

2020



# Wyoming Trauma Registry Data Dictionary

STATE REQUIRED ELEMENTS – APPLICABLE TO  
ADMISSIONS STARTING JANUARY 1, 2020

# Wyoming Trauma Registry Data Dictionary v2020.1

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## Data Dictionary Element Legend

This data dictionary contains required fields for the State of Wyoming and the National Trauma Data Standard. The data items on the following pages are listed by category. Each data element description contains:

<b>STATE/HOSPITAL</b>	This will appear if the element is required by the State of Wyoming and/or the hospital.
<b>NTDB</b>	This will appear if the element is required by the National Trauma Data Bank (NTDB)

<b>Element Requirement (State/NTDB)</b>
<b>ImageTrend Tab Location – Element Number - Registry Title</b>

<b>Definition</b>
The definition of the data element, as shown on the data entry form within the ImageTrend Registry

<b>Reporting Criterion</b> *May not be included for every element.
Criteria for which patients to report to the National Trauma Data Bank.

<b>Element Values</b>
Lists all available values for data element entry The order in which these fields appear do not necessarily correspond with data import mappings

<b>Data Format</b>
List the format for data element entry

<b>Additional Information</b>
Any additional information about the data element

**Associated Edit Checks (NTDB)**

If the element is NTDB required, the associated validity rules will be displayed in the most up to date version of the National Trauma Data Standard Data Dictionary

# Section A: Wyoming Trauma Patient Registry Elements and Descriptions

## Demographics Tab Elements

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.3 - Medical Record Number**

**Definition**

Patients Medical Record Number

**Element Values**

Relevant value for the data element as long as it does not exceed 50 characters

**Data Format**

[TEXT]

**Additional Information**

This data element is for audit and linking purposes only and will never be made public

**STATE/HOSPITAL ELEMENT**

**Demographics - TR5.13 - Registry Number**

**Definition**

Trauma Registry Number

**Element Values**

Relevant value for the data element as long as it does not exceed 50 characters

**Data Format**

[TEXT]

**Additional Information**

This number provides a unique identifier for a patient across the Wyoming Trauma Registry

## STATE/HOSPITAL ELEMENT

### Demographics - TR1.28 - Account Number

#### Definition

Account Number

#### Element Values

Relevant value for the data element as long as it does not exceed 50 characters

#### Data Format

[TEXT]

#### Additional Information

This number provides a hospital unique identifier for a patient.

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR5.1 - Incident Date

#### Definition

The date the injury occurred

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

- Collected as YYYY-MM-DD
- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider Other proxy measures (eg, 911 call times) should not be reported

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.9 - Last Name**

**Definition**

The patient's last name

**Element Values**

Relevant value for the data element as long as it does not exceed 100 characters

**Data Format**

[TEXT]

**Additional Information**

This data element is for audit and linking purposes only and will never be made public

## STATE/HOSPITAL ELEMENT

### Demographics - TR1.8 - Patient's First Name

#### Definition

The patient's first name

#### Element Values

Relevant value for the data element as long as it does not exceed 100 characters

#### Data Format

[TEXT]

#### Additional Information

This data element is for audit and linking purposes only and will never be made public

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.10 - Middle Initial**

**Definition**

The patient's middle initial

**Element Values**

Relevant value for the data element as long as it does not exceed 100 characters

**Data Format**

[TEXT]

**Additional Information**

This data element is for audit and linking purposes only and will never be made public

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.7 - Date of Birth

#### Definition

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

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as YYYY-MM-DD
- If Date of Birth is “Not Known/Not Recorded,” report variables: Age and Age Units
- If Date of Birth equals Injury Date, then the Age and Age Units variables must be reported

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.12 - Age (at date of incident)

#### Definition

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

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- If Date of Birth is “Not Known/Not Recorded,” report variables: Age and Age Units
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be reported
- Must also report variable: Age Units
- The null value “Not Applicable” is reported if Date of Birth is documented

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.14 - Age Units

#### Definition

The units used to document the patient's age (years, months, days, hours)

#### Element Values

- Weeks
- Hours
- Days
- Months
- Years
- Minutes
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.6.1 - Height in inches**

**Definition**

Indicate the patient's height in inches

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.6 - Height**

**Definition**

Indicate the patient's height in centimeters

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

**STATE/HOSPITAL ELEMENT**

**Demographics - TR1.6.5 - Estimated Body Weight**

**Definition**

The patients body weight in kilograms, either measured or estimated

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.16 - Race

#### Definition

The patient's race

#### Element Values

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

#### Data Format

[Combo] Multiple-Choice

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.17 - Ethnicity

#### Definition

The patient's ethnicity

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.15 - Gender

#### Definition

The patient's gender

#### Element Values

- Select
- Female
- Male
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using their current assignment

## STATE/HOSPITAL ELEMENT

### Demographics - TR1.18 - Address

#### Definition

The patient's home address

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

This data element is for audit and linking purposes only and will never be made public

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.21 - City

#### Definition

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

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is documented
- The null value "Not Applicable" is reported for non-US hospitals

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.22 - County

#### Definition

The patient's home county of residence

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is documented
- The null value "Not Applicable" is reported for non-US hospitals

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.23 - State

#### Definition

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

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when ZIP/Postal code is "Not Known/Not Recorded" and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is reported if Patient's Home ZIP/Postal Code is documented
- The null value "Not Applicable" is reported for non-US hospitals

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.20 - Postal Code

#### Definition

The patient's home ZIP code of primary residence

#### Element Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.19 - Country

#### Definition

The patient's home country of primary residency

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Values are two-character FIPS codes representing the country (eg, US)
- If Patient's Home Country is not US, then the null value "Not Applicable" is reported for: Patient's Home State, Patient's Home County, and Patient's Home City

## NTDB & STATE/HOSPITAL ELEMENT

### Demographics - TR1.13 - Alternate Residence

#### Definition

Documentation of the type of patient without a home zip code

#### Element Values

- Undocumented Citizen
- Migrant
- Homeless
- Foreign Visitor
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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 reported if Patient's Home ZIP/Postal Code is documented
- Report all that apply

# Injury Tab Elements

## STATE/HOSPITAL ELEMENT

### Injury - TR20.12 - Injury Description

#### Definition

The description of injury

#### Element Values

- All values are allowed
- Enter the details of the injury/event
- This information may repeat information contained in other fields

#### Data Format

TEXT\_AREA

#### Additional Information

This data element helps to better convey the context of the injury event and to include important information such as intentionality that is not otherwise captured in the other data elements

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR200.5 - ICD 10 Location

#### Definition

Where did the injury/event occur? Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92x)

#### Element Values

Relevant ICD-10-CM code value for injury event

#### Data Format

[NUMBER]

#### Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital
- ICD-10-CM codes are accepted for this data element Activity codes are not collected under the NTDS and should not be reported in this field
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR5.6 - Incident Location Zip Code

#### Definition

The ZIP code of the incident location

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and CA, or can be stored in the postal code format of the applicable country
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only)
- May require adherence to HIPAA regulations
- If ZIP/Postal code is documented, then must report Incident Country

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR5.11 - Incident Country

#### Definition

The country where the patient was found or to which the unit responded (best approximation)

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR5.10 - Incident City

#### Definition

The city or township where the patient was found or to which the unit responded (or best approximation)

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US
- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented
- If Incident Country is not US, report the null value "Not Applicable"

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR5.9 - Incident County

#### Definition

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

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented
- If Incident Country is not US, report the null value "Not Applicable"

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR5.7 - Incident State

#### Definition

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

#### Element Values

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

#### Data Format

[TEXT]

#### Additional Information

- Only reported when Incident Location ZIP/Postal Code is "Not Known/Not Recorded," and country is US
- Used to calculate FIPS code
- The null value "Not Applicable" is reported if Incident Location ZIP/Postal Code is documented
- If Incident Country is not US, report the null value "Not Applicable"

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR200.3 - ICD 10 Injury

#### Definition

What was the cause(s) of the injury? External cause code used to describe the mechanism (or external factor) that caused the injury event

#### Element Values

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

#### Data Format

[Combo] Multiple-Choice

#### Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital
- ICD-10-CM codes are accepted for this data element Activity codes are not collected under the NTDS and should not be reported in this field
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above

## STATE/HOSPITAL ELEMENT

### Injury – TR200.3.2 - Intentionality

#### Definition

Indicate the intentionality of the injury to the patient.

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

## STATE/HOSPITAL ELEMENT

### Injury – TR200.3.3 – Trauma Type

#### Definition

Indicate the type of injury the patient sustained

#### Element Values

- Penetrating
- Other
- Not Known/Not Recorded
- Burn
- Blunt

#### Data Format

[COMBO] Single-Choice

#### Additional Information

## NTDB & STATE/HOSPITAL ELEMENT

### Injury - TR29.24 - Safety Device Used

#### Definition

Protective devices (safety equipment) in use (or lack of use) by the patient at the time of the injury

#### Element Values

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>▪ Shoulder Belt</li> <li>▪ Protective Non-Clothing Gear (eg, shin guard)</li> <li>▪ Protective Clothing (eg, padded leather pants)</li> <li>▪ Personal Flotation Device</li> </ul> | <ul style="list-style-type: none"> <li>▪ Not Known/Not Recorded</li> <li>▪ None</li> <li>▪ Select</li> <li>▪ Lap Belt</li> <li>▪ Helmet (eg, bicycle, skiing, motorcycle)</li> </ul> | <ul style="list-style-type: none"> <li>▪ Hard Hat</li> <li>▪ Eye Protection</li> <li>▪ Child Car Restraint (booster seat or child car seat)</li> <li>▪ Airbag Present</li> <li>▪ Other</li> </ul> |
|---|--|---|

#### Data Format

[Combo] Multiple-Choice

#### Additional Information

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

# Pre-Hospital Tab Elements

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR16.22 - Arrived From

#### Definition

Location the patient arrived from

#### Element Values

- Scene
- Referring Hospital
- Clinic/MD Office
- Jail
- Home
- Nursing Home
- Supervised Living
- Urgent Care
- Not Known/Not Recorded

#### Data Format

[Combo] Single- Choice

#### Additional Information

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR8.8 - Transported To Your Facility By

#### Definition

The party of transport delivering the patient to the hospital

#### Element Values

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

#### Data Format

[Radio]

#### Additional Information

The last mode of transportation that brought the patient to your facility

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR25.54 - Inter-facility Transfer

#### Definition

Inter-Facility Transfer

#### Element Values

- Yes
- No
- Not Known / Not Recorded

#### Data Format

[NUMBER]

#### Additional Information

- Must complete "Arrived From" (TR1622) and "Transported to your Facility By" (TR88) to populate this field
- Patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by non-EMS transport are not considered inter-facility transfers
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities (Stand-Alone Emergency Rooms)

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR17.22 - Trauma Triage Criteria (Steps 1 and 2)

#### Definition

Physiologic 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 This information must be found on the scene of the injury EMS Run Report

#### Element Values

- |   |   |   |  |
|---|---|---|--|
| <ul style="list-style-type: none"> <li>▪ Glasgow Coma Score &lt;=13</li> <li>▪ Systolic blood pressure &lt; 90 mmHg</li> <li>▪ Respiratory rate &lt; 10 or &gt; 29 breaths per minute (&lt;20 in infants aged &lt; 1 year) or need for ventilatory support</li> </ul> | <ul style="list-style-type: none"> <li>▪ All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee</li> <li>▪ Chest wall instability or deformity (eg, flail chest)</li> </ul> | <ul style="list-style-type: none"> <li>▪ Two or more proximal long-bone fractures</li> <li>▪ Crushed, degloved, mangled, or pulseless extremity</li> <li>▪ Amputation proximal to wrist or ankle</li> </ul> | <ul style="list-style-type: none"> <li>▪ Pelvic fracture</li> <li>▪ Open or depressed skull fracture</li> <li>▪ Paralysis</li> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> </ul> |
|---|---|---|--|

#### Data Format

[Combo] Multiple-Choice

#### 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
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Check all that apply
- Consistent with NEMSIS v3

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR17.47 – 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 This information must be found on the scene of injury EMS run sheet

#### Element Values

- |   |   |   |  |
|---|---|---|--|
| <ul style="list-style-type: none"> <li>▪ Crash intrusion, including roof: &gt; 12 in occupant site; &gt; 18 in any site</li> <li>▪ Crash ejection (partial or complete) from automobile</li> <li>▪ Crash death in same passenger compartment</li> </ul> | <ul style="list-style-type: none"> <li>▪ Crash vehicle telemetry data (AACN) consistent with high risk injury</li> <li>▪ Auto v pedestrian/bicyclist thrown, run over, or &gt; 20 MPH impact</li> </ul> | <ul style="list-style-type: none"> <li>▪ Motorcycle crash &gt; 20 mph</li> <li>▪ For adults &gt;65; SBP &lt;110</li> <li>▪ Patients on anticoagulants and bleeding disorders</li> </ul> | <ul style="list-style-type: none"> <li>▪ Pregnancy &gt; 20 weeks</li> <li>▪ EMS Provider judgment</li> <li>▪ Burns</li> <li>▪ Burns with Trauma</li> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> </ul> |
|---|---|---|--|

#### Data Format

[Combo] Multiple-Choice

#### 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
- Element Values must be determined by the EMS provider and must not be assigned by the index hospital
- Check all that apply
- Consistent with NEMSIS v3

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR7.1 - Run Number

#### Definition

The number identifying the EMS run

#### Element Values

Relevant value for the data element as long as it does not exceed 50 characters

#### Data Format

[TEXT]

#### Additional Information

- The run number is assigned to the incident by the EMS agency transporting the patient to your facility
- Run Report can be found by searching for the patient
- Data will be generated from the EMS Run Report
- This data element is for audit and linking purposes only and will never be made public

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR7.3 - Service

#### Definition

The name of the EMS Agency the patient was transferred from

#### Element Values

Relevant value for the data element

#### Data Format

[Combo] Single-Choice

#### Additional Information

- Picked from a drop-down menu after selecting agency state
- If agency cannot be found, select "Other State Agency" and inform the Wyoming Trauma Program

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.1 - Unit Notified Date

#### Definition

The date and time EMS unit transporting to the hospital was notified by dispatch

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Date is collected as MM-DD-YYYY
- Time is collected as HH:MM
- For inter-facility transfer patients, this is the date and time in which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the date and time on which the unit transporting the patient to your facility from the scene was dispatched
- Leave blank for patients not transported by EMS

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.17 - En Route Date

#### Definition

The date the EMS Agency began travel to the location of the patient

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.17.1 - En Route Time

#### Definition

The time the EMS Agency began travel to place where patient EMS transport was to begin

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Data will be generated from the EMS Run Report

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.2 - Arrive Scene - Date

#### Definition

The date the EMS unit transporting to the hospital arrived on the scene (the date the vehicle stopped moving)

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Date is collected as MM-DD-YYYY
- For inter-facility transfer patients, this is the date in which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched
- Leave blank for patients not transported by EMS

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.2.1 - Arrive Scene - Time

#### Definition

The time the EMS unit transporting to your hospital arrived on the scene/transferring facility

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Time is collected as HH:MM
- For inter-facility transfer patients, this is the time in which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the time on which the unit transporting the patient to your facility from the scene was dispatched
- Leave blank for patients not transported by EMS

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.3 - Leave Scene- Date

#### Definition

The date the EMS unit transporting to your hospital left the scene/transferring facility

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure)
- For inter-facility transfer patients, this is the date in which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched
- Leave blank for patients not transported by EMS

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.3 - Leave Scene- Time

#### Definition

The date the EMS unit transporting to the hospital left the scene

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure)
- For inter-facility transfer patients, this is the date in which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched
- Leave blank for patients not transported by EMS

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR9.4 - Arrive Hospital

#### Definition

The date the EMS unit arrived at the hospital

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR8.10 - Transport Mode

#### Definition

The mode of transport used by the EMS agency to transport patient from the scene/referring facility to the hospital

#### Element Values

- ALS
- BLS
- Fixed Wing
- Helicopter
- Not Available
- Not Known/ Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.32 - Destination Determination

#### Definition

The reason the hospital was chosen to transport the patient to

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.38 - EMS Report Status

#### Definition

This field applies only if an ambulance/flight selection was made from previous "Transport Mode" field Select "Complete" if a full EMS report was available Select "Missing" if no EMS report was available

#### Element Values

- Missing
- Incomplete
- Complete
- Not Applicable
- Not Available

#### Data Format

[COMBO] Single-Choice

#### Additional Information

Select "Complete" if a full EMS report was available Select "Missing" if no EMS report was available

## NTDB & STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.53 - Pre Hospital Cardiac Arrest

#### Definition

Indicate whether the person suffered a cardiac arrest at any stage prior to arrival at the definitive care hospital

#### Element Values

- Yes
- No
- Not Known / Not Recorded

#### Data Format

[COMBO] Single-Choice

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

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.39 - CPR Performed

#### Definition

Did the EMS unit staff perform CPR on the patient?

#### Element Values

- CPR in progress
- Yes
- No
- Not Performed
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.41 - CPR Location

#### Definition

Location of the EMS unit staff during CPR Event

#### Element Values

- Scene & Route CPR
- En Route CPR
- Scene CPR
- Not Performed
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR18.97 - Tube Thoracostomy

#### Definition

Did the EMS unit staff perform a tube thoracostomy?

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR18.96 - Needle Thoracostomy

#### Definition

Did the EMS unit staff perform a needle thoracostomy?

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.40 - Airway Management

#### Definition

Did the EMS unit staff perform any airway procedure prior to arriving at your facility?

#### Element Values

- Non-Rebreather Mask
- Nasal Cannula
- CPAP
- Alternative Airway Device
- Airway cleared
- Bag & Mask
- Combitube
- Crico
- LMA
- Nasal ETT
- Oral Airway
- Oral ETT
- Trach
- Not Performed
- Nasal Trumpet
- Supplemental Oxygen
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.30 - Fluids

#### Definition

Did the EMS unit staff administer fluids to the patient?

#### Element Values

- Saline Lock
- Not Performed
- < 500
- 500-2000
- >2000
- IVF Attempted
- IVF Unk Amount
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.31 - Medications

#### Definition

Did the EMS unit staff administer medications to the patient?

