Trauma Data Collection File Specification

For XML Data Filers

November 2019

Version 5.08

2019 Admissions

This edition is effective for all

trauma patients presenting for

treatment on or after October 1, 2018 until September 30, 2019

Bureau of Health Care Safety and Quality

Massachusetts Department of Public Health

# Acknowledgements

The Bureau of Health Care Safety and Quality would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create the Massachusetts Trauma Registry. The current upgrades to the system and variable list are being done to continue the growth of the trauma registry and keep building on their knowledge and hard work.

**Table of Contents**

*Massachusetts Trauma Registry is maintained by the Bureau of Health Care Safety and Quality, 250 Washington Street, Boston, MA 02108. For more information about the Massachusetts Trauma Registry, contact the Massachusetts Department of Public Health, Bureau of Health Care Safety and Quality (Bureau), at*

*(617)-753-8000, or visit* [*https://www.mass.gov/service-details/state-trauma-registry-data-submission*](https://www.mass.gov/service-details/state-trauma-registry-data-submission)

[Acknowledgements 1](#_Toc1992830)

[Revision History 4](#_Toc1992831)

[Data Collection Requirement 7](#_Toc1992832)

[Submittal Schedule 8](#_Toc1992833)

[Protection of Confidentiality of Data 8](#_Toc1992834)

[Trauma Data Submission Overview 8](#_Toc1992835)

[Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-10 8](#_Toc1992836)

[FOR ICD-10-CM External Cause Code: 9](#_Toc1992837)

[Common Null Value 10](#_Toc1992838)

[Definition 10](#_Toc1992839)

[Field Values 10](#_Toc1992840)

[Additional Information 12](#_Toc1992841)

[Validation Edit Report 12](#_Toc1992842)

[Flag Fields for File Submission 13](#_Toc1992843)

[Resources 13](#_Toc1992844)

[Data File Format 14](#_Toc1992845)

[Data Transmission Media Specifications 14](#_Toc1992846)

[Link to Documentation 14](#_Toc1992847)

[Help Desk Information 14](#_Toc1992848)

[Health Safety Net Links 14](#_Toc1992849)

[Applicable Regulations 14](#_Toc1992850)

[Standard Definitions 15](#_Toc1992851)

[Data Field Service Level Code Definitions 15](#_Toc1992852)

[Trauma Data Quality Standards 16](#_Toc1992853)

[Differences Between Trauma File Specification Version 4.0 and Version 5.0 (this version) 17](#_Toc1992854)

[Version 5.0 XML File 17](#_Toc1992855)

[Edits based on Submitting Entity Type 17](#_Toc1992856)

[2019 Admissions updates reflected in Specification Guides 17](#_Toc1992857)

[Fields no Longer Required 17](#_Toc1992858)

[Trauma Data Record Specification 19](#_Toc1992859)

[Record Specification Elements 19](#_Toc1992860)

[Trauma Data Code Tables 208](#_Toc1992861)

[Massachusetts Trauma Sample XML File 219](#_Toc1992862)

# Revision History

All notes made about guide changes prior to Jan 1, 2018 can be found in the specification guides for 2017 and 2018 submissions for XML Data Filers at our website: <https://www.mass.gov/service-details/state-trauma-registry-data-submission>.

The 2019 revision history will only contain any notes starting at January 1, 2018 onward.

2/21/2018 Added in a 0. Not Recorded code to Initial Glasgow Eye Component in ED, Initial Glasgow Verbal Component in ED, Initial Glasgow Motor Component in ED, Glasgow Coma Score Total in the ED, Glasgow Coma Score Assessment Qualifier in the ED 1, Glasgow Coma Score Assessment Qualifier in the ED 2, and Glasgow Coma Score Assessment Qualifier in the ED 3. ‘Field can not be not applicable.’ sentence will be taken out of Incident County. Remove Incident City from the Incident Country description.

4/26/2018 Updated the sample .XSD file in Appendix.

5/3/2018 Injury Incident Date - when there is a partial date where only the month and year are able to be determine but the day is not able to be confirmed then enter ‘01’.

6/11/2018 Changing field to reflect changes determined in 10/29/2017 Total ICU Length of Stay, Total Ventilator Days: Added: If data field is “Not Applicable” then enter code 888.

10/3/2018 Change from B type errors to warnings for Hospital Procedure Start Date and Hospital Procedure Start Time.

11/21/2018 Went through the specification guide and highlighted the areas that will need to be updated for the 2019 submissions. Change the month, version, submission year and time frame in the specification guide to reflect the 2019 submissions. Changed Care in the message box and updated the link to the Website. Removed all the revision history except any notes that were made after 2019 and placed a few sentences at beginning section that communicates the changes that were made.

11/24/2018 Boxed in the sentences at the beginning of Revision History. Added some words to clarify a sentence in Data Collection Requirement. Updated the paragraph in the Submittal Schedule. Removed the ICD-9 coding information from the Trauma Data Submission Overview left on the ICD-10 coding information. Added a few words to the paragraph in the Validation Edit Report. Updated the links in Resources section and Data Transmission Media Specification section. Added in the links to Healthy Safety Net INET and Home page. Added wording to the paragraph in the Standard Definitions section. Added wording and rearranged the bullets in the Trauma Data Quality Standards section. Updated and added words/sentences/paragraphs in the Differences Between Trauma File Specification Version 4.0 and Version 5.0 section. Updated the wording in the Trauma Data Record Specification section right before the table.

11/26/2018 Updated the edit table current fields with additional edits and removal of old edit information. Inter-Facility Transfer – added single entry edit, Glasgow Coma Score Assessment Qualifier in the ED – added reasons for null values and multiple entry edit, Patient Home Country – added single entry edit, Patient Home County – added single entry edit, Alternate Home Residence – added single entry edit, Age – removed several edits, added single entry edit, Age Units – added a code, removed several edits, added single entry edit, Ethnicity – changed an edit to include US hospitals only, added single entry edit, Patient Occupational Industry – added single entry edit, Patient Occupation – added single entry edit, Incident Location Postal Code – added single entry edit, Incident Country – added single entry edit, Incident County – added non-US hospitals to an edit, added single entry edit, Report of Physical Abuse – added as defined by state/local authorities, added single entry edit, Investigation of Physical Abuse – remove a code, added single entry edit, Caregiver at Discharge – added single entry edit, EMS Dispatch Date – removed several edits, added a reason for a null value, added single entry edit, EMS Dispatch Time – removed several edits, added a reason for a null value, added single entry edit, EMS Unit Arrival Date at Scene or Transferring Facility – removed an edit, changed a null value reason, added single entry edit, EMS Unit Arrival Time at Scene or Transferring Facility – removed an edit, changed a null value reason, added single entry edit, EMS Unit Departure Date from Scene or Transferring Facility – removed an edit, changed a null value reason, added single entry edit, EMS Unit Departure Time from Scene or Transferring Facility – removed an edit, changed a null value reason, added single entry edit, Initial Field systolic blood pressure – changed a null value reason, added single entry edit, Initial Field Pulse Rate – changed a null value reason, added single entry edit, Initial Field Respiratory Rate – changed a null value reason, removed several edits, added an edit, added single entry edit, Initial Field Oxygen Saturation – changed a null value reason, added single entry edit, Initial Field GCS EYE – changed a null value reason, added several null value reasons, removed an edit, added single entry edit, Initial Field GCS Verbal – removed an edit, changed a null value reason, added a null value reason, added single entry edit, Initial Field GCS Motor – removed an edit changed a null value reason, added a null value reason, added single entry edit, Initial Field GCS Total – change a null value reason, added several null value reasons, added single entry edit , Trauma Center Criteria – added an entry directive, added single entry edit, Vehicular Pedestrian Other Risk Injury – added an entry directive, added a null value reason, added single entry edit, Pre Hospital Cardiac Arrest – added a code, added single entry edit, Initial ED Hospital Temperature – added single entry edit, Initial ED Hospital Respiratory Assistance – added single entry edit, Initial ED Hospital Oxygen Saturation – added single entry edit, Initial ED Hospital Supplemental Oxygen – removed an edit, added a null value reason, added single entry edit, Initial ED Hospital Height – changed the definition, added a null value reason, added single entry edit, Initial ED Hospital Weight – changed the definition, added a null value reason, added single entry edit, ED Discharge Disposition – added single entry edit, Signs of life – removed an edit, changed several definitions, added single entry edit, Total ICU Length of Stay - added single entry edit, Total Ventilator Days - added single entry edit, Hospital Discharge Date – removed an edit, added single entry edit, Hospital Discharge Time – removed an edit, added single entry edit, Hospital Discharge Disposition – removed an edit, added single entry edit, Primary Method of Payment – added single entry edit, Race1 & Race2 – removed several edits, added a null value reason, added multiple entry edit (2) , OtherTransportMode – added multiple entry edit (5), ICD10 Hospital Procedure Code – changed an edit, updated a definition, removed an edit, added multiple entry edit (200),Hospital Procedures Start Date – removed an edit, added multiple entry edit (200), added an unknown code, and Hospital Procedures Start Time – added an unknown code, added multiple entry edit (200).

11/27/2018 Updated the edit table current fields with additional edits and removal of old edit information. ED Discharge Date – changed the definition, added a null value edit, added an edit, added single entry edit, Ed Discharge Time - changed the definition, added a null value edit, added an edit, added single entry edit, ED/Hospital Arrival Date – removed several edits, added single entry edit, ED/Hospital Arrival Time – added single entry edit, Date of Birth – changed an edit, added single entry edit, Gender – added single entry edit, Patient Street Address – changed an edit, Alcohol Screen – added single entry edit, Alcohol Screen Results – changed the results definition and example, added single entry edit, DrugScreen – added multiple entry edit (5), Patient City – change an edit, add an edit, Transport Mode – added single entry edit, ICD10 Primary External Cause Code – changed an edit, ICD10 Place of Occurrence External Cause Code - added single entry edit, and Additional ICD10 External Cause Code – removed an edit, added single entry edit.

