported when *Patient's Home ZIP/Postal Code* is "Not Known/Not Recorded," and country is US. Used to calculate FIPS code.

Element will default to Michigan when ZIP is 99999.

The null value "Not Applicable" is reported if *Patient's Home ZIP/Postal Code* is reported.

The null value "Not Applicable" is reported for non-US hospitals.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0201	1	Invalid value
0202	2	Element cannot be blank
0204	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0205	2	Element cannot be "Not Known/Not Recorded" when <i>Patient's Home Zip/Postal Code</i> is reported
0240	1	Single Entry Max exceeded



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

### Description

The patient's county (or parish) of residence.

### Element Values

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

### Additional Information

Only reported when *Patient's Home ZIP/Postal Code* is "Not Known/Not Recorded," and the country is the US.

Used to calculate the FIPS code.

The null value "Not Applicable" is reported if *Patient's Home ZIP/Postal Code* is reported.

The null value "Not Applicable" is reported for non-US hospitals.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0301	1	Invalid value
0302	2	Element cannot be blank
0304	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0305	2	Element must be "Not Applicable" when <i>Patient's Home Zip/Postal Code</i> is reported
0340	1	Single Entry Max exceeded



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

### Description

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

### Element Values

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

### Additional Information

Only reported when *Patient's Home Zip/Postal Code* is "Not Known/Not Recorded," and country is the US.

Used to calculate the FIPS code.

The null value "Not Applicable" is reported if *Patient's Home ZIP/Postal Code* is reported.

The null value "Not Applicable" is reported for non-US hospitals.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet /Medical Records Coding Summary Sheet
3. Admission Form

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0401	1	Invalid value
0402	2	Element cannot be blank
0404	2	Element cannot be "Not Applicable" (Non-US hospitals only)
0405	2	Element must be "Not Applicable" when <i>Patient's Home Zip/Postal Code</i> is reported
0440	1	Single Entry Max exceeded



## Demographics TR1.13 – Alternate Home Residence

### Description

Documentation of the type of patient without a home ZIP/postal code.

### Element Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

### Additional Information

Only reported when *Patient’s Home ZIP/Postal Code* is “Not Applicable.”

Report all that apply.

Homeless is defined as a person who lacks housing and includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.

Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.

Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country to accept seasonal employment in the same or different country.

The null value “Not Applicable” is reported if *Patient’s Home ZIP/Postal Code* is reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Element cannot be blank
0503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
0540	1	Multiple Entry Max exceeded



## Demographics TR1.7 – Date of Birth

### Description

The patient’s date of birth.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

If *Date of Birth* is “Not Known/Not Recorded,” report *Age* and *Age Units*.

If *Date of Birth* is the same as the *Injury Incident Date*, then the *Age* and *Age Units* data elements must be reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
0601	1	Invalid value
0602	2	Date out of range
0603	2	Element cannot be blank
0612	2	Date of Birth + 120 years must be less than <i>Injury Incident Date</i>
0613	2	Element cannot be “Not Applicable”
0640	1	Single Entry Max exceeded
0650	1	Date cannot be later than upload



## Demographics TR1.12 – Age

### Description

The patient’s age at the time of injury (best approximation).

### Element Values

Relevant value for data element

### Additional Information

Must also report *Age Units*.

Auto calculated unless *Date of Birth* is unknown or is the same as date of ED Arrival.

Report *Age* and *Age Units* if *Date of Birth* is reported as “Not Known/Not Recorded.”

Report *Age* and *Age Units* if *Date of Birth* is reported as the same as *ED/Hospital Arrival Date*.

The null value “Not Applicable” is reported if *Date of Birth* is reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0-120
0703	2	Element cannot be blank
0705	3	Age is greater than expected for the <i>Age Units</i> specified. Age must not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0708	2	Element must be “Not Known/Not Recorded” when must is “Not Known/Not Recorded”
0709	2	Element must be and can only be “Not Applicable” if <i>Date of Birth</i> is reported unless <i>Date of Birth</i> is same as <i>ED/Hospital Arrival Date</i>
0740	1	Single Entry Max exceeded



## Demographics TR1.14 – Age Units

### Description

The units used to report the patient’s age.

### Element Values

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

### Additional Information

Must also report *Age*.

*Age Units* is either auto-populated using the date of birth and the incident injury date or is manually entered when either the *Date of Birth* is unknown, or the patient arrives on the first day of life.

Report *Age Units* and *Age* if *Date of Birth* is “Not Known/Not Recorded.”

Report *Age Unit* and *Age* if *Date of Birth* is the same as the *ED/Hospital Arrival Date*.

The null value “Not Applicable” is reported if *Date of Birth* is reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Element cannot be blank
0806	2	Element must be “Not Known/Not Recorded” when <i>Age</i> is “Not Known/Not Recorded”
0810	2	Element must be and can only be “Not Applicable” if <i>Age</i> is “Not Applicable”
0840	1	Single Entry Max exceeded



## Demographics TR1.16 – Race

### Description

The patient’s race.

### Element Values

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

### Additional Information

Report all that apply.

Patient race should be based upon self-report or identified by a family member.

Based on the 2010 US Census Bureau.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
0901	1	Value is not a valid menu option
0902	2	Element cannot be blank
0903	2	Element must be “Not Applicable” (excluding Canadian hospitals)
0905	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
0950	1	Multiple Entry Max exceeded



## Demographics TR1.17 – Ethnicity

### Description

The patient’s ethnicity.

### Element Values

1. Hispanic or Latino
2. Not Hispanic or Latino

### Additional Information

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1001	1	Value is not a valid menu option
1002	2	Element cannot be blank
1003	2	Element cannot be “Not Applicable” (excluding Canadian hospitals)
1040	1	Single Entry Max exceeded



## Demographics TR1.156 – Sex Assigned at Birth

### Description

The patient's sex assigned at birth.

### Element Values

1. Male
2. Female
3. Intersex

### Additional Information

Also referred to as birth sex, natal sex, and biological sex.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1101	1	Value is not a valid menu option
1102	2	Element cannot be blank
1103	2	Element cannot be "Not Applicable"
1140	1	Single Entry Max exceeded



## Demographics TR1.51 - Gender

### Description

The patient's gender identity.

### Element Values

1. Man
2. Woman
3. Non-binary, genderqueer, gender nonconforming
4. Non-disclosed

### Additional Information

Patient gender should be based upon self-report or identified by a family member.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1111	1	Value is not a valid menu option
1112	2	Element cannot be blank
1113	2	Element cannot be "Not Applicable"
1140	1	Single Entry Max exceeded



## Demographics TR1.55 – Gender-Affirming Hormone Therapy

### Description

Is the patient currently (i.e., within the past 30 days) taking hormone therapy?

EXCLUDE: Patients who undergo hormone therapy for other medical reasons.

### Element Values

1. Yes
2. No
3. Non-disclosed

### Additional Information

- Gender affirming hormone therapy includes but is not limited to estrogen, antiandrogens, and testosterone.
- If unclear if medication was for gender-affirming hormone therapy, then consult TMD or relevant physician/physician extender.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1331	1	Value is not a valid menu option
1332	2	Element cannot be blank
13340	1	Single Entry Max exceeded

## NTDS Injury Information



## Injury TR5.1 – Injury Incident Date

### Description

The date the injury occurred.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

Direct entry allows for use of the calendar function, typing YYYY-MM-DD, or MMDDYYYY.

Estimated injury date must be based on patient, witness, family, or health care provider report. Other proxy measures (e.g., 911 call times) must not be reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
1201	1	Date is not valid
1202	1	Date out of range
1203	2	Element cannot be blank
1204	2	<i>Injury Incident Date</i> is earlier than <i>Date of Birth</i>
1211	2	Element cannot be “Not Applicable”
1212	3	<i>Incident Injury Date</i> is greater than 14 days earlier than the <i>ED/Hospital Arrival Date</i>
1213	1	Date cannot be later than upload date
1240	1	Single Entry Max exceeded



## Injury TR5.18 – Injury Incident Time

### Description

The time the injury occurred.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM Military time.

Estimated injury time must be based on patient, witness, family, or health care provider report. Other proxy measures (e.g., for example, 911 call times) must not be reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Element cannot be blank
1310	2	Element cannot be “Not Applicable”
1340	1	Single Entry Max exceeded



## Injury TR2.10 – Work Related

### Description

Indication of whether the injury occurred during paid employment.

### Element Values

1. Yes
2. No

### Additional Information

If work-related, Patient's Occupational Industry and Patient's Occupation must be reported.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1401	1	Value is not a valid menu option
1402	2	Element cannot be blank
1407	2	Element cannot be "Not Applicable"
1440	1	Single Entry Max exceeded



## Injury TR2.6 – Patient’s Occupational Industry

### Description

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

### Element Values

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

### Additional Information

If work-related, *Patient’s Occupation* must be reported.

The null value “Not Applicable” is reported if *Work-Related* is Element Value “2. No.”

Based upon US Bureau of Labor Statistics Industry Classification.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Element cannot be blank
1505	2	If <i>Work-Related</i> is “1. Yes,” <i>Patient’s Occupational Industry</i> cannot be “Not Applicable”
1506	2	“Not Applicable” must be reported if <i>Work-Related</i> is “2. No”
1540	1	Single Entry Max exceeded

## **PATIENT'S OCCUPATIONAL INDUSTRY:**

The occupational industry associated with the patient's work environment as defined by the US Bureau of Labor Statistics Industry Classification.

### **Field Value Descriptions:**

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

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

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

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

This sector comprises two main types of retailers:

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

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

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

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

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

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

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

**Natural Resources and Mining** -The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations,

beneficiating (for example, crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.

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

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

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

**Leisure and Hospitality** -The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.

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



## Injury TR2.11 – Patient’s Occupation

### Description

The occupation of the patient.

### Element Values

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

### Additional Information

Only reported if injury is work-related.

If work-related, *Patient’s Occupational Industry* must also be reported.

The null value “Not Applicable” is reported if *Work-Related* is Element Value “2. No.”

Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1601	1	Value is not a valid menu option
1604	2	Element cannot be blank
1605	2	If <i>Work-Related</i> is "1. Yes," <i>Patient's Occupation</i> cannot be "Not Applicable"
1606	2	"Not Applicable" must be reported if <i>Work-Related</i> is "2. No"
1640	1	Single Entry Max exceeded



## Injury TR200.3, TR200.3.1 – ICD-10 Primary External Cause Code; Additional External Cause Code

### Description

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

### Element Values

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

### Additional Information

The primary external cause code should describe the main reason a patient is admitted to the hospital. External cause codes are used to auto-generate two calculated fields: Trauma type (Blunt, Penetrating, Burn) and intentionality (Based upon CDC Matrix).

ICD-10-CM or ICD-10 CA codes are accepted for ICD-10 Additional External Cause Code.

Activity codes are not reported under the NTDS.

ImageTrend® does not have separate elements for Primary and Secondary External cause codes. Primary cause code must be entered first in this field. and secondary codes should be entered into this field.

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

External cause codes for child and adult abuse take priority over all other external cause codes.

External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.

External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.

External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.

The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

### Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
8902	2	Element cannot be blank
8904	2	Must not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD- 10 CM only)
8905	2	ICD-10 External Cause Code must not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)
8907	2	Element cannot be “Not Applicable”
8908	1	Cannot be Y62.X-Y69.X
8940	1	Single Entry Max exceeded
9101	1	E-code is not a valid ICD-10-CM code (ICD-10-CM only)
9102	3	Additional External Cause Code ICD-10 must not be equal to Primary External
9103	2	Element cannot be blank
9104	1	E-code is not a valid ICD-10-CA code (ICD-10 CA only)
9105	2	ICD-10-CM T74 and T76 codes cannot be submitted as Additional External Cause Codes
9106	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any value
9140	1	Multiple Entry Max exceeded



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

### Description

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

### Element Values

Relevant ICD-10-CM or ICD-10 CA codes value for injury event

### Additional Information

Only ICD-10-CM or ICD-10 CA codes are accepted.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
9001	1	Invalid value (ICD-10 CM only)
9002	2	Element cannot be blank
9003	3	Place of Injury code must be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I, O] or 0-9) (ICD-10 CM only)
9004	1	Invalid value (ICD-10 CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)
9006	2	Element cannot be “Not Applicable”
9040	1	Single Entry Max exceeded



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

### Description

The ZIP/Postal code of the incident location.

### Element Values

Relevant value for the data element

### Additional Information

Can be stored as a 5 of 9-Digit code (XXXXX-XXXX) for US and Canada or can be stored in the postal code format of the applicable country.

If *Incident Location ZIP/Postal Code* is reported, report *Incident Country*.

If “Not Known/Not Recorded,” report *Incident Country*, *Incident State* (US Only), *Incident County* (US Only) and *Incident City* (US Only).

May require adherence to HIPAA regulations.

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Element cannot be blank
2006	2	Element cannot be “Not Applicable”
2040	1	Single Entry Max exceeded



## Injury TR5.11 – Incident Country

### Description

The country where the incident occurred.

### Element Values

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

### Additional Information

Values are two-character FIPS codes representing the country (for example, US).

If *Incident Country* is not US, then the null value “Not Applicable” is reported for *Incident State*, *Incident County*, and *Incident City*.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
2101	1	Invalid value
2102	2	Element cannot be blank
2104	2	Element cannot be “Not Applicable”
2015	2	Element cannot be “Not Known/Not Recorded” when <i>Incident Location ZIP/Postal Code</i> is any response other than not “Not Known/Not Recorded”
2140	1	Single Entry Max exceeded



## Injury TR5.7 – Incident State

### Description

The state, territory, or province where the incident occurred.

### Element Values

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

### Additional Information

Only reported when *Incident Location ZIP/Postal Code* is “Not Known/Not Recorded,” and the country is the US.

The null value “Not Applicable” is reported if *Incident Location ZIP/Postal Code* is reported.

The null value “Not Applicable” is reported if *Incident Country* is not the US.

Used to calculate the FIPS code.

Element will default to Michigan when ZIP is “99999.”

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2201	1	Invalid value
2203	2	Element cannot be blank
2204	2	Element cannot be “Not Applicable” (Non-US hospitals)
2205	2	Element must be “Not Applicable” when <i>Incident Location ZIP/Postal Code</i> is reported
2240	1	Single Entry Max exceeded



## Injury TR5.9 – Incident County

### Description

The county or parish where the incident occurred.

### Element Values

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

### Additional Information

Only reported when *Incident Location ZIP/Postal Code* is “Not Known/Not Recorded” and country is the US.

The null value “Not Applicable” is reported if *Incident Location ZIP/Postal Code* is reported.

The null value “Not Applicable” is reported if *Incident Country* is not the US.

Used to calculate FIPS code.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
2301	1	Invalid value (US only)
2303	2	Element cannot be blank
2304	2	Element cannot be “Not Applicable” (Non-US hospitals)
2305	2	Element must be “Not Applicable” when <i>Incident Location ZIP/Postal Code</i> is reported
2340	1	Single Entry Max exceeded



## Injury TR5.10 – Incident City

### Description

The city or township where the incident occurred.

### Element Values

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

### Additional Information

Only reported when *Incident Location ZIP/Postal Code* is “Not Known/Not Recorded,” and country is the US.

If incident location resides outside of formal city boundaries, report nearest city/town.

The null value “Not Applicable” is reported if *Incident Location ZIP/Postal Code* is reported.

The null value “Not Applicable” is reported if *Incident Country* is not the US.

Used to calculate the FIPS code.

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2401	1	Invalid value
2403	2	Element cannot be blank
2404	2	Element cannot be “Not Applicable” (Non-US hospitals)
2405	2	Element must be “Not Applicable” when <i>Incident Location ZIP/Postal Code</i> is reported
2440	1	Single Entry Max exceeded



## Injury TR29.94, TR29.32, TR29.31 - Protective Devices *et al.*

### Description

*Protective devices*: protective devices (safety equipment) in use or worn by the patient at the time of the injury. *Airbag deployment*: indication of airbag deployment during a motor vehicle crash.

*Child specific restraints*: protective child restraint devices used by patient at the time of injury.

### Element Values & Data Element

#### TR29.24: Protective Devices

- |  |  |
|--|--|
| 1. None  | 8. Airbag Present                              |
| 2. Lap Belt                                      | 9. Protective Clothing (example: padded pants) |
| 3. Personal Flotation Device                     | 10. Shoulder Belt                              |
| 4. Protective Non-Clothing Gear (ex: shin guard) | 11. Other                                      |
| 5. Eye Protection                                |  |
| 6. Child Restraint (infant/child, booster seat)  |  |
| 7. Helmet (any style)                            |  |

#### TR29.32: Airbag Deployment

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

#### TR29.31: Child Specific Restraint

1. Child Car Seat forward-facing
2. Infant Car Seat rear-facing
3. Child Booster Seat

### Additional Information

Report all that apply.

Evidence of the use of safety equipment may be reported or observed.

If Element Value “6. Child Care Restraint (booster seat or child car seat)” is reported, report *Child Specific Restraint*.

If Element Value “8. Airbag Present” is reported, report *Airbag Deployment*.

Lap belt should be reported to include those patients that are restrained but not further specified.

If the documentation indicates “3-point restraint,” report Element Value “3. Lap Belt and 11. Shoulder Belt.”

If documented that a “Child Restraint (booster seat or childcare seat)” was used or worn, but not properly fastened, either on the child or in the car, report Element Value “1. None.”

Report Element Value “1. Airbag Deployed Front” for patients with documented airbag deployment but are not further specified.

Report the null value “Not Applicable” if Element Value “8. Airbag Present” is NOT reported for Protective Devices.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Element cannot be blank
2507	2	Element cannot be “Not Applicable”
2508	2	Element cannot be “Not Known/Not Recorded” or ”1. None” along with element values 2, 3, 4, 5, 6, 7, 8, 9, 10 and/or 11.
2550	1	Multiple Entry Max exceeded
2601	1	Value is not a valid menu option
2603	2	Element cannot be blank
2604	2	Element cannot be “Not Applicable” when <i>Protective Devices</i> is 7: Child Restraint
2640	1	Single Entry Max exceeded
2701	1	Value is not a valid menu option
2703	2	Element cannot be blank
2704	2	Element cannot be “Not Applicable” when <i>Protective Devices</i> is 9: Airbag Present
2705	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2750	1	Multiple Entry Max exceeded

## NTDS Pre-Hospital Information



## Pre-Hospital TR8.8 – Transport Mode

### Description

The mode of transport delivering the patient to your hospital.

### Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing Ambulance
4. Private/Public vehicle/Walk-in
5. Police
6. Other

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3401	1	Value is not a valid menu option
3402	2	Element cannot be blank
3404	2	Element cannot be “Not Applicable”
3440	1	Single Entry Max exceeded



## Pre-Hospital TR8.11 – Other Transport Mode

### Description

All other modes of transport used during the patient care event (prior to arrival at your hospital) except the mode delivering the patient to your hospital.

### Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing Ambulance
4. Private/Public vehicle/Walk-in
5. Police
6. Other

### Additional Information

Report all that apply (maximum of 5).

Report Element Value “6. Other” for unspecified modes of transport.

The null value “Not Applicable” is reported to indicate that a patient had a single mode of transport.

### Data Source Hierarchy Guide

EMS Run Report

Transfer Facility Records

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3501	1	Value is not a valid menu option
3502	2	Element cannot be blank
3503	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
3550	1	Multiple Entry Max exceeded



## Pre-Hospital TR7.7 – EMS Patient Care Report Universally Unique Identifier (UUID)

### Description

The universally unique identifier (UUID) of the patient care report (PCR) of each emergency service (EMS) unit treating the patient from the time of injury to arrival at your ED/hospital.

### Element Values

-Relevant value for data element.

-Must be represented in canonical form, matching the following regular expression.

`[a-fA-F0-9]{8}-[a-fA-F0-9]{4}-[1-5][a-fA-fA-F0-9]{3}-[89abAB][a-fA-F0-9]{3}-[a-fA-F0-9]{12}`

### Additional Information

Report all that apply (maximum 20).

A sample *UUID* is: e48cd734-01cc-4da4-ae6a-915b0b1290f6.

Automated abstraction technology provided by registry product providers/vendors must be used for this data element in the absence of automated technology, report the null value “Not Known/Not Recorded.” Consistent with NEMESIS v3.5.0.

The null value "Not Known/Not Recorded" must be reported if the *UUID* is not documented on the EMS Run Report. The *UUID* will not be documented on EMS Run Reports in NEMESIS versions lower than 3.5.0.

In collaboration with NEMESIS, the ACS will communicate when NEMESIS 3.5.0 is widely implemented. The null value “Not Applicable” must be reported if the patient was never transported via EMS prior to arrival at your hospital.

Assigned by any applicable transporting EMS agency in accordance with the IETF RFC 4122 standard.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
90000	1	Invalid value
90001	2	Element cannot be blank
90002	2	Element cannot be “Not Applicable/Not Known/Not Recorded” along with any other value
9940	1	Multiple Entry Max exceeded



## Pre-Hospital TR25.54 – Inter-Facility Transfer

### Description

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

#### INCLUDE:

Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center.