#### Element Values

<ul style="list-style-type: none"> <li>▪ Other Vasoactive Agent</li> <li>▪ Other Opiate/Narcotic</li> <li>▪ Other Benzodiazepine</li> <li>▪ Other Antiseizure</li> <li>▪ Other Antihypertensive</li> <li>▪ Other Antibiotic (instead of antibiotic)</li> <li>▪ Levetiracetam (Keppra)</li> <li>▪ Ketamine</li> <li>▪ Hypertonic Solution</li> <li>▪ CT Contrast</li> <li>▪ Calcium Gluconate</li> <li>▪ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>▪ ACLS drugs</li> <li>▪ Not Available</li> <li>▪ Adenosine</li> <li>▪ Albuterol</li> <li>▪ Amiodarone</li> <li>▪ Aspirin (ASA)</li> <li>▪ Ativan (Lorazepam)</li> <li>▪ Atropine</li> <li>▪ Atrovent (Ipratropium)</li> <li>▪ Benadryl (Diphenhydramine)</li> <li>▪ Colloid Solution</li> <li>▪ Compazine (Prochlorperazine)</li> <li>▪ Crystalloid solution</li> </ul>	<ul style="list-style-type: none"> <li>▪ Decadron (Dexamethasone)</li> <li>▪ Defibrillation</li> <li>▪ Demerol (Meperidine)</li> <li>▪ Dextrose (Glucose)</li> <li>▪ Dopamine</li> <li>▪ Epinephrine (Aqueous)</li> <li>▪ External pacemaker</li> <li>▪ Fentanyl</li> <li>▪ Glucagon</li> <li>▪ Heparin</li> <li>▪ Lasix (Furosemide)</li> <li>▪ Lidocaine</li> <li>▪ Magnesium Sulfate</li> <li>▪ Methylprednisolone</li> </ul>	<ul style="list-style-type: none"> <li>▪ Morphine sulfate</li> <li>▪ Narcan (Naloxone)</li> <li>▪ Needle decompression of chest</li> <li>▪ Nitroglycerin</li> <li>▪ Oxygen</li> <li>▪ Pelvic Wrap</li> <li>▪ Prasugrel (Effient)</li> <li>▪ Sodium bicarbonate</li> <li>▪ Not Known/Not Recorded</li> <li>▪ Valium (Diazepam)</li> <li>▪ Tissue Plasminogen Activator (tPA)</li> <li>▪ Versed (Midazolam)</li> <li>▪ Zofran (Ondansetron)</li> </ul>
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#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.36 - Temperature Maintained

#### Definition

Indicate whether or not the temperature of the patient was maintained by the actions of the EMS unit staff

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

## STATE/HOSPITAL ELEMENT

### Pre-Hospital - TR15.37 - Appropriate Wound Management

#### Definition

Indicate whether or not the wounds of the patient were managed appropriately

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Data will be generated from the EMS Run Report

# Referring Tab Elements

## STATE/HOSPITAL ELEMENT

### Referring - TR33.1 - Referring Hospital

#### Definition

The name of the facility that cared for the patient immediately before the patient arrived at your facility

#### Element Values

- List of facilities in or around Wyoming

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If "other" is selected, complete additional fields with the referring hospitals information

## STATE/HOSPITAL ELEMENT

### Referring - TR33.2 - Referring Hospital Arrival Date

#### Definition

Indicate the date the patient arrived at the outside facility

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Date is collected as MM-DD-YYYY
- If date of arrival is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.3 - Referring Hospital Arrival Time

#### Definition

Indicate the time the patient arrived at the outside facility

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Time is collected as HH:MM
- If time of arrival is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.30 - Discharge Date

#### Definition

Indicate the date the patient left the outside facility

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Date is collected as MM-DD-YYYY
- If date of discharge is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.31 - Discharge Time

#### Definition

Indicate the time the patient left the outside facility

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Time is collected as HH:MM
- If time of discharge is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.48 - Transported to referring facility by

#### Definition

The mode of transport used to transport the patient to your facility

#### Element Values

- Commercial Flight
- Charter Helicopter
- Charter Fixed-Wing
- Select
- ALS Ambulance
- BLS Ambulance
- Pending
- Fixed-Wing Ambulance
- Helicopter Ambulance
- Other
- Police
- Private/Public Vehicle/Walk-In
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- This information may be found on the medical record information that accompanies the patient from the referring hospital

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.4 - Physician Name**

**Definition**

Name of the physician that referred the patient to your hospital

**Element Values**

Relevant value for the data element

**Data Format**

[TEXT]

**Additional Information**

If the physician name was not provided by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.45 - Medical Record Number

#### Definition

Patients Medical Record Number from the referring hospital

#### Element Values

Relevant value for the data element as long as it does not exceed 50 characters

#### Data Format

[TEXT]

#### Additional Information

This data element is for audit and linking purposes only and will never be made public

## STATE/HOSPITAL ELEMENT

### Referring - TR33.54 - Referring Hospital Vitals Date

#### Definition

Indicate the date the referring hospital recorded the patients vitals

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Date is collected as MM-DD-YYYY
- If the date the vitals were taken at the referring hospital is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - Referring Hospital Vitals Time

#### Definition

Indicate the time the referring hospital recorded the patients vitals

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Time is collected as HH:MM
- If the time the vitals were taken at the referring hospital is not documented, leave blank

**STATE/HOSPITAL ELEMENT**

Referring - TR33.5 - Sys BP

**Definition**

Systolic Blood Pressure as documented by the referring facility

**Element Values**

Relevant value for the data elements long as it does not exceed 299

**Data Format**

[NUMBER]

**Additional Information**

Is the Systolic Blood Pressure is not documented, leave blank

**STATE/HOSPITAL ELEMENT**

Referring - TR33.40 - Dia BP

**Definition**

Diastolic Blood Pressure as documented by the referring facility

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

If the Diastolic Blood Pressure is not documented, leave blank

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.6 - Pulse Rate**

**Definition**

Pulse rate as documented by the referring facility

**Element Values**

Relevant value for the data elements long as it does not exceed 299

**Data Format**

[NUMBER]

**Additional Information**

If the Pulse Rate is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.7 - Temperature: Celsius

#### Definition

Patients temperature in Celsius as documented by the referring facility

#### Element Values

Relevant value for the data element as long as it does not exceed 45

#### Data Format

[NUMBER]

#### Additional Information

- Entry in this unit will auto populate the other element for Fahrenheit
- If the temperature is not documented, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.7.1 - Temperature: Fahrenheit

#### Definition

Patients temperature in Fahrenheit as documented by the referring facility

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Entry in this unit will auto populate once the element for Celsius has been documented
- If the temperature is not documented, leave blank

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.8 - Resp Rate**

**Definition**

Patients Respiratory Rate as documented by the referring facility

**Element Values**

Relevant value for the data element as long as it does not exceed 120

**Data Format**

[NUMBER]

**Additional Information**

If the respiratory rate is not documented, leave blank

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.9 - Resp Assistance**

**Definition**

Did the patient receive respiratory assistance by the referring hospital?

**Element Values**

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

**Data Format**

[COMBO] Single-Choice

**Additional Information**

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

## STATE/HOSPITAL ELEMENT

### Referring - TR33.10 - Supplemental Oxygen

#### Definition

Indicate whether the patient received Supplemental Oxygen as documented by the referring hospital

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If supplemental oxygen has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

Referring - TR33.11 - O2Sat

### Definition

Indicate the patients oxygen saturation as documented by the referring hospital

### Element Values

Relevant value for the data element

### Data Format

[NUMBER]

### Additional Information

- Value should be based upon assessment before administration of supplemental oxygen

## STATE/HOSPITAL ELEMENT

### Referring - TR33.44 - AVPU

#### Definition

Indicate the patients level of consciousness using the AVPU scale (Alert, Verbal, Pain, Unresponsive) as documented by the referring hospital

#### Element Values

- Alert
- Verbal Stimuli
- Responds to pain
- Unresponsive
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the patients level of consciousness was not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.12 - Glasgow Eye

#### Definition

Indicate the patients Glasgow Coma Score (Eye) as documented by the referring facility

#### Element Values

- 1 - No Eye Movement When Assessed
- 2 - Open Eyes in Response to Painful Stimulation
- 3 - Opens Eyes in Response to Verbal Stimulation
- 4 - Opens Eyes Spontaneously
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale The appropriate numeric score may be listed Eg the chart indicates: "Patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded GCS Eye was not measured or documented

## STATE/HOSPITAL ELEMENT

### Referring - TR33.13.2 - Glasgow Verbal

#### Definition

Indicate the patients Glasgow Coma Score (Verbal) as documented by the referring facility

#### Element Values

- 1 - No Verbal Response
- 2 - Incomprehensible Sounds
- 3 - Inappropriate Words
- 4 - Confused
- 5 - Oriented
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the 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 EG the chart indicates: "Patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

## STATE/HOSPITAL ELEMENT

### Referring - TR33.14.2 - Glasgow Motor

#### Definition

Indicate the patients Glasgow Coma Score (Motor) as documented by the referring facility

#### Element Values

- 1 - No Motor Response
- 2 - Extension to Pain
- 3 - Flexion to Pain
- 4 - Withdrawal from Pain
- 5 - Localizing Pain
- 6 - Obeys Commands
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the 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 Eg the chart indicates: "Patient withdraws from a painful stimulus" a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.16 - GCS Qualifier**

**Definition**

Indicate any documentation of factors that potentially affected the GCS Assessment as documented by the referring facility

**Element Values**

- |                                      |  |
|--------------------------------------|--|
| ▪ Patient Chemically Sedated         | ▪ Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye |
| ▪ Obstruction to the Patient Eye     | ▪ Not Applicable   |
| ▪ Patient Intubated                  | ▪ Not Known/Not Recorded   |
| ▪ Valid GCS: Legitimate              |  |
| ▪ Intubated and chemically paralyzed |  |

**Data Format**

[COMBO] Multiple-Choice

**Additional Information**

- Identifies treatments given to the patient that may affect the GCS Assessment This field does not apply to self-medications the patient may administer (ie, ETOH, prescriptions, ect)
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given For example, succinylcholine's effects last for only 5-10 minutes
- Report all that apply (Select control on your keyboard and select each applicable field value using the mouse)
- If the GCS Assessment Qualifiers are not documented, select "Not Known/Not Recorded"

## STATE/HOSPITAL ELEMENT

### Referring - TR33.15 - Manual GCS

#### Definition

Indicate the patients Total GCS Score as documented by the referring facility

#### Element Values

Relevant value for the data element as long as it is between 3-15

#### Data Format

[NUMBER]

#### Additional Information

- If the manual GCS is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.50 - GCS Total Calc

#### Definition

Total GCS Score using the information indicated in the previous fields: Glasgow Eye, Glasgow Verbal, and Glasgow Motor

#### Element Values

Auto populated field based on documentation from previous fields: Glasgow Eye, Glasgow Verbal, and Glasgow Motor

#### Data Format

[STRING]

#### Additional Information

- If the previous fields (Glasgow Eye, Glasgow Verbal, and Glasgow Motor) were not documented, this field will be left blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.17 - Manual RTS

#### Definition

Indicate the Revised Trauma Score as documented by the referring facility

#### Element Values

Relevant value for the data element as long as it is between does not exceed 12

#### Data Format

[NUMBER]

#### Additional Information

Calculation for RTS is as follows:

$$\rightarrow \text{RTS} = 09368 \text{ GCS} + 07326 \text{ SBP} + 02908 \text{ RR}$$

- Manual GCS overwrites the calculated GCS
- Valid values for GCS, SBP and RR need to be filled out in order to calculate the correct RTS

## STATE/HOSPITAL ELEMENT

### Referring - TR33.51 - RTS Calc

#### Definition

Total RTS calculated using the information indicated in the previous fields: GCS, SBP, RR

#### Element Values

Relevant value for the data element

#### Data Format

[STRING]

#### Additional Information

- If the previous fields (GCS, SBP, RR) were not documented, this field will be left blank

**STATE/HOSPITAL ELEMENT**

Referring - TR33.32 - PTS

**Definition**

Indicate the pediatric trauma score as documented by the referring facility

**Element Values**

Relevant value for the data element as long as it is between -6 and 12

**Data Format**

[NUMBER]

**Additional Information**

Please note that this chart may also be found within the registry by selecting the question mark next to the element

## STATE/HOSPITAL ELEMENT

### Referring - TR33.18 - Hospital ICU

#### Definition

Indicate whether the patient was admitted to the referring hospital's ICU as documented by the referring hospital

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If the Hospital ICU status is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.19 - Hospital OR

#### Definition

Indicate whether the patient was admitted to the referring hospital's Operating Room as documented by the referring hospital

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If the Hospital OR status is not documented by the referring facility, leave blank

**STATE/HOSPITAL ELEMENT**

**Referring - TR33.20 - CPR Performed**

**Definition**

Indicate whether the patient received CPR at the referring facility as documented by the referring facility

**Element Values**

- Yes
- No
- Not Performed
- Not Applicable

**Data Format**

[COMBO] Single-Choice

**Additional Information**

If CPR was not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.21 - CT Head

#### Definition

Indicate whether the patient received a Head CT at the referring facility as documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If a Head CT was not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.22 - CT Abd/Pelvis

#### Definition

Indicate whether the patient received a Abdominal/Pelvis CT at the referring facility as documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If a Abd/Pelvis CT is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.23 - CT Chest

#### Definition

Indicate whether the patient received a Chest CT at the referring facility as documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If a Chest CT is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.24 - Abdominal Ultrasound

#### Definition

Indicate whether the patient received an Abdominal Ultrasound at the referring facility as documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If an Abdominal Ultrasound is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.25 - Aortogram

#### Definition

Indicate whether the patient received an Aortogram at the referring facility as documented by the referring facility

#### Element Values

- Positive
- Negative
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If an Aortogram is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.26 - Arteriogram

#### Definition

Indicate whether the patient received an Arteriogram at the referring facility as documented by the referring facility

#### Element Values

- Positive
- Negative
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If an Arteriogram is not documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.27 - Airway Management

#### Definition

Indicate whether the patient received any method of airway management as documented by the referring facility

#### Element Values

- |                       |                          |
|-----------------------|--------------------------|
| ▪ Non-Rebreather Mask | ▪ Oral Airway            |
| ▪ Nasal Cannula       | ▪ Oral ETT               |
| ▪ CPAP                | ▪ Trach                  |
| ▪ Bag & Mask          | ▪ Not Performed          |
| ▪ Combitube           | ▪ EOA                    |
| ▪ Crico               | ▪ Not Applicable         |
| ▪ LMA                 | ▪ Not Known/Not Recorded |
| ▪ Nasal ETT           |                          |

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If no airway management method has been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.28 - Referring Hospital Medication Given

#### Definition

Indicate whether the patient received medication as documented by the referring facility

#### Element Values

<ul style="list-style-type: none"> <li>▪ Other Vasoactive Agent</li> <li>▪ Other Opiate/Narcotic</li> <li>▪ Other Benzodiazepine</li> <li>▪ Other Antiseizure</li> <li>▪ Other Antihypertensive</li> <li>▪ Other Antibiotic (instead of antibiotic)</li> <li>▪ Levetiracetam (Keppra)</li> <li>▪ Ketamine</li> <li>▪ Hypertonic Solution</li> <li>▪ CT Contrast</li> <li>▪ Calcium Gluconate</li> <li>▪ Not Applicable</li> </ul>	<ul style="list-style-type: none"> <li>▪ ACLS drugs</li> <li>▪ Not Available</li> <li>▪ Adenosine</li> <li>▪ Albuterol</li> <li>▪ Amiodarone</li> <li>▪ Aspirin (ASA)</li> <li>▪ Ativan (Lorazepam)</li> <li>▪ Atropine</li> <li>▪ Atrovent (Ipratropium)</li> <li>▪ Benadryl (Diphenhydramine)</li> <li>▪ Colloid Solution</li> <li>▪ Compazine (Prochlorperazine)</li> <li>▪ Crystalloid Solution</li> </ul>	<ul style="list-style-type: none"> <li>▪ Decadron (Dexamethasone)</li> <li>▪ Defibrillation</li> <li>▪ Demerol (Meperidine)</li> <li>▪ Dextrose (Glucose)</li> <li>▪ Dopamine</li> <li>▪ Epinephrine (Aqueous)</li> <li>▪ External pacemaker</li> <li>▪ Fentanyl</li> <li>▪ Glucagon</li> <li>▪ Heparin</li> <li>▪ Lasix (Furosemide)</li> <li>▪ Lidocaine</li> <li>▪ Magnesium Sulfate</li> <li>▪ Methylprednisolone</li> </ul>	<ul style="list-style-type: none"> <li>▪ Morphine Sulfate</li> <li>▪ Narcan (Naloxone)</li> <li>▪ Needle decompression of chest</li> <li>▪ Nitroglycerin</li> <li>▪ Oxygen</li> <li>▪ Pelvic Wrap</li> <li>▪ Prasugrel (Effient)</li> <li>▪ Sodium Bicarbonate</li> <li>▪ Not Known/Not Recorded</li> <li>▪ Valium (Diazepam)</li> <li>▪ Tissue Plasminogen Activator (tPA)</li> <li>▪ Versed (Midazolam)</li> <li>▪ Zofran (Ondansetron)</li> </ul>
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#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

If medications have not been documented by the referring hospital, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.29 - Destination Determination

#### Definition

Indicate the reason the referring hospital transported the patient to your facility as it is documented by the referring facility

#### Element Values

- Hospital of Choice
- Specialty Resource Center
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If the destination determination has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.33 - CT Cervical

#### Definition

Indicate whether the patient received a CT Cervical Scan at the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If CT Cervical has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.34 - Imaging Head

#### Definition

Indicate whether the patient received imaging of the head by the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If imaging has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.35 - Imaging Chest

#### Definition

Indicate whether the patient received imaging of the chest by the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If imaging has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.36 - Imaging Abd/Pelvis

#### Definition

Indicate whether the patient received imaging of the abdomen/pelvis by the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If imaging has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.37 - Echo

#### Definition

Indicate whether the patient received an echo by the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If an Echo has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.38 - TPA Administered

#### Definition

Indicate whether TPA was administered by the referring facility as it is documented by the referring facility

#### Element Values

- Yes
- No
- NC-Documented reason
- Not Applicable
- Not Available
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If TPA Administered has not been documented by the referring facility, leave blank

## STATE/HOSPITAL ELEMENT

### Referring - TR33.39 - Sent to Cath Lab

#### Definition

Indicate whether the patient was sent to the cath lab by the referring facility as it is documented by the referring facility

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If there is no documentation regarding the cath lab by the referring facility, leave blank

# ED/Acute Care Tab Elements

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.30 - Direct Admit to Hospital

#### Definition

Was the patient admitted to the hospital directly?

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

This field should be marked NO unless this patient bypassed the ED and was directly admitted to the facility

## NTDB & STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR18.55 - Date Arrived in ED/Acute Care

#### Definition

Indicate the date the patient arrived in the ED -or- was admitted directly into the hospital

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR18.56 - Time Arrived in ED/Acute Care

#### Definition

Indicate the time the patient arrived in the ED - or- was admitted directly into the hospital

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED If patient was directly admitted to the hospital, enter time patient was admitted to the hospital
- Collected as HH:MM military time

**STATE/HOSPITAL ELEMENT**

**ED/Acute Care - TR18.131 - ED Attending MD/Staff**

**Definition**

Indicate the ED attending Medical Doctor/Staff

**Element Values**

Relevant value for the data element

**Data Format**

[COMBO] Single-Choice

**Additional Information**

Report writer:TR18131 (different title)

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR18.132 - ED Attending MD/Staff Service Type

#### Definition

Indicate the service type for the attending Medical Doctor/ Staff

#### Element Values

- Emergency Medicine
- Trauma Nurse

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Default to Emergency Medicine
- Report writer: TR18132 (different title)

## NTDB & STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.41 - Decision to Discharge/Transfer Date

#### Definition

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

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Date is the date of death as indicated on the patient's death certificate
- If ED Discharge Disposition is 10 Left Against Medical Advice, report the date the patient signed the AMA form. If a patient signature was not obtained on the eAMA form, report the date it was noted in the medical record the patient indicated that they were going to leave AMA
- If the decision to discharge date is unknown, leave blank

## NTDB & STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.42 - Decision to Discharge/Transfer Time

#### Definition

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

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate
- If ED Discharge Disposition is 10 Left Against Medical Advice, report the time the patient signed the AMA form. If a patient signature was not obtained on the AMA form, report the time it was noted in the medical record the patient indicated that they were going to leave AMA
- If the decision to discharge time is unknown, leave blank

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.25 - Date Discharged from ED

#### Definition

Indicate the date the patient was physically discharged from the ED or transferred to an inpatient unit/OR

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY
- Used to auto-generate an additional calculated field: Length of Stay (elapsed time from ED admit to ED discharge)

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.26 - Time Discharged from ED

#### Definition

Indicate the time the patient was physically discharged from the ED or transferred to inpatient unit/OR

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated field: Length of Stay: elapsed time from ED admit to ED discharge)

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.99 - Length of Stay in ED (Physical D/C)

#### Definition

Indicate the total minutes the patient was staying in the ED (Total Minutes)

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

Auto-generated field calculated based on previous fields entered within the registry (Date/Time Arrived in ED/Acute Care - Date/Time patient was physically discharged from ED/Acute Care)

## NTDB & STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.27 - ED Disposition

#### Definition

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

#### Element Values

- |   |                                  |                                   |
|---|----------------------------------|-----------------------------------|
| ▪ Left without being seen/eloped                        | ▪ Deceased/Expired               | ▪ Transferred to another hospital |
| ▪ Floor bed (general admission, non specialty unit bed) | ▪ Other (jail, institution, ect) | ▪ Floor (Labor & Delivery)        |
| ▪ Telemetry/step-down unit (less acuity than ICU)       | ▪ Operating room                 | ▪ Radiology                       |
| ▪ Home with services                                    | ▪ Intensive Care Unit            | ▪ Not Applicable                  |
|   | ▪ Home without services          | ▪ Not Known/Not Recorded          |
|   | ▪ AMA                            |                                   |

