Ohio Trauma Registry

2023

Trauma Acute Care Registry

Data Dictionary

Version 2023.1 (12/08/2022)

This edition is effective for all trauma patients presenting for treatment on or after January 1, 2023.

Ohio Department of Public Safety

EMS Ohio Emergency Medical Services

ACKNOWLEDGEMENTS

The Ohio State Board of Emergency Medical, Fire and Transportation Services and the EMS Division of the Ohio Department of Public Safety would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create, expand and transform the Ohio Trauma Registry from its inception and embryonic beginnings in the late 1990s into the powerful research and policymaking tool it is today. This growth and development would not have been possible without the strength of their combined knowledge, wisdom and hard work.

Trauma Acute Care Registry (TACR) is a component of the Ohio Trauma Registry (OTR) and is maintained by the Ohio Department of Public Safety, 1970 W. Broad St., Columbus, Ohio 43223. For more information about the TACR, OTR and/or the State of Ohio's Trauma System, contact the Ohio Department of Public Safety, Division of EMS, Research and Analysis Section, at (800)233-0785, EMSdata@dps.ohio.gov or visit www.ems.ohio.gov.

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STATEMENT ABOUT ITDX / TECHNICAL STANDARDS VS. CLINICAL STANDARDS

The State of Ohio recognizes the ITDX as the transmission standard. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2023. The manner of end-point collection is left to the trauma vendor(s) provided that these vendors are able to meet both State and ACS reporting requirements.

NATIONAL ELEMENTS THAT WILL NOT BE COLLECTED IN THE OHIO TRAUMA ACUTE CARE REGISTRY

The following elements will not be collected and should be defaulted to Not Applicable.

- Initial ED/Hospital GCS 40 – Eye
- Initial ED/Hospital GCS 40 – Verbal
- Initial ED/Hospital GCS 40 – Motor

OHIO SPECIFIC ELEMENTS

- Hospital Code
- Unique Admission Number
- Trauma Tracking Number
- Facility Type
- Transport Agency
- EMS Dispatch Date
- EMS Dispatch Time
- EMS Unit Arrival Date at Scene or Transferring Facility
- EMS Unit Arrival Time at Scene or Transferring Facility
- EMS Unit Departure Date From Scene or Transferring Facility
- EMS Unit Departure Time From Scene or Transferring Facility
- Initial Field Systolic Blood Pressure
- Initial Field Pulse Rate
- Initial Field Respiratory Rate
- Initial Field Oxygen Saturation
- Initial Field GCS Eye
- Initial Field GCS Verbal
- Initial Field GCS Motor
- Initial Field GCS Total
- Initial Field GCS Qualifier
- Scene Interventions
- Transferring Hospital Code
- ED Discharge Order Written Date
- ED Discharge Order Written Time
- ED Transfer to Hospital
- Procedure Episode
- DNR Status
- Injury Severity Score
- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
- Inpatient Transfer To Hospital
- Discharge Status
- Date of Death
- Autopsy Performed

DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)

Inclusion Criteria Differences

- Ohio follows NTDS Inclusion Criteria with exceptions:
  - Ohio INCLUDES: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in/out or died.)
    - Note that these codes are excluded when patients with these isolated injuries were **NOT** transferred in/out or died, per NTDS.
  - Ohio INCLUDES:
    - J70.5
    - T20-28
    - T30-32
    - T33
    - T34
    - T59.81
    - T67
    - T68
    - T69
    - T70.4
    - T70.8
    - T70.9
    - T71
    - T74.1
    - T74.4
    - T75
    - T75.1
    - T75.4

OH Definition Is Different Than NTDS

- Height
  - OH does not include "within 24 hours or less of ED/Hospital arrival" in definition
- Weight
  - OH does not include "within 24 hours or less of ED/Hospital arrival" in definition

OH Additional Information Is Different Than NTDS

- Patient Home City
  - OH does not include "Only reported when patients home zip postal code is not known not recorded and country is US."
  - OH does not include "Null value NA is reported if patients home zip / postal code is reported."
- Patient Home State
  - OH does not include "Only reported when patient home zip / postal code is not known / not recorded and country is US."
  - OH does not include "Null value NA is reported if patients home zip / postal code is reported."
- Patient Home County
  - OH does not include "Only reported when patient home zip / postal code is not known not recorded and country is US."

    - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
- Patient Home Zip Code
    - OH does not include “May require adherence to HIPAA regulations.”
- Age
    - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Age Units
    - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Incident City
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident State
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident County
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip postal code is reported.”
- Incident Zip Code
    - NTDS says “Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or CA and can be stored in the postal code format of the applicable country.”
    - Ohio says “Stored as a five-digit code (XXXXX)”
- Transport mode for arrival at your hospital
    - OH added examples
- Other Transport Modes
    - OH added examples
- Height
    - OH does not include “…within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
- Weight
    - OH does not include “…within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
- Hospital Procedure Start Date
    - OH added “Linked to hospital procedures element”
- Hospital Procedure Start Time
    - OH added “Linked to hospital procedures element”
    - OH added “If distinct procedures with the same procedure code are performed, their start time must be different”

Other Element Name and Definition Differences

- ED Discharge Order Written Date
- ED Discharge Order Written Time
    - These are Ohio specific elements. However, they match in definition to NTDS ED Discharge Date and ED Discharge Time

- ED Discharge Date
- ED Discharge Time
    - These are NTDS elements, however the Ohio definition is different

- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
    - These are Ohio specific elements. However, they match in definition to NTDS Hospital Discharge Date and Hospital Discharge Time

- Hospital Discharge Date
- Hospital Discharge Time
    - These are NTDS elements, however the Ohio definition is different

Element Value Differences

- ED Discharge Disposition
    - Ohio added "12 Interventional Radiology (IR)"
- Primary Method of Payment
    - Ohio added "8 Workers Compensation"

Edit Check Differences

- For element Hospital Procedure Start Date, the following edit check should not be present:
    - 6607 Hospital Procedure Start Date is later than Hospital Discharge Order Written Date. (Note: NTDS refers to this field as Hospital Discharge Date – Ohio has a different definition for this field.)
- For element Hospital Procedure Start Time, the following edit check should not be present:
    - 6707 Hospital Procedure Start Time is later than Hospital Discharge Order Written Time. (Note: NTDS refers to this field as Hospital Discharge Time – Ohio has a different definition for this field.)

NOTE: Reference to this section is included on each individual element page that is affected by the differences listed.

TACR INCLUSION/EXCLUSION CRITERIA – ICD-10

TRAUMA PATIENT DEFINITION

To ensure consistent data collection across the State of Ohio and to follow the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria:

PATIENT INCLUSION CRITERIA

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

The patient must have incurred at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):

- **J70.5 with character modifier of A ONLY** (Respiratory conditions due to smoke inhalation – initial encounter)
- **S00-S99 with 7th character modifier of A, B or C ONLY** (Injuries to specific body parts – initial encounter):
- **T07** (Unspecified multiple injuries);
- **T14** (Injury of unspecified body region);
- **T20-T28 with 7th character modifier of A ONLY** (Burns by specified body parts – initial encounter);
- **T30-T32** (Burn by TBSA percentage);
- **T33 with character modifier of A ONLY** (Superficial frostbite – initial encounter)
- **T34 with character modifier of A ONLY** (Frostbite with tissue necrosis – initial encounter)
- **T59.81 with 7th character modifier of A ONLY** (Toxic effect of smoke - initial encounter)
- **T67 with character modifier of A ONLY** (Effects of heat and light – initial encounter)
- **T68 with character modifier of A ONLY** (Hypothermia – initial encounter)
- **T69 with character modifier of A ONLY** (Other effects of reduced temperature – initial encounter)
- **T70.4 with character modifier of A ONLY** (Effects of high-pressure fluids – initial encounter)
- **T70.8 with character modifier of A ONLY** (Other effects of air pressure and water pressure – initial encounter)
- **T70.9 with character modifier of A ONLY** (Effect of air pressure and water pressure, unspecified – initial encounter)
- **T71 with character modifier of A ONLY** (Asphyxiation – initial encounter)
- **T74.1 with character modifier of A ONLY** (Physical abuse, confirmed – initial encounter)
- **T74.4 with character modifier of A ONLY** (Shaken infant syndrome – initial encounter)
- **T75.0 with character modifier of A ONLY** (Effects of lightning – initial encounter)
- **T75.1 with character modifier of A ONLY** (Unspecified effects of drowning and nonfatal submersion – initial encounter)
- **T75.4 with character modifier of A ONLY** (Electrocution – initial encounter)
- **T79.A1-T79.A9 with 7th character modifier of A ONLY** (Traumatic compartment syndrome – initial encounter)
- **S00, S10, S20, S30, S40, S50, S60, S70, S80, S90** (Patients with these isolated injuries that were transferred in/out or died.)

PATIENT EXCLUSION CRITERIA

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

- **S00, S10, S20, S30, S40, S50, S60, S70, S80, S90** (Patients with these isolated injuries that were **not** transferred in/out or died would be excluded.);
- **7th character modifiers of D through S** (Late effects)

THE PATIENT MUST ALSO IN ADDITION TO THE ABOVE INCLUSION 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;