#### EXCLUDE:

Patients transferred from a private doctor's office or stand-alone ambulatory surgery center.

### Element Values

1. Yes
2. No

### Additional Information

Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" [https://www.cms.gov/Research-Statistics-Data-and-systems/Research/ResearchGenInfo/Downloads/DataNav\\_Glossary\\_Alpha.pdf](https://www.cms.gov/Research-Statistics-Data-and-systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf) (accessed Jan 15, 2019).

Must complete TR16.22 *Arrived From* and TR8.8 *Mode of Arrival* to populate this field.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4401	2	Element cannot be blank
4402	1	Value is not a valid menu option
4405	2	Element cannot be "Not Applicable"
4440	1	Single Entry Max exceeded



## Pre-Hospital TR46.11 – Pre-Hospital Cardiac Arrest

### Description

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

### Element Values

1. Yes
2. No

### Additional Information

A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.

The event must have occurred outside of the index hospital.

Pre-hospital cardiac arrest could occur at a transferring institution.

Any component of basic and/or advanced cardiac life support must have been initiated.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
9701	1	Value is not a valid menu option
9702	2	Element cannot be blank
9703	2	Element cannot be “Not Applicable”
9740	1	Single Entry Max exceeded



## Pre-Hospital TR60.1 – Intubation Prior To Arrival

### Description

The patient is intubated with a definitive airway due to this injury prior to arrival at your hospital.

**INCLUDE:** Definitive airways placed below the vocal cords (e.g., endotracheal tube (ET), tracheostomy, cricothyroidotomy).

**EXCLUDE:** Airways not placed below the vocal cords (e.g., Combitube, KING, laryngeal mask airway (LMA), iGel).

### Element Values

1. Yes
2. No

### Additional Information

If the Element Value “1. Yes” is reported, report Intubation Location.

The null value “Not Applicable” is reported for patients who had an established airway prior to this injury event (e.g., chronic ventilator dependence).

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
2661	1	Value is not a valid menu option
2602	2	Element cannot be blank
26640	1	Single Entry Max exceeded

## Pre-Hospital TR60.2 – Intubation Location

### Description



The location the patient was intubated at prior to hospital arrival.

### Element Values

1. Out of hospital intubation
2. Transferring facility

### Additional Information

Only reported if Intubation Prior to Arrival is Element Value “1. Yes.”

The null value “Not Applicable” is reported if Intubation Prior to Arrival is reported as Element Value “2. No.”

The null value “Not Known/Not Recorded” is reported if Intubation Prior to Arrival is reported as “Not Known/Not Recorded.”

Element Value “1. Out of Hospital Intubation” includes intubations performed in the field, during transport to the hospital, or during an inter-facility transport.

If multiple intubations occurred report the location of the first intubation.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2771	1	Value is not a valid menu option
2702	2	Element cannot be blank
2773	2	Element must be and can only be “Not Applicable” when Intubation Prior to Arrival is “Not Applicable” or Element Value “2. No”
2774	2	Element must be “Not Known/Not Recorded” when Intubation Prior to Arrival is “Not Known/Nor Recorded”
2740	1	Single Entry Max exceeded

## **NTDS Emergency Department Information**



## ED/TTA TR17.21.1 – Highest Activation

### Description

Patient received the highest level of trauma activation at your hospital.

#### INCLUDE:

Patients who receive the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.

Patients who received the highest level of trauma activation initiated by EMS or by ED personnel at your hospital and were downgraded after arrival to your center.

Patients who received a lower level of trauma activation initiated by EMS or ED personnel at your hospital and were upgraded to the highest level of trauma activation.

#### EXCLUDE:

Patients who received the highest level of trauma activation after ED discharge.

### Element Values

1. Yes
2. No

### Additional Information

The highest level of activation is defined by your hospital's criteria.

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. History & Physical
4. Physician Notes/Flow Sheet
5. Discharge Summary

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
14201	1	Value is not a valid menu option
14202	2	Element cannot be blank
14203	2	Element cannot be Not Applicable
14240	1	Single Entry Max exceeded



## ED/TTA TR17.15.1 – Trauma Surgeon Arrival Date

### Description

The date the first trauma surgeon arrived at the patient’s bedside.

### Element Values

Relevant value for data element

### Additional Information

Direct entry allows for use of the calendar function, typing YYYY-MM-DD, or MMDDYYYY.

Limited reporting to the 24 hours after ED/hospital arrival.

The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.

The null value “Not Applicable” is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.

The null value “Not Applicable” is reported if Element Value “2. No” is reported for *Highest Activation*.

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. History & Physical
3. Physician Notes/Flow Sheet
4. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
14301	1	Date is not valid
14302	1	Date is out of range
14303	2	Element cannot be blank
14304	3	<i>Trauma Surgeon Arrival Date</i> is earlier than <i>Injury Incident Date</i>
14340	1	Single Entry Max exceeded
14450	1	Date cannot be later than upload date



## ED/TTA TR17.15.2 – Trauma Surgeon Arrival Time

### Description

The time the first trauma surgeon arrived at the patient’s bedside.

### Element Values

Relevant value for data element

### Additional Information

Collected as HH:MM Military time.

Limited reporting to the 24 hours after ED/hospital arrival.

The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.

The null value “Not Applicable” is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.

The null value “Not Applicable” is reported if Element Value “2. No” is reported for *Highest Activation*.

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. History & Physical
3. Physician Notes
4. Nursing Notes

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
14401	1	Time is not valid
14402	1	Time is out of range
14403	2	Element cannot be blank
14404	3	<i>Trauma Surgeon Arrival Time</i> is earlier than <i>Injury Incident Time</i>
14405	2	Element must be and can only be “Not Applicable” when Trauma Surgeon Arrival Date is “Not Applicable”
14406	2	Element must be “Not Known/Not Recorded” when Trauma Surgeon Arrival Date is “Not Known/Not Recorded”
14440	1	Single Entry Max exceeded



## ED/TTA TR18.55 – ED/Hospital Arrival Date

### Description

The date the patient arrived at the ED/Hospital.

### Element Values

Relevant value for data element

### Additional Information

If the patient was brought to the ED, report the date patient arrived at the ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
4501	1	Date is not valid
4502	1	Date is out of range
4503	2	Element cannot be blank
4505	2	Element cannot be “Not Known/Not Recorded”
4511	3	<i>ED/Hospital Arrival Date</i> is earlier than <i>Date of Birth</i>
4513	3	<i>ED/Hospital Arrival Date</i> occurs more than 14 days after <i>Injury Incident Date</i>
4515	2	Element cannot be “Not Applicable”
4516	3	<i>ED/Hospital Arrival Date</i> is earlier than the <i>Injury Incident Date</i>
4540	1	Single Entry Max exceeded
4550	1	Date cannot be later than upload date



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

### Description

The time the patient arrived at the ED/Hospital.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM military time.

If the patient was brought to the ED, report the time patient arrived at the ED. If the patient was directly admitted to the hospital, report the time the patient was admitted to the hospital.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time is out of range
4603	2	Element cannot be blank
4609	2	Element cannot be “Not Applicable”
4610	3	<i>ED/Hospital Arrival Time</i> is earlier than <i>Injury Incident Time</i>
4640	1	Single Entry Max exceeded



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

### Description

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

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. Nursing Notes/Flow Sheet
3. Physician Notes
4. History and Physical

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4701	1	Invalid Value
4702	2	Element cannot be blank
4704	3	The value is above 220
4705	2	Element cannot be “Not Applicable”
4706	2	The value submitted falls outside the valid range of 0 - 380
4707	3	The value is below 30
4740	1	Single Entry Max exceeded
-	-	If no initial vital signs were obtained or none recorded, map to not known/not recorded



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

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Please note the first recorded hospital vitals do not need to be from the same assessment. Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who received CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4801	1	Invalid Value
4802	2	Element cannot be blank
4804	3	The value is above 220
4805	2	Element cannot be “Not Applicable”
4806	2	The value submitted falls outside the valid range of 0 – 300
4807	3	The value is below 30
4840	1	Single Entry Max exceeded
-	-	If no initial vital signs were obtained or none recorded, map to not known/not recorded



## Initial Assessment TR18.30 – Initial ED/Hospital Temperature

### Description

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

### Element Values

Relevant value for data element

Units:

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

### Additional Information

Please note the first recorded/hospital vitals do not need to be from the same assessment.

Entry in one unit will auto-populate the other.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4901	1	Invalid Value
4902	2	Element cannot be blank
4903	3	The value is above 40.0
4904	2	Element cannot be “Not Applicable”
4905	2	The value submitted falls outside the valid range of 10.0 – 45.0
4906	3	The value is below 25.0
4940	1	Single Entry Max exceeded
-	-	If no initial vital signs were obtained or none recorded, map to not known/not recorded



## Initial Assessment TR18.7 – Initial ED/Hospital Respiratory Rate

### Description

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

### Element Values

Relevant value for data element

### Additional Information

If reported, report Initial ED/Hospital Respiratory Assistance.

Please note the first recorded/hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5001	1	Invalid Value
5002	2	Element cannot be blank
5005	2	The value submitted falls outside the valid range 0 – 100
5006	2	Element cannot be “Not Applicable”
5007	3	The value is below 5
5008	3	The value is above 75
5040	1	Single Entry Max exceeded
-	-	If no initial vital signs were obtained or none recorded, map to not known/not recorded



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

### Description

Determination of respiratory assistance associated with the *Initial ED/Hospital Respiratory Rate* within 30 minutes of ED/hospital arrival.

### Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

### Additional Information

Only reported if Initial ED/Hospital Respiratory Rate is reported.

Respiratory Assistance is defined as mechanical and/or external support of respiration.

The null value “Not Applicable” is reported if Initial ED/Hospital Respiratory rate is “Not Known/Not Recorded.”

Please note the first recorded hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5101	1	Value is not a valid menu option
5102	2	Element cannot be blank
5103	2	Element must be “Not Applicable” when <i>Initial ED/Hospital Respiratory Rate</i> is “Not Known/Not Recorded”
5140	1	Single Entry Max exceeded



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

### Description

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

### Element Values

Relevant value for data element

### Additional Information

If reported, report Initial ED/Hospital Supplemental Oxygen.

Please note the first recorded/hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5201	1	Invalid value
5202	2	Element cannot be blank
5205	2	Element cannot be “Not Applicable”
5206	2	The value submitted falls outside the valid range of 0 - 100
5207	3	The value is below 40
5240	1	Single Entry Max exceeded
-	-	If no initial vital signs were obtained or none recorded, map to not known/not recorded



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

### Description

Determination of the presence of supplemental oxygen during assessment of *Initial ED/Hospital Oxygen Saturation* level within 30 minutes or less of ED/hospital arrival.

### Element Values

1. No supplemental oxygen
2. Supplemental oxygen

### Additional Information

The null value “Not Applicable” is reported if the *Initial ED/Hospital Oxygen Saturation* is “Not Known/Not Recorded.”

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5301	1	Value is not a valid menu option
5303	2	Element cannot be blank
5304	2	Element cannot be “Not Applicable” when <i>Initial ED/Hospital Oxygen Saturation</i> is “Not Known/Not Recorded”
5340	1	Single Entry Max exceeded



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

### Description

First recorded Glasgow Coma Scale (GCS) Eye in the ED/hospital within 30 minutes of ED/hospital arrival.

### Element 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

### Additional Information

If a patient does not have a numeric GCS documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported (for example, the chart indicates "patient's pupils are PERRL," a GCS Eye of 4 may be reported, IF there is no other contradicting documentation).

The null value "Not Known/Not Recorded" is reported if *Initial ED/Hospital GCS-40 Eye* is documented.

The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS – Eye* was not measured within 30 minutes of ED/hospital arrival.

Please note the first recorded hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Element cannot be blank
5404	2	Element cannot be "Not Applicable"
5405	2	Element must be "Not Known/Not Recorded" when <i>Initial ED/Hospital GCS – 40 Eye</i> is reported
5440	1	Single Entry Max exceeded



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

### Description

First recorded Glasgow Coma Scale (GCS) Verbal within 30 minutes of ED/hospital arrival.

### Element Values

#### Adult TR18.15.2:

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

#### Pediatric ( $\leq 2$ years) TR18.15.0:

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

### Additional Information

If patient is intubated, then the GCS Verbal is equal to 1.

If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (For example, the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be reported, IF there is no other contradicting documentation).

The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS-40 Verbal* is reported. The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS – Verbal* was not measured within 30 minutes of ED/hospital arrival. Please note that first recorded hospital vitals do not need to be from the same assessment. Elements automatically switch to Pediatrics for patients  $\leq 2$  years.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Element cannot be blank
5504	2	Element cannot be "Not Applicable"
5505	2	Element must be "Not Known/Not Recorded" when <i>Initial ED/Hospital GCS – 40 Verbal</i> is reported
5540	1	Single Entry Max exceeded



## Initial Assessment TR18.16.2 & TR18.16.0 – Initial ED/Hospital GCS - Motor Description

First recorded Glasgow Coma Scale (GCS) Motor within 30 minutes of ED/hospital arrival.

### Element Values

#### Adult TR18.16.2:

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

#### Pediatric (≤ 2 years) TR18.16.0:

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

### Additional Information

If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported. (For example, the chart indicates: “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation).

The null value “Not Known/Not Recorded” is reported if *Initial ED/Hospital GCS-40 Motor* is reported.

The null value “Not Known/Not Recorded” is reported if the patient’s *Initial ED/Hospital GCS – Motor* was not measured within 30 minutes of ED/hospital arrival.

Please note that the first recorded/hospital vitals do not need to be from the same assessment.

Elements automatically switch to Pediatrics for patients ≤2 years.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Element cannot be blank
5604	2	Element cannot be “Not Applicable”
5605	2	Element must be “Not Known/Not Recorded” when <i>Initial ED/Hospital GCS – 40 Motor</i> is reported
5640	1	Single Entry Max exceeded



## Initial Assessment TR18.22 – Initial ED/Hospital GCS – Total

### Description

First recorded Glasgow Coma Scale (GCS) Total Score within 30 minutes of ED/hospital arrival.

### Element Values

Relevant value for data element

### Additional Information

If a patient does not have a numeric GCS score recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," report this as GCS score of 15 IF there is no other contradicting documentation.

The null value “Not Known/Not Recorded” is reported if *Initial ED/Hospital GCS-40* is reported.

The null value “Not Known/Not Recorded” is reported if *Initial ED/Hospital GCS – Eye*, *Initial ED/Hospital GCS – Motor*, *Initial ED/Hospital GCS – Verbal* was not measured within 30 minutes of ED/Hospital arrival.

Please note that the first recorded/hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5701	1	GCS Total is outside the valid range of 3 - 15
5703	3	<i>Initial ED/Hospital GCS- Total</i> does not equal the sum of <i>Initial ED/Hospital GCS – Eye</i> , <i>Initial ED/Hospital GCS – Verbal</i> , and <i>Initial ED/Hospital GCS – Motor</i> , unless any of these values are “Not Known/Not Recorded”
5705	2	Element cannot be blank
5706	2	Element cannot be “Not Applicable”
5707	2	Element must be “Not Known/Not Recorded” when <i>Initial ED/Hospital GCS – 40 Eye</i> , <i>Initial ED/Hospital GCS – 40 Verbal</i> , or <i>Initial ED/Hospital GCS – 40 Motor</i> are reported.
5740	1	Single Entry Max exceeded



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

### Description

Factors potentially affecting the first assessment of GCS within 30 minutes of ED/hospital arrival.

### Element Values

1. Patient chemically sedated or paralyzed
2. Obstruction to the patient’s eye
3. Patient intubated
4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye

### Additional Information

Report all that apply.

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 (such as, ETOH, prescriptions, etc.).

Element Value “1. Patient chemically sedated or paralyzed” is reported if an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible.

Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, etc. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.

Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.

Please note that first recorded/hospital vitals do not need to be from the same assessment.

The null value “Not Known/Not Recorded” is reported if *Initial ED/Hospital GCS-40* is reported.

The null value “Not Known/Not Recorded” is reported if the *Initial ED/Hospital GCS Assessment Qualifiers* are not documented within 30 minutes of ED/Hospital arrival.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5801	1	Value is not a valid menu option
5802	2	Element cannot be blank
5803	2	Element cannot be “Not Applicable”
5804	2	Element must be “Not Known/Not Recorded” when <i>Initial ED/Hospital GCS – 40 Eye</i> , <i>Initial ED/Hospital GCS – 40 verbal</i> , or <i>Initial ED/Hospital GCS – 40 Motor</i> are reported.

5805	2	Element cannot be “Not Known/Not Recorded” along with any other value
5806	2	The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS – Eyes, Verbal, Motor are reported as “Not Known/Not Recorded”
5850	1	Multiple Entry Max exceeded



## Initial Assessment TR18.40.2 & TR18.40.0 – Initial ED/Hospital GCS – 40 Eye

### Description

First recorded Glasgow Coma Scale 40 (GCS-40) Eye score in the ED/hospital within 30 minutes of ED/hospital arrival.

### Element Values

#### Adults TR18.40.2:

- |                |                 |
|----------------|-----------------|
| 1. None        | 4. Spontaneous  |
| 2. To Pressure | 0. Not Testable |
| 3. To Sound    |                 |

#### Pediatric ≤ 5 Years TR18.40.2:

- |             |                 |
|-------------|-----------------|
| 1. None     | 4. Spontaneous  |
| 2. To Pain  | 0. Not Testable |
| 3. To Sound |                 |

### Additional Information

If a patient does not have a numeric GCS-40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be reported. (For example, the chart indicates: "patient's eyes open spontaneously," an GCS-40 Eye of 4 may be recorded, IF there is no other contradicting documentation).

Report Element Value "5. Not Testable" if unable to assess (for example, swelling to the eye(s)).

The null value "Not Known/Not Recorded" is reported if *Initial ED/Hospital GCS – Eye* is reported.

The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS-40 Eye* was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
15301	1	Value is not a valid menu option
15303	2	Element cannot be blank
15304	2	Element cannot be "Not Applicable"
15305	2	Element must be "Not Known/Not Recorded" when <i>Initial ED/Hospital GCS – Eye</i> is reported
15340	1	Single Entry Max exceeded



## Initial Assessment TR18.41.2 & TR18.41.0 – Initial ED/Hospital GCS – 40 Verbal

### Description

First recorded Glasgow Coma Scale 40 (GCS-40) Verbal within 30 minutes of ED/hospital arrival.

### Element Values

#### Adults TR18.41.2:

- |           |                 |
|-----------|-----------------|
| 1. None   | 4. Confused     |
| 2. Sounds | 5. Oriented     |
| 3. Words  | 0. Not Testable |

#### Pediatric ≤ 5 Years TR18.41.0:

- |                 |                   |
|-----------------|-------------------|
| 1. None         | 4. Words          |
| 2. Cries        | 5. Talks normally |
| 3. Vocal Sounds | 0. Not Testable   |

### Additional Information

If a patient does not have a numeric GCS-40 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40 scale, the appropriate numeric score may be reported. (For example, the chart indicates: "patient's eyes open spontaneously," an GCS-40 Eye of 4 may be recorded, IF there is no other contradicting documentation).

Report Element Value “5. Not Testable” if unable to assess (for example, patient is intubated).

The null value “Not Known/Not Recorded” is reported if *Initial ED/Hospital GCS – Verbal* is reported.

The null value “Not Known/Not Recorded” is reported if the patient’s *Initial ED/Hospital GCS-40 Verbal* was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
15401	1	Value is not a valid menu option
15403	2	Element cannot be blank
15404	2	Element cannot be “Not Applicable”
15405	2	Element must be “Not Known/Not Recorded” when <i>Initial ED/Hospital GCS – Verbal</i> is reported
15440	1	Single Entry Max exceeded



## Initial Assessment TR18.42.2 & TR18.42.0 – Initial ED/Hospital GCS – 40 Motor

### Description

First recorded Glasgow Coma Scale 40 (GCS-40) Motor within 30 minutes or less of ED/hospital arrival.

### Element Values

#### Adults TR18.42.2:

- |                     |                   |
|---------------------|-------------------|
| 1. None             | 5. Localizing     |
| 2. Extension        | 6. Obeys Commands |
| 3. Abnormal Flexion | 0. Not Testable   |
| 4. Normal Flexion   |                   |

#### Pediatric ≤ 5 Years TR18.42.0:

- |                      |                   |
|----------------------|-------------------|
| 1. None              | 4. Localizes Pain |
| 2. Extension to Pain | 5. Obeys Commands |
| 3. Flexion to Pain   | 0. Not Testable   |

### Additional Information

If a patient does not have a numeric GCS-40 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be listed. (For example, the chart indicates: "patient opened mouth and stuck out tongue when asked" a GCS-40 Motor of 6 may be reported, IF there is no other contradicting documentation). Report Field Value "7. Not Testable" if unable to assess (for example, neuromuscular blockade). The null value "Not Known/Not Recorded" is reported if *Initial ED/Hospital GCS – Motor* is reported. The null value "Not Known/Not Recorded" is reported if the patient's *Initial ED/Hospital GCS-40 Motor* was not measured within 30 minutes or less of ED/hospital arrival.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
15501	1	Value is not a valid menu option
15503	2	Element cannot be blank
15504	2	Element cannot be "Not Applicable"
15505	2	Element must be "Not Known/Not Recorded" when <i>Initial ED/Hospital GCS – Motor</i> is reported
15506	2	If patient age is less than 5, Element Value 6 is not a valid menu option
15540	1	Single Entry Max exceeded



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

### Description

First recorded height after ED/hospital arrival.