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- The null value "Not Applicable" is used if the patient is directly admitted to the hospital
- If ED Discharge Disposition is included on the list below, then Hospital Discharge Date, Time, and Disposition will lock and not be available for data entry
  - Home with services
  - Deceased/Expired
  - Other (jail, institution, ect)
  - Home without services
  - AMA
  - Transferred to another hospital
- If multiple orders were written, report the final disposition order

## STATE/HOSPITAL ELEMENT

ED/Acute Care - TR18.98 - Admitting MD/Staff

### Definition

Indicate the admitting Medical Doctor/Staff that admitted the patient to your hospital from the ED

### Element Values

Relevant value for the data element

### Data Format

[COMBO] Single-Choice

### Additional Information

Do not complete this field if the patient was not admitted to your hospital from the ED

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR18.99 - Admitting Service

#### Definition

Indicate the service type for the attending Medical Doctor/ Staff that admitted the patient to your hospital from the ED

#### Element Values

Relevant value for the data element

#### Data Format

[COMBO] Single-Choice

#### Additional Information

Do not complete this field if the patient was not admitted to your hospital from the ED

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.21 - Trauma Team Activation

#### Definition

Indicate whether the facility-specific trauma activation/alert activated

#### Element Values

- Not Activated
- Level 1 (Full)
- Level 2 (Partial)
- Level 3 (Stand By)

#### Data Format

[RADIO]

#### Additional Information

- This should be the initial level/alert that was sent out If the level was upgraded put the first activation that went out
- If the patient was a direct admit, select "Not Activated"
- Not Applicable should not be used for this field
- If your facility has only one level of activation, select Level 1
- If you facility has two levels of activation, Level 1 is associated with the highest level

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.78.1 - Date Changed

#### Definition

Indicate the date the trauma team activation level was changed

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY
- If the trauma team activation level was not changed, leave blank

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.78.1.1 - Time Changed

#### Definition

Indicate the time the trauma team activation level was changed

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time
- If the trauma team activation level was not changed, leave blank

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.78.2 - Upgrade/Downgrade

#### Definition

Indicate whether the trauma team activation level was changed

#### Element Values

- Yes, Upgraded
- Yes, Downgraded
- Not Known/Not Recorded
- Select

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the trauma team activation level was not changed, leave field "select"

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.78.3 - New Activation Level

#### Definition

Indicate the new trauma team activation level

#### Element Values

- Not Known/Not Recorded
- Not Activated
- Non-Trauma
- Level Unknown
- Level 3
- Level 2
- Level 1
- Consultation
- Select

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the activation was cancelled, select "Not Activated"
- If your facility has only one level of activation, select Level 1
- If your facility has two levels of activation, Level 1 is associated with the highest level
- If the activation level was not updated, select "Not Applicable"

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.78.4 - Old Activation Level

#### Definition

Indicate the old trauma team activation level

#### Element Values

- Not Known/Not Recorded
- Not Activated
- Non-Trauma
- Level Unknown
- Level 3
- Level 2
- Level 1
- Consultation
- Select

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If the activation was cancelled, select "Not Activated"
- If your facility has only one level of activation, select Level 1
- If your facility has two levels of activation, Level 1 is associated with the highest level
- If the activation level was not updated, select "Not Applicable"

## STATE/HOSPITAL ELEMENT

### ED/Acute Care - TR17.29 - Consulting Services

#### Definition

Indicate whether the patient received consulting services while in your facility?

#### Element Values

- Select
- Yes
- No

#### Data Format

[COMBO] Single-Choice

#### Additional Information

# Initial Assessment Tab Elements

## State/Hospital Element

### Initial Assessment - TR18.104 - Initial Assessment Vitals Date

#### Definition

Indicate the date the vitals were performed

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY

## State/Hospital Element

### Initial Assessment - TR18.110 - Initial Assessment Vitals Time

#### Definition

Indicate the time the vitals were performed

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time

## NTDB & STATE

### Initial Assessment - TR18.11 - Systolic Blood Pressure

#### Definition

Indicate the first systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

Relevant value for the data element as long as it does not exceed 299

#### Data Format

[NUMBER]

#### 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
- If not known select "Not Known/Not Recorded"

## State/Hospital Element

### Initial Assessment - TR18.13 - Diastolic Blood Pressure

#### Definition

Indicate the first diastolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

Relevant value for the data element as long as it does not exceed 299

#### Data Format

[NUMBER]

#### 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
- If not known select "Not Known/Not Recorded"

## NTDB & STATE

### Initial Assessment - TR18.2 - Pulse Rate

#### Definition

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

#### Element Values

Relevant value for the data element as long as it does not exceed 300

#### Data Format

[NUMBER]

#### 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
- If not known select "Not Known/Not Recorded"

## NTDB & STATE

### Initial Assessment - TR18.30 - Temperature (Celcius)

#### Definition

Indicate the first recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment
- Entry in one unit will auto-populate the other
- If temperature is not known, select "Not Known/Not Recorded", and select "Not Known/Not Recorded" for Route

## NTDB & STATE

### Initial Assessment - TR18.30.1 - Temperature (Fahrenheit)

#### Definition

Indicate the first recorded temperature (in degrees Fahrenheit) in the ED/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment
- Entry in one unit will auto-populate the other
- If temperature is not known, select "Not Known/Not Recorded", and select "Not Known/Not Recorded" for Route

## NTDB & STATE

### Initial Assessment - TR18.147 - Temperature Route

#### Definition

Indicate the initial emergency department/hospital temperature measurement route

#### Element Values

- Typanic
- Temporal Artery
- Rectal
- Other
- Oral
- Foley
- Axillary
- Select
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment
- Entry in one unit will auto-populate the other
- If temperature is not known, select "Not Known/Not Recorded", and select "Not Known/Not Recorded" for Route

## NTDB & STATE

### Initial Assessment - TR18.31 - Oxygen Saturation

#### Definition

Indicate the first recorded oxygen saturation in ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage)

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### 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
- If Not Known, select "Not Known/Not Recorded"

## NTDB & STATE

### Initial Assessment - TR18.7 - Respiratory Rate

#### Definition

Indicate the first recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute)

#### Element Values

Relevant value for the data element as long as it does not exceed 120

#### Data Format

[NUMBER]

#### Additional Information

- If available, complete additional field: "Resp. Assistance"
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- If not known, select "Not Known/Not Recorded" and select "Not Applicable" for "Resp. Assistance"

## NTDB & STATE

### Initial Assessment - TR18.109 - Supplemental Oxygen

#### Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/Hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival

#### Element Values

- Yes
- No
- Room Air
- Respiratory Arrest
- Intubated
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

## State/Hospital Element

### Initial Assessment - TR18.135 - RTS Calc

#### Definition

Indicate the first recorded calculation of the Revised Trauma Score (RTS) Total

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

## State/Hospital Element

### Initial Assessment - TR21.10 - PTS

#### Definition

Indicate the first recorded calculation of the Pediatric Trauma Score (PTS) Total

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Please note that this will only be applicable for pediatric patients

## NTDB & STATE

### Initial Assessment - TR18.14 - Glasgow Eye

#### Definition

Indicate first recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Eye is documented
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival

## NTDB & STATE

### Initial Assessment - TR18.15.2 - Glasgow Verbal

#### Definition

Indicate first recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival

#### Element Values

- |                               |                |                          |
|-------------------------------|----------------|--------------------------|
| ▪ 1 - No verbal response      | ▪ 4 – Confused | ▪ Not Applicable         |
| ▪ 2 - Incomprehensible sounds | ▪ 5 - Oriented | ▪ Not Known/Not Recorded |
| ▪ 3 - Inappropriate words     |                |                          |

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient’s Initial ED/Hospital GCS –Verbal was not measured within 30 minutes or less of ED/Hospital arrival.

## NTDB & STATE

### Initial Assessment - TR18.16.2 - Glasgow Motor

#### Definition

Indicate first recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Motor is reported
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/Hospital arrival

<b>NTDB &amp; STATE</b>
<b>Initial Assessment - TR18.21 - GCS Qualifier</b>

<b>Definition</b>
Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival.

- |   |
|---|
| <b>Element Values</b>   |
| <ul style="list-style-type: none"> <li>▪ Select</li> <li>▪ Patient Chemically Sedated or Paralyzed</li> <li>▪ Obstruction to the Patients Eye</li> <li>▪ Patient Intubated</li> <li>▪ Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye</li> </ul> |

<b>Data Format</b>
[COMBO] Multiple-Choice

<b>Additional Information</b>
<ul style="list-style-type: none"> <li>▪ 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.)</li> <li>▪ 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</li> <li>▪ Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record</li> <li>▪ 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</li> <li>▪ Please note that first recorded hospital vitals do not need to be from the same assessment.</li> <li>▪ Report all that apply</li> <li>▪ The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported</li> <li>▪ The null value "Not Known/Not Recorded" is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.</li> </ul>

## NTDB & STATE

### Initial Assessment - TR18.22 - GCS Total Calc

#### Definition

Indicate first recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival

#### Element Values

Relevant value for the data element

#### Data Format

String

#### Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15 IF there is no other contradicting documentation
- Please note that first recorded/hospital vitals do not need to be from the same assessment
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal were not measured within 30 minutes or less of ED/Hospital arrival

## NTDB & STATE

### Initial Assessment - TR18.40.2 - Glasgow Coma Score 40 (Eye)

#### Definition

Indicate first recorded Glasgow Coma Score 40 (Eye) in the Ed/hospital within 30 minutes or less of ED/hospital arrival

#### Element Values

- |                    |                   |                          |
|--------------------|-------------------|--------------------------|
| ▪ Select           | ▪ 2 - To Pressure | ▪ Not Applicable         |
| ▪ 0 - Not Testable | ▪ 3 - To Sound    | ▪ Not Available          |
| ▪ 1 - None         | ▪ 4 - Spontaneous | ▪ Not Known/Not Recorded |

#### Data Format

[COMBO]Single-Choice

#### 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 "0. Not Testable" if unable to assess (e.g. swelling to eye(s))
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Eye is reported
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40- Eye was not measured within 30 minutes or less of ED/hospital arrival

<b>NTDB &amp; STATE</b>
<b>Initial Assessment - TR18.41.2 - Glasgow Coma Score 40 (Verbal)</b>

<b>Definition</b>
Indicate first recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of ED/hospital arrival

- |  |   |   |
|--|---|---|
| <b>Element Values</b>  |   |   |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>▪ Select</li> <li>▪ 0 - Not Testable</li> <li>▪ 1 - None</li> <li>▪ 2 - Sounds</li> <li>▪ 3 - Words</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>▪ 4 - Confused</li> <li>▪ 5 - Oriented</li> <li>▪ Not Applicable</li> <li>▪ Not Available</li> <li>▪ Not Known/Not Recorded</li> </ul> </td> </tr> </table> | <ul style="list-style-type: none"> <li>▪ Select</li> <li>▪ 0 - Not Testable</li> <li>▪ 1 - None</li> <li>▪ 2 - Sounds</li> <li>▪ 3 - Words</li> </ul>                         | <ul style="list-style-type: none"> <li>▪ 4 - Confused</li> <li>▪ 5 - Oriented</li> <li>▪ Not Applicable</li> <li>▪ Not Available</li> <li>▪ Not Known/Not Recorded</li> </ul> |
| <ul style="list-style-type: none"> <li>▪ Select</li> <li>▪ 0 - Not Testable</li> <li>▪ 1 - None</li> <li>▪ 2 - Sounds</li> <li>▪ 3 - Words</li> </ul>  | <ul style="list-style-type: none"> <li>▪ 4 - Confused</li> <li>▪ 5 - Oriented</li> <li>▪ Not Applicable</li> <li>▪ Not Available</li> <li>▪ Not Known/Not Recorded</li> </ul> |   |

<b>Data Format</b>
[COMBO]Single-Choice

- |  |
|--|
| <b>Additional Information</b>  |
| <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ Report Field Value "0. Not Testable" if unable to assess (e.g. patient is intubated)</li> <li>▪ The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Verbal is reported</li> <li>▪ 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</li> </ul> |

## NTDB & STATE

### Initial Assessment - TR18.42.2 - Glasgow Coma Score 40 (Motor)

#### Definition

Indicate first recorded Glasgow Coma Score 40 (Motor) within 30 minutes or less of ED/hospital arrival

#### Element Values

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>▪ Select</li> <li>▪ 0 - Not Testable</li> <li>▪ 1 - None</li> <li>▪ 2 - Extension</li> </ul> | <ul style="list-style-type: none"> <li>▪ 3 - Abnormal Flexion</li> <li>▪ 4 - Normal Flexion</li> <li>▪ 5 - Localizing</li> <li>▪ 6 - Obeys Commands</li> </ul> | <ul style="list-style-type: none"> <li>▪ Not Applicable</li> <li>▪ Not Available</li> <li>▪ Not Known/Not Recorded</li> </ul> |
|---|--|---|

#### Data Format

[COMBO]Single-Choice

#### 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 "0. Not Testable" if unable to assess (e.g. neuromuscular blockade)
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Motor is reported
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS 40 - Motor was not measured within 30 minutes or less of ED/hospital arrival

## State/Hospital Element

### Initial Assessment - TR18.44.1 - GCS 40 Total Calc

#### Definition

Total GCS Score using the information indicated in the previous fields: Glasgow Eye, Glasgow Verbal, and Glasgow Motor

#### Element Values

Autopopulated field based on documentation from previous fields: Glasgow Eye, Glasgow Verbal, and Glasgow Motor

#### Data Format

[STRING]

#### Additional Information

- If the previous fields (Glasgow Eye, Glasgow Verbal, and Glasgow Motor) were not documented, this field will be left blank

## State/Hospital Element

### Initial Assessment - TR18.44 - GCS 40 Manual Total

#### Definition

Total GCS Score 40 using the information indicated in the previous fields: Glasgow Eye 40, Glasgow Verbal 40, and Glasgow Motor 40

#### Element Values

Autopopulated field based on documentation from previous fields: Glasgow Eye 40, Glasgow Verbal 40, and Glasgow Motor 40

#### Data Format

[STRING]

#### Additional Information

- If the previous fields (Glasgow Eye 40, Glasgow Verbal 40, and Glasgow Motor 40) were not documented, this field will be left blank

## State/Hospital Element

### Initial Assessment - TR18.53 - AVPU

#### Definition

Indicate the patients first recorded level of consciousness using the AVPU scale (Alert, Verbal, Pain, Unresponsive) within 30 minutes or less of ED/Hospital arrival

#### Element Values

- Alert
- Verbal Stimuli
- Responds to pain
- Unresponsive
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

## State/Hospital Element

### Initial Assessment - TR14.36 - Airway Management

#### Definition

Indicate whether the patient received any method of airway management within 30 minutes or less of ED/hospital arrival

#### Element Values

- |                       |               |                          |
|-----------------------|---------------|--------------------------|
| ▪ Simple Mask         | ▪ Bag & Mask  | ▪ Oral ETT               |
| ▪ Arrived Intubated   | ▪ Combitube   | ▪ Trach                  |
| ▪ Bipap               | ▪ Crico       | ▪ Not Performed          |
| ▪ Non-Rebreather Mask | ▪ LMA         | ▪ EOA                    |
| ▪ Nasal Cannula       | ▪ Nasal ETT   | ▪ Not Applicable         |
| ▪ CPAP                | ▪ Oral Airway | ▪ Not Known/Not Recorded |

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If no airway management method has been documented, leave blank

## State/Hospital Element

### Initial Assessment - TR18.71 - CPR Performed

#### Definition

Indicate whether the patient received CPR within 30 minutes or less of ED/Hospital arrival

#### Element Values

- CPR in Progress, continued
- Yes
- No
- Not Applicable
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

## State/Hospital Element

### Initial Assessment - TR18.176 - Backboard Removed Date

#### Definition

Indicate the date the backboard was removed from the patient

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

If no backboard was used, leave blank

## State/Hospital Element

### Initial Assessment - TR18.177 - Backboard Removed Time

#### Definition

Indicate the time the backboard was removed from the patient

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

If no backboard was used, leave blank.

## State/Hospital Element

### Initial Assessment - TR22.20 - Blood Product Location

#### Definition

Indicate the location the blood products were used for the patient

#### Element Values

- Critical Care Unit
- Elsewhere
- Emergency Department
- Floor
- ICU
- Operating Room
- Prehospital
- Referring facility
- Unspecified

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.21 - Blood Product

#### Definition

Indicate the type of blood product that was used on the patient

#### Element Values

- Cryoprecipitate
- Fresh Frozen Plasma
- Massive Blood Transfusion Protocol Initiated
- Packed Red Blood Cells
- Platelets
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.22 - Units of Blood

#### Definition

Indicate the total units of blood given to the patient

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.23 - Blood Product Measurement

#### Definition

Indicate the measurement used to document the patient's blood product transfusion (Units, CCs [MLs])

#### Element Values

- Units
- CCs (MLs)

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.14 - Blood Ordered Date

#### Definition

Indicate the date the first unit of blood was ordered for the patient

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.17 - Blood Ordered Time

#### Definition

Indicate the time the first unit of blood was ordered for the patient

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.15 - Crossmatch Date

#### Definition

Indicate the date the first unit of blood was crossmatched

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR22.18 - Crossmatch Time

#### Definition

Indicate the time the first unit of blood was crossmatched

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

If blood products were not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - SK38.203.1 - Patient's Anticoagulant Meds

#### Definition

Indicate the patients anticoagulant medication

#### Element Values

- Warfarin (Coumadin)
- Unfractionated heparin IV
- Ticagrelor (Brillinta)
- Rivaroxaban
- Prasugrel (Effient)
- Plavix (Clopidogrel)
- Lepirudin (Refludan)
- Full dose LMW Heparin
- Fondaparinux (Arixtra)
- Dabigatran (Pradaxa)
- Argatroban
- Apixaban (Eliquis)
- Other Anticoagulant

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If the patient is not on anticoagulant medication, leave blank

## State/Hospital Element

### Initial Assessment - SK38.163 - Anti-Coagulant Reversal Medication Administered

#### Definition

Indicate the treatment used to reverse International Normalization Ratio (INR) with procoagulant

#### Element Values

- Yes
- No

#### Data Format

[RADIO]

#### Additional Information

If the patient is not on anticoagulant medication, leave blank

## State/Hospital Element

### Initial Assessment - TR18.189 - Antibiotic Therapy

#### Definition

Indicate whether intravenous antibiotic therapy was administered to the patient within 24 hours after first hospital encounter

#### Reporting Criterion

Report on all patients with any open fracture(s)

#### Element Values

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

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- The null value “Not Applicable” is reported for patients that do not meet the reporting criterion
- Report intravenous antibiotic therapy that was administered to the patient within 24 hours after first hospital encounter, at either your facility or the transferring facility
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines

## State/Hospital Element

### Initial Assessment - TR18.190 - First Antibiotic Administration Date

#### Definition

Indicate the date the first intravenous antibiotic therapy was administered

#### Reporting Criterion

Report on all patients with any open fracture(s)

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- If the patient does not have an open fracture, leave blank
- If the patient did not receive intravenous antibiotic therapy, leave blank
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines

## State/Hospital Element

### Initial Assessment - TR18.190.1 - First Antibiotic Administration Time

#### Definition

Indicate the time the first intravenous antibiotic therapy was administered

#### Reporting Criterion

Report on all patients with any open fracture(s)

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- If the patient does not have an open fracture, leave blank
- If the patient did not receive intravenous antibiotic therapy, leave blank
- Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines

## NTDB & STATE

### Initial Assessment - TR18.46 - Alcohol Use Indicator/Alcohol Screen

#### Definition

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

#### Element Values

- Select
- Yes
- No (Not tested)
- No (Confirmed by test)
- No
- Yes (Confirmed by test [trace levels])
- Yes (Confirmed by test [beyond legal limits])
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