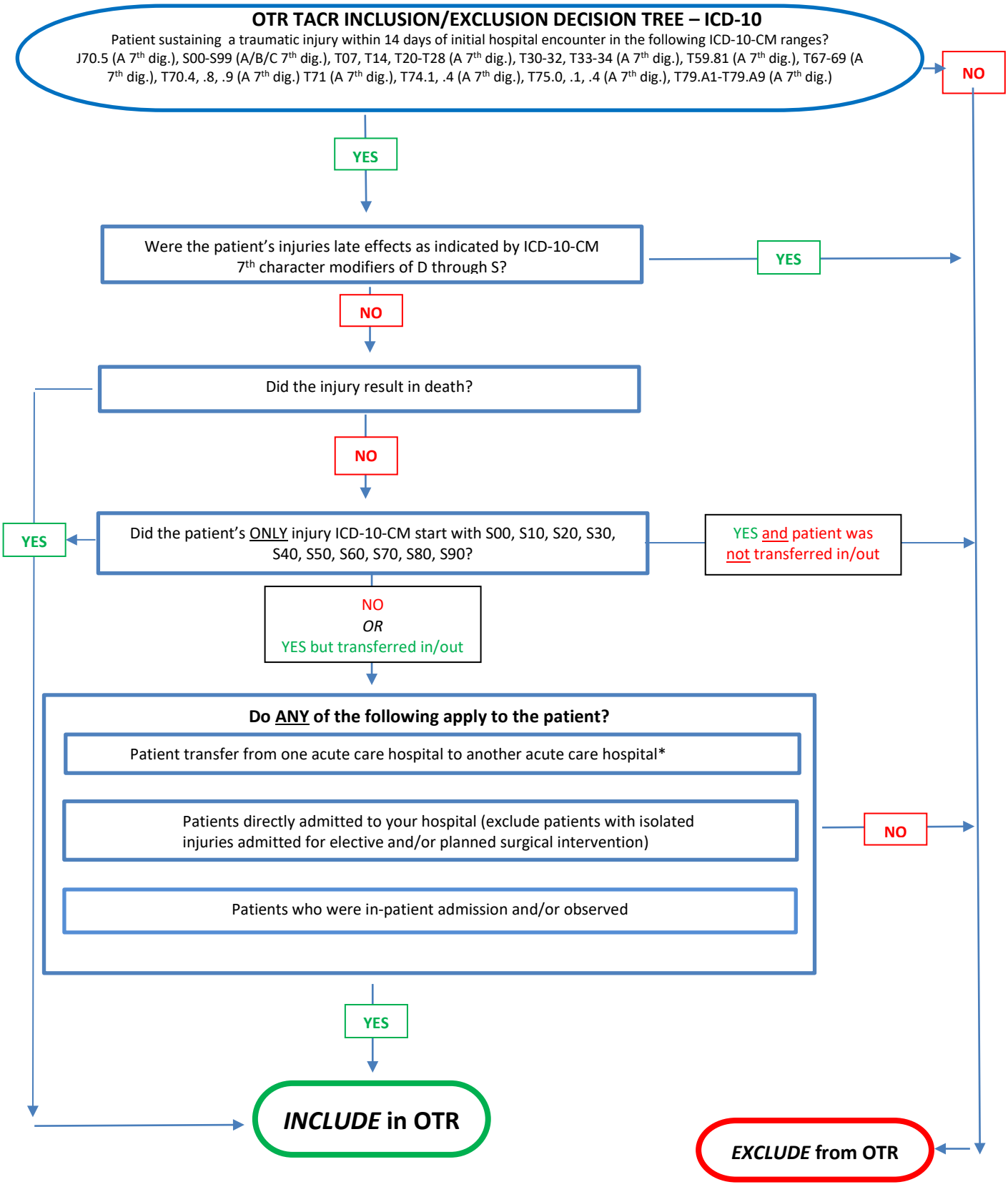
  OR
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);

  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 short-term illness or condition). "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-andsystems/Research/ResearchGeninfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed January 15, 2019).

NOTE: INCLUSION / EXCLUSION CRITERIA differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.


OTR TACR INCLUSION/EXCLUSION DECISION TREE – ICD-10
Patient sustaining a traumatic injury within 14 days of initial hospital encounter in the following ICD-10-CM ranges? J70.5 (A 7th dig.), S00-S99 (A/B/C 7th dig.), T07, T14, T20-T28 (A 7th dig.), T30-32, T33-34 (A 7th dig.), T59.81 (A 7th dig.), T67-69 (A 7th dig.), T70.4, .8, .9 (A 7th dig.) T71 (A 7th dig.), T74.1, .4 (A 7th dig.), T75.0, .1, .4 (A 7th dig.), T79.A1-T79.A9 (A 7th dig.)
NO
YES
Were the patient's injuries late effects as indicated by ICD-10-CM 7th character modifiers of D through S?
YES
NO
Did the injury result in death?
NO
YES
Did the patient's ONLY injury ICD-10-CM start with S00, S10, S20, S30, S40, S50, S60, S70, S80, S90?
YES and patient was not transferred in/out
NO
OR
YES but transferred in/out
Do ANY of the following apply to the patient?
Patient transfer from one acute care hospital to another acute care hospital*
Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)
Patients who were in-patient admission and/or observed
NO
YES
INCLUDE in OTR
EXCLUDE from OTR

COMMON NULL VALUES

Definition

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

Element Values

NA= Not Applicable
ND= Not Known/Not Recorded/Not Documented

Additional Information

- Although not written out on the following pages, these Common Null Values are included in the TACR dataset for every allowable data element. To ascertain their allowability by data field, see the "Accepts Null Value" notation on every data element descriptor page.

- *Not Applicable (Element Value NA):* This null value code applies if, at any time of patient care documentation, the information requested was "Not Applicable" *(NA)* to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be *NA* if a patient self-transports to the hospital.

- *Not Known/Not Recorded/Not Documented (Element Value ND):* This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, healthcare provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown". Another example, Not Known/Not Recorded/Not Documented should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the TACR are to be electronically stored in a database or moved from one database to another, the indicated null values should be applied.

References to Other Databases

- NTDS 2023

HOSPITAL CODE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Stored as a four-digit code (xxxx)

Data Source Hierarchy Guide

1 Ohio Department of Public Safety Hospital (Facility) Code List

References to Other Databases

- Not an NTDS element

UNIQUE ADMISSION NUMBER

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

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

References to Other Databases

- Not an NTDS Element

TRAUMA TRACKING NUMBER

Description

Trauma Tracking Number is a number automatically generated by the trauma registry system.

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

FACILITY TYPE

Description

Facility Type is the type of facility at time of admission, transfer in or transfer out for each patient.

Element Values

1 Free Standing Emergency Department
2 Acute Care Hospital
3 Adult Trauma 1
4 Adult Trauma 2
5 Adult Trauma 3
6 Pediatric Trauma 1
7 Pediatric Trauma 2

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

PATIENT'S HOME CITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2023

NOTE: PATIENT HOME CITY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME STATE

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2023

NOTE: PATIENT HOME STATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2023

NOTE: PATIENT HOME COUNTY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME ZIP CODE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country.
- If ZIP/Postal code is "Not Applicable," report variable: Alternate Home Residence.
- If ZIP/Postal code is "Not Known/Not Recorded," report variables: Patient's Home Country, Patient's Home State (US only), Patient's Home County (US only) and Patient's Home City (US only).
- If ZIP/Postal code is documented, must also report Patient's Home Country.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2023

NOTE: PATIENT HOME ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTRY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing the country (e.g. U.S.)
- 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

References to Other Databases

- NTDS 2023

ALTERNATE HOME RESIDENCE

Description

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

Element Values

1 Homeless
2 Undocumented Resident
3 Migrant Worker

Common Null Values

- Accepted

Additional Information

- Only used when Patient's Home ZIP/Postal Code is "Not Applicable"
- Report all that apply
- *Homeless* is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters
- *Undocumented* Citizen is defined as a national of another country who has entered or stayed in another country without permission
- *Migrant Worker* is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is documented

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2023

DATE OF BIRTH

Description

Date of Birth is the patient's date of birth at time of injury.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- If Date of Birth is "Not Known/Not Recorded," report variables: Age and Age Units.
- If Date of Birth equals Injury Date, then the Age and Age Units variables 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

References to Other Databases

- NTDS 2023

AGE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If Date of Birth is "Not Known/Not Recorded," report variables: Age and Age Units.
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
- Must also report variable: Age Units.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

NOTE: AGE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

AGE UNITS

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- If Date of Birth is "Not Known/Not Recorded," report variables: Age and Age Units.
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported.
- Must also report variable: Age.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

NOTE: AGE UNITS differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

SEX

Description

The patient's sex.

Element Values

1 Male
2 Female
3 Non-binary

Common Null Values

- Not Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

RACE

Description

Race is 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

Common Null Values

- Accepted

Additional Information

- Patient race should be based upon self-report or identified by a family member
- Based on the 2010 US Census Bureau
- Select all that apply

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

References to Other Databases

- NTDS 2023

ETHNICITY

Description

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

Element Values

1 Hispanic or Latino
2 Not Hispanic or Latino

Common Null Values

- Accepted

Additional Information

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

References to Other Databases

- NTDS 2023

PRIMARY ICD-10 EXTERNAL CAUSE CODE

Description

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

Element Values

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

Common Null Values

- Not Accepted

Additional Information

- The Primary External Cause Code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM codes are accepted for this data element. Activity codes should not be reported for this data element.
- Activity codes should not be reported for this data element.
- 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 Sheet
2 Triage Form/Trauma Flow Sheet
3 Nursing Notes/Flow Sheet
4 History & Physical
5 Progress Notes

References to Other Databases

- NTDS 2023

ADDITIONAL ICD-10 EXTERNAL CAUSE CODE

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is used if no additional external cause codes are used
- Activity codes should not be reported for this data element
- Report all that apply (maximum 2)
- 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 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 accident 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 Sheet
2 Triage Form/Trauma Flow Sheet
3 Nursing Notes/ Flow Sheet
4 History & Physical
5 Progress Notes

References to Other Databases

- NTDS 2023

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Description

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

Element Values

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

Common Null Values

- Not Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

WORK-RELATED

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

PATIENT'S OCCUPATIONAL INDUSTRY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- If work related, also report *Patient's Occupation*
- Based upon US Bureau of Labor Statistics Industry Classification
- Code as *NA* if injury is not work-related AND Work-Related value is coded is given a value of "2. No".

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

References to Other Databases

- NTDS 2023

PATIENT'S OCCUPATION

Description

Patient's Occupation is the occupation of the patient.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Only report if injury is work related.
- If work related, also report *Patient's Occupational Industry.*
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- Code as *NA* if injury is not work-related AND Work-Related value is coded is given a value of "2. No".

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

References to Other Databases

- NTDS 2023

INJURY INCIDENT DATE

Description

Injury Incident Date is the date that the injury occurred.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INJURY INCIDENT TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INCIDENT CITY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2023

NOTE: INCIDENT CITY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT STATE

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2023

NOTE: INCIDENT STATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT COUNTY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2023

NOTE: INCIDENT COUNTY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT LOCATION ZIP CODE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Stored as a five-digit code (XXXXX).
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is documented, then must report Incident Country.

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2023

NOTE: INCIDENT LOCATION ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT COUNTRY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing a country (e.g. US)
- If Incident Country is not US, then the null value "Not Applicable" is reported for: Incident State, Incident County, and Incident Home City

Data Source Hierarchy Guide

1 EMS Run report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2023

PROTECTIVE DEVICES

Description

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

Element Values

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

Common Null Values

- Accepted
- Element cannot be “Not Applicable”

Additional Information

- Report all that apply
- If “Child Restraint” is present, report variable *Child Specific Restraint*
- If “Airbag” is present, report variable *Airbag Deployment*
- Evidence of the use of safety equipment may be reported or observed
- “Lap belt” should be reported to include those patients that are restrained, but not further specified
- If chart indicates "3-point-restraint," report element value “2. Lap Belt” and “10. Shoulder Belt.”
- If documented that a “Child Restraint (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, report Element Value “1. None.”

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

CHILD SPECIFIC RESTRAINT

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only reported when *Protective Devices* include “6. Child Restraint (booster seat or child car seat).”
- The null value "Not Applicable" is reported if Element Value 6. "Child Restraint" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

AIRBAG DEPLOYMENT

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Report all that apply.
- Evidence of the use of airbag deployment may be reported or observed.
- Only report when Protective Devices include "8. Airbag Present."
- Airbag Deployed Front should be reported for patients with documented airbag deployments, but are not further specified.
- The null value "Not Applicable" is reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Example of "Other Transport Mode" include boat
- Examples of "Public or Private or Walk-in" include: bus, bicycle or personal vehicle
- If a patient was a visitor/in-house patient at your facility and experienced an event to require admission to the ED select patient's mode of arrival as "4/Private or Public Vehicle or Walk-In".