### Element Values

Relevant value for data element for height.

Units:

Centimeters: TR1.6

Inches: TR1.6.1

### Additional Information

Can be recorded in centimeters or inches and will be converted and reported in centimeters for NTDS submission.

Entering a value into one unit will auto-populate the other.

May be based on family or self-report.

Report the null value “Not Known/Not Recorded” if the patient’s *Initial ED/Hospital Height* was not recorded prior to discharge.

Please note the first recorded/hospital vitals do not need to be from the same assessment.

This field is listed in NTDS under Initial ED/Hospital and some registry vendors may have it located within demographics.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Element cannot be blank
8503	3	The value is above 215
8504	2	Element cannot be “Not Applicable”
8505	2	The value submitted falls outside the valid range of 30 – 275
8506	3	The value is below 50
8540	1	Single Entry Max exceeded



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

### Description

First recorded weight within 24 hours of ED/hospital arrival.

### Element Values

Relevant value for data element for weight.

Units:

Kilograms

Pounds

### Additional Information

Can be recorded in kilograms or pounds, will be converted to kilograms for NTDS submission.

May be based on family or self-report.

Report the value “Not Known/Not Recorded” if the patient’s *Initial ED/Hospital Weight* was not measured within 24 hours of ED/hospital arrival.

Please note the first recorded/hospital vitals do not need to be from the same assessment.

This field is listed in NTDS under Initial ED/Hospital and some registry vendors may have it located within demographics.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Element cannot be blank
8603	3	The value is above 200
8604	2	Element cannot be “Not Applicable”
8605	2	The value submitted falls outside the valid range of 1 – 650
8606	3	The value is below 3
8640	1	Single Entry Max exceeded



## Initial Assessment TR18.91 – Drug Screen

### Description

First recorded positive drug screen results within 24 hours after first hospital encounter.

### Element Values

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

### Additional Information

Report all that apply.

Record positive drug screen results within 24 hours after the patient’s first hospital encounter, at either your facility or the transferring facility.

Report Element Value “14. None” for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event or for patients who were tested and had no positive results.

If multiple drugs are detected, only report drugs that were NOT administered at any facility (or setting) treating this patient event.

Selections are made in a picklist.

### Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Element cannot be blank
6013	2	Element cannot be “Not Applicable”
6014	2	Element must be “Not Known/Not Recorded” “14. None” or “15. Not tested” along with element values 1,2,3,4,5,6,7,8,9,10,11,12, and/or 13
6050	1	Multiple Entry Max exceeded



## Initial Assessment TR18.46– Alcohol Screen

### Description

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

### Element Values

1. Yes
2. No

### Additional Information

Alcohol screen may be administered at any facility, unit, or setting treating this patient event.

### Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5911	1	Value is not a valid menu option
5912	2	Element cannot be blank
5913	2	Element cannot be “Not Applicable”
5940	1	Single Entry Max exceeded



## Initial Assessment TR18.103 – Alcohol Screen Results

### Description

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

### Element Values

Relevant value for data elements

Units:

1. X.XX grams per deciliter (g/dl) – TR18.103

### Additional Information

Record BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.

Report the null value “Not Applicable” for those patients who were not tested.

### Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
5931	1	Invalid value
5932	2	Element cannot be blank
5933	2	Element must and can only be “Not Applicable” when <i>Alcohol Screen</i> is Element Value “2. No”
5934	1	Single Entry Max exceeded
5935	1	The value submitted falls outside the valid range of 0.0 – 1.5
5936	3	The value is above 0.4



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

### Description

The disposition unit the order was written for the patient to be discharged from the ED.

### Element Values

- |  |  |
|--|--|
| 1. Floor bed (general admission, non-specialty unit bed) | 7. Operating Room (hybrid OR)                                    |
| 2. Observation unit                                      | 8. Intensive Care Unit (ICU)                                     |
| 3. Telemetry/step-down unit (less acuity than ICU)       | 9. Home without services   |
| 4. Home with services                                    | 10. Left against medical advice                                  |
| 5. Deceased/Expired                                      | 11. Transferred to another hospital                              |
| 6. Other (jail, institutional care, mental health, etc.) | 12. Interventional radiology suite                               |
|  | 13. Hospice (e.g., hospice facility, hospice unit, home hospice) |

### Additional Information

If the patient was boarded in the ED, the disposition must be the location the patient was ordered to go when the ED workup was complete.

The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.

If *ED Discharge Disposition* is 4, 5, 6, 9, 10, 11, and 13 then *Hospital Discharge Date*, *Hospital Discharge Time*, and *Hospital Discharge Disposition* must be "Not Applicable."

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Element cannot be blank
6104	2	Element cannot be "Not Known/Not Recorded"
6140	1	Single Entry Max exceeded
6141	2	Element cannot be 4, 6, 9, 10 when <i>Interfacility Transfer</i> is "2. No"



## ED/TTA TR17.41– ED Discharge Date

### Description

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

### Element Values

Relevant value for data elements

### Additional Information

Reported as YYYY-MM-DD. Direct entry allows for use of the calendar function, typing YYYY-MM-DD, or MMDDYYYY.

The null value "Not Applicable" is reported if the patient was directly admitted to the hospital.

If *ED Discharge Disposition* is Element Value “5. Deceased/Expired,” then *ED Discharge Date* is the date of death as indicated on the patient’s death certificate.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Element cannot be blank
6307	2	<i>ED Discharge Date</i> cannot be earlier than <i>ED/Hospital Arrival Date</i>
6310	3	<i>ED Discharge Date</i> occurs more than 365 days after <i>ED/Hospital Arrival Date</i>
6311	2	Element must be and can only be “Not Applicable” when <i>ED Discharge Disposition</i> is “Not Applicable”
6312	3	<i>ED Discharge Date</i> is earlier than <i>Injury Incident Date</i>
6313	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Hospital Procedures Start Date</i>
6314	3	<i>Hospital Discharge Disposition</i> is “Not Applicable,” and <i>ED Discharge Date</i> cannot be earlier than <i>Cerebral Monitor Date</i>

6315	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Venous Thromboembolism Prophylaxis Date</i>
6316	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Angiography Date</i>
6317	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Surgery for Hemorrhage Control Date</i>
6318	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Withdrawal of Life Supporting Treatment Date</i>
6319	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” and <i>ED Discharge Date</i> cannot be earlier than <i>Antibiotic Therapy Date</i>
6340	1	Single Entry Max exceeded
6350	1	Date cannot be later than upload date



## ED/TTA TR17.42– ED Discharge Time

### Description

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

### Element Values

Relevant value for data elements

### Additional Information

Reported as HH:MM military time.

The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.

If *ED Discharge Disposition* is Element Value “5. Deceased/Expired,” then *ED Discharge Time* is the time of death as indicated on the patient’s death certificate.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Element cannot be blank
6407	2	<i>ED Discharge Time</i> cannot be earlier than <i>ED/Hospital Arrival Time</i>
6409	2	Element must and can only be “Not Applicable” when <i>ED Discharge Date</i> is “Not Applicable”
6410	3	Element must be “Not Known/Not Recorded” when <i>ED Discharge Date</i> is “Not Known/Not Recorded”
6411	3	<i>ED Discharge Time</i> is earlier than <i>Injury Incident Time</i>
6412	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Hospital Procedure Time</i>
6413	3	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Cerebral Monitor Time</i>
6414	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Venous Thromboembolism Prophylaxis Time</i>

6415	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Angiography Time</i>
6416	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Surgery for Hemorrhage Control Time</i>
6417	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Withdrawal of Life Supporting Treatment Time</i>
6418	2	If <i>Hospital Discharge Disposition</i> is “Not Applicable” then <i>ED Discharge Time</i> cannot be earlier than <i>Antibiotic Therapy Time</i>
6440	1	Single Entry Max exceeded



## ED/TTA TR18.205– Primary Trauma Service Type

### Description

The primary service type responsible for the care of this patient.

### Element Values

1. Adult
2. Pediatric

### Additional Information

The primary service type responsible for trauma evaluation and care of the patient.

This element will be used to determine which eligible Trauma Quality Program report (adult or pediatric) the patient will appear; report age criteria will still apply.

Adult trauma centers that do not have a separate pediatric service must report Element Value “1. Adult.”

Pediatric trauma centers that do not have a separate adult service must report Element Value “2. Pediatric.”

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. History & Physical
3. Discharge Summary

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
22501	1	Value is not a valid menu option
22502	2	Element cannot be blank
22540	1	Single Entry Max exceeded



## ED/TTA TR18.220 – Primary Medical Event

### Description

The patient experienced a documented primary medical event (must be one of these: stroke, myocardial infarction, cardiac arrest, intracranial bleeding, sepsis) that immediately preceded the traumatic injury.

### Element Values

1. Yes
2. No

### Additional Information

Element Value “1. Yes” is reported if the patient experienced a medical event immediately preceding the trauma.

The null value “Not Known/Not Recorded” is reported if it is unknown the primary medical event immediately preceded the traumatic injury.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
2551	1	Value is not a valid menu option
2552	2	Element cannot be blank
2503	2	Element cannot be “Not Applicable”
2540	1	Single Entry Max exceeded

**NTDS Procedures Information**



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

### Description

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDS.

### Element Values

Major and minor procedure ICD-10 PCS or ICD-10 CA procedure codes

The maximum number of procedures that may be reported for a patient is 200

### Additional Information

Only report procedures performed at your institution.

Report all procedures performed in the operating room.

Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.

Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, report only the first event. If there is no asterisk, report each event even if there is more than one.

Note that the hospital may report additional procedures.

Report the null value “Not Applicable” if the patient did not have procedures.

#### **Diagnostic and Therapeutic Imaging**

Computerized tomographic Head\*  
Computerized tomographic Chest\*  
Computerized tomographic Abdomen\*  
Computerized tomographic Pelvis\*  
Computerized tomographic C-Spine\*  
Computerized tomographic T-Spine\*  
Computerized tomographic L-Spine\*  
Doppler ultrasound of extremities \*  
Diagnostic ultrasound (includes FAST) \*  
Angioembolization  
Angiography  
IVC filter  
REBOA  
Diagnostic imaging interventions on the total body  
Plain radiography of whole body

#### **Musculoskeletal**

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

#### **Transfusion**

Transfusion of red cells\* (only report first 24 hours after hospital arrival)  
Transfusion of platelets\* (only report first 24 hours after hospital arrival)  
Transfusion of plasma\* (only report first 24 hours after hospital arrival)

#### **Gastrointestinal**

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

Plain radiography of whole skeleton  
Plain radiography of infant whole body

Percutaneous (endoscopic) gastrojejunoscopy

### **Cardiovascular**

Open cardiac massage  
CPR

### **Genitourinary**

Ureteric catheterization (such as, Ureteric stent)  
Suprapubic cystostomy

### **Respiratory**

Insertion of ET (exclude ET in the OR)\*  
Continuous mechanical ventilation\*  
Chest tube\*  
Bronchoscopy\*  
Tracheostomy

### **CNS**

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

## **Data Source Hierarchy Guide**

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

## **Associated Edit Checks (NTDS)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
8801	1	Invalid value (ICD-10 PCS only)
8803	2	Element cannot be blank
8804	2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
8805	1	Invalid value (ICD-10 CA only)
8850	1	Multiple Max Entry exceeded



## Procedures TR200.8– Hospital Procedures Start Date

### Description

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

### Element Values

Relevant value for the data element

### Additional Information

Reported as YYYY-MM-DD. Direct entry allows for use of the calendar function, typing YYYY-MM-DD, or MMDDYYYY.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6606	3	<i>Hospital Procedures Start Date</i> is earlier than <i>ED/Hospital Arrival Date</i>
6609	2	Element cannot be blank
6610	2	Element must be and can only be “Not Applicable” when <i>ICD-10 Hospital Procedures</i> is “Not Applicable”
6611	2	Element must be “Not Known/Not Recorded when <i>ICD-10 Hospital Procedures</i> is “Not Known/Not Recorded”
6650	1	Multiple Entry Max exceeded
6660	1	Date cannot be later than upload date



## Procedures TR200.9 – Hospital Procedures Start Time

### Description

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

### Element Values

Relevant value for the data element

### Additional Information

Reported as HH:MM military time.

Procedure start time is defined as the time the incision was made (or the procedure started).

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6706	3	<i>Hospital Procedures Start Time</i> is earlier than <i>ED/Hospital Arrival Time</i>
6708	2	Element cannot be blank
6709	2	Element must be and can only be “Not Applicable” when <i>Hospital Procedure Start Date</i> is “Not Applicable”
6710	2	Element must be “Not Known/Not Recorded” when <i>Hospital Procedure Start Date</i> is “Not Known/Not Recorded”
6750	1	Multiple Entry Max exceeded

## **NTDS Pre-Existing Conditions**



## Pre-Existing Conditions – Advance Directive Limiting Care

### Description

The patient had a written request to limit life-sustaining treatment that restricted the scope of care for the patient during this patient care event.

### Element Values

1. Yes
2. No

### Additional Information

The written request was signed/dated by the patient and/or the patient’s designee prior to arrival at your center.

Life-sustaining treatments, include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional, or radiological procedure (for example, decompressive craniectomy, operation for hemorrhage control, angiography).

Report Element Value “2. No” for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16001	1	Value is not a valid menu option
16003	2	Element cannot be blank
16004	2	Element cannot be “Not Applicable”
16040	1	Single Entry Max exceeded



## Pre-Existing Conditions – Alcohol Use Disorder

### Description

Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient’s medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient’s age on the day of arrival at your hospital.

The null value “Not Applicable” must be reported for patients < 15 years-of-age.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Consistent with American Psychiatric Association (APA) DSM 5, 2013.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16101	1	Value is not a valid menu option
16103	2	Element cannot be blank
16104	2	Element must be and can only be “Not Applicable” for patients < 15 years-of-age
16140	1	Single Entry Max exceeded



## Pre-Existing Conditions – Anticoagulant Therapy

### Description

Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting,

#### EXCLUDE:

Patients whose only anticoagulant therapy is chronic aspirin.

#### ANTICOAGULANTS

Fondaparinux	Pentasaccharide	Rivoraxaban
Warfarin	APC	Apixaban
Dalteparin	Ximelegatran	Heparin
Lovenox	Pentoxifylline	

#### ANTIPLATELET AGENTS

Tirofiban	Clopidogrel	Prasugrel
Dipyridamole	Cilostazol	Ticagrel
Anagrelide	Abciximab	
Eptifibatide	Ticlopidine	

#### THROMBIN INHIBITORS

Bevalirudin	Drotrecogin alpha
Argatroban	Dabigatran
Lepirudin, Hirudin	

#### THROMBOLYTIC AGENTS

Alteplase	Kabikinase
Reteplase	tPA
Tenecteplase	

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Anticoagulant must be part of the patient’s active medication.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

## Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16301	1	Value is not a valid menu option
16303	2	Element cannot be blank
16304	2	Element cannot be “Not Applicable”
16340	1	Single Entry Max exceeded



## Pre-Existing Conditions – Attention deficit disorder/hyperactivity disorder (ADD/ADHD)

### Description

A disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of ADD/ADHD must be documented in the patient’s medical record.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16401	1	Value is not a valid menu option
16403	2	Element cannot be blank
16404	2	Element cannot be “Not Applicable”
16440	1	Single Entry Max exceeded



## Pre-Existing Conditions – Autism Spectrum Disorder (ASD)

### Description

A disorder involving problems with social communication and interaction, and restricted or repetitive behaviors or interests as well as different ways of learning, moving, or paying attention.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of ASD must be documented in the patient’s medical record (e.g., autism, autism spectrum disorder, or Asperger’s syndrome/disorder).

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
6201	1	Value is not a valid menu option
6202	2	Element cannot be blank
6203	2	Element cannot be “Not Applicable”
6240	1	Single Entry Max exceeded



## Pre-Existing Conditions – Bipolar I/II Disorder

### Description

A bipolar I/II disorder diagnosis documented in the medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital

Only report on patients  $\geq 15$  years-of-age.

The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
21901	1	Value is not a valid menu option
21902	2	Element cannot be blank
21903	2	Element must be and can only be "Not Applicable" for patients $< 15$ years-of-age
21940	1	Single Entry Max exceeded



## Pre-Existing Conditions – Bleeding Disorder

### Description

A group of conditions that result when the blood cannot clot properly.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A bleeding disorder diagnosis must be documented in the patient’s medical record (for example, Hemophilia, von Willebrand Disease, Factor V Leiden).

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Consistent with American Society of Hematology, 2015.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16501	1	Value is not a valid menu option
16503	2	Element cannot be blank
16504	2	Element cannot be “Not Applicable”
16540	1	Single Entry Max exceeded



## Pre-Existing Conditions –Bronchopulmonary Dysplasia/Chronic Lung Disease

### Description

The disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over many months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF) and other causes of bronchiectasis such as immunodeficiency, post-infective bronchiectasis, Bronchopulmonary Dysplasia, or lung disease of prematurity. INCLUDE: Patients with a diagnosis of CF with pulmonary involvement. EXCLUDE: Patient with a diagnosis of CF with no documentation of lung disease.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury. Based on the patient’s age on the day of arrival at your hospital.

Only report on patients <15 years of age.

The null value “Not Applicable” must be reported for patients ≥15 years of age. The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients <15 years of age. Examples of evidence of CF associated pulmonary disease include, but are not limited to: Use of Chest Physiotherapy (CPT) or other airway clearing techniques; Vest therapy or intrapulmonary percussive ventilator; Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to CF; Consistent with the [ncbi.nlm.nih.gov](http://ncbi.nlm.nih.gov).

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
6331	1	Value is not a valid menu option
6332	2	Element cannot be blank
6303	2	Element cannot be “Not Applicable” for patients <15 years of age
63340	1	Single Entry Max exceeded



## Pre-Existing Conditions – Cerebral Vascular Accident (CVA)

### Description

A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (for example, hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of CVA must be documented in the patient’s medical record.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16601	1	Value is not a valid menu option
16603	2	Element cannot be blank
16604	2	Element cannot be “Not Applicable”
16640	1	Single Entry Max exceeded



## Pre-Existing Conditions – Chronic Obstructive Pulmonary Disease (COPD)

### Description

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used but are now included within the COPD diagnosis.

### EXCLUDE:

Patients whose only pulmonary disease is asthma.

Patients with diffuse interstitial fibrosis or sarcoidosis.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of COPD must be documented in the patient’s medical record.

Based on the patient’s age on the day of arrival at your hospital. Only report on patients ≥ 15 years-of-age. The null value “Not Applicable” must be reported for patients < 15 years-of-age.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age. Consistent with World Health Organization (WHO), 2019.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
16701	1	Value is not a valid menu option
16703	2	Element cannot be blank
16704	2	Element must be and can only be “Not Applicable” for patients < 15 years-of-age
16740	1	Single Entry Max exceeded



## Pre-Existing Conditions – Chronic Renal Failure

### Description

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

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of chronic renal failure must be documented in the patient's medical record.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
16801	1	Value is not a valid menu option
16803	2	Element cannot be blank
16804	2	Element cannot be "Not Applicable"
16840	1	Single Entry Max exceeded



## Pre-Existing Conditions – Cirrhosis

### Description

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

### EXCLUDE:

Patients who no longer have cirrhosis due to a successful liver transplant.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.

Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
16901	1	Value is not a valid menu option
16903	2	Element cannot be blank
16904	2	Element cannot be "Not Applicable"
16940	1	Single Entry Max exceeded



## Pre-Existing Conditions – Congenital Anomalies

### Description

Documentation of a cardiac, pulmonary, airway, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of congenital anomaly must be documented in the patient's medical record.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients < 15 years-of-age.

The null value "Not Applicable" must be reported for patients  $\geq$  15 years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients < 15 years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
17001	1	Value is not a valid menu option
17003	2	Element cannot be blank
17004	2	Element must be and can only be "Not Applicable" for patients $\geq$ 15 years-of-age
17040	1	Single Entry Max exceeded



## Pre-Existing Conditions – Congestive Heart Failure

### Description

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.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of CHF must be documented in the patient's medical record.

To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.

Common manifestations are:

Abnormal limitation in exercise tolerance due to dyspnea or fatigue

Orthopnea (dyspnea or lying supine)

Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)

Increased jugular venous pressure

Pulmonary rales on physical examination

Cardiomegaly

Pulmonary vascular engorgement

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
17101	1	Value is not a valid menu option
17103	2	Element cannot be blank
17104	2	Element cannot be “Not Applicable”
17140	1	Single Entry Max exceeded



## Pre-Existing Conditions – Current Smoker

### Description

A patient who reports inhaling nicotine by smoking cigars, pipes, cigarettes, e-cigarettes, vaping, or juuling every day or some days within the last 30 days.