## State/Hospital Element

### Initial Assessment - TR18.45 - Drug Use Indicator

#### Definition

Indicate use of drugs by the patient within 24 hours after first hospital encounter

#### Element Values

- Select
- No (Confirmed by test)
- Yes (Confirmed by test [prescription drug])
- Yes (Confirmed by test [illegal use drug])
- Not Performed
- Not Known/Not Recorded

#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- Does not include medications given at ED/Hospital on this admission
- If drug use is suspected, but not confirmed by test, record null value "Not Known/Not Recorded"

<b>NTDB &amp; STATE</b>
<b>Initial Assessment - TR18.91 - Drug Screen</b>

<b>Definition</b>
Indicate first recorded positive drug screen results within 24 hours after first hospital encounter (Select all that apply)

- |   |   |  |  |
|---|---|--|--|
| <b>Element Values</b>   |   |  |  |
| <ul style="list-style-type: none"> <li>▪ TCA (Tricyclic Antidepressant)</li> <li>▪ OXY (Oxycodone)</li> <li>▪ OPI (Opioid)</li> <li>▪ MDMA (Ecstasy)</li> <li>▪ AMP (Amphetamine)</li> <li>▪ Antidepressants (including tricyclics)</li> <li>▪ BAR (Barbiturate)</li> </ul> | <ul style="list-style-type: none"> <li>▪ BZO (Benzodiazepines)</li> <li>▪ COC (Cocaine)</li> <li>▪ Ethanol</li> <li>▪ Marijuana (THC/Cannabis)</li> <li>▪ mAMP (Methamphetamine)</li> </ul> | <ul style="list-style-type: none"> <li>▪ Opiates (including Propoxyphene)</li> <li>▪ PCP (Phencyclidine)</li> <li>▪ Amitriptyline</li> <li>▪ Morphine</li> <li>▪ Diazepam</li> <li>▪ Meprobamate</li> <li>▪ Codeine</li> <li>▪ Heroin</li> </ul> | <ul style="list-style-type: none"> <li>▪ MTD (Methadone)</li> <li>▪ Imipramine</li> <li>▪ Doxepin</li> <li>▪ Hashish</li> <li>▪ Sedatives - Hypnotics</li> <li>▪ Not Tested</li> <li>▪ None</li> <li>▪ Not Known/Not Recorded</li> </ul> |

<b>Data Format</b>
[SLUSH] Multiple-Choice

- |   |
|---|
| <b>Additional Information</b>   |
| <ul style="list-style-type: none"> <li>▪ Record positive drug screen results from drug screening in the ED</li> <li>▪ "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</li> <li>▪ If multiple drugs are detected, only report drugs that were NOT administered at any facility (or setting) treating this patient event</li> <li>▪ You may enter more than one drug, selections are made in a pick-list</li> </ul> |

**State/Hospital Element**

**Initial Assessment - TR18.95 - Hematocrit**

**Definition**

Indicate the volume of red blood cells in the patients blood

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

## State/Hospital Element

### Initial Assessment - TR18.93 - Base Deficit

#### Definition

Indicate whether the patient had a value greater than 4 for the reported components of arterial or venous blood gases

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- This number may be reported by the lab as Base Deficit or as Base Excess with a negative value

## State/Hospital Element

Initial Assessment - TR18.117 - Bicarb - HCO3

### Definition

Indicate the level of Bicarb - HCO3 found in the patients blood

### Element Values

Relevant value for the data element

### Data Format

[NUMBER]

### Additional Information

## State/Hospital Element

### Initial Assessment - TR18.160 - Radiology Type

#### Definition

Indicate the type of radiology procedure that was used for the patient

#### Element Values

- X-Ray
- Transesophageal Echocardiogram
- Transcranial Dopler
- MRI
- FAST (Focused Assessment with Sonography in Trauma)
- EFAST (Extended Focused Assessment with Sonography in Trauma)
- Echo
- CT-Perfusion
- CT- Angiogram
- CT

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If radiology was not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR18.143 - Radiology Region

#### Definition

Indicate the body region on which the specified radiology procedure was performed

#### Element Values

- Abdomen
- Angiogram
- Brain
- Chest
- Head/Face
- Limbs
- Neck
- Orbits
- Other
- Pelvis
- Spine - Cervical
- Spine - Lumbar
- Spine - Thoracic

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If radiology was not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR18.163 - Date Radiology Performed

#### Definition

Indicate the date the radiology procedure was performed

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

If radiology was not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR18.163.1 - Time Radiology Performed

#### Definition

Indicate the time the radiology procedure was performed

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

If radiology was not used for the patient, leave blank

## State/Hospital Element

### Initial Assessment - TR18.161 - Radiology Results

#### Definition

Indicate the results from the radiology procedure that was performed on the patient

#### Element Values

- Inconclusive Result
- Negative
- Not Known/Not Recorded
- Positive

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If radiology was not used for the patient, leave blank

# Diagnosis Tab Elements

## NTDB & STATE/HOSPITAL ELEMENT

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

#### Definition

Indicate the diagnoses related to all identified injuries

#### Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-99, T07, T14, T20-T28 and T30-32
- The maximum number of diagnoses that may be reported for an individual patient is 50

#### Data Format

[Combo] Multiple-Choice

#### Additional Information

ICD-10-CM codes pertaining to other medical conditions (eg, CVA, MI, co-morbidities, ect) may also be included in this field

**STATE/HOSPITAL ELEMENT**

**Diagnosis - TR200.120 - Diagnosis Comments**

**Definition**

Indicate any comments as they relate to the ICD 10 Diagnosis

**Element Values**

Relevant value for the data element

**Data Format**

[TEXT]

**Additional Information**

If there are no comments relating to the ICD 10 Diagnosis, leave blank

## NTDB & STATE/HOSPITAL ELEMENT

### Diagnosis - TR200.14.1 - AIS Code

#### Definition

Indicate the Abbreviated Injury Scale (AIS) codes that reflect the patient's injuries

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

No additional information

## NTDB & STATE/HOSPITAL ELEMENT

### Diagnosis - AIS Version

#### Definition

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

#### Element Values

- AIS 05, Update 08
- AIS 2015

#### Data Format

[COMBO] Single-Choice

#### Additional Information

No additional information

## STATE/HOSPITAL ELEMENT

### Diagnosis - TR201.0 - Additional AIS Codes

#### Definition

Indicate any additional Abbreviated Injury Scale (AIS) codes that reflect the patient's injuries

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- The predot code is the 6 digits preceding the decimal point in an associated AIS code
- In ImageTrend, this field includes both the AIS PreDot (IS\_01) and AIS Severity (IS\_02) codes:
  - Minor Injury
  - Moderate Injury
  - Serious Injury
  - Severe Injury
  - Critical Injury
  - Maximum Injury, Virtually Unsurvivable
  - Not Possible to Assign

## STATE/HOSPITAL ELEMENT

### Diagnosis - Diagnosis-ISS Region

#### Definition

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

#### Element Values

- Head/Neck Region - TR212
- Face Region - TR215
- Chest Region - TR213
- Abdomen Region - TR216
- Extremities Region - TR214
- Skin/Soft Tissue (External Injury) - TR217

#### Data Format

[NUMBER]

#### Additional Information

- Auto-populated by entering ICD 10 Diagnosis and AIS Code
- Head or neck injuries include injury to the brain or cervical spine, skull or cervical spine fractures
- Facial injuries include those involving the mouth, ears, nose, and facial bones
- Chest injuries include all lesions to internal organs Chest injuries also include those to the diaphragm, rib cage, and thoracic spine
- Abdominal or pelvic contents injuries include all lesions to internal organs Lumbar spine lesions are included in the abdominal or pelvic region
- Injuries to the extremities or to the pelvic or shoulder girdle including sprains, fractures, dislocations, and amputations, except for the spinal column, skull and rib cage
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface

## STATE/HOSPITAL ELEMENT

### Diagnosis - ISS-Injury Severity Score

#### Definition

The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- 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
- It's 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

## STATE/HOSPITAL ELEMENT

### Diagnosis - Probability of Survival

#### Definition

Indicate the probably of survival based on the Trauma Injury Severity Score

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

TRISS (blunt):  $\text{Logit} = -04499 + \text{RTS} * 08085 + \text{ISS} * -00835 + (\text{age Points}) * -17430$

Predicted death rate =  $1 / (1 + e^{-\text{Logit}})$

TRISS (penetrating):  $\text{Logit} = -25355 + \text{RTS} * 09934 + \text{ISS} * -00651 + (\text{age Points}) * -11360$

Predicted death rate =  $1 / (1 + e^{-\text{Logit}})$

Age Points:

Age < 15 years = 0

15 <= Age < 55 = 0

Age >= 55 years = 1

## STATE/HOSPITAL ELEMENT

### Diagnosis - New Injury Severity Score

#### Definition

New injury severity score (NISS) considers the three most severe injuries, regardless of body region

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- This field will be auto-generated based on previous fields
- Recently, researchers have proposed a new injury severity score (NISS) which, unlike the ISS, considers the three most severe injuries, regardless of body region
- The NISS is computed as the simple sum of squares of the three most severe AIS (1990 revision) injuries To date, two studies have reported that the NISS is more predictive of survival and performs better, statistically, than the ISS

# Comorbidity Tab Elements

## NTDB & STATE/HOSPITAL ELEMENT

### Comorbidity - TR21.21 - Co-Morbid Condition

#### Definition

Indicate any pre-existing comorbid factors present prior to patient arrival at the ED/Hospital

#### Element Values

<ul style="list-style-type: none"> <li>▪ Substance Abuse Disorder</li> <li>▪ Pre-Hospital cardiac arrest with CPR</li> <li>▪ Peripheral Arterial Disease (PAD)</li> <li>▪ Myocardial Infarction (MI)</li> <li>▪ Mental/Personality Disorder</li> <li>▪ Chronic renal failure</li> <li>▪ Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)</li> <li>▪ Anticoagulant Therapy</li> <li>▪ Angina Pectoris</li> <li>▪ Advanced directive limiting care</li> <li>▪ Acquired Coagulopathy</li> <li>▪ Currently receiving chemotherapy for cancer</li> <li>▪ Alcohol Use Disorder</li> <li>▪ Alzheimer's Disease</li> <li>▪ Ascites within 30 days</li> <li>▪ Asthma</li> <li>▪ Autoimmune Diseases</li> <li>▪ Bilirubin &gt; 2mg % (on Admission), ESLD</li> <li>▪ Bleeding Disorder</li> <li>▪ Chemotherapy for cancer within 30 days</li> <li>▪ Chronic Alcohol Abuse</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cor Pulmonale</li> <li>▪ Coronary Artery Disease</li> <li>▪ Coumadin Therapy</li> <li>▪ Current smoker</li> <li>▪ Currently requiring or on dialysis</li> <li>▪ Cerebrovascular Accident (CVA)</li> <li>▪ Diabetes mellitus</li> <li>▪ Dialysis (excludes transplant patients)</li> <li>▪ Disseminated cancer</li> <li>▪ Do Not Resuscitate (DNR) status</li> <li>▪ Documented history of cirrhosis</li> <li>▪ Documented Prior History of Pulmonary Disease with Ongoing Active Treatment</li> <li>▪ DVT history</li> <li>▪ Esophageal varices</li> <li>▪ Functionally dependent health status</li> <li>▪ GI (Peptic ulcer disease, GERD)</li> <li>▪ Hemophilia</li> <li>▪ History of angina within past 1 month</li> <li>▪ Congestive heart failure</li> <li>▪ History of Cardiac Surgery</li> </ul>	<ul style="list-style-type: none"> <li>▪ History of myocardial infarction</li> <li>▪ No co-morbid condition present</li> <li>▪ Obesity</li> <li>▪ Organic Brain Syndrome</li> <li>▪ Osteoporosis requiring treatment</li> <li>▪ Other Cardiac Diseases (CAD, CABG, Stent, Pacemaker, Cardiomyopathy, Valvular Heart Disease, Cardiac Dysrhythmias, Cor Pulmonale)</li> <li>▪ Other Liver Diseases (Hepatitis B, Hepatitis C)</li> <li>▪ Pancreatitis</li> <li>▪ Parkinsons Disease</li> <li>▪ Post-splenectomy</li> <li>▪ Pre-existing Anemia</li> <li>▪ Pregnancy</li> <li>▪ Prematurity</li> <li>▪ Pulmonary Embolus history</li> <li>▪ Renal Disease</li> <li>▪ Chronic Obstructive Pulmonary Disease (COPD)</li> <li>▪ Rheumatoid Arthritis</li> <li>▪ Seizures</li> <li>▪ Seizures and Anemia</li> <li>▪ Serum Creatinine &gt; 2mg % (on Admission)</li> <li>▪ Spinal Cord Injury</li> <li>▪ Steroid Use</li> <li>▪ Systemic Lupus Erythematosus</li> <li>▪ Transplants</li> </ul>
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**Wyoming Trauma Registry Data Dictionary v2020.1**

<ul style="list-style-type: none"><li>▪ Dementia</li><li>▪ Chronic Demyelinating Disease</li><li>▪ Drug Use Disorder</li><li>▪ Chronic Obstructive Pulmonary Disease</li><li>▪ Chronic Pulmonary Condition</li><li>▪ Concurrent or Existence of Metastasis</li><li>▪ Congenital Anomalies</li></ul>	<ul style="list-style-type: none"><li>▪ History of myocardial infarction within past 6 months</li><li>▪ Major psychiatric illness</li><li>▪ History of PVD</li><li>▪ History of severe COPD</li><li>▪ HIV/AIDS</li><li>▪ Hypertension</li><li>▪ Inflammatory Bowel Disease</li><li>▪ Insulin Dependent</li><li>▪ Insulin Non-Dependent</li><li>▪ Multiple Sclerosis</li></ul>	<ul style="list-style-type: none"><li>▪ Undergoing Current Therapy</li><li>▪ Cirrhosis</li><li>▪ Other</li><li>▪ Not Applicable</li><li>▪ Not Known/Not Recorded</li></ul>
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<b>Data Format</b>
[COMBO] Single-Choice

<b>Additional Information</b>
<ul style="list-style-type: none"><li>▪ Present prior to ED/Hospital arrival</li><li>▪ The null value "Not Known/Not Recorded" is only reported if no past medical history is available</li></ul>

## NTDB & STATE/HOSPITAL ELEMENT

### Comorbidity - TR21.23 - Co-Morbid Condition Notes

#### Definition

Indicate any additional information about the patient's pre-existing medical conditions

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

If there is no co-morbid conditions for the patient, leave blank

# Procedures Tab Elements

## NTDB & STATE/HOSPITAL ELEMENT

### Procedures - TR200.2 - ICD 10 Procedure

#### Definition

Indicate 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

#### Element Values

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

#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures
- Include only procedures performed at your institution
- Report all procedures performed in the operating room
- Report all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization In this case, report only the first event If there is no asterisk, report each event even if there is more than one
- Note that the hospital may report additional procedures

**STATE/HOSPITAL ELEMENT**

**Procedures - TR22.29 - Procedure Performed Location**

**Definition**

Indicate the hospital location where the procedure was performed on the patient

**Element Values**

- Transport from scene
- Tele
- Step-Down
- Special Procedure Unit
- Scene
- Rehabilitation
- Recovery
- Readmit OR (planned OR)
- Radiology
- PTA (Referring Hospital)
- Prehospital
- Outpatient Clinic
- Other
- Operating Room
- Observation
- Nuclear Medicine
- Minor Surgery Unit
- ICU
- GI Lab
- Floor
- ED
- Catherization Lab
- Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**Additional Information**

- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## STATE/HOSPITAL ELEMENT

### Procedures - TR200.10 - Physician Performing the Procedure

#### Definition

Indicate the name of the physician that performed the procedure on the patient

#### Element Values

Relevant value for the data element

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## STATE/HOSPITAL ELEMENT

### Procedures - TR200.7 - Procedure Comments

#### Definition

Indicate comments as they relate to the operative and selected non-operative procedures that were performed on the patient

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## NTDB & STATE/HOSPITAL ELEMENT

### Procedures - TR200.8 - Date Procedure Performed

#### Definition

Indicate the date that the operative and selected non-operative procedures were performed

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- Collected as MM-DD-YYYY
- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## NTDB & STATE/HOSPITAL ELEMENT

### Procedures - TR200.9 - Time Procedure Performed

#### Definition

Indicate the time that the operative and selected non-operative procedures were performed

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- Collected as HH:MM military time
- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## STATE/HOSPITAL ELEMENT

### Procedures - TR200.6 - Service Type of the Physician

#### Definition

Indicate the service type of the physician that performed the operative and selected non-operative procedures

#### Element Values

- |                          |                               |                     |
|--------------------------|-------------------------------|---------------------|
| ▪ Anesthesia             | ▪ Medicine                    | ▪ Pediatric Surgery |
| ▪ Cardiology             | ▪ Nephrology                  | ▪ Plastic Surgery   |
| ▪ Critical Care Medicine | ▪ Neurology                   | ▪ Podiatry          |
| ▪ Ear Nose Throat        | ▪ Neurosurgery                | ▪ Pulmonary         |
| ▪ Emergency Medicine     | ▪ Not Known/Not Recorded      | ▪ Radiology         |
| ▪ Gastroenterology       | ▪ Obstetrics                  | ▪ Thoracic Surgery  |
| ▪ General Surgery        | ▪ Ophthalmology               | ▪ Trauma Surgery    |
| ▪ Gynecology             | ▪ Oral Maxillo Facial Surgery | ▪ Urology           |
| ▪ Hand Surgery           | ▪ Orthopedic Surgery          | ▪ Vascular Surgery  |
| ▪ Hospitalist            | ▪ Pediatric Orthopedic        |                     |

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Validity is activated when an ICD 10 Procedure code (TR2002) has been entered
- If the patient did not receive a procedure, leave blank

## STATE/HOSPITAL ELEMENT

### Procedures - TR26.59 - Resource Utilization

#### Definition

Indicate the resources used on the patient while in the ED/hospital

#### Element Values

<ul style="list-style-type: none"> <li>▪ Adult Protective Service</li> <li>▪ Arterial Line</li> <li>▪ Bi-Pap</li> <li>▪ Bolt</li> <li>▪ Case Management</li> <li>▪ Cerebral Brain Flow Studies</li> <li>▪ Child Protective Service</li> <li>▪ CRRT</li> <li>▪ Dialysis</li> <li>▪ Endotracheal Intubation</li> <li>▪ Epidural Catheter</li> <li>▪ Exceeds LOS</li> <li>▪ Hemodialysis</li> </ul>	<ul style="list-style-type: none"> <li>▪ Factor VIIa (Novoseven)</li> <li>▪ High dose methylprednisolone</li> <li>▪ Hypertonic Saline</li> <li>▪ ICP Catheter</li> <li>▪ Immobilizer/Traction Device for Fxs</li> <li>▪ Inferior Vena Cava Filter</li> <li>▪ Level-1 Blood/Fluid Warmer</li> <li>▪ LiCox Monitor</li> <li>▪ Massive Blood Transfusion</li> <li>▪ Miami J Collar</li> <li>▪ MRI</li> <li>▪ None</li> </ul>	<ul style="list-style-type: none"> <li>▪ Occupational Therapy</li> <li>▪ Pentobarbital Coma</li> <li>▪ Peripheral Parenteral Nutrition (PPN)</li> <li>▪ Physical Therapy</li> <li>▪ PICC Line</li> <li>▪ PRISMA (CVVHD)</li> <li>▪ Respiratory Therapy</li> <li>▪ RN accompanied transfer</li> <li>▪ Specialized Bed</li> <li>▪ Speech Therapy</li> <li>▪ Thoracentesis</li> <li>▪ TLSO Brace</li> <li>▪ Total Parenteral Nutrition (TPN)</li> <li>▪ Tracheostomy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Traction</li> <li>▪ Transfusion of FFP</li> <li>▪ Transfusion of Platelets</li> <li>▪ Transfusion of PRBC</li> <li>▪ Tube Feeding</li> <li>▪ Tube Thoracostomy (Chest Tube)</li> <li>▪ Uncrossmatched Blood</li> <li>▪ Use of the Level One</li> <li>▪ Vaccine Post-Splenectomy</li> <li>▪ Venous Doppler</li> <li>▪ Ventriculostomy</li> <li>▪ Wound Care RN</li> <li>▪ Would Vacuum</li> </ul>
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#### Data Format