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- NTDS 2023

NOTE: TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

TRANSPORT AGENCY

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report
2 ED Record

References to Other Databases

- Not an NTDS element

OTHER TRANSPORT MODES

Description

Other Transport Modes documents all other types of transport used during patient care prior to the patient arriving at your hospital, except the transport mode delivering the patient to your hospital.

Element Values

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

Common Null Values

- Accepted

Additional Information

- For patients with an unspecified mode of transport, select 6, *Other*
- The null value "Not Applicable" is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.
- An example is an ambulance transporting the patient to the helicopter landing zone.

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- NTDS 2023

NOTE: OTHER TRANSPORT MODES differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

EMS PATIENT CARE REPORT 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-F0-9]{3}-[89abAB][a-fA-F0-9]{3}-[afA-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 NEMSIS 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 NEMSIS versions lower than 3.5.0. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 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

1 EMS Run Report

References to Other Databases

- NTDS 2023

EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For interfacility 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.
- The null value "Not Applicable" is reported for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For interfacility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For interfacility 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).
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For interfacility 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).
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For interfacility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For interfacility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- The null value “Not Applicable” is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Description

Initial Field *Systolic Blood Pressure* is the first recorded systolic blood pressure measured.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD PULSE RATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD RESPIRATORY RATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD OXYGEN SATURATION

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- 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 Known/Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - EYE

Description

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

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

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye 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-Eye was NOT measured

Data Source Hierarchy Guide

1 EMS Run Record

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - VERBAL

Description

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

Element Values

- Pediatric(<= 2 years of age)
  1 No vocal response
  2 Inconsolable, agitated
  3 Inconsistently consolable, moaning
  4 Cries but is consolable, inappropriate interactions
  5 Smiles, oriented to sounds, follows objects, interacts
- Adult
  1 No verbal response
  2 Incomprehensible sounds
  3 Inappropriate words
  4 Confused
  5 Oriented

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If patient is intubated, then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 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 - Verbal was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - MOTOR

Description

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

Element Values

- Pediatric (<= 2 years of age)
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Appropriate response to stimulation
- Adult
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Obeys commands

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1. EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - TOTAL

Description

Initial Field GCS Total is the first recorded total Glasgow Coma Score done.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation
- 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 GCS - Total was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS QUALIFIER

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., 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, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that the first recorded vitals do not need to be from the same assessment.
- Select *NA* if the patient was not transported to your hospital by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

SCENE INTERVENTIONS

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

PREHOSPITAL CARDIAC ARREST

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation
- The event must have occurred outside of the reporting hospital, prior to admission at the center in which the registry is maintained.
- Pre-hospital cardiac arrest could occur at a transferring institution
- Any component of basic and/or advanced cardiac life support must have been initiated

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INTERFACILITY TRANSFER

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Patients transferred from a private doctor's office or stand-alone ambulatory surgery centers are NOT considered interfacility transfers.
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

TRANSFERRING HOSPITAL CODE

Description

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

Element Values

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

Common Null Values

- Accepted

Data Source Hierarchy Guide

1 ED Record
2 History & Physical

References to Other Databases

- Not an NTDS element

ED/HOSPITAL ARRIVAL DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

ED/HOSPITAL ARRIVAL TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient was brought to your hospital ED, enter the time patient arrived at the ED. If the patient was a directly admit to your hospital and bypassed the ED, enter that time that the patient was admitted to your hospital.
- Collected as HHMM military time

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

HIGHEST ACTIVATION

Description

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

INCLUDE:

- Patients who received 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 by 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

- 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
5 Discharge Summary

References to Other Databases

- NTDS 2023

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

- Collected as YYYY-MM-DD.
- Limit 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 the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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 HHMM military time.
- Limit 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 the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Physician Notes
4 History & Physical

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL PULSE RATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL RESPIRATORY RATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If documented, report additional element *Initial ED/Hospital Respiratory Assistance*
- Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Description

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

Element Values

1 Unassisted Respiratory Rate
2 Assisted Respiratory Rate

Common Null Values

- Accepted

Additional Information

- Only reported if *Initial ED/Hospital Respiratory Rate* is documented
- 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
- The null value “Not Applicable” is reported if “Initial ED/Hospital Respiratory Rate” is “Not Known/Not Recorded”

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL OXYGEN SATURATION

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If documented, report additional element *Initial ED/Hospital Supplemental Oxygen*
- Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Description

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

Element Values

1 No Supplemental Oxygen
2 Supplemental Oxygen

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the *Initial ED/Hospital Oxygen Saturation* is "Not Known/Not Recorded"
- Please note that first recorded hospital vitals do not need to be from the same assessment

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL TEMPERATURE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL GCS - EYE

Description

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

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

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/ hospital vitals do not need to be from the same assessment.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – 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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL GCS - VERBAL

Description

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

Element Values

- Pediatric(<= 2 years of age)
  1. No vocal response
  2. Inconsolable, agitated
  3. Inconsistently consolable, moaning
  4. Cries but is consolable, inappropriate interactions
  5. Smiles, oriented to sounds, follows objects, interacts
- Adult
  1. No verbal response
  2. Incomprehensible sounds
  3. Inappropriate words
  4. Confused
  5. Oriented

Common Null Values

- Accepted

Additional Information

- If patient is intubated then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/ hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – 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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL GCS - MOTOR

Description

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

Element Values

- Pediatric(<= 2 years of age)
  1 No motor response
  2 Extension to pain
  3 Flexion to pain
  4 Withdrawal from pain
  5 Localizing pain
  6 Appropriate response to stimulation
- Adult
  1 No motor response
  2 Extension to pain
  3 Flexion to pain
  4 Withdrawal from pain
  5 Localizing pain
  6 Obeys commands

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – 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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL GCS - TOTAL

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- 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 were 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

References to Other Databases

- NTDS 2023

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Description

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

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

Common Null Values

- Accepted

Additional Information

- Report all that apply.
- Identifies treatments given to the patient that may affect the first GCS assessment. This element does not apply to self-medications the patient may administer (i.e., 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, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that the 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

References to Other Databases

- NTDS 2023

HEIGHT

Description

Height is the patient's height in centimeters.

Element Values

- Height in centimeters

Common Null Values

- Accepted

Additional Information

- Recorded in centimeters
- May be based on family or self-report
- 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 the patient's Initial ED/Hospital Height was not measured

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

NOTE: HEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

WEIGHT

Description

Weight is the patient's weight in kilograms.

Element Values

- Weight in kilograms

Common Null Values

- Accepted

Additional Information

- Recorded in kilograms
- May be based on family or self-report
- 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 the patient's Initial ED/Hospital Weight was not measured

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

NOTE: WEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE ORDER WRITTEN DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

NOTE: ED DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED DISCHARGE ORDER WRITTEN TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Time is the time of death as indicated on the patient’s death certificate
- Collected as HHMM military time

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

NOTE: ED DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED DISCHARGE DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of death as indicated on the patient’s death certificate

Data Source Hierarchy 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

References to Other Databases

- NTDS 2023 (element name only)

NOTE: ED DISCHARGE DATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED DISCHARGE TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Time is the time of death as indicated on the patient’s death certificate

Data Source Hierarchy Guide

1 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

References to Other Databases

- NTDS 2023 (element name only)

NOTE: ED DISCHARGE TIME differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11 the Hospital Discharge Date, Time, Disposition and Inpatient Transfer to Hospital should be “Not Applicable”
- If multiple orders were written, report the final disposition order

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

References to Other Databases

- NTDS 2023

NOTE: ED DISCHARGE DISPOSITION differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED TRANSFER TO HOSPITAL

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11 the Hospital Discharge date, Time, Disposition and Inpatient Transfer to Hospital should be “Not Applicable”

Data Source Hierarchy Guide

1 ED Record
2 History & Physical

References to Other Databases

- Not an NTDS element

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 Programs 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 Hierarch y Guide

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

References to Other Databases

- NTDS 2023

ALCOHOL SCREEN

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Not Accepted

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

References to Other Databases

- NTDS 2023

ALCOHOL SCREEN RESULTS

Description

Alcohol Screen Results is the first recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collect as X.XX grams per deciliter (g/dl)
- Record BAC results within 24 hours after first hospital encounter at either your facility or the transferring facility
- The null value “Not Applicable” is used for those patients who were not tested

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2023

DRUG SCREEN

Description

Drug Screen is the first recorded positive drug screen within 24 hours after first hospital encounter (select all that apply).

Element Values

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

Common Null Values

- Not Accepted

Additional Information

- Report positive drug screen results within 24 hours after first hospital encounter, at either your facility or transferring facility
- "None" is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and hand no positive results
- If multiple drugs are detected, only report drugs that were not administered at any facility (or setting) treating this patient event

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2023

ICD-10 HOSPITAL PROCEDURES

Description

Hospital Procedures are all 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 the OTR.

Element Values

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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures
- Include only procedures performed at your institution
- Report all procedure performed in the operating room
- Report all procures 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.
- Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.
- Note that the hospital may capture additional procedures

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

References to Other Databases

- NTDS 2023

PROCEDURE LIST FOR *HOSPITAL PROCEDURES* ELEMENT

DIAGNOSTIC & THERAPEUTIC IMAGING
Computerized tomographic studies* (Head, Chest, Abdomen, Pelvis, C-Spine, T-Spine, L-Spine)
Diagnostic ultrasound (includes FAST)*
Doppler ultrasound of extremities*
Angiography
Angioembolization
REBOA
Inferior vena cava (IVC) filter
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton
Plain radiography of infant whole body

CARDIOVASCULAR
Open cardiac massage
Cardiopulmonary Resuscitation (CPR)

CENTRAL NERVOUS SYSTEM
Insertion of ICP monitor*
Ventriculostomy
Cerebral oxygen monitoring*

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

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

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

RESPIRATORY
Insertion of endotracheal tube* (Exclude intubations performed in the OR)
Continuous invasive mechanical ventilation*
Chest tube*
Bronchoscopy*
Tracheostomy

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

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

PROCEDURE EPISODE

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Operative Reports

References to Other Databases

- Not an NTDS element

HOSPITAL PROCEDURE START DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This element is linked to the Hospital Procedures element
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

NOTE: HOSPITAL PROCEDURE START DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL PROCEDURE START TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This element is linked to the Hospital Procedures element
- Collected as HHMM military time
- Procedure start time is defined as the time that the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start time must be different.

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

References to Other Databases

- NTDS 2023

NOTE: HOSPITAL PROCEDURE START TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ADVANCE DIRECTIVE LIMITING CARE

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
- Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
- 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 (e.g. decompressive craiectomy, operation for hemorrhage control, angiography)
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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 American Psychiatric Association (APA) DSM 5, 2013.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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.