11/28/2018 Changed the several table headings XSD Field Name and XSD Data Type to XML Field Name and XML Data Type. Patient Zip Code – added single entry edit, changed several edits, Injury Incident Date – added single entry edit, Injury Incident Time – added single entry edit, Work-related – added single entry edit, Incident City – changed edit error to B, removed an edit, added single entry edit, Initial Glasgow Eye Component in ED – removed an edit, added several edits, added single entry edit, Initial Glasgow Verbal Component in ED - removed an edit, added several edits, added single entry edit, Initial Glasgow Motor Component in ED - removed an edit, added several edits, added single entry edit, Glasgow Coma Score Total in the ED - added several edits, added single entry edit, Respiration Rate - added single entry edit, Blood Pressure - added single entry edit, Pulse Rate - added single entry edit, Incident State – changed edit error to A, added single entry edit, Injury Diagnosis – removed an edit, added multiple entry edit, AIS – added multiple entry edit, AIS Version – added how to enter version AIS 2015, added single entry edit, Protective Devices – added an edit, added multiple entry edit, Child Specific restraint – added multiple entry edit, and Airbag Deployment – added multiple entry edit. Started to check and change hospital names.

11/29/2018 Finished checking and changing hospital names. DPH Facility ID Number – change edit error type to A. Removed the retired fields ICD9CMDiagnosiscode, Comorbid Conditions, and Complications and changed the row numbers in the table. Insert the new fields into the table using the information provide by vendor. Started to format the new fields.

11/30/2018 Continued to format new fields and check against change log for consistency.

12/3/2018 Finished checking the new fields against the change log. Started to pull table information from National Trauma Data Dictionary to enter the tables into the Trauma Data Code Tables section of document. Finished pulling and formatting tables for Deep Surgical Site Infection.

12/4/2108 Finished pulling and formatting tables for Organ Space Surgical Site Infection and Ventilator Associated Pneumonia VAP. All the tables were transferred into the specification guide and references about the tables were entered into the appropriate field information.

12/5/2018 Added the Drug Screen 1- 5 66 = (More than 5 drug categories in patient’s system) as a null value since we are only allowing 5 entries. Removed Used to calculate FIPS code from Incident State. Added all the GCS – 40 fields to null value with 0 = Not Recorded. Added all new yes/no fields to null value with 8 = Not Recorded and 9 = Unknown. Removed the Massachusetts Trauma .XSD section from the document to reduce any confusion about the XML file setup. Updated Massachusetts Trauma Sample XML File with version sent over by vendor.

12/13/2018 Corrected the table references in Deep Surgical Site Infection, Organ Space Surgical Site Infection and Ventilator Associated Pneumonia (VAP). Corrected Table 6 heading.

2/25/2019 Add in a note under Table 1. DPH and CHIA organizations IDs for Hospitals that explains the combination of two MetroWest facilities records (#49 MetroWest Medical Center – Framingham Union Campus and #457 MetroWest Medical Center – Leonard Morse / Natick) being submitted under one number (#49).

2/25/2019 Made a change in Table 1. Trauma Data Code Tables. Based on information from Health Safety Network, UMass Memorial Health Alliance Hospital – Leominister Campus Org ID 8509 needs to be changed to the prior Org ID 71 to be consistent with HSN Master Org ID list.

4/4/2019 Changed the Service Level edit error back to a Warning.

4/19/2019 Added a paragraph describing the new due dates for the 2019 Q1 and Q2 submissions. Changed the table back to the generic dates.

7/8/2019 Changed the CatheterAssocatedUrinaryTractInfectionCAUTI and ExtremityCompartmentSysndrom field names to CatheterAssociatedUrinaryTractInfectionCAUTI and ExtremityCompartmentSysndrome in the Massachusetts Trauma Sample XML File. Removed ‘ISO’ from the Patient Home Country description. It will only read ‘2-digit alpha country code’ with FIPS code in further explanation found in the table.

7/15/2019 Changed the address from 67 Forest Street, Marlborough, MA 01752 to 250 Washington Street, Boston, MA 02111.

9/25/2019 Add a code 7=Not Applicable choice to Unplanned Return to the Operating Room field.

10/9/2019 Change from B type errors to warnings for ICD 10 Hospital Procedure Code.

11/26/2019 Changed the ‘Not Applicable’ null value to ‘Not Recorded’ in the statement ‘The null value Not Applicable is used for patients who arrive by 4. Private/Public Vehicle/Walk-in’, for Initial Field Systolic Blood Pressure and Initial Field Pulse Rate.

# Data Collection Requirement

The Trauma Registry is a state database to which all hospitals are required to submit their trauma records, in accordance with the Department’s Hospital Licensure regulations (105 CMR 130.851 and 105 CMR 130.852) and Circular Letter (DHCQ 16-04-660, which is currently in the process of being updated).  Submission of the state trauma data is based on the criteria that are outlined in the submission guides.  Any hospital that does not receive any trauma patients needs to send an e-mail to verify that they have no trauma patients entering into their institution.

The trauma registry data initial submission is required to be submitted on the designated submission quarter due date. If the records for the designated quarter are completed and closed by the hospital prior to the submission date, the hospital may submit the data early to the trauma registry for that designated quarter.

Trauma Registry personnel may, at their discretion, and for good cause, grant an extension in time to a hospital submitting trauma data.

If the Validation Detail Report indicates to a hospital it is required to resubmit data after the initial submission quarter due date because the submission was rejected **or as part of a data verification process**, the hospital must submit its data no later than 30 days following the date of the notice to resubmit.

The use of ‘unknown’, ‘not applicable’, and ‘not recorded’ codes should be used as a last resort coding option after all other data resources have been exhausted for information about the specific variable being recorded.

# Submittal Schedule

Trauma Data File **must be submitted quarterly** through the Health Safety Network (HSN) SENDS/INET software application and must be submitted within 75 days of the close of the quarter. The records may have the injury incident date and final discharge date within the same quarter of submission or within different quarters of submission. The records included in each quarter is based on the injury incident date within the quarter of submission.

Per the circular letter: DHCQ – 19 – 4 – 689, the 2019 Q1 and 2019 Q2 submission files will be due by **July 31, 2019**. The subsequent due date for 2019 Q3 submissions will follow the reporting period dates provided in the table below.

|  |  |  |
| --- | --- | --- |
| **Quarter** | **Quarter Begin & End Dates** | **Due Date for Data File: 75 days following the end of the reporting period** |
| 1 | 10/1 - 12/31 | 3/16 |
| 2 | 1/1 - 3/31 | 6/14 |
| 3 | 4/1 - 6/30 | 9/13 |
| 4 | 7/1 - 9/30 | 12/14 |

# Protection of Confidentiality of Data

HSN shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, HSN shall ensure that any contract entered into with other parties for the purposes of processing and analysis of this data shall contain assurances such other parties shall also comply with the provisions of M.G.L. c. 66A.

# Trauma Data Submission Overview

## Massachusetts Trauma Registry Inclusion / Exclusion Criteria ICD-10

A trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria as a principle or primary diagnosis for the state trauma registry:

**ICD-10-CM starting 10/1/2015**

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

T07 (unspecified multiple injuries)

T14 (injury of unspecified body region)

T20 – T28 with 7th character modifier of A only (burns by specific body parts – initial encounter)

T30 – T32 (burn by TBSA percentages)

T79.A1 – T79.A19 (Upper extremity) T79.A2 - T79.A29 (Lower extremity) with 7th character modifier of A only (Traumatic Compartment Syndrome (extremity only) – initial encounter)

T75.1 with 7th character modifiers of A only (Unspecified effects of drowning and nonfatal submersion – initial encounter)

T71 with 7th character modifiers of A only (Asphyxiation / Strangulation – initial encounter)

**Excluding the following isolated injuries:**

S00 (Superficial injuries of the head)

S10 (Superficial injuries of the neck)

S20 (Superficial injuries of the thorax)

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

S40 (Superficial injuries of the shoulder and upper arm)

S50 (Superficial injuries of the elbow and forearm)

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

S70 (Superficial injuries of the hip and thigh)

S80 (Superficial injuries of the knee and lower leg)

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

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

**AND**

**Patient Admission Definition:**

* Hospital inpatient admission; **OR**
* Observation stay admission; **OR**
* Transfer patient via EMS transport (including air ambulance) from one hospital to another hospital (includes inpatient or observation or emergency department); **OR**
* Death (independent of hospital admission source or hospital transfer status)

**Note**:  When coding out all the variable fields use the best code to describe the direct injury or the information surrounding how the injury occurred.  Avoid using non-specified codes unless there is no other code that is better suited for the field after reviewing all the necessary documentation around the injury.

## FOR ICD-10-CM External Cause Code:

**MUST** be present if principal diagnosis is an injury: ICD-10-CM **(S00-S99)** or the following T-Codes:

(T07) unspecified multiple injuries

(T14) injury of unspecified body region

(T20-T32) burns and corrosions

(T79.A1 – T79.A19) upper extremity

(T79.A2 - T79.A29) lower extremity

(T75.1) drowning or nonfatal submersion

(T71) asphyxiation / strangulation

- If present, **MUST** be a valid ICD-10-CM External Cause Code of **V00-Y38, Y62-Y84** (3 - 7 digits with decimal point excluded).

- **ASSOCIATED** diagnostic fields may be used for additional external cause codes (V, W, X, Y) including supplemental codes: Y90-Y99 (place of injury, activity, status) and Z00-Z99 (factors influencing health status and seeking services).

# Common Null Value

## Definition

*Common Null Value* is a term used with Trauma Registry Data Elements to describe a blank field for specifically-defined data fields when an answer cannot be provided.

