Iowa State Trauma Registry Data Dictionary

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Version: 2025.1

IOWA Health and Human Services

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Introduction

The Iowa Trauma System Development Act was signed into Law April 19, 1995. The Bureau of Emergency Medical and Trauma Services (BEMTS) is the lead agency for Iowa's EMS/trauma system. BEMTS is within the Division of Public Health the State of Iowa Department of Health and Human Services (HHS). The all-inclusive trauma care system has been fully operational since January 1, 2001.

The Trauma Registry was established as part of the State of Iowa Code: 147A.26 Trauma registry. This trauma data dictionary will serve as a guide for trauma nurse coordinators and data registrars in the trauma hospitals of Iowa. The success of the Trauma Registry is wholly dependent upon the day-to-day dedication of EMS personnel, health care providers, and especially the trauma coordinators and registrars, to ensure optimal data quality. This document is intended to provide a guideline for collecting information and offers clear instructions for completion of the required information.

Definition

Trauma patient - a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical or chemical energy, or by the absence of heat or oxygen.

Trauma Registry Inclusion Criteria

Patients should be included in the Trauma Data Registry if the following criteria are met:

At least ONE of the following injury diagnostic codes defined as follows:

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

- S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts–initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)

- T20-T28 with 7th character modifier of A ONLY (burns by specific body parts – initial encounter)
- T30-T32 (burn by TBSA percentages)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)

EXCLUDING the following isolated injuries:

ICD-10-CM diagnosis codes below have a third character of 0:

- S00 (Superficial injuries of the head)
- S10 (Superficial injuries of the neck)
- S20 (Superficial injuries of the thorax)
- S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
- S40 (Superficial injuries of shoulder and upper arm)
- S50 (Superficial injuries of elbow and forearm)
- S60 (Superficial injuries of wrist, hand and fingers)
- S70 (Superficial injuries of hip and thigh)
- S80 (Superficial injuries of knee and lower leg)
- S90 (Superficial injuries of ankle, foot and toes)

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

***Note*:** 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.

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO

(ICD-10-CM S00-S99, T07, T14, T20-28, T30-32, and T79.A1-T79.A9):

- Patients who died after receiving any evaluation or treatment or were dead on arrival

  OR

- Patients who were transferred into or out of the trauma care facility;

  OR

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

  OR

- Patients who receive treatment, are admitted, or are observed beyond the Emergency Department;

  AND

- The patient must have sustained a traumatic injury within 14 days of initial hospital encounter.
- The trauma care facility trauma team is activated. Include all patients with activation, not just those meeting diagnostic or other criteria.

ISOLATED HIP FRACTURES

Isolated hip fractures due to same level falls are a significant issue in the state. Much consideration has been provided to requiring submission of these data to the trauma registry. However, it would be overly burdensome for most trauma care facilities to report on all isolated hip fractures associated with same level falls. Some trauma care facilities have made it a priority to track same level fall isolated hip fractures and would like to submit the data to the trauma registry.

While hospitals submitting data to the NTDB must enter patients with these injuries, non-NTDB hospitals are not required to do so. These non-NTDB hospitals may optionally submit data associated with same level fall isolated hip fractures. If the facility elects to complete those submissions, all same level fall isolated hip fractures should be included. Notify HHS if the facility plans to submit these data. The submitted data will be used to develop a model to extrapolate the prevalence and impact of isolated hip fractures from same level falls in the state.

Hospitals that elect to not submit same level fall isolated hip fractures should not enter any isolated hip fractures associated with same level falls. Hip fractures associated with poly trauma or isolated hip fractures not associated with a same level fall (e.g. motor vehicle crash) should be included in the trauma registry.

ISOLATED PERIPROSTHETIC FRACTURES

Hospitals may optionally submit data associated with isolated periprosthetic fractures from same level falls. If the facility elects to complete those submissions, all isolated periprosthetic fractures should be included. Notify HHS if the facility plans to submit these data. The submitted data will be used to develop a model to extrapolate the prevalence and impact of isolated periprosthetic fractures in the state.

Hospitals that elect to not submit isolated periprosthetic fractures data should not enter any isolated

periprosthetic fractures associated with same level falls. Periprosthetic fractures associated with poly trauma or isolated hip fractures not associated with a same level fall (e.g. motor vehicle crash) should be included in the trauma registry.

Data Submission and Forms

TRAUMA SHORT FORM ICD-10, TRAUMA INCIDENT FORM ICD-10, AND TRAUMA + TQIP ICD-10 FORM

The trauma forms only need to be completed on patients that meet trauma inclusion criteria.

Complete the Trauma Short Form when*:

- Patient dies in the emergency department
- Patient is transferred to another facility for definitive care
- Trauma activation occurred that resulted in discharge of patient

Complete the Trauma Incident/Trauma +TQIP Forms when*:

- Patient is admitted to the facility. Including:
  - Admitted for observation
  - Admitted for surgery; even when discharged from surgery

***IMPORTANT NOTE:** For hospitals that elect to submit data to NTDB, patient information should always be entered on the Trauma Incident Form ICD-10. For hospitals electing to submit NTDB and TQIP data, patient information should always be entered on the Trauma + TQIP ICD-10 form.

NATIONAL TRAUMA DATA BANK (NTDB) AND ACS TRAUMA QUALITY IMPROVEMENT PROGRAM (TQIP) SUBMISSION

Submission to NTDB and TQIP is not required for non-ACS verified hospitals. Some hospitals elect to submit to NTDB and/or TQIP. The trauma data registry is designed to meet those reporting requirements. To seek additional information on the National Trauma Data Bank (NTDB) go to: https://www.facs.org/quality-programs/trauma/ntdb.

READMISSIONS

The readmission form only needs to be completed for patients readmitted within 72 hours for care to treat traumatic injuries associated with the original visit.

TIMING OF SUBMISSIONS

Timely submission of registry data is necessary to facilitate beneficial quality and performance improvement.

DIRECT DATA ENTRY INTO THE TRAUMA REGISTRY

Trauma Care facilities that enter data directly into the state registry system shall enter, at a minimum, 80% of cases within 60 days of patients discharge. It is expected that 100% of cases will be entered within 120 days of patient's discharge.

THIRD PARTY UPLOAD OF DATA INTO THE TRAUMA REGISTRY

Trauma care facilities that submit trauma registry data via upload shall submit, at a minimum, 80% of cases the first business day of every even numbered calendar month. Any cases not submitted (remaining 20%) in the initial upload shall be submitted with the next scheduled upload to ensure 100% of cases are submitted within approximately 120 days of patient's discharge.

REQUIRED DATA ELEMENTS AND FORM PLACEMENT

The following table appears for each data element. The purpose of this table is to identify if the field is required by a certain entity (State, NTDB, TQIP), association of validation rules applicable to the data element, and the form and tab where the data element is located.

Inclusion Entity	Required Data Element	Validated Field
*State**	Yes/No	Yes/No
NTDB	Yes/No	Yes/No
TQIP	Yes/No	Yes/No

Form	Location of Data Element
Short Form ICD-10	Tab Name or NA
Trauma Incident Form ICD-10	Tab Name or NA
Trauma + TQIP ICD-10	Tab Name or NA

***Note:** For trauma facilities conducting third party upload: Some data fields may be a direct upload of data while other fields may be calculated values based on direct upload data. HHS will assist in facilitating with the current State vendor, the trauma care facilities, and the third-party vendors to ensure the intent of State required fields are met within the parameters of the data systems being utilized.

VALIDATION SCORES

Validation rules have been developed for the state trauma registry. These validation rules are in place to help ensure complete data is submitted. The completeness of the data directly impacts the usefulness of data in quality and performance improvement. In the ImageTrend registry, this corresponds with the system validation which is represented by a percentage, with scores being reduced for missing information. Hospitals that are completing direct data entry into the registry should have a minimum average validation score of 85% for records. Scores lower than 85% are indicative of records with significant discrepancies. There is a separate NTDB validation that shows errors pertaining to hospitals submitting data to the NTDB/TQIP, and errors of severity 1 or 2 should be corrected prior to submission. Hospitals not submitting data to the NTDB/TQIP are not required to rectify these errors.

Hospitals that are using a third-party vendor to upload data will innately have a validation score lower than 100%. There are fields that are not required for state submission that have validation scores within the State registry system.

These validation rules are in place to assist facilities that complete direct data entry. When a third-party upload of data is completed, the State trauma registry will automatically run a system validation on the uploaded data. Since the uploaded data will not have all the same components as the direct entry data, some validation rules will not be met, resulting in a lower validation score. HHS will monitor uploaded data to ensure state required fields are completed.

FARM RELATED INJURY

A non-household injury incurred on the farm by any farmer, farm worker, farm family member, or other individual, or any non-farm injury incurred by a farmer, farm worker, or farm family member in the course of handling, producing, processing, transporting, or warehousing farm commodities.

Indicates injury meets the farm-related injury definition. Agricultural injury may not have been necessarily work-related or directly related to the farm.

Includes:

- Motor vehicle crash while hauling livestock or grain (some type of farm commodity)
- Motor vehicle collision with a piece of agricultural equipment on the highway
- Railroad crash of grain cars
- Tractor roll-over
- Caught in power take-off
- Unloading grain wagon
- Being struck by a piece of metal while operating a grinding wheel on the farm
- Getting caught in a barbed wire fence on the farm
- Falling or slipping on the farm
- Being bitten by, struck by, or fallen on by an animal on the farm

Excludes:

- Injuries incurred by farmers or non-farmers who are on farm environs for a wide variety of purposes (e.g., visiting, hunting, swimming, and other recreational activities).
- Farmhouse or home premises of farm

TRAUMATIC BRAIN INJURY (TBI)

Defined as "clinically evident brain damage resulting from trauma or anoxia which temporarily or permanently impairs a person's physical or cognitive functions". The injury may be a penetrating or closed head injury resulting in death, or temporary or permanent impairment. Persons with brain injuries may display loss of consciousness, post-traumatic amnesia, a skull fracture, or damage to brain tissue as evidenced by neurological findings that can be reasonably attributed to a traumatic brain injury.

TRAUMATIC SPINAL CORD INJURY (SCI)

An acute, traumatic lesion of the neural elements in the spinal canal, resulting in any degree of sensory deficit, motor deficit, or bladder/bowel dysfunction. The deficit can be temporary, permanent, or result in death. The lesion can occur at any level of the spinal cord and may be complete or incomplete. Spinal cord injuries include: cauda equina, conus medullaris injuries, central cord syndrome, anterior cord syndrome, posterior cord syndrome, Brown-Sequard syndrome, mixed syndrome, and cord compression. Patients presenting neurological symptoms upon admission which resolve before hospital discharge should also be reported.

FARM, TRAUMATIC BRAIN INJURY (TBI), AND TRAUMATIC SPINAL CORD INJURY (SCI) REPORTING

Patients that meet both the Trauma Registry Inclusion Criteria and have a farm related, traumatic brain injury, or traumatic spinal cord injury should be entered into the trauma registry. For questions related to submission of traumatic brain injuries or traumatic spinal cord injuries that don't meet trauma registry inclusion criteria contact the HHS Traumatic Brain Injury Program. For farm injuries that don't meet trauma registry inclusion criteria contact the HHS Reportable Environmental and Occupational Diseases, Poisonings and Conditions for additional assistance.

HIPPA Statement

The State of Iowa Department of Health and Human Services (HHS), in conjunction with the Attorney General's Office, has completed a comprehensive review of its programs and has determined that neither the agency as a whole, nor any of its programs, are covered entities under HIPAA. Given that HHS is not a covered entity, agencies and facilities in Iowa that are covered entities have questioned whether they can continue to disclose the

protected health information of their patients or clients to the HHS as they have in the past. HHS position is that such disclosures may continue to occur under HIPAA.

First, HIPAA recognizes that if there is a statute or administrative rule that requires a specific disclosure of protected health information (PHI), a covered entity must obey that law (45 CFR 164.512). Therefore, if there is another federal or state statute or administrative rule which requires a covered entity to disclose protected health information to the HHS, the covered entity should follow that requirement. Many disclosures of PHI to HHS are required by state laws, including Iowa Code chapters 135, 136A, 136B, 136C, 139A, 141A, 144, 147A, and 272C and the administrative rules that implement these chapters. These disclosures are legally required and must continue to be made as mandated by state law.

Second, HIPAA allows a covered entity to disclose protected health information to public health authorities for public health activities (Section 164.512). HIPAA defines a public health authority as "an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate," (Section 164.501). The HHS has such a mandate and, therefore, is a public health authority under HIPAA.

The HHS, in conjunction with the Iowa Attorney General's Office, has reviewed its programs and determined that protected health information being received by the Department from covered entities in Iowa is disclosed for public health activities. The disclosure of such information to HHS is, therefore, unaffected by HIPAA and should continue in accordance with past practices. Because HHS is a public health authority that is authorized to receive PHI under this provision, covered entities are not required to enter into a business associate agreement with HHS in order for the exchange of protected health information to take place.

Third, in some instances, the HHS is a health oversight agency as defined by HIPAA. Under HIPAA, a "health oversight agency" is "an agency or authority of the United States, a state, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to

whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant."

HIPAA permits a covered entity to disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

i. The health care system (e.g. State insurance commissions, state health professional licensure agencies, Offices of Inspectors General of federal agencies, the Department of Justice, state Medicaid fraud control units, Defense Criminal Investigative Services, the Pension and Welfare Benefit Administration, the HHS Office for Civil Rights, the FDA, data analysis to detect health care fraud);

ii. Government benefit programs for which health information is relevant to beneficiary eligibility (e.g. SSA and Dept. of Education);

iii. Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards (e.g. Occupational Health and Safety Administration and the EPA; the FDS's oversight of food, drugs, biologics, devices, and other products pursuant to the Food, Drug, and Cosmetic Act and the Public Health Service Act); or

iv. Entities subject to civil rights laws for which health information is necessary for determining compliance (the U.S. Department of Justice's civil rights enforcement activities, enforcement of the Civil Rights of Institutionalized Persons Act, the Americans with Disabilities Act, the EEOC's civil rights enforcement activities under titles I and V of the ADA) (Section 164.512(Date)).

"Overseeing the health care system," encompasses activities such as oversight of health care plans, oversight of health benefit plans; oversight of health care providers; oversight of health care and health care delivery; oversight activities that involve resolution of consumer complaints; oversight of pharmaceutical, medical products and devices, and dietary supplements; and a health oversight agency's analysis of trends in health care costs, quality, health care delivery, access to care, and health insurance coverage for health oversight purposes.

Health oversight agencies may provide more than one type of health oversight. Such entities are considered health oversight agencies under the rule for any and all of the health oversight functions that they perform. The disclosure of protected health information to HHS for these purposes is unaffected by HIPAA and should continue in accordance with past practices.

Finally, local public health departments and local contractors, which are covered entities, may release protected health information to HHS under the above-cited legal authority applicable to all covered entities. For example, certain statutes and rules require local public health departments and local contractors to disclose protected health information to HHS. Further, as a health oversight agency a local health department is permitted, and in most cases required, to disclose protected health information to HHS. Disclosures of PHI by local public health departments and local contractors to HHS do not require business associate agreements and are not prohibited or otherwise affected by HIPAA.

Acknowledgements

Thank you to the members of the Trauma System Advisory Council, Data Management Committee, and all the members of the Trauma System Advisory Council and Iowa's Trauma Nurse Coordinators for their continued input into the trauma registry data dictionary.

Software

The Iowa Department of Public Health is required by law to seek bids from software vendors. For those seeking further information on application and contracting opportunities, please contact the Iowa Department of Administrative Services, General Services Enterprise, http://das.gse.iowa.gov/.

Data Dictionary

DEMOGRAPHIC INFORMATION

MEDICAL RECORD NUMBER

Definition: Medical record number of patients at this trauma care facility.

Field Values:

Relevant value for data element (alpha or numeric)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR1.2

IMAGETREND REGISTRY NUMBER

Definition: Auto-generated unique incident number.

Field Values:

Relevant value for data element (alpha or numeric)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: NA | **ImageTrend Data Element Tag:** TR5.12

ACCOUNT NUMBER

Definition: Account number used by facility.

Field Values:

Relevant value for data element (alpha or numeric)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: NA | **ImageTrend Data Element Tag:** TR1.27

INJURY DATE

Definition: The date the injury occurred.

Field Values:

Format in Month/Day/Year

Additional Information:

Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) should not be used.

Data Sources: EMS Run Report**,** Triage/Trauma Flow Sheet**,** History and Physical**,** Face Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR5.1

Comments: The equivalent NTDB field is called Injury Incident Date.

INJURY TIME

Definition: Time injury was sustained by trauma patient (or nearest estimate).

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

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

Data Sources: EMS Run Report**,** Triage/Trauma Flow Sheet**,** History and Physical**,** Face Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR5.18

Comments: The equivalent NTDB field is called Injury Incident Time.

LAST NAME

Definition: The patient's last name.

Field Values:

Open text box

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR1.9

FIRST NAME

Definition: The patient's first name.

Field Values:

Open text box

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR1.8

MIDDLE INITIAL

Definition: The patient's middle initial.

Field Values:

Open text box

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: NA | **ImageTrend Data Element Tag:** TR1.10

DATE OF BIRTH

Definition: The date of the patient's birth. This date is used to auto calculate the patient's age at the time of injury (best approximation).

Field Values:

Enter Month / Day / Year, example 12 / 25 / 1903.

Additional Information:

None.

Data Sources: Face Sheet, Billing Sheet, Admission Form, Triage/Trauma Flow Sheet, EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -4 | **ImageTrend Data Element Tag:** TR1.7

AGE (AT DATE OF INCIDENT)

Definition: The patient's age at the time of the injury (best approximation).

Field Values: The field will allow values from 0 to 120.

Additional Information:

This information will auto calculate if the patient's date of birth is entered and the patient is over one year in age.

Manually enter the patient's age at the time of injury (best approximation) only if the patient's date of birth is not available.

For patients less than one year of age, the Age (at date of incident) must be manually entered. Ensure the "Month, Days, or Hours" label selected coincides with the manually entered age.

Data Sources: Face Sheet**,** Billing Sheet**,** Admission Form**,** Triage/Trauma Flow Sheet**,** EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR1.12

AGE UNITS

Definition: The units used to document the patient's age (Years, Months, Days, or Hours).