EXCLUDE: Patients who chew tobacco or snuff.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Vaping and juuling includes vape pens, dab pens, dab rings, mods, pod-mods, or any other electronic delivery system used to inhale nicotine.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
17201	1	Value is not a valid menu option
17203	2	Element cannot be blank
17204	2	Element cannot be “Not Applicable”
17240	1	Single Entry Max exceeded



## Pre-Existing Conditions – Currently Receiving Chemotherapy for Cancer

### Description

A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
17301	1	Value is not a valid menu option
17303	2	Element cannot be blank
17304	2	Element cannot be “Not Applicable”
17340	1	Single Entry Max exceeded



## Pre-Existing Conditions – Dementia

### Description

Documentation in the patient’s medical record of dementia including senile or vascular dementia (for example: Alzheimer’s).

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of dementia including Alzheimer’s, Lewy Body Dementia, frontotemporal dementia (Pick’s Disease) or vascular dementia must be documented in the patient’s medical record.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Consistent with the National Institute on Aging, December 2017.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
17401	1	Value is not a valid menu option
17403	2	Element cannot be blank
17404	2	Element cannot be “Not Applicable”
17440	1	Single Entry Max exceeded



## Pre-Existing Conditions – Diabetes Mellitus

### Description

Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of diabetes mellitus must be documented in the patient’s medical record.

Report Element Value “1. Yes” for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
17501	1	Value is not a valid menu option
17503	2	Element cannot be blank
17504	2	Element cannot be “Not Applicable”
17540	1	Single Entry Max exceeded



## Pre-Existing Conditions – Disseminated Cancer

### Description

Cancer that has spread to one or more sites in addition to the primary site and in the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Another term describing disseminated cancer is "metastatic cancer."

A diagnosis of cancer that has spread to one or more sites must be documented in the patient's medical record.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
17601	1	Value is not a valid menu option
17603	2	Element cannot be blank
17604	2	Element cannot be "Not Applicable"
17640	1	Single Entry Max exceeded



## Pre-Existing Conditions – Functionally Dependent Health Status

### Description

Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living (ADL).

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

If Ventilator Dependence is Element Value "1. Yes," Functionally Dependent Health Status must be Element Value "1. Yes."

Activities of daily living include bathing, feeding, dressing, toileting, and walking.

Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, were partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
17701	1	Value is not a valid menu option
17703	2	Element cannot be blank
17704	2	Element cannot be "Not Applicable"
17740	1	Single Entry Max exceeded



## Pre-Existing Conditions – Hypertension

### Description

History of persistent elevated blood pressure requiring antihypertensive medication.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of hypertension must be documented in the patient’s medical record.

Report Element Value “1. Yes” for patients who were non-compliant with their prescribed antihypertensive medication.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
17801	1	Value is not a valid menu option
17803	2	Element cannot be blank
17804	2	Element cannot be “Not Applicable”
17840	1	Single Entry Max exceeded



## Pre-Existing Conditions – Major Depressive Disorder

### Description

A major depressive disorder diagnosis documented in the medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients  $\geq 15$  years-of-age.

The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
22001	1	Value is not a valid menu option
22002	2	Element cannot be blank
22003	2	Element must be and can only be "Not Applicable" for patient's $< 15$ years-of-age
22040	1	Single Entry Max exceeded



## Pre-Existing Conditions – Myocardial Infarction (MI)

### Description

History of a myocardial infarction (MI) in the six months prior to injury.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of myocardial infarction must be documented in the patient’s medical record.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
18001	1	Value is not a valid menu option
18003	2	Element cannot be blank
18004	2	Element cannot be “Not Applicable”
18040	1	Single Entry Max exceeded



## Pre-Existing Conditions – Other Mental/Personality Disorders

### Description

A diagnosis of any of the following documented in the medical record:

Antisocial personality disorder	Narcissistic personality disorder
Avoidant personality disorder	Obsessive-compulsive disorder
Borderline personality disorder	Obsessive-compulsive personality disorder
Dependent personality disorder	Panic disorder
Generalized anxiety disorder	Paranoid personality disorder
Histrionic personality disorder	Schizotypal personality disorder

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient’s age on the day of arrival at your hospital.

Only report on patients ≥ 15 years-of-age.

The null value “Not Applicable” must be reported for patients < 15 years-of-age.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
22101	1	Value is not a valid menu option
22102	2	Element cannot be blank
22103	2	Element must be and can only be “Not Applicable” for patients < 15 years-of-age
22140	1	Single Entry Max exceeded



## Pre-Existing Conditions – Peripheral Arterial Disease (PAD)

### Description

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. Peripheral Arterial Disease (PAD) can occur in any blood vessel, but it is more common in the legs than the arms.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

A diagnosis of Peripheral Arterial Disease or Peripheral Vascular Disease must be documented in the patient’s medical record.

Based on the patient’s age on the day of arrival at your hospital.

Only report on patients ≥ 15 years-of-age.

The null value “Not Applicable” must be reported for patients < 15 years-of-age.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Consistent with Centers for Disease Control, 2014 Fact Sheet.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
18101	1	Value is not a valid menu option
18103	2	Element cannot be blank
18104	2	Element must be and can only be “Not Applicable” for patients < 15 years-of-age
18140	1	Single Entry Max exceeded



## Pre-Existing Conditions – Post-Traumatic Stress Disorder

### Description

A post-traumatic stress disorder diagnosis documented in the medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients  $\geq$  15 years-of-age.

The null value "Not Applicable" must be reported for patients  $<$  15 years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available or patients  $\geq$  15 years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
22201	1	Value is not a valid menu option
22202	2	Element cannot be blank
22203	2	Element must be and can only be "Not Applicable" for patients $<$ 15 years-of-age
22240	1	Single Entry Max exceeded



## Pre-Existing Conditions – Pregnancy

### Description

Pregnancy confirmed by lab, ultrasound, or other diagnostic tool or diagnosis of pregnancy documented in the patient’s medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to arrival at your center.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
21501	1	Value is not a valid menu option
21503	2	Element cannot be blank
21504	2	Element cannot be “Not Applicable”
21540	1	Single Entry Max exceeded



## Pre-Existing Conditions – Prematurity

### Description

Babies born before 37 weeks of pregnancy are completed.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients < 15 years-of-age.

A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.

The null value "Not Applicable" must be reported for patients  $\geq$  15 years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients < 15 years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
18201	1	Value is not a valid menu option
18203	2	Element cannot be blank
18204	2	Element must be and can only be "Not Applicable" for patients > 15 years-of-age
18240	1	Single Entry Max exceeded



## Pre-Existing Conditions – Schizoaffective Disorder

### Description

A schizoaffective disorder diagnosis documented in the medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients  $\geq 15$  years-of-age.

The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
22301	1	Value is not a valid menu option
22302	2	Element cannot be blank
22303	2	Element must be and can only be "Not Applicable" for patients $< 15$ years-of-age
22340	1	Single Entry Max exceeded



## Pre-Existing Conditions – Schizophrenia

### Description

A schizophrenia diagnosis documented in the medical record.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Based on the patient's age on the day of arrival at your hospital.

Only report on patients  $\geq 15$  years-of-age.

The null value "Not Applicable" must be reported for patients  $< 15$  years-of-age.

The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
22401	1	Value is not a valid menu option
22402	2	Element cannot be blank
22403	2	Element must be and can only be "Not Applicable" for patients $< 15$ years-of-age
22440	1	Single Entry Max exceeded



## Pre-Existing Conditions – Steroid Use

### Description

Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

### EXCLUDE:

Topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.

Examples of chronic medical conditions are Chronic Obstructive Pulmonary Disease (COPD), asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
18301	1	Value is not a valid menu option
18303	2	Element cannot be blank
18304	2	Element cannot be “Not Applicable”
18340	1	Single Entry Max exceeded



## Pre-Existing Conditions – Substance Use Disorder

### Description

Descriptors documented in the patient’s medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (for example, patient has a history of drug use; patient has a history of opioid use) or diagnosis of any of the following documented in the patient’s medical record:

Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder  
Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder;  
Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder

Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder

Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder

Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder;  
Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder

Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

### Element Values

1. Yes

2. No

### Additional Information

Present prior to injury.

Based on the patient’s age on the day of arrival at your hospital.

Only report on patients  $\geq 15$  years-of-age.

The null value “Not Applicable” must be reported for patients  $< 15$  years-of-age.

The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients  $\geq 15$  years-of-age.

Consistent with the American Psychiatric Association (APA) DSM 5, 2013.

### Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
18401	1	Value is not a valid menu option
18403	2	Element cannot be blank
18404	2	Element must be and can only be “Not Applicable” for patients < 15 years-of-age
18440	1	Single Entry Max exceeded



## Pre-Existing Conditions – Ventilator Dependence

### Description

Patients who are ventilator dependent with a tracheostomy prior to injury.

### Element Values

1. Yes
2. No

### Additional Information

Present prior to injury.

If Ventilator Dependence is Element Value "1. Yes," Functionally Dependent Health Status must be Element Value "1. Yes."

The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
17901	1	Value is not a valid menu option
17902	2	Element cannot be blank
17903	2	Element cannot be "Not Applicable"
17904	2	If <i>Total Ventilator Days</i> is "Not Applicable," <b>Ventilator Dependence</b> must be Element Value "2. No"
17940	1	Single Entry Max exceeded

## NTDS Diagnosis Information



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

### Description

Diagnoses related to all identified injuries.

### Element Values

Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A.1-T79.A9 or compatible ICD 10-CA range code. The maximum number of diagnoses that may be reported for an individual patient is 50.

### Additional Information

ICD-10 codes pertaining to other medical conditions (for example, CVA, MI, co-morbidities, etc.) may also be included in this element.

Depending on your facility's setup configuration, an AIS code may auto-associate.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
8701	1	Invalid value (ICD-10 CM only)
8702	2	Element cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CM only)
8705	1	Invalid value (ICD-10 CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria (ICD-10 CA only)
8707	2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
8750	1	Multiple Entry Max exceeded



## AIS Code TR200.14.1 – AIS Code

### Description

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

### Element Values

The code is the 8-digit AIS code

### Additional Information

None

### Data Source Hierarchy Guide

AIS Coding Manual

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
21001	1	Invalid value
21004	2	AIS codes submitted are not valid AIS 2015 codes
21007	2	Element cannot be blank
21008	2	Element cannot be “Not Applicable”
21009	2	Element cannot be “Not Known/Not Recorded” along with any other value
21050	1	Multiple Entry Max exceeded



## AIS Version TR200.14.5 - AIS 2015 Version

### Description

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

### Element Values

16. AIS 2015

### Additional Information

None

### Data Source Hierarchy Guide

AIS Coding Manual

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
7301	1	Value is not a valid menu option
7302	2	Element cannot be blank
7303	2	Element cannot be “Not Applicable”
7340	1	Single Entry Max exceeded

## NTDS Hospital Events



## Hospital Events TR23.1 – Acute Kidney Injury (AKI)

### Description

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

#### EXCLUDE:

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

### KDIGO Staging of AKI for Stage 3:

(SCr) 3 times baseline

#### OR;

Increase in SCr to  $\geq 4\text{mg/dl}$  ( $\geq 353.6\mu\text{mol/l}$ )

#### OR;

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

#### OR;

Urine output  $< 0.3\text{ ml/kg/h}$  for  $\geq 24$  hours

#### OR;

Anuria for  $\geq 12$  hrs.

### Element Values

- |        |       |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

### Additional Information

Onset of AKI stage 3 began after arrival to your ED/hospital.

A diagnosis of acute kidney injury (AKI) must be documented in the patient's medical record.

Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
18501	1	Value is not a valid menu option
18503	2	Element cannot be blank
18504	2	Element cannot be "Not Applicable"
18540	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Acute Respiratory Distress Syndrome (ARDS)

### Description

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

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

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

Oxygenation:

Mild:  $200 \text{ mm Hg} < \text{PaO}_2/\text{FIO}_2 < 300 \text{ mm Hg}$  With PEEP or CPAP  $\geq 5 \text{ cm H}_2\text{O}$

Moderate:  $100 \text{ mm Hg} < \text{PaO}_2/\text{FIO}_2 < 200 \text{ mm Hg}$  With PEEP  $> 5 \text{ cm H}_2\text{O}$

Severe:  $\text{PaO}_2/\text{FIO}_2 < 100 \text{ mm Hg}$  With PEEP or CPAP  $\geq 5 \text{ cm H}_2\text{O}$

### Element Values

- |        |       |
|--------|-------|
| 1. Yes | 2. No |
|--------|-------|

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of ARDS must be documented in the patient's medical record.

Consistent with the 2012 New Berlin Definition.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
18601	1	Value is not a valid menu option
18603	2	Element cannot be blank
18604	2	Element cannot be "Not Applicable"
18640	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Alcohol Withdrawal Syndrome

### Description

Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6- 48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens).

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

Documentation of alcohol withdrawal must be in the patient’s medical record.

Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
18701	1	Value is not a valid menu option
18703	2	Element cannot be blank
18704	2	Element cannot be “Not Applicable”
18740	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Cardiac Arrest with CPR

### Description

Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

#### INCLUDE:

Patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

#### EXCLUDE:

Patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.  
Cardiac arrest must be documented in the patient's medical record.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
18801	1	Value is not a valid menu option
18803	2	Element cannot be blank
18804	2	Element cannot be “Not Applicable”
18840	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Catheter-Associated Urinary Tract Infection

### Description

A urinary tract infection (UTI) where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

### AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for more than 2 consecutive days in an inpatient location and then removed, the date of event for the UTI must be the day of device discontinuation or the next day for the UTI to be catheter associated.

### January 2019 CDC CAUTI Criterion SUTI 1a:

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

1. Patient has an indwelling urinary catheter in place for more than 2 consecutive days in an inpatient location on the date of event **AND** was either:  
Present for any portion of the calendar day on the date of event, **OR**  
Removed the day before the event
2. Patient has at least one of the following signs or symptoms:  
Fever (>38<sup>0</sup>C) Reminder: To use fever in a patient >65 years of age, the IUC need to be in place for more than 2 consecutive days in an inpatient location on date of even and is either still in place **OR** removed the day before the DOE. Suprapubic tenderness; Costovertebral angle pain or tenderness; Urinary urgency; Urinary frequency; Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium >10<sup>5</sup> CFU/ml.

### January 2019 CDC CAUTI Criterion SUTI 2:

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

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

## Element Values

1. Yes
2. No

## Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of UTI must be documented in the patient's medical record.

Consistent with the January 2019 CDC defined CAUTI.

## Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
18901	1	Value is not a valid menu option
18903	2	Element cannot be blank
18904	2	Element cannot be "Not Applicable"
18940	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Central Line-Associated Bloodstream Infection (CLABSI)

### Description

A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

### AND

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

### January 2016 CDC Criterion LCBI 1:

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

### AND

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

### OR

### January 2016 CDC Criterion LCBI 2:

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

### AND

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

### AND

The same common commensal (such as, diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based

microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

**OR**

### January 2016 CDC Criterion LCBI 3:

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

**AND**

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

**AND**

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

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of CLABSI must be documented in the patient's medical record.

Consistent with the January 2016 CDC defined CLABSI.

### Data Source Hierarchy Guide

1. History and Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes

5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

#### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19001	1	Value is not a valid menu option
19003	2	Element cannot be blank
19004	2	Element cannot be “Not Applicable”
19040	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Deep Surgical Site Infection

### Description

Must meet the following criteria:

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

### AND

involves deep soft tissues of the incision (for example, fascial and muscle layers),

### AND

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

Purulent drainage from the deep incision

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

### AND

Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture-based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion),

### AND

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

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

\* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (for example, C-section incision or chest incision for CBGB)

Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB).

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

<b>30 DAY SURVEILLANCE</b>			
<b>Code</b>	<b>Operative Procedure</b>	<b>Code</b>	<b>Operative Procedure</b>
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

<b>90 DAY SURVEILLANCE</b>	
<b>Code</b>	<b>Operative Procedure</b>
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

## Element Values

1. Yes 2. No

## Additional Information

Onset of symptoms began after arrival to your ED/hospital.

Consistent with the CDC January 2024 defined SSI.

Consistent with the January 2019 CDC defined SSI.

## Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19101	1	Value is not a valid menu option
19103	2	Element cannot be blank
19104	2	Element cannot be "Not Applicable"
19140	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Deep Vein Thrombosis

### Description

The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of deep vein thrombosis (DVT) must be documented in the patient’s medical record, which may be confirmed by 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.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19201	1	Value is not a valid menu option
19203	2	Element cannot be blank
19204	2	Element cannot be “Not Applicable”
19240	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Delirium

### Description

Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

#### OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).

#### OR

A diagnosis of delirium documented in the patient's medical record.

### EXCLUDE:

Patient's whose delirium is due to alcohol withdrawal.

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
21601	1	Value is not a valid menu option
21603	2	Element cannot be blank
21604	2	Element cannot be "Not Applicable"
21640	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Myocardial Infarction (MI)

### Description

An acute myocardial infarction (MI) must be noted with documentation of ECG changes indicative of an acute MI

#### **AND**

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

#### **AND**

Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center.

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19401	1	Value is not a valid menu option
19403	2	Element cannot be blank
19404	2	Element cannot be “Not Applicable”
19440	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Organ/Space Surgical Site Infection

### Description

Must meet the following criteria:

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

#### AND

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

#### AND

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

Purulent drainage from a drain that is placed into the organ/space (for example, closed suction drainage system, open drain, T-tube drain, CT guided drainage).

Organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST)).

An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection,

#### AND

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

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

90 DAY SURVEILLANCE	
Code	Operative Procedure
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

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

Code	SITE	Code	SITE
BONE	Osteomyelitis	MED	Mediastinitis
BRST	Breast abscess or mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity infection (mouth, tongue, or gums)
DISC	Disc space infection	OREP	Deep pelvic tissue infection or other infection of the male or female reproductive tract
EAR	Ear, mastoid infection	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess/infection
ENDO	Endocarditis	SINU	Sinusitis
GIT	Gastrointestinal (GI) tract infection	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
IAB	Intraabdominal infection, not specified elsewhere	USI	Urinary System Infection
IC	Intracranial infection	VASC	Arterial or venous infection
JNT	Joint or bursa infection	VCUF	Vaginal cuff infection
LUNG	Other infection of the lower respiratory tract		

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of SSI must be documented in the patient's medical record.

Consistent with the CDC January 2019 defined SSI.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19501	1	Value is not a valid menu option
19503	2	Element cannot be blank
19504	2	Element cannot be "Not Applicable"
19540	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Osteomyelitis

### Description

Osteomyelitis must meet at least one of the following criteria:

Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).

Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.

Patient has at least two of the following localized signs or symptoms: fever (>38.0°C), swelling\*, pain or tenderness\*, heat\*, or drainage\*

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

Organisms identified from blood by culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST) AND Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

Imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically physician documentation of antimicrobial treatment for osteomyelitis).

\* With no other recognized cause

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of osteomyelitis must be documented in the patient's medical record.

Consistent with the January 2020 CDC definition of Bone and Joint infection.

### Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19601	1	Value is not a valid menu option
19603	2	Element cannot be blank
19604	2	Element cannot be “Not Applicable”
19640	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Pressure Ulcer

### Description

A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

### Element Values

- 1. Yes
- 2. No

### Additional Information

Onset of NPUAP stage 2 began after arrival to your ED/hospital.  
 Pressure ulcer documentation must be in the patient’s medical record.  
 Consistent with the NPUAP 2014.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
19801	1	Value is not a valid menu option
19803	2	Element cannot be blank
19804	2	Element cannot be “Not Applicable”
19840	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Pulmonary Embolism (PE)

### Description

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.

### EXCLUDE:

Subsegmental PEs.

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

Consider the condition present if the patient has a VQ scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19701	1	Value is not a valid menu option
19703	2	Element cannot be blank
19704	2	Element cannot be "Not Applicable"
19740	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Severe Sepsis

### Description

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

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

### Element Values

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of sepsis must be documented in the patient’s medical record.

Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
19901	1	Value is not a valid menu option
19903	2	Element cannot be blank
19904	2	Element cannot be “Not Applicable”
19940	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Stroke/CVA

### Description

A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

Change in level of consciousness

Hemiplegia

Hemiparesis

Numbness or sensory loss affecting one side of the body

Dysphasia or aphasia

Hemianopia

Amaurosis fugax

Other neurological signs or symptoms consistent with stroke

### AND

Duration of neurological deficit  $\geq 24$  h

### OR

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

### AND

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

### AND

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

### Element Values

1. Yes

2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of stroke/CVA must be documented in the patient's medical record.

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (for example, blunt cerebrovascular injury, dysrhythmia) may be present on admission.

## Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
20001	1	Value is not a valid menu option
20003	2	Element cannot be blank
20004	2	Element cannot be "Not Applicable"
20040	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Superficial Incisional Surgical Site Infection

### Description

Must meet the following criteria:

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

#### AND

Involves only skin and subcutaneous tissue of the incision

#### AND

Patient has at least one of the following:

Purulent drainage from the superficial incision.

Organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST)).

Superficial incision that is deliberately opened by a surgeon, attending physician\*\* or other designee and culture or non-culture-based testing is not performed.

#### AND

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

Diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or another designee.

\*\* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (for example, C-section incision or chest incision for CBGB)

Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB)

### Element Values

1. Yes

2. No

## Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of SSI must be documented in the patient's medical record.

Consistent with the January 2019 CDC defined SSI.

## Data Source Hierarchy Guide

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

## Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
20101	1	Value is not a valid menu option
20103	2	Element cannot be blank
20104	2	Element cannot be "Not Applicable"
20140	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Unplanned Admission to ICU

### Description

Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

#### INCLUDE:

Patients who required ICU care due to an event that occurred during surgery or in the PACU.

#### EXCLUDE:

Patients with a planned post-operative ICU stay.

### Element Values

1. Yes
2. No

### Additional Information

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
20201	1	Value is not a valid menu option
20203	2	Element cannot be blank
20204	2	Element cannot be “Not Applicable”
20240	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Unplanned Intubation

### Description

Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

### Element Values

1. Yes
2. No

### Additional Information

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

For patients who were intubated in the field or emergency department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
20301	1	Value is not a valid menu option
20303	2	Element cannot be blank
20304	2	Element cannot be "Not Applicable"
20340	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Unplanned Return to the Operating Room

### Description

The patient underwent a subsequent operative procedure at the same operative site as the initial operative procedure. Both procedures must have been performed in the operating room at your center.

### EXCLUDE:

Planned return to the operating room after damage control surgery or staged surgical interventions.

Procedures performed in an interventional radiology suite.

Procedures performed in a hybrid operating room where the intervention is limited to a percutaneous approach.

Pre-planned multiple-stage approach procedures.

### Element Values

1. Yes

2. No

### Additional Information

The same operative site usually (but not exclusively) implies there was a need to re-open the previous incision.

Element Value “1. Yes” is reported whether the initial intervention was related to the injuries (e.g., anastomotic leak after laparotomy, hardware failure/infection after ORIF of fractures) OR if there is a return to the operating room for an unplanned intervention related to a secondary procedure (e.g., return to the OR for bleeding after tracheostomy).

Element Value “2. No” is reported if there is intent to return to the operating room for a two-stage approach.

### Data Source Hierarchy Guide

1. Operative Report
2. Physician Notes/Flow Sheet
3. Progress Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
21701	1	Value is not a valid menu option
21703	2	Element cannot be blank
21704	2	Element cannot be “Not Applicable”
21740	1	Single Entry Max exceeded



## Hospital Events TR23.1 – Ventilator-Associated Pneumonia (VAP)

### Description

A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

### AND

The ventilator was in place on the date of event or the day before.

VAP Algorithm ( <i>PNU2</i> Bacterial or Filamentous Fungal Pathogens):		
IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least <b>one</b> of the following:	At least <b>one</b> of the following:	At least <b>one</b> of the following:
<ul style="list-style-type: none"> <li>• New and persistent <b>or</b> progressive and persistent</li> <li>• Infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1-year-old</li> </ul> <p><b>NOTE:</b> In patients <i>without</i> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <u>one definitive</u> chest imaging test result is acceptable.</p>	<ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) or leukocytosis (≥12,000 WBC/mm<sup>3</sup>)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (for example: O<sub>2</sub> desaturations [for example: PaO<sub>2</sub>/FiO<sub>2</sub> &lt;240], increased oxygen requirements, or increased ventilator demand)</li> </ul>	<ul style="list-style-type: none"> <li>• Organism identified from blood</li> <li>• Organism identified from pleural fluid</li> <li>• Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate)</li> <li>• ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain)</li> <li>• Positive quantitative culture or corresponding semi-quantitative culture result of lung tissue</li> <li>• Histopathologic exam shows at least <b>one</b> of the following evidences of pneumonia: <ul style="list-style-type: none"> <li>– Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</li> <li>– Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</li> </ul> </li> </ul>

<b>VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):</b>		
<b>IMAGING TEST EVIDENCE</b>	<b>SIGNS/SYMPTOMS</b>	<b>LABORATORY</b>
Two or more serial chest imaging test results with at least <b>one</b> of the following:	At least <b>one</b> of the following:	At least <b>one</b> of the following:
<ul style="list-style-type: none"> <li>• New and persistent or progressive and persistent</li> <li>• Infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1-year-old</li> </ul> <p><b>NOTE:</b> In patients <i>without</i> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <u>one definitive</u> chest imaging test result is acceptable.</p>	<ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) or leukocytosis (≥12,000 WBC/mm<sup>3</sup>)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (for example: O<sub>2</sub> desaturations [for example: PaO<sub>2</sub>/FiO<sub>2</sub> &lt;240], increased oxygen requirements, or increased ventilator demand)</li> </ul>	<ul style="list-style-type: none"> <li>• Virus, <i>Bordetella</i>, <i>Legionella</i>, <i>Chlamydia</i> or <i>Mycoplasma</i> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example: not Active Surveillance Culture/ Testing (ASC/AST).</li> <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, <i>Chlamydia</i>)</li> <li>• Fourfold rise in <i>Legionella pneumophila</i> serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA.</li> <li>• Detection of L. <i>pneumophila</i> serogroup 1 antigens in urine by RIA or EIA</li> </ul>

VAP Algorithm (PNU3 Immunocompromised Patients):		
IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New and persistent or progressive and persistent</li> <li>• Infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatocoles, in infants ≤1-year-old</li> </ul> <p><b>NOTE:</b> In patients <i>without</i> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <u>one definitive</u> chest imaging test result is acceptable.</p>	<p>Patient who is immunocompromised (see definition in footnote) has at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> <li>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2&lt;240], increased oxygen requirements, or increased ventilator demand)</li> <li>• Hemoptysis</li> <li>• Pleuritic chest pain</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Identification of matching <i>Candida</i> spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing.</li> <li>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>– Direct microscopic exam</li> <li>– Positive culture of fungi</li> <li>– Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Any of the following from:</li> </ul> <p><b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤ 1 year old:	
IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New and persistent <b>or</b> progressive and persistent</li> <li>• Infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatocoles, in infants ≤1-year-old</li> </ul> <p><b>NOTE:</b> In patients <i>without</i> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<p>Worsening gas exchange (for example: 2 desaturations [for example pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</p> <p>And at least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Temperature instability</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (&gt;15,000 WBC/mm<sup>3</sup>) and left shift (&gt;10% band forms)</li> <li>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions or increased suctioning requirements</li> <li>• Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting</li> <li>• Wheezing, rales, or rhonchi</li> <li>• Cough</li> <li>• Bradycardia (&lt;100 beats/min) or tachycardia (&gt;170 beats/min)</li> </ul>

VAP Algorithm ALTERNATE CRITERIA (PNU1), for children > 1 year old or ≤ 12 years old:	
IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New and persistent <b>or</b> progressive and persistent</li> <li>• Infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatocoles, in infants ≤1-year-old</li> </ul> <p><b>NOTE:</b> In patients <i>without</i> underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<p>ALTERNATE CRITERIA, for child &gt;1 year old or ≤12 years old, at least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38.0°C or &gt;100.4°F) or hypothermia (&lt;36.0°C or &lt;96.8°F)</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (≥15,000 WBC/mm<sup>3</sup>)</li> <li>• New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (for example: O<sub>2</sub> desaturations [for example pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</li> </ul>

1. Yes
2. No

### Additional Information

Onset of symptoms began after arrival to your ED/hospital.

A diagnosis of pneumonia must be documented in the patient's medical record.

Consistent with the January 2019 CDC defined VAP.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
20501	1	Value is not a valid menu option
20503	2	Element cannot be blank
20504	2	Element cannot be "Not Applicable"
20540	1	Single Entry Max exceeded

## NTDS Outcome Information



## Outcome TR26.9 – Total ICU Length of Stay

### Description

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

### Element Values

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

### Additional Information

Recorded in full day increments with any partial calendar day counted as a full calendar day.

The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.

At no time should the *Total ICU LOS* exceed the hospital LOS.

The null value “Not Known/Not Recorded” is reported if any dates are missing.

If patient has multiple ICU episodes on the same calendar day, count as one calendar day.

The null value “Not Applicable” is reported if the patient has no ICU days according to the above description.

This field is auto calculated but can be manually edited/entered.

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

## Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
7501	1	Value is not a valid menu option
7502	2	Element cannot be blank
7503	2	<i>Total ICU Length of Stay</i> is greater than the difference between <i>ED/Hospital Arrival Date</i> and <i>Hospital Discharge Date</i>
7504	3	The value is above 60
7505	2	The value submitted falls outside the valid range of 1 – 575
7540	1	Single Entry Max exceeded



## Outcome TR26.58 – Total Ventilator Days

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Excludes mechanical ventilation time associated with OR procedures.

Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.

Reported 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.

At no time should the *Total Ventilator Days* exceed the hospital LOS.

The null value “Not Known/Not Recorded” is reported if any dates are missing.

The null value “Not Applicable” is reported if the patient was not on the ventilator according to the above description.

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

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
7601	1	Invalid value
7602	2	Element cannot be blank
7603	2	<i>Total Ventilator Days</i> is greater than the difference between <i>ED/Hospital Arrival Date</i> and the latter of the known <i>ED Discharge Date</i> or <i>Hospital Discharge Date</i>
7604	3	The value is above 60
7605	2	The value submitted falls outside the valid range of 1 – 575
7640	1	Single Entry Max exceeded



## Outcome TR25.27 – Hospital Discharge Disposition

### Description

The disposition of the patient when discharged from the hospital.

### Element Values

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

### Additional Information

Element Values adapted from UB-04 disposition coding.

Element Value “6. Home” refers to the patient’s current place of residence (for example, Prison, Child protective services, etc.).

Disposition to any other non-medical facility must be reported as Element Value “6. Discharged to home or self-care (routine discharge).”

Discharged to any other medical facility must be reported as Element Value “14. Discharged/Transferred to another type of institution not defined elsewhere.”

Disposition to any federal healthcare facility must be reported by selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a veteran’s hospital SNF must be reported as element value 7.)

The null value “Not Applicable” is reported if *ED Discharge Disposition* is reported as Element Value 4,5,6,9,10, 11, or 13.

Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS versions are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.

There is no nine in the list.

### Data Source Hierarchy Guide

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

#### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
7901	1	Value is not a valid menu option
7902	2	Element cannot be blank
7907	2	Element must be and can only be “Not Applicable” when <i>ED Discharge Disposition</i> is 4,5,6,9,10,11, or 13
7909	2	Element cannot be “Not Known/Not Recorded”
7940	1	Single Entry Max exceeded



## Outcome TR25.93 – Hospital Discharge Date

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD

The null value “Not Applicable” if *ED Discharge Disposition* is reported as “Not Applicable.”

If *Hospital Discharge Disposition* is Element Value “5. Deceased/Expired,” then *Hospital Discharge Date* is the date of death as indicated on the patient’s death certificate.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Element cannot be blank
7707	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>ED/Hospital Arrival Date</i>
7708	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>ED Discharge Date</i>
7711	3	<i>Hospital Discharge Date</i> occurs more than 365 days after <i>ED/Hospital Arrival Date</i>
7713	2	Element must be and can only be “Not Applicable” when <i>Hospital Discharge Disposition</i> is “Not Applicable”
7714	3	<i>Hospital Discharge Date</i> is earlier than <i>Injury Incident Date</i>
7715	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>Hospital Procedure Start Date</i>
7716	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>Cerebral Monitor Date</i>
7717	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>Venous Thromboembolism Prophylaxis Date</i>
7718	2	<i>Hospital Discharge Date</i> cannot be than <i>Angiography Date</i>
7719	2	<i>Hospital Discharge Date</i> cannot be earlier than <i>Surgery for Hemorrhage Control Date</i>
7720	2	<i>Hospital DC Date</i> is earlier than <i>Withdrawal of Life Supporting Treatment Date</i>
7721	3	<i>Hospital Discharge Date</i> is earlier than <i>Antibiotic Therapy Date</i>
7740	1	Single Entry Max exceeded
7750	1	Date cannot be later than upload date



## Outcome TR25.94 – Hospital Discharge Time

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM Military time.

The null value “Not Applicable” is reported if *Hospital Discharge Date* is reported as “Not Applicable”. If *Hospital Discharge Disposition* is Element Value “5. Deceased/Expired,” then *Hospital Discharge Time* is the time of death as indicated on the patient’s death certificate.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Element cannot be blank
7807	2	<i>Hospital Discharge Time</i> cannot be earlier than <i>ED/Hospital Arrival Time</i>
7808	2	<i>Hospital Discharge Time</i> cannot be earlier than <i>ED Discharge Time</i>
7810	3	Element must be and can only be “Not Applicable” when <i>Hospital Discharge Date</i> is “Not Applicable”
7811	2	Element must be “Not Known/Not Recorded” when <i>Hospital Discharge Date</i> is “Not Known/Not Recorded”
7812	3	<i>Hospital Discharge Time</i> is earlier than the <i>Injury Incident Time</i>
7813	2	<i>Hospital Discharge Time</i> cannot be earlier than the <i>Hospital Procedure Start Time</i>
7814	2	<i>Hospital Discharge Time</i> cannot be earlier than the <i>Cerebral Monitor Time</i>
7815	2	<i>Hospital Discharge Time</i> cannot be earlier than the <i>Venous Thromboembolism Prophylaxis Time</i>
7816	2	<i>Hospital Discharge Time</i> cannot be earlier than the <i>Angiography Time</i>
7817	2	<i>Hospital Discharge Time</i> cannot be earlier than the <i>Surgery for Hemorrhage Control Time</i>

7818	2	<i>Hospital Discharge Time</i> is earlier than the <i>Withdrawal of Life Supporting Treatment Time</i>
7819	3	<i>Hospital Discharge Time</i> is earlier than the <i>Antibiotic Therapy Time</i>
7840	1	Single Entry Max exceeded

## NTDS Financial Information



## Outcome TR2.5 – Primary Method of Payment

### Description

Primary source of payment for hospital care.

### Element Values

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

### Additional Information

No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as Element “4. Private/Commercial Insurance.”

Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values. Refer to the NTDS Change Log for a full list of retired *Primary Methods of Payments*.

Numbers missing from the element values are on purpose.

### Data Source Hierarchy Guide

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

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
8001	1	Value is not a valid menu option
8002	2	Element cannot be blank
8003	2	Element cannot be “Not Applicable”
8040	1	Single Entry Max exceeded

## **SECTION B**

### Michigan Core Data Elements

**MI Pre-Hospital Information**

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

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

Reported as YYYY-MM-DD.

For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.

For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	<i>EMS Dispatch Date is earlier than Date of Birth</i>
2804	3	<i>EMS Dispatch Date is later than EMS Unit Arrival on Scene Date</i>
2805	3	<i>EMS Dispatch Date is later than EMS Unit Scene Departure Date</i>
2806	3	<i>EMS Dispatch Date is later than ED/Hospital Arrival Date</i>
2807	3	<i>EMS Dispatch Date is later than ED Discharge Date</i>
2808	3	<i>EMS Dispatch Date is later than Hospital Discharge Date</i>
2809	2	Element cannot be blank
2840	1	Single Entry Max exceeded

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

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

Reported as HH:MM military time.

For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.

For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	3	<i>EMS Dispatch Time is later than EMS Unit Arrival on Scene Time</i>
2904	3	<i>EMS Dispatch Time is later than EMS Unit Scene Departure Time</i>
2905	3	<i>EMS Dispatch Time is later than ED/Hospital Arrival Time</i>
2906	3	<i>EMS Dispatch Time is later than ED Discharge Time</i>
2907	3	<i>EMS Dispatch Time is later than Hospital Discharge Time</i>
2908	2	Element cannot be blank
2940	1	Single Entry Max exceeded

## Pre-Hospital TR9.2 – EMS Unit Arrived on Scene Date

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

Reported as YYYY-MM-DD.

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).

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	<i>EMS Unit Arrival on Scene Date</i> is earlier than <i>Date of Birth</i>
3004	3	<i>EMS Unit Arrival on Scene Date</i> is earlier than <i>EMS Dispatch Date</i>
3005	3	<i>EMS Unit Arrival on Scene Date</i> is later than <i>EMS Unit Scene Departure Date</i>
3006	3	<i>EMS Unit Arrival on Scene Date</i> is later than <i>ED/Hospital Arrival Date</i>
3007	3	<i>EMS Unit Arrival on Scene Date</i> is later than <i>ED Discharge Date</i>
3008	3	<i>EMS Unit Arrival on Scene Date</i> is later than <i>Hospital Discharge Date</i>
3009	3	<i>EMS Unit Arrival on Scene Date</i> minus <i>EMS Dispatch Date</i> is greater than 7 days
3010	2	Element cannot be blank
3040	1	Single Entry Max exceeded

## Pre-Hospital TR9.2.1 – EMS Arrive Scene Time

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

Reported as HH:MM military time.

Used to auto-generate two additional calculated fields: *Total EMS Response Time* (elapsed time from EMS dispatch to scene arrival) and *Total EMS Scene Time* (elapsed time from EMS scene arrival to scene departure).

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

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

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	3	<i>EMS Unit Arrival on Scene Time</i> is earlier than <i>EMS Dispatch Time</i>
3104	3	<i>EMS Unit Arrival on Scene Time</i> is later than <i>EMS Unit Scene Departure Time</i>
3105	3	<i>EMS Unit Arrival on Scene Time</i> is later than <i>ED/Hospital Arrival Time</i>
3106	3	<i>EMS Unit Arrival on Scene Time</i> is later than <i>ED Discharge Time</i>
3107	3	<i>EMS Unit Arrival on Scene Time</i> is later than <i>ED Discharge Time</i>
3108	2	Element cannot be blank
3140	1	Single Entry Max exceeded

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

### Description

The date the unit transporting to your hospital left the scene/transferring facility.

### Element Values

Relevant value for the data element.

### Additional Information

Reported as YYYY-MM-DD.

Used to auto-generate two additional calculated fields: *Total EMS Response Time* (elapsed time from EMS dispatch to scene arrival) and *Total EMS Scene Time* (elapsed time from EMS scene arrival to scene departure).

For inter-facility transfer patients, this is the date at which the unit transporting the patient to your facility from the transferring facility departed the transferring facility (arrival is defined at date/time when the vehicle stopped moving).

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

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	<i>EMS Unit Scene Departure Date</i> is earlier than <i>Date of Birth</i>
3204	3	<i>EMS Unit Scene Departure Date</i> is earlier than <i>EMS Dispatch Date</i>
3205	3	<i>EMS Unit Scene Departure Date</i> is earlier than <i>EMS Unit Arrival on Scene Date</i>
3206	3	<i>EMS Unit Scene Departure Date</i> is later than <i>ED/Hospital Arrival Date</i>
3207	3	<i>EMS Unit Scene Departure Date</i> is later than <i>ED Discharge Date</i>
3208	3	<i>EMS Unit Scene Departure Date</i> is later than <i>Hospital Discharge Date</i>
3209	3	<i>EMS Unit Scene Departure Date</i> minus <i>EMS Unit Arrival on Scene Date</i> is greater than 7 days
3210	2	Element cannot be blank
3240	1	Single Entry Max exceeded

## Pre-Hospital TR9.3.1 – EMS Leave Scene Time

### Description

The time the unit transporting to your hospital left the scene/transferring facility.

### Element Values

Relevant value for the data element.

### Additional Information

Reported as HH:MM military time.

Used to auto-generate two additional calculated fields: *Total EMS Response Time* (elapsed time from EMS dispatch to scene arrival) and *Total EMS Scene Time* (elapsed time from EMS scene arrival to scene departure).

For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed the transferring facility (arrival is defined at date/time when the vehicle stopped moving).

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

Leave blank for patients not transported by EMS.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	3	<i>EMS Unit Scene Departure Time</i> is earlier than <i>EMS Dispatch Time</i>
3304	3	<i>EMS Unit Scene Departure Time</i> is earlier than <i>EMS Unit Arrival on Scene Time</i>
3305	3	<i>EMS Unit Scene Departure Time</i> is later than <i>ED/Hospital Arrival Time</i>
3306	3	<i>EMS Unit Scene Departure Time</i> is later than the <i>ED Discharge Time</i>
3307	3	<i>EMS Unit Scene Departure Time</i> is later than <i>Hospital Discharge Time</i>
3308	2	Element cannot be blank
3340	1	Single Entry Max exceeded

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

### Description

First recorded systolic blood pressure measured by EMS.

### Element Values

Relevant value for the data element.

### Additional Information

The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field systolic blood pressure was NOT measured at the scene of injury.

If Not Known, select "Not Known/Not Recorded."