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Reteplase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenacteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- Anticoagulant must be part of the patient's active medication.
- Exclude patients whose only anticoagulant therapy is chronic Aspirin.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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.
- 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 Hierarch y 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

References to Other Databases

- NTDS 2023

BLEEDING DISORDER

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden).
- Consistent with American Society of Hematology, 2015.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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 (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Element Values

1 Yes
2 No

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

CONGENITAL ANOMALIES

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of a congenital anomaly must be documented in the patient's medical record.
- 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's Notes
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References to Other Databases

- NTDS 2023

CONGESTIVE HEART FAILURE (CHF)

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

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

CURRENT SMOKER

Description

A patient who reports smoking cigarettes every day or some days within the last 12 months.

EXCLUDE:

- Patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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's Notes
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7 Discharge Summary

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
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7 Discharge Summary

References to Other Databases

- NTDS 2023

DEMENTIA

Description

Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's).

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

DIABETES MELLITUS

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
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References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
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7 Discharge Summary

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

HYPERTENSION

Description

History of persistent elevated blood pressure requiring antihypertensive medication.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of Hypertension 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.
- Report Element Value ‘1. Yes’ for patients who were non-compliant with their prescribed antihypertensive medication.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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.
- 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 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

References to Other Databases

- NTDS 2023

MYOCARDIAL INFARCTION (MI)

Description

History of a MI in the six months prior to injury.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of MI 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

OTHER MENTAL/PERSONALITY DISORDERS

Description

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

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

Element Values

1 Yes
2 No

Additional Information

- Present prior to injury.
- 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 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

References to Other Databases

- NTDS 2023

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. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of Peripheral Arterial Disease must be documented in the patient's medical record.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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.
- 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 Hierarch y 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

References to Other Databases

- NTDS 2023

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

PREMATURITY

Description

Babies born before 37 weeks of pregnancy are completed.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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 ≥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's Notes
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5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

SCHIZOAFFECTIVE DISORDER

Description

A schizoaffective disorder diagnosis documented in the medical record.

Element Values

1 Yes
2 No

Additional Information

- Present prior to injury.
- 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 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

References to Other Databases

- NTDS 2023

SCHIZOPHRENIA

Description

A schizophrenia diagnosis documented in the medical record.

Element Values

1 Yes
2 No

Additional Information

- Present prior to injury.
- 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 Hierarch y 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

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone.
- Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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 (e.g. 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; Other Stimulant-Related Disorder

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- 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 the American Psychiatric Association (APA) DSM 5, 2013.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

DNR STATUS

Description

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

Element Values

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

Common Null Values

- Not Accepted

Additional Information

- This element is completed for each patient.
- DNR status is typically ordered for a patient who does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing) near the end of life.
- A DNR status includes both *DNR-CC* (comfort care) and *DNR-CCA* (comfort care arrest) orders.
- DNR may also be referred to as Allow Natural Death (AND)
- Until DNR status is documented, the patient is considered to be "not a DNR patient".
- DNR Status is to be collected at time of discharge if patient has multiple status changes during stay.
- Refer to Ohio Department of Health for additional details: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/do-not-resuscitate-comfort-care.

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

ICD-10 INJURY DIAGNOSES

Description

Injury Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses are defined by ICD-10-CM codes; refer to inclusion criteria
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Common Null Values

- Not Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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

1 AIS Coding Manual

References to Other Databases

- NTDS 2023

AIS VERSION

Description

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

Element Values

6 AIS 05, Updated 08

Additional Information

None

Common Null Values

- Accepted

Data Source Hierarchy Guide

1 AIS Coding Manual

References to Other Databases

- NTDS 2023

INJURY SEVERITY SCORE

Description

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

Element Values

- Relevant ISS value for the constellation of injuries

Additional Information

None

Common Null Values

- Accepted

Data Source Hierarchy Guide

1 AIS Coding Manual

References to Other Databases

- Not an NTDS element

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

Common Null Values

- Accepted

Additional Information

- 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 an ICU episode are recorded in the patient's chart.
- 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 that day as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- The null value "Not applicable" is reported if the patient had no ICU days according to the above definition.
- A '0' (zero) in this field is not an acceptable value.
- See Appendix B for examples of ICU LOS calculations

Data Source Hierarchy Guide

1 ICU Flow Sheet
2 Nursing Notes/Flow Sheet

References to Other Databases

- NTDS 2023

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

Common Null Values

- Accepted

Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- 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.
- The null value "Not known / Not Recorded" is reported if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.
- A '0' (zero) in this field is not an acceptable value.
- See Appendix B for examples of Total Ventilator Days calculations.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

HOSPITAL DISCHARGE ORDER WRITTEN DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is reported if ED Discharge Disposition is 5. Deceased/Expired

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE ORDER WRITTEN TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- The null value "Not Applicable" is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/ expired).

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE DATE

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is reported if ED Discharge Disposition is 5. Deceased/Expired

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023 (element name only)

NOTE: HOSPITAL DISCHARGE DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE TIME

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- The null value "Not Applicable" is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/ expired).

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023 (element name only)

NOTE: HOSPITAL DISCHARGE TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE DISPOSITION

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Element value “6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- Element values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be coded as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- The null value "Not Applicable" is reported if ED Discharge Disposition is “5, Deceased/Expired.”
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version 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.
- If multiple orders were written, report the final disposition order.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

INPATIENT TRANSFER TO HOSPITAL

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

None

Data Source Hierarchy Guide

1 Discharge Summary
2 Progress Notes
3 Billing/Registration Sheet

References to Other Databases

- Not an NTDS element

DISCHARGE STATUS

Description

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

Element Values

1 Alive
2 Dead

Common Null Values

- Not Accepted

Additional Information

None

Data Source Hierarchy Guide

1 Discharge Summary
2 Progress Notes
3 Billing Sheet

References to Other Databases

- Not an NTDS element

DATE OF DEATH

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- *Date of Death* must be ≤ *Hospital Discharge Date*
- Only complete element when *Discharge Status* is completed as *Dead*
- This may differ from the date of discharge

Data Source Hierarchy Guide

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

References to Other Databases

- Not an NTDS element

PRIMARY METHOD OF PAYMENT

Description

Primary Method of Payment is the primary source of payment for hospital care.

Element Values

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

Common Null Values

- Accepted

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "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.
- Examples of "Other Government Payer Source": Veterans Affairs (VA), TRICARE, CHAMPVA
- Charity or HCAP should be coded under "Not Billed"

Data Source Hierarchy Guide

1 Billing Sheet
2 Admission Form
3 Face Sheet

References to Other Databases

- NTDS 2023

NOTE: PRIMARY METHOD OF PAYMENT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

AUTOPSY PERFORMED

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Select *NA* if the patient is alive
- If only an external or visual-type exam was done and no internal organs were surgically explored, element value #2, *No, an autopsy was not performed,* should be selected.

Data Source Hierarchy Guide

1 Autopsy Report
2 Discharge Summary

References to Other Databases

- Not an NTDS element

ACUTE KIDNEY INJURY (AKI)

Description

Acute kidney injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient's stay at your hospital.

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 (Stage 3) Table:

(SCr) 3 times baseline

OR

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR

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

OR

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

OR

Anuria for ≥ 12 hours

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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 collage, or nodules
Origin of edema:	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation:	
Mild	200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP >= 5 cm H2Oc
Moderate	100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O
Severe	PaO2/FIO2 < 100 mm Hg With PEEP or CPAP >5 cm H2O

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Description
A UTI where an indwelling urinary catheter was in place for > 2 calendar days on the date of the 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 the event for the UTI must be 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 had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of the event AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    - Fever (≥ 38^{o} C): Reminder: to use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE.
    - Suprapubic tenderness with no other recognized cause
    - 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 bacteria > 10^5 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°C)
    - Hypothermia (<36.0°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 bacteria of ≥ 10^5 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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 remove, 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 central line, day of first access in an inpatient location is considered Day. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule). Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms:

- Fever (>38°C)
- Chills
- Hypotension

AND

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

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. Not C. diphtheria], 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 non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms:

- Fever (>38°C)
- Hypothermia (<36°C)
- Apnea
- Bradycardia

AND

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

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. Not C. diphtheria], 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 non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

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

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 purposed of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ACS/AST) or culture or non-culture based microbiologic test method is not performed

AND

Patient has at least one of the following signs or symptoms:

- Fever (>38°C)
- Localized pain or tenderness
- A culture or non-culture based test that has a negative finding does not meet this criterion
- An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

- Deep Incisional Primary (DIP): a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
- Deep Incisional Secondary (DIS): a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB.)

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

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
BIBL	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 check 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.
- 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

DEEP VEIN THROMBOSIS (DVT)

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.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2023

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 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:

- Patients 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's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2023

MYOCARDIAL INFARCTION (MI)

Description
An acute myocardial infarction must be noted with documentation of ECG changes indicative of 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.

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ORGAN/SPACE SURGICAL SITE INFECTION

Description

Must meet the following criteria:

Infection that occurs within 30 or 90 days after the NHS operative procedure (where da 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:

a) Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)

b) Organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment) e.g., not Active Surveillance Culture/Testing (ASC/AST).

c) An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

Meets at least one criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

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

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
BIBL	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 check 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	LUNG	Other infections of respiratory tract
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or Pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, Mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI Tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

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.

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OSTEOMYELITIS

Description

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified by culture or non-cultured based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/ASST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic examination.
3. Patient has at least two of the following localized signs or symptoms:
    - Fever (>38^{o} C)
    - Swelling*
    - Pain or Tenderness*
    - Heat*
    - Drainage*

AND at least one of the following:

a. Organisms identified from blood by culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, 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.

b. 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.

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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 V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

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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 symptoms began after arrival to your ED/hospital.
- Pressure ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

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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.

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STROKE/CVA

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

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

  AND

- Duration of neurological deficit ≥ 24 h

  OR

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

  AND

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

  AND

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

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 (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

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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 or subcutaneous tissue of the incision

AND

Patient has at least **one** of the following:

a. Purulent drainage from the superficial incision.
b. Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
c. Superficial incision is deliberately opened by the 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
- Heat
- A culture or non-culture based test hat has a negative finding does not meet this criterion

d. Diagnosis of Superficial incisional SSI by the surgeon or attending physician** or other designee.

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

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

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.

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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.

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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.
- In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

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UNPLANNED VISIT TO THE OPERATING ROOM

Description

Patients with an unplanned operative procedure OR patients returned to the operating room after initial operation management of a related previous procedure.

EXCLUDE:

- Non-urgent tracheostomy and percutaneous endoscopic gastrostomy.
- Pre-planned, staged and/or procedures for incidental findings.
- Operative management related to a procedure that was initially performed prior to arrival at your center.