Field Values: Dropdown menu options: Years, Months, Weeks, Days, Hours, Minutes.

Additional Information:

For patients less than one year of age, the Age (at date of incident) must be manually entered. Ensure the "Month, Days, or Hours" label selected coincides with the manually entered age.

Data Sources: Face Sheet**,** Billing Sheet**,** Admission Form**,** Triage/Trauma Flow Sheet**,** EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR1.14

ETHNICITY

Definition: The patient's ethnicity.

Field Values:

Single select dropdown menu with the following options:

- Not Known/Not Recorded
- Not Hispanic or Latino
- Hispanic or Latino

Additional Information:

Patient ethnicity must be based upon self-report or identified by a family member. Based on the 2010 US Census Bureau.

Data Source: Face Sheet, Billing Sheet, Admission Form, Triage/Trauma Flow Sheet, History and Physical, EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR1.17

RACE

Definition: The patient's race.

Field Values:

Multi-select field with the following options:

- Asian
- Native Hawaiian or Other Pacific Islander
- Other Race
- American Indian or Alaska Native
- White
- Not Known/Not Recorded
- Black or African American
-

Additional Information:

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

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form**,** Triage/Trauma Flow Sheet**,** EMS Run Report**,** History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR1.16

SEX ASSIGNED AT BIRTH

Definition: The patient's sex assigned at birth.

Field Values:

Single select dropdown menu with the following options:

- Male
- Female
- Not Known/Not Recorded

Additional Information:

The NTDB document contains the following information: “Also referred to as birth sex, natal sex, biological sex.”

This element was TR1.15 Gender, which is now deprecated as of 1/1/2025.

Data Source: Face Sheet, Billing Sheet, Admission Form, Triage/Trauma Flow Sheet, History and Physical, EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -4 | **ImageTrend Data Element Tag:** TR1.56

PATIENT GENDER IDENTITY

Definition: The patient's gender identity. Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment.

Field Values:

Single select dropdown menu with the following options:

- Male
- Female
- Non-binary, genderqueer, gender nonconforming
- Did not disclose

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR1.51

Comments: This data element is called Gender in the NTDB document.

GENDER-AFFIRMING HORMONE THERAPY

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

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

Field Values:

Single select dropdown menu with the following options:

- Yes
- No
- Non-disclosed

Additional Information:

Gender-affirming hormone therapy includes but is not limited to estrogen, antiandrogens, and testosterone.

If unclear if medication was for gender-affirming hormone therapy, then consult TMD or relevant physician/physician extender.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form**,** Triage/Trauma Flow Sheet**,** EMS Run Report, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR1.55

ADDRESS

Definition: Home street address of the trauma patient.

Field Values:

Open text box

Additional Information:

Field TR1.18.1 is Address Line 2, where further information on the patient's address can be added.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Demographics
NTDB	No	No	**Trauma Incident Form ICD-10**	Demographics
TQIP	No	No	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: NA | **ImageTrend Data Element Tag:** TR1.18

COUNTRY

Definition: The patient's country where he/she resides.

Field Values:

Dropdown menu of countries is provided.

Additional Information:

None.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	No	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: NA | **ImageTrend Data Element Tag:** TR1.19

Comments: The NTDB document calls this field Patient's Home Country.

POSTAL CODE

Definition: The patient's home ZIP code of primary residence.

Field Values:

The field will accept a 5-digit zip code.

Additional Information:

The patient's home city, county, and state will auto populate when a zip code is entered.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -4 | **ImageTrend Data Element Tag:** TR1.20

Comments: This data element is called Patient's Home Zip/Postal Code in the NTDB document.

CITY

Description

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

Field Values:

The patient's city of residence will be automatically generated after the postal code is entered.

Additional Information:

Used to calculate the FIPS code.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR1.21

Comments: This data element is called Patient's Home City in the NTDB document.

COUNTY

Description

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

Field Values:

The patient's county of residence will be automatically generated after the postal code is entered.

Additional Information:

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

Used to calculate the FIPS code.

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

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

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR1.22

Comments: This data element is called Patient's Home County in the NTDB document.

STATE

Description

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

Field Values:

The patient’s state of residence will be automatically generated after the postal code is entered.

Additional Information:

Used to calculate the FIPS code.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR1.23

Comments: This data element is called Patient’s Home State in the NTDB document.

ALTERNATE RESIDENCE

Definition: Documentation of the type of patient without a home zip/postal code.

Field Values:

Single select dropdown menu with the following options:

Migrant Worker	Undocumented Citizen
Homeless	Not Applicable

Additional Information:

Only reported when ZIP/Postal code is "Not Applicable."

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

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

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

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

Report all that apply.

Data Source: Face Sheet**,** Billing Sheet**,** Admission Form

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Demographics

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Demographics
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Demographics

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR1.13

Comments: This data element is called Alternate Home Residence in the NTDB document.

INJURY INFORMATION

INJURY LOCATION ICD-10

Definition: Place of occurrence external cause code used to describe the place/site/location of the injury event.

Field Values:

Relevant ICD-10-CM code values for injury event.

Additional Information:

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

Data Source: EMS Run Report, Triage/Trauma Flow Sheet, Nursing Notes/Flow Sheet, History and Physical, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR200.5

Comment: This data element is called ICD-10 Place of Occurrence External Cause Code in the NTDB document.

PLACE OF INJURY

Definition: Address of where injury took place if available.

Field Values:

Open text box.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Injury
NTDB	No	No	**Trauma Incident Form ICD-10**	Injury
TQIP	No	No	**Trauma + TQIP ICD-10**	Injury

State Validation Score: NA | **ImageTrend Data Element Tag:** TR5.17

INJURY LOCATION-COUNTRY

Definition: The country where the incident took place.

Field Values:

Dropdown menu of countries is provided.

Additional Information:

If Incident Country is not US, then the null value "Not Applicable" is used for: Incident State, Incident County, and Incident City.

Data Source: EMS Run Report, Triage/Trauma Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR5.11

Comments: This data element is called Incident Country in the NTDB document.

INJURY LOCATION-POSTAL CODE

Definition: The ZIP code of the incident location (best approximation).

Field Values:

The field will accept a 5-digit zip code.

Additional Information:

The city, county, and state associated with the place of injury will auto populate when a zip code is entered.

If "Not Known/Not Recorded," complete variables: Incident Country, Incident State (US ONLY), Incident County (US ONLY) and Incident City (US ONLY).

Data Source: EMS Run Report, Triage/Trauma Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR5.6

INCIDENT CITY

Definition: The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

Field Values:

The field will auto populate the associated city once the injury location postal code is entered.

Additional Information:

The city, county, and state associated with the place of injury will auto populate when a zip code is entered. If injury location postal code is "Not Known/Not Recorded," complete this variable.

Data Source: EMS Run Report, Triage/Trauma Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR5.10

INCIDENT COUNTY

Definition: The county or parish where the patient was found or to which the unit responded (or best approximation).

Field Values:

The field will auto populate the associated county once the injury location postal code is entered.

Additional Information:

The city, county, and state associated with the place of injury will auto populate when a zip code is entered. If injury location postal code is "Not Known/Not Recorded," complete this variable.

Data Source: EMS Run Report, Triage/Trauma Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR5.9

INCIDENT STATE

Definition: The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

Field Values:

The field will auto populate the associated state once the injury location postal code is entered.

Additional Information:

The city, county, and state associated with the place of injury will auto populate when a zip code is entered. If injury location postal code is "Not Known/Not Recorded," complete this variable.

Data Source: EMS Run Report, Triage/Trauma Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR5.7

CAUSE OF INJURY-ICD 10

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

Field Values: Relevant ICD-10-CM code value for injury event is accepted in this field. NOTE: Supplemental Cause of Injury is required with a State Validation Score of -2.

Additional Information:

The primary external cause code must describe the main reason a patient is admitted to the hospital. Activity codes are not reported under the NTDS. Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code must be reported for each cause. The first-listed external cause code will be selected in the following order:

1. External cause codes for child and adult abuse take priority over all other external cause codes.
2. External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
3. External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
4. External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
5. The first listed external cause code must 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: EMS Run Report, Triage/Trauma Flow Sheet, Nursing Notes/Flow Sheet, History and Physical, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR200.3

Comment: This data element is called ICD-10 Primary External Cause Code in the NTDB document.

INJURY DESCRIPTION

Definition: The description of how the injury occurred.

Field Values:
Open text box for entering data with a maximum limit of 762 characters.

Additional Information:
This is not a description of the injury.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Injury
Trauma Incident Form ICD-10	Injury
Trauma + TQIP ICD-10	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR20.12

INTENTIONALITY

Definition: Indicates if the cause of injury was intentional or unintentional.

Field Values: Dropdown menu with the following options:

Unintentional	Undetermined	Assault
Self-inflicted	Other	Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR200.3.2

Comments: This field is calculated for NTDB with the values entered for ICD-10 Primary External Cause Code.

TRAUMA TYPE

Definition: This indicates the type of trauma the injury caused.

Field Values: Dropdown menu with the following options:

- Blunt
- Penetrating
- Burn
- Other

Additional Information:

Either Blunt or Penetrating must be selected for the Probability of Survival to calculate. Trauma Type is required for each ICD 10 Injury code.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR200.3.3

Comments: This field is calculated for NTDB with the values entered for ICD-10 Primary External Cause Code.

VEHICLE POSITION

Definition: Identify the location/position related to the vehicle the trauma patient was in before the incident occurred.

Field Values: Dropdown menu with the following options:

- Not Known/Not Recorded
- Driver
- Motorcycle Passenger
- Pedestrian
- ATV Driver
- Moped Driver
- Other Specified
- Ride Animal
- ATV Passenger
- Moped Passenger
- Passenger Front
- Street Car Occupant
- Bus Occupant
- Motorcycle Driver
- Pedal Cyclist
- Truck Bed Passenger
- Front Seat-Middle
- Passenger Rear Seat - Center
- Passenger Rear Seat - Driver Side
- Passenger Rear Seat - Passenger Side
- Third Row-Middle
- Third Row-Right Side
- Third Row-Left Side (or motorcycle passenger)

Additional Information:

If Other Specified is selected, an open text box appears to enter the patient's location prior to the incident occurring.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Injury
NTDB	No	No	**Trauma Incident Form ICD-10**	Injury

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	No	No	**Trauma + TQIP ICD-10**	Injury

State Validation Score: NA | **ImageTrend Data Element Tag:** TR5.14

SAFETY DEVICE USED

Definition: The use (or lack of use) of safety equipment relevant to the injury cause. NOTE: To make multiple selections, hold the Ctrl key and click each desired value.

Field Values: Select all that apply by clicking into the selection box with the following options:

▪ Lap Belt	▪ Helmet (e.g., bicycle, skiing, motorcycle)	▪ Protective Clothing (e.g. padded leather pants)	▪ Airbag Present	▪ Not Known/Not Recorded
▪ Child Car Restraint (booster seat or child car seat)	▪ Other	▪ Protective Non-Clothing Gear (e.g. shin guard)	▪ Eye Protection	▪ Hard Hat
▪ Hard Hat	▪ Personal Flotation Device	▪ Shoulder Belt	▪ None	

Additional Information:

Report all that apply. Evidence of the use of safety equipment may be reported or observed. When the items below are selected, ImageTrend will produce their corresponding detail fields for further documentation:

Child Car Restraint → Child Specific Restraint (TR29.31)

Airbag Present → Airbag Deployment (TR29.32)

Other → Safety Equipment Description (TR29.10)

Data Source: EMS Run Report, Triage/Trauma Flow Sheet, Nursing Notes/Flow Sheet, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	Injury
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Injury
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR29.24

Comments: This data element is called Protective Devices in the NTDB document.

CHILD SPECIFIC RESTRAINT

Definition: Protective child restraint devices used by patient at the time of injury.

Field Values:
Single selection dropdown menu with the following options:

- Infant Car Seat
- Child Care Seat
- Child Booster Seat
- Not Applicable
- Not Known/Not Recorded

Additional Information:
Evidence of the use of a child restraint may be reported or observed. This field will only appear if Airbag Present is selected in Safety Device Used (TR29.24).

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Injury
Trauma Incident Form ICD-10	Injury
Trauma + TQIP ICD-10	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR29.31

AIRBAG DEPLOYMENT

Definition: Indication of airbag deployment during a motor vehicle crash. NOTE: To make multiple selections, hold the Ctrl key and click each desired value.

Field Values: Select all that apply by clicking into the selection box with the following options:

- Airbag Deployed Front
- Airbag Deployed Side
- Not Applicable
- Airbag Deployed Other (e.g., knee, curtain, air belt)
- Airbag Deployed Not Deployed

Additional Information:

Evidence of airbag deployment may be reported or observed. This field will only appear if Airbag Present is selected in Safety Device Used (TR29.24).

Data Source: EMS Run Report, Triage/Trauma Flow Sheet, Nursing Notes/Flow Sheet, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Injury
Trauma Incident Form ICD-10	Injury
Trauma + TQIP ICD-10	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR29.32

SAFETY EQUIPMENT DESCRIPTION

Definition: Provide a brief description of the safety equipment used that was not otherwise specified within Safety Device Used (TR29.24).

Field Values:

Open text box.

Additional Information:

This field will only appear if Other is selected in Safety Device Used (TR29.24).

Data Source: EMS Run Report, Triage/Trauma Flow Sheet, Nursing Notes/Flow Sheet, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Injury
Trauma Incident Form ICD-10	Injury
Trauma + TQIP ICD-10	Injury

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR29.10

PRE-HOSPITAL INFORMATION

PATIENT ARRIVED FROM

Definition: Location the patient arrived from.

Field Values:

Single selection dropdown menu with the following options:

- Not Known/Not Recorded
- Clinic/MD Office
- Home
- Jail
- Nursing Home
- Referring Hospital
- Scene
- Supervised Living
- Urgent Care
- Free-Standing ER
- Emergency Room

Additional Information:

If Referring Hospital is selected, the field Inter-Facility Transfer (TR25.54) will auto populate “Yes”. Otherwise, Inter-Facility Transfer will be “No”.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR16.22

INTUBATION PRIOR TO ARRIVAL

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

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

EXCLUDE: Airways not placed below the vocal cords (e.g., combitube, KING, laryngeal mask airway

(LMA), I-Gel).

Field Values:

Single selection dropdown menu with the following options:

- Yes
- No
- Not Known

Additional Information:

If “Yes” is reported, report Intubation Location.

The null value "Not Known" is reported for patients who had an established airway prior to this injury event (e.g., Chronic Ventilator Dependence).

Data Source: Triage/Trauma Flow Sheet, ED Record, Face Sheet, Billing Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR60.1

INTUBATION LOCATION PRIOR TO ARRIVAL

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

Field Values:

Single selection dropdown menu with the following options:

- Out of Hospital Intubation
- Transferring Facility
- Not Known

Additional Information:

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

The null value “Not Known” is reported if Intubation Prior to Arrival is reported as “No.”

The null value "Not Known" is reported if Intubation Prior to Arrival is reported as "Not Applicable."

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

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Pre-hospital
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR60.2

TRANSPORTED TO YOUR FACILITY BY

Definition: The mode of transport delivering the patient to your hospital.

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- ALS Ground
- BLS Ground
- Ground Ambulance
- ALS/Helicopter
- Fixed-wing Ambulance
- Private/Public Vehicle/Walk-In
- Other
- Police

Additional Information:

None.

Data Source: EMS Run Report

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR8.8

Comments: The NTDB data element is called Transport Mode.

INTER-FACILITY TRANSFER

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

Field Values:

Binary "yes" or "no" responses are auto populated based on the response to Patient Arrived From (TR16.22). A response of "yes" in this field corresponds only to the "Referring Hospital" response to Patient Arrived From.

Additional Information:

Patients transferred from a private doctor's office or stand-alone ambulatory surgery center should not be included as a "yes" to this field. Include patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center. Outlying facilities providing emergency care services or utilized to stabilize a patient are considered acute care facilities. Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf (accessed November 6, 2023).

Data Source: EMS Run Report**,** Triage/Trauma Flow Sheet**,** History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	No
NTDB	Yes	Yes
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.54

EMS TRIAGE INFORMATION-VEHICULAR, PEDESTRIAN, OTHER RISK INJURY (TRAUMA TRIAGE CRITERIA STEPS 3 AND 4)

Definition: EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma.

Field Values: Multi-select menu with the following options:

▪ Auto v. pedestrian/bicyclist thrown, run over, or >20 mph impact	▪ Crash ejection (partial or complete, from automobile	▪ Fall adults: > 20ft. (one story is equal to 10 feet)	▪ Patients on anticoagulants and bleeding disorders
▪ Burns	▪ Crash intrusion, including roof: > 12 inches occupant site; > 18 inches any site	▪ Fall children: > 10 ft. or 2-3 times the height of the child	▪ Pregnancy > 20 weeks
▪ Burns with Trauma	▪ Crash vehicle telemetry data (AACN) consistent with high risk injury	▪ For adults >65; SBP <110	▪ Not Applicable
▪ Crash death in same passenger compartment	▪ EMS provider judgement	▪ Motorcycle crash > 20 mph	▪ Not Known/Not Recorded

Additional Information:

The null value “Not Applicable” should be used to indicate that the patient did not arrive by EMS. The null value “Not Applicable” should be used if EMS Run Report indicates patient did not meet any Vehicular, Pedestrian, Other Risk Injury criteria. The null value “Not Known/Not Recorded” should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.47

TRAUMA CENTER CRITERIA (TRAUMA TRIAGE CRITERIA STEPS 1 AND 2)

Definition: Physiological and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma.

Field Values: Multi-select menu with the following options:

▪ All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee	▪ Crushed, degloved, mangled, or pulseless extremity	▪ Paralysis	▪ Systolic blood pressure < 90mmHg	▪ Not Know/Not Recorded
▪ Amputation proximal to wrist or ankle	▪ Glasgow Coma Score <=13	▪ Pelvic fracture	▪ Two or more proximal long-bone fractures	
▪ Chest wall instability or deformity (e.g., flail chest)	▪ Open or depressed skull fracture	▪ Respiratory rate < 10 or > 29 breaths per minute (< 20 in infants aged < 1 year) or need for ventilatory support	▪ Not applicable	

Additional Information:

The null value “Not Applicable” should be used to indicate that the patient did not arrive by EMS. The null value “Not Applicable” should be used if EMS Run Report indicates patient did not meet any Trauma Center Criteria. The null value “Not Known/Not Recorded” should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.22

EMS RUN NUMBER

Definition: The EMS Run number is assigned by the EMS agency that generated the incident. The NEMSIS data section is eResponse.03 (Incident Number).