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3601	1	Invalid value
3602	1	Element cannot be blank
3603	3	The value is above 220
3606	2	The value submitted falls outside the valid range of 0-380
3607	3	The value is below 30
3640	1	Single Entry Max exceeded

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

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in. The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured at the scene of injury.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3701	1	Invalid value
3702	1	Element cannot be blank
3703	3	The value submitted is above 220
3706	2	The value submitted falls outside the valid range of 0-300
3707	3	The value submitted is below 30
3740	1	Single Entry Max exceeded



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

### Description

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

### Element Values

Relevant value for the data element

### Additional Information

Leave blank if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

The null value “Not Applicable” is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field pulse rate was NOT measured at the scene of injury.

Completion of this field will show TR18.80 *Pre-Hospital Respiratory Assistance*.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
3801	1	Invalid value or Respiratory Rate exceeds 120
3802	1	Element cannot be blank
3806	2	The value submitted falls outside the valid range of 0-100
3807	3	The value is below 5
3808	3	The value is above 75
3840	1	Single Entry Max exceeded



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

### Description

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

### Element Values

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

### Additional Information

Only completed if a value is provided for TR18.70 *Pre-Hospital Respiratory Rate*.

Respiratory Assistance is defined as mechanical and/or external support of respiration.

Please note that first recorded hospital vitals do not need to be from the same assessment.

When *Pre-Hospital Respiratory Rate* is “Not Known/Not Recorded,” select “Not Applicable.”

### Data Source Hierarchy Guide

EMS Run Report

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

### Description

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

### Element Values

Relevant value for the data element.

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

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

The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Value/Not Recorded" is reported if the patient's first recorded initial field oxygen saturation was NOT measured at the scene of injury.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3901	1	Invalid value
3902	2	Element cannot be blank
3906	2	The value submitted falls outside the valid range of 0-100
3907	3	The value is below 40
3940	1	Single Entry Max exceeded

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

### Description

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

### Element Values

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

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. (for example, the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be reported, IF there is no other contradicting documentation.

The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS Eye was NOT measured at the scene of injury.

The null value "Not Known/Not Recorded" is reported if Initial Field GCS-40 Eye is reported.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Element cannot be blank
4006	2	Element must be "Not Applicable" when <i>Initial Field GCS-40 Eye</i> is reported
4040	1	Single Entry Max exceeded

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

### Description

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

### Element Values

#### Adult:

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

#### Pediatric ( $\leq 2$ years):

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

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

If patient is intubated, then the GCS Verbal score is equal to 1.

If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. For example, the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be reported, IF there is no other contradicting documentation.

The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS Verbal* was NOT measured at the scene of injury.

The null value "Not Known/Not Recorded" is reported if *Initial Field GCS-40 Verbal* is reported.

Data elements automatically switched to Pediatrics for patients younger than 2 years.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Element cannot be blank
4106	2	Element must be "Not Applicable" when <i>Initial Field GCS-40 Verbal</i> is reported
4140	1	Single Entry Max exceeded

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

### Description

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

### Element Values

#### Adult:

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

#### Pediatric ( $\leq 2$ years):

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

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

If a patient does not have a numeric GCS recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS Motor* was NOT measured at the scene of injury.

The null value "Not Known/Not Recorded" is reported if *Initial Field GCS-40 Motor* is reported.

Data elements automatically switched to Pediatrics for patients younger than 2 years.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Element cannot be blank
4206	2	Element must be "Not Applicable" when <i>Initial Field GCS-40 Motor</i> is reported
4240	1	Single Entry Max exceeded

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

### Description

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

### Element Values

Relevant value for data element

### Additional Information

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no *EMS Run Report* from the scene of injury.

If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15, IF there is no other contradicting documentation.

Auto-calculated when GCS Eye, GCS Verbal, and GCS Motor are complete.

The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.

The null value "Not Known/Not Recorded" is reported if the patient's first recorded *Initial Field GCS Total* was NOT measured at the scene of injury.

The null value "Not Known/Not Recorded" is reported if *Initial Field GCS-40* is reported.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
4301	1	GCS Total is outside the valid range of 3 – 15
4303	3	<i>Initial Field GCS - Total</i> does not equal the sum of <i>Initial Field GCS - Eye</i> , <i>Initial Field GCS - Verbal</i> , and <i>Initial Field GCS – Motor</i> , unless any of these values are "Not Known/Not Recorded"
4304	2	Element cannot be blank
4306	2	Element must be "Not Known/Not Recorded" when <i>Initial Field GCS-40 Eye</i> , <i>Initial Field GCS-40 Verbal</i> , or <i>Initial Field GCS-40 Motor</i> are reported.
4340	1	Single Entry Max exceeded



## Pre-Hospital TR17.102 – Trauma Triage Criteria (High Risk for Serious Injury)

### Description

Trauma triage criteria for the red boxes (Injury Patterns and Mental Status and Vital Signs) in the 2021 ACS National Guideline for the Field Triage of Injured Patients.

### Element Values

Penetrating injuries to head, neck, torso, and proximal extremities; Skull deformity, suspected skull fracture; Suspected spinal injury with new motor or sensory loss  
Chest wall instability, deformity, or suspected flail chest; Suspected pelvic fracture  
Suspected fracture of two or more proximal long bones; Crushed, degloved, mangled, or pulseless extremity; Amputation proximal to wrist or ankle; Active bleeding requiring a tourniquet or wound packing with continuous pressure.

### Additional Information

The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.

The null value "Not Applicable" should be used if *EMS Run Report* indicates patient did not meet any *Trauma Triage Criteria*.

The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the *EMS Run Report* or if the *EMS Run Report* is not available.

Element values must be determined by the EMS provider and must not be assigned by the index hospital. Check all that apply.

Consistent with NEMSIS v3.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Element cannot be blank
9506	2	Element cannot be "Applicable" or "Not Known/Not Recorded" along with any other valid value
9550	1	Multiple Entry Max exceeded

## Pre-Hospital TR17.103 – Trauma Triage Criteria (Moderate Risk for Serious Injury)

### Description

Trauma triage criteria for the yellow boxes (Mechanism of Injury and EMS Judgment) in the 2021 ACS National Guideline for the Field Triage of Injured Patients. This information must be found on the scene of injury EMS Run Report.

### Element Values

High-Risk Auto Crash: Partial or complete ejection, Significant intrusion (including roof), >12 inches occupant site OR 18 inches any site OR Need for extrication for entrapped patient, Death in passenger compartment, Child (age 0–9 years) unrestrained or in unsecured child safety seat, Vehicle telemetry data consistent with severe injury, Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.), Pedestrian/bicycle rider thrown, run over, or with significant impact, Fall from height > 10 feet (all ages).

Consider risk factors, including: Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact, Anticoagulant use, Suspicion of child abuse, Special, high-resource healthcare needs, Pregnancy > 20 weeks, Burns in conjunction with trauma, Children should be triaged preferentially to pediatric capable centers.

### Additional Information

The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.

The null value "Not Applicable" should be used if *EMS Run Report* indicates patient did not meet any Trauma Triage Criteria.

The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the *EMS Run Report* or if the *EMS Run Report* is not available.

Element Values must be determined by the EMS provider and must not be assigned by the index hospital. Check all that apply.

Consistent with NEMESIS v3.

### Data Source Hierarchy Guide

EMS Run Report

### Associated Edit Checks (NTDS)

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Element cannot be blank
9607	2	Element cannot be “Applicable” or “Not Known/Not Recorded” along with any other valid value
9650	1	Multiple Entry Max exceeded

## MI Outcome Information



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

### Description

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

### Element Values

Relevant data values in YYYY-MM-DD

### Additional Information

If date of discharge is not documented, leave blank.

### Data Source Hierarchy Guide

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



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

### Description

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

### Element Values

Reported as HH:MM.

### Additional Information

If date of discharge is not documented, leave blank.

### Data Source Hierarchy Guide

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



## Outcome TR25.33 – Hospital Admission Date

### Description

The date the patient was admitted in the hospital.

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source Hierarchy Guide

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



## Outcome TR25.47– Hospital Admission Time

### Description

The time patient was admitted in the hospital.

### Element Values

Relevant value for data element

### Additional Information

- Reported as HH:MM.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

### Data Source Hierarchy Guide

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



## Outcome TR25.34– Hospital Physical Discharge Date

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

Used to auto-generate an additional calculated field: *Hospital Length of Stay – Calendar Days*: (elapsed time from hospital admit to hospital discharge).

The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

### Data Source Hierarchy Guide

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



## Outcome TR25.48– Hospital Physical Discharge Time

### Description

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

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM military time.

Used to auto-generate an additional calculated field: *Hospital Length of Stay – Calendar Days*: (elapsed time from hospital admit to hospital discharge).

The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

### Data Source Hierarchy Guide

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

**SECTION C**  
Optional Elements

## Optional Demographics Information

## Demographics TR1.2 – Medical Record Number



### Description

The facility medical record number that represents the patient.

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source Hierarchy Guide

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

## Demographics TR5.12 – Registry Number



### Description

The registry assigned number or case number.

### Element Values

Auto generated by the registry software that can be customized

### Additional Information

### Data Source Hierarchy Guide

Vendor provided

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



### Description

The last name of the patient.

### Element Values

Relevant value for data element

### Additional Information

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

### Data Source Hierarchy Guide

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

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



### Description

The first name of the patient.

### Element Values

Relevant value for data element

### Additional Information

If alias is used it will be documented in the alias sections, this field should be the patient’s actual legal name.

If the patient’s legal name is not known, leave blank.

### Data Source Hierarchy Guide

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

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



### Description

The patient’s middle initial

### Element Values

Relevant value for data element

### Additional Information

Free text

## Demographics TR1.18 –Patient Address



### Description

The patient’s home address.

### Element Values

Relevant value for data element

### Additional Information

Free text

## Demographics TR1.18.1 – Address Line 2



### Description

The patient’s home address line 2.

### Element Values

Relevant value for data element

### Additional Information

Free text

## **Optional Referring Facility Information**

## Referring Facility TR33.1 – Referring Hospital



### Description

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

### Element Values

Michigan Facilities

Other (used for out of state facilities)

### Additional Information

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

### Data Source Hierarchy Guide

1. EMS Run Report
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork

## Referring Facility TR33.1.1 – Other Facility



### Description

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

### Element Values

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

### Additional Information

Only used when the referring facility is not listed.

Will show when Referring Hospital is set to Other.

### Data Source Hierarchy Guide

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

## Referring Facility TR33.1.2 – Other Facility Transferred From City



### Description

The city the patient was transferred from.

### Element Values

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

### Additional Information

Only used when the referring facility is not listed.

Will show when Referring Hospital is set to Other.

### Data Source Hierarchy Guide

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

## Referring Facility TR33.1.3 – Other Facility Transferred From State



### Description

The name of the state the patient was transferred from.

### Element Values

Relevant value for data element

### Additional Information

Only used when the referring facility is not listed.

Will show when Referring Hospital is set to Other.

### Data Source Hierarchy Guide

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

## Referring Facility TR33.1.4 – Other Facility Transferred From Country

### Description

The name of the country the patient was transferred from.

### Element Values

Relevant value for data element

### Additional Information

Only used when the referring facility is not listed.

Will show when Referring Hospital is set to Other.

### Data Source Hierarchy Guide

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

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

### Description

The date the patient arrived at the referring hospital

### Element Values

Relevant value for data element

### Additional Information

YYYY-MM-DD

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

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



### Description

The time the patient arrived at the referring hospital

### Element Values

Relevant value for data element

### Additional Information

HH:MM

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

## Referring Facility TR33.30 – Referring Hospital Discharge Date



### Description

The date the patient was physically discharged from the referring hospital

### Element Values

Relevant value for data element

### Additional Information

YYYY-MM-DD

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

## Referring Facility TR33.31 – Referring Hospital Discharge Time

### Description

The time the patient was physically discharged from the referring hospital

### Element Values

Relevant value for data element

### Additional Information

HH:MM

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records
3. EMS record

## Referring Facility TR33.48 – Transported to referring facility by

### Description

Mode of transport from referring facility

### Element Values

ALS

BLS

Helicopter ambulance

Fixed wing ambulance

Other

Police

Private / public vehicle / Walk in

Not known / not recorded

### Additional Information

### Data Source Hierarchy Guide

1. EMS record
2. Trauma / Triage / Hospital Flow sheet
3. Transfer center records

## Referring Facility TR33.4 – Physician Name



### Description

The name of the physician who ordered the transfer.

### Element Values

As cited by referral hospital

### Additional Information

Free text

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

## Referring Facility TR33.45 – Medical Record Number



### Description

The patient's medical record number at the referring hospital

### Element Values

As cited by referral hospital

### Additional Information

Free text

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

## Referring Facility TR33.46 – Trauma Registry Number

### Description

The patient's trauma registry number at the referring hospital

### Element Values

As cited by referral hospital

### Additional Information

Free text or auto populated by integrated software

### Data Source Hierarchy Guide

1. Referring facility paperwork
2. Transfer center records

## Optional Injury Information

## Injury TR200.3.2 – Intentionality

### Description

Intentionality.

### Element Values

Assault

Not Known/Not Recorded

Other

Self-inflicted

Undetermined

Unintentional

### Additional Information

#### Data Source Hierarchy Guide

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

## Injury TR5.8 – Supplemental Cause of Injury

### Description

Injury complaint

### Element Values

Accident	Fire	Paddle boarding
Aircraft	Fireworks related	Pending
All-terrain vehicle	Frostbite	Police
Assault	Gunshot wound	Power tools
Bicycle crash	Hanging	Rape
Bite/sting	Heat related	Rollerblading
Boating	Homicide	Rollerskating
Burn	Horse drawn carriage	Scooter
Child abuse	Industrial accident	Skateboarding
Crushing injury	Injured by animal	Skiing
Cut/pierce accidental	Jetski (personal watercraft)	Skydiving
Dirt bike	Lightning	Sledding
Diving	Moped driver	Snowboarding
Dog bite	Moped passenger	Snowmobile
Domestic abuse	Moped crash	Sport related
Drowning	Motor pedestrian crash	Stab wound
Electrical injury	Motor vehicle crash	Struck by object
Exposure/inhalation	Motor vehicle non-traffic	Suicide
Fall	Motorcycle crash	Tornado
Fall not further specified	Motorized stand-up scooter	Train
Fall 1-6 meters (3-19 feet)	Natural causes	Trampoline
Fall over 6 meters (20 feet)	Not Applicable	Waterskiing
Fall under 1 meter (3 feet)	Not Known/Not Recorded	
Farm/Heavy Equipment/Machine	Other	

### Additional Information

#### Data Source Hierarchy Guide

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

## Injury TR5.14 – Vehicle Position



### Description

The position of the patient in the motor vehicle at the time of the injury. Information gathered from EMS run sheet. This field only applies if the mechanism of injury is motor vehicle collision.

### Element Values

Driver  
Moped driver  
Moped passenger  
Motorcycle driver  
Motorcycle passenger  
Other specified  
Passenger back seat  
Passenger front  
Passenger rear seat center  
Passenger rear seat driver side  
Passenger rear seat passenger side  
Pedal cyclist  
Pedestrian  
Ride animal  
Streetcar occupant  
Truck bed passenger  
Not Applicable  
Not Known/Not Recorded

### Additional Information

#### Data Source Hierarchy Guide

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

## Injury TR5.15 – Vehicle Position Other



### Description

The position of the patient in the motor vehicle at the time of the injury.

### Element Values

Relevant value for data element

### Additional Information

Free text field used only when vehicle position list has no applicable choice

## Injury TR20.12 – Injury Description



### Description

The description of injury

### Element Values

Relevant value for data element

### Additional Information

Free text

## Optional Pre-Hospital Information

## Pre-Hospital TR18.68– EMS Diastolic Blood Pressure

### Description

EMS diastolic blood pressure.

### Element Values

Relevant value for data element

### Additional Information

Free text numeric field

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR18.59– EMS Temperature

### Description

Patient temperature as obtained by EMS.

### Element Values

Relevant value for data element

Units:

C (Celsius) – TR18.59

F (Fahrenheit) – TR18.59.1

### Additional Information

- Free text numeric field.
- Entry in one unit will auto-populate the other.

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR18.106 – Vital Sign Date

### Description

The date the vital sign was obtained

### Element Values

Relevant value for the data element.

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report



## Pre-Hospital TR18.106.1 – Vital Sign Time

### Description

The time the vital sign was obtained

### Element Values

Relevant value for the data element.

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report



## Pre-Hospital TR18.63 – GCS Qualifier



### Description

GCS qualifier for the score

### Element Values

Not applicable

Obstruction to the patient's eye

Patient chemically sedated

Intubated

Valid GCS: legitimate

Intubated and chemically paralyzed

Valid GCS: not sedated, not intubated

Not known/not recorded

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR8.10 – Transport Mode from Scene



### Description

The mode of transport delivering the patient from the scene to your hospital

### Element Values

Ambulance

Helicopter

Fixed wing

Private / public vehicle / walk in

Police

Other

Not known / not recorded

### Additional Information

NTDS TR8.8 is the field to use for how the patient was delivered to a hospital; however, patients may be transported from a scene by more than one method. TR8.10 is from the scene to the hospital, or from the scene to the next type of transport.

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.32 – Destination Determination



### Description

The reason the hospital was chosen to transport the patient to

### Element Values

Closest facility

Diversion

Hospital of choice

Not applicable

Not known / not recorded

Not transported (tiered response)

Online medical direction

Other

Specialty resource center

Trauma center

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report

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



### Description

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

### Element Values

Relevant value for the data element

### Additional Information

Picked from a drop-down menu after selecting agency state.

If agency name is not listed, contact State Trauma Data Administrator

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.38 – EMS Report Status



### Description

This field applies only if an ambulance/flight selection was made from previous “Mode” field. Select “Complete” if a full EMS report was available.

### Element Values

Missing / No

Incomplete

Complete / Yes at Arrival

Not Applicable

Not Known / Not Recorded

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR7.1 – EMS Run Number



### Description

The EMS run number is assigned by the EMS agency that generated the incident.

### Element Values

Relevant value for data element

### Additional Information

Free text

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.11– EMS Patient Care Report (PCR) Number



### Description

EMS Patient Care Report (PCR) Number

### Element Values

Relevant value for data element

### Additional Information

Free text

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.17 – En Route Date



### Description

The date the EMS agency started toward the injury scene.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.17.1 – En Route Time



### Description

The time the EMS agency started toward the injury scene.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.6 – Patient Contact Date



### Description

The date the service arrived at the patient at the injury scene.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.5 – Patient Contact Time

### Description

The time the service arrived at the patient at the injury scene.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.16 – Trauma Notification Called in by EMS Date

### Description

This field collects the date EMS contacted the hospital to provide information on the condition of their patient and estimated date of arrival at the hospital.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.16.1 – Trauma Notification Called in by EMS Time



### Description

This field collects the time EMS contacted the hospital to provide information on the condition of their patient and estimated time of arrival at the hospital.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.4 – Unit Arrived Hospital Date



### Description

The date the unit arrived at the hospital.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR9.4.1 – Unit Arrived Hospital Time



### Description

The time the unit arrived at the hospital.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR8.12 – EMS Role



### Description

The role EMS provider played in transport to facility.

### Element Values

Transport from scene

Transport from rendezvous

Intercept

Non-transport

Not Applicable

Unknown

### Additional Information

Relevant value for data element

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.40 – Airway Management



### Description

The management of the patient's airway, adjuncts and devices.

### Element Values

Airway cleared  
Alternative Airway Device  
Bag and mask  
CPAP  
Crico  
EOA  
LMA  
Nasal Cannula  
Nasal ETT  
Nasal trumpet  
Non-rebreather Mask  
Not Applicable  
Not Done / Not Documented  
Not Known / Not Recorded  
Not Performed  
Oral Airway  
Oral ETT  
Supplemental Oxygen  
Supraglottic Airway  
Trach

### Additional Information

- Relevant value for data element.
- Can select more than one with control + select.

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.30 – Fluids

### Description

Fluids given to the patient.

### Element Values

IO fluids  $\leq$  500 ml

IO fluids > 2000 ml

IO fluids 500 – 2000 ml

IO fluids attempted

IO fluids unknown amount

IV fluids  $\leq$  500 ml

IV fluids > 2000 ml

IV fluids 500 – 2000 ml

IVF attempted

IVF unknown amount

Not Applicable

Not Known / Not Recorded

Saline Lock

### Additional Information

Relevant value for data element

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.56 – Total Fluids Administered

### Description

Prehospital total amount of fluids administered.

### Element Values

Relevant value for data element

### Additional Information

Free numerical text field

Recorded in CC/ML

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.60 – Prehospital Procedures



### Description

Prehospital procedures.