## Field Values

Blank field – Not Applicable/Not Known/Not Recorded/Not Documented

**State Trauma Registry Codes**

**Date and Time Coding**

99:99 - Not Applicable/Not Known/Not Recorded/Not Documented

99999999 - Not Applicable/Not Known/Not Recorded/Not Documented

XXXXXX01 – If partial date is the only date available for the Injury Incident Date then make sure month and year are filled in with the known information. The date can be filled in as the first of the month or ‘01’ in spaces that represent the date.

**Coded Unknowns**

**Work Related, Transport Mode, Ethnicity, Age Units, Investigation of Physical Abuse, Caregiver at Discharge, Initial Field GCS Eye, Initial Field GCS Verbal, Initial Field GCS Motor, Initial ED Hospital Respiratory Assistance, Initial ED Hospital Supplemental Oxygen, Race1, Race2, and Other Transport Mode**

9 = unknown/not recorded/not applicable (Definition depends on the data field)

**Patient Occupational Industry, Patient Occupation, and Signs of Life**

99=unknown

**Abbreviated Injury Scale (Predote Code and Severity Code)**

999999.9=unknown

**Patient Zip Code and Incident Location Postal Code**

999999999=unknown and 888888888=foreign zip code

**ED/Hospital Temperature and Protective Devices**

99.9 = Unknown and 88.8 = Not Recorded

**ED/Hospital Height and ED/Hospital Weight**

999 = Unknown

**ED Discharge Disposition, Hospital Discharge Disposition, and Primary Method of Payment**

99 = Not Applicable and 88 = Unknown (Definition depends on the data field)

**Airbag Deployment 1 -3**

8 = Not Applicable and 9 = Unknown

**ED/Hospital Blood Pressure, ED/Hospital Pulse Rate, ED/Hospital Respiration Rate, ED/Hospital Oxygen Saturation, Initial Field Systolic Blood Pressure, Initial Field Pulse Rate, Initial Field Respiratory Rate, and Initial Field Oxygen Saturation**

888 = Not Recorded, 999 = Unknown, and 777=Not Applicable (Definition depends on the data field)

**Total Ventilator Days and ICU Length of Stay**

888=Not Applicable

**Protective Devices**

88 = Not Recorded and 99 = Unknown

**Initial Field GCS Total, Trauma Center Criteria, and Vehicular Pedestrian Other Risk Injury**

88=Not Applicable and 99=Unknown/Not Recorded

**INITIAL FIELD GCS 40 – EYE, INITIAL FIELD GCS 40-VERBAL, INITIAL FIELD GCS 40 – MOTOR, INITIAL ED/HOSPITAL GCS 40 – EYE, INITIAL ED/HOSPITAL GCS 40 – VERBAL, INITIAL ED/HOSPITAL GCS 40 – MOTOR**

0 = Not Recorded

**ADVANCED DIRECTIVE LIMITING CARE, ALCOHOL USE DISORDER, ANGINA PECTORIS, ANTICOAGULANT THERAPY, ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD), BLEEDING DISORDER, CEREBRAL VASCULAR ACCIDENT (CVA), CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHRONIC RENAL FAILURE, CIRRHOSIS, CONGENITAL ANOMALIES, CONGESTIVE HEART FAILURE (CHF), CURRENT SMOKER, CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER, DEMENTIA, DIABETES MELLITUS, DISSEMENATED CANCER, FUNCTIONALLY DEPENDENT HEALTH STATUS, HYPERTENSION, MENTAL/PERSONALITY DISORDERS, MYOCARDIAL INFARCTION (MI), PERIPHERAL ARTERIAL DISEASE (PAD), PREMATURITY, STEROID USE, SUBSTANCE ABUSE DISORDER, ACUTE KIDNEY INJURY, ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS), ALCOHOL WITHDRAWAL SYNDROME, CARDIAC ARREST WITH CPR, CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI), CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI), DEEP SURGICAL SITE INFECTION, DEEP VEIN THROMBOSIS (DVT), EXTREMITY COMPARTMENT SYNDROME, MYOCARDIAL INFARCTION (MI), ORGAN/SPACE SURGICAL SITE INFECTION, OSTEOMYELITIS, PULMONARY EMBOLISM, PRESSURE ULCER, SEVERE SEPSIS, STROKE/CVA, SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION, UNPLANNED ADMISSION TO ICU, UNPLANNED INTUBATION, UNPLANNED RETURN TO THE OPERATING ROOM, VENTILATOR-ASSOCIATED PNEUMONIA (VAP)**

8 = Not Recorded and 9 = Unknown

**Drug Screen 1 – 5**

66 = (More than 5 drug categories in patient’s system)

## Additional Information

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

# Validation Edit Report

Once the file is submitted through the INET application software, a validation edit report is generated and sent back through INET to the submitter. It is the responsibility of the submitter to get the report from INET and make sure that the file passed all edit checks. The validation edit report specifies the edit errors that triggered the file failure. The hospital trauma team has 30 days to clean and resubmit the file. The file needs to be reprocessed until there is a passing file sent in for that year and quarter.

When making an inquiry about an error, the Submission Control ID is the identifier for the submission file and the Edit ID is the identifier of the error. These two identifiers are needed to determine what issues are present on the submission file. When emailing the State Trauma Registry about a submission file that failed or dropped include the Submission Control ID and Edit ID. A warning error is a trigger that will show an error has occurred but it will not count towards failing the submission. See the Trauma Data Quality Standards section for more information about how a submission fails or dropped.

# Flag Fields for File Submission

There are two flag fields used to identify the file that should be processed. One flag identifies the most recent file that was sent to be processed (Active) and the other flag identifies the file status (Status). Once a file has been identified as passed and the most recent file, another file sent into the same year and quarter can knock the file out of the most recent file category.

# Resources

Resources for Optimal Care of the Injured Patient – This document corresponds with the evolution of the philosophy of care set by the American College of Surgeons Committee on Trauma (ACS – COT). This is the oldest standing committee of ACS. This document emphasizes the principle that the needs of all injured patients are addressed wherever they are injured and wherever they receive care. Available at: <https://www.facs.org/quality-programs/trauma/vrc/resources/>

American College of Surgeons National Trauma Data Standard: Data Dictionary 2019 (NTDB) – These documents are designed to establish a national standard for the exchange of trauma registry data, and to serve as the operational definitions for the National Trauma Data Bank. These documents will serve as reference guides when working with the data variables that are being required for the state trauma registry. Available at: <http://www.ntdsdictionary.org/> Archives of the data dictionary are available at: <https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds/archived-dictionary>

ICD - 10 – CM - The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). The ICD-10-CM coding contains up to 7 characters and are alphanumeric. Available at: <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html>

ICD – 10 – PCS – The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is used to code out the procedures that were done for the trauma cases. The ICD-10-PCS coding contains 7 characters that represent the section, body system, root operation, body part, approach, device, and qualifier which are coded using the information in the PCS code tables. Available at: <https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-PCS.html>

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### Data File Format

The data for Trauma Data must be submitted in a XML file consistent with the .XSD sample and Massachusetts Trauma XML sample in the back of this guide.

The file layout needs to be set up by the information technology (IT) services in your institution using the samples as guides in the back of this guide. This will help with the transfer of the data from the hospital system to the state trauma registry system.

### Data Transmission Media Specifications

## Link to Documentation

This is the link to the circular letter, submission guides based on submission type, and the data elements that are required based on trauma designation:

<https://www.mass.gov/service-details/state-trauma-registry-data-submission>

## Help Desk Information

If you have any questions or need to set up the SENDS/INET submission system to send in trauma data files, you can contact the HSN help desk.  The HSN help desk email is [hsnhelpdesk@state.ma.us](mailto:hsnhelpdesk@state.ma.us) and the help desk phone number is 1-800-609-7232 for any SENDS/INET questions, updates, and installation.

## Health Safety Net Links

These are links that can be used to connect with the Health Safety Net INET application. This web site is only for HSN and trauma data submissions: <https://dhcfpinet.hcf.state.ma.us>

The link below is to the HSN homepage which also provides you with a link to INET application.

<https://www.mass.gov/service-details/learn-about-hsn-inet>

# Applicable Regulations

Terms used in this bulletin are defined in the Hospital Licensure regulations’ general definition section (105 CMR 130.020) or are defined in this bulletin. If a term is not otherwise defined, use any applicable definitions from the other sections of the regulation. Relevant sections of the regulation include:

Designated Trauma Center: A hospital that has been verified by the American College of Surgeons as a level 1, 2 or 3 adult trauma center, or a level 1 or 2 pediatric trauma center, as defined in the document ‘Resources for Optimal Care of the Injured Patient: 2014 (6th edition)’ by the Trauma Subcommittee of the American College of Surgeons (ACS) and its successors; and meets applicable Department standards for designation, or a hospital that has applied for and is in the process of verification as specified in 105 CMR 130.851 and meets applicable. (105 CMR 130.020, definition of “service,” (Z))

Data Submission Requirement for Designated Trauma Centers: The hospital provides to the Division of Health Care Finance and Policy (now the Center for Health Information and Analysis – hereinafter, CHIA) the designated trauma center data set to be specified in administrative requirements jointly developed by the Department and the Division of Health Care Finance and Policy (CHIA), and promulgated by the Department. (105 CMR 130.851(D))

Data Submission Requirement for Hospitals that are not Designated Trauma Centers: (A) The hospital provides to the Division of Health Care Finance and Policy (CHIA) the trauma service hospital data set to be specified in administrative requirements jointly developed by the Department and the Division of Health Care Finance and Policy (CHIA). (105 CMR 130.852(A))

# Standard Definitions

Terms used in this document and resources are defined in this section.

Division of Health Care Finance and Policy – Former name of the Center for Health Information and Analysis (CHIA), which monitors a wide variety of health care indicators in Massachusetts to promote improved quality, affordability, access, and outcomes in the Massachusetts health care system. CHIA reports provide data and analysis on providers, insurers, and payers to help legislators, policymakers, insurers, and providers understand the health care indicators in Massachusetts.