Field Values:

Open text field

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: -10 | **ImageTrend Data Element Tag:** TR7.1

EMS PCR NUMBER (IMAGETREND PCR#)

Definition: EMS Patient Care Report (PCR) Number specific to the trauma patient. This is the auto generated ImageTrend Number within in the EMS data registry specific to the trauma patient.

Field Values:

Open text field

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Pre-hospital
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR9.11

EMS SERVICE

Definition: The name of the EMS service the patient was transferred from.

Field Values:

Identify the EMS transporting service from the dropdown options.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR7.3

EMS UNIT NOTIFIED/DISPATCHED DATE

Definition: The date the unit transporting the patient to the hospital was notified by dispatch.

Field Values:

Enter date using calendar option or by entering the month/day/year.

Additional Information:

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.

For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR9.1

EMS UNIT NOTIFIED/DISPATCHED TIME

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

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

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.

For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR9.10

EN ROUTE DATE

Definition: The date the EMS Agency began travel to place where patient EMS transport was to begin.

Field Values:

Enter date using calendar option or by entering the month/day/year.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR9.17

EMS UNIT ARRIVED AT SCENE (OR TRANSFERRING FACILITY)

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

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

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).

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

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR9.2

TIME EMS UNIT LEFT/DEPARTED SCENE OR TRANSFERRING FACILITY

Definition: The time the EMS unit transporting to the hospital left the scene or transferring facility.

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

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

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR9.3

EMS UNIT ARRIVED AT HOSPITAL DATE

Definition: The date the unit transporting to the hospital arrived to the hospital (the time the vehicle stopped moving).

Field Values:

Enter date using calendar option or by entering the month/day/year.

Additional Information:

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

For inter-facility transfer patients, this is the date when the unit transporting the patient to your facility arrived (arrival is defined at date/time when the vehicle stopped moving).

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 **| ImageTrend Data Element Tag:** TR9.4

EMS UNIT ARRIVED AT HOSPITAL TIME

Definition: The time the unit transporting to the hospital arrived to the hospital (the time the vehicle stopped moving).

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

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

For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility arrived (arrival is defined at date/time when the vehicle stopped moving).

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 **|** **ImageTrend Data Element Tag:** TR9.4.1

DESTINATION DETERMINATION

Definition: Rationale for selection of EMS unit hospital destination.

Field Values:

Drop down menu with the following options:

- Not known/Not Recorded
- Closest Facility
- Hospital of Choice
- Other
- Not transported (tiered response)
- Diversion
- On-line Medical Direction
- Specialty Resource Center

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR15.32

TRIAGE DESTINATION PROTOCOL

Definition: Indicates whether the out of hospital triage destination protocol was used to determine patient needed resources of this trauma care facility.

Field Values:

Drop down menu with the following options:

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

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	Pre-hospital
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR9.13

TRIAGE CRITERIA

Definition: Indicates criterion (a) used to triage patient Criteria that may be selected are those in the adult out of hospital trauma triage criteria decision protocol of the EMS Bureau of the IDPH. Up to 20 criteria may be chosen (If EMS run sheet unavailable, give best estimate of circumstances of injury).

Field Values: Multi-select field with the following options:

- Suspected Pelvic Fx
- Suspected fractures, 2 or more long bones (humerus, femur)
- Suspected alcohol/drug intoxication
- Significant intrusion of passenger compartment
- SBP <90
- RR 29
- Pregnancy
- Penetration, head/neck/torso/groin/axilla
- Pedestrian/vehicle impact > 20mph
- Pedestrian, thrown, > 15 feet or run over
- Neck or spinal cord injury with extremity paralysis or paresis
- MV-rollover
- MV-extrication
- MV-death in same passenger compartment
- Motorcycle, ATV, Bicycle > 20 mph
- Medical illness, COPD, CHF, Cardiac
- HR > 120
- Hostile environment, heat/cold
- High speed crash
- GCS < 13
- Flail Chest
- Falls > 20ft (Peds = 15 ft)
- EMT “high index of suspicion” of abdominal or thoracic injuries
- EMT “high index of suspicion”
- Ejection from vehicle
- Burns > 10%, or face/airway/hand/feet/genitalia
- Amputation, proximal to wrist or ankle
- Age 60
- Not Applicable
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR9.14

EMS REPORT STATUS

Definition: EMS Report Status

Field Values:

Drop down menu with the following options:

- Complete
- Incomplete
- Missing
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Pre-hospital
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR15.38

PRE HOSPITAL CARDIAC ARREST

Definition: Indication of whether the person experienced a cardiac arrest at any stage prior to arrival at the definitive care hospital.

Field Values: Drop down menu with the following options:

- No
- Yes
- Not Known/Not Recorded

Additional Information:

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

The event must have occurred outside of the index hospital.

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

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

Data Source: EMS Run Report**,** Nursing Notes/Flow Sheet**,** History and Physical**,** Transfer Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR 15.53

CPR LOCATION

Definition: The location of the EMS CPR event.

Field Values:

Drop down menu with the following options:

- Scene & Route CPR
- En Route CPR
- Scene CPR
- Not Performed

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR 15.41

AIRWAY MANAGEMENT

Definition: Airway management initiated in the pre-hospital setting.

Field Values:

Drop down menu with the following options:

- Not Applicable
- Airway cleared
- Alternative Airway Device
- Bag & Mask
- CPAP
- Crico
- EOA
- King LT
- i-Gel
- LMA
- Nasal Cannula
- Nasal ETT
- Nasal Trumpet
- Non-Rebreather Mask
- Oral Airway
- Oral ETT
- Supplemental Oxygen
- Trach

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR15.40

EMS VITALS DATE

Definition: Date the first set of EMS vitals were taken.

Field Values:

Enter the month/day/year.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.106

EMS VITALS TIME

Definition: Time the first set of EMS vitals were taken.

Field Values:

Military time, examples: 0900 or 1300

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.106.1

EMS SYSTOLIC BLOOD PRESSURE

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

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.67

Comments: This data element is called Initial Field Systolic Blood Pressure in the NTDB document.

EMS DIASTOLIC BLOOD PRESSURE

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

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.68

EMS PULSE RATE

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

Field Values:

Relevant value for data element

Additional Information:

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.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.69

EMS TEMPERATURE

Definition: First recorded temperature (in degrees Celsius or degrees Fahrenheit) by EMS.

Field Values:

Relevant value for data element

Additional Information:

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.66

EMS OXYGEN SATURATION

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

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR 18.82

Comments: This data element is called Initial Field Oxygen Saturation in the NTDB document.

EMS RESPIRATORY RATE

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

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.70

Comments: This data element is called Initial Field Respiratory Rate in the NTDB document.

RESPIRATORY ASSISTANCE

Definition: Identify if respiratory rate was assisted.

Field Values:

Drop down menu with the following options:

- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable

Additional Information:

The null value "Not Applicable" is used if "EMS Respiratory Rate" is "Not Known/Not Recorded."

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.80

EMS REVISED TRAUMA SCORE

Definition: This number is the revised trauma score/pediatric trauma score comprised from the Glasgow Coma Scale, Systolic blood pressure, and respiratory rate.

Field Values:

The revised trauma score/pediatric trauma score auto populates when the GCS is calculated and systolic blood pressure and respiratory rate are entered. Users may manually enter a GCS score, but this is not recommended.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Pre-hospital
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.136

EMS GLASGOW EYE

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

Field Values:

Drop down menu with the following options:

- 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
- Not Known/Not Recorded

Additional Information:

Used to calculate Overall EMS GCS score.

The null value “Not Known/Not Recorded” is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient’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 Private/Public Vehicle/Walk-in.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.60

Comments: This data element is called Initial Field GCS – Eye in the NTDB document.

EMS GLASGOW VERBAL

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

Field Values: Dropdown menu with the following options:

Pediatric Values (≤ 2 years)

- Not Applicable
- Not Known/Not Recorded
- 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 Values

- 1 No verbal response
- 2 Incomprehensible sounds
- 3 Inappropriate words
- 4 Confused
- 5 Oriented
- Not Applicable
- Not Know/Not Recorded

Additional Information:

Used to calculate Overall EMS GCS Score.

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

If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient 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 Private/Public Vehicle/Walk-in.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Pre-hospital

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.61.0 (peds) & TR18.61.2 (adult)

Comments: This data element is called Initial Field GCS – Verbal in the NTDB document.

EMS GLASGOW MOTOR

Definition: The first recorded Glasgow Coma Score (Motor) measured at the scene of injury.

Field Values:

Pediatric (≤ 2 years):

- Not Known/Not Recorded
- Not Applicable
- 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:

- Not Known/Not Recorded
- Not Applicable
- 1 No motor response
- 2 Extension to pain
- 3 Flexion to pain
- 4 Withdrawal from pain
- 5 Localizing pain
- 6 Obeys commands

Additional Information:

Used to calculate Overall EMS GCS Score.

The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

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

The null value "Not Applicable" is used for patients who arrive by Private/Public Vehicle/Walk-in.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Pre-hospital

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.62.0 (peds) and TR18.62.2 (adult)

Comments: This data element is called Initial Field GCS – Motor in the NTDB document.

EMS GCS QUALIFIER

Definition: Documentation of factors potentially affecting the first assessment of GCS by EMS. Up to three field values may be selected.

Field Values: Multi-select box with the following options:

- Patient Chemically Sedated
- Patient Intubated
- Obstruction to the Patient's Eye
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
- Not Known/Not Recorded

Additional Information:

Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.

Please note that first EMS vitals do not need to be from the same assessment.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.63

EMS GCS TOTAL CALC

Definition: This number is the total GCS score compiled from the GCS Eye, GCS Verbal, and GCS Motor scores.

Field Values:

The GCS calculated score auto populates when GCS eye, verbal, and motor scores are entered. Users may manually enter a GCS score, but this is not recommended.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.65

Comments: This data element is called Initial Field GCS – Total in the NTDB document.

EMS GCS 40 EYE

Definition: First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.

Field Values: Drop down menu with the following options:

Adults:

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

Pediatric < 5 years:

- 1. None
- 2. To Pain
- 3. To Sound
- 4. To Sound
- 5. Not Testable

Additional Information:

The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury. 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 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 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”. Report Field Value “5. Not Testable” if unable to assess (e.g. swelling to eye(s)).

The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS 40 – Eye was NOT measured at the scene of injury.

The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Eye is reported.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	Pre-hospital

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	No	No	**Trauma Incident Form ICD-10**	Pre-hospital
TQIP	No	No	**Trauma + TQIP ICD-10**	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.90.2

Comments: This data element is called Initial Field GCS 40 – Eye in the NTDB document.

EMS GCS 40 VERBAL

Definition: First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.

Field Values: Drop down menu with the following options:

Adults:

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

Pediatric < 5 years:

- 1. None
- 2. Cries
- 3. Vocal Sounds
- 4. Words
- 5. Talks Normally
- 6. Not Testable

Additional Information:

The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 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”.

Report Field Value “6. Not Testable” if unable to assess (e.g. patient is intubated).

The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS 40-Verbal was not measured at the scene of injury.

The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Verbal is reported

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.91.2

Comments: This data element is called Initial Field GCS 40 – Verbal in the NTDB document.

EMS GCS 40 MOTOR

Definition: First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.

Field Values: Drop down menu with the following options:

Adults:

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

Pediatric < 5 years:

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

Additional Information:

The null value "Not Known/Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.

If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 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".

Report Field Value "7. Not Testable" if unable to assess (e.g. neuromuscular blockade).

The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS 40 – motor was NOT measured at the scene of injury.

The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.92.2

Comments: This data element is referred to as Initial Field GCS 40 – Motor in the NTDB document.

EMS GCS 40 TOTAL CALC

Definition: This number is the total GCS score compiled from the GCS 40 Eye, GCS 40 Verbal, and GCS 40 Motor scores.

Field Values: The GCS 40 calculated score auto populates when GCS 40 eye, verbal, and motor scores are entered. Users may manually enter a GCS 40 score, but this is not recommended.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.94.1

ALERT, VOICE, PAIN, UNRESPONSIVE (AVPU) SCORE

Definition: This field is entered by EMS to measure and record the patient's level of consciousness.

Field Values: Dropdown menu with the following options:

- Alert
- Responds to Pain
- Unresponsive
- Verbal Stimuli
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.107

REFERRING HOSPITAL DATA

REFERRING HOSPITAL

Definition: The name of the referring hospital that transferred the patient.

Field Values:

Identify the referring hospital from the dropdown options.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.1

REFERRING HOSPITAL ARRIVAL DATE

Definition: Indicate the date/time the patient arrived at the outside facility.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.2 (Date), TR33.3 (Time)

REFERRING HOSPITAL DISCHARGE DATE/TIME

Definition: Indicate the date/time the patient left the outside facility.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.30 (Date), TR33.31 (Time)

TRANSPORTED TO REFERRING FACILITY BY

Definition: Method in which trauma patient was transported and arrived at referring facility.

Field Values:

Drop down menu with the following options:

- Not Known/Not Recorded
- ALS Ground EMS
- ALS/Helicopter
- BLS Ground EMS
- Fixed-wing Ambulance
- Other
- Police
- Private/Public Vehicle/Walk-in

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.48

MEDICAL RECORD NUMBER

Definition: Medical record number of patient at the referring trauma care facility.

Field Values

Relevant value for data element (alpha or numeric)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR33.45

TRAUMA REGISTRY NUMBER

Definition: The unique incident number from the referring facility.

Field Values

Relevant value for data element (alpha or numeric)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.46

REFERRING HOSPITAL VITALS DATE/TIME

Definition: Date/time the first set of vitals taken by the referring hospital. Please note that the referring hospital vitals do not need to be from the same assessment.

Field Values:

Relevant value for data element

Additional Information:

Please note that the referring hospital vitals do not need to be from the same assessment.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.54 (Date), TR33.56 (Time)

REFERRING HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition: First recorded systolic blood pressure at the referring hospital.

Field Values:

Relevant value for data element

Additional Information:

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

Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.5

REFERRING HOSPITAL DIASTOLIC BLOOD PRESSURE

Definition: First recorded diastolic blood pressure measured at the referring hospital.

Field Values:

Relevant value for data element

Additional Information:

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

Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.40

REFERRING HOSPITAL PULSE RATE

Definition: First recorded pulse in the referring hospital (palpated or auscultated). Pulse rate is expressed as a number per minute.

Field Values:

Relevant value for data element

Additional Information:

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

Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.6

REFERRING HOSPITAL TEMPERATURE

Definition: First recorded temperature (in degrees Celsius or Fahrenheit) at the referring hospital. The first recorded vitals do not need to be from the same assessment.

Field Values:

Relevant value for data element

Additional Information:

The first recorded vitals do not need to be from the same assessment.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.7 (degrees Celsius), TR33.7.1 (degrees Fahrenheit)

REFERRING HOSPITAL RESPIRATORY RATE

Definition: First recorded respiratory rate measured at the referring hospital (expressed as a number per minute).

Field Values:

Relevant values for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.8

REFERRING HOSPITAL RESPIRATORY ASSISTANCE

Definition: Determination of respiratory assistance associated with the referring hospital respiratory rate.

Field Values:

Drop down menu with the following options:

- Not Known/Not Recorded
- Assisted Respiratory Rate
- Unassisted Respiratory Rate

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.9

REFERRING HOSPITAL SUPPLEMENTAL OXYGEN

Definition: Determination of the presence of supplemental oxygen during assessment of initial referring hospital oxygen saturation level.

Field Values: Drop down menu with the following options:

- Not Known/Not Recorded
- No
- Yes

Additional Information:

Only completed if a value is provided for Initial ED/Hospital Oxygen Saturation, otherwise report as "Not Applicable".

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.10

REFERRING HOSPITAL OXYGEN SATURATION

Definition: First recorded oxygen saturation in the referring hospital (expressed as a percentage).

Field Values: Relevant value for data element

Additional Information:

If available, complete additional field: Initial ED/Hospital Supplemental Oxygen.

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.11

REFERRING ALERT, VOICE, PAIN, UNRESPONSIVE (AVPU) SCORE

Definition: This field is entered by the referring facility to measure and record the patient's level of consciousness.

Field Values: Dropdown menu with the following options:

- Alert
- Responds to Pain
- Unresponsive
- Verbal Stimuli
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.44

REFERRING HOSPITAL GLASGOW-EYE

Definition: First recorded Glasgow Coma Score (Eye) measured at the referring hospital.

Field Values:

Drop down menu with the following options:

- Not Known/Not Recorded
- 1 No eye movement when assessed
- 2 Opens eyes in response to painful stimulation
- 3 Opens eyes in response to verbal stimulation
- 4 Opens eyes spontaneously

Additional Information:

Used to calculate Overall GCS - ED Score.

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

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.12

REFERRING HOSPITAL GLASGOW-VERBAL

Definition: First Recorded Glasgow Coma Score (Verbal) measured at the referring hospital.

Field Values:

Pediatric Values (≤ 2 years)		Adult Values	
Not Applicable	3 Inconsistently consolable, moaning	Not Applicable	3 Inappropriate words
Not Known/Not Recorded	4 Cries but is consolable, inappropriate interactions	Not Know/Not Recorded	4 Confused
1 No vocal response	5 Smiles, oriented to sounds, follows objects, interacts	1 No verbal response	5 Oriented
2 Inconsolable, agitated		2 Incomprehensible sounds	

Additional Information:

Used to calculate Overall Referring hospital GCS Score.

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

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

The null value “Not Applicable” is used for patients who arrive by Private/Public Vehicle/Walk-in.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring

Inclusion Entity	Required Data Element	Validated Field
TQIP	No	No

Form	Location of Data Element
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.13.2 (adult) and TR33.13.0 (peds)

REFERRING HOSPITAL GLASGOW-MOTOR

Definition: First Recorded Glasgow Coma Score (Motor) measured at the referring hospital.