[SLUSH] Multiple-Choice

#### Additional Information

If there were no resources used for this patient, leave blank

# Ventilator Hx

**STATE/HOSPITAL ELEMENT**

**Ventilator Hx - TR26.74 - Placed on Ventilator Date**

**Definition**

Indicate the date the patient was placed on a ventilator

**Element Values**

Relevant value for the data element

**Data Format**

[DATE]

**Additional Information**

If the patient was not placed on a ventilator, leave blank

**STATE/HOSPITAL ELEMENT**

**Ventilator Hx - TR26.74.1 - Placed on Ventilator Time**

**Definition**

Indicate the time the patient was placed on a ventilator

**Element Values**

Relevant value for the data element

**Data Format**

[TIME]

**Additional Information**

If the patient was not placed on a ventilator, leave blank

## STATE/HOSPITAL ELEMENT

### Ventilator Hx - TR26.75 - Taken Off Ventilator Date

#### Definition

Indicate the date the patient was taken off of the ventilator

#### Element Values

Relevant value for the data element

#### Data Format

[DATE]

#### Additional Information

- If the patient was transferred to another facility while on the ventilator, this field will be the discharge date from your facility
- If the patient was not placed on a ventilator, leave blank

## STATE/HOSPITAL ELEMENT

### Ventilator Hx - TR26.75.1 - Taken Off Ventilator Time

#### Definition

Indicate the time the patient was taken off of the ventilator

#### Element Values

Relevant value for the data element

#### Data Format

[TIME]

#### Additional Information

- If the patient was transferred to another facility while on the ventilator, this field will be the discharge time from your facility
- If the patient was not placed on a ventilator, leave blank

## STATE/HOSPITAL ELEMENT

### Ventilator Hx - TR26.75.2 - Total Time On Ventilator

#### Definition

Total time in minutes the patient was on the ventilator

#### Element Values

Relevant value for the data element

#### Data Format

[String]

#### Additional Information

- This field will automatically calculate using the date and time that the patient was placed on and taken off of the ventilator as documented in the previous fields
- If the patient was not placed on a ventilator, leave blank

**STATE/HOSPITAL ELEMENT**

**Ventilator Hx - TR26.76 - Ventilator Details**

**Definition**

Indicate the ventilator details as they apply to your patient being placed on a ventilator

**Element Values**

Relevant value for the data element

**Data Format**

[TextArea]

**Additional Information**

If the patient was not placed on a ventilator, leave blank

## STATE/HOSPITAL ELEMENT

### Ventilator Hx - TR26.58.1 - Total Calendar Days on Ventilator

#### Definition

The count of each calendar day the patient has been on the ventilator

#### Element Values

Relevant value for the data element

#### Data Format

[String]

#### Additional Information

- This field will automatically calculate using the date that the patient was placed on and taken off of the ventilator as documented in the previous fields
- If the patient was not placed on a ventilator, this field will be blank

## STATE/HOSPITAL ELEMENT

### Ventilator Hx - TR26.58.2 - Total Computed Time on Ventilator

#### Definition

The total computed time the patient has been on the ventilator

#### Element Values

Relevant value for the data element

#### Data Format

[String]

#### Additional Information

- This field will automatically calculate using the times that the patient was placed on and taken off of the ventilator as documented in the previous fields
- If the patient was not placed on a ventilator, this field will be blank

# Trauma Quality Improvement Program

## Measures for Processes of Care

\*The elements in this section should be reported and transmitted ONLY by  
Regional Trauma Centers participating in TQIP

**NTDB & STATE**

**TQIP – TR40.1– Venous Thromboembolism (VTE) Prophylaxis Type**

**Definition**

Type of first dose of VTE prophylaxis administered to patient at your hospital

**Reporting Criterion**

Report on all patients

**Field Values**

- |   |                                     |
|---|-------------------------------------|
| 5. None   | 8. Xa Inhibitor (Rivaroxaban, ect.) |
| 6. LMWH (Dalteparin, Enoxaparin, ect)           | 10. Other                           |
| 7. Direct Thrombin Inhibitor (Dabigatran, ect.) | 11. Infractionated Heparin (UH)     |

**Data Format**

[COMBO] Single-Choice

**Additional Information**

- Element value "5. None" is reported if the first dose of Venous Thrombembolism Prophylaxis is administered post discharge order date/time
- 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
- Exclude sequential compression devices
- Element Value "10. Other" is reported if "Coumadin" and/or "aspirin" are given as Venous Thromboembolism Prophylaxis

## NTDB & STATE

### TQIP– TR40.2– Venous Thromboembolism (VTE) Prophylaxis Date

#### Definition

Date of administration of first dose of VTE prophylaxis administered to patient at your hospital

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[DATE]

#### Additional Information

- Reported as YYYY-MM-DD
- Refers to date upon which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None."

## NTDB & STATE

### TQIP– TR40.3– VTE Prophylaxis Time

#### Definition

Time of administration of first dose of VTE prophylaxis administered to patient at your hospital

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TIME]

#### Additional Information

- Reported as HH:MM military time
- Refers to time at which patient first received the prophylactic agent indicated in VTE Prophylaxis Type element
- The null value "Not Applicable" is reported if Venous Thromboembolism Prophylaxis Type is "5. None"

## NTDB & STATE

### TQIP – Packed Red Blood Cells

#### Definition

Volume of packed red blood cells transfused (CCs [mLs]) within first 4 hours after ED/Hospital arrival

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

- Refers to amount of transfused packed red blood cells (CCs [mLs]) within first 4 hours after arrival to your hospital
- If no packed red blood cells were given, then volume reported should be 0 (zero).
- EXCLUDE: Packed red blood cells transfusing upon patient arrival

## NTDB & STATE

### TQIP – Whole Blood

#### Definition

Volume of whole blood transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

- Refers to amount of transfused whole blood (CCs [mLs]) within first 4 hours after arrival to your hospital
- If no whole blood was given, then volume reported should be 0 (zero)
- EXCLUDE: Whole blood transfusing upon patient arrival

## NTDB & STATE

### TQIP – Plasma

#### Definition

Volume of plasmas (CCs [mLs]) transfused within first 4 hours after ED/hospital arrival

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

- Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs [mLs]) within first 4 hours after arrival to your hospital
- EXCLUDE: Plasma transfusing upon patient arrival
- If no plasma was given, then volume reported should be 0 (zero)

## NTDB & STATE

### TQIP – Platelets

#### Definition

Volume of platelets (CCs [mLs]) transfused within first 4 hours after arrival to your hospital

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

- Refers to amount of transfused platelets (CCs [mLs]) within first 4 hours after arrival at your hospital
- EXCLUDE: Platelets transfusing upon patient arrival
- If no platelets were given, then volume reported should be 0 (zero)

## NTDB & STATE

### TQIP – Cryoprecipitate

#### Definition

Volume of solution enriched with clotting factors transfused (CCs [mLs]) within first 4 hours after ED/hospital arrival

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TEXT]

#### Additional Information

- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first 4 hours after arrival to your hospital
- EXCLUDE: Cryoprecipitate transfusing upon patient arrival
- If no cryoprecipitate was given, then volume reported should be 0 (zero)

## NTDB & STATE

### TQIP– TR40.12– Angiography

#### Definition

First interventional angiogram for hemorrhage control within first 24 hours of ED/hospital arrival

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

1. None
2. Angiogram only
3. Angiogram with embolization
4. Angiogram with stenting

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Limiting reporting angiography data to the first 24 hours following ED/hospital arrival
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Excludes computerized tomographic angiography (CTA)
- Only report Element value "4. Angiogram with stenting" if stenting was performed specifically for hemorrhage control

## NTDB & STATE

### TQIP– TR40.13– Angiography Date

#### Definition

Date the first angiogram with or without embolization was performed

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

Relevant value for data element

#### Data Format

[DATE]

#### Additional Information

- Reported as YYYY-MM-DD
- The null value "Not Applicable" is reported if the data element Angiography is "1. None"
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Procedure start date is the date of needle insertion in the groin

## NTDB & STATE

### TQIP– TR40.14– Angiography Time

#### Definition

Time the first angiogram with or without embolization was performed

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

Relevant value for data element

#### Data Format

[TIME]

#### Additional Information

- Reported as HH:MM military time
- The null value "Not Applicable" is reported if the data element Angiography is "1. None"
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Procedure start time is the time of needle insertion in the groin

## NTDB & STATE

### TQIP– TR40.18– Embolization Site

#### Definition

Organ/site of embolization for hemorrhage control

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

1. Liver
2. Spleen
3. Kidneys
4. Pelvic (iliac, gluteal, obturator)
5. Retroperitonuem (lumbar, sacral)
6. Perpheral vascular (neck, extremities)
8. Other

#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- The null value "Not Applicable" is reported if Angiography is "1. None", "2. Angiogram Only", or "4. Angiogram with stenting"
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Report all that apply

**NTDB & STATE**

**TQIP– TR40.19– Hemorrhage Surgery Control Type**

**Definition**

First type of surgery for hemorrhage control within the first 24 hours of ED/hospital arrival

**Reporting Criterion**

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

**Field Values**

- |                |   |
|----------------|---|
| 1. None        | 6. Neck   |
| 2. Laparotomy  | 7. Mangled extremity/traumatic amputation         |
| 3. Thoracotomy | 8. Other skin/soft tissue (e.g. scalp laceration) |
| 4. Sternatomy  | 9. Extraperitoneal Pelvic Packing                 |
| 5. Extremity   |   |

**Data Format**

[COMBO] Single-Choice

**Additional Information**

- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Element Value "1. None" is reported if Surgery for Hemorrhage Control Type is not a listed Element Value option

## NTDB & STATE

### TQIP– TR40.20– Hemorrhage Surgery Control Date

#### Definition

Date of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

Relevant value for data element

#### Data Format

[DATE]

#### Additional Information

- Reported as YYYY-MM-DD
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None"
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion
- Procedure start time is defined as the time the incision was made (or the procedure started)

## NTDB & STATE

### TQIP– TR40.21– Hemorrhage Surgery Control Time

#### Definition

Time of first surgery for hemorrhage control within first 24 hours of ED/hospital arrival

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

Relevant value for data element

#### Data Format

[TIME]

#### Additional Information

- Reported as HH:MM military time
- If unclear if surgery was for hemorrhage control, then consult TMD or operating/consulting/relevant surgeon
- The null value "Not Applicable" is reported if Surgery for Hemorrhage Control Type is "1. None"
- The null value "Not Applicable" is reported for patients that do not meet the reporting criteria
- Procedure start time is defined as the time the incision was made (or the procedure started)

<b>NTDB &amp; STATE</b>
<b>TQIP– TR40.15– Withdrawal of Life Supporting Treatment</b>

<b>Definition</b>
Treatment was withdrawn based on a decision to either remove or withhold further life supporting 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.

<b>Reporting Criterion</b>
Report on all patients

<b>Field Values</b>			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">1. Yes</td> <td style="width: 33%;">2. No</td> <td style="width: 33%;">▪ Not Known/Not Recorded</td> </tr> </table>	1. Yes	2. No	▪ Not Known/Not Recorded
1. Yes	2. No	▪ Not Known/Not Recorded	

<b>Data Format</b>
[COMBO] Single-Choice

<b>Additional Information</b>
<ul style="list-style-type: none"> <li>▪ DNR not a requirement.</li> <li>▪ 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).</li> <li>▪ Excludes the discontinuation of CPR and typically involves prior planning.</li> <li>▪ DNR order is not the same as withdrawal of life supporting treatment.</li> <li>▪ Element Value "2. No" should 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.</li> </ul>

## NTDB & STATE

### TQIP– TR40.16– Withdrawal of Life Supporting Treatment Date

#### Definition

Indicate the date the treatment was withdrawn

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[DATE]

#### Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the date the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-supporting intervention(s) occurs (e.g. intubation).

## NTDB & STATE

### TQIP– TR40.17– Withdrawal of Life Supporting Treatment Time

#### Definition

Indicate the time the treatment was withdrawn

#### Reporting Criterion

Report on all patients

#### Field Values

Relevant value for data element

#### Data Format

[TIME]

#### Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported for patients when Withdrawal of Life Supporting Treatment is "2. No."
- Report the time the first of any existing life-supporting intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-supporting intervention(s) occurs (e.g. intubation).

## NTDB & STATE

### TQIP– TR40.22– Lowest Systolic Blood Pressure

#### Definition

Lowest systolic blood pressure measured within the first hour of ED/hospital arrival

#### Reporting Criterion

Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival

#### Field Values

Relevant value for data element

#### Data Format

[NUMBER]

#### Additional Information

- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion

## NTDB & STATE

### TQIP– TR39.1– Highest GCS Total

#### Definition

Indicate highest total GCS on calendar day after ED/hospital arrival

#### Reporting 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 value for data element

#### Data Format

[NUMBER]

#### Additional Information

- Refers to highest total GCS on calendar day after ED/hospital arrival to index hospital, where index hospital is the hospital abstracting the data.
- 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 score 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.
- 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 reporting Highest GCS Motor 40.
- If reporting Highest GCS Total, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

## NTDB & STATE

### TQIP– TR39.2– GCS Motor Score of Highest GCS Total

#### Definition

Indicate highest GCS motor on calendar day after ED/hospital arrival

#### Reporting 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

##### Pediatric (≤ 2 years):

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

##### Adult:

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

#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- Refers to highest GCS motor on calendar day after 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.
- 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.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

<b>NTDB &amp; STATE</b>
<b>TQIP– TR39.3– GCS Qualifiers with Highest GCS Total</b>

<b>Definition</b>
Documentation of factors potentially affecting the highest GCS on calendar day after ED/hospital arrival.

<b>Reporting Criterion</b>
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).

<b>Field Values</b>		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ol style="list-style-type: none"> <li>1. Patient chemically sedated or paralyzed</li> <li>2. Obstruction to the patient's eye</li> <li>3. Patient intubated</li> <li>4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye</li> </ol> </td> <td style="width: 50%; vertical-align: top; border-left: 1px solid black; padding-left: 10px;"> <ul style="list-style-type: none"> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> </ul> </td> </tr> </table>	<ol style="list-style-type: none"> <li>1. Patient chemically sedated or paralyzed</li> <li>2. Obstruction to the patient's eye</li> <li>3. Patient intubated</li> <li>4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye</li> </ol>	<ul style="list-style-type: none"> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> </ul>
<ol style="list-style-type: none"> <li>1. Patient chemically sedated or paralyzed</li> <li>2. Obstruction to the patient's eye</li> <li>3. Patient intubated</li> <li>4. Valid GCS: patient was not sedated, not intubated, and did not have obstruction to the eye</li> </ol>	<ul style="list-style-type: none"> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> </ul>	

<b>Data Format</b>
[COMBO] Multiple-Choice

<b>Additional Information</b>
<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.</li> <li>▪ 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.</li> </ul>

- 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 should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should 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.
- Report all that apply.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

## NTDB & STATE

### TQIP– TR39.40.2– GCS Motor Component of Highest GCS 40 Total

#### Definition

Indicate highest GCS 40 motor on calendar day after ED/hospital arrival.

#### Reporting 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

##### Pediatric < 5 years:

1. None
2. Extension to pain
3. Flexion to pain
4. Localizes pain
5. Obeys commands
0. Not Testable

##### Adult:

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

#### Data Format

[COMBO] Multiple-Choice

#### 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.
- 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 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).
- The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS 40 – Motor, the null value "Not Applicable" is reported if the patient's ED Discharge Date or Hospital Discharge Date is prior to the next calendar day.

## NTDB & STATE

### TQIP– TR40.32– Initial ED/Hospital Pupillary Response

#### Definition

Indicate physiological response of the pupil size within 30 minutes or less of ED/hospital arrival.

#### Reporting 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

1. Both reactive
2. One reactive
3. Neither reactive

#### Data Format

[COMBO] Multiple-Choice

#### 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 PERRL "Pupils Equal Round Reactive to Light" report Element Value "1. Both reactive" IF there is no other contradicting documentation.
- The null value "Not Known/Not Recorded" should 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" should 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.

<b>NTDB &amp; STATE</b>
<b>TQIP– TR40.33– Midline Shift</b>

<b>Definition</b>
> 5mm shift of the brain past its center line within 24 hours after time of injury.

<b>Reporting Criterion</b>
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).

<b>Field Values</b>			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">1. Yes</td> <td style="width: 33%;">2. No</td> <td style="width: 33%;">3. Not Imaged (e.g. CT Scan, MRI)</td> </tr> </table>	1. Yes	2. No	3. Not Imaged (e.g. CT Scan, MRI)
1. Yes	2. No	3. Not Imaged (e.g. CT Scan, MRI)	

<b>Data Format</b>
[COMBO] Single-Choice

<b>Additional Information</b>
<ul style="list-style-type: none"> <li>▪ If there is documentation of "massive" midline shift in lieu of &gt;5mm shift measurement, report element value "1. Yes."</li> <li>▪ Radiological and surgical documentation from transferring facilities should be considered for this data element.</li> <li>▪ The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.</li> <li>▪ The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.</li> <li>▪ If the injury time is unknown, but there is supporting documentation that the injury occurred within 24- hours of any CT measuring a &gt;5mm shift, report the element value "1. Yes" if there is no other contradicting documentation.</li> <li>▪ 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)."</li> </ul>

## NTDB & STATE

### TQIP– TR39.40.2– Cerebral Monitor

#### Definition

Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb.

#### Reporting 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

1. Intraventricular drain/catheter (e.g. ventriculostomy; external ventricular drain)
2. Intraparenchymal pressure monitor (e.g. Camino bolt, subarachnoid bolt, intraparenchymal catheter)
3. Intraparenchymal oxygen monitor (e.g. Licox)
4. Jugular venous bulb
5. None

#### Data Format

[COMBO] Multiple-Choice

#### Additional Information

- 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.
- Report all that apply.

## NTDB & STATE

### TQIP– TR39.5– Cerebral Monitor Date

#### Definition

Indicate the date of first cerebral monitor placement

#### Reporting 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 value for data element

#### Data Format

[DATE]

#### Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

## NTDB & STATE

### TQIP– TR39.5.1– Cerebral Monitor Time

#### Definition

Indicate the time of first cerebral monitor placement

#### Reporting 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 value for data element

#### Data Format

[TIME]

#### Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the data element Cerebral Monitor is "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

# NTDB Preexisting/Hospital Events

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/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  $\geq 40$  mg/dl ( $\geq 3536$   $\mu\text{mol/l}$ )

**OR**

Initiation of renal replacement therapy OR, In patients  $< 18$  years, decrease in eGFR to  $< 35$  ml/min per  $173 \text{ m}^2$

**OR**

Urine output  $< 03$  ml/kg/h for  $> 24$  hours

**OR**

Anuria for  $> 12$  hours

#### Element Values

▪ Yes

▪ No

▪ Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- A diagnosis of AKI must be documented in the patient's medical record
- If the patient or family refuses treatment (eg, dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present
- EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 collapse, or nodules

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

**Oxygenation:**

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

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

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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)

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- Documentation of alcohol withdrawal must be in the patient's medical record
- Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- Cardiac Arrest must be documented in the patient's medical record
- EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital
- INCLUDE patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Catheter-Associated Urinary Tract Infection (CAUTI)

#### Definition

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

**AND**

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for > 2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

#### January 2016 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, and 3 below:

1. Patient had an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1) AND was either:
  - Present for any portion of the calendar day on the date of event, OR
  - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
  - Fever (>38°C)
  - Suprapubic tenderness with no other recognized cause
  - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10<sup>5</sup> CFU/ml

#### January 2016 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°C)
  - hypothermia (<36°C)
  - apnea with no other recognized cause
  - bradycardia with no other recognized cause
  - lethargy with no other recognized cause
  - vomiting with no other recognized cause
  - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10<sup>5</sup> CFU/ml

**Element Values**

- Yes
- No
- Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**Additional Information**

- Must have occurred during the patient's initial stay at your hospital
- A diagnosis of UTI must be documented in the patient's medical record
- Consistent with the January 2016 CDC defined CAUTI

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 (eg, not Active Surveillance Culture/Testing (ASC/AST)

#### AND

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

#### OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38°C), chills, or hypotension

#### AND

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

#### AND

the same common commensal (ie, diphtheroids [*Corynebacterium* spp not *C diphtheria*], *Bacillus* spp [not *B anthracis*], *Propionibacterium* spp, coagulase-negative staphylococci [including *S epidermidis*], viridans group streptococci, *Aerococcus* spp, and *Micrococcus* spp) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (eg, not Active Surveillance Culture/Testing (ASC/AST) Criterion elements must occur within the Infection Window Period, the 7-

day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after

**OR**

**January 2016 CDC Criterion LCBI 3:**

Patient  $\leq$  1 year of age has at least one of the following signs or symptoms: fever ( $>38^{\circ}$  C), Page 130 of 209 hypothermia ( $<36^{\circ}$ C), apnea, or bradycardia

**AND**

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

**AND**

the same common commensal (ie, diphtheroids [Corynebacterium spp not C diphtheriae], Bacillus spp [not B anthracis], Propionibacterium spp, coagulase-negative staphylococci [including S epidermidis], viridans group streptococci, Aerococcus spp, Micrococcus spp) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (eg, not Active Surveillance Culture/Testing (ASC/AST) Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after

**Element Values**

▪ Yes

▪ No

▪ Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**Additional Information**

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 (eg, 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 (eg, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

#### AND

patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness A culture or non-culture based test that has a negative finding does not meet this criterion  
c an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

- 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 (eg, 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 (eg, 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**

Wyoming Trauma Registry Data Dictionary v2020.1

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

**Element Values**

- Yes
- No
- Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 test 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- EXCLUDE: Patient's whose delirium is due to alcohol withdrawal

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Extremity Compartment Syndrome

#### Definition

A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder.