Health Safety Net (HSN) - pays acute care hospitals and community health centers for essential health care services provided to uninsured and underinsured Massachusetts residents. The SENDS/INET applications are provided by HSN to be used by trauma data submitters.

# Data Field Service Level Code Definitions

Outpatient Emergency Department Stay: All emergency department visits, including Satellite Emergency Facility visits, by patients whose visits result in neither an outpatient observation stay nor an inpatient admission at the reporting facility.

Outpatient Observation Stay: Patient who receive observation services and who are not admitted. Example: A post-surgical day care patient who, after a normal recovery period, continues to require hospital observation and then is released from the hospital.

Inpatient Stay: Patient who has been admitted as an inpatient visit at the reporting facility.

Death on Arrival: A patient becomes decreased in route to the reporting facility.

### Trauma Data Quality Standards

The data will be edited for compliance with the edit specifications set forth in this document. The standards to be employed for rejecting data submissions from hospitals will be based upon the presence of Category A and B errors as listed for each data element under the following conditions:

All errors will be recorded for each patient Record and for the Submission as a whole. An Edit Report will be provided to the data submitter, displaying detail for all errors found in the Submission.

A Trauma **Record** will be rejected if there is:

* Presence of one or more errors for Category A (A) elements.
* Presence of two or more errors for Category B (B) elements.
* 1% or more of Trauma records are rejected or
* 50 consecutive records are rejected.

A Trauma data **Submission** will be rejected (Dropped) if:

* The file format is not correct
* FilingOrgID on the Record Type 10 does not match the OrgID of the Organization who files the submission on INET

Failed filings must be resubmitted **within** 30 days.

Warnings – Warnings (W) may be reported on the validation detail reports or edit error reports to Hospitals. These data fields are noted but will not cause a file or record to fail. An example, a date field is not filled out since there is no data available for that case/patient.

***Acceptance of data under the edit check procedures identified in this document shall not be deemed acceptance of the factual accuracy of the data contained therein.***

# Differences Between Trauma File Specification Version 4.0 and Version 5.0 (this version)

### Version 5.0 XML File

Version 5.0 will continue to allow for the XML based file format to be accepted into the system. The files will have updated information on how the data is being sent over to the system.

## Edits based on Submitting Entity Type

The Trauma Registry will consist of two tier edits with a warning option on the newer data fields performed on the submitted data. The edits performed will be different based on data submitted by trauma centers and that submitted by non-trauma center acute care hospitals that treat trauma centers. The edit differences will be noted in the file specification section below. The Trauma Registry data and its edits will be generally compatible with the ACS’s National Trauma Data Bank (NTDB). The Not Recorded / Not Applicable / Unknown codes will fit into a coding schema that allows the data to be counted in a category the majority of the time. The data fields that accepts text has specific abbreviations to use in the data field that will give the analyst a better chance of recognizing the exceptions in the text fields.

## 2019 Admissions updates reflected in Specification Guides

This version of the specification guide will represent the 2019 admissions for the time period of October 1, 2018 thru September 30, 2019. The most significant change between the 2017 and 2018 submissions and 2019 submissions is the retirement of Co-Morbid Conditions and Complication fields. The 2019 submissions have the choices from the retired fields entered as separate fields. This allows each illness or medical situation to be captured as separate answers making it easier to look at disease or medical situation co-factors that may contribute to traumatic injuries.

This adds at least 52 new fields to the database that will require a yes/no answer with the choice to enter unknown or not recorded with a numeric code.

## Fields no Longer Required

The following fields were required in Trauma File Specification Version 4.0 but are no longer required. The fields that are no longer collected in Version 5.0 will be removed from the XML table and rows will be renumbered.

Fields No Longer Required

Co-Morbid Conditions

Complications

Primary E-code ICD-9-CM

ICD-9-CM Diagnosis Code

Location E-code ICD-9-CM

**The Difference between the 2017 and 2018 admission data fields and the 2019** **admission data fields in this Trauma File Specification Version 5.0**

All the changes that are contained in this specification guide started with the changes that NTDB made to their 2019 admissions data dictionary. The unknown/not applicable/not recorded codes were added to the data fields to allow the type of data to code into a category for the new numeric code fields. All the new fields will all have the numeric codes added to allow the registrars to code the unknown and not recorded answers.

# Trauma Data Record Specification

### Record Specification Elements

The Trauma Data File is modeled after the National Trauma Data Bank’s National Trauma Data Standard 2019 Data Dictionary. There are several fields that are specific to Massachusetts that will not be a part of the National Trauma Data Standards. The data variables from the National Trauma Data Standard may have been modified to allow coded null values or create a better state definition/standards. Every effort has been made to keep the definition of elements found in the National Trauma Data Standard consistent in this specification.