Field Values:

Pediatric (≤ 2 years):

- Not Known/Not Recorded
- 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

- Not Known/Not Recorded
- 1 No motor response
- 2 Extension to pain
- 3 Flexion to pain
- 4 Withdrawal from pain
- 5 Localizing pain
- 6 Obeys commands

Additional Information:

Used to calculate Overall Referring hospital GCS Score. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

The null value "Not Applicable" is used for patients who arrive by Private/Public Vehicle/Walk-in.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.14.2 (adult) and TR33.14.0 (peds)

REFERRING HOSPITAL GLASGOW-QUALIFIER

Definition: Documentation of factors potentially affecting the first assessment of GCS by the referring hospital. Up to three field values may be selected.

Field Values:

Multi-select box with the following options:

- Not Known/Not Recorded
- Obstruction to the Patient's Eye
- Patient Chemically Sedated or Paralyzed
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information:

Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.16

REFERRING HOSPITAL GLASGOW SCORE-MANUAL

Definition: This number is the total GCS score compiled from the GCS Eye, GCS Verbal, and GCS Motor scores.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.15

REFERRING HOSPITAL CALCULATED REVISED TRAUMA SCORE TOTAL

Definition: This number is the revised trauma score/pediatric trauma score comprised from the Glasgow Coma Scale, Systolic blood pressure, and respiratory rate from the referring hospital.

Field Values:

The revised trauma score/pediatric trauma score auto populates when the GCS is calculated and systolic blood pressure and respiratory rate are entered. Users may manually enter a GCS score, but this is not recommended.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.51

REFERRING HOSPITAL CPR PERFORMED

Definition: Identify if CPR was performed at the referring hospital.

Field Values:

- Not Performed
- Yes

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.20

IMAGING HEAD

Definition: Indicate whether or not head imaging was completed at the referring facility, and if so the result.

Field Values:

Dropdown menu with the following options:

- Not Performed
- Positive
- Negative
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.34

IMAGING CHEST

Definition: Indicate whether or not chest imaging was completed at the referring facility, and if so the result.

Field Values:

Dropdown menu with the following options:

- Not Performed
- Positive
- Negative
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.35

IMAGING ABDOMEN/PELVIS

Definition: Indicate whether or not abdomen/pelvis imaging was completed at the referring facility, and if so the result.

Field Values:

Dropdown menu with the following options:

- Not Performed
- Positive
- Negative
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.36

ECHO

Definition: Indicate whether or not echocardiography was utilized at the referring facility, and if so the result.

Field Values:

Dropdown menu with the following options:

- Not Performed
- Positive
- Negative
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.37

SENT TO CATH LAB

Definition: Was the patient sent to cath lab at the referring facility?

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Applicable

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Referring
TQIP	No	No	**Trauma + TQIP ICD-10**	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.39

REFERRING HOSPITAL DESTINATION DETERMINATION TO DEFINITIVE CARE

Definition: Identify determinants for selecting the definitive care hospital for the trauma patient.

Field Values: Drop down menu with the following options:

- Specialty Care / Higher Level Care
- Specialty - Vascular/Aortic Injuries
- Specialty - Spine
- Specialty - Replantation
- Specialty - Pediatrics
- Specialty - Other Orthopaedics
- Specialty - Orthopaedics - Soft Tissue Coverage
- Specialty - Orthopaedics - Pelvic Ring/Acetabular Fxs
- Specialty - Neurosurgery
- Specialty - Hand
- Specialty - Facial Trauma
- Specialty - Cardiac (Bypass)
- Specialty - Burns
- Not Known/Not Recorded
- Hospital Of Choice
- Specialty Resource Center
- Physician/Services Available

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.29

REFERRING PROCEDURE CODES

Definition: Referring ICD 9 / ICD 10 Procedure Code.

Field Values:

Relevant ICD-10-PCS code values for injury event.

Additional Information:

Only ICD-10-PCS codes are accepted.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.55

TRANSFERRING SERVICE REPORT AVAILABLE AT REFERRING HOSPITAL

Definition: Indicates whether transferring trauma care facility service report for this run is available at this facility.

Field Values: Dropdown menu with the following options:

- Not Known/Not Recorded
- Received, complete, legible, in a timely fashion (< 24 hours)
- Received, complete legible, not in a timely fashion
- Received, illegible
- Received, incomplete, (all or missing)
- Not received

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Referring
Trauma + TQIP ICD-10	Referring

State Validation Score: NA | **ImageTrend Data Element Tag:** TR33.66

EMERGENCY DEPARTMENT / ACUTE CARE

DIRECT ADMIT TO HOSPITAL

Definition: Was the patient admitted to hospital directly?

Field Values:

Dropdown menu with the following options:

- No
- Yes

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.30

PRIMARY MEDICAL EVENT

Definition: The patient experienced a documented primary medical event (e.g., seizure, cerebral vascular accident, myocardial infarction, arrythmia, syncope, stroke, hypoglycemia) that immediately preceded the traumatic injury.

Field Values:

Dropdown menu with the following options:

- No
- Yes
- Not Known

Additional Information:

“Yes" is reported if the patient experienced a medical event immediately preceding the trauma.

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

Data Source: Physician's Notes**,** History & Physical**,** Progress Notes**,** Case Management/Social Services**,** Nursing Notes/Flow Sheet**,** Triage/Trauma Flow Sheet**,** Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR18.220

DATE/TIME ARRIVED IN ED/ACUTE CARE

Definition: The date and time the patient arrived in the emergency department.

Field Values:

Relevant value for data element

Additional Information:

None.

Data Source: Triage/Trauma Flow Sheet, ED Record, Face Sheet, Billing Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -4 (Date), -3 (Time) | **ImageTrend Data Element Tag:** TR18.55(Date), TR18.56 (Time)

Comments: There are 2 fields, 1 for Date and 1 for Time.

PRIMARY TRAUMA SERVICE TYPE

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

Field Values:

Dropdown menu with the following options:

- Adult
- Pediatric
- Not Known

Additional Information:

None.

Data Source: Triage/Trauma Flow Sheet, History and Physical, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR18.205

TRAUMA TEAM ACTIVATION

Definition: Level of trauma team activation called as part of the trauma service response of this trauma care facility emergency department for this trauma patient.

Field Values:

Radio buttons with the following options:

- Full Trauma Activation (Level I)
- Partial Team Activation (Level II)
- Consultation (Consultation by the hospital's trauma service.)
- Not Activated (This is used for trauma patients that meet the trauma registry inclusion criteria but did not have a trauma alert called or require a trauma service consult.)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR 17.21

HIGHEST ACTIVATION LEVEL

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

Field Values:

Radio buttons with the following options:

- No
- Yes
- Not Known

Additional Information:

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

Include highest level activations by EMS or hospital personnel even if the activation level was downgraded after the patient arrived at your hospital.

Include patients who were upgraded to the highest level before or during their treatment in the ED.

Exclude/select No if the highest activation level was declared after patient was discharged from the ED.

Data Source: Triage/Trauma Flow Sheet, ED Record, History and Physical, Physician Notes/Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR 17.21.1

TRAUMA TEAM ACTIVATION DATE/TIME

Definition: The date and time trauma team was activated.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR17.31 (Date), TR17.34 (Time)

Comments: The Date and Time fields on the ImageTrend form are separate.

TRAUMA TEAM MEMBER

Definition: ED Physician Dropdown menu based on “Staff” identified by the trauma care facility.

Field Values:

Dropdown menu based on “Staff” identified by the trauma care facility.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR17.9

TRAUMA TEAM MEMBER SERVICE TYPE

Definition: ED Trauma Physician or Provider Service Type

Field Values:

Dropdown menu of the following options:

- Not Known/Not Recorded
- Anesthesia
- Crisis RN
- CRNA
- Hospitalist
- Pediatric Hospitalist
- Pediatric Intensivist
- Social Work
- Cardiologist
- Neurosurgery
- Dental
- Emergency Medicine
- ENT
- Family Practice
- Internal Medicine
- Interventionalist
- Laboratory
- Maxillofacial Surgery
- Nephrology
- Radiology
- Nurse Practitioner
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pediatric Surgery
- Pediatrician
- Physician Assistant
- Plastic Surgery
- Pulmonology
- Surgery Senior Resident
- Surgery/Trauma
- Trauma Nurse
- Urology
- Vascular Surgery
- ED Tech / CNA
- ED Nurse / RN
- EMT / AEMT / Paramedic

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR17.13

TRAUMA TEAM MEMBER CALLED-DATE/TIME

Definition: The date and time the physician was called to evaluate the patient.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -2 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR 17.10 (Date), TR17.14 (Time)

TRAUMA TEAM MEMBER ARRIVED-DATE/TIME

Definition: The date and time the physician arrived to evaluate the patient.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR 17.15 (Date), TR17.11 (Time)

TIMELY ARRIVAL OF TRAUMA TEAM MEMBER

Definition: Was the ED physician arrival timely?

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- Yes
- No

Additional Information:

For Level I and II facilities, did the trauma surgeon respond within 15 mins?

For Level III and IV facilities, did the physician (if available) or midlevel provider respond within 30 mins?

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.12

ACTIVATION LEVEL DATE/TIME CHANGED

Definition: Date and time that the activation level was changed

Field Values:

Relevant value for data element

Additional Information:

This field only applies if there has been a trauma activation, and if the trauma activation level needs to change. Otherwise, this field can be left blank.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.78.1 (Date), TR17.78.1.1 (Time)

ACTIVATION LEVEL UPGRADE/DOWNGRADE

Definition: Was the activation level changed? If so, document the direction of the change.

Field Values:

Dropdown menu with the following options:

- Yes, Upgraded
- Yes, Downgraded
- Not Applicable

Additional Information:

This field only applies if there has been a trauma activation, and if the trauma activation level needs to change. Otherwise, this field can be left blank.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.78.2

NEW ACTIVATION LEVEL

Definition: The new activation level after the trauma activation level was changed.

Field Values:

Dropdown menu with the following options:

- Not Activated
- Level 2
- Level 1
- Consultation

Additional Information:

This field only applies if there has been a trauma activation, and if the trauma activation level needs to change. Otherwise, this field can be left blank.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.78.3

OLD ACTIVATION LEVEL

Definition: The activation level before the trauma activation level was changed.

Field Values:

Dropdown menu with the following options:

- Not Activated
- Level 2
- Level 1
- Consultation

Additional Information:

This field only applies if there has been a trauma activation, and if the trauma activation level needs to change. Otherwise, this field can be left blank.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.78.4

FIRST TRAUMA SURGEON ARRIVAL-DATE/TIME

Definition: The date and time the first trauma surgeon arrived to evaluate the patient.

Field Values:

Relevant value for data element

Additional Information:

If the Trauma Team Member Service Type of “Surgery/Trauma” is selected, this field will impose a validation score penalty of -2 for the date, and/or a penalty of -1 for the time if left blank.

Data Source: Triage/Trauma Flow Sheet, History and Physical, Physician Notes/Flow Sheet, Nursing Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -2 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR 17.15.1 (Date), TR 17.15.2 (Time)

DECISION TO DISCHARGE/TRANSFER DATE/TIME

Definition: The date and time the order was written for the patient to be discharged from the Emergency Department.

Field Values:

Relevant value for data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR17.41 (Date), TR17.42 (Time)

Comments: Note that this data element is the same as the combination of ED Discharge Date and ED Discharge Time elements from the NTDB dictionary. The following element in this document, Date/Time Discharged from Emergency Department, is different, despite the similarities of names.

DATE/TIME PHYSICALLY DISCHARGED FROM EMERGENCY DEPARTMENT

Definition: The date and time the patient was discharged from the Emergency Department.

Field Values:

Relevant value for data element

Additional Information:

None.

Data Source: Physician Order, ED Record, Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet, Discharge Summary, Billing Sheet, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 (Date), -3 (Time) | **ImageTrend Data Element Tag:** TR17.25 (Date), TR17.26 (Time)

LENGTH OF STAY IN ED (TOTAL MINUTES) (PHYSICAL D/C)

Definition: The length of time in minutes the patient was served in the ED.

Field Values:

This field auto generates from the difference in date/times by subtracting the date arrived in the ED (TR18.55 / TR18.56) from the date/time the patient was discharged (TR17.25 / TR17.26) to arrive at total minutes.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.99

ED DISPOSITION

Definition: The disposition of the patient at the time of discharge from the Emergency Department.

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- AMA
- Deceased/ Expired
- Hospice
- Floor Bed (general admission, non-specialty unit)
- Home with services
- Home without services
- Operating Room (Hybrid OR)
- Interventional Radiology
- Intensive Care Unit
- Observation unit
- Other (jail, institution, etc.)
- Telemetry/step-down unit (less acuity than ICU)
- Transferred to another hospital

Additional Information:

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

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

If ED Discharge Disposition is Floor bed (general admission, non-specialty unit bed), Observation unit, Telemetry/step-down unit (less acuity than ICU), Operating Room (Hybrid OR), Intensive Care Unit (ICU), or Interventional Radiology Suite, then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be a null value.

Data Source: Physician Order, Discharge Summary, Nursing Notes/Flow Sheet, Case Management/Social Services Notes, ED Record, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR17.27

HOSPITAL TRANSFERRED TO

Definition: Name of the facility the patient was transferred to.

Field Values:

Dropdown menu based on the “Facility” identified by the trauma care facility.

Additional Information:

This field will only appear to be filled out if ED Disposition (TR17.27) is set to “Transferred to another hospital”.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.61

TRANSPORT MODE

Definition: The type of transportation used to transfer the patient. Patient who are transferred by private vehicle are considered to have been discharged and referred. These cases need not be reported.

Field Values:

Dropdown menu with the following options:

- Ambulance
- EMS
- Fixed Wing
- Ground
- Helicopter
- Not Known/Not Recorded
- Other
- Police
- Private Vehicle
- Public Safety

Additional Information:

This field will only appear to be filled out if ED Disposition (TR17.27) is set to Transferred to another hospital.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.60

TRANSFER DELAY

Definition: A patient with an ED stay > 2 hours (120 minutes) before transfer to definitive care. This is defined as 2 hours from the patient's arrival at your facility to physical discharge.

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

This field will only appear to be filled out if ED Disposition (TR17.27) is set to Transferred to another hospital.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.45

REASON FOR TRANSFER DELAY

Definition: Indicate the reason(s) for the transfer delay.

Field Values:

Multiple select menu with the following options:

- EMS Issue
- Late requesting transporting EMS unit
- Unexpected Patient Deterioration
- Receiving Facility Issue
- In-house imaging delay
- Surgery (Performed Before Transport)
- Referring Hospital Issue-Radiology
- High ED census at transferring hospital/busy
- Prolonged Resuscitation
- Referring Physician Decision Making
- High ED census at receiving hospital/busy
- Planned Delay
- Weather or Nature Factors Issue
- Inpatient Bed Availability at Receiving Facility
- Lack of Receiving MD
- Waiting for transporting EMS unit
- Family, Legal Guardian, or Patient Issue
- Delayed Diagnosis
- Transportation Issue
- Error Issue
- Other
- Religious/community restraints
- Equipment Issue
- Specialty Services Not Available
- Referring Facility Issue
- Delayed identification that the patient needed trauma center resources
- Not Applicable

- Patient status change/complication
- Communication Issue
- Not Known/Not Recorded
- Low patient acuity
- Delay Issue
- Delay with Obtaining Specialty Consult
- Receiving Hospital Requesting Radiology
- Further Imaging Requested by Other Specialty
- Further Imaging Requested by Orthopedics
- Further Imaging Requested by Neurosurgery

Additional Information:

This field will only appear to be filled out if ED Disposition (TR17.27) is set to Transferred to another hospital.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	ED/Acute Care
TQIP	No	No	**Trauma + TQIP ICD-10**	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.44

DATE DEATH OCCURRED

Definition: Date the patient died.

Field Values:

Relevant value for data element.

Additional Information:

If ED Disposition (TR17.27) is Deceased/Expired, then this field will be available for data entry.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.36

TIME DEATH OCCURRED

Definition: Time of death.

Field Values:

Relevant value for data element.

Additional Information:

If ED Disposition (TR17.27) is Deceased/Expired, then this field will be available for data entry.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.36.1

ORGAN DONATION

Definition: Organ Donation. Was a referral made to the Iowa Donor Network?

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

If ED Disposition (TR17.27) is Deceased/Expired, then this field will be available for data entry.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.29

AUTOPSY PERFORMED

Definition: Was autopsy performed?

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

If ED Disposition (TR17.27) is Deceased/Expired, then this field will be available for data entry.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	ED/Acute Care
TQIP	No	No	**Trauma + TQIP ICD-10**	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.37

ADVANCED DIRECTIVE

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

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

If ED Disposition (TR17.27) is Deceased/Expired, then this field will be available for data entry.

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

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 craniectomy, operation for hemorrhage control, angiography).

Report *Element Value* “No” for patients with Advance Directives that did not limit lifesustaining treatments during this patient care event.

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.28

OPERATING ROOM (OR) DISCHARGE DISPOSITION

Definition: The disposition of the patient at the time of discharge from the Operating Room.

Field Values:

Dropdown menu with the following options:

- Died
- Floor bed (general admission, non specialty unit bed
- Home with services
- Home without services
- Intensive Care Unit
- Left against medical advice
- Observation unit (unit that provides < 24 hour stays)
- Other (jail, institution, etc)
- Telemetry/step-down unit (less acuity than ICU)
- Transferred to another hospital
- Not Known/Not Recorded

Additional Information:

This selection is available only when Operating room is selected from ED Disposition (TR 17.27).

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.28

ED CHIEF COMPLAINT

Definition: Statement of problem by patient or other person.

Field Values:

Open text field.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA | **ImageTrend Data Element Tag:** TR17.46

HEIGHT

Definition: First recorded height after ED/hospital arrival.

Field Values:

Relevant value for data element.

Additional Information:

May be recorded in either the inches or centimeters box, and the other field will auto populate.

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 within 24 hours or less of ED/hospital arrival.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet, Pharmacy Record

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR1.6.1 (inches) and TR1.6 (cm)

ESTIMATED BODY WEIGHT

Definition: First recorded weight within 24 hours or less of ED/hospital arrival.

Field Values:

Relevant value for data element.

Additional Information:

May be entered in either the pounds (lbs) or kilograms (kg) box, and the other will auto populate.