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability
- A diagnosis of extremity compartment syndrome must be documented in the patient's medical record

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Myocardial Infarction (MI)

#### Definition

An acute myocardial infarction must be noted with documentation of ECG changes indicative of an acute MI

**AND**

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

**AND**

Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 (eg, closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (eg, not Active Surveillance Culture/Testing (ASC/AST)
- c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

**AND**

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

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

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
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		
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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	LUNG	Other infections of the respiratory tract
BRST	Breast abscess mastitis	MED	<u>Mediastinitis</u>
CARD	Myocarditis or pericarditis	MEN	Meningitis or <u>ventriculitis</u>
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	<u>Periprosthetic Joint Infection</u>
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

**Element Values**

- Yes
- No
- Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Osteomyelitis

#### Definition

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (eg, 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 (>380°C), swelling\*, pain or tenderness\*, heat\*, or 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 (eg, not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (eg, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc]), which if equivocal is supported by clinical correlation (ie, physician documentation of antimicrobial treatment for osteomyelitis)
- b. imaging test evidence suggestive of infection (eg, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc]), which if equivocal is supported by clinical correlation (ie, physician documentation of antimicrobial treatment for osteomyelitis)

\* With no other recognized cause

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- Pressure Ulcer documentation must be in the patient's medical record
- Consistent with the NPUAP 2014

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record
- Exclude sub segmental PE's

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Stroke/CVA

#### Definition

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

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

**AND:**

- Duration of neurological deficit  $\geq 24$  h

**OR:**

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

**AND:**

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

**AND:**

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

**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 (eg, blunt cerebrovascular injury, dysrhythmia) may be present on admission

**NTDB & STATE/HOSPITAL ELEMENT**

**NTDB Preexisting/Hospital Events - 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 subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (eg, 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

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 (eg, 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 (eg, donor site incision for CBGB)

**Element Values**

- Yes
- No
- Not Known/Not Recorded

**Data Format**

[COMBO] Single-Choice

**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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

**\*Please refer to the most up to date copy of the National Trauma Data Standard Dictionary for the VAP Algorithm table**

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Must have occurred during the patient's initial stay at your hospital
- A diagnosis of pneumonia must be documented in the patient's medical record
- Consistent with the January 2016 CDC defined VAP

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Advance Directive Limiting Care

#### Definition

The patient had a written request limiting life sustaining therapy, or similar advanced directive

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Alcohol Use Disorder

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Consistent with American Psychiatric Association (APA) DSM 5, 2013
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Angina Pectoris

#### Definition

Chest pain or discomfort due to coronary heart disease Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men.

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of Angina or Chest Pain must be documented in the patient's medical record
- Consistent with American Heart Association (AHA), May 2015
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Exclude patients whose only anticoagulant therapy is chronic Aspirin
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Bleeding Disorder

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A Bleeding Disorder diagnosis must be documented in the patient's medical record (eg 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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 (eg, hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory)

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Chronic Obstructive Pulmonary Disease (COPD)

#### Definition

Lung ailment that is characterized by a persistent blockage of airflow from the lungs It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (eg, dyspnea, inability to perform activities of daily living [ADLs])
- Hospitalization in the past for treatment of COPD
- Requires chronic bronchodilator therapy with oral or inhaled agents
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of COPD must be documented in the patient's medical record
- Do not include patients whose only pulmonary disease is acute asthma
- Do not include patients with diffuse interstitial fibrosis or sarcoidosis
- Consistent with World Health Organization (WHO), 2015
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Chronic Renal Failure

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Cirrhosis

#### Definition

Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present
- A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Myocardial Infarction (MI)

#### Definition

History of a MI in the six months prior to injury

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Congenital Anomalies

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of a Congenital Anomaly 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of CHF must be documented in the patient's medical record
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury
- Common manifestations are:
  - Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  - Orthopnea (dyspnea or lying supine)
  - Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  - Increased jugular venous pressure
  - Pulmonary rales on physical examination
  - Cardiomegaly
  - Pulmonary vascular engorgement
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Currently Receiving Chemotherapy for Cancer

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Current Smoker

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Exclude patients who report smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff)
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Dementia

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Diabetes Mellitus

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of Diabetes Mellitus 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis"
- Common sites of metastases include major organs, (eg, brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone)
- 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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)

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Hypertension

#### Definition

History of persistent elevated blood pressure requiring medical therapy

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- A diagnosis of Hypertension must be documented in the patient's medical record
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Mental/Personality Disorders

#### Definition

History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record:

- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Social Anxiety Disorder
- Posttraumatic Stress Disorder
- Antisocial Personality Disorder

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Consistent with American Psychiatric Association (APA) DSM 5, 2013
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- Consistent with Centers for Disease Control, 2014 Fact Sheet
- A diagnosis of PAD 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Pregnancy

#### Definition

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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - Prematurity

#### Definition

Babies born before 37 weeks of pregnancy are completed

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to injury
- 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 Known/Not Recorded" is only reported if no past medical history is available

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events - 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

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### 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

## NTDB & STATE/HOSPITAL ELEMENT

### NTDB Preexisting/Hospital Events – 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:

- Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
- Phencyclidine Use Disorder; Other Hallucinogen Use Disorder; Hallucinogen Persisting Perception Disorder; Other Phencyclidine-Induced Disorder; Other Hallucinogen-Induced Disorder; Unspecified Phencyclidine-Related Disorder; Unspecified Hallucinogen-Related Disorder
- Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
- Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
- Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder

#### Element Values

- Yes
- No
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Present prior to arrival at your center
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available

# Outcome Tab Elements

## STATE/HOSPITAL ELEMENT

Outcome - TR25.44 - Hospital Length of Stay- Calendar Days (Physical D/C)

### Definition

Indicate the number of days the patient was admitted to the hospital

### Element Values

Relevant value for the data element

### Data Format

[NUMBER]

### Additional Information

This field will be auto-generated based on the elapsed number of days from hospital admit to hospital discharge

**STATE/HOSPITAL ELEMENT**

**Outcome - TR25.44Mins - Hospital Length of Stay (Total Minutes)  
(Physical D/C)**

**Definition**

Indicate the total number of minutes the patient was admitted to the hospital

**Element Values**

Relevant value for the data element

**Data Format**

[NUMBER]

**Additional Information**

This field will be auto-generated based on the elapsed time in minutes from hospital admit to hospital discharge

## NTDB & STATE/HOSPITAL ELEMENT

### Outcome - TR26.9 - Total ICU Days

#### Definition

Indicate the cumulative amount of time spent in the ICU Each partial or full day should be measured as one calendar day

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Reported in full day increments with any partial calendar day counted as a full calendar day
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart
- The null value "Not Known/Not Recorded" is reported if any dates are missing
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day
- At no time should the ICU LOS exceed the Hospital LOS
- The null value "Not Applicable" is reported if the patient had no ICU days according to the above definition

Wyoming Trauma Registry Data Dictionary v2020.1

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

## NTDB & STATE/HOSPITAL ELEMENT

### Outcome - TR26.58 - Total Vent Days

#### Definition

Indicate the cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day

#### Element Values

Relevant value for the data element

#### Data Format

[NUMBER]

#### Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days
- Reported in full day increments with any partial calendar day counted as a full calendar day
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart
- The null value "Not Known/Not Recorded" is reported if any dates are missing
- At no time should the Total Vent Days exceed the Hospital LOS
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition

Wyoming Trauma Registry Data Dictionary v2020.1

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	

## NTDB & STATE/HOSPITAL ELEMENT

### Outcome - TR2.5 - Primary Method of Payment

#### Definition

Indicate the primary source of payment for hospital care

#### Element Values

- Not Billed (for any reason)
- Medicare
- Medicaid
- Private/Commercial Insurance
- Self Pay
- Other Government
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "Private/Commercial Insurance"
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments

**STATE/HOSPITAL ELEMENT**

**Outcome - TR2.8 - Reimbursed Charges**

**Definition**

Indicate the amount in reimbursed charges

**Element Values**

Relevant value for the data element

**Data Format**

[MONEY]

**Additional Information**

- If there are no reimbursed charges, leave blank

## STATE/HOSPITAL ELEMENT

### Outcome - TR2.7 - Secondary Method of Payment

#### Definition

Indicate the secondary source of payment for hospital care

#### Element Values

- Self Pay
- Private/Commercial Insurance
- Other Government
- Other
- Not Billed (for any reason)
- Medicare
- Medicaid
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "Private/Commercial Insurance"
- If there is no secondary method of payment, leave field blank

## STATE/HOSPITAL ELEMENT

### Outcome - TR2.18 - Third Method of Payment

#### Definition

Indicate the third method of payment for hospital care

#### Element Values

- Not Billed (for any reason)
- Medicare
- Medicaid
- Private/Commercial Insurance
- Self Pay
- Other Government
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be reported as "Private/Commercial Insurance"
- If there is not a third method of payment, leave field blank

**STATE/HOSPITAL ELEMENT**

**Outcome - TR2.9 - Billed Hospital Charges**

**Definition**

Indicate the total amount of charges the patient was billed for the hospital stay

**Element Values**

Relevant value for the data element

**Data Format**

[MONEY]

**Additional Information**

## STATE/HOSPITAL ELEMENT

### Outcome - TR2.10 - Work Related

#### Definition

Indicate whether the injury was work related

#### Element Values

- Select
- No
- Yes
- Not Known/Not Recorded

#### Data Format

[COMBO] Single-Choice

#### Additional Information

**STATE/HOSPITAL ELEMENT**

**Outcome - TR44.3 - Admission Ward**

**Definition**

Indicate the ward the patient was admitted to

**Element Values**

Relevant value for the data element

**Data Format**

[COMBO] Single-Choice

**Additional Information**

**STATE/HOSPITAL ELEMENT**

**Outcome - TR44.4 - Bed Number**

**Definition**

Indicate the bed number the patient was admitted to

**Element Values**

Relevant value for the data element

**Data Format**

[TEXT]

**Additional Information**

**STATE/HOSPITAL ELEMENT**

**Outcome - TR44.5 - Consultant/Staff**

**Definition**

Indicate the consultant/staff that admitted the patient

**Element Values**

Relevant value for the data element

**Data Format**

[COMBO] Single-Choice

**Additional Information**

**STATE/HOSPITAL ELEMENT**

**Outcome - TR44.6 - Medical Specialty**

**Definition**

Indicate the medical specialty that admitted the patient

**Element Values**

<ul style="list-style-type: none"> <li>▪ Acute Rehabilitation Medicine</li> <li>▪ Anesthesia</li> <li>▪ Bariatric</li> <li>▪ Burn</li> <li>▪ Cardiology</li> <li>▪ Cardiothoracic Surgery</li> <li>▪ Chemical Dependency</li> <li>▪ Critical Care Medicine</li> <li>▪ Critical Care Surgery</li> <li>▪ Dentistry</li> <li>▪ Dermatology</li> <li>▪ Ear Nose Throat</li> <li>▪ Endocrinology</li> <li>▪ Family Medicine</li> <li>▪ Gastroenterology</li> </ul>	<ul style="list-style-type: none"> <li>▪ General Pediatrics</li> <li>▪ General Surgery</li> <li>▪ Geriatric</li> <li>▪ Gynecology</li> <li>▪ Hand</li> <li>▪ Hematology Oncology</li> <li>▪ Hospitalist</li> <li>▪ Infectious Disease</li> <li>▪ Internal Medicine</li> <li>▪ Kidney Transplant</li> <li>▪ Liver</li> <li>▪ Neonatal</li> <li>▪ Nephrology</li> <li>▪ Neurology</li> <li>▪ Neurosurgery</li> </ul>	<ul style="list-style-type: none"> <li>▪ Not Applicable</li> <li>▪ Not Known/Not Recorded</li> <li>▪ Obstetric</li> <li>▪ Occuloplastic</li> <li>▪ Ophthalmology</li> <li>▪ Oral Maxillo Facial Surgery</li> <li>▪ Orthopedic Surgeon</li> <li>▪ Pain</li> <li>▪ Pediatric Cardiology</li> <li>▪ Pediatric Critical Care Medicine</li> <li>▪ Pediatric Dentistry</li> <li>▪ Pediatric Gastroenterology</li> <li>▪ Pediatric Hematology Oncology</li> </ul>	<ul style="list-style-type: none"> <li>▪ Pediatric Hospitalist</li> <li>▪ Pediatric Infectious Disease</li> <li>▪ Pediatric Intensivist</li> <li>▪ Pediatric Nephrology</li> <li>▪ Pediatric Neurology</li> <li>▪ Pediatric Orthopedic</li> <li>▪ Pediatric Pulmonary</li> <li>▪ Plastic Surgeon</li> <li>▪ Psychology</li> <li>▪ Pulmonary</li> <li>▪ Rheumatology</li> <li>▪ Trauma Surgeon</li> <li>▪ Urology</li> <li>▪ Vascular Surgery</li> <li>▪ Select</li> </ul>
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**Data Format**

[COMBO] Single-Choice

**Additional Information**



**STATE/HOSPITAL ELEMENT**

**Outcome - TR44.1 - Admission Date**

**Definition**

Indicate the date the patient was admitted to the hospital

**Element Values**

Relevant value for the data element

**Data Format**

[DATE]

**Additional Information**

- Collected as MM-DD-YYYY

## STATE/HOSPITAL ELEMENT

### Outcome - TR44.9 - Total Log of Admission Time

#### Definition

Indicate the total amount of time that the patient was admitted to the hospital

#### Element Values

Relevant value for the data element

#### Data Format

[STRING]

#### Additional Information

This field will be generated based on the elapsed time in minutes from hospital admit to hospital discharge

## STATE/HOSPITAL ELEMENT

### Outcome - TR25.27 - Hospital Department Discharge Disposition

#### Definition

Indicate the disposition of the patient when discharged from the hospital

#### Element Values

- Select
- Not Applicable
- Not Known/Not Recorded
- 1. Discharged/Transferred to a short-term General Hospital for Inpatient Care
- 2. Discharged/Transferred to an Intermediate Care Facility (ICF)
- 3. Discharged/Transferred to home under care of organized home health service
- 4. Left against medical advice or discontinued care
- 5. Deceased/Expired
- 6. Discharged to home or self-care (routine discharge)
- 7. Discharged/Transferred to Skilled Nursing Facility (SNF)
- 8. Discharged/Transferred to hospice care
- 10. Discharged/Transferred to court/law enforcement
- 11. Discharged/Transferred to Inpatient Rehabilitation Facility (IRF) or designated unit
- 12. Discharged/Transferred to Long Term Care Hospital (LTCH)
- 13. Discharged/Transferred to psychiatric hospital or psychiatric distinct part unit of a hospital
- 14. Discharged/Transferred to another type of institution not defined elsewhere

#### Data Format

[COMBO] Single-Choice

#### Additional Information

- Element value "6. Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services, ect)
- Element values based upon UB-04 disposition coding
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be reported as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions
- If multiple orders were written, report the final disposition order

## STATE/HOSPITAL ELEMENT

### Outcome - TR5.27 - Clinical Note Type

#### Definition

Indicate the type of clinical note related to the injury of the patient which are significant to the care of the patient

#### Element Values

- Select
- Demographic Notes
- Emergency Department Notes
- Handover Notes
- Injury Notes
- Intervention Page Notes
- Quality Notes
- Trauma Service Investigations Note
- Trauma Service Issues Note
- Trauma Service Operation Note
- Trauma Service Plan Not

#### Data Format

[COMBO] Single-Choice

#### Additional Information

If there are no clinical notes relating to this patients injury, leave field blank

**STATE/HOSPITAL ELEMENT**

**Outcome - TR5.24 - Clinical Note**

**Definition**

Indicate the notes related to the injury of the patient which are significant to the care of the patient

**Element Values**

Relevant value for the data element

**Data Format**

[TextArea]

**Additional Information**

If there are no clinical notes relating to this patients injury, leave field blank

## STATE/HOSPITAL ELEMENT

### Outcome - TR5.26 - Clinical Note Entered by

#### Definition

Indicate the name of the person who created the notes related to the injury of the patient which are significant to the care of the patient

#### Element Values

Relevant value for the data element

#### Data Format

[TEXT]

#### Additional Information

If there are no clinical notes relating to this patients injury, leave field blank

**STATE/HOSPITAL ELEMENT**

**Outcome - TR525 - Clinical Note Date/Time**

**Definition**

Indicate the date and time when notes related to the injury of a patient which are significant to the care of the patient are taken

**Element Values**

Relevant value for the data element

**Data Format**

[DateTime]

**Additional Information**

If there are no clinical notes relating to this patients injury, leave field blank

# State of Wyoming Element List

Wyoming Trauma Registry Data Dictionary v2020.1

Registry Title	Data Section (TR)	National Trauma Data Dictionary	Wyoming Trauma Data Dictionary
Medical Record Number	TR1.2		STATE REQUIRED
Registry Number	TR5.12		STATE REQUIRED
Account Number	TR1.27		STATE REQUIRED
Incident Date	TR5.12	NTDB REQUIRED	
Last Name	TR1.9		STATE REQUIRED
Patient's First Name	TR1.8		STATE REQUIRED
Middle Initial	TR1.10		STATE REQUIRED
Date of Birth	TR1.7	NTDB REQUIRED	
Age (at date of incident)	TR1.12	NTDB REQUIRED	
Age Units	TR1.14	NTDB REQUIRED	
Height in inches	TR1.6.1		STATE REQUIRED
Height	TR1.6		STATE REQUIRED
Estimated Body Weight	TR1.6.5		STATE REQUIRED
Race	TR1.16	NTDB REQUIRED	
Ethnicity	TR1.17	NTDB REQUIRED	
Gender	TR1.15	NTDB REQUIRED	

Wyoming Trauma Registry Data Dictionary v2020.1

Address	TR1.18		STATE REQUIRED
City	TR1.21	NTDB REQUIRED	
County	TR1.22	NTDB REQUIRED	
State	TR1.23	NTDB REQUIRED	
Postal Code	TR1.20	NTDB REQUIRED	
Country	TR1.19	NTDB REQUIRED	
Alternate Residence	TR1.13	NTDB REQUIRED	
Injury Description	TR20.12		STATE REQUIRED
ICD 10 Location	TR200.5	NTDB REQUIRED	
Incident Location Zip Code	TR5.6	NTDB REQUIRED	
Incident Country	TR5.11	NTDB REQUIRED	
Incident City	TR5.10	NTDB REQUIRED	
Incident County	TR5.9	NTDB REQUIRED	
Incident State	TR5.7	NTDB REQUIRED	
ICD 10 Injury	TR200.3	NTDB REQUIRED	
Intentionality	TR200.3.2		STATE REQUIRED
Trauma Type	TR200.3.3		STATE REQUIRED
Report of Physical Abuse	TR41.1	NTDB REQUIRED	