Element Values

1 Yes
2 No

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Non-urgent tracheostomy and percutaneous endoscopic gastrostomy.
- EXCLUDE: Pre-planned, staged and/or procedures for incidental findings.
- EXCLUDE: Operative management related to a procedure that was initially performed prior to arrival at your center.

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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 (PNU2 Bacterial or Filamentous Fungal Pathogens):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38^{o}C or >100.4^{o}F) • Leukopenia (<4000 WBC/mm^{3}) or leukocytosis (≥12,000 WBC/mm^{3}) • For adults ≥70 years old, altered mental status with no other recognized cause **AND at least two of the following**: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable	At least **one** of the following: • Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause **AND at least two of the following:** • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Virus, *Bordetella, Legionella, Chlamydia or Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). • Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in Legionella. pneumophila serogroup 1 antibody titer to ≥1:128 in pared acute and convalescent sera by indirect IFA. • Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY

Two or more serial chest radiographs with at least **one** of the following:
 	
• New or progressive **and** persistent infiltrate
 	
• Consolidation
 	
• Cavitation
 	
• Pneumatoceles, in infants ≤1 year old
 	
NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable
	Patient who is immunocompromised has at least **one** of the following:
	
	• Fever (>38°C or >100.4°F)
	
	• For adults ≥70 years old, altered mental status with no other recognized cause
	
	• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
	
	• New onset or worsening cough, or dyspnea, or tachypnea
	
	• Rales or bronchial breath sounds
	
	• Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)
	
	• Hemoptysis
	
	• Pleuritic chest pain
		At least **one** of the following:
		
		• Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13
		• Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:
		  ○ Direct microscopic exam
		  ○ Positive culture of fungi
		  ○ Non-culture diagnostic laboratory test
		
		Any of the following from:
		LABORATORY CRITERIA DEFINED UNDER PNU2

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable	At least **three** of the following: • Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F) • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Element Values

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.

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Appendix A - Discharge Disposition Definitions

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

Appendix B - Calculating ICU Length of Stay and Ventilator Days

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

Appendix C - Glossary of Abbreviations

ACE	Angiotensin Converting Enzyme
ACS	Abdominal compartment syndrome; American College of Surgeons
ADL	Activities of daily living
AIS	Abbreviated Injury Scale
ARDS	Acute respiratory distress syndrome
ARF	Acute Renal Failure
BMI	Body mass index
BP	Blood pressure
CDC	Centers for Disease Control and Prevention
CHF	Congestive heart failure
CPAP/BIPAP	Continuous positive airway pressure/variable bi-level positive airway pressure
CT	Computerized topography
CVA	Cerebral vascular accident
DNR	Do not resuscitate
DNR-CC	Do not resuscitate; comfort care only
DNR-CCA	Do not resuscitate; comfort care arrest
DVT	Deep vein thrombosis
EOA	Esophageal Obturator Airway
ED	Emergency department
EMS	Emergency medical services
FAST	Focused assessment with sonography for trauma
FIPS	Federal Information Processing Standard codes
GCS	Glasgow Coma Score
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IgG	Immunoglobulin G
ISS	Injury Severity Score
LMA	Laryngeal Mask Airway
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NTDS	National Trauma Data Standard
OPO	Organ Procurement Organization
OR	Operating Room
OTR	Ohio Trauma Registry
PT	Prothrombin time
PTT	Partial thromboplastin time
PVD	Peripheral vascular disease
SaO2	Saturation of oxygen in arterial blood
TACR	Trauma Acute Care Registry
UB-04	Uniform Billing Form-04
XSD	XML (Extensible Markup Language) Schema definition

Appendix D – Acronyms

- AIS: Abbreviated Injury Scale
- CDC: Centers for Disease Control
- CPR: cardiopulmonary resuscitation
- CT: computerized tomography
- ED: emergency department
- EMS: emergency medical service
- GCS: Glasgow Coma Scale
- ICD-10: International Classification of Diseases, Tenth Revision
- ICD-10-CA: International Classification of Diseases, Tenth Revision, Canada
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- ICD-10-PCS: International Classification of Diseases, Tenth Revision, Procedure Coding System
- ICU: intensive care unit
- LOS: length of stay
- NA: not applicable
- NEMSIS: National Emergency Medical Services Information System
- NK/NR: not known/not recorded
- NTDB: National Trauma Data Bank
- NTDS: National Trauma Data Standard
- OR: operating room
- PACU: post-anesthesia care unit
- TQIP: Trauma Quality Improvement Program
- TQP: Trauma Quality Programs

References to Other Databases

- NTDS 2023

Appendix E – Ohio Regional Trauma System Data Dictionary

Ohio contains several regional trauma systems. These are organized, coordinated efforts in a defined geographic area that deliver the full range of care to all injured patients and work together with emergency services and disaster preparedness making efficient use of health care resources to improve patient outcomes in the state of Ohio. Membership in a regional trauma system is voluntary and not generally restricted by a facility's location.

This "Ohio Regional Data Dictionary" is an effort to collapse individual regional dictionaries into a single unified regional dictionary to improve state, regional and vendor responsiveness during the annual reconciliation with the changes issued by the American College of Surgeons (ACS).

It has been included as a reference in the State of Ohio Trauma Acute Care Registry's data dictionary and intended as a shared reference and data set common to all regional trauma systems. Specific questions about its contents should be directed to the regional trauma system to which you are a member.

If you are not a member of a regional trauma system then you are not required to collect the items in this appendices. These items are for regional trauma system use only and should not be submitted to the state unless otherwise directed by the Division of EMS.

Ohio Regional Data Dictionary (ORDD) 2023

COTS, NORTN, NORTR, NOTS, SORTS, TRISTATE

TABLE OF CONTENTS

CAUSE CODE

Description

Cause Code is the code for the cause or mechanism of injury.

Element Values

ANIMAL	Animal injury (includes bite and struck by)	INHAL	Inhalation
ASSAULT	Assault by person (blunt mechanism)	MACHINE	Machine
BIKE	Bicycle	MCC	Motorcycle Crash
BITING	Biting (human)	MVC	Motor Vehicle Crash
BURN	Burns (Chemical, Thermal, Electrical)	OV	Other Vehicle/ Off road (ATV, Animal, Golf Cart)
CRUSH	Crush Injury	OVEREX	Overexertion
CUT	Cut	PED	Pedestrian
DROWN	Drowning/ Submersion	SPORT	Sport Injury (organized)
EXPOSURE	Exposure effects of heat or cold only	STAB	Stabbing/ Pierce/ Impalement
FALL.SL	Fall same Level	STRUCK	Struck by or against
FALL.MINOR	Fall < 10 feet (not same level fall)	SUFF	Suffocation/ Hanging/ Asphyxiation
FALL.MAJOR	Fall > 10 feet	WATERCRAFT	Watercraft
FALL.NFS	Fall NFS (unwitnessed fall)	UNK	Unknown (Found down)
GSW	Gun Shot Wound		

Common Null Values

- Not Accepted

Additional Information

- The Primary E-Code assigned should correlate with the patient's cause code.
- See page 16 or ORDD.
- Intention of the cause of injury will be captured using the software provided fields that include ICD-10 code intent classifications based off of the ICD-10 – Cause of Injury Matrix.
- The definition of a physical crush differs from that of the AIS injury definition of crush. Do not use AIS dictionary definition.

Data Source Hierarchy Guide

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

INJURY DETAILS

Description

Injury Details is a free text description that describes the circumstances of how the patient was injured.

Element Values

- Relevant value for data element

Additional Information

- Include as many details as possible
- Recommended examples:
    - 23- year old male, restrained driver, was T-boned by a tractor-trailer on the driver's side of the car, positive LOC, from Scene
    - 56- year old female fell down a flight of basement stairs and struck her head on the concrete floor, denies LOC, transfer by EMS from OSH

Data Source Hierarchy Guide

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

SCENE DELAY

Description

Scene Delay is if there was a delay on the scene by EMS due to the patient being entrapped and requiring extrication (i.e. vehicle, building, trench, etc.) or due to scene circumstances delaying care being provided to the patient.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Examples of Scene Delay are:
  - The “Jaws of Life” was used to extricate a patient from a vehicle, building or other confined structure
  - Debris was moved off the patient
  - Patient was placed in a safety basket and air lifted out of a flooded stream or deep trench
  - Access to building where EMS has to wait to be taken to patient, or due to unsafe environment such as active shooter or hoarder house.
- “Not-applicable” (NA) is used to indicate that a patient was not transported by EMS.

Data Source Hierarchy Guide

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

SCENE EMS RUN REPORT PRESENT

Description

Scene EMS Run Report Present documents whether the run report generated by EMS at the injury scene is found in the patient's medical record.

- For patients transported from the scene of injury to your hospital, this is the run report transporting the patient to your facility from the scene.

Element Values

1 Yes, EMS run sheet is present in hospital medical record
2 No, EMS run sheet is not present in hospital medical record

Additional Information

- If the patient arrives by any means other than ground or air EMS (i.e. private vehicle, walk-in, law enforcement, etc.) then enter the appropriate code for NA
- "Non-applicable" (NA) is used to indicate that a patient was not transported by EMS.

- The intention of the field is to improve the data collection process of this variable

Common Null Value

- Accepted

Data Source Hierarchy Guide

1 EMS Run Sheet

TRAUMA TYPE

Description

Trauma Type is injury to human tissues or organs resulting from the transfer of energy from the environment to the human body, in which the human body lacks resilience to resist the energy transference. Trauma refers to critical injury that threatens life or permanent loss of function of a body part. There are five classifications of trauma, also referred to as trauma type. *Trauma Type* is the classification of the trauma.

Element Values

A	Asphyxia
B	Blunt Trauma
P	Penetrating Trauma
TH	Thermal
OTHER	Other

Common Null Values

- Not Accepted

Additional Information

- Enter the trauma type which causes the highest injury severity
- *Penetrating Trauma:* Injury resulting from a projectile or thrust foreign object with perforation of tissues and underlying structures.
- *Blunt Trauma:* Injury secondary to a violent diffuse force that displaces tissues and or underlying structures.
- *Thermal:* Injury as a result of exposure to extreme temperatures of heat or cold, including chemical and electrical burns.
- *Asphyxia:* Injury as a result of inhalation, drowning, asphyxiation, hanging, strangulation, or suffocation.
- Other: Injury as a result of none of the above choices, such as overexertion resulting in injury
- Enter the injury type that causes the most serious injury as determined by the attending physician.

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage Form/Trauma Flow Sheet
3 ED Documentation
4 E-Code Matrix
5 Discharge Summary

TRAUMA ACTIVATION LEVEL*

Description

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

Element Values

1 Highest Level of Activation
2 Intermediate Level of Activation
3 Lowest Level of Activation (includes consults)
4 No Trauma Activation
5 Direct Admission

Common Null Value

- Accepted

Additional Information

- Enter a common null value of "Not Applicable" if your facility does not have a trauma service and is NOT a verified trauma center.
- Highest level of activation is defined by your hospital's criteria.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- INCLUDE: patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (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 emergency department (ED) discharge.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2022
- Ohio Trauma Registry, Trauma Acute Care Registry 2022

**__Element Values__ different than NTDS and OTR*

ADMITTING SPECIALTY

Description

Admitting Specialty is the medical specialty of the attending physician who admits the patient to your hospital.