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 within 24 hours or less of ED/hospital arrival.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet, Pharmacy Record

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR1.6.5 (body weight in kg), TR1.6.6 (lbs)

BODY MASS INDEX (BMI)

Definition: A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess on admission to definitive care. Preferred method is actually measurement although reported height is accepted.

Field Values:

This field auto-calculates based on height and weight data.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR1.36

ADMITTING MD/STAFF

Definition: Admitting MD/Staff is the person who will be care for the patient after they have been discharged from the Emergency Department and transferred to their inpatient room.

Field Values:

Dropdown menu based on “Staff” identified by the trauma care facility.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR 18.98

ADMITTING SERVICE

Definition: If the patient was admitted to the hospital, enter the service to which the patient was admitted. (NS=Nonsurgical Service)

Field Values: Dropdown menu with the following options:

- Burn Surgery
- Cardiology (NS)
- Critical Care Medicine
- Emergency Medicine
- ENT
- Family Medicine/Practice (NS)
- General Surgery
- Geriatrics (NS)
- GI (NS)
- GYN
- Hand
- Hospitalist Service (NS)
- Infectious Diseases (NS)
- Internal Medicine
- Liver
- Neurology (NS)
- Neurosurgery
- Not Applicable
- OB
- Podiatry
- Ophthalmology
- Oral Surgery
- Oromaxillo Facial Service
- Orthopedics
- Other
- Pediatric Hospitalist
- Pediatric Intensivist
- Pediatric Surgery
- Plastic Surgery
- Psychiatry
- Pulmonary Medicine
- Rehab
- Renal (NS)
- Respiratory Therapy
- Thoracic-Cardiovascular
- Trauma Surgery
- Urology
- Vascular

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	ED/Acute Care

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	No	No	**Trauma + TQIP ICD-10**	ED/Acute Care

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.99

ED ATTENDING MD/STAFF

Definition: ED Attending MD/Staff is the physician who took care of the patient in the Emergency Department.

Field Values:

Dropdown menu based on “Staff” identified by the trauma care facility.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR 18.131

ED ATTENDING MD/STAFF SERVICE TYPE

Definition: ED Attending MD/Staff Service Type

Field Values: Dropdown menu of the following options:

- Not Known/Not Recorded
- Anesthesia/CRNA
- Burn
- Cardiology
- Emergency Medicine
- ENT
- Family Practice
- Gen Surgery
- Hand
- Hematology/Oncology
- Hospitalist
- Medicine
- Neurology
- Neurosurgery
- Oromaxillo Facial Service
- Orthopedics
- Pedi Surgery
- Peds
- Plastics
- Podiatry
- Surgery Subspecialty
- Thoracic Surg
- Trauma
- Urology

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	ED/Acute Care
TQIP	No	No	**Trauma + TQIP ICD-10**	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR18.132

CONSULTING SERVICES

Definition: Trauma patient received consultative services.

Field Values:

Dropdown menu with the following options:

- Not Applicable
- Yes
- No

Additional Information:

If yes is selected, Consulting Service Type, Consulting Staff, and Consult Date/Time should be completed.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	ED/Acute Care
TQIP	No	No	**Trauma + TQIP ICD-10**	ED/Acute Care

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR17.29

CONSULTING SERVICE TYPE

Definition: Type of the consulting service the patient received.

Field Values: Dropdown of the following menu items:

- Not Applicable
- Acute Rehabilitation Medicine
- Anesthesia
- Bariatric
- Burn
- Cardiology
- Cardiothoracic Surgery
- Chemical Dependency
- Colo-Rectal
- Critical Care Medicine
- Critical Care Surgery
- Dentistry
- Dermatology
- Ear Nose Throat
- Kidney Transplant
- Electrophysiology
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Geriatric
- Gynecology
- Hand
- Hematology Oncology
- Hospitalist
- Infectious Disease
- Intensive Care
- Internal Medicine
- Interventional Radiology
- Other Surgeon
- Liver
- Neonatal
- Nephrology
- Neurointensive Care
- Neurology
- Neurosurgery
- Obstetric
- Occuloplastic
- Occupational Therapy
- Oncology
- Ophthalmology
- Oral Maxillo Facial Surgery
- Orthopedic Surgeon
- Other Non-Surgeon
- Pediatric Surgery
- Pain
- Palliative Care
- Pediatric Cardiology
- Pediatric Critical Care Medicine
- Pediatric Dentistry
- Pediatric Gastroenterology
- Pediatric Hematology Oncology
- Pediatric Hospitalist
- Pediatric Infectious Disease
- Pediatric Intensivist
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Orthopedic
- Pediatric Pulmonary

Additional Information:

Only completed if yes is selected for Consulting Services.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR17.32

CONSULTING STAFF

Definition: Staff consulted for the service.

Field Values: Dropdown menu based on “Staff” identified by the trauma care facility.

Additional Information:

Only completed if yes is selected for Consulting Services.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR17.33

CONSULTING SERVICE DATE/TIME REQUESTED

Definition: Date and time the consulting practitioner was requested.

Field Values:

Relevant field values for data element.

Additional Information:

Only completed if yes is selected for Consulting Services.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR17.7 (Date), TR17.8 (Time)

CONSULTING SERVICE DATE/TIME ARRIVED

Definition: Date and time the consulting practitioner arrived.

Field Values:

Relevant field values for data element.

Additional Information:

Only completed if yes is selected for Consulting Services.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR17.75 (Date), TR17.76 (Time)

CONSULTING TIMELY ARRIVAL

Definition: Was the Consulting Practitioner physician arrival timely?

Field Values:

Relevant field values for data element.

- No
- Yes
- Not Known/Not Recorded

Additional Information:

Only completed if yes is selected for Consulting Services.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **| ImageTrend Data Element Tag:** TR17.77

LOG OF ADMISSION

Definition: Section identifies the date, time, ward, bed number, consultant, and medical specialty for the patient in different areas of the hospital the patient was cared for during admission. This is not required data, but may be used by the facility to track patient care and for performance improvement processes.

Field Values:

Date/Time: The date and time the patient was moved to the location identified.

Ward/Bed number: The floor or ward and the room number of the location of the patient.

Consultant/Medical Specialty: The name of the physician and physician specialty of the doctor who cared for the patient in this location.

Additional Information:

Ward information has been pre-identified to the following areas: Adult Medical/Surgical, Cardiac/Telemetry, ICU/CCU, Neurology, NICU, Observation, Obstetrics, Orthopedics, Pediatric Medical/Surgical, PICU, and Step-down unit.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	ED/Acute Care
Trauma + TQIP ICD-10	ED/Acute Care

State Validation Score: NA **| ImageTrend Data Element Tag:** TR44.1 (date), TR44.2 (time), TR44.3 (ward), TR44.4 (bed number), TR44.5 (consultant), TR44.6 (medical specialty), and TR44.9 (Total Log of Admission Time)

INITIAL ASSESSMENT

INITIAL ASSESSMENT VITALS DATE/TIME

Definition: The date and time the initial assessment was completed within 30 minutes or less of ED/hospital arrival.

Field Values:

Relevant field values for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	No	No	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.104 (Date), TR18.110 (Time)

INITIAL ASSESSMENT TEMPERATURE

Definition: First recorded temperature (in degrees Celsius or Fahrenheit) in the ED/Hospital within 30 minutes or less of ED/hospital arrival.

Field Values:

Relevant field value for the data element

Additional Information:

May be entered in degrees Celsius or Fahrenheit and the other field will auto-calculate.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.30 (Celsius), TR18.30.1 (Fahrenheit)

INITIAL ASSESSMENT TEMPERATURE ROUTE

Definition: Indicate the initial emergency department/hospital temperature measurement route.

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- Axillary
- Foley
- Oral
- Other
- Rectal
- Temporal Artery
- Tympanic

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **| ImageTrend Data Element Tag:** TR18.147

INITIAL ASSESSMENT OXYGEN SATURATION

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

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Respiratory Therapy Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.31

INITIAL ASSESSMENT SYSTOLIC BLOOD PRESSURE

Definition: First recorded systolic blood pressure in ED/hospital within 30 minutes or less of ED/hospital arrival.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Physician Notes, History and Physical

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.11

INITIAL ASSESSMENT DIASTOLIC BLOOD PRESSURE

Definition: First recorded diastolic blood pressure in ED/hospital within 30 minutes or less of ED/hospital arrival.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.13

INITIAL ASSESSMENT PULSE RATE

Definition: First recorded pulse rate in ED/hospital (palpitated or auscultated, expressed as a number per minute) within 30 minutes or less of ED/hospital arrival.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **|** **ImageTrend Data Element Tag:** TR18.2

INITIAL ASSESSMENT RESPIRATORY RATE

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

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Respiratory Therapy Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **|** **ImageTrend Data Element Tag:** TR18.7

INITIAL ASSESSMENT RESPIRATORY ASSISTANCE

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

Field Values: Dropdown menu of the following options:

- Not Known/Not Recorded
- Assisted Respiratory Rate
- Unassisted Respiratory Rate

Additional Information:

Field will open when respiratory rate is entered. Assisted respiratory rate may include ventilator support or bag/valve mask. Unassisted respiratory rate is the patient's natural respirations.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Respiratory Therapy Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.10

INITIAL ASSESSMENT SUPPLEMENTAL OXYGEN

Definition: Determination of the presence of supplemental oxygen during assessment of the initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.

Field Values: Dropdown menu with the following options:

- Intubated
- Not Known/Not Recorded
- Respiratory Arrest
- Room Air
- Yes
- No

Additional Information:

None.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.109

INITIAL ASSESSMENT REVISED TRAUMA SCORE/PEDIATRIC TRAUMA SCORE

Definition: Auto calculation of initial ED/hospital revised trauma score.

Field Values:

Auto calculation when associated data elements are entered

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	No	No	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR18.135

INITIAL ASSESSMENT GLASGOW-EYE

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

Field Values:

Dropdown menu with the following options:

- Drop down menu with the following options:
- Not Known/Not Recorded
- 1 No eye movement when assessed
- 2 Opens eyes in response to painful stimulation
- 3 Opens eyes in response to verbal stimulation
- 4 Opens eyes spontaneously

Additional Information:

Used to calculate Overall GCS – ED/Hospital Score.

If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient'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.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Physician Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.14

INITIAL ASSESSMENT GLASGOW-VERBAL

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

Field Values: Dropdown menu with the following options:

Pediatric Values (≤ 2 years):	Adult Values:
Not Known/Not Recorded	Not Known/Not Recorded
1 No vocal response	1 No verbal response
2 Inconsolable, agitated	2 Incomprehensible sounds
3 Inconsistently consolable, moaning	3 Inappropriate words
4 Cries but is consolable, inappropriate interactions	4 Confused
5 Smiles, oriented to sounds, follows objects, interacts	5 Oriented

Additional Information:

Used to calculate Overall ED/hospital GCS Score. If patient is intubated then the GCS Verbal score is equal to 1. If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient 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 Private/Public Vehicle/Walk-in.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Physician Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.15.2

INITIAL ASSESSMENT GLASGOW-MOTOR

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

Field Values: Dropdown menu with the following options:

Pediatric (≤ 2 years):	Adult:
Not Known/Not Recorded	Not Known/Not Recorded
1 No motor response	1 No motor response
2 Extension to pain	2 Extension to pain
3 Flexion to pain	3 Flexion to pain
4 Withdrawal from pain	4 Withdrawal from pain
5 Localizing pain	5 Localizing pain
6 Appropriate response to stimulation	6 Obeys commands

Additional Information:

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

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Physician Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR18.16.2

INITIAL ASSESSMENT GLASGOW-QUALIFIERS

Definition: Documentation of factors potentially affecting the first assessment of GCS upon arrival in the ED/hospital within 30 minutes or less of ED/hospital arrival. Up to three field values may be selected.

Field Values: Multi-select box with the following options:

- Not Known/Not Recorded
- Obstruction to the Patient's Eye
- Patient Chemically Sedated or Paralyzed
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information:

Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.

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

Check all that apply.

Data Source: Triage/Trauma/Hospital Flow Sheet, Nursing Notes/Flow Sheet. Physician Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR18.21

INITIAL ASSESSMENT GCS CALCULATED SCORE

Definition: Initial ED/Hospital GCS total auto calculated with entered GCS data.

Field Values: Auto calculated

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.22

INITIAL ASSESSMENT GCS 40 - EYE

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

Field Values: Dropdown menu with the following options:

Adult:		*Pediatric < 5 years:*	
1. None	4. Spontaneous	1. None	4. Spontaneous
2. To Pressure	5. Not Testable	2. To Pressure	5. Not Testable
3. To Sound		3. To Sound	

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 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.

Report Field Value “5. Not Testable” if unable to assess (e.g. swelling to eye(s)).

The null value “Not Known/Not Recorded” is reported if Initial Field GCS – Eye is reported.

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: 0 **| ImageTrend Data Element Tag:** TR18.40.2

INITIAL ASSESSMENT GCS 40 - VERBAL

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

Field Values:

Adult:		*Pediatric < 5 years:*	
1. None	4. Confused	1. None	4. Words
2. Sounds	5. Oriented	2. Cries	5. Talks Normally
3. Words	6. Not Testable	3. Vocal Sounds	6. Not Testable

Additional Information:

If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.

Report Field Value “6. Not Testable” if unable to assess (e.g. patient is intubated).

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

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.41.2

INITIAL ASSESSMENT GCS 40 - MOTOR

Definition: First recorded Glasgow Coma Score 40 (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Field Values:

Adult:		*Pediatric < 5 years:*	
1. None	5. Localizing	1. None	4. Localizes Pain
2. Extension	6. Obeys Commands	2. Extension to Pain	5. Obeys Commands
3. Abnormal Flexion	7. Not Testable	3. Flexion to Pain	6. Not Testable
4. Normal Flexion			

Additional Information:

If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.

Report Field Value "7. Not Testable" if unable to assess (e.g. neuromuscular blockade).

The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: 0 | **ImageTrend Data Element Tag:** TR18.42.2

INITIAL ASSESSMENT GCS 40 CALCULATED SCORE

Definition: Initial ED/Hospital GCS total auto calculated with entered GCS 40 data.

Field Values: Auto calculated

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.44.1

INITIAL ASSESSMENT ALERT, VOICE, PAIN, UNRESPONSIVE (AVPU) SCORE

Definition: First recorded measurement and recording of the patient's level of consciousness in the ED/hospital.

Field Values:

Dropdown menu with the following options:

- Alert
- Responds to Pain
- Unresponsive
- Verbal Stimuli
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Pre-hospital
Trauma Incident Form ICD-10	Pre-hospital
Trauma + TQIP ICD-10	Pre-hospital

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.53

INITIAL ASSESSMENT FAST DATE/TIME

Definition: Date and time the Focused Assessment with Sonography in Trauma (FAST) exam was performed.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **| ImageTrend Data Element Tag:** TR18.102 (Date), TR18.112 (Time)

ALCOHOL SCREEN/QUESTIONNAIRE

Definition: Was an alcohol screen/questionnaire performed?

Field Value:

Single choice radio button with the following options:

- Yes
- No

Additional Information:

Universal screening for alcohol use must be performed for all injured patients and must be documented.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -3 **| ImageTrend Data Element Tag:** TR18.150

ALCOHOL USE INDICATOR

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

Field Values:

Dropdown menu with the following options:

- Yes
- No

Additional Information:

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

Data Source: Lab Results, Transferring Facility Records

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR18.46

BLOOD ALCOHOL CONTENT

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

Field Values:

Relevant value for data element.

Additional Information:

Collect as X.XX standard lab value (e.g. 0.08).

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

The null value "Not Applicable" is used for those patients who were not tested.

Data Source: Lab Results, Transferring Facility Records

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR18.103

DRUG SCREEN

Definition: Laboratory test used to detect the presence of drugs in the patient's blood. Enter the drugs present when drug screening was performed in ED. You may enter more than one drug. Do not include drugs given to the patient during any phase of resuscitation. First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

Field Values: Dropdown menu with the following options:

- AMP (Amphetamine)
- BAR (Barbiturate)
- BZO (Benzodiazepines)
- COC (Cocaine)
- mAMP (Methamphetamine)
- MDMA (Ecstasy)
- MTD (Methadone)
- OPI (Opioid)
- OXY (Oxycodone)
- PCP (Phencyclidine)
- TCA (Tricyclic Antidepressant)
- THC (Cannabinoid)
- Other
- None
- Not Tested

Additional Information:

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

• "None" is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and had no positive results.

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

Data Source: Lab Results, Transferring Facility Records

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR18.91

SBIRT COMPLETION

Definition: Was the process of screening, brief intervention and referral to treatment completed?

Field Values:

Dropdown menu with the following options:

- Yes
- No

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **| ImageTrend Data Element Tag:** TR45.1

SBIRT PROVIDED BY

Definition: If alcohol indicated, who provided the screening, brief intervention and referral to treatment?

Field Values:

Dropdown menu with the following options:

- Nurse
- Other
- Physician
- Social Worker
- Student
- Trauma Program Coordinator
- Trauma Program Manager

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR45.2

SBIRT SCREENING TOOL

Definition: Hospitals should select one (or more) evidence-based screening tool that is used to conduct the SBIRT screening.

Field Values:

Multiple select box with the following options:

- ASSIST
- AUDIT
- CAGE
- CAGE-AID
- CRAFFT
- DAST
- Emergency Department Prescription and Recreational Drug Screening Tool
- GAIN
- GAIN-SS
- Not Known
- POSIT

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR45.3

SBIRT FINDINGS

Definition: SBIRT Screening results are considered positive when the results indicate a brief intervention should be performed

Field Values:

Single choice radio button with the following options:

- No/Negative
- Yes/Positive
- Not Known

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	ED Record
NTDB	No	No	**Trauma Incident Form ICD-10**	Initial Assessment
TQIP	No	No	**Trauma + TQIP ICD-10**	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR45.4

SBIRT INTERVENTION

Definition: Following a screening result indicating moderate to high risk, brief treatment is provided. Much like brief intervention, this involves motivational discussion and patient empowerment. Brief treatment is more comprehensive and includes education, problem solving, coping mechanisms, and building a support system.

Field Values:

Single-select radio button with the following options:

- No/brief intervention not performed
- Yes/brief intervention performed
- Not Known

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR45.5

SBIRT REFERRAL TO TREATMENT

Definition: Following a screening result of severe or dependence, a referral to treatment is provided. This is a proactive process that facilitates access to care for individuals requiring more extensive treatment.