Wyoming Trauma Registry Data Dictionary v2020.1

Investigation of Physical Abuse	TR41.2	NTDB REQUIRED	
Caregiver at Discharge	TR41.3	NTDB REQUIRED	
Safety Device Used	TR29.24	NTDB REQUIRED	
Arrived From	TR16.22		STATE REQUIRED
Transported To Your Facility By	TR8.8		
Inter-facility Transfer	TR25.54	NTDB REQUIRED	
Trauma Alert Type	TR17.22	NTDB REQUIRED	
Vehicular, Pedestrian, Other Risk Injury	TR17.47	NTDB REQUIRED	
Run Number	TR7.1		STATE REQUIRED
Service	TR7.3		STATE REQUIRED
Unit Notified Date	TR9.1	NTDB REQUIRED	
En Route Date	TR9.17		STATE REQUIRED
En Route Time	TR9.2		STATE REQUIRED
Arrive Scene - Date	TR9.2.1	NTDB REQUIRED	
Arrive Scene - Time	TR9.3	NTDB REQUIRED	
Leave Scene- Date	TR9.3	NTDB REQUIRED	
Leave Scene- Time	TR9.4	NTDB REQUIRED	
Arrive Hospital	TR8.10	NTDB REQUIRED	

Wyoming Trauma Registry Data Dictionary v2020.1

Transport Mode	TR15.32	<b>NTDB REQUIRED</b>	
Destination Determination	TR15.38		<b>STATE REQUIRED</b>
EMS Report Status	TR15.53		<b>STATE REQUIRED</b>
Pre Hospital Cardiac Arrest	TR15.39	<b>NTDB REQUIRED</b>	
CPR Performed	TR15.41		<b>STATE REQUIRED</b>
CPR Location	TR18.97		<b>STATE REQUIRED</b>
Tube Thoracostomy	TR18.96		<b>STATE REQUIRED</b>
Needle Thoracostomy	TR15.40		<b>STATE REQUIRED</b>
Airway Management	TR15.30		<b>STATE REQUIRED</b>
Fluids	TR15.31		<b>STATE REQUIRED</b>
Medications	TR15.36		<b>STATE REQUIRED</b>
Temperature Maintained	TR15.37		<b>STATE REQUIRED</b>
Appropriate Wound Management	TR15.37		<b>STATE REQUIRED</b>
Referring Hospital	TR33.1		<b>STATE REQUIRED</b>
Referring Hospital Arrival Date	TR33.2		<b>STATE REQUIRED</b>
Referring Hospital Arrival Time	TR33.3		<b>STATE REQUIRED</b>
Discharge Date	TR33.30		<b>STATE REQUIRED</b>
Discharge Time	TR33.31		<b>STATE REQUIRED</b>

Wyoming Trauma Registry Data Dictionary v2020.1

Transported to referring facility by	TR33.48		STATE REQUIRED
Physician Name	TR33.4		STATE REQUIRED
Medical Record Number	TR33.45		STATE REQUIRED
Referring Hospital Vitals Date	TR33.54		STATE REQUIRED
Referring Hospital Vitals Time			STATE REQUIRED
Sys BP	TR33.5		STATE REQUIRED
Dia BP	TR33.40		STATE REQUIRED
Pulse Rate	TR33.6		STATE REQUIRED
Temperature: Celsius	TR33.7		STATE REQUIRED
Temperature: Fahrenheit	TR33.7.1		STATE REQUIRED
Resp Rate	TR33.8		STATE REQUIRED
Resp Assistance	TR33.9		STATE REQUIRED
Supplemental Oxygen	TR33.10		STATE REQUIRED
O2Sat	TR33.11		STATE REQUIRED
AVPU	TR33.44		STATE REQUIRED
Glasgow Eye	TR33.12		STATE REQUIRED
Glasgow Verbal	TR33.13.2		STATE REQUIRED
Glasgow Motor	TR33.14.2		STATE REQUIRED

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GCS Qualifier	TR33.16		STATE REQUIRED
Manual GCS	TR33.15		STATE REQUIRED
GCS Total Calc	TR33.50		STATE REQUIRED
Manual RTS	TR33.17		STATE REQUIRED
RTS Calc	TR33.51		STATE REQUIRED
PTS	TR33.32		STATE REQUIRED
Hospital ICU	TR33.18		STATE REQUIRED
Hospital OR	TR33.19		STATE REQUIRED
CPR Performed	TR33.20		STATE REQUIRED
CT Head	TR33.21		STATE REQUIRED
CT Abd/Pelvis	TR33.22		STATE REQUIRED
CT Chest	TR33.23		STATE REQUIRED
Abdominal Ultrasound	TR33.24		STATE REQUIRED
Aortogram	TR33.25		STATE REQUIRED
Arteriogram	TR33.26		STATE REQUIRED
Airway Management	TR33.27		STATE REQUIRED
Referring Hospital Medication Given	TR33.28		STATE REQUIRED
Destination Determination	TR33.29		STATE REQUIRED

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CT Cervical	TR33.33		STATE REQUIRED
Imaging Head	TR33.34		STATE REQUIRED
Imaging Chest	TR33.35		STATE REQUIRED
Imaging Abd/Pelvis	TR33.36		STATE REQUIRED
Echo	TR33.37		STATE REQUIRED
TPA Administered	TR33.38		STATE REQUIRED
Sent to Cath Lab	TR33.39		STATE REQUIRED
Direct Admit to Hospital	TR17.30		STATE REQUIRED
Date Arrived in ED/Acute Care	TR18.55	NTDB REQUIRED	
Time Arrived in ED/Acute Care	TR18.56	NTDB REQUIRED	
ED Attending MD/Staff	TR18.131		STATE REQUIRED
ED Attending MD/Staff Service Type	TR18.132		STATE REQUIRED
Decision to Discharge/Transfer Date	TR17.41	NTDB REQUIRED	
Decision to Discharge/Transfer Time	TR17.42	NTDB REQUIRED	
Date Discharged from ED	TR17.25		STATE REQUIRED
Time Discharged from ED	TR17.26		STATE REQUIRED
Length of Stay in ED (Physical D/C)	TR17.99		STATE REQUIRED
ED Disposition	TR17.27	NTDB REQUIRED	

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Signs of Life	TR27.14	<b>NTDB REQUIRED</b>	
Admitting MD/Staff	TR18.98		<b>STATE REQUIRED</b>
Admitting Service	TR18.99		<b>STATE REQUIRED</b>
Trauma Team Activation	TR17.21		<b>STATE REQUIRED</b>
Date Changed	TR17.78.1		<b>STATE REQUIRED</b>
Time Changed	TR17.78.1.1		<b>STATE REQUIRED</b>
Upgrade/Downgrade	TR17.78.2		<b>STATE REQUIRED</b>
New Activation Level	TR17.78.3		<b>STATE REQUIRED</b>
Old Activation Level	TR17.78.4		<b>STATE REQUIRED</b>
Consulting Services	TR17.29		<b>STATE REQUIRED</b>
Initial Assessment Vitals Date	TR18.104		<b>STATE REQUIRED</b>
Initial Assessment Vitals Time	TR18.110		<b>STATE REQUIRED</b>
Systolic Blood Pressure	TR18.11	<b>NTDB REQUIRED</b>	
Diastolic Blood Pressure	TR18.13		<b>STATE REQUIRED</b>
Pulse Rate	TR18.2	<b>NTDB REQUIRED</b>	
Temperature (Celcius)	TR18.30	<b>NTDB REQUIRED</b>	
Temperature (Fahrenheit)	TR18.30.1	<b>NTDB REQUIRED</b>	
Temperature Route	TR18.147	<b>NTDB REQUIRED</b>	

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Oxygen Saturation	TR18.31	NTDB REQUIRED	
Respiratory Rate	TR18.7	NTDB REQUIRED	
Supplemental Oxygen	TR18.109	NTDB REQUIRED	
RTS Calc	TR18.135		STATE REQUIRED
PTS	TR21.10		STATE REQUIRED
Glasgow Eye	TR18.14	NTDB REQUIRED	
Glasgow Verbal	TR18.15.2	NTDB REQUIRED	
Glasgow Motor	TR18.16.2	NTDB REQUIRED	
GCS Qualifier	TR18.21	NTDB REQUIRED	
GCS Total Calc	TR18.22	NTDB REQUIRED	
Glasgow Coma Score 40 (Eye)	TR18.40.2	NTDB REQUIRED	
Glasgow Coma Score 40 (Verbal)	TR18.41.2	NTDB REQUIRED	
Glasgow Coma Score 40 (Motor)	TR18.42.2	NTDB REQUIRED	
GCS 40 Total Calc	TR18.44.1		STATE REQUIRED
GCS 40 Manual Total	TR18.44		STATE REQUIRED
AVPU	TR18.53		STATE REQUIRED
Airway Management	TR14.36		STATE REQUIRED
CPR Performed	TR18.71		STATE REQUIRED

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Backboard Removed Date	TR18.176		STATE REQUIRED
Backboard Removed Time	TR18.177		STATE REQUIRED
Blood Product Location	TR22.20		STATE REQUIRED
Blood Product	TR22.21		STATE REQUIRED
Units of Blood	TR22.22		STATE REQUIRED
Blood Product Measurement	TR22.23		STATE REQUIRED
Blood Ordered Date	TR22.14		STATE REQUIRED
Blood Ordered Time	TR22.17		STATE REQUIRED
Crossmatch Date	TR22.15		STATE REQUIRED
Crossmatch Time	TR22.18		STATE REQUIRED
Patient's Anticoagulant Meds	SK38.203.1		STATE REQUIRED
Anti-Coagulant Reversal Medication Administered	SK38.163		STATE REQUIRED
Antibiotic Therapy	TR18.189		STATE REQUIRED
First Antibiotic Administration Date	TR18.190		STATE REQUIRED
First Antibiotic Administration Time	TR18.190.1		STATE REQUIRED
Alcohol Use Indicator/Alcohol Screen	TR18.46	NTDB REQUIRED	
Drug Use Indicator	TR18.45		STATE REQUIRED
Drug Screen	TR18.91	NTDB REQUIRED	

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Hematocrit	TR18.95		STATE REQUIRED
Base Deficit	TR18.93		STATE REQUIRED
Bicarb - HCO3	TR18.117		STATE REQUIRED
Radiology Type	TR18.160		STATE REQUIRED
Radiology Region	TR18.143		STATE REQUIRED
Date Radiology Performed	TR18.163		STATE REQUIRED
Time Radiology Performed	TR18.163.1		STATE REQUIRED
Radiology Results	TR18.161		STATE REQUIRED
ICD 10 Diagnosis	TR200.1	NTDB REQUIRED	
Diagnosis Comments	TR200.120		STATE REQUIRED
ICD 10 AIS Codes	TR200.14.1	NTDB REQUIRED	
Additional AIS Codes	TR201.0		STATE REQUIRED
Diagnosis - ISS Region			STATE REQUIRED
ISS - Injury Severity Score			STATE REQUIRED
Probability of Survival			STATE REQUIRED
New Injury Severity Score			STATE REQUIRED
Co-Morbid Condition	TR21.21	NTDB REQUIRED	
Co-Morbid Condition Notes	TR21.23	NTDB REQUIRED	

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ICD 10 Procedure	TR200.2	<b>NTDB REQUIRED</b>	
Procedure Performed Location	TR22.29		<b>STATE REQUIRED</b>
Physician Performing the Procedure	TR200.10		<b>STATE REQUIRED</b>
Procedure Comments	TR200.7		<b>STATE REQUIRED</b>
Date Procedure Performed	TR200.8	<b>NTDB REQUIRED</b>	
Time Procedure Performed	TR200.9	<b>NTDB REQUIRED</b>	
Service Type of the Physician	TR200.6		<b>STATE REQUIRED</b>
Resource Utilization	TR26.59		<b>STATE REQUIRED</b>
Placed on Ventilator Date	TR26.74		<b>STATE REQUIRED</b>
Placed on Ventilator Time	TR26.74.1		<b>STATE REQUIRED</b>
Taken Off Ventilator Date	TR26.75		<b>STATE REQUIRED</b>
Taken Off Ventilator Time	TR26.75.1		<b>STATE REQUIRED</b>
Total Time On Ventilator	TR26.75.2		<b>STATE REQUIRED</b>
Ventilator Details	TR26.76		<b>STATE REQUIRED</b>
Total Calendar Days on Ventilator	TR26.58.1		<b>STATE REQUIRED</b>
Total Computed Time on Ventilator	TR26.58.2		<b>STATE REQUIRED</b>
Acute Kidney Injury (AKI)		<b>NTDB REQUIRED</b>	
Acute Respiratory Distress Syndrome (ARDS)		<b>NTDB REQUIRED</b>	

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Alcohol Withdrawal Syndrome		<b>NTDB REQUIRED</b>	
Cardiac Arrest with CPR		<b>NTDB REQUIRED</b>	
Catheter-Associated Urinary Tract Infection (CAUTI)		<b>NTDB REQUIRED</b>	
Central Line-Associated Bloodstream Infection (CLABSI)		<b>NTDB REQUIRED</b>	
Deep Surgical Site Infection		<b>NTDB REQUIRED</b>	
Deep Vein Thrombosis (DVT)		<b>NTDB REQUIRED</b>	
Extremity Compartment Syndrome		<b>NTDB REQUIRED</b>	
Myocardial Infarction (MI)		<b>NTDB REQUIRED</b>	
Organ/Space Surgical Site Infection		<b>NTDB REQUIRED</b>	
Osteomyelitis		<b>NTDB REQUIRED</b>	
Pressure Ulcer		<b>NTDB REQUIRED</b>	
Pulmonary Embolism (PE)		<b>NTDB REQUIRED</b>	
Severe Sepsis		<b>NTDB REQUIRED</b>	
Stroke/CVA		<b>NTDB REQUIRED</b>	
Superficial Incisional Surgical Site Infection		<b>NTDB REQUIRED</b>	
Unplanned Admission to ICU		<b>NTDB REQUIRED</b>	
Unplanned Intubation		<b>NTDB REQUIRED</b>	
Ventilator-Associated Pneumonia (VAP)		<b>NTDB REQUIRED</b>	

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Unplanned Return to the Operating Room		<b>NTDB REQUIRED</b>	
Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)		<b>NTDB REQUIRED</b>	
Advance Directive Limiting Care		<b>NTDB REQUIRED</b>	
Alcohol Use Disorder		<b>NTDB REQUIRED</b>	
Angina Pectoris		<b>NTDB REQUIRED</b>	
Anticoagulant Therapy		<b>NTDB REQUIRED</b>	
Bleeding Disorder		<b>NTDB REQUIRED</b>	
Cerebral Vascular Accident (CVA)		<b>NTDB REQUIRED</b>	
Chronic Obstructive Pulmonary Disease (COPD)		<b>NTDB REQUIRED</b>	
Chronic Renal Failure		<b>NTDB REQUIRED</b>	
Cirrhosis		<b>NTDB REQUIRED</b>	
Myocardial Infarction (MI)		<b>NTDB REQUIRED</b>	
Congenital Anomalies		<b>NTDB REQUIRED</b>	
Congestive Heart Failure (CHF)		<b>NTDB REQUIRED</b>	
Currently Receiving Chemotherapy for Cancer		<b>NTDB REQUIRED</b>	
Current Smoker		<b>NTDB REQUIRED</b>	
Dementia		<b>NTDB REQUIRED</b>	

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Diabetes Mellitus		<b>NTDB REQUIRED</b>	
Disseminated Cancer		<b>NTDB REQUIRED</b>	
Functionally Dependent Health Status		<b>NTDB REQUIRED</b>	
Hypertension		<b>NTDB REQUIRED</b>	
Mental/Personality Disorders		<b>NTDB REQUIRED</b>	
Peripheral Arterial Disease (PAD)		<b>NTDB REQUIRED</b>	
Prematurity		<b>NTDB REQUIRED</b>	
Steroid Use		<b>NTDB REQUIRED</b>	
Substance Abuse Disorder		<b>NTDB REQUIRED</b>	
Hospital Length of Stay- Calendar Days (Physical D/C)	TR25.44		<b>STATE REQUIRED</b>
Hospital Length of Stay (Total Minutes) (Physical D/C)	TR25.44.Mins		<b>STATE REQUIRED</b>
Total ICU Days	TR26.9	<b>NTDB REQUIRED</b>	
Total Vent Days	TR26.58	<b>NTDB REQUIRED</b>	
Primary Method of Payment	TR2.5	<b>NTDB REQUIRED</b>	
Reimbursed Charges	TR2.8		<b>STATE REQUIRED</b>
Secondary Method of Payment	TR2.7		<b>STATE REQUIRED</b>
Third Method of Payment	TR2.18		<b>STATE REQUIRED</b>
Billed Hospital Charges	TR2.9		<b>STATE REQUIRED</b>

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Work Related	TR2.10		STATE REQUIRED
Admission Ward	TR44.3		STATE REQUIRED
Bed Number	TR44.4		STATE REQUIRED
Consultant/Staff	TR44.5		STATE REQUIRED
Medical Specialty	TR44.6		STATE REQUIRED
Admission Date	TR44.1		STATE REQUIRED
Total Log of Admission Time	TR44.9		STATE REQUIRED
Hospital Department Discharge Disposition	TR25.27		STATE REQUIRED
Clinical Note Type	TR5.27		STATE REQUIRED
Clinical Note	TR5.24		STATE REQUIRED
Clinical Note Entered by	TR5.26		STATE REQUIRED
Clinical Note Date/Time	TR5.25		STATE REQUIRED

# 2020 NTDB Dictionary Change Log

**Wyoming Trauma Registry Data Dictionary v2020.1**

<b>Change Date</b>	<b>Admission Year</b>	<b>Field Name</b>	<b>Change Location</b>	<b>Change Text</b>
Aug-19	2020	NTDS PATIENT INCLUSION CRITERIA		CHANGED
Aug-19	2020	MULTIPLE ENTRIES	TAG NUMBER	REMOVAL OF TAG NUMBERS IN UPPER RIGHT HAND CORNER
Aug-19	2020	MULTIPLE ENTRIES	Collection Criterion	CHANGED TO: REPORTING CRITERION
Aug-19	2020	MULTIPLE ENTRIES	Element Values	CHANGED TO: Element Value
Aug-19	2020	ALTERNATE HOME RESIDENCE	Associated Edit Checks	NEW: 0503 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	ALTERNATE HOME RESIDENCE	Associated Edit Checks	CHANGED: 0540 to Multiple Entry Max exceeded
Aug-19	2020	ALTERNATE HOME RESIDENCE	Additional Information	ADDED: Report all that apply
Aug-19	2020	INJURY INCIDENT DATE	Associated Edit Checks	CHANGED: 1212 Injury Incident Date is greater than 14 days earlier than the ED/Hospital Arrival Date
Aug-19	2020	PROTECTIVE DEVICES	Associated Edit Checks	ADDED: 2508 Element cannot be "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	REPORT OF PHYSICAL ABUSE		RETIRED
Aug-19	2020	INVESTIGATION OF PHYSICAL ABUSE		RETIRED
Aug-19	2020	CAREGIVER AT DISCHARGE		RETIRED
Aug-19	2020	TRAUMA CENTER CRITERIA	TITLE	CHANGED TO: TRAUMA TRIAGE CRITERIA (Steps 1 and 2)
Aug-19	2020	VEHICULAR, PEDESTRIAN, OTHER RISK INJURY	TITLE	CHANGED TO: TRAUMA TRIAGE CRITERIA (Steps 3 and 4)
Aug-19	2020	INITIAL FIELD SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	CHANGED: 3603 to The value is above 220
Aug-19	2020	INITIAL FIELD SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 3606 The value submitted falls outside the valid range of 0-380
Aug-19	2020	INITIAL FIELD SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 3607 The value is below 30
Aug-19	2020	INITIAL FIELD SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	RETIRED: 3605
Aug-19	2020	INITIAL FIELD PULSE RATE	Associated Edit Checks	CHANGED: 3703 The value submitted is above 220
Aug-19	2020	INITIAL FIELD PULSE RATE	Associated Edit Checks	ADDED: 3706 The value submitted falls outside the valid range of 0-300
Aug-19	2020	INITIAL FIELD PULSE RATE	Associated Edit Checks	ADDED: The value submitted is below 30
Aug-19	2020	INITIAL FIELD PULSE RATE	Associated Edit Checks	RETIRED: 3705