### Element Values

12 lead ECG	Hemorrhage tourniquet
Airway bag & mask	Laryngeal mask airway (LMA)
Airway nasal cannula	Lower extremity immobilization
Airway non-rebreather mask	Nasopharyngeal airways (NPA)
Airway supplemental oxygen	Needle decompression
Cardio-pulmonary resuscitation (CPR)	Oral endotracheal tube (ETT)
Chest tube	Packed red blood cells
Cricothyroidotomy	Pelvic wrap
Defibrillation	Rapid sequence induction
External pacemaker	Spinal immobilization
Hemorrhage hemostatic dressing	Upper extremity immobilization
Hemorrhage pressure	

### Additional Information

Relevant value for data element

Can select multiple options

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.39 – CPR Performed



### Description

Indication of whether CPR was given to the patient prior to ED / hospital

### Element Values

Not performed

No

Yes

Not applicable

Not known / not recorded

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.41 – CPR Location



### Description

Location that CPR was given to the patient prior to arrival at the ED / hospital

### Element Values

Scene

Enroute

Not applicable

Not known / not recorded

### Additional Information

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR18.97 – Tube Thoracostomy



### Description

Thoracentesis / tube thoracostomy

### Element Values

Yes

No

Not applicable

Not known / not recorded

### Additional Information

#### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR18.96 – Needle Thoracostomy / Decompression



### Description

Needle thoracostomy

### Element Values

Yes

No

Not applicable

Not known / not recorded

### Additional Information

#### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.36 – Temperature Maintained

### Description

Whether or not the temperature of the patient was maintained



### Element Values

Yes

No

Not applicable

Not known / not recorded

### Additional Information

#### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.37 – Appropriate Wound Management

### Description

Whether or not the wounds of the patient were managed appropriately



### Element Values

Yes

No

Not applicable

Not known / not recorded

### Additional Information

#### Data Source Hierarchy Guide

EMS Run Report

## Description

## Medications

## Element Values

ACLS drugs	Geodon (ziprasidone)	Other Vaso Active Agent
Adenosine	Glucagon	Oxygen
Albuterol	Haldol (Haloperidol)	Packed red blood cells
Amiodarone	Heparin	Pancuronium
Ancef (Cefazolin)	Inderal (Propranolol)	Pentothal (Thiopental)
Anectine (Succinylcholine)	Insulin	Pepcid (Famotidine)
Antibiotic	Isuprel (Isoproterenol)	Phenergan (Promethazine)
Aspirin (ASA)	Ketamine	Phenobarbital
Ativan (Lorazepam)	Lasix (Furosemide)	Phytonadione (Vitamin K)
Atracurium	Levaquin (Levofloxacin)	Prasugel
Atropine	Levetiracetam (Kepra)	Procainamide
Atrovent (Ipratropium)	Levophed (Norepinephrine)	Propofol
Benadryl (Diphenhydramine)	Lidocaine	Protonix (Pantaprozole)
Bretylium	Lovenox (Enoxaparin)	Reglan (Metoclopramide)
Calcium chloride	Magnesium sulfate	Rocephin (Ceftriaxone)
Calcium gluconate	Mannitol	Salbutamol
Cardizem (Diltiazem)	Methylprednisolone	Sodium bicarbonate
Cerebyx (Fosphenytoin)	Mivacron (Mivacurium)	Sodium nitroprusside
Cipro (Ciprofloxacin)	Morphine sulfate	Tetanus (TT, DT, or DPT)
Claforan (Cefotaxime)	Motrin (Ibuprofen)	Thiamine (Vitamin B1)
Colloid solution	Narcan (Naloxene)	Tissue plasminogen activator (tPA)
Compazine (Prochlorperzine)	Nardil (Phenelzine)	Toradol (Ketorolac)
Crystalloid solution	Nifedipine	Tranexamic acid (TXA)
Darvocet	Nimbex (Cistracurium)	Tylenol (Acetaminophen)
Decadron (Dexamethasone)	Nitroglycerin	Ultram (Tramadol)
Demerol (Meperidine)	Nitrous oxide	Unasyn
Dextrose (glucose)	Norcuron (Vecuronium)	Unknown
Dilantin (Phenytoin)	Not Applicable	Valium (Diazepam)
Dilaudid (Hydromorphone)	Not Available	Vancomycin
Dobutamine	Not Known/Not Recorded	Verapamil
Dopamine	Nubain (Nalbuphine)	Versed (Midazolam)
Epinephrine (aqueous)	Other Antibiotic	Vistaril (Hydroxyzine)
Etomidate	Other Anti-hypertensive	Xanax (Alprazolam)
Fentanyl	Other Anti-seizure	Zantac (Ramtidine)
Flagyl (metronidazole)	Other Benzodiazapine	Zemuron (Rocuronium)
Gentamicin	Other Opiate / Narcotic	

Zofran (Ondansetron)

### Additional Information

Relevant value for data element.

Can select multiple options.

### Data Source Hierarchy Guide

EMS Run Report

## Pre-Hospital TR15.61 – Provider’s Primary Impression

### Description

Provider’s primary impression

### Element Values

Relevant value for data element

### Additional Information

Free text.

Can use lookup feature.

### Data Source Hierarchy Guide

EMS Run Report



## **Optional ED/Trauma Team Activation (TTA) Information**

## ED/TTA TR17.30 – Direct Admit to Hospital

### Description

Was the patient admitted to the hospital, directly

### Element Values

Yes

No

Not known / not recorded

### Additional Information

Relevant value for data element.

### Data Source Hierarchy Guide

1. Nursing Notes
2. H & P
3. Physician Notes
4. Access Center Record/Communication Center

## ED/TTA TR17.31 – Date of Trauma Team Activation

### Description

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

### Element Values

Yes

No

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element as described by regional benchmarks and regional discussions.

### Data Source Hierarchy Guide

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

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



### Description

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

### Element Values

Reported as HH:MM.

### Additional Information

Required if a leveled trauma activation is entered (Level 1, Level 2, Level 3).

If the patient was not an activation/alert, leave blank.

### Data Source Hierarchy Guide

Trauma/Triage/Hospital Flow Sheet

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



### Description

Was the facility-specific trauma activation/alert activated?

### Element Values

Level 1

Level 2

Level 3

Not Activated

Not Known/Not Recorded

### Additional Information

This should be the initial level/alert that was sent out. If the level was upgraded put the first activation that went out.

If no activation/alert was sent out but trauma/surgeon saw the patient in the ED, select “Level 3.”

If the patient was a direct admit, select “Not Activated.”

Not applicable should not be used for this field.

If your facility has only one level of activation, select Level 1.

If your facility has two levels of activation, Level 1 is associated with the highest level.

### Data Source Hierarchy Guide

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

## ED/TTA TR17.78.1 – TTA Date Change

### Description

The date the activation level was changed

### Element Values

Relevant

### Additional Information

YYYY-MM-DD

### Data Source Hierarchy Guide

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

## ED/TTA TR17.78.2 – TTA Upgrade/Downgrade

### Description

The activation level upgrade / downgrade

### Element Values

Not known / not recorded

Yes downgraded

Yes upgraded

### Additional Information

Relevant value for data element

### Data Source Hierarchy Guide

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

## ED/TTA TR17.78.4 – Old Level of TTA

### Description

The original level of trauma team activation at the emergency department

### Element Values

Level 1

Level 2

Level 3

Not activated

Not known / not recorded

Not applicable

### Additional Information

Relevant value for data element

### Data Source Hierarchy Guide

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

## ED/TTA TR17.78.3 – New Level of TTA

### Description

The new level of trauma team activation

### Element Values

Level 1

Level 2

Level 3

Not activated

Not known / not recorded'

Not applicable

### Additional Information

Relevant value for data element

### Data Source Hierarchy Guide

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

## ED/TTA TR16.22 – Arrived From

### Description

Location the patient arrived from.

### Element Values

Scene

Referring Hospital

Clinic/MD Office

Jail

Home

Nursing Home

Supervised Living

Urgent Care

Not Known/Not Recorded

### Additional Information

Patients injured at home should be coded as “Scene.”

### Data Source Hierarchy Guide

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

## ED/TTA TR17.45 – Transfer Delay

### Description

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

### Element Values

Yes

No

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element as described by regional benchmarks and regional discussions.

### Data Source Hierarchy Guide

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

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

### Description

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

### Element Values

#### 1. Communication Issue

- a. Selecting this field value will show TR17.44. Communication with the following options:
  - i. Miscommunication between sending and receiving facility
  - ii. Nursing delay in calling for/arranging transportation
  - iii. Nursing delay in contacting EMS
  - iv. Physician response delay
  - v. Not Known

#### 2. Delay Issue

- a. Selecting this field value will show TR17.44. Delay with the following options:
  - i. Delay in diagnosis
  - ii. Delay in Emergency Department disposition decision
  - iii. Delay in trauma team activation
  - iv. Not Known

#### 3. Delayed identification that the patient needed trauma center resources

#### 4. EMS Issue

- a. Selecting this field value will show TR17.44.EMS with the following options:
  - i. Air transport ETA greater than ground transport ETA
  - ii. Air transport not available due to weather
  - iii. Out of county
  - iv. Shortage of available ground transportation
  - v. Not Known

#### 5. Error Issue

- a. Selecting this field value will show TR17.44. Error with the following options:
  - i. Error in judgement
  - ii. Error in technique
  - iii. Error in treatment
  - iv. Not Known

#### 6. Family, Legal Guardian, or Patient Issue

- a. Selecting this field value will show TR17.44. Patient with the following options:
  - i. Change in patient condition
  - ii. Child Protective Services (CPS)
  - iii. Family requested transfer
  - iv. Patient requested transfer
  - v. Not Known

#### 7. Referring Facility Issue

- a. Selecting this field value will show TR17.44. Referring with the following options:

- i. Physician decision making
- ii. Priority of transfer
- iii. Radiology workup delay
- iv. Surgeon availability
- v. Not Known

8. Equipment issue

- a. Selecting this field value will show TR17.44. Equipment with the following options:
  - i. Equipment broken
  - ii. Equipment missing/unavailable
  - iii. Not Known

9. Weather or Natural Factors Issue

- a. Selecting this field value will show TR17.44. Weather with the following options:
  - i. Flooding
  - ii. Rain
  - iii. Snow
  - iv. Tornado
  - v. Not Known

10.5.39

11. Not Applicable

12. Not Known/Not Recorded

13. High ED census at receiving hospital/busy

14. High ED census at transferring hospital/busy

15. In-house imaging delay

16. Late requesting transporting EMS unit

17. Low patient acuity

18. Other

- a. Selecting this field will open a free-text field

19. Patient status change/complication

20. Referring hospital Issue – Radiology

21. Receiving Facility Issue

- a. Selecting this field value will show TR17.44. Receiving with the following options:
  - i. Physician decision making
  - ii. Priority of transfer
  - iii. Radiology workup delay
  - iv. Surgeon availability
  - v. Not Known

22. Referring Physician Decision Making

### Additional Information

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

### Data Source Hierarchy Guide

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

## ED/TTA TR17.61 – Hospital Transferred To

### Description

The name of the acute care facility the patient was transferred to.

### Element Values

Favorites

MI

Other

### Additional Information

Relevant value for data element

Other requires additional fields of facility name, city, state

### Data Source Hierarchy Guide

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

## ED/TTA TR17.62 – Facility Name

### Description

When Hospital Transferred To is OTHER, this field is the for the facility name

### Element Values

Alpha

### Additional Information

Free text

## ED/TTA TR17.63 – Facility City



### Description

When Hospital Transferred To is OTHER, this field is the for the city where that other hospital is located

### Element Values

Alpha

### Additional Information

Free text

## ED/TTA TR17.64 – Facility State



### Description

When Hospital Transferred To is OTHER, this field is the for the state where that other hospital is located

### Element Values

Alpha

### Additional Information

Free text

## ED/TTA TR17.60 – Discharge Transport Mode



### Description

This type of transportation used to transfer the patient. Patient who are transferred by private vehicles are considered to have been discharged and referred. These cases need not be reported.

### Element Values

Ambulance

Helicopter

Fixed wing

Private vehicle

Police

Public safety

Other

Not Applicable

Not Known/Not Recorded

### Additional Information

None

### Data Source Hierarchy Guide

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

## ED/TTA TR18.99 – Admitting Service



### Description

The service the patient was admitted to at your facility.

### Element Values

Anesthesia/CRNA	Not Known/Not Recorded
Burn	Obstetrics
Cardiology	Ophthalmology
Cardiovascular (CV) surgery	Oral Surgery
Critical Care Medicine	Oromaxillo Facial Service
Emergency Medicine	Orthopedics
Ears, Nose, Throat	Other
Gastrointestinal	Pediatric Surgery
General Surgery	Pediatrics
Gynecology	Plastic Surgery
Hospitalist	Pulmonary Medicine
Infection Control	Radiology
Internal Medicine	Respiratory Therapy
Nephrology	Thoracic Surgery
Neurology	Trauma
Neurosurgery	Trauma Nurse
Non-Surgical	Urology
Not Applicable	Vascular

### Additional Information

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

### Data Source Hierarchy Guide

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

## ED/TTA TR25.69– Organs/Tissue Donation Requested



### Description

Was there a documented request of the next of kin to donate organs or tissues of the patient that is currently in the Emergency Department?

### Element Values

Yes

No

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element

## ED/TTA TR25.29– Organ Donation



### Description

Was organ tissue donated from a patient that was in the Emergency Department?

### Element Values

Yes

No

Tissue donation

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element

## ED/TTA TR25.70– Organs Donated



### Description

If the patient was an organ donor, what organs were recovered?

### Element Values

Adrenal glands	Lung
Bone	Nerve
Bone marrow	Other
Cartilage	Pancreas
Cornea	Skin
Dura mater	Small intestines
Fascia lata	Stomach
Heart	Tendons
Kidney	Unknown
Large intestines	Valve
Liver	Whole eye

### Additional Information

Relevant value for data element.

Select that all are appropriate.

Hold the control key to select multiple items within the software.

## ED/TTA TR25.37– Autopsy Performed



### Description

Was an autopsy performed or does the chart indicate that one will be performed?

### Element Values

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

### Additional Information

Relevant value for data element

## ED/TTA TR17.59– ED Destination Determination



### Description

The reason the facility was chosen as the destination.

### Element Values

- |                                  |   |
|----------------------------------|---|
| Specialty Care/Higher Level Care | Specialty- orthopedics – pelvic ring/acetabular fxs |
| Patient/family request           | Specialty – orthopedics – soft tissue coverage      |
| Other-specify                    | Specialty – other orthopedics                       |
| Hospital of choice               | Specialty – pediatrics                              |
| Specialty- burns                 | Specialty – replantation                            |
| Specialty – cardiac (bypass)     | Specialty – spine                                   |
| Specialty – facial trauma        | Specialty – vascular/aortic injuries                |
| Specialty – hand                 | Not Known/Not Recorded                              |
| Specialty – neurosurgery         |   |

### Additional Information

Relevant value for data element

## ED/TTA TR17.28– OR Discharge Disposition



### Description

The operating room discharge disposition.

### Element Values

Died	Not Applicable
Floor bed	Not Known/Not Recorded
Home with services	Observation unit (unit that provides < 24 hour stay)
Home without services	Other (jail, institution, etc.)
Intensive care unit	Telemetry/step-down unit (less acuity than ICU)
Left against medical advice	Transferred to another hospital

### Additional Information

Relevant value for data element.

## ED/TTA TR25.99– Discharge Physician



### Description

The physician responsible for the discharge summary or discharge orders from the ED.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry.

## ED/TTA TR18.98– Admitting MD/Staff



### Description

Admitting MD/staff.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## ED/TTA TR17.29– Consulting Service



### Description

Did the patient see a consulting service?

### Element Values

Yes

No

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element.

## ED/TTA TR17.32– Consulting Service Type



### Description

Type of the consulting service.

### Element Values

Acute rehabilitation medicine	Kidney transplant
Anesthesia	Liver
Bariatric	Neonatal
Burn	Nephrology
Cardiology	Neurointensive care
Cardiothoracic surgery	Neurology
Chemical dependency	Neurosurgery
Colo-rectal	Neurosurgery – spine
Critical care medicine	Not applicable
Critical care surgery	Not known/not recorded
Dentistry	Obstetrics
Dermatology	Occuloplastics
Ear Nose Throat	Oncology
Electrophysiology	Ophthalmology
Emergency Medicine	Oral Maxillo Facial Surgery
Endocrinology	Orthopedic surgery
Family Medicine	Ortho-spine
Gastroenterology	Pain
General surgery	Palliative care
Geriatrics	Plastic surgery
Gynecology	Podiatry
Hand	Psychiatry
Hematology oncology	Psychology
Hospitalist	Pulmonary Medicine
Hyperbaric medicine	Rheumatology
Infectious disease	Trauma surgery
Intensive care unit	Urology
Internal medicine	Vascular surgery
Interventional radiology	

### Additional Information

Relevant value for data element.

## ED/TTA TR17.33– Consulting Staff



### Description

Staff consulted for the service.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## ED/TTA TR17.7– Date Consulting Practitioner Requested



### Description

The date the consulting practitioner was requested.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## ED/TTA TR17.8- Time Consulting Practitioner Requested



### Description

The time the consulting practitioner was requested.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## ED/TTA TR17.75– Date Arrived



### Description

The date the consulting practitioner arrived.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## ED/TTA TR17.76– Time Arrived



### Description

The time the consulting practitioner arrived.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## ED/TTA TR18.131– Attending MD/Staff



### Description

Attending MD/staff member.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.



## ED/TTA TR18.132– Attending Service

### Description

Attending MD/staff service type.

### Element Values

- |                        |                      |
|------------------------|----------------------|
| Burn                   | Obstetrics           |
| Cardiology             | Ophthalmology        |
| Emergency Medicine     | Orthopedics          |
| ENT                    | Pediatric surgery    |
| Family Practice        | Pediatrics           |
| General surgery        | Plastics             |
| Hand                   | Podiatry             |
| Hospitalist            | Surgery subspecialty |
| Internal Medicine      | Trauma               |
| Neurosurgery           | Urology              |
| Not Applicable         |                      |
| Not Known/Not Recorded |                      |

### Additional Information

Relevant value for data element.

## ED/TTA TR17.9– ED Provider

### Description

ED physician or APP.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## ED/TTA TR17.13– ED Provider Service Type

### Description

The responding trauma team member's service type.

### Element Values

Anesthesia	Nurse practitioner
Dental	Obstetrics & gynecology
ED RN	Ophthalmology
Emergency department technician	Organ retrieval
Emergency medicine	Orthopedic surgery
Endocrinology	Pediatric surgery
Ears Nose Throat	Physician assistant
Family practice	Plastic surgery
Infectious diseases	Pulmonology
Intensive care unit	Radiology
Internal medicine	Respiratory therapy
Laboratory	Social work
Maxillofacial surgery	Surgery senior resident
Nephrology	Surgery/trauma
Neurosurgery	Trauma nurse
Not Applicable	Urology
Not Known/Not Recorded	Vascular surgery

### Additional Information

Relevant value for data element.

## ED/TTA TR17.10– Date Provider Called



### Description

The date provider was called.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## ED/TTA TR17.14– Time Physician Called



### Description

The time provider was called.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## ED/TTA TR17.15– Date Provider Arrived



### Description

The date provider arrived.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## ED/TTA TR17.11 – Time Provider Arrived



### Description

The time provider arrived.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## ED/TTA TR17.12– Was Trauma Provider Arrival in ED Timely



### Description

Was the trauma surgeon arrival timely?

### Element Values

Yes

No

Not Known/Not Recorded

### Additional Information

Relevant value for data element as determined by hospital trauma program or regional benchmark.

## ED/TTA TR17.79– Response Time



### Description

Calculated by difference between team member called and team member arrived in minutes.

### Element Values

Auto calculation

### Additional Information

Relevant value for data element.

## ED/TTA TR17.99– Length of Stay in ED (total Min to Physical D/C)



### Description

## Element Values

Auto calculation

## Additional Information

Relevant value for data element.

## **Optional Initial Assessment Information**

## Initial Assessment TR18.104– Vitals Date



### Description

The date the assessment was performed.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Initial Assessment TR18.110 – Vitals Time



### Description

The time the assessment was performed.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Initial Assessment TR18.13 – Initial Assessment Diastolic Blood Pressure



### Description

Initial assessment diastolic blood pressure of patient.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

## Initial Assessment TR18.147 – Temperature Route

### Description

Indicates the initial ED hospital temperature measurement route

### Element Values

Axillary

Foley

Oral

Other

Rectal

Temporal artery

Tympanic

Not applicable

Not known / not recorded

### Additional Information

## Initial Assessment TR18.135 – RTS Calculation

### Description

Glasgow Coma Scale, systolic blood pressure, and respiratory rate are weighted factors in the equation using a 0-12 scale.