Field Values:

Single-select radio button with the following options:

- No/referral to treatment not provided
- Yes/referral to treatment provided
- Not Known

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR45.7

DID THE PATIENT MEET CRITERIA FOR MENTAL HEALTH SCREENING?

Definition: This field allows for the documentation of whether or not a patient met criteria for a mental health screening.

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Applicable

Additional Information:

This is based on a given facility's policy or current medical/behavioral health guidance to perform such a screening.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR49.1

WAS A MENTAL HEALTH SCREENING PERFORMED?

Definition: Indicate whether or not a mental health screening was performed if the patient met criteria for mental health screening.

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Declined
- Not Applicable

Additional Information:

This field can be left as "No" if the patient did not meet criteria for a mental health screening.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR49.2

WAS A REFERRAL FOR MENTAL HEALTH SERVICES OFFERED?

Definition: Indicate whether or not a referral for mental health services was offered.

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Applicable

Additional Information:

This field can be left as "No" if the patient did not meet criteria for a mental health screening.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **| ImageTrend Data Element Tag:** TR49.6

HEMATOCRIT

Definition: Patient's initial hematocrit.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR18.95

BASE DEFICIT

Definition: Defined as a value greater than 4 at any time during admission. This number is reported as a component of arterial or venous blood gases. The number may be reported by the lab as Base Deficit, or as Base Excess with a negative value.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR18.93

BLOOD TRANSFUSION IN THE ED

Definition: Whether the person was administered any blood products at any stage prior to discharge from the emergency department.

Field Values:

Dropdown menu with the following options:

- Not Determined/Unknown
- Yes
- No

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **| ImageTrend Data Element Tag:** TR17.51

BLOOD AND BLOOD PRODUCTS

Definition: Blood and blood products given.

Field Values:

Multi-select dropdown menu with the following options:

- Not Applicable
- Cryoprecipitate
- Factor VII
- Fibrinogen concentrate
- Fresh Frozen Plasma
- Thromboelastography (TEG)
- Massive Blood Transfusion Protocol Initiated
- Packed Red Bood Cells
- Platelets
- Prothrombinex
- Rotational Thromboelastometry (ROTEM) Guided Transfusion

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA | **ImageTrend Data Element Tag:** TR42.1

PREGNANCY

Definition: Indication of the possibility by the patient's history of current pregnancy.

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- Yes
- No

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR14.38

TRANEXAMIC ACID GIVEN

Definition: Whether the person received Tranexamic Acid at any stage of care, whether prior to or at the definitive care hospital.

Field Values:

Dropdown menu with the following options:

- Not Known/Not Recorded
- Yes-Given within first 3 hours from time of injury
- Yes-Given after first 3 hours from time of injury
- Not Given

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Initial Assessment
Trauma + TQIP ICD-10	Initial Assessment

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR17.57

DIAGNOSIS INFORMATION

DIAGNOSIS CODE-ICD 10

Definition: Diagnoses related to all identified injuries.

Field Values:

Relevant field value for the data element.

Additional Information:

More than one diagnosis code may be entered for a patient.

Comments may be added for each diagnosis code entered.

Data Source: Autopsy/Medical Examiner Report, Operative Reports, Radiology Reports, Physician Notes/Flow Sheet, Trauma Flow Sheet, History and Physical, Nursing Notes/Flow Sheet, Progress Notes, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis
Trauma + TQIP ICD-10	Diagnosis

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR200.1

AIS PRE-DOT CODE

Definition: The Abbreviated Injury Scale (AIS) pre-dot codes that reflect the patient's injuries.

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

Additional Information:

Field cannot be Not Applicable.

Data Source: AIS coding manual

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis
Trauma + TQIP ICD-10	Diagnosis

State Validation Score: 0 **| ImageTrend Data Element Tag:** TR200.14

AIS SEVERITY

Definition: The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries.

Field Values:

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

Additional Information:
Field cannot be Not Applicable.

Data Source: AIS coding manual

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis
Trauma + TQIP ICD-10	Diagnosis

State Validation Score: 0 **| ImageTrend Data Element Tag:** TR200.14

AIS VERSION

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

Field Values:

AIS 2015 is currently the default version for all sites.

Additional Information:

Field cannot be Not Applicable.

Data Source: AIS coding manual

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	ED Record
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	Diagnosis
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Diagnosis

State Validation Score: 0 **| ImageTrend Data Element Tag:** TR200.14

INJURY SEVERITY SCORE/NEW INJURY SEVERITY SCORE

Definition: The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis), External). Only the highest AIS score in each body region is used. The 3 most severely injured body regions have their score squared and added together to produce the ISS score.

The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (unsurvivable injury), the ISS score is automatically assigned to 75. The ISS score is virtually the only anatomical scoring system in use and correlates linearly with mortality, morbidity, hospital stay and other measures of severity.

Its weaknesses are that any error in AIS scoring increases the ISS error, many different injury patterns can yield the same ISS score and injuries to different body regions are not weighted. Also, as a full description of patient injuries is not known prior to full investigation & operation, the ISS (along with other anatomical scoring systems) is not useful as a triage tool.

Baker SP et al, "The Injury Severity Score: a method for describing patients with multiple injuries and evaluating emergency care", J Trauma 14:187-196;1974

Field Values:

This field auto calculates based on associated data elements.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	No
NTDB	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	No	No	**Trauma + TQIP ICD-10**	Diagnosis

State Validation Score: NA **|** **ImageTrend Data Element Tag:** NA

PROBABILITY OF SURVIVAL SCORE

Definition: The probability of survival score is calculated using the following method:

TRISS (blunt): Logit =-0.4499 + RTS*0.8085 + ISS*-0.0835 + (age.points)*-1.7430
Predicted death rate = $1/(1 + e^{-Logit})$

TRISS (penetrating): Logit =-2.5355 + RTS*0.9934 + ISS*-0.0651 + (age.points)*-1.1360
Predicted death rate = $1/(1 + e^{-Logit})$

Age Points:
Age < 15 years = 0
15 <= Age < 55 = 0
Age >= 55 years = 1

Field Values:

Auto calculated based on associated data elements.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis
Trauma + TQIP ICD-10	Diagnosis

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR21.9 or TR43.2

REVISED TRAUMA SCORE

Definition: The calculated Revised Trauma Score for the patient.

Field Values:

The revised trauma score auto calculates.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	ED Record
Trauma Incident Form ICD-10	Diagnosis
Trauma + TQIP ICD-10	Diagnosis

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR18.135

PROCEDURES

PROCEDURE PERFORMED

Definition: Was a procedure performed? See definition of a procedure in element TR200.2 (Procedure ICD-10).

Field Values:

Dropdown menu with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

This is not the field where the ICD-10-PCS code(s) is entered. This is a field that indicates whether or not a procedure was performed. If this field is yes, ImageTrend will require that you enter relevant ICD-10-PCS code(s) along with the corresponding date/time value(s).

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Procedures
Trauma Incident Form ICD-10	Procedures
Trauma + TQIP ICD-10	Procedures

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR22.30

PROCEDURE-ICD 10

Definition: Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications.

Field Values: Relevant field value for the data element

DIAGNOSTIC AND THERAPEUTIC IMAGING	**CARDIOVASCULAR**
Computerized tomographic Head *	Open cardiac massage
Computerized tomographic Chest *	CPR
Computerized tomographic Abdomen *	**CNS**
Computerized tomographic Pelvis *	Insertion of ICP monitor *
Computerized tomographic C-Spine *	Ventriculostomy
Computerized tomographic T-Spine *	Cerebral oxygen monitoring *
Computerized tomographic L-Spine *	**GENITOURINARY**
Doppler ultrasound of extremities *	Ureteric catheterization (i.e., Ureteric stent)
Diagnostic ultrasound (includes FAST) *	Suprapubic cystostomy
Angioembolization	**MUSCULOSKETETAL**
Angiography	Soft tissue/bony debridement *
IVC filter	Closed reduction of fractures
REBOA	Skeletal and halo traction
Diagnostic imaging interventions on the total body	Fasciotomy
Plain radiography of whole body Plain radiography of whole skeleton Plain radiography of infant whole body	**GASTROINTESTINAL** Endoscopy (includes gastroscopy, colonoscopy)

	Gastrostomy/jejunostomy (percutaneous or
TRANSFUSION	**RESPIRATORY**
Transfusion of red cells * (only report first 24 hours after hospital arrival)	Insertion of endotracheal tube * (exclude
Transfusion of platelets * (only report first hours after hospital arrival)	intubations performed in the OR)
Transfusion of plasma * (only report first 24 hours after hospital arrival)	Continuous mechanical ventilation *
	Chest tube *
	Bronchoscopy *
	Tracheostomy

Additional Information:

Additional information related to the procedure may be requested: Date/time procedure was performed, location of procedure, staff/service type of individual conducting procedure, comments, and other relevant elements. A list of commonly used ICD-10 procedures is available within the system.

Multiple procedures can be added for each patient. Capture all procedures performed in the operating room. Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.

*Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one. Note that the hospital may capture additional procedures.

Data Source: Operative Reports, Procedure Notes, Trauma Flow Sheet, ED Record, Nursing Notes/Flow Sheet, Radiology Reports, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Procedures
Trauma Incident Form ICD-10	Procedures
Trauma + TQIP ICD-10	Procedures

State Validation Score: -1 **| ImageTrend Data Element Tag:** TR200.2

PROCEDURE PERFORMED LOCATION

Definition: The hospital location where the procedure was performed.

Field Values:

Dropdown menu with the following options:

- Transport from Scene
- Readmit OR (planned OR)
- Observation
- Endoscopy
- Tele
- Radiology
- Nuclear Medicine
- ED
- Step-Down
- PTA (Referring Hospital)
- Not Known/Not Recorded
- Catheterization Lab
- Special Procedure Unit
- Prehospital
- Minor Surgery Unit
- Scene
- Outpatient Clinic
- ICU
- Rehabilitation
- Other
- GI Lab
- Recovery
- Operating Room
- Floor

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Procedures
Trauma Incident Form ICD-10	Procedures
Trauma + TQIP ICD-10	Procedures

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR200.11

STAFF/PHYSICIAN PERFORMING THE PROCEDURE

Definition: Physician Performing the Procedure.

Field Values:

Dropdown menu based on “Staff” identified by the trauma care facility.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Procedures
NTDB	No	No	**Trauma Incident Form ICD-10**	Procedures
TQIP	No	No	**Trauma + TQIP ICD-10**	Procedures

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR200.10

PROCEDURE COMMENTS

Definition: A comment relevant to the procedure being entered.

Field Values:

Open text field.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Procedures
NTDB	No	No	**Trauma Incident Form ICD-10**	Procedures
TQIP	No	No	**Trauma + TQIP ICD-10**	Procedures

State Validation Score: NA **|** **ImageTrend Data Element Tag:** TR200.7

PROCEDURE PERFORMED DATE/TIME

Definition: The date and time the operative and selected non-operative procedure(s) was performed.

Field Values:

Relevant field values for the data element

Additional Information:

None.

Data Source: Operative Reports, Procedure Notes, Trauma Flow Sheet, ED Record, Nursing Notes/Flow Sheet, Radiology Reports, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Procedures
Trauma Incident Form ICD-10	Procedures
Trauma + TQIP ICD-10	Procedures

State Validation Score: -2 (Date), -1 (Time) **| ImageTrend Data Element Tag:** TR200.8 (Date), TR200.9 (Time)

PROCEDURE SERVICE TYPE

Definition: Service type of the physician.

Field Value:

Dropdown menu with the following options:

- Pulmonary
- Emergency Medicine
- Neurosurgery
- Plastic Surgery
- Not Known/No Recorded
- Neurology
- Gastroenterology
- Obstetrics
- Podiatry
- Nephrology
- General Surgery
- Ophthalmology
- Radiology
- Cardiology
- Gynecology
- Oral Maxillofacial Surgery
- Thoracic Surgery
- Anesthesia
- Hand Surgery
- Orthopedic Surgery
- Trauma Surgery
- Critical Care Medicine
- Hospitalist
- Pediatric Orthopedic
- Urology
- Ear Nose Throat
- Medicine
- Pediatric Surgery
- Vascular Surgery

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	Procedures
NTDB	No	No	**Trauma Incident Form ICD-10**	Procedures
TQIP	No	No	**Trauma + TQIP ICD-10**	Procedures

State Validation Score: NA | **ImageTrend Data Element Tag:** TR200.6

BURN INFORMATION

CARBOXYHEMOGLOBIN LEVEL

Definition: The patients initial carboxyhemoglobin level at the facility.

Field Values:

Relevant field value for the data element.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Burn
Trauma Incident Form ICD-10	Burn
Trauma + TQIP ICD-10	Burn Information

State Validation Score: NA | **ImageTrend Data Element Tag:** TR34.4

INHALATION INJURY

Definition: Indicate if the patient suffered from an inhalation burn injury.

Field Values:

Dropdown menu with the following field options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Burn
Trauma Incident Form ICD-10	Burn
Trauma + TQIP ICD-10	Burn Information

State Validation Score: NA | **ImageTrend Data Element Tag:** TR34.5

LUND BROWDER ASSESSMENT TYPE

Definition: Lund Browder Assessment Type.

Field Values:

Dropdown menu with the following options:

- Upon Admission (Initial)
- Discharge Chart of Initial Admission
- Subsequent During Readmission

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Burn
Trauma Incident Form ICD-10	Burn
Trauma + TQIP ICD-10	Burn Information

State Validation Score: NA | **ImageTrend Data Element Tag:** TR34.27

LUND BROWDER ASSESSMENT DATE/TIME

Definition: Lund Browder Assessment Date and Time.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Burn
Trauma Incident Form ICD-10	Burn
Trauma + TQIP ICD-10	Burn Information

State Validation Score: NA | **ImageTrend Data Element Tag:** TR34.26 (Date) ; TR34.26.1 (Time)

LUND AND BROWDER CHART-BURN ASSESSMENT

Definition: Identifies the amount and severity of the patient's burns.

Field Values: Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Burn
Trauma Incident Form ICD-10	Burn
Trauma + TQIP ICD-10	Burn Information

State Validation Score: NA | **ImageTrend Data Element Tag:** TR34.7 (Body Area/Part), TR34.9 (2ø), TR34.10 (3ø), TR34.11 (%TBSA), TR34.12 (Partial Thickness), TR34.13 (Full Thickness), TR34.14 (Total Burn Size)

TRAUMA QUALITY IMPROVEMENT PROGRAM

*The elements in this section must be reported and transmitted by Level 1 and Level 2 TQIP participating centers only.

*Please contact TraumaQuality@facs.org for information about joining TQIP.

VTE PROPHYLAXIS TYPE

Definition: Type of first dose of VTE prophylaxis administered to patient at your hospital.

EXCLUDE: Sequential compression devices

Field Values: Dropdown menu with the following options:

- None
- Not known/not recorded
- Unfractionated Heparin (UH)
- Direct Thrombin Inhibitor (Dabigatran, etc.)
- LMWH (Dalteparin, Enoxaparin, etc.)
- Xa Inhibitor (Rivaroxaban, etc.)
- Other

Additional Information:

Element Value “None” is reported if the first dose of venous thromboembolism prophylaxis is administered post discharge order date/time.

Element Value "None" is reported if the patient refuses venous thromboembolism prophylaxis.

Element Value “Other” is reported if “Coumadin” and/or “aspirin” are given as venous thromboembolism prophylaxis.

Venous Thromboembolism Prophylaxis Types 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 Venous Thromboembolism Prophylaxis Types.

Data Source: Medication Summary, Nursing Notes/Flow Sheet, Pharmacy Record

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.1

VTE PROPHYLAXIS DATE AND TIME

Definition: Date and time of administration of first dose of venous thromboembolism prophylaxis administered to patient at your hospital.

Field Values:

Relevant field value for the data element

Additional Information:

Refers to date upon which patient first received the prophylactic agent indicated in Venous Thromboembolism Prophylaxis Type.

The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is Element Value "None."

Registry Specifications:

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.2

ANTIBIOTIC THERAPY

Definition: Intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter.

INCLUDE: Collect on all patients with any open fracture(s).

Field Values: Dropdown menu with the following options:

- Yes
- No
- Not Applicable

Additional Information:

The null value “Not Applicable” is reported for patients that do not meet the reporting criterion.

Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines and includes all AIS code descriptors that contain "open" and all AIS extremity/limb codes descriptors that contain "amputation."

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR18.189

FIRST ANTIBIOTIC ADMINISTRATION DATE/TIME

Definition: The date and time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.

INCLUDE: Collect on all patients with any open fracture(s).

Field Values:

Relevant value for data element

Additional Information:

Collect as YYYY-MM-DD

The null value “Not Applicable” is reported for patients that do not meet the collection criterion.

Report the date of the first intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter, at either your facility of the transferring facility.

The null value “Not Applicable” is reported if the data element Antibiotic Therapy is Field Value “2. No”.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR 18.190 (Date), TR18.190.1 (Time)

ANGIOGRAPHY

Definition: First interventional angiogram with or without embolization within the first 24 hours after ED/hospital arrival.

INCLUDE: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

EXLUDE: Computerized Tomographic Angiography (CTA).

Field Values:

Dropdown menu with the following options:

- Angiogram only
- Angiogram with embolization
- Angiogram with stenting
- Not Applicable

Additional Information:

Limit reporting angiography data to the first 24 hours following ED/hospital arrival.

Only report Element Value “Angiogram with stenting” if stenting was performed specifically for hemorrhage control.

The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source: Radiology Reports, Operative Reports, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.12

ANGIOGRAPHY DATE/TIME

Definition: The date and time the first angiogram with or without embolization was performed.

INCLUDE: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

EXLUDE: Computerized Tomographic Angiography (CTA).

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Radiology Reports, Operative Reports, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.13 (Date), TR40.14 (Time)

EMBOLIZATION SITE

Definition: Organ/site of embolization for hemorrhage control.

Field Values:

Multi-select menu with the following options:

- Not Applicable
- Kidneys
- Liver
- Other
- Pelvic (iliac, gluteal, obturator)
- Peripheral vascular (neck, extremities)
- Retroperitoneum (lumbar, sacral)
- Spleen

Additional Information:

None.