**Note:** XML submitters need to make sure the element tags that are used in the filing is the same as the field names in the table (upper grid), .XSD, or sample data. For example, "FieldNAME" would need to be "FieldNAME" in the file not FieldName.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **F#** | **Field Name** | **Must be Filed By Trauma Centers** | **Must be Filed by Non-Trauma Centers** | **National Element** | **XML Field Name** | **XML Data Type** | **Multiple Entry** | **Required** | **Edit Specification** | **Field Definition** | **Error Type** |
| 1 | FilingOrgId | X | X | Yes | FacilityId | xs:string | No | R | Must be present.  Characters must be numeric.  Must be valid entry as specified in Data Code Tables. (Table I) | The Organization ID assigned by the Center for Center for Health Information and Analysis (CHIA) to the provider filing the submission. | Drop File |
| 2 | SiteOrgID | X | X | No | FacilitySiteId | xs:string | No | R | Must be present.  Characters must be numeric. Must be valid entry as specified in Data Code Tables. (Table I)  Must be equal to the FilingOrgID if the Site and Filing Organization are the same Organization. | The Organization ID assigned by the Center for Health Information and Analysis (CHIA) to the provider of care for the trauma. | Drop File |
| 3 | Inter-Facility Transfer | X | X | Yes | InterFacilityTransfer | xs:integer | No | R | Must be Present.  Must be a 1 or 2.  Single Entry Max exceeded if entered more than once. | Was the patient transferred to your facility from another acute care facility?  1 = Yes  2 = No  A patient transferred from a private doctor’s office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport is not considered an inter-facility transfer. | A |
| 4 | SiteOrgID of Transferring Hospital | X | X | No | FacilitySiteIdOfTransferringHospital | xs:integer | No | C | Must be present if Inter-Facility Transfer is ‘1’  If present and the Transferring Hospital is in-state, must be valid entry as specified in Data Code Tables. (Table 1)  If the Transferring Hospital is out of state enter ‘9999999’. | The Organization ID assigned by the Center for Health Information and Analysis (CHIA) to the site from which the patient was transferred. | A |
| 5 | Departure Time from Scene of Transferring | X | X | No | DepartureTimeSceneOrTransferring | Xs:time | No | C | May be present if Inter-Facility Transfer=1.  Collected as HH:MM military time.  Must range from 00:00 to 23:59  If time is unknown then enter 99:99. | Time the patient left the originating hospital if a transfer patient. | W |
| 6 | ED Discharge Date | X | X |  | EDDischargeDate | Xs:date | No | R | Must be a valid date format (CCYYMMDD).  If date is unknown/not applicable then enter ‘99999999’  The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.  If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Date is the date of  death as indicated on the patient’s death certificate.  Single entry max exceeded if entered more than once. | The date the order was written for the patient to be discharged from the ED. | B |
| 7 | Ed Discharge Time | X | X |  | EDDischargeTime | Xs:time | No | R | Collected as HH:MM military time.  Must range from 00:00 to 23:59  If time is unknown/not applicable then enter ’99:99’  The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.  If ED Discharge Disposition is “5. Deceased/Expired,” then ED Discharge Time is the time of  death as indicated on the patient’s death certificate.  Single entry max exceeded if entered more than once. | The time the order was written for the patient to be discharged from the ED. | B |
| 8 | ED/Hospital Arrival Date | X | X | Yes | HospitalArrivalDate | Xs:date | no | R | Must be a valid date format (CCYYMMDD).  ED/Hospital Arrival Date cannot be earlier than EMS Dispatch Date.  ED/Hospital Arrival Date cannot be earlier than EMS Unit Arrival on Scene Date.  ED/Hospital  Arrival Date cannot be earlier than EMS Unit Scene Departure Date.  ED/Hospital Arrival Date cannot be later than ED Discharge Date.  ED/Hospital Arrival Date cannot be later than Hospital Discharge Date.  ED/Hospital Arrival Date cannot be earlier than Date of Birth.  ED/Hospital Arrival Date minus Injury Incident Date should be less than 30 days  Single entry max exceeded if entered more than once. | 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. | A |
| 9 | ED/Hospital Arrival Time | X | X | Yes | HospitalArrivalTime | Xs:time | no | R | Collected as HH:MM military time.  Must range from 00:00 to 23:59.  If time is unknown then enter 99:99.  Field cannot be Not Applicable.  ED/Hospital Arrival Time cannot be earlier than EMS Dispatch Time.  ED/Hospital Arrival Time cannot be earlier than EMS Unit Arrival on Scene Time.  ED/Hospital Arrival Time cannot be earlier than EMS Unit Scene Departure Time.  ED/Hospital Arrival Time cannot be later than ED Discharge Time.  ED/Hospital Arrival Time cannot be later than Hospital Discharge Time.  Single entry max exceeded if entered more than once. | The time the patient arrived to the ED/Hospital. 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. | A |
| 10 | Medical Record Number | X | X | No | MedicalRecordNumber | Xs:string | No | R | Must be present. | Patient’s hospital Medical Record Number | A |
| 11 | Social Security Number | X | X | No | PatientId | Xs:string | No | R | Must be present if known.  Must be numeric.  Must be a valid social security number or '000000001' if Unknown | Patient's Social Security Number | A |
| 12 | Date of Birth | X | X | Yes | DateOfBirth | Xs:date | no | R | Must be present.  Must be a valid date format (CCYYMMDD).  If date is unknown then enter ‘99999999’.  If Date of Birth is “Not Known” then complete variables: Age and Age Units.  If Date of Birth equals Injury Date, then the Age and Age Units variables must be completed.  Date of Birth cannot be later than EMS Dispatch Date.  Date of Birth cannot be later than EMS Unit Arrival on Scene Date.  Date of Birth cannot be later than EMS Unit Scene Departure Date.  Date of Birth cannot be later than Injury Date.  Date of Birth cannot be later than ED Discharge Date.  Date of Birth cannot be later than Hospital Discharge Date.  Date of Birth + 120 years must be less than Injury Date.  Single entry max exceeded if entered more than once. | Patient's Date of Birth | A |
| 13 | Gender | X | X | Yes | Sex | Xs:integer | no | R | Must be present.  Must be 1-Male, 2-Female.  Single entry max exceeded if entered more than once. | Patient Gender.  Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment. | A |
| 14 | Patient Zip Code | X | X | Yes | HomeZip | Xs:string | No | C | Must be present unless Patient Country is not the United States.  Must be numeric.  Must be a valid postal code.  If patient zip code is unknown then enter ‘999999999’. If patient zip code is a foreign zip code then enter ‘888888888’.  If ZIP/Postal code is Unknown, record 'UNK', and complete variable: Alternate Home Residence.  If ZIP/Postal code is "Not Known/Not Recorded," record UNK code, and complete variables: Patient's Home Country, Patient's Home County (US only), and Patient's Home City.  Single entry max exceeded if entered more than once. | The patient’s home ZIP code of primary residence. 4-Digit zip code extension can be applied.  May require adherence to HIPAA regulations. | A |
| 15 | Injury Incident Date | X | X | Yes | IncidentDate | Xs:date | No | R | Must be present.  Must be a valid date format (CCYYMMDD).  InjuryIncidentDate cannot be earlier than Date of Birth.  InjuryIncidentDate cannot be later than EMS Dispatch Date.  InjuryIncidentDate cannot be later than EMS Unit Arrival on SceneDate.  InjuryIncidentDate cannot be later than EMS Unit Scene Departure Date.  InjuryIncidentDate cannot be later than ED/Hospital Arrival Date.  InjuryIncidentDate cannot be later than ED Discharge Date.  InjuryIncidentDate cannot be later than HospitalDischargeDate.  Single entry max exceeded if entered more than once. | The date the injury occurred.  Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.  For partial date entries see Common Null Value | A |
| 16 | Injury Incident Time | X | X | Yes | IncidentTime | Xs:time | No | R | Must be present.  Collected as HH:MM military time.  Must range from 00:00 to 23:59.  If time is unknown then enter ’99:99’  InjuryIncidentTime cannot be later than EMS Dispatch Time.  InjuryIncidentTime cannot be later than EMS Unit Arrival on Scene Time.  InjuryIncidentTime cannot be later than EMS Unit Scene Departure Time.  InjuryIncidentTime cannot be later than ED/Hospital Arrival Time.  InjuryIncidentTime cannot be later than ED Discharge Time.  InjuryIncidentTime cannot be later than Hospital Discharge Time.  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | The time the injury occurred.  Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used. | A |
| 17 | Work-related | X | X | Yes | WorkRelated | Xs:integer | No | R | Must be a 1, 2, or 9.  If Work-Related is 1 (Yes) then Patient's Occupation should not be entered as (99) unknown.  If Work-Related is 1 (Yes) then Patient's Occupational Industry should not be entered as (99) unknown.  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | Indication of whether the injury occurred during paid employment.  1 = Yes 2 = No 9=UNK | A |
| 18 | Patient Street Address | X | X | No | PatientStreetAddress | Xs:string | No | R | Must be present.  If patients are not classified as homeless, migrant workers, or undocumented citizen and address is unknown then enter ‘UNK’. If patients are classified as homeless, migrant workers, or undocumented citizen then address is not applicable enter ‘NA’ and fill out Alternate Home Residence. | The patient’s home street address. | A |
| 19 | Incident City | X | X | Yes | IncidentCity | Xs:string | No | R | Must be present and must be the text value of the Incident City name.  Completed when Incident Location ZIP/Postal code is "Not Known/Not Recorded", and country is US.  If Incident Country is not US, report the null value "Not Applicable"  If Incident City is unknown then enter ‘UNK’ and not applicable then enter 'NA'.  Single entry max exceeded if entered more than once. | The city or township where the patient was found or to which the unit responded (or best approximation).  If incident location resides outside of formal city boundaries, report nearest city/town. | B |
| 20 | Alcohol Screen | X |  | Yes | AlcoholScreen | Xs:String | No | R | A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.  1. Yes  2. No  Single entry max exceeded if entered more than once. | Alcohol screen may be administered at any facility, unit, or setting treating this patient event.  Field cannot be blank.  Field cannot be Not Applicable | A |
| 21 | Alcohol Screen Results | X |  | Yes | AlcoholScreenResults | Xs:String | No | C | First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.  Single entry max exceeded if entered more than once. | Collect as X.XX standard lab value for serum sample (e.g. result is 80 mg/dL serum ethanol level report out as 0.08 (g/dL) BAC or 0.08 % (weight/volume) ).  Record BAC results within 24 hours after first hospital encounter, at either your facility or the  transferring facility.  Leave empty for those patient who were not tested.  Cannot be blank if Alcohol Screen = 1(Yes) | A |
| 22 | DrugScreen | X |  | Yes | DrugScreen | Xs:String | YES: Max 5 | R | First recorded positive drug screen results within 24 hours after first hospital encounter (select all that  apply).  1. AMP (Amphetamine)  2. BAR (Barbiturate)  3. BZO (Benzodiazepines)  4. COC (Cocaine)  5. mAMP (Methamphetamine)  6. MDMA (Ecstasy)  7. MTD (Methadone)  8. OPI (Opioid)  9. OXY (Oxycodone)  10. PCP (Phencyclidine)  11. TCA (Tricyclic Antidepressant)  12. THC (Cannabinoid)  13. Other  14. None  15. Not Tested  66. (More than 5 drug categories in patient’s system)  Multiple entry max exceeded if entered more than 5 times. | Record positive drug screen results within 24 hours after first hospital encounter, at either your  facility or the transferring facility.  "None" is reported for patients whose only positive results are due to drugs administered at any  facility (or setting) treating this patient event, or for patients who were tested and had no positive  results.  If multiple drugs are detected, only report drugs that were not administered at any facility (or  setting) treating this patient event.  Field cannot be blank.  Field cannot be Not Applicable | A |