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Aug-19	2020	INITIAL FIELD RESPIRATORY RATE	Associated Edit Checks	ADDED: 3806 The value submitted falls outside the valid range of 0-100
Aug-19	2020	INITIAL FIELD RESPIRATORY RATE	Associated Edit Checks	ADDED: The value is below 5
Aug-19	2020	INITIAL FIELD RESPIRATORY RATE	Associated Edit Checks	ADDED: 3808 The value is above 75
Aug-19	2020	INITIAL FIELD RESPIRATORY RATE	Associated Edit Checks	RETIRED: 3805
Aug-19	2020	INITIAL FIELD OXYGEN SATURATION	Associated Edit Checks	CHANGED: 3901 Invalid value
Aug-19	2020	INITIAL FIELD OXYGEN SATURATION	Associated Edit Checks	ADDED: 3906 The value submitted falls outside the valid range 0-100
Aug-19	2020	INITIAL FIELD OXYGEN SATURATION	Associated Edit Checks	ADDED: The value is below 40
Aug-19	2020	INITIAL FIELD OXYGEN SATURATION	Associated Edit Checks	RETIRED: 3905
Aug-19	2020	INITIAL FIELD GCS - EYE	Associated Edit Checks	RETIRED: 4005
Aug-19	2020	INITIAL FIELD GCS - VERBAL	Associated Edit Checks	RETIRED: 4105
Aug-19	2020	INITIAL FIELD GCS - MOTOR	Associated Edit Checks	RETIRED: 4205
Aug-19	2020	INITIAL FIELD GCS - TOTAL	Associated Edit Checks	RETIRED: 4305
Aug-19	2020	INITIAL FIELD GCS 40 - EYE	Associated Edit Checks	RETIRED: 15005
Aug-19	2020	INITIAL FIELD GCS 40 - VERBAL	Associated Edit Checks	RETIRED: 15105
Aug-19	2020	INITIAL FIELD GCS 40 - MOTOR	Associated Edit Checks	RETIRED: 15206
Aug-19	2020	TRAUMATRIAGE CRITERIA (STEPS 1 AND 2)	Associated Edit Checks	RETIRED: 9505
Aug-19	2020	TRAUMA TRIAGE CRITERIA (STEPS 3 AND 4)	Associated Edit Checks	RETIRED: 9605
Aug-19	2020	TRAUMATRIAGE CRITERIA (STEPS 1 AND 2)	Associated Edit Checks	ADDED: 9506 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	TRAUMA TRIAGE CRITERIA (STEPS 3 AND 4)	Associated Edit Checks	ADDED: 9607 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	PRE-HOSPITAL CARDIAC ARREST	Additional Information	REMOVED: "by a healthcare provider who is trained to perform basic and/or advanced cardiac life support" from the 3rd bullet
Aug-19	2020	INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	CHANGED: 4704 The value is above 220
Aug-19	2020	INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 4706 The value submitted falls outside the valid range of 0-380
Aug-19	2020	INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 4707 The value is below 30
Aug-19	2020	INITIAL ED/HOSPITAL PULSE RATE	Associated Edit Checks	CHANGED: 4804 The value is above 220
Aug-19	2020	INITIAL ED/HOSPITAL PULSE RATE	Associated Edit Checks	ADDED: 4806 The value submitted falls outside the valid range of 0-300
Aug-19	2020	INITIAL ED/HOSPITAL PULSE RATE	Associated Edit Checks	ADDED: The value is below 30

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Aug-19	2020	INITIAL ED/HOSPITAL TEMPERATURE	Associated Edit Checks	CHANGED: 4903 The value is above 42.0
Aug-19	2020	INITIAL ED/HOSPITAL TEMPERATURE	Associated Edit Checks	ADDED: 4905 The value submitted falls out the valid range of 10.0-45.0
Aug-19	2020	INITIAL ED/HOSPITAL TEMPERATURE	Associated Edit Checks	ADDED: 4906 The vlue is below 20.0
Aug-19	2020	INITIAL ED/HOSPITAL RESPIRATORY RATE	Associated Edit Checks	CHANGED: 5001 Invalid Value
Aug-19	2020	INITIAL ED/HOSPITAL RESPIRATORY RATE	Associated Edit Checks	CHANGED: 5005 The value submitted falls outside the valid range of 0-100
Aug-19	2020	INITIAL ED/HOSPITAL RESPIRATORY RATE	Associated Edit Checks	ADDED: 5007 The value is below 5
Aug-19	2020	INITIAL ED/HOSPITAL RESPIRATORY RATE	Associated Edit Checks	ADDED: 5008 The value is above 75
Aug-19	2020	INITIAL ED/HOSPITAL OXYGEN SATURATION	Associated Edit Checks	CHANGED: 5201 Invalid value
Aug-19	2020	INITIAL ED/HOSPITAL OXYGEN SATURATION	Associated Edit Checks	ADDED: 5206 The value submitted falls outside the valid range of 0-100
Aug-19	2020	INITIAL ED/HOSPITAL OXYGEN SATURATION	Associated Edit Checks	ADDED: 5207 The value is below 40
Aug-19	2020	INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS	Associated Edit Checks	ADDED: 5805 Element cannot bel "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	INITIAL ED/HOSPITAL HEIGHT	Associated Edit Checks	CHANGED: 8503 The value is above 215
Aug-19	2020	INITIAL ED/HOSPITAL HEIGHT	Associated Edit Checks	ADDED: 8505 The value submitted falls outside the valid range of 30-275
Aug-19	2020	INITIAL ED/HOSPITAL HEIGHT	Associated Edit Checks	ADDED: 8506 The value is below 50
Aug-19	2020	INITIAL ED/HOSPITAL WEIGHT	Associated Edit Checks	CHANGED: 8603 The value is above 200
Aug-19	2020	INITIAL ED/HOSPITAL WEIGHT	Associated Edit Checks	ADDED: 8605 The value submitted falls outside the valid range 1-650
Aug-19	2020	INITIAL ED/HOSPITAL WEIGHT	Associated Edit Checks	ADDED: 8606 The value is below 3
Aug-19	2020	DRUG SCREEN	Associated Edit Checks	ADDED: 6014 Element cannot be "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	ALCOHOL SCREEN RESULTS	Associated Edit Checks	ADDED: 5935 The value submitted falls outside the valid range of 0.0-1.5
Aug-19	2020	ALCOHOL SCREEN RESULTS	Associated Edit Checks	ADDED: 5936 The value is above 0.4
Aug-19	2020	ED DISCHARGE DISPOSITION	Definition	CHANGED TO: The disposition unit the order was written for the patient to be discharged from the ED.
Aug-19	2020	ED DISCHARGE DISPOSITION	Element Values	Removed "(unit that provide <24 hour stays)" from Field Value 2.

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Aug-19	2020	ED DISCHARGE DISPOSITION	Additional Information	Added: If multiple orders were written, report the final disposition order.
Aug-19	2020	SIGNS OF LIFE	ELEMENT	RETIRED
Aug-19	2020	ALCOHOL USE DISORDER	Definition	CHANGED TO: Descriptors documented in the medical record consistent with the diagnostic criteria of alcohol use disorder OR a diagnosis of alcohol use disorder documented in the patient's medical record.
Aug-19	2020	ALCOHOL USE DISORDER	Additional Information	REMOVED: A diagnosis of Alcohol Use Disorder must be documented in the patient's medical record.
Aug-19	2020	MENTAL/PERSONALITY DISORDERS (Pre-Existing Condition)	Definition	CHANGED TO: History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record: <ul style="list-style-type: none"> <li>• Schizophrenia</li> <li>• Bipolar Disorder</li> <li>• Major Depressive Disorder</li> <li>• Social Anxiety Disorder</li> <li>• Posttraumatic Stress Disorder</li> <li>• Antisocial Personality Disorder</li> </ul>
Aug-19	2020	MENTAL/PERSONALITY DISORDERS (Pre-Existing Condition)	Additional Information	REMOVED: A diagnosis of Mental/Personality disorder must be documented in the patient's medical record.
Aug-19	2020	PREGNANCY (Pre-Existing Condition)	ELEMENT	NEW
Aug-19	2020	SUBSTANCE ABUSE DISORDER (Pre-Existing Condition)	TITLE	CHANGED TO: SUBSTANCE USE DISORDER

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Aug-19	2020	SUBSTANCE USE DISORDER (Pre-Existing Condition)	Definition	<p>CHANGED TO: 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:</p> <ul style="list-style-type: none"> <li>• Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder</li> <li>• 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</li> <li>• Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder</li> <li>• Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder</li> <li>• Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder</li> <li>• Stimulant Use Disorder; Other Stimulant-Induced Disorder; Unspecified Stimulant-Related Disorder</li> </ul>
Aug-19	2020	SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	CHANGED TO: Present prior to arrival at your center
Aug-19	2020	SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	REMOVED: A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record
Aug-19	2020	SUBSTANCE USE DISORDER (Pre-Existing Condition)	Additional Information	REMOVED: EXCLUDE: Tobacco Use Disorder and Alcohol Use Disorder
Aug-19	2020	AIS PREDOT CODE	ELEMENT	RETIRED
Aug-19	2020	AIS CODE	ELEMENT	NEW
Aug-19	2020	AIS SEVERITY	ELEMENT	RETIRED

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Aug-19	2020	CARDIAC ARREST WITH CPR	Additional Information	CLARIFIED TO: "EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital."
Aug-19	2020	CARDIAC ARREST WITH CPR	Additional Information	CLARIFIED TO: "INCLUDE patients who after arrival at your hospital have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation."
Aug-19	2020	DELIRIUM (Hospital Event)	ELEMENT	NEW
Aug-19	2020	MYOCARDIAL INFARCTION (MI) (Hospital Event)	Definition	CHANGED TO: An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI AND New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia AND Physician diagnosis of an acute myocardial infarction that occurred subsequent to arrival at your center
Aug-19	2020	MYOCARDIAL INFARCTION (MI) (Hospital Event)	Additional Information	Removed: A diagnosis of MI must be documented in the patient's medical record.
Aug-19	2020	UNPLANNED RETURN TO THE OPERATING ROOM (Hospital Event)	ELEMENT	RETIRED
Aug-19	2020	UNPLANNED VISIT TO THE OPERATING ROOM (Hospital Event)	ELEMENT	NEW
Aug-19	2020	HOSPITAL DISCHARGE DATE	Associated Edit Checks	CHANGED 7712 TO: Element must be "Not Applicable" when ED Discharge Disposition is 4,5, 6, 9,10, or 11
Aug-19	2020	HOSPITAL DISCHARGE TIME	Associated Edit Checks	CHANGED 7809 TO: Element must be "Not Applicable" when ED Discharge Disposition is 4, 5, 6, 9, 10, or 11
Aug-19	2020	TOTAL ICU LENGTH OF STAY	Associated Edit Checks	CHANGED: 7501 Invalid value
Aug-19	2020	TOTAL ICU LENGTH OF STAY	Associated Edit Checks	CHANGED: 7504 The value is above 60
Aug-19	2020	TOTAL ICU LENGTH OF STAY	Associated Edit Checks	ADDED: 7505 The value submitted falls outside the valid range of 1-575
Aug-19	2020	TOTAL VENTILATOR DAYS	Associated Edit Checks	CHANGED: 7601 Invalid value
Aug-19	2020	TOTAL VENTILATOR DAYS	Associated Edit Checks	CHANGED: 7604 The value is above 60
Aug-19	2020	TOTAL VENTILATOR DAYS	Associated Edit Checks	ADDED: 7605 The value submitted falls outside the valid range 1-575

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Aug-19	2020	HOSPITAL DISCHARGE DISPOSITION	Additional Information	Added: If multiple orders were written, report the final disposition order.
Aug-19	2020	HOSPITAL DISCHARGE DISPOSITION	Associated Edit Checks	CHANGED: 7908 Element cannot be "Not Applicable" if ED Discharge Disposition is not 4, 5, 6, 9, 10 or 11
Aug-19	2020	GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL	Associated Edit Checks	ADDED: 10207 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	CEREBRAL MONITOR	Associated Edit Checks	ADDED: 10306 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE	Definition	CHANGED TO: Date of administration of first dose of VTE prophylaxis administered to patient at your hospital
Aug-19	2020	VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME	Definition	CHANGED TO: Time of administration of first dose of VTE prophylaxis administered to patient at your hospital
Aug-19	2020	TRANSFUSION BLOOD (4 HOURS)	ELEMENT	RETIRED
Aug-19	2020	PACKED RED BLOOD CELLS	ELEMENT	NEW
Aug-19	2020	TRANSFUSION BLOOD MEASUREMENT	ELEMENT	RETIRED
Aug-19	2020	TRANSFUSION BLOOD CONVERSION	ELEMENT	RETIRED
Aug-19	2020	WHOLE BLOOD	ELEMENT	NEW
Aug-19	2020	TRANSFUSION PLASMA (4 HOURS)	ELEMENT	RETIRED
Aug-19	2020	PLASMA	ELEMENT	NEW
Aug-19	2020	TRANSFUSION PLASMA MEASUREMENT	ELEMENT	RETIRED
Aug-19	2020	TRANSFUSION PLASMA CONVERSION	ELEMENT	RETIRED
Aug-19	2020	TRANSFUSION PLATELETS (4 HOURS)	ELEMENT	RETIRED
Aug-19	2020	PLATELETS	ELEMENT	NEW
Aug-19	2020	TRANSFUSION PLATELETS MEASUREMENT	ELEMENT	RETIRED
Aug-19	2020	TRANSFUSION PLATELETS CONVERSION	ELEMENT	RETIRED
Aug-19	2020	CRYOPRECIPITATE (4 HOURS)	ELEMENT	RETIRED
Aug-19	2020	CRYOPRECIPITATE	ELEMENT	NEW
Aug-19	2020	CRYOPRECIPITATE MEASUREMENT	ELEMENT	RETIRED
Aug-19	2020	CRYOPRECIPITATE CONVERSION	ELEMENT	RETIRED

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Aug-19	2020	LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Additional Information	REMOVED: Refers to lowest SBP in the ED/Hospital of the index hospital, where index hospital is the hospital abstracting the data.
Aug-19	2020	LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	CHANGED: 10903 The value is above 220
Aug-19	2020	LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 10908 The value submitted falls outside the valid range of 0-380
Aug-19	2020	LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE	Associated Edit Checks	ADDED: 10909 The value is below 30
Aug-19	2020	ANGIOGRAPHY	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	ANGIOGRAPHY	Definition	CHANGED TO: First interventional angiogram for hemorrhage control within first 24 hours of ED/Hospital arrival.
Aug-19	2020	EMBOLIZATION SITE	Element Values	RETIRED: Field Value 7. Aorta (thoracic or abdominal)
Aug-19	2020	EMBOLIZATION SITE	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	EMBOLIZATION SITE	Associated Edit Checks	CHANGED: 11804 Element should be "Not Applicable" when Angiography is "1. None", or "2. Angiogram only", or "4. Angiogram with stenting"
Aug-19	2020	EMBOLIZATION SITE	Associated Edit Checks	ADDED: 11805 Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other valid value
Aug-19	2020	ANGIOGRAPHY DATE	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	ANGIOGRAPHY DATE	Associated Edit Checks	CHANGED: 11904 Element cannot be "Not Applicable" when Angiography is "2. 'Angiogram only', 3. 'Angiogram with embolization', or 4. 'Angiogram with stenting'"

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Aug-19	2020	ANGIOGRAPHY TIME	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	ANGIOGRAPHY TIME	Associated Edit Checks	CHANGED: 12004 Element cannot be "Not Applicable" when Angiography is "2.'Angiogram only', 3. 'Angiogram with embolization', or 4. 'Angiogram with stenting'"
Aug-19	2020	SURGERY FOR HEMORRHAGE CONTROL TYPE	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	SURGERY FOR HEMORRHAGE CONTROL DATE	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	SURGERY FOR HEMORRHAGE CONTROL DATE	Additional Information	ADDED: Procedure start date is defined as the date the incision was made (or the procedure started).
Aug-19	2020	SURGERY FOR HEMORRHAGE CONTROL TIME	Reporting Criterion	CHANGED TO: Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/hospital arrival
Aug-19	2020	SURGERY FOR HEMORRHAGE CONTROL TIME	Additional Information	ADDED: Procedure start time is defined as the time the incision was made (or the procedure started).
Aug-19	2020	ANTIBIOTIC THERAPY	Additional Information	ADDED: Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines
Aug-19	2020	ANTIBIOTIC THERAPY DATE	Additional Information	ADDED: Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines
Aug-19	2020	ANTIBIOTIC THERAPY TIME	Additional Information	ADDED: Open fractures as defined by the Association for the Advancement of Automotive Medicine AIS Coding Rules and Guidelines
Aug-19	2020	ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Additional Information	ADDED: Report all that apply (maximum 2)
Aug-19	2020	ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Associated Edit Checks	CHANGED: 9140 TO: Multiple Entry Max exceeded

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Aug-19	2020	ICD-10 ADDITIONAL EXTERNAL CAUSE CODE	Associated Edit Checks	ADDED: 9105 ICD-10 T74 and T76 codes cannot be submitted as Additional External Cause Codes
Aug-19	2020	RACE	Associated Edit Checks	CHANGED: 0903 TO: Element cannot be "Not Applicable" (excluding CA hospitals)
Aug-19	2020	ETHNICITY	Associated Edit Checks	CHANGED: 1003 TO: Element cannot be "Not Applicable" (excluding CA hospitals)
Aug-19	2020	INJURY INCIDENT DATE	Associated Edit Checks	CHANGED: 1212 to Level 3
Aug-19	2020	INITIAL FIELD GCS - TOTAL	Associated Edit Checks	CHANGED: 4303 to Level 3
Aug-19	2020	INITIAL FIELD GCS - TOTAL	Associated Edit Checks	CHANGED: 4303 TO: Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS -- Motor, unless any of these values are "Not Known/Not Recorded"
Aug-19	2020	INITIAL ED/HOSPITAL GCS - TOTAL	Associated Edit Checks	CHANGED: 5703 TO Level 3
Aug-19	2020	INITIAL ED/HOSPITAL GCS - TOTAL	Associated Edit Checks	CHANGED: 5703 TO: Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS -- Motor, unless any of these values are "Not Known/Not Recorded"
Aug-19	2020	HOSPITAL DISCHARGE DATE	Associated Edit Checks	RETIRED: 7713
Aug-19	2020	HOSPITAL DISCHARGE DISPOSITION	Associated Edit Checks	RETIRED: 7903
Aug-19	2020	HIGHEST GCS TOTAL	Associated Edit Checks	CHANGED: 10005 TO: Element should not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
Aug-19	2020	HIGHEST GCS MOTOR	Associated Edit Checks	CHANGED: 10105 TO: Element should not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
Aug-19	2020	GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL	Associated Edit Checks	CHANGED: 10204 TO: Element should not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day

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Aug-19	2020	HIGHEST GCS 40 - MOTOR	Associated Edit Checks	CHANGED 20605 TO: Element should not be "Not Applicable" as the AIS codes provided meet the reporting criteria, unless the patients ED Discharge Disposition Date or Hospital Discharge Date is prior to the next calendar day
Aug-19	2020	HOSPITAL DISCHARGE TIME	Associated Edit Checks	RETIRED: 7810