Data Source: Radiology Reports, Operative Reports, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.18

HEMORRHAGE SURGERY CONTROL TYPE

Definition: Type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.

INCLUDE: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Field Values:

Dropdown menu with the following options:

- None
- Extremity
- Laparotomy
- Mangled extremity/traumatic amputation
- Neck
- Other skin/soft tissue
- Sternotomy
- Thoracotomy
- Extraperitoneal Pelvic Packing

Additional Information:

If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/ relevant surgeon.

Data Source: Operative Reports, Procedure Notes, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.19

HEMORRHAGE SURGERY CONTROL DATE AND TIME

Definition: Date and time of first surgery for hemorrhage control within the first 24 hours of ED/hospital arrival.

INCLUDE: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival.

Field Values: Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.20 (Date), TR40.21 (Time)

WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Definition: Care was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Field Values: Dropdown menu with the following options:

- Yes
- No

Additional Information:

If yes is selected, the date and time care was withdrawn must be entered.

Do-not-resuscitate (DNR) order not a requirement.

DNR order is not the same as withdrawal of life supporting treatment.

A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment.

These interventions are limited to: ventilator support (with or without extubation), 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 craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g., extubation) and a decision not to proceed with a life-supporting intervention (e.g., intubation).

Excludes the discontinuation of CPR and typically involves prior planning.

Element Value ”No” must be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA

Inclusion Entity	Required Data Element	Validated Field
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.15

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE/TIME

Definition: The date/time that life supporting treatment was withdrawn from the patient.

Field Values:

Relevant value for data element.

Additional Information:

None.

Data Source: Physician Order, Progress Order, Respiratory Therapy Notes/Flow Sheet, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.16 (Date), TR40.17 (Time)

DATE/TIME BLOOD WAS ADMINISTERED

Definition: The date and time that a blood product was administered to the patient.

Field Value:

Relevant value for data element.

Additional Information:

None.

Data Source: Trauma Flow Sheet, Anesthesia Record, Operative Reports, Nursing Notes/Flow Sheet, Blood Bank

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR22.45 (Date), TR22.45.1 (Time)

VOLUME OF BLOOD

Definition: The volume of blood reported to the NTDB will be in CCs. The trauma exports will take the actual value recorded for blood products administered within the first four hours.

Field Value:

Relevant value for data element.

Additional Information:

The trauma exports will take the actual value recorded for blood products administered within the first four hours. (Note: the system does not convert units to CCs)

Data Source: Trauma Flow Sheet, Anesthesia Record, Operative Reports, Nursing Notes/Flow Sheet, Blood Bank

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR22.22

BLOOD PRODUCT

Definition: The specific blood product that was administered to the patient.

Field Value:

Relevant value for data element.

Additional Information:

- Cryoprecipitate
- Fresh Frozen Plasma
- Massive Blood Transfusion Protocol Initiated
- Packed Red Blood Cells
- Platelets
- Not Known/Not Recorded

Data Source: Trauma Flow Sheet, Anesthesia Record, Operative Reports, Nursing Notes/Flow Sheet, Blood Bank

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR22.21

Comment: The field values of this data element act as separate data elements within the NTDB document. These elements are referred to as Packed Red Blood Cells, Whole Blood, Plasma, Platelets, and Cryoprecipitate within the NTDB document.

HIGHEST GCS TOTAL-TRAUMATIC BRAIN INJURY

Definition: Highest total GCS on calendar day after ED/Hospital arrival. Collection Criterion: Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s), and/or scalp avulsion(s).

Field Values: Relevant field value for the data element

Additional Information:

Refers to highest total GCS score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.

For patients who were discharged from your hospital prior to the next calendar day after ED/ hospital arrival, the null value “Not Applicable” is reported.

For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value “Not Known/Not Recorded” is reported if reporting ***Highest GCS-40 Motor***.

The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.

Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.

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

Best obtained when sedatives or paralytics are withheld as part of sedation holiday.

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," report this as GCS of 15 IF there is no other contradicting

documentation.

Data Source: Neurology Assessment Flow Sheet, Triage/Trauma /ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.1

GCS MOTOR COMPONENT SCORE OF HIGHEST GCS TOTAL

Definition: Highest motor GCS on calendar day after ED/hospital arrival. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values: Dropdown menu with the following options:

Pediatric (≤ 2 years):		Adult:	
1. No motor response	4. Withdrawal from pain	1. No motor response	4. Withdrawal from pain
2. Extension to pain	5. Localizing pain	2. Extension to pain	5. Localizing pain
3. Flexion to pain	6. Appropriate response to stimulation	3. Flexion to pain	6. Obeys commands

Additional Information:

Refers to highest GCS motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.

For patients who were discharged from your hospital prior to the next calendar day after ED/ hospital arrival, the null value “Not Applicable” is reported.

For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value “Not Known/Not Recorded” is reported if reporting ***Highest GCS-40 Motor***.

The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.

Requires review of all data sources to obtain the highest GCS motor on calendar day after ED/hospital arrival.

Best obtained when sedatives or paralytics are withheld as part of sedation holiday.

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 reported. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.

Data Source: Neurology Assessment Flow Sheet, Triage/Trauma /ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.2

GCS QUALIFIERS WITH HIGHEST GCS TOTAL

Definition: GCS qualifiers of the highest GCS within 24 hours of ED/hospital arrival. Collection Criterion: Collect on patients with at least one injury in AIS head region.

Field Values: Multi-select menu with the following options:

- Not Applicable
- Not Known/Not Recorded
- Obstruction to the Patient's Eye
- Patient chemically sedated
- Patient intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstructions to the eye

Additional Information:

Report all that apply.

Refers to highest GCS assessment qualifier score on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.

The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.

Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e., ETOH, prescriptions, etc.).

Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.

If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient must be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier must be reported.

Neuromuscular blockade is typically induced following the administration of agents 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.

The null value “Not Known/Not Recorded” is reported if reporting Highest GCS-40 Motor.

If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value

“Not Applicable” is reported if the patient is discharged from your hospital prior to the next calendar day.

Data Source: Neurology Assessment Flow Sheet, Triage/Trauma /ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes, Medication Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.3

GCS 40 MOTOR SCORE OF HIGHEST GCS TOTAL

Definition: Highest GCS 40 motor on calendar day after ED/hospital arrival. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values: Dropdown menu with the following options:

Pediatric (≤ 2 years):		Adult:	
1. None	4. Localizes Pain	1. None	4. Normal Flexion
2. Extension to Pain	5. Obeys Commands	2. Extension	5. Localizing
3. Flexion to Pain	0. Not Testable	3. Abnormal Flexion	6. Obeys commands
		0. Not Testable	

Additional Information:

Refers to highest GCS-40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.

For patients who were discharged from your hospital prior to the next calendar day after ED/ hospital arrival, the null value “Not Applicable” is reported.

For patients who were at your hospital on the calendar day after ED/hospital arrival, the null value “Not Known/Not Recorded” is reported if reporting ***Highest GCS Motor***.

The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.

Requires review of all data sources to obtain the ***Highest GCS-40 Motor*** score on the calendar day after ED/hospital arrival.

If a patient does not have a numeric GCS-40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the

GCS scale, the appropriate numeric score may be reported (e.g., the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult

patient's, a Motor GCS-40 of 6 may be reported, IF there is no other contradicting documentation).

Report *Element Value* "0. Not Testable" if unable to assess (e.g., neuromuscular blockade).

Data Source: Neurology Assessment Flow Sheet, Triage/Trauma /ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.40.2

INITIAL ED/HOSPITAL PUPILLARY RESPONSE

Definition: Physiological response of the pupil size within 30 minutes or less of ED/Hospital arrival. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values:

Dropdown menu with the following options:

- Not Applicable
- Not Known/Not Recorded
- Neither Reactive
- One Reactive
- Both Reactive

Additional Information:

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

If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as Pupils Equal Round Reactive to Light (PERRL), report Element Value “1. Both reactive” IF there is no other contradicting documentation.

The null value "Not Known/Not Recorded" must be reported if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.

Element Value “2. One reactive” must be reported for patients who have a prosthetic eye.

The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	No	No	**Trauma Incident Form ICD-10**	NA
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.32

MIDLINE SHIFT

Definition: >5mm shift of the brain past its center line within 24 hours after time of injury. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values:

Dropdown menu with the following options:

- Not applicable
- Not Known/Not Recorded
- Not Imaged (e.g. CT Scan, MRI)
- Yes
- No

Additional Information:

If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, report Element Value “1. Yes.”

Radiological and surgical documentation from transferring facilities must be considered for this data element.

The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.

If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the Element Value "1. Yes" if there is no other contradicting documentation.

If the patient was not imaged within 24 hours from the time of injury, report the Element Value "3. Not Imaged (e.g., CT Scan, MRI)."

Data Source: Radiology Reports, Operative Reports, Physician Notes/Flow Sheet, Nursing Notes/Flow Sheet, Hospital Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR40.33

CEREBRAL MONITOR

Definition: Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camio bolt, external ventricular drain (EVD), licox monitor, jugular venous blub. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values:

Multi-select menu with the following options:

- Not Applicable
- Intraparenchymal oxygen monitor
- Intraparenchymal pressure monitor
- Intraventricular drain/catheter
- Jugular venous bulb
- None
- Not Known/Not Recorded

Additional Information:

Report all that apply.

Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.

Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.

The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Data Source: Operative Reports, Procedure Notes, Triage/Trauma/ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes, Anesthesia Record

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.4

CEREBRAL MONITOR DATE AND TIME

Definition: Date and time of first cerebral monitor placement. Collection Criterion: Collect on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and scalp avulsion(s).

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Operative Reports, Procedure Notes, Triage/Trauma/ICU Flow Sheet, Nursing Notes/Flow Sheet, Progress Notes, Anesthesia Record

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	NA
Trauma + TQIP ICD-10	TQIP

State Validation Score: NA | **ImageTrend Data Element Tag:** TR39.5

HOSPITAL EVENTS

ACUTE KIDNEY INJURY (AKI)

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

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 m²

OR

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

OR

Anuria for >= 12 hours

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	Yes	Yes	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.AcuteKidneyInjury

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Definition: 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

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information: Must have occurred during the patient's initial stay at your hospital. A diagnosis of ARDS must be documented in the patient's medical record. Consistent with the 2012 New Berlin Definition.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag:
HospitalEvents.AcuteRespiratoryDistressSyndrome

ALCOHOL WITHDRAWAL SYNDROME

Definition: 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).

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.AlcoholWithdrawalSyndrome

CARDIAC ARREST WITH CPR

Definition: 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.

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

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.CardiacArrestCPR

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

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

AND

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

January 2019 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, and 3 below:

- 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 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.
- Patient has at least one of the following signs or symptoms:
    - Fever (> 38^{0}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
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - Dysuria
- Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium > 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 a bacterium of ≥ 10^5 CFU/ml.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

A diagnosis of Urinary Tract Infection (UTI) must be documented in the patient's medical record.

Consistent with the January 2019 CDC defined CAUTI.

Data Source: Autopsy/Medical Examiner Report, Operative Reports, Radiology Reports, Physician Notes/Flow Sheet, Trauma Flow Sheet, History and Physical, Nursing Notes/Flow Sheet, Progress Notes, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.CathAssociatedUTI

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Definition: A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

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

January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38^{0}C), chills, or

hypotension.

AND

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

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group

streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or 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 (>38^0 C), hypothermia (<36^{0}C), apnea, or bradycardia.

AND

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

AND

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

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

A diagnosis of central line-associated bloodstream infection (CLABSI) must be documented in the patient's medical record.

Consistent with the January 2016 CDC defined CLABSI.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.CentralLineAssociatedBSI

DEEP SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

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

AND

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

AND

Patient has at least one of the following:

a. Purulent drainage from the deep incision.

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

AND

Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.

AND

Patient has at least one of the following signs or symptoms: fever (> 38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

c. An abscess or other evidence of infection involving the deep incision that is detected on

gross anatomical or histopathologic exam, or imaging test

* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease,

other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB).

2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB).

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
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90-day Surveillance	
Code	Operative Procedure
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion

90-day Surveillance	
Code	Operative Procedure
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury.

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

Consistent with the January 2016 CDC defined SSI.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.DeepSurgicalSiteInfection

DEEP VEIN THROMBOSIS (DVT)

Definition: The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

A diagnosis of deep vein thrombosis (DVT) must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.DeepVeinThrombosis

DELIRIUM

Definition: Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment

Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

EXCLUDE:

• Patients whose delirium is due to alcohol withdrawal.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.Delirium

MYOCARDIAL INFARCTION (MI)

Definition: An acute myocardial infarction (MI) must be noted with documentation of ECG changes indicative of an acute MI

AND

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

AND

Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your hospital.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.MyocardialInfarction

ORGAN/SPACE SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the

procedure date) according to the list in Table 2

AND

Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or

manipulated during the operative procedure

AND

Patient has at least one of the following:

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 fluid or tissue in the organ/space by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).

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

AND

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90-day Surveillance	
Code	Operative Procedure
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI.

Code	Site	Code	Site
BONE	Osteomyelitis	MED	Mediastinitis
BRST	Breast abscess mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity (mouth, tongue, or gums)
DISC	Disc space	OREP	Other infections of the male or female reproductive tract
EAR	Ear, mastoid	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess without meningitis
ENDO	Endocarditis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract

Code	Site	Code	Site
IAB	Intraabdominal, not specified	USI	Urinary System Infection
IC	Intracranial, brain abscess or dura	VASC	Arterial or venous infection
JNT	Joint or bursa	VCUF	Vaginal cuff
LUNG	Other infections of the respiratory tract		

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

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

Consistent with the January 2016 CDC defined SSI.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag:
HospitalEvents.OrganSpaceSurgicalSiteInfection

OSTEOMYELITIS

Definition: Osteomyelitis must meet at least one of the following criteria:

1. Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least two of the following localized signs or symptoms:
    - Fever (> 38.0°C)
    - Swelling*
    - Pain or tenderness*
    - Heat*
    - 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

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

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

Consistent with the January 2016 CDC definition of Bone and Joint infection.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.Osteomyelitis

PRESSURE ULCER

Definition: 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.

Field Values:
Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Onset of NPUAP Stage II began after arrival to your ED/hospital.

Pressure Ulcer documentation must be in the patient's medical record.

Consistent with the NPIAP 2014.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.PressureUlcer

PULMONARY EMBOLISM (PE)

Definition: 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.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

Consider the condition present if the patient has a VQ scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

Exclude sub segmental PE's.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.PulmonaryEmbolism

SEVERE SEPSIS

Definition: 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.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

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

Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.SevereSepsis

STROKE/CVA

Definition: A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting 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)

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.StrokeCva

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

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

date)

AND

Involves only skin and subcutaneous tissue of the incision

AND

Patient has at least one of the following:

a. Purulent drainage from the superficial incision.

b. Organisms identified from an aseptically-obtained specimen from the superficial incision or sub cutaneous 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 that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.

AND

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

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

*The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

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).

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

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

Consistent with the January 2016 CDC defined SSI.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag:
HospitalEvents.SuperficialIncisionSurgicalSiteInfection

UNPLANNED ADMISSION TO ICU

Definition: 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.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

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

INCLUDE: Patients who required ICU care due to an event that occurred during surgery or in the PACU.

EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.UnplannedAdmissionToICU

UNPLANNED INTUBATION

Definition: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Known/Not Recorded

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.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.UnplannedIntubation

UNPLANNED VISIT TO THE OPERATING ROOM

Definition: 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 hospital.

Field Values:

Single-select checkbox group with the following options:

- Yes
- No
- Not Applicable

Additional Information:

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

The null value "Not Applicable" is reported for patients who were never in the OR during their initial stay at your hospital.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0
ImageTrend Data Element Tag: HospitalEvents.UnplannedVisitToOR

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Definition: 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 and persistent **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 one 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.,	At least **one** of the following: ▪ Organism identified from blood ▪ Organism identified from pleural fluid ▪ Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate) ▪ ≥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:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
	$PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	○ 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, Legionnella, 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 and persistent **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	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 **one** of the following: ▪ New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or	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 paired sera (IgG) for pathogen (e.g.,

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
disease), **one definitive** chest imaging test result is acceptable.	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)	influenza viruses, Chlamydia) ▪ Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to ≥1:128 in paired 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 imaging test results with at least **one** of the following: ▪ New and persistent **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	Patient who is immunocompromised has at least **one** of the following: ▪ Fever (>38ºC or >100.4ºF) ▪ 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	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: o Direct microscopic exam

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
disease), **one definitive** chest imaging test result is acceptable.	▪ Rales or bronchial breath sounds ▪ Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand) ▪ Hemoptysis ▪ Pleuritic chest pain	○ 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 infant's ≤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 and persistent **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.	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/mm^3) **or** leukocytosis (≥15,000 WBC/mm^3) 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 and persistent **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.	ALTERNATE CRITERIA, for child > 1 year old or ≤ 12 years old, at least **three** of the following: ▪ Fever (>38.0°C or >100.4°F) or hypothermia (<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)

Field Values:

Single-select checkbox group with the following options:

▪ Yes ▪ No ▪ Not Known/Not Recorded

Additional Information:

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

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

Consistent with the January 2019 CDC defined VAP.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: HospitalEvents.VentilatorAssociatedPneumonia

PRE-EXISTING CONDITIONS

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

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to ED/Hospital arrival.

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.AddAdhd

ADVANCE DIRECTIVE LIMITING CARE

Definition: The patient had a written request limiting life sustaining therapy, or similar advanced directive.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.AdvanceDirectiveLimitingCare

ANTICOAGULANT THERAPY

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

EXCLUDE: Patients whose only anticoagulant therapy is chronic Aspirin.

ANTICOAGULANTS	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		

Field Values: Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury. Anticoagulant must be part of the patient's active medication. The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.AnticoagulantTherapy

BLEEDING DISORDER

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.BleedingDisorder

CEREBRAL VASCULAR ACCIDENT (CVA)

Definition: 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).

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CerebralVascularAccident

CHRONIC RENAL FAILURE

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.ChronicRenalFailure

CIRRHOSIS

Definition: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Cirrhosis

MYOCARDIAL INFARCTION (MI)

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CoMorbidConditionsMyocardialInfarction

CONGESTIVE HEART FAILURE (CHF)

Definition: 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.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Pulmonary rales on physical examination
- Pulmonary vascular engorgement
- Orthopnea (dyspnea or lying supine)
- Increased jugular venous pressure
- Cardiomegaly

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CongestiveHeartFailure

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CurrentlyReceivingChemotherapyCancer

CURRENT SMOKER

Definition: 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).