| 23 | Patient City | X | X | Yes | HomeCity | Xs:string | No | R | Must be present and must be the text value of the Patient’s Home City name.  If patient city is not a US city and known then enter either city name or 'UNK'.  If patient city is unknown then enter ‘UNK’. | The patient’s city (or township, or village) of residence.  If patient city is not a US city and known then enter either city name or 'UNK'. | A |
| 24 | Initial Glasgow Eye Component in ED | X |  | Yes | GcsEye | Xs:integer | no | C | Must be coded as:  0. Not Recorded  1. No eye movement whenassessed  2. Opens eyes in responseto painful stimulation  3. Opens eyes in responseto verbal stimulation  4. Opens eyes spontaneously  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.  The 'Not Recorded' code is reported if the patient’s Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.  The 'Not Recorded' code is reported if Initial Field GCS 40 – Eye is documented.  If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patients pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.  Field cannot be Not Applicable.  Please note that first recorded/hospital vitals do not need to be from the same assessment. | A |
| 25 | Initial Glasgow Verbal Component in ED | X |  | Yes | GcsVerbal | Xs:integer | No | C | Must be coded as:  Pediatric (<= 2 Years)  1.No Vocal Response  2. Inconsolable, agitated  3. Inconsistently consolable, moaning  4. Cries but is consolable, inappropriate interactions  5. Smiles, oriented to sounds, follow objects, interacts  Adult  1. No verbal response  2. Incomprehensible sounds  3. Inappropriate words  4. Confused  5. Oriented  Pediatric/ Adult  0. Not Recorded  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival.  The 'Not Recorded' code is reported if the patient’s Initial ED/Hospital GCS – Verbal was not measured within 30 minutes or less of ED/Hospital arrival.  The 'Not Recorded' code is reported if Initial ED/Hospital GCS 40 – Verbal is reported.  If patient is intubated then the GCS Verbal scoreis 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.  Field cannot be Not Applicable.  Please note that first recorded/hospital vitals do not need to be from the same assessment. | A |
| 26 | Initial Glasgow Motor Component in ED | X |  | Yes | GcsMotor | Xs:integer | No | C | Must be coded as:  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  Pediatric/ Adult  0. Not Recorded  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival.  The 'Not Recorded' code is reported if the patient’s Initial ED/Hospital GCS – Motor was not measured within 30 minutes or less of ED/Hospital arrival.  The 'Not Recorded' code is reported if Initial ED/Hospital GCS 40 – Motor is reported.  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 maybe recorded, IF there is no other contradicting documentation.  Field cannot be Not Applicable.  Please note that first recorded/hospitalvitals do not need to be from the same assessment.  Field cannot be Not Applicable. | A |
| 27 | Glasgow Coma Score Total in the ED | X |  | Yes | TotalGcs | Xs:integer | No | C | May be present.  If present must be numeric and must be the sum of Eye, Verbal and Motor.  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival.  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.  Field must be “Not Known/Not Recorded” when Initial ED/Hospital GCS 40 – Eye, Initial ED/Hospital GCS 40 – Verbal, or Initial ED/Hospital GCS 40 – Motor are reported.  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.  Sum of Eye, Verbal, and Motor valid 2 digit score should add up to the total. Do not include unknown or not applicable code in summation.  Field cannot be Not Applicable. | A |
| 28 | Glasgow Coma Score Assessment Qualifier in the ED | X |  | Yes | GcsQualifier | Xs:integer | Yes Max 3 | C | May be present.  If present must be coded as:  0. Not Recorded  1. Patient Chemically Sedated or Paralyzed  2. Obstruction to the Patient's Eye  3. Patient Intubated  4. Valid GCS: Patient was not sedated, not  intubated, and did not have obstruction to the eye  The null value “Not Known/Not Recorded” is reported if Initial ED/Hospital GCS 40 is reported.  The null value “Not Known/Not Recorded” is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.  Multiple entry max exceeded if entered more than three times. | Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival.  Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).  If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.  Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium,rocuronium, (cis)atracurium, vecuronium,or pancuronium.While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.  Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.  Please note that first recorded/hospital vitals do not need to be from the same assessment. | A |
| 29 | Respiration Rate | X | X | Yes | RespiratoryRate | Xs:integer | No | R | Must be present.  Must be numeric.  888 = Not Recorded  999 = Unknown  Cannot be > 99 for age in years >= 6 OR RR cannot be > 120 for age in years < 6. If age and age units are not valued, RR cannot be> 120  Cannot be > 99 and < = 120 for age in years < 6. If age and  age units are not valued, RR cannot be > 99  Single entry max exceeded if entered more than once. | First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).  If available, complete additional field:Initial ED/Hospital RespiratoryAssistance.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Field cannot be Not Applicable. | W |
| 30 | Blood Pressure | X | X | Yes | Sbp | Xs:integer | No | R | Must be present.  Must be numeric.  Must be between 0 and 299.  888 = Not Recorded  999 = Unknown  Single entry max exceeded if entered more than once. | First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.  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.  Field cannot be Not Applicable. | W |
| 31 | Pulse Rate | X | X | Yes | PulseRate | Xs:integer | No | R | Must be present.  Must be numeric.  Must be between 0 and 299.  888 = Not Recorded  999 = Unknown  Single entry max exceeded if entered more than once. | First recorded pulse in theED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).  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.  Field cannot be Not Applicable. | W |
| 32 | Incident State | X | X | Yes | IncidentState | Xs:string | No | R | Must be present and must be a valid 2-digit postal state code as found in Table 2.  Single entry max exceeded if entered more than once. | The state, territory, or province where the patient was found or to which the unit responded (or best approximation).    Completed when Incident Location ZIP/Postal code is filled out or "Not Known/Not Recorded", and country is US.  If incident Country is not US, report the null value "Not Applicable" coded as "NA". | A |
| 33 | Transport Mode | X | X | Yes | TransportMode | Xs:string | No | R | Must be present.  When present must be coded as:  1. Ground Ambulance  2. Helicopter Ambulance  3. Fixed-wing Ambulance  4. Private/Public Vehicle/Walk-in  5. Police  6. Other  9. Unknown  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | The mode of transport delivering the patient to your hospital. | B |
| 34 | DPH Facility ID Number | X | X | No | DPHFacilityIDNumber | Xs:string | No |  | Must be valid code from table 1. | A number assigned by the Department of Public Health to identify the facility. | A |
| 35 | Service Level | X |  | No | ServiceLevel | Xs:integer | No |  | Must be coded as:  1 - Outpatient Emergency Department Stay  2- Outpatient Observation Stay  3 – Inpatient Stay  4 - Death on Arrival | The highest level of service provided in the hospital setting.  Code values 1-4. | W |
| 36 | Patient Home Country | X | X | Yes | PatientHomeCountry | Xs:string | No | C | 2 digit alpha country code.  If patient home country unknown or not applicable then enter ‘NA’.  If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home County.  Single entry max exceeded if entered more than once. | The country where the patient resides.  Relevant value for data element (two digit alpha country code)  Values are two character FIPS codes representing the country (e.g.,US).  If Patient's Home Country is not US, then the null value "Not Applicable" is used for: Patient's Home County and Patient's Home City. | B |
| 37 | Patient Home County | X | X | Yes | PatientHomeCounty | Xs:integer | No | C | Must be a 3 digit numeric FIPS code.  If patient home county unknown or not applicable then enter ‘NA’.  The null value "Not Applicable" coded as "NA" is used if Patient's Home Zip/Postal Code is reported.  Single entry max exceeded if entered more than once. | The patient's county (or parish) of residence.  Relevant value for data element (three digit numeric FIPS code).  Only completed when ZIP/Postal code is "Not Known/Not Recorded" and country is US.  Used to calculate FIPS code. | B |
| 38 | Alternate Home Residence | X | X | Yes | AlternateHomeResidence | Xs:String | No | C | Must be coded as:  1 – Homeless  2 – Undocumented Citizen  3 – Migrant worker  The null value "Not Applicable" coded as "NA" is used if Patient's Home Zip/Postal Code is reported.  Single entry max exceeded if entered more than once. | Documentation of the type of patient without a home ZIP/Postal code.  Only completed when ZIP/Postal code is "Unknown."  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. | B |
| 39 | Age | X | X | Yes | Age | Xs:integer | No | R | Age must be within the valid range of 0 – 120.  Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days,24 months, or 120 years.  Field must be Not Known/Not Recorded when Age Units is Not Known/Not  Recorded.  If the age is not recorded or unknown along with the date of birth then code as '999'. Otherwise, calculate the age and age units using the date of birth and/or notes pertaining to the patient's age.  Single entry max exceeded if entered more than once. | The patient's age at the time of injury (best approximation).  If Date of Birth is “Not Known/Not Recorded”, complete variables: Age and Age Units.  If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.  Must also complete variable: Age Units.  Must be less than or equal to 120. | B |
| 40 | Age Units | X | X | Yes | AgeUnits | Xs:integer | No | R | Must be coded as:  1 – Hours  2 - Days  3 – Months  4 – Years  5 – Minutes  6 - Weeks  Field must be Not Known/Not Recorded when Age is Not Known/Not Recorded.  If the age units is not recorded or unknown along with the date of birth then code as '9'. Otherwise, calculate the age and age units using the date of birth and/or notes pertaining to the patient's age.  Single entry max exceeded if entered more than once. | The units used to document the patient's age (Minutes, Hours, Days, Months, Years).  If Date of Birth is “Not Known/Not Recorded”, complete variables: Age and Age Units.  If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.  Must also complete variable: Age. | B |
| 41 | Ethnicity | X | X | Yes | Ethnicity | Xs:integer | No | R | Must be coded as:  1. Hispanic or Latino  2. Not Hispanic or Latino  9. Unknown  Based on the 2010 US Census Bureau .  Field cannot be "Not Applicable" (US hospitals only).  Single entry max exceeded if entered more than once. | The patient's ethnicity.  Patient ethnicity should be based upon self-report or identified by a family member. | B |
| 42 | Patient Occupational Industry | X |  | Yes | PatientOccupationalIndustry | Xs:integer | No | C | Must be coded as:  1. Finance, Insurance, and Real Estate 2. Manufacturing  3. Retail Trade  4. Transportation and Public Utilities 5. Agriculture, Forestry, Fishing  6. Professional and Business Services  7. Education and Health Services  8. Construction  9. Government  10. Natural Resources and Mining  11. Information Services  12. Wholesale Trade  13. Leisure and Hospitality  14. Other Services  99. Unknown  If the injury is work related then complete the Patient Occupation and Patient Occupational Industry data fields. Otherwise, complete when the information is available. If no information is available then code as unknown '99'.  Single entry max exceeded if entered more than once. | The occupational industry associated with the patient's work environment.  If work related, also complete Patient's Occupation.  Based upon US Bureau of Labor Statistics Industry Classification. | B |