Element Values

0 Not Admitted (Died in your ED, transferred to another facility or discharged home)
1 General Adult Surgery
2 Neurosurgery
3 Orthopedic Surgery
4 General Pediatric Surgery
5 Burn Service
6 Thoracic Surgery
7 Plastic Surgery
8 All Other Surgical Services
9 All Other Non-Surgical Services
10 Cardio Thoracic Surgery
11 Vascular Surgery
12 Hand Surgery
13 Microvascular Surgery
14 OBGYN Surgery
15 Ophthalmology
16 Otolaryngology
17 Urology
18 Intensivist/ Critical Care
19 Geriatrics
20 Endocrinology
21 Trauma - Pediatric
22 Trauma – Adult
23 Oral-Maxillofacial Surgery
24 Pediatrics

Additional Information

- This is not necessarily the service to which the patient is designated upon admission to the hospital, but the medical specialty of the patient's attending physician
- #9, All Other Non-Surgical Services would include specified observation service line if it pertains to your facility

Common Null Value

- Not Accepted

Data Source Hierarchy Guide

1 ED Record
2 Trauma Flow Sheet
3 Billing/Registration Sheet
4 History & Physical

PROCEDURE LOCATION

Description

Procedure Location documents the location of the procedures performed while the patient was in your hospital.

Element Values

1 Emergency Department
2 Operating Room
3 ICU
4 Floor
5 Radiology
6 Other Specialty Area
7 Interventional radiology (IR)
8 Stepdown/Telemetry Unit
9 Observation Unit
10 Post Anesthesia Care Unit

Additional Information

- Include only those procedures performed at your hospital.
- This field is linked to the *Hospital Procedures* Field
- Other Specialty Area includes: Endo, cardiac cath lab, dialysis, etc.
- Scene Procedures are not part of this data variable but are collected elsewhere

Common Null Value

- Accepted

Data Source Hierarchy Guide

1 Operative Reports
2 Procedure Notes
3 ED and ICU Records
4 Trauma Flow Sheet
5 Nursing Notes
6 Radiology Reports
7 Anesthesia Record
8 Billing Sheet/Medical Records Coding Summary Sheet
9 Hospital Discharge Summary

HOSPITAL PROCEDURE CODE

Description

Hospital Procedure Code is all operative or essential procedures conducted on the patient during his/her stay at your hospital.

Element Values

- All values for data element

At minimum:

AGRAM	**Arteriograms (includes angiography)**	**FASC**	**Fasciotomy**
ANGIOEMB	**Angioembolization**	**FAST**	**FAST Exam (includes diagnostic Ultrasound)***
BRONCH	**Bronchoscopy***	**GAST**	**Gastrostomy/ jejunostomy (percutaneous or endoscopic)**
PRBC	**Packed Red Blood Cells***	**GASTJEJ**	**Percutaneous (endoscopic) gastrojejunoscopy**
FFP	**Fresh Frozen Plasma***	**ICP**	**Intracranial pressure monitor insertion***
MASS	*Massive Transfusion*	**INTUB**	**Insertion of Oral intubation Tube***
PLAT	**Platelets***	**IVC**	**IVC filter**
CRANI	*Craniotomy*	*MRIBRAIN*	*MRI Brain*
OXYMON	**Cerebral oxygen monitoring***	*MRISPINE*	*MRI Spine*
CHEST	**Chest Tube insertion/Thoracostomy***	*MRIOTHER*	*MRI Other*
CLRD	**Closed reduction of Fracture**	*NONE*	*None*
CPR	**CPR**	*NEEDLE*	*Needle decompression*
CTABD	**CT Scan Abdomen***	**OCM**	**Open cardiac massage**
CTCHEST	**CT Scan Chest***	*OTHER*	*Other unspecified procedure*
CTFACE	*CT Scan Face**	**REBOA**	**Resuscitative Endovascular Balloon Occlusion of Aorta**
CTHEAD	**CT Scan Head***	**SUPCYST**	**Suprapubic cystostomy**
CTPELVIS	**CT Scan Pelvis***	*THORC*	*Open Thoracotomy*
CTSPINE.C	**CT Scan Spine – Cervical***	**TRACH**	**Tracheostomy**
CTSPINE.T	**CT Scan Spine – Thoracic***	**TRACT**	**Skeletal and halo traction**
CTSPINE.L	**CT Scan Spine – Lumbar***	**URSTNT**	**Ureteric catheterization (Ureteric stent)**
DEBRD	**Soft tissue/ bony debridement***	**VENT**	**Mechanical Ventilation (continuous)***
DOPPLER	**Doppler of Extremities***	**VENTRIC**	**Ventriculostomy**
ENDO	**Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)**	**XRAY**	**Plain radiography (whole body, whole skeleton, infant whole body)**

Bolded element value indicates NTDS required data element

Italicized element value indicates ORDD required data element

See additional information

Additional Information

- Operative and/or essential procedures are defined as procedures performed in the Operating Room, Emergency Department, and/or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries or their complications at your hospital.
- Include only procedures performed at your hospital.
- At a minimum, the procedures listed should be captured. The hospital may choose to capture additional procedures for internal use. Procedures included in the Procedures List that are designated with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- FAST is defined as a rapid bedside ultrasound examination 'Focused Assessment with Sonography for Trauma'
- XRAY – If facility chooses to collect additional x-ray procedures, report as "OTHER – Other unspecified procedure"
- See page 18 of the ORDD.

Data Source Hierarchy Guide

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

INJURY DIAGNOSES DESCRIPTION

Description

Injury Diagnoses Description is a free text element of the patient's description for all injuries identified at your ED/hospital for this injury event that match the corresponding ICD-10 assigned. Diagnoses must be confirmed by a physician at your facility.

Element Values

- Relevant Value for Data Element

Additional Information

- Provide detailed information of injury
  - Example: Right femur fx, comminuted and displaced
  - Scalp laceration, 7 cm
  - SAH with coma > 6 hours
- Can be utilized to generate Abbreviated Injury Score and Injury Severity Score
- The maximum number of diagnoses that may be reported for an individual patient is 50
- In DI system this would be completed in the narrative

Common Null Values

- Accepted

Data Source Hierarchy Guide

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

ISS BODY REGION

Description

ISS Body Region is the Injury Severity Score assigned by body region codes that reflects the patient's injury(ies) diagnosed at your ED/hospital for this injury event.

Element Values

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

Additional Information

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

Common Null Values

- Accepted

Data Source Hierarchy Guide

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

LENGTH OF STAY

Description

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

Element Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy Guide

1 Registration Form
2 Discharge Form

INJURY MECHANISM DEFINITION (Ohio Regional Data Dictionary) Reference

Mechanism	Definition
ANIMAL	Animal Injury (Including but not limited to, bite, struck by) (rider of animal – see OV)
ASSAULT	Assault by person (blunt mechanism only)
BIKE	Any accident involving a bicyclist
BITING	Human bite only
BURN	Burn – Chemical, Thermal, Electrical, or Other
CRUSH	Crushing mechanism (when force or pressure is put onto the body)
CUT	Cut (includes cut by machine or chainsaw)
DROWN	Drowning/ Submersion
EXPOSURE	Exposure effects of heat and cold only Primary injury – environmental, not treatment related or sequela (AIS2015)
FALL.SL	Any fall from standing (feet on ground), may include subsequent strike against object
FALL.MINOR	Any fall <10 feet that is not a same level fall
FALL.MAJOR	Any fall >/= 10 feet.
FALL.NFS	Use only if no details stated about the fall, unwitnessed fall
GSW	Gunshot wound
INHAL	Smoke or chemical inhalation type injuries
MACHINE	Injury caused by machinery
MCC	Motorcycle related injuries (includes 2 wheel motor scooter and electric bike)
MVC	Cars, trucks, vans, SUV's on roads or parking lots etc.
OV	All off road and other vehicles not included elsewhere. (ATVs, snowmobiles, riding lawnmowers, 4-wheelers, golf carts, rider of animal, etc.)
OVEREX	Overexertion injuries (ie. heavy lifting). To be used for strains and sprains from improper lifting or repetitive motion. Do not include stress fractures here.
PED	Person walking (or using their typical mode of mobility) struck by motor vehicle. (If a person uses a wheelchair, mobility scooter, or other such conveyance to get around, they are still considered a pedestrian though they are not walking)
SPORT	Injury sustained while person is involved in playing a sport (organized only). Also includes fall from skateboard, skis, snowboard etc. Organized sport means any game or sport that is played by 3 or more persons who play or practice together regularly (lawinsider.com)
STAB	Stabbing/ Pierce/ Impalement
STRUCK	Struck by or against a person or object (not intentionally by someone)
SUFF	Suffocation, Hanging, or Asphyxiation
WATERCRAFT	Injury involving any boat (including jet skis), to include anything pulled behind watercraft (water skis, inner tubes, etc.)
UNK	Unknown (Found Down)

INJURY MECHANISM REFERENCES

Height Categories

House Story Height: The average height of 1, 2, and 3 story houses are respectively 10, 20, and 30 feet. A good rule of thumb when calculating the height of a house is to allocate approximately 10 feet per floor plus the height of the roof. (www.weekendbuilds.com)

Commercial building height: Average commercial building single story roof equals 12 feet

Office/ skyscraper building height: Building story height varies widely from just under the 14-foot average to well above it. That's because several factors affect the story's-to-feet standard for a building: building material, insulation type, and different height allowances for different levels. (theskydeck.com)

Step height: Standard should be between 7 or 7 ¾ inches at the most, and no less than 4 inches (www.stairsupplies.com)

ICD-10-PCS CODING REFERENCE

DIAGNOSTIC AND THERAPEUTIC IMAGING		
Computerized Tomography of Head	BW28	
Computerized Tomography of Chest	BW24	If wanting to combine CHEST/ABD/PELV- BW25
Computerized Tomography of Abdomen	BW20	If wanting to combine ABD/PELV- BW21
Computerized Tomography of Pelvis	BW2G	
Computerized Tomography of C-Spine	BR20	
Computerized Tomography of T-Spine	BR27	
Computerized Tomography of L-Spine	BR29	
Computerized Tomography Angiography	See Computerized Tomography Codes	
Doppler Ultrasound of extremities	RLE- B54B	
	LLE- B54C	
	BLE- B54D	
	RUE- B54M	
	LUE- B54N	
	BUE- B54P	
Diagnostic ultrasound (Includes FAST)	BW40ZZZ (abdomen), BW4GZZZ (pelvic), B24CZZZ (pericardium), BB4CZZZ (mediastinum)	
Angioembolization	Head, neck, upper arm artery- 03L	
	Aorta, abdominal, leg arteries- 04L	
	Head, neck, upper arm vein 05L	
	Leg veins- 06L	
Angiography	Upper arteries- B30	
	Lower arteries- B40	
IVC Filter	06H03DZ	
REBOA	Heart & Great Vessels- 02L	
	Lower Arteries- 04L	
Plain Radiography of Adult whole body	BW0KZZZ	
Plain Radiography of whole skeleton	BW0LZZZ	
Plain Radiography of infant whole body	BW0MZZZ	