Field Values: Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CurrentSmoker

DEMENTIA

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury.

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

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

Consistent with the National Institute on Aging December 2017.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Dementia

DIABETES MELLITUS

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury.

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

Report Element Value "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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.DiabetesMellitus

DISSEMINATED CANCER

Definition: Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.DisseminatedCancer

FUNCTIONALLY DEPENDENT HEALTH STATUS

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.FunctionallyDependentHealthStatus

HYPERTENSION

Definition: History of persistent elevated blood pressure requiring medical therapy.

Field Values: Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury.

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

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Hypertension

PREGNANCY

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

Field Values:

- Yes
- No
- Not Known/Not Recorded

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Pregnancy

STEROID USE

Definition: Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

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.

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0 **| ImageTrend Data Element Tag:** Pre-ExistingConditions.SteroidUse

ALCOHOL USE DISORDER

Definition: Diagnosis of alcohol use disorder documented in the patient medical record.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

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

A diagnosis of Alcohol Use Disorder 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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.AlcoholUseDisorder

AUSTISM SPECTRUM DISORDER

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.AutismSpectrumDisorder

BIPOLAR I/II DISORDER

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

Only report on patients ≥ 15 years-of-age. The null value "Not Applicable" must be reported for patients < 15 years-of-age. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.BipolarDisorder

MAJOR DEPRESSIVE DISORDER

Definition: A major depressive disorder diagnosis documented in the medical record.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

Only report on patients ≥ 15 years-of-age. The null value "Not Applicable" must be reported for patients < 15 years-of-age. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.MajorDepressiveDisorder

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition: 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.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

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

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

Consistent with World Health Organization (WHO), 2019.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.ChronicObstructivePulmonaryDisease

OTHER MENTAL/PERSONALITY DISORDERS

Definition: 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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.OtherMentalPersonalityDisorder

PERIPHERAL ARTERIAL DISEASE (PAD)

Definition: 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.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

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

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

Consistent with Centers for Disease Control, 2014 Fact Sheet.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NTDB Preexisting/ Hosp. Events
NTDB	Yes	Yes	**Trauma Incident Form ICD-10**	NTDB Preexisting/ Hosp. Events
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.PeripheralArterialDisease

POST-TRAUMATIC STRESS DISORDER

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

Only report on patients ≥ 15 years-of-age. The null value "Not Applicable" must be reported for patients < 15 years-of-age. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.PTSD

SCHIZOAFFECTIVE DISORDER

Definition: A schizoaffective disorder diagnosis documented in the medical record.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

Only report on patients ≥ 15 years-of-age. The null value "Not Applicable" must be reported for patients < 15 years-of-age. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.SchizoaffectiveDisorder

SCHIZOPHRENIA

Definition: A schizophrenia disorder diagnosis documented in the medical record.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

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

Only report on patients ≥ 15 years-of-age. The null value "Not Applicable" must be reported for patients < 15 years-of-age. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years-of-age.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Schizophrenia

SUBSTANCE USE DISORDER

Definition: 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:

EXCLUDE: Tobacco Use Disorder and Alcohol Use Disorder.

- Cannabis Use Disorder
- Other Cannabis-Induced Disorder
- Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder
- Hallucinogen Persisting Perception Disorder
- Other Phencyclidine-Induced Disorder
- Other Hallucinogen-Induced Disorder
- Unspecified Phencyclidine-Related Disorder
- Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder
- Other Inhalant-Induced Disorder
- Unspecified Inhalant-Related Disorder
- Opioid Use Disorder
- Other Opioid-Induced Disorder
- Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder
- Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder
- Other Stimulant-Induced Disorder
- Unspecified Stimulant-Related Disorder

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

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

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

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.SubstanceAbuseDisorder

VENTILATOR DEPENDENCE

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.VentilatorDependence

BRONCHOPULMONARY DYSPLASIA / CHRONIC LUNG DISEASE

Definition: The disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over many months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF), and other causes of bronchiectasis (such as immunodeficiency, and in the third world, post-infective bronchiectasis (e.g., measles), Bronchopulmonary Dysplasia (BPD), or lung disease of prematurity).

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

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

Examples of evidence of Cystic Fibrosis-associated pulmonary disease include, but are not limited to:

Use of Chest Physiotherapy (CPT) or other airway clearing techniques.

Vest therapy or intrapulmonary percussive ventilator.

Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to Cystic Fibrosis.

Consistent with the ncbi.nlm.nih.gov.

Data Source: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma + TQIP ICD-10	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag:

Pre-ExistingConditions.BronchopulmonaryDysplasiaChronicLungDisease

CONGENITAL ANOMALIES

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

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

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

Additional Information:

Present prior to injury.

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

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

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

The null value "Not Applicable" must be reported for patients ≥ 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: History and Physical, Physician Notes/Flow Sheet, Progress Notes, Case Management/Social Services Notes, Nursing Notes/Flow Sheet, Triage/Trauma Flow Sheet, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.CongenitalAnomalies

PREMATURITY

Definition: Babies born before 37 weeks of pregnancy are completed.

Field Values:

Single-select checkbox group with the following options, including a free text comment box to the side:

- Yes
- No
- Not Known/Not Recorded

Additional Information:

Present prior to injury.

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

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

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

The null value "Not Applicable" must be reported for patients ≥ 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.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NTDB Preexisting/ Hosp. Events
Trauma Incident Form ICD-10	NTDB Preexisting/ Hosp. Events

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	NTDB Preexisting/ Hosp. Events

State Validation Score: 0

ImageTrend Data Element Tag: Pre-ExistingConditions.Prematurity

OUTCOME

HOSPITAL DISCHARGE SERVICE

Definition: The hospital service that is discharging the patient from the hospital.

Field Values: Dropdown menu with the following options:

- Acute Rehabilitation Medicine
- Anesthesia
- Bariatric
- Burn
- Cardiology
- Cardiothoracic Surgery
- Chemical Dependency
- Critical Care Medicine
- Critical Care Surgery
- Dentistry
- Dermatology
- Ear Nose Throat
- Endocrinology
- Family Medicine
- Gastroenterology
- General Pediatrics
- General Surgery
- Geriatric
- Hematology Oncology
- Hospitalist
- Infectious Disease
- Internal Medicine
- Kidney Transplant
- Liver
- Neonatal
- Nephrology
- Neurology
- Neurosurgery
- Not Known/Not Recorded
- Obstetric
- Occuloplastic
- Ophthalmology
- Oral Maxillo Facial Surgery
- Orthopedic Surgeon
- Pain
- Pediatric Cardiology
- Pediatric Gastroenterology
- Pediatric Hematology Oncology
- Pediatric Hospitalist
- Pediatric Infectious Disease
- Pediatric Intensivist
- Pediatric Nephrology
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Orthopedic
- Pediatric Pulmonary
- Pediatric Surgery
- Plastic Surgeon
- Podiatry
- Psychiatry
- Psychology
- Pulmonary
- Rheumatology
- Trauma Surgeon

- Gynecology
- Hand
- Pediatric Critical Care Medicine
- Pediatric Dentistry
- Urology
- Vascular Surgery

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	No	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Outcome
TQIP	No	No	**Trauma + TQIP ICD-10**	Outcome

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.31

HOSPITAL ADMISSION DATE AND TIME

Definition: Date and time the patient was admitted to the hospital.

Field Values:

Relevant field value for the data element

Additional Information:

Reported as YYYY-MM-DD.

If multiple orders were written, report the final disposition order date.

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

Data Source: Physician Order, Discharge Instructions, Nursing Notes/Flow Sheet, Case Management/Social Services Notes, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR25.33 (Date), TR25.47 (Time)

HOSPITAL DISCHARGE ORDERS WRITTEN DATE AND TIME

Definition: The date and time the order was written for the patient to be discharged from the hospital. If patient expires after admission to the hospital, use time of death for this field.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specification

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 (Date), -1 (Time) **| ImageTrend Data Element Tag:** TR25.93 (Date), TR25.94 (Time)

HOSPITAL DISCHARGE DATE AND TIME

Definition: The date and time the patient was discharged from the hospital.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Data Source: Physician Order, Discharge Instructions, Nursing Notes/Flow Sheet, Case Management/Social Services Notes, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 (Date), -1 (Time) | **ImageTrend Data Element Tag:** TR25.34 (Date), TR25.48 (Time)

LENGTH OF STAY

Definition: The total number of days and hours the patient was in the hospital.

Field Values:

This field auto calculates.

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: NA | **ImageTrend Data Element Tag:** TR25.44

TOTAL ICU DAYS

Definition: The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.

Field Values:

Relevant field value for the data element

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.

At no time can the ***Total ICU Days*** exceed the hospital LOS.

The null value "Not Known/Not Recorded" is reported if any dates are missing.

If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.

The null value "Not Applicable" is reported if the patient had no ICU days according to the above description.

Data Source: ICU Flow Sheet, Nursing Notes/Flow Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -2 | **ImageTrend Data Element Tag:** TR26.9

TOTAL VENT DAYS

Definition: The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.

Field Values:

Relevant field value for the data element

Additional Information:

Excludes mechanical ventilation time associated with OR procedures.

Non-invasive means of ventilatory support (CPAP or BiPAP) must not be considered in the calculation of ventilator days.

Reported in full day increments with any partial calendar day counted as a full calendar day.

The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart.

At no time can the ***Total Vent Days*** exceed the hospital LOS.

The null value "Not Known/Not Recorded" is reported if any dates are missing.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR26.58

PRIMARY METHOD OF PAYMENT

Definition: Primary source of payment to this trauma care facility for this visit. No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be captured as Private/Commercial Insurance.

Field Values: Dropdown menu with the following options:

- Not Known/Not Recorded
- Liability
- Managed Care
- Medicaid
- Medicare
- None
- Not Billed (for any reason)
- Other
- Other Government
- Private Pay
- Private/Commercial Insurance
- Self-Pay
- Unreimbursed

Additional Information:

Field cannot be Not Applicable.

Data Source: Billing Sheet, Admission Form, Face Sheet

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR2.5

SECONDARY METHOD OF PAYMENT

Definition: Secondary source of payment for hospital care.

Field Values: Dropdown menu with the following options:

- Active
- Not Known/Not Recorded
- Not Applicable
- None
- Liability
- Medicaid
- Medicare
- No Fault Automobile
- Other
- Other Government
- Private/Commercial Insurance
- Self Pay
- Worker's compensation

Additional Information:
None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: NA | **ImageTrend Data Element Tag:** TR2.7

BILLED HOSPITAL CHARGES

Definition: Total charges the patient was billed for the hospital stay.

Field Values:

Relevant field value for the data element

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
State	No	Yes	**Short Form ICD-10**	NA
NTDB	No	No	**Trauma Incident Form ICD-10**	Outcome
TQIP	No	No	**Trauma + TQIP ICD-10**	Outcome

State Validation Score: NA | **ImageTrend Data Element Tag:** TR2.9

WORK RELATED

Definition: Indication of whether the injury occurred during paid employment. If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation.

Field Values:
Dropdown menu with the following options:

- No
- Yes

Additional Information:
Patient's Occupational Industry field response values: Agriculture, Forestry, Fishing; Construction; Educational and Health Services; Finance, Insurance, and Real Estate; Government; Information Services; Leisure and Hospitality; Manufacturing; Natural Resources and Mining; Other Services; Professional and Business Services; Retail Trade; Transportation and Public Utilities; Wholesale and Retail Trade; Not Applicable

Patient's Occupation field response values: Not applicable; Architecture and Engineering Occupations; Arts, Design, Entertainment, Sports and Media; Building and Grounds Cleaning and Maintenance; Business and Financial Operations; Community and Social Services; Computer and Mathematical; Construction and Extraction; Education, Training, and Library; Farming, Fishing, and Forestry; Food Preparation and Serving Related; Healthcare Practitioners and Technical; Healthcare support; Installation, Maintenance and Repair; Legal; Life, Physical and Social Science; Management; Military Specific; Office and Administrative support; Personal care and service; Production; Protective Services; Sales; Transportation and Material Moving; Not Known/Not Recorded

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes
TQIP	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -2 **| ImageTrend Data Element Tag:** TR2.10

DISABILITY AT ADMISSION

Definition: A quantification of disability upon admission.

Field Values:

The following data points are available with dropdown menus:

- Feeding
- Locomotion (Independence)
- Expression (Motor)
- Disability at Admission Score

For each of the four data points above, the following responses are available in a dropdown menu:

- 1 - Dependent - Total Help
- 2 - Dependent - Partial Help
- 3 - Independent With Device
- 4 - Independent

Additional Information:

The Disability at Admission Score is auto calculated based on the preceding values entered.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	NA

State Validation Score: NA | **ImageTrend Data Element Tag:** TR26.62 – TR26.65

DISABILITY AT DISCHARGE

Definition: A quantification of disability upon discharge.

Field Values:

The following data points are available with dropdown menus:

- Feeding
- Locomotion (Independence)
- Expression (Motor)
- Disability at Discharge Score

For each of the four data points above, the following responses are available in a dropdown menu:

- 1 - Dependent - Total Help
- 2 - Dependent - Partial Help
- 3 - Independent With Device
- 4 - Independent

Additional Information:

The Disability at Discharge Score is auto calculated based on the preceding values entered.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	NA

State Validation Score: NA | **ImageTrend Data Element Tag:** TR26.54 – TR26.56, TR26.61, TR25.46

GENERAL CONDITION AT DISCHARGE

Definition: An evaluation of the impacts of the trauma on the patient.

Field Values:

A dropdown menu with the following options:

- Not Known/Not Recorded
- Not Applicable
- Good, Return to Previous Level of Function
- Moderate Disability with Self Care
- Persistent Vegetative State
- Severe Disability, Dependent
- Temporary Disability, Expected to Return to Previous Level of Function

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	NA

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR25.46

INJURY DISABILITY SCALE

Definition: The Injury Disability Scale states the level of disability caused by the traumatic injury.

Field Values: The following data points are available with dropdown menus:

- No disability (able to be fully employed and pursue full recreational activities)
- Minor (Self support with reduced recreational activities)
- Moderate (Self support with no recreational activities)
- Severe (Living at home with assistance of an aid less than 4 hours per day or requires some assistance with shopping, meal preparation or medications)
- Very Severe (full care at home with assistance more than 4 hours a day or institutional care providing some assistance with activities of daily living)
- Extreme (Requires institutional care with an external life support system)

Additional Information:

None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	No	No
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	NA
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: NA | **ImageTrend Data Element Tag:** TR26.1

DISCHARGE DISPOSITION

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

Field Values: The following data points are available with dropdown menus:

- Not Known/Not Recorded
- Acute care hospital
- AMA / Discontinued Care
- Burn care hospital
- Deceased/ Expired
- Intermediate Care Facility
- Discharge/Transferred to home under care of organized Home Health Services
- Skilled Nursing Facility
- Discharged to home or self-care (routine discharge)
- Discharged/Transferred to a short-term general hospital for inpatient care
- Discharged/Transferred to another type of institution not defined elsewhere
- Discharged/Transferred to court/law enforcement
- Discharged/Transferred to Hospice care
- Inpatient Rehabilitation Facility (IRF)
- Long Term Care Hospital (LTCH)
- Psychiatric hospital or psychiatric distinct part/unit of a hospital

Additional Information: The following fields are available upon selecting the corresponding field value:

Acute care hospital: Destination Determination (TR25.42), Hospital Transferred To (TR25.35), Transport Mode (TR25.43)

Burn care hospital: Hospital Transferred To (TR25.35)

Deceased/Expired: Date/Time Death Occurred (TR25.36), Location of Death (TR25.30), Death Circumstance (TR25.32), Circumstances of Death (TR25.53), Organ Donation (TR25.29), Autopsy Performed (TR25.37), Advanced Directive (TR25.28), Hospital Transferred To (TR25.35)

Discharged/Transferred to a short-term general hospital for inpatient care: Destination Determination (TR25.42), Hospital Transferred To (TR25.35), Transport Mode (TR25.43)

Discharged/Transferred to inpatient rehab or designated unit: Hospital Transferred To (TR25.35)

Element Values adapted from UB-04 disposition coding.

Element Value “Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).

Disposition to any other non-medical facility must be reported as Element Value "Discharged to home or self-care (routine discharge)."

Disposition to any other medical facility must be reported as Element Value "Discharged/ Transferred to another type of institution not defined elsewhere."

Disposition to any Federal Health Care facility must be reported by selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a Veteran's hospital skilled nursing facility must be reported as Element Value " Skilled Nursing Facility.")

The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Values similar to AMA, Deceased/Expired, Discharged to home or self-care (routine discharge), Discharged/Transferred to Hospice care, Discharged/Transferred to court/law enforcement, Long Term Care Hospital (LTCH), or Discharged/Transferred to another type of institution not defined elsewhere.

Data Source: Physician Order, Discharge Instructions, Nursing Notes/Flow Sheet, Case Management/Social Services Notes, Discharge Summary

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	Yes	Yes

Form	Location of Data Element
Short Form ICD-10	Hospital Outcome
Trauma Incident Form ICD-10	Outcome

Inclusion Entity	Required Data Element	Validated Field	Form	Location of Data Element
TQIP	Yes	Yes	**Trauma + TQIP ICD-10**	Outcome

State Validation Score: -3 | **ImageTrend Data Element Tag:** TR25.27

INJURY MEETS FARM-RELATED INJURY DEFINITION

Definition: Indicates the injury meets the farm-related injury definition. Agricultural injury (e.g. grain truck accident while in transit, railroad crash of grain cars). May not have been necessarily work-related or directly related to the farm.

Field Values:
Dropdown menu with the following options:

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

Additional Information:
None.

Registry Specifications

Inclusion Entity	Required Data Element	Validated Field
State	Yes	Yes
NTDB	No	No
TQIP	No	No

Form	Location of Data Element
Short Form ICD-10	Hospital Outcome
Trauma Incident Form ICD-10	Outcome
Trauma + TQIP ICD-10	Outcome

State Validation Score: -1 | **ImageTrend Data Element Tag:** TR5.28