| 43 | Patient Occupation | X | X | Yes | PatientOccupation | Xs:integer | No | C | Must code as:  1. Business and Financial Operations Occupations  2. Architecture and Engineering Occupations  3. Community and Social Services Occupations  4. Education, Training, and Library Occupations  5. Healthcare Practitioners and Technical Occupations  6. Protective Service Occupations  7. Building and Grounds Cleaning and Maintenance  8. Sales and Related Occupations  9. Farming, Fishing, and Forestry Occupations  10. Installation, Maintenance, and Repair  Occupations  11. Transportation and Material Moving Occupations  12. Management Occupations  13. Computer and Mathematical Occupations  14. Life, Physical, and Social Science Occupations  15. Legal Occupations  16. Arts, Design, Entertainment, Sports ,and Media  17. Healthcare Support Occupations  18. Food Preparation and Serving Related  19. Personal Care and Service Occupations  20. Office and Administrative Support Occupations  21. Construction and Extraction Occupations  22. Production Occupations  23. Military Specific Occupations  99. Unknown  Single entry max exceeded if entered more than once. | The occupation of the patient.  Only completed if injury is work-related.  If work related, also complete Patient's Occupational Industry.  Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).  If the injury is work related then complete the Patient Occupation and Patient Occupational Industry data fields. Otherwise, complete when the information is available. If no information is available then code as unknown '99'. | B |
| 44 | ICD10 Primary External Cause Code | X | X | Yes | ICD10PrimaryExternalCauseCode | Xs:string | No | R | Must be present.  Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84 with exclusion criteria listed below.  Exclude Y90.XXX - Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code.  Single entry max exceeded if entered more than once. | Relevant ICD-10-CM code value for injury event  The primary external cause code should describe the main reason a patient is admitted to the hospital.  External cause codes are used to determine the fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix).  ICD-10-CM codes will be accepted for this data element. Activity codes should not be reported in this field.  Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84 with exclusion criteria listed below.  Exclude Y90.XXX - Y99.XXX, and Z00.XXX – Z99.XXX as they are not valid for Primary code. | W |
| 45 | ICD10 Place of Occurrence External Cause Code | X | X | Yes | ICD10PlaceofOccurrenceExternalCauseCode | Xs:string | No | R | Must be a valid value (ICD-10 CM only).  Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is A-Z [excluding I,O]or 0-9) (ICD-10 CM only).  Invalid value (ICD-10 CA only).  Place of Injury code should be U98X (where X is 0-9)(ICD-10 CA only).  Single entry max exceeded if entered more than once. | Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).  Relevant ICD-10-CM code value for injury event.  Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code.  Must be a valid ICD-10-CM code Y92.XXXX 3 to 7 digits/characters long (exclude decimal point). | W |
| 46 | Incident Location Postal Code | X | X | Yes | IncidentLocationPostalCode | Xs:string | No | R | Must be a valid Zip/Postal code if Incident Country is US.    If incident location postal code is unknown then enter ‘999999999’. If incident location postal code is a foreign zip code then enter ‘888888888’.  If "Not Known/Not Recorded", record appropriate code and complete variables: Incident Country, Incident State (US ONLY), Incident County (US ONLY) and Incident City (US ONLY).  Field cannot be Not Applicable .  Single entry max exceeded if entered more than once. | The ZIP/Postal code of the incident location.  Can be stored as a 5 or 9 digit code (XXXXXXXXX) for US and CA, or can be stored in the postal code format of the applicable country.  If "Not Known/Not Recorded, "complete 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 known, then must complete Incident Country. | B |
| 47 | Incident Country | X |  | Yes | IncidentCountry | Xs:string | No | R | Must be a valid 2 character FIPS code.  If Incident Country is unknown or not applicable then enter ‘NA’.  Field cannot be Not Known/Not Recorded when Incident Zip is not:(1) blank, (2)Not  Applicable, or(3) Not Known/Not Recorded.  If Incident Country is not US, then the null value "Not Applicable" coded as "NA" is used for: Incident State and Incident County.  Single entry max exceeded if entered more than once. | The country where the patient was found or to which the unit responded (or best approximation).  Relevant value for data element (two digit alpha country code).  Values are two character FIPS codes representing the country (e.g.,US).  If Incident Country is not US, then the null value "Not Applicable" is used for: Incident State and Incident County. | B |
| 48 | Incident County | X |  | Yes | IncidentCounty | Xs:string | No | R | Must be a valid 3 character FIPS code.  Field must be "Not Applicable" (Non-US hospitals).  If Incident County is unknown or not applicable then enter ‘NA’.  The null value "Not Applicable" coded as "NA" is used if Incident Location Zip/Postal Code is reported.  If Incident Country is not US, report the null value "Not Applicable" coded as "NA".  Single entry max exceeded if entered more than once. | The county or parish where the patient was found or to which the unit responded (or best approximation).  Relevant value for data element (three digit numeric FIPS code)  Only completed when Incident Location ZIP/Postal code is "Not Applicable" or "Not Known/Not Recorded", and country is US.  Used to calculate FIPS code. | B |
| 49 | Report of Physical Abuse | X | X | Yes | ReportofPhysicalAbuse | Xs:integer | No | R | Must be coded as:  1. Yes  2. No  Single entry max exceeded if entered more than once. | A report of suspected physical abuse was made to law enforcement and/or protective services.  This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse as defined by state/local authorities. | B |
| 50 | Investigation of Physical Abuse | X |  | Yes | InvestigationofPhysicalAbuse | Xs:integer | No | C | Must be coded as:  1. Yes  2. No  9. Not Applicable  Field should be completed with a responsive code (1 or 2) when Report of Physical Abuse = 1 (Yes).  Field should be completed with a responsive code (1, 2 or 9) when Report of Physical Abuse = 2 (No).  Single entry max exceeded if entered more than once. | An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.  This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse. | B |
| 51 | Caregiver at Discharge | X |  | Yes | CaregiveratDischarge | xs:integer | No | C | Must be coded as:  1. Yes  2. No  9. Not Applicable  If the Report of Physical Abuse has been coded a 1 (Yes) then Caregiver at Discharge can be coded according to the circumstances at the time of release (1, 2, or 9).  Single entry max exceeded if entered more than once. | The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.  Only complete when Report of Physical Abuse is 1. Yes.  Only complete for minors as determined by state/local definition, excluding emancipated minors.  The null value "Not Applicable" should be used for patients where Report of Physical Abuse is 2. No or where older than the state/local age definition of a minor.  The null value “Not Applicable” should be used if the patient expires prior to discharge. | B |
| 52 | EMS Dispatch Date | X | X | Yes | EMSDispatchDate | Xs:date | no | R | Must be a valid date format (CCYYMMDD).  If date is unknown/not applicable then enter ‘99999999’.  EMS Dispatch Date cannot be earlier than Date of Birth  EMS Dispatch Date cannot be later than EMS Unit Arrival on Scene Date.  EMS Dispatch Date cannot be later than EMS Unit Scene Departure Date.  EMS Dispatch Date cannot be later than ED/Hospital Arrival Date.  EMS Dispatch Date cannot be later than ED Discharge Date.  EMS Dispatch Date cannot be later than Hospital Discharge Date.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The date the unit transporting to your hospital was notified by dispatch.  For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.  For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched. | W |
| 53 | EMS Dispatch Time | X | X | Yes | EMSDispatchTime | Xs:time | No | R | Collected as HH:MM military time.  Must range from 00:00 to 23:59.  If time is unknown/not applicable then enter ’99:99’  EMS Dispatch Time cannot be later than EMS Unit Arrival on Scene Time.  EMS Dispatch Time cannot be later than EMS Unit Scene Departure Time.  EMS Dispatch Time cannot be later than ED/Hospital ArrivalTime.  EMS Dispatch Time cannot be later than ED Discharge Time.  EMS Dispatch Time cannot be later than Hospital Discharge Time.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The time the unit transporting to your hospital was notified by dispatch.  For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.  For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched. | W |
| 54 | EMS Unit Arrival Date at Scene or Transferring Facility | X | X | Yes | EMSUnitArrivalDateatSceneorTransferringFacility | Xs:date | No | R | Must be a valid date format (CCYYMMDD).  If date is unknown/not applicable then enter ‘99999999’.  EMS Unit Arrival on Scene Date cannot be earlier than Date of Birth.  EMS Unit Arrival on Scene Date cannot be earlier than EMS Dispatch Date.  EMS Unit Arrival on Scene Date cannot be later than EMS Unit Scene Departure Date.  EMS Unit Arrival on Scene Date cannot be later than ED/Hospital Arrival Date.  EMS Unit Arrival on Scene Date cannot be later than ED Discharge Date.  EMS Unit Arrival on Scene Date cannot be later than Hospital Discharge Date.  EMS Unit Arrival on Scene Date minus EMS Dispatch Date cannot be greater than 7 days.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The date the unit transporting to your hospital arrived on the scene/transferring facility.  For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility(arrival is defined at date/time when the vehicle stopped moving).  For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving). | W |
| 55 | EMS Unit Arrival Time at Scene or Transferring Facility | X | X | Yes | EMSUnitArrivalTimeatSceneorTransferringFacility | Xs:time | No | R | Collected as HH:MM military time.  Must range from 00:00 to 23:59.  If time is unknown/not applicable then enter ’99:99’.  EMS Unit Arrival on Scene Time cannot be earlier than EMS Dispatch Time.  EMS Unit Arrival on Scene Time cannot be later than EMS Unit Scene Departure Time.  EMS Unit Arrival on Scene Time cannot be later than ED/Hospital Arrival Time.  EMS Unit Arrival on Scene Time cannot be later than ED Discharge Time.  EMS Unit Arrival on Scene Time cannot be later than Hospital Discharge Time.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The time the unit transporting to your hospital arrived on the scene.  For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility(arrival is defined at date/time when the vehicle stopped moving).  For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving). | W |
| 56 | EMS Unit Departure Date from Scene or Transferring Facility | X | X | Yes | EMSUnitDepartureDatefromSceneorTransferringFacility | Xs:date | No | R | Must be a valid date format (CCYYMMDD).  If date is unknown/not applicable then enter ‘99999999’.  EMS Unit Scene Departure Date cannot be earlier than Date of Birth.  EMS Unit Scene Departure Date cannot be earlier than EMS Dispatch Date.  EMS Unit Scene Departure Date cannot be earlier than EMS Unit Arrival on Scene Date.  EMS Unit Scene Departure Date cannot be later than ED/Hospital Arrival Date.  EMS Unit Scene Departure Date cannot be later than ED Discharge Date.  EMS Unit Scene Departure Date cannot be later than Hospital Discharge Date.  EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date cannot be greater than 7 days.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The date the unit transporting to your hospital left the scene.  For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).  For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene  departed from the scene (departure is defined at date/time when the vehicle started moving). | W |
| 57 | EMS Unit Departure Time from Scene or Transferring Facility | X | X | Yes | EMSUnitDepartureTimefromSceneorTransferringFacility | Xs:time | No | R | Collected as HH:MM military time.  Must range from 00:00 to 23:59.  If time is unknown/not applicable then enter ’99:99’.  EMS Unit Scene Departure Time cannot be earlier than EMS Dispatch Time.  EMS Unit Scene Departure Time cannot be earlier than EMS Unit Arrival on Scene Time.  EMS Unit Scene Departure Time cannot be later than ED/Hospital Arrival Time.  EMS Unit Scene Departure Time cannot be later than the ED Discharge Time.  EMS Unit Scene Departure Time cannot be later than Hospital Discharge Time.  The null value "Not Applicable" code is used for patients who were not transported by EMS.  Single entry max exceeded if entered more than once. | The time the unit transporting to your hospital left the scene.  For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).  For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined at date/time when the vehicle started moving). | W |