CARDIOVASCULAR		
Open Cardiac Massage	02QA0ZZ	
CPR	5A12012 (manual) 5A1221J (mechanical)	
CNS		
Insertion of ICP Monitor	4A103BD	
Ventriculostomy	009630Z	
Cerebral Oxygen Monitor	4A103RD	
GENITOURINARY		
Ureteric Catherization (Ureteric Stent)	0T7	
Suprapubic Cystostomy	0T1B0ZD	
MUSCULOSKETETAL		
Soft Tissue/Bony Debridement	Excisional Tissue Debridement- 0JB	
	Excisional Debridement- Upper Bone- 0PB	
	Excisional Debridement- Lower Bone- 0QB	
	Non Excisional Tissue Debridement- 0JD	
	Non Excisional Debridement- Upper Bone- 0PD	
	None Excisional Debridement- Lower Bone- 0QD	
Closed Reduction of Fractures	Upper Bones- 0PS	
	Lower Bones- 0QS	
Skeletal and Halo Traction	2W6	
Fasciotomy	0J8	
TRANSFUSION		
Transfusion of red blood cells (first 24 hours)	302_3N1	
Transfusion of platelets (first 24 hours)	302_3R1	
Transfusion of plasma (first 24 hours)	302_3K1	
RESPIRATORY		
Insertion of endotracheal tube	0BH17EZ	
Continuous mechanical ventilation	<24 HR- 5A1935Z	

	24-96HR- 5A1945Z	
	>96HR- 5A1955Z	
Chest Tube/ Thoracostomy	R- 0W9930Z	
	L- 0W9B30Z	
Bronchoscopy	Inspection- 0BJ	
	Drainage- 0B9	
	Excision- 0BB	
Thoracotomy	R- 0W99	
	L- 0W9B	
Tracheostomy	0B110F4	
GASTROINTESTINAL		
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)	Gastroscopy- 0DJ68ZZ	
	Sigmoidoscopy- 0DJD8ZZ	
	Colonoscopy- 0DJD8ZZ	
Gastrostomy/jejunostomy (percutaneous or endoscopic)	Bypass- 0D1	
	Drainage- 0D9	
Percutaneous (endoscopic) gastrojejunoscopy	0DJ	

Ohio Regional Data Dictionary CHANGE LOG

2023 CHANGES

CAUSE CODE

CHANGE	Element Value	ANIMAL – removed fall from value description
CHANGE	Element Value	CUT – Removed unintentional
ADDITION	Element Value	EXPOSURE
DELETION	Element Value	Deleted element values GSW.I, GSW.U, GSW.S, GSW. NK
ADDITION	Element Value	Added element value GSW
CHANGE	Element Value	OV – addition of Animal to value description
ADDITION	Element Value	OVEREX – Overexertion
CHANGE	Element Value	SPORT – Addition of organized to value description
DELETION	Element Value	Deleted element values STAB.I, STAB.U, STAB.S, STAB. NK
ADDITION	Element Value	Added element value STAB – Stabbing/ Pierce/ Impalement
ADDITION	Additional Information	Addition of clarification regarding tracking intention
ADDITION	Additional Information	The definition of a physical crush differs from that of the AIS injury definition of crush. Do not use AIS dictionary definition.

INJURY DETAILS

SCENE DELAY

SCENE EMS RUN REPORT PRESENT

DELETION	Element Value	0 Yes, EMS scene run sheet is present in hospital medical record after registrar intervention (Trauma Registrar had to contact agency to obtain the EMS scene run sheet)
CHANGE	Element Values	1 Yes, EMS run sheet is present in hospital medical record
ADDITION	Additional information	Addition: The intention of the field is to improve the data collection process of this variable

TRAUMA TYPE

DELETION	Additional information	Removal of: It also or the absence of oxygen as in asphyxiation from smoke or drowning from Blunt Trauma
DELETION	Additional information	Removal of: Carbon monoxide intoxication from Asphyxia

TRAUMA ACTIVATION LEVEL*

ADDITION	Description	Added: emergency department
ADDITION	Element Value	5 Direct Admission

ADMITTING SPECIALTY

ADDITION	Additional Information	If patient is admitted to Observation service, report as element value #9, All Other Non-Surgical Services
CHANGE	Common Null Value	Changed from Accepted to Not Accepted
ADDITION	Additional Information	#9, All Other Non-Surgical Services would include specified observation service line if it pertains to your facility

PROCEDURE LOCATION

ADDITION	Additional Information	Scene Procedures are not part of this data variable but are collected elsewhere

HOSPITAL PROCEDURE CODE

CHANGE	Element Value	AGRAM – Added includes angiography
ADDITION	Element Value	ANGIOEMB - Angioembolization
DELETION	Element Value	BBOARD - Backboard
ADDITION	Element Value	BRONCH - Bronchoscopy
DELETION	Element Value	CCOLLAR – Cervical collar
DELETION	Element Value	CENTLINE – Central line
DELETION	Element Value	CELL – Cell saver
CHANGE	Element Value	CLRD – Closed reduction of dislocation changed to closed reduction of fracture
DELETION	Element Value	CRYO – Cryoprecipitate
DELETION	Element Value	CTA – Computed tomography Angiography
DELETION	Element Value	CT – Other CT Scan
DELETION	Element Value	CTSPINE – CT Spine
ADDITION	Element Value	CTSPINE.C – CT Scan Spine – Cervical*
ADDITION	Element Value	CTSPINE.T – CT Scan Spine – Thoracic*
ADDITION	Element Value	CTSPINE.L – CT Scan Spine – Lumbar*
ADDITION	Element Value	DEBRD – Soft tissue/ bony debridement*
ADDITION	Element Value	DOPPLER – Doppler of extremities*
ADDITION	Element Value	ENDO – (includes gastroscopy, sigmoidoscopy, colonoscopy)
ADDITION	Element Value	FASC - Fasciotomy
CHANGE	Element Value	FAST added (includes diagnostic ultrasound)*
ADDITION	Element Value	GAST – Gastostomy/ Jejunostomy (percutaneous or endoscopic)
ADDITION	Element Value	GASTJEJ – Percutaneous (endoscopic) gastrojejunoscopy

CHANGE	Element Value	ICP – Added insertion to element value description
DELETION	Element Value	IMMOB – Immobilization (splinting, cast, braces, etc.)
ADDITION	Element Value	INTUB – Insertion of oral intubation tube*
DELETION	Element Value	INTUB.OETT – Oral intubation
DELETION	Element Value	INTUB.NETT – Nasal Intubation
ADDITION	Element Value	IVC – IVC Filter
ADDITION	Element Value	OCM – Open cardiac massage
DELETION	Element Value	ORTHO – Orthopedic Procedure
ADDITION	Element Value	OXYMON – Cerebral Oxygen monitoring
ADDITION	Element Value	REBOA – Resuscitative Endovascular Balloon Occlusion of Aorta
ADDITION	Element Value	SUPCYST – Suprapubic cystostomy
DELETION	Element Value	SURG.AIR - Tracheostomy, Surgical, needle or percutaneous cricothyrotomy
DELETION	Element Value	SUTURE – Suture/ staples/ glue of skin
CHANGE	Element Value	THORA - Element value code changed from THORA to NEEDLE
DELETION	Element Value	TOURNI - Tourniquet
ADDITION	Element Value	TRACH - Tracheostomy
ADDITION	Element Value	TRACT – Skeletal and halo traction
ADDITION	Element Value	URSTNT – Ureteric catheterization (Ureteric stent)
CHANGE	Element Value	VENT – added continuous to element value description
CHANGE	Element Value	XRAY – added (whole body, whole skeleton, infant whole body) to element value description
CHANGE	Element Value	Formatting: 1. Addition of asterisks to mirror NTDS additional information 2. Bold Element Values indicates mirroring NTDS procedures to be captured at minimum
ADDITION	Additional Information	XRAY – If facility chooses to collect additional x-ray procedures, report as “OTHER – Other unspecified procedure”
ADDITION	Additional Information	Addition of Appendix for procedure coding
CHANGE	Element Value	Description of Mass Transfusion changed to Massive Transfusion
CHANGE	Element Value	Ct Scan Face – Addition of Asterisk
ADDITION	Additional Information	Addition of procedure table formatting key

INJURY DIAGNOSES DESCRIPTION

ADDITION	Additional Information	Additional example added under additional information: SAH with coma > 6 hours
ADDITION	Additional Information	In DI system this would be completed in the narrative

ISS BODY REGION

LENGTH OF STAY

INJURY DIAGNOSES KNOWN

RETIRED	Data Element	Injury Diagnosis Known retired/ removed from dictionary

INJURY MECHANISM DEFINITION

MECHANISM	DEFINITION CHANGE
ANIMAL	Removed fall from Added (rider of animal – see OV)
CRUSH	Added (when force or pressure is put onto the body)
CUT	Removed Unintentional only
CUT	Added (includes cut by machine or chainsaw)
EXPOSURE	Added mechanism Exposure effects of heat and cold only Primary injury – environmental, not treatment related or sequela (AIS2015)
GSW	Added
GSW.I	Removed
GSW.U	Removed
GSW.S	Removed
GSW.NK	Removed
MCC	Added (includes 2 wheel motor scooter and electric bike)
OV	Added rider of animal
OVEREX	Added
PED	Added verbiage mobility scooter
SPORT	Removed recreational. Added organized only. Added definition of organized sport.
STAB	Added
STAB	Changed to Stabbing, Pierce, Impalement
STAB.I	Removed
STAB.U	Removed
STAB.S	Removed
STAB.NK	Removed

ICD-10-PCS Procedure Coding Guide

CHANGE	Data Element	Title changed from ICD-10-PCS Procedure Coding Guide name changed to ICD-10-PCS Procedure Coding Reference

Appendix F – CHANGE LOG for the Ohio Trauma Acute Care Data (TACR)

* If "*See NTDB 2023.*" Is found in the 'Change Text' column, then you must refer to the NTDB data dictionary for information on that element as it is not included in the Ohio data dictionary.