### Element Values

Whole number 0 to 12

### Additional Information

Vendor should auto calculate

## Initial Assessment TR21.10 – Initial ED/Hospital PTS Total



### Description

Initial ED/Hospital pediatric trauma score (PTS) total.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

## Initial Assessment TR18.44.1 – GCS 40 Total Calculation



### Description

The total of the GCS 40 values

### Element Values

Alpha numeric including non testable and zero to six summed across categories

### Additional Information

Auto-calculate

## Initial Assessment TR14.36 – Airway Management



### Description

Airway management that was performed in the emergency department

### Element Values

Bag and mask

BIPAP

Combitube

CPAP

Crico

EOA

King

LMA

Nasal airway

Nasal cannula

Nasal ETT

Non rebreather mask

Not known / not recorded

Not performed

Oral airway

Oral ETT

Simple mask

Trach

Ventilator

### Additional Information

## Initial Assessment TR18.71 – CPR Performed



### Description

Was CPR performed in the emergency department

### Element Values

CPR in progress, continued

Yes

No

Not known / not recorded

### Additional Information

## Initial Assessment TR22.13 – Units of Blood



### Description

Total units of blood administered in the emergency department

### Element Values

Numeric

### Additional Information

Number of units

## Initial Assessment TR22.14 – Blood Ordered Date



### Description

Blood ordered for the patient date

### Element Values

### Additional Information

YYYY-MM-DD

## Initial Assessment TR22.14 – Blood Ordered Time



### Description

Blood ordered for the patient time

### Element Values

Relevant

### Additional Information

HH:MM

## Initial Assessment TR22.15 – Crossmatch Date



### Description

Date the patient's blood was crossmatched

### Element Values

Relevant

### Additional Information

YYYY-MM-DD

Initial Assessment TR22.18 – Crossmatch Time



Description

Time the patient’s blood was crossmatched

Element Values

Relevant

Additional Information

HH:MM

Initial Assessment TR22.16. – Blood Administered Date



Description

Date the blood was administered to the patient

Element Values

Relevant

Additional Information

YYYY-MM-DD

Initial Assessment TR22.19 – Blood Administered Time



Description

Time the blood was administered to the patient

Element Values

Relevant

Additional Information

HH:MM

## Initial Assessment TR18.72 – CT Head



### Description

CT of the patient's head results.

### Element Values

Positive

Negative

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.73 – CT Abdomen / Pelvis



### Description

CT of the patient's abdomen / pelvis results

### Element Values

Positive

Negative

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.74 – CT Chest



### Description

CT of the patient's chest results

### Element Values

Positive

Negative

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.105 – CT Cervical

### Description

CT of the patient’s cervical spine

### Element Values

Positive

Negative

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.101 – Date to CT

### Description

Date the patient was sent to CT

### Element Values

Relevant

### Additional Information

YYYY-MM-DD

## Initial Assessment TR18.111 – Time to CT

### Description

Time the patient was sent to CT

### Element Values

Relevant

### Additional Information

HH:MM

Initial Assessment TR18.124 – Date CT Read



Description

Date the patient’s CT was read

Element Values

Relevant

Additional Information

YYYY-MM-DD

Initial Assessment TR18.125 – Time CT Read



Description

Time the patient’s CT was read

Element Values

Relevant

Additional Information

HH:MM

Initial Assessment TR18.76 – Abdominal Ultrasound



Description

Results of patient’s abdominal ultrasound

Element Values

Not performed

Inconclusive

Negative

Positive

Not known / not recorded

Additional Information

## Initial Assessment TR18.102– Abdominal Ultrasound Date



### Description

Date the patient received an abdominal ultrasound

### Element Values

Relevant

### Additional Information

YYYY-MM-DD

## Initial Assessment TR18.112 – Abdominal Ultrasound Time



### Description

Time the patient received an abdominal ultrasound

### Element Values

Relevant

### Additional Information

YYYY-MM-DD

## Initial Assessment TR18.76 – Arteriogram



### Description

A medical imaging technique in which an X-ray picture is taken to visualize the inner opening of blood filled structures, including arteries, veins and the heart chambers.

### Element Values

Not applicable

Negative

Positive

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.77 – Aortogram



### Description

Results of patient's aortogram

### Element Values

Not applicable

Negative

Positive

Not performed

Not known / not recorded

### Additional Information

## Initial Assessment TR18.95 – Initial ED/Hospital Hematocrit



### Description

Hematocrit.

### Element Values

Relevant value for data element

### Additional Information

Populated with numeric reading selections

## Initial Assessment TR18.93 – Base deficit



### Description

Defined as a value greater than 4 at a time during admission. This number is reported as a component or arterial or venous blood gases. The number may be reported by the lab as base deficit, or as base excess with a negative value.

### Element Values

Relevant value for data element

### Additional Information

Populated with numeric reading selections

## Initial Assessment TR18.47 – Prothrombin Time



### Description

The time, in seconds, that it takes for the patient's blood to clot.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

Recorded in seconds.

## Initial Assessment TR18.48 – Partial Thromboplastin Time



### Description

The time, in seconds, that it takes for the patient's blood to coagulate.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

Recorded in seconds.

## Initial Assessment TR18.182– ABGs drawn



### Description

Were arterial blood gases drawn?

### Element Values

Yes

No

Not Known/Not Recorded

### Additional Information

Relevant value for data element.

## Initial Assessment TR18.179– ABGs pH



### Description

Initial ABG pH.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

## Initial Assessment TR18.180– Pa02



### Description

Initial Pa02.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

## Initial Assessment TR18.181– PaC02



### Description

Initial PaC02.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field.

## Optional Procedures Information

## Procedures TR200.11– Procedure Performed Location



### Description

The hospital location where the procedure was performed.

### Element Values

Catheterization lab	Other
Emergency department	Outpatient clinic
Endoscopy	PTA (referring hospital)
Floor	Radiology
GI lab	Readmit OR (planned OR)
ICU	Recovery
Minor surgery unit	Rehabilitation
Not Applicable	Scene
Not Known/Not Recorded	Special procedure unit
Nuclear medicine	Step-down
Observation	Tele
Operating room	

### Additional Information

Relevant value for data element.

## Procedures TR200.10– Physician Performing the Procedures



### Description

The physician performing the procedures.

### Element Values

Relevant value for data element

### Additional Information

Physicians can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## Procedures TR200.7– Physician Comments



### Description

Procedure comments.

### Element Values

Relevant value for data element

### Additional Information

Free text.

## Procedures TR200.6– Service Type of the Physician



### Description

Service type of the physician.

### Element Values

Anesthesia	Obstetrics
Cardiology	Ophthalmology
Critical care medicine	Oral maxilla facial surgery
Ear nose throat	Orthopedic surgery
Emergency medicine	Pediatric orthopedic surgery
Gastroenterology	Pediatric surgery
General surgery	Plastic surgery
Gynecology	Podiatry
Hand surgery	Radiology
Medicine	Thoracic surgery
Neurosurgery	Trauma surgery
Not Applicable	Urology
Not Known/Not Recorded	Vascular surgery

### Additional Information

Relevant value for data element.

## Procedures TR200.2.2.2 – Urgency



### Description

Timeliness of a procedure

### Element Values

Emergency  
Elective

### Additional Information

## Procedures TR200.2.2.3 – Date in OR/Time in OR



### Description

The date the patient was in the OR and time the patient was in the OR.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD and HH:MM.

## Procedures TR200.2.2.4– Date out of OR/Time out of OR



### Description

The date the patient was out of the OR and time the patient was out of the OR.

### Element Values

Relevant value for data element

### Additional Information

Reported as MM/DD/YYYY and HH:MM.

## Procedures TR200.2.2.9– Staff Involved with Procedure

### Description

The staff that are involved with the procedure.

### Element Values

Relevant value for data element

### Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## Procedures TR200.2.1.6 – Exam Arrival Date

### Description

The date the patient was sent to radiology for the procedure.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Procedures TR200.2.1.6.1– Exam Arrival Time

### Description

The time the patient was sent to radiology for the procedure.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Procedures TR200.2.1.8 – Exam Finished



### Description

The date the patient left radiology following the procedure.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Procedures TR200.2.1.8.1– Exam Finished Time



### Description

The time the patient left radiology following the procedure.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Procedures TR200.2.1.4 – Request Date

### Description

The date the radiology procedure was requested.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.



## Procedures TR200.2.1.4.1 – Request Time

### Description

The time the radiology procedure was requested.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.



## Procedures TR200.15 – Procedure Arterial Puncture Date



### Description

The date the procedure arterial puncture was performed.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Procedures TR200.15.1 – Procedure Arterial Puncture Time



### Description

The time the procedure arterial puncture was performed.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Procedures TR200.2.3.2 – Radiology Results Read Date



### Description

The date the radiology procedure was read by radiologist.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Procedures TR200.2.3.3–Radiology Results Read Time



### Description

The time the radiology procedure was read by radiologist.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Procedures TR200.2.3.1– Radiology Results



### Description

Enter the results of the radiology procedures as recorded by the radiologist.

### Element Values

Inconclusive result

Negative

Not Known/Not Recorded

Positive

### Additional Information

Relevant value for data element.

## Procedures TR200.2.1.3– Requesting Staff



### Description

The radiology staff member who wrote the orders for this procedure.

### Element Values

Relevant value for data element

### Additional Information

Staff can be added in the staff section of Patient Registry by hospital administrators or system administrators.

## Procedure TR18.190 – Date of First Antibiotic Administration



### Description

Date of first antibiotic administration. Recommended antibiotics < 60 min from time of arrival to ED on an open fracture.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Procedure TR18.190.1– Time of First Antibiotic Administration



### Description

Time of first antibiotic administration. Recommended antibiotics < 60 min from time of arrival to ED on an open fracture.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Procedure TR26.59– Resource Utilization



### Description

Resources utilized during hospital stay

### Element Values

Adult Protective Services	Pelvic binder
Blood / fluid warmer	Pentobarbital coma
Case management	Peripheral parenteral nutrition (PPN)
Cerebral brain flow studies	Physical therapy
Cervical collar	PRISMA (CVVHD)
Child Protective Services	Respiratory therapy
Exceeds length of stay	RN accompanied transfer
Massive blood transfusion	Specialized bed
None	Speech therapy
Not adequately stated / documented	TLSO brace
Not applicable	Traction
Not known / not recorded	Uncrossmatched blood
Occupational therapy	Wound care RN

### Additional Information

## Optional Diagnosis Information

## Diagnosis TR21.2 – AIS Head/Neck

### Description

AIS Score for Head Related Injury/Disease.

### Element Values

Relevant value for data element

### Additional Information

Free text



## Diagnosis TR21.5 – AIS Face

### Description

AIS Score for Face Related Injury/Disease

### Element Values

Relevant value for data element

### Additional Information

Free text



## Diagnosis TR21.3 – AIS Chest

### Description

AIS Score for Chest Related Injury/Disease.

### Element Values

Relevant value for data element

### Additional Information

Free text



## Diagnosis TR21.6 – AIS Abdomen



### Description

AIS Score for Abdomen Related Injury/Disease

### Element Values

Relevant value for data element

### Additional Information

Free text

## Diagnosis TR21.4 – AIS Extremity



### Description

AIS Score for Extremities Related Injury/Disease

### Element Values

Relevant value for data element

### Additional Information

Free text

## Diagnosis TR21.7 – AIS External



### Description

AIS Score for External Related Injury/Disease

### Element Values

Relevant value for data element

### Additional Information

Free text

## Diagnosis TR21.8 – ISS Calculated



### Description

ISS total score

### Element Values

Numeric auto calculation

### Additional Information

Numeric

## Diagnosis TR200.120– Comments



### Description

Diagnosis comments.

### Element Values

Relevant value for data element

### Additional Information

Free text

## **Optional Comorbidities**

## Comorbidities TR21.21 – Description



### Description

The patient's comorbidities that are not reportable under NTDS preexisting conditions and were present prior to arrival at the ED / hospital

### Element Values

Alzheimer's	Inflammatory bowel disease
Angina pectoris	Multiple sclerosis
Arthritis	Neurological impairment
Ascites	Not known / not recorded
Asthma	Obstructive sleep apnea
Autoimmune disease	Other
Bilirubin > 2mg	Other cardiac diseases
Chronic demyelinating disease	Other liver diseases
Connective tissue disease	Pancreatitis
Coronary arteries disease	Paraplegia/quadriplegia
Developmental delay	Peptic ulcer disease
Eczema	Respiratory disease
History of revascularization/amputation PDD	Rheumatoid arthritis
HIV/AIDS	Seizures
Hyperlipidemia	Transplants
Hypothyroidism	Traumatic brain injury

### Additional Information

## Comorbidities TR21.23 – Additional Notes



### Description

Any additional relevant information on listed comorbidity

### Element Values

### Additional Information

Free text

## Optional Outcome Information

## Outcome TR25.56 – Hospital Admission



### Description

Hospital admission based on hospital admission date, ED disposition, and/or direct admit fields

### Element Values

Yes

No

### Additional Information

Value changes based upon prior field entries

## Outcome TR25.31 – Hospital Discharge Service



### Description

The service that discharged the patient from the hospital

### Element Values

Bariatric	Ophthalmology
Burn	Oral maxillo facial surgery
Cardiology	Orthopedics
Cardiothoracic surgery	Pain
Critical care medicine	Pediatric cardiology
Critical care surgery	Pediatric critical care medicine
Dentistry	Pediatric dentistry
Dermatology	Pediatric gastroenterology
Ear Nose Throat	Pediatric hematology oncology
Endocrinology	Pediatric hospitalist
Family Medicine	Pediatric infectious disease
Gastroenterology	Pediatric intensivist
General surgery	Pediatric nephrology
Geriatrics	Pediatric neurology
Gynecology	Pediatric orthopedic
Hand	Pediatric pulmonary
Hematology / Oncology	Pediatric surgery
Hospitalist	Plastic surgery
Infectious Disease	Podiatry
Internal Medicine	Psychiatry
Neonatal	Psychology
Nephrology	Pulmonary
Neurology	Rehabilitation
Neurosurgery	Rheumatology
Not applicable	Trauma surgeon
Not known / not recorded	Urology
Obstetrics	Vascular surgery
Oculoplastic	

### Additional Information

## Outcome TR25.42– Hospital Discharge Destination Determination



### Description

Hospital discharge destination determination.

### Element Values

- Facial trauma
- Obstetrics
- Ophthalmology
- Orthopedic surgery
- Patient request
- Plastic surgery
- Podiatry
- Specialty burns
- Specialty hand
- Specialty neurosurgery
- Specialty orthopedics (pelvic ring / acetabular fxs)
- Specialty pediatrics
- Specialty replantation
- Specialty spine
- Specialty vascular / aorta injuries
- Thoracic surgery
- Urology

### Additional Information

Relevant value for data element.

## Outcome TR25.42.Other– Other Destination Determination



### Description

Other destination determination.

### Element Values

Relevant value for data element

### Additional Information

Free text

## Outcome TR25.35 – Hospital Transferred To



### Description

The state and then the name of the facility the patient was transferred to.

### Element Values

1. Favorites
2. MI
3. Other

### Additional Information

Relevant value for data element.

Other will require facility name, city, state.

## Outcome TR25.39 – Facility Name



### Description

When Hospital Transferred To is OTHER, this field is the for the facility name

### Element Values

Alpha

### Additional Information

Free text

## Outcome TR25.40 – Facility City



### Description

When Hospital Transferred To is OTHER, this field is the for the city where that other hospital is located

### Element Values

Alpha

### Additional Information

Free text

## Outcome TR25.41 – Facility State



### Description

When Hospital Transferred To is OTHER, this field is the for the state where that other hospital is located

### Element Values

Alpha

### Additional Information

Free text

## Outcome TR25.43– Hospital Discharge Transport Mode



### Description

The mode of transport by which the patient was transported from your facility to the facility that you transferred the patient to.

### Element Values

Ambulance

Helicopter

Fixed wing

Private vehicle

Police

Public safety

Other

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element.



## Outcome TR25.36 – Date of Death

### Description

The date the patient died.

### Element Values

Relevant value for data element

### Additional Information

Reported as YYYY-MM-DD.

## Outcome TR25.36.1– Time of Death

### Description

The time the patient died.

### Element Values

Relevant value for data element

### Additional Information

Reported as HH:MM.

## Outcome TR25.30– Location of Death



### Description

The location where the patient died.

### Element Values

Emergency Department

Floor

ICU

Not Known/Not Recorded

Not recorded

Operating room

PICU

Prior to arrival

### Additional Information

Relevant value for data element

## Outcome TR25.53 – Circumstances of death



### Description

The circumstances of the patient’s death comment.

### Element Values

Relevant value for data element

### Additional Information

Free text

## Outcome TR25.69– Organs/Tissue Donation Requested



### Description

Was there a documented request of the next of kin to donate organs or tissues?

### Element Values

Yes

No

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element

## Outcome TR25.29– Organ Donation



### Description

Was there a donation of patient's organs?

### Element Values

Yes

No

Tissue donation

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element

## Outcome TR25.70– Organs Donated



### Description

If the patient was an organ donor, what organs were recovered?

### Element Values

Adrenal glands	Lung
Bone	Nerve
Bone marrow	Other
Cartilage	Pancreas
Cornea	Skin
Dura mater	Small intestines
Fascia lata	Stomach
Heart	Tendons
Kidney	Unknown
Large intestines	Valve
Liver	Whole eye

### Additional Information

- Relevant value for data element
- Select that all are appropriate

## Outcome TR25.37– Autopsy Performed



### Description

Was an autopsy performed or does the chart indicate that one will be performed?

### Element Values

Yes  
No  
Not Applicable  
Not Known/Not Recorded

### Additional Information

Relevant value for data element

## Outcome TR25.46– General Condition at Discharge

### Description

The general condition of the patient at discharge.

### Element Values

Good, return to previous level of function

Temporary disability, expected to return to previous level of function

Moderate disability with self-care

Severe disability, dependent

Persistent vegetative state

Not Applicable

Not Known/Not Recorded

### Additional Information

Relevant value for data element.

## Outcome TR25.99– Discharge Physician

### Description

The physician responsible for the discharge summary or discharge orders from the ED.

### Element Values

Relevant value for data element

### Additional Information

Staff can be added in the staff section administrators or system administrators

## Outcome TR25.44.Written – Hospital Length of Stay to Discharge Calendar



### Days

#### Description

Formula is TR25.93 Discharge Orders Written Date and TR25.94 Discharge Order Written Time MINUS TR25.33 Hospital Admission Date and TR25.47 Hospital Admission Time in **full calendar days**.  
(Discharge order – Admission order = Hospital Length of Stay)

#### Element Values

Auto calculation

#### Additional Information

## Outcome TR25.44 – Hospital Length of Stay to Discharge Calendar Days



### Description

Formula is TR25.34 Physical Discharge Date and TR25.48 Physical Discharge Time MINUS TR25.33 Hospital Admission Date and TR25.47 Hospital Admission Time in **full calendar days**.  
(Discharge order – Admission order = Hospital Length of Stay)

#### Element Values

Auto calculation

#### Additional Information

## Outcome TR25.44.Mins – Hospital Length of Stay to Discharge Minutes



### Description

Formula is TR25.34 Physical Discharge Date and TR25.48 Physical Discharge Time MINUS TR25.33 Hospital Admission Date and TR25.47 Hospital Admission Time in **minutes**.

#### Element Values

Auto calculation

#### Additional Information

## Outcome TR26.62 – Disability Admission Feeding Description



### Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded
- Not applicable

### Additional Information

## Outcome TR26.63 – Disability Admission Locomotion Description



### Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded

### Additional Information

Outcome TR26.64 – Disability Admission Expression  
Description



Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded

Additional Information

Outcome TR26.62 – Disability Admission Score  
Description



Element Values

Sum of the values

Additional Information

Auto calculated

Outcome TR26.54 – Disability Discharge Feeding  
Description



Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded

Additional Information

## Outcome TR26.55 – Disability Discharge Locomotion



### Description

#### Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded

#### Additional Information

## Outcome TR26.56 – Disability Discharge Expression



### Description

#### Element Values

- 1 – dependent – total help
- 2 – dependent – partial help
- 3 – independent with device
- 4 – independent
- Not known / not recorded

#### Additional Information

## Outcome TR26.61 – Disability Discharge Score



### Description

#### Element Values

Sum of the values

#### Additional Information

Auto calculation

## Outcome TR26.62 – Disability Discharge General Condition



### Description

#### Element Values

- Good, return to previous level of function
- Moderate disability with self care
- Persistent vegetative state
- Severe disability dependent
- Temporary disability expected to return to previous level of function
- Not applicable
- Not known / not recorded

#### Additional Information

## Outcome TR25.100 – Discharge Summary



### Description

A comprehensive narrative of any information you feel should be detailed for this patient's record.

#### Element Values

- Relevant value for data element

#### Additional Information

Free text

## Outcome TR2.7– Secondary Method of Payment



### Description

The secondary source of payment for hospital care.

### Element Values

Auto	Not billed (for any reason)
Blue Cross/Blue Shield	Not Known/Not Recorded
HMO	Other
Managed care	Other government
Medicaid	PPO
Medicare	Private charity
Military / CHAMPUS	Private/commercial insurance
No fault automobile	Self-pay
None	Shriners
Not Applicable	Worker's compensation

### Additional Information

## Outcome TR2.14– Secondary Other Billing Source

### Description

Specify the other secondary billing source.

### Element Values

Relevant value for data element

### Additional Information

Free text

## Outcome TR2.8 – Reimbursed Charges

### Description

### Element Values

Number

### Additional Information

Free text

## Outcome TR2.9 – Billed Charges



### Description

The total charges the patient was billed for the hospital stay.

### Element Values

Relevant value for data element

### Additional Information

Free numeric text field

## Outcome TR25.49 – DRG Codes



### Description

Diagnosis related group codes.

### Element Values

Relevant value for data element

### Additional Information

Free text

Can use lookup feature

## Optional Performance Improvement