Effective January, 2023

Field Name	Change Location	Change Text
STATE OF OHIO CHANGES		
IINCLUSION	ORDD	ADDED: Ohio Regional Data Dictionary 2023 – Appendix E
INCLUSION/EXCLUSION CRITERIA – ICD-10	State Inclusion Criteria	ADDED: T59.81 with 7th character modifier of A ONLY (Toxic effect of smoke - initial encounter)
INCLUSION/EXCLUSION CRITERIA – ICD-10	State Inclusion Decision Tree	ADDED: T59.81 with 7th character modifier of A ONLY (Toxic effect of smoke - initial encounter)
DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)	Inclusion Criteria Differences	ADDED T59.81
Acronyms	Appendix D	ADDED. Inserted new content. Other appendices reordered from D to the end.
DNR STATUS	Description	CHANGED: added "… and/or written order from a physician or mid-level provider to withhold select …"
AIS VERSION	ELEMENT	REMOVED: "16 AIS 2015"
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS	ELEMENT	CHANGED: to match 2023 NTDS verbiage.
INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS	Additional Information	CHANGED: to match 2023 NTDS verbiage.
INITIAL FIELD GCS QUALIFER	Additional Information	ADDED: 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.
INITIAL FIELD GCS QUALIFER	Additional Information	ADDED: Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
INITIAL FIELD GCS QUALIFER	Additional Information	ADDED: 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.
INITIAL FIELD GCS QUALIFER	Additional Information	ADDED: Please note that the first recorded hospital vitals do not need to be from the same assessment.
ACS BASED CHANGES		

ALL ELEMENTS	Description	Notes in the Additional Information section to "INCLUDE" and/or "EXCLUDE" certain values have been moved to the Description.
ANGINA PECTORIS (Pre-Existing Condition)	ELEMENT	RETIRED
MENTAL/PERSONALITY DISORDERS (Pre-Existing Condition)	ELEMENT	RETIRED
BIPOLAR I/II DISORDER (Pre-Existing Condition)	ELEMENT	NEW
MAJOR DEPRESSIVE DISORDER (Pre-Existing Condition)	ELEMENT	NEW
OTHER MENTAL/PERSONALITY DISORDERS (Pre-Existing Condition)	ELEMENT	NEW
POST-TRAUMATIC STRESS DISORDER (Pre-Existing Condition)	ELEMENT	NEW
SCHIZOAFFECTIVE DISORDER (Pre-Existing Condition)	ELEMENT	NEW
SCHIZOPHRENIA (Pre-Existing Condition)	ELEMENT	NEW
PRIMARY TRAUMA SERVICE TYPE (ED Information)	ELEMENT	NEW
CIRRHOSIS (Pre-Existing Condition)	Description	CHANGED: 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.
CIRRHOSIS (Pre-Existing Condition)	Additional Information	RETIRED: If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present.
CIRRHOSIS (Pre-Existing Condition)	Additional Information	ADDED: Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
DEMENTIA (Pre-Existing Condition)	Additional Information	CHANGED: A diagnosis of dementia including Alzheimer's Lewy Body Dementia, frontotemporal dementia (Pick's Disease) and vascular dementia must be documented in the patient's medical record.
DEMENTIA (Pre-Existing Condition)	Additional Information	ADDED: Consistent with the National Institute on Aging December 2017.
ANTIBIOTIC THERAPY (TQIP PROCESS MEASURES)	Description	CHANGED: Intravenous antibiotic therapy was administered to the patient within 24 hours after injury. *See NTDB 2023.*

ANTIBIOTIC THERAPY (TQIP PROCESS MEASURES)	Additional Information	CHANGED: Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation." *See NTDB 2023.*
ANTIBIOTIC THERAPY (TQIP PROCESS MEASURES)	Additional Information	RETIRED: Report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility. *See NTDB 2023.*
ANTIBIOTIC THERAPY (TQIP PROCESS MEASURES)	Data Source Hierarchy Guide	ADDED: EMS Run Sheet *See NTDB 2023.*
ANTIBIOTIC THERAPY DATE (TQIP PROCESS MEASURES)	Description	CHANGED: Intravenous antibiotic therapy was administered to the patient within 24 hours after injury. *See NTDB 2023.*
ANTIBIOTIC THERAPY DATE (TQIP PROCESS MEASURES)	Additional Information	CHANGED: Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation." *See NTDB 2023.*
ANTIBIOTIC THERAPY DATE (TQIP PROCESS MEASURES)	Additional Information	RETIRED: Report the date of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility. *See NTDB 2023.*
ANTIBIOTIC THERAPY DATE (TQIP PROCESS MEASURES)	Data Source Hierarchy Guide	ADDED: EMS Run Sheet *See NTDB 2023.*
ANTIBIOTIC THERAPY TIME (TQIP PROCESS MEASURES)	Description	CHANGED: Intravenous antibiotic therapy was administered to the patient within 24 hours after injury. *See NTDB 2023.*
ANTIBIOTIC THERAPY TIME (TQIP PROCESS MEASURES)	Additional Information	CHANGED: Open fractures as defined by the Association of Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb code descriptors that contain "amputation." *See NTDB 2023.*
ANTIBIOTIC THERAPY TIME (TQIP PROCESS MEASURES)	Additional Information	RETIRED: Report the time of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility. *See NTDB 2023.*
ANTIBIOTIC THERAPY TIME (TQIP PROCESS MEASURES)	Data Source Hierarchy Guide	ADDED: EMS Run Sheet *See NTDB 2023.*
PREMATURITY (Pre-Existing Condition)	Additional Information	CHANGED: Only report on patients <15 years-of-age.
PREMATURITY (Pre-Existing Condition)	Additional Information	CHANGED: The null value "Not Applicable" must be reported for patients ≥15 years-of-age.

PREMATURITY (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
PREMATURITY (Pre-Existing Condition)	Associated Edit Checks	ADDED: Rule ID 18204 Element must be and can only be "Not Applicable" for patients ≥15 years-of-age.
CONGENITAL ANOMALIES (Pre-Existing Condition)	Additional Information	CHANGED: Only report on patients <15 years-of-age.
CONGENITAL ANOMALIES (Pre-Existing Condition)	Additional Information	CHANGED: The null value "Not Applicable" must be reported for patients ≥15 years-of-age.
CONGENITAL ANOMALIES (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients <15 years-of-age.
CONGENITAL ANOMALIES (Pre-Existing Condition)	Associated Edit Checks	ADDED: Rule ID 17004 Element must be and can only be "Not Applicable" for patients ≥15 years-of-age. *See NTDB 2023.*
ALCOHOL USE DISORDER (Pre-Existing Condition)	Additional Information	ADDED: Only report on patients ≥15 years-of-age.
ALCOHOL USE DISORDER (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Applicable" must be reported for patients <15 years-of-age.
ALCOHOL USE DISORDER (Pre-Existing Condition)	Additional Information	CHANGED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.
ALCOHOL USE DISORDER (Pre-Existing Condition)	Associated Edit Checks	CHANGED: Rule ID 16104 to Element must be and can only be "Not Applicable" for patients <15 years-of-age. *See NTDB 2023.*
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (Pre-Existing Condition)	Additional Information	ADDED: Only report on patients ≥15 years-of-age.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Applicable" must be reported for patients <15 years-of-age.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (Pre-Existing Condition)	Additional Information	CHANGED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (Pre-Existing Condition)	Associated Edit Checks	CHANGED: Rule ID 16704 to Element must be and can only be "Not Applicable" for patients <15 years-of-age. *See NTDB 2023.*
PERIPHERAL ARTERIAL DISEASE (Pre-Existing Condition)	Additional Information	ADDED: Only report on patients ≥15 years-of-age.
PERIPHERAL ARTERIAL DISEASE (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Applicable" must be reported for patients <15 years-of-age.

PERIPHERAL ARTERIAL DISEASE (Pre-Existing Condition)	Additional Information	CHANGED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.
PERIPHERAL ARTERIAL DISEASE (Pre-Existing Condition)	Associated Edit Checks	CHANGED: Rule ID 18104 to Element must be and can only be "Not Applicable" for patients <15 years-of-age. *See NTDB 2023.*
SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	ADDED: Only report on patients ≥15 years-of-age.
SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	ADDED: The null value "Not Applicable" must be reported for patients <15 years-of-age.
SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	CHANGED TO: The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of-age.
SUBSTANCE USE DISORDER (Pre-Existing Condition)	Associated Edit Checks	CHANGED: Rule ID 18404 to Element must be and can only be "Not Applicable" for patients <15 years-of-age. *See NTDB 2023.*
INITIAL ED/HOSPITAL HEIGHT (Emergency Department Information)	Description	REMOVED: Within 24 hours of ED/hospital arrival
INITIAL ED/HOSPITAL HEIGHT (Emergency Department Information)	Additional Information	REMOVED: Within 24 hours of ED/hospital arrival
DIABETES MELLITUS (Pre-Existing Condition)	Additional Information	ADDED: Report Element Value "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin or oral hypoglycemic agent.
WHOLE BLOOD (TQIP Measures for Processes of Care)	Data Source Hierarchy Guide	ADDED: Blood Bank *See NTDB 2023.*
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD) (Pre-Existing Condition)	Additional Information	CHANGED: Present prior to injury.
SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	CHANGED: Present prior to injury.
APPENDIX 5: ACRONYMS	Appendices	ADDED: State Data Dictionary Appendix D.
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Description	CHANGED: The universally unique identifier (UUID) of the patient care report (PCR) of each emergency medical service (EMS) unit treating the patient from the time of injury to arrival at your hospital.

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	RETIRED: The null value “Not Applicable” must be reported for all patients where Inter-facility Transfer is Element Value “1. Yes.”
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	RETIRED: The null value “Not Applicable” must be reported for all patients where Transport Mode is Element Values “4. Private/Public Vehicle/Walk-in,” “5. Police,” or “6. Other.”
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	RETIRED: If Transport Mode is Element Value "1. Ground Ambulance," "2. Helicopter Ambulance" or "3. Fixed Wing Ambulance" but the patient was not transported from the scene of injury, report the null value "Not Known/Not Recorded."
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	RETIRED: For patients with multiple modes of transport from the scene of injury, report the UUID assigned by the EMS agency that delivered the patient to your hospital.
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	CHANGED: 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 NEMSIS versions lower than 3.5.0. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is widely implemented.
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	CHANGED: Assigned by any applicable transporting EMS agency in accordance with the IETF RFC 4122 standard.
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	ADDED: The null value “Not Applicable” must be reported if the patient was never transported via EMS prior to arrival at your hospital.
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Additional Information	ADDED: Report all that apply (maximum 20).
EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)	Associated Edit Checks	CHANGED: Rule ID 90002 Element cannot be “Not Known/Not Recorded” along with any other value *See NTDB 2023.*
EMS PATIENT CARE REPORT UNIVERSALLY	Associated Edit Checks	CHANGED: Rule ID 9940 Multiple Entry Max exceeded *See NTDB 2023.*

UNIQUE IDENTIFIER (UUID) (Pre-Hospital Information)		
AGGREGATE INFORMATION	Appendix 2	ADDED: Rule ID 9917 Value submitted for Hospital Events is not valid *See NTDB 2023.*
AGGREGATE INFORMATION	Appendix 2	ADDED: Rule ID 9918 Value submitted for Pre-Existing Conditions is not Valid. *See NTDB 2023.*