| 58 | Initial Field systolic blood pressure | X |  | Yes | InitialFieldsystolicbloodpressure | Xs:integer | No |  | Must be a 3 digit entry between 0 and 299.  If Initial Field Systolic Blood Pressure is Not Known then enter code ’999'.  If Initial Field Systolic Blood Pressure is Not Recorded then enter code ’888'.  Single entry max exceeded if entered more than once. | First recorded systolic blood pressure measured at the scene of injury.  The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field systolic blood pressure was NOT measured at the scene of injury.  Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.  The null value "Not Recorded" is used for patients who arrive by 4.Private/Public Vehicle/Walk-in. | W |
| 59 | Initial Field Pulse Rate | X |  | Yes | InitialFieldPulseRate | Xs:integer | No | R | Must be a 3 digit entry between 0 and 299.  If Initial Field Pulse Rate is Not Known then enter ‘999’.  If Initial Field Pulse Rate is Not Recorded then enter ‘888’.  Single entry max exceeded if entered more than once. | First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.  The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured at the scene of injury.  Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.  The null value "Not Recorded" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 60 | Initial Field Respiratory Rate | X |  | Yes | InitialFieldRespiratoryRate | Xs:integer | No | R | Must be a 3 digit numeric entry.  If Initial Field Respiratory Rate is Not Known then enter ‘999’.  If Initial Field Respiratory Rate is Not Recorded then enter ‘888’.  If Initial Field Respiratory Rate is Not Applicable then enter ‘777’.  The respiratory rate is an invalid value if it exceeds 120.  Single entry max exceeded if entered more than once. | First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).  The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field respiratory rate was NOT measured at the scene of injury.  The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 61 | Initial Field Oxygen Saturation | X |  | Yes | InitialFieldOxygenSaturation | Xs:integer | No | R | Must be a 3 digit entry and numeric.  Must be a value between 0 and 100.  If Initial Field Oxygen Saturation is Not Known then enter ‘999’.  If Initial Field Oxygen Saturation is Not Recorded then enter ‘888’.  If Initial Field Oxygen Saturation is Not Applicable then enter ‘777’.  Single entry max exceeded if entered more than once. | First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).  The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured at the scene of injury.  Value should be based upon assessment before administration of supplemental oxygen.  The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 62 | Initial Field GCS EYE | X |  | Yes | InitialFieldGCSEYE | Xs:integer | No | R | Must be present and coded as:  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  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Eye) measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Eye was NOT measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Eye is reported.  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: "patients pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation.  If Initial Field GCS Eye is unknown/not recorded then enter '9'.  The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 63 | Initial Field GCS Verbal | X |  | Yes | InitialFieldGCSVerbal | Xs:integer | No | R | Must be present and coded as:  Pediatric (<= 2 Years)  1.No Vocal Response  2. Inconsolable, agitated  3. Inconsistently consolable, moaning  4. Cries but is consolable, inappropriate interactions  5. Smiles, oriented to sounds, follow objects, interacts  Adult  1. No verbal response  2. Incomprehensible sounds  3. Inappropriate words  4. Confused  5. Oriented  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Verbal is reported.  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.  If Initial Field GCS Verbal is unknown/not recorded then enter '9'.  The null value "Not Applicable" is used for patients who arrive by 4.Private/Public Vehicle/Walk-in. | W |
| 64 | Initial Field GCS Motor | X |  | Yes | InitialFieldGCSMotor | Xs:integer | No | R | Must be present and coded as:  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  If Initial Field GCS Motor is unknown/not recorded then enter '9'.  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (Motor) measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Motor was NOT measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if Initial Field GCS 40 - Motor is reported.  If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.  The null value "Not Applicable" is used for patients who arrive by 4.Private/Public Vehicle/Walk-in. | W |
| 65 | Initial Field GCS Total | X |  | Yes | InitialFieldGCSTotal | Xs:integer | No | R | The GSC Total has a valid range of 3 - 15; anything outside of the range is not valid.  Initial Field GCS - Total should equal the sum of the Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS – Motor. the unknown/not recorded values are not valid entries for the Total.  If the entry is not known/not recorded then enter '99'.  If the entry in not applicable then enter '88'.  Single entry max exceeded if entered more than once. | First recorded Glasgow Coma Score (total) measured at the scene of injury.  The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Total was NOT measured at the scene of injury.  The null value “Not Known/Not Recorded” is used Initial Field GCS 40 – Eye, Initial Field GCS 40 – Verbal, or Initial Field GCS 40 – Motor are reported.  If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented, "or "patient with normal mental status, "interpret this as GCS of 15 IF there is no other contradicting documentation.  The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 66 | Trauma Center Criteria | X |  | Yes | Traumacentercriteria | Xs:String | No | R | Must be coded as:  1. Glasgow Coma Score <= 13  2. Systolic blood pressure< 90 mmHg  3. Respiratory rate < 10 or > 29 breaths per minute (<20 in infants aged < 1 year) or need for ventilator support  4. All penetrating injuries to head, neck, torso, and  Extremities proximal to elbow or knee  5. Chest wall instability or deformity(e.g., flail chest)  6. Two or more proximal long-bone fractures  7. Crushed, degloved, mangled, or pulseless extremity  8. Amputation proximal to wrist or ankle  9. Pelvic fracture  10. Open or depressed skull fracture  11. Paralysis  88. Not Applicable  99. Unknown/Not Recorded  Single entry max exceeded if entered more than once. | 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 injury EMS Run Report.  Field Values must be determined by the EMS provider and must not be assigned by the index hospital.  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. | W |
| 67 | Vehicular Pedestrian Other Risk Injury | X |  | Yes | Vehicularpedestrianotherriskinjury | Xs:integer | No | R | Must be coded as:  1. Fall adults:> 20 ft.(one story is equal to 10 ft.)  2. Fall children: > 10 ft.or 2-3 times the height of the child  3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site  4. Crash ejection (partial or complete) from automobile  5. Crash death in same passenger compartment  6. Crash vehicle telemetry data (AACN) consistent with high risk injury  7. Auto v. pedestrian/bicyclist thrown, run over, or >  20 MPH impact  8. Motorcycle crash> 20 mph  9. For adults > 65; SBP < 110  10. Patients on anticoagulants and bleeding disorders  11. Pregnancy> 20 weeks  12. EMS provider judgment  13. Burns  14. Burns with Trauma  88. Not Applicable  99. Unknown/Not Recorded  Single entry max exceeded if entered more than once. | 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 Report.  Field Values must be determined by the EMS provider and must not be assigned by the index hospital.  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.  The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in. | W |
| 68 | Pre Hospital Cardiac Arrest | X | X | Yes | Prehospitalcardiacarrest | Xs:integer | No | R | Must be coded as:  1. Yes  2. No  9. Unknown/Not Recorded  Single entry max exceeded if entered more than once. | Indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.  A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.  The event must have occurred outside of the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution.  Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider. | W |
| 69 | Initial ED Hospital Temperature | X |  | Yes | InitialEDHospitaltemperature | Xs:string | No | R | Must be a valid 4 digit temperature with decimals included.  Temperature cannot exceed the max of 45 Celsius.  99.9 = Unknown  88.8 = Not Recorded  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Must be a valid 4 digit temperature with decimal included.  Temperature cannot exceed the max of 45 Celsius. | B |
| 70 | Initial ED Hospital Respiratory Assistance | X |  | Yes | InitialEDHospitalRespiratoryAssistance | Xs:integer | No | R | Must be coded as:  1. Unassisted Respiratory Rate  2. Assisted Respiratory Rate  9. Unknown  Code=9 is used if "Initial ED/Hospital Respiratory Rate" is "Not Known/Not Recorded."  Single entry max exceeded if entered more than once. | Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.  Complete when Initial ED/Hospital Respiratory Rate is completed.  Respiratory Assistance is defined as mechanical and/or external support of respiration.  Please note that first recorded/hospital vitals do not need to be from the same assessment. | B |
| 71 | Initial ED Hospital Oxygen Saturation | X |  | Yes | InitialEDHospitalOxygenSaturation | Xs:integer | No | R | Must be a valid 3 digit entry between 0 and 100.  888 = Not Recorded  999= Unknown  Filed cannot be Not Applicable.  Single entry max exceeded if entered more than once. | First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).  Complete additional field: Initial ED/Hospital Supplemental Oxygen.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Must be a valid 3 digit entry between 0 and 100. | B |
| 72 | Initial ED Hospital Supplemental Oxygen | X |  | Yes | InitialEDHospitalSupplementalOxygen | Xs:integer | No | R | Must be coded as:  1. No Supplemental Oxygen  2. Supplemental Oxygen  9. NA  Single entry max exceeded if entered more than once. | 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.  The null value “Not Applicable” code is reported if the Initial ED/Hospital Oxygen Saturation is coded as “Not Known/Not Recorded.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Must be valid 2 digit entry as specified in Field Values. | B |
| 73 | Initial ED Hospital Height | X |  | Yes | InitialEDHospitalHeight | Xs:integer | No | R | Must be a 3 digit entry in centimeters, no greater than 244 centimeters.  999 = Unknown  The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Height was not measured within 24 hours or less of ED/hospital arrival.  Fiield cannot be Not Applicable.  Single entry max exceeded if entered more than once. | First recorded height within 24 hours or less of ED/hospital arrival.  Recorded in centimeters.  May be based on family or self-report.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Must be a valid 3 digit entry in centimeters.  No values greater than 244 centimeters. | B |
| 74 | Initial ED Hospital Weight | X |  | Yes | InitialEDHospitalweight | Xs:integer | No | R | Must be a 3 digit entry in kilograms, no greater than 907 kilograms.  999 = Unknown  The null value “Not Known/Not Recorded” is reported if the patient’s Initial ED/Hospital Weight was not measured within 24 hours or less of ED/hospital arrival.  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | First recorded weight within 24 hours or less of ED/hospital arrival.  Recorded in kilograms.  May be based on family or self-report.  Please note that first recorded/hospital vitals do not need to be from the same assessment.  Must be a valid 3 digit entry in kilograms.  No values greater than 907 kilograms. | B |
| 75 | ED Discharge Disposition | X | X | Yes | EDDischargeDisposition | Xs:integer | No | R | Must be coded as:  1. Floor bed (general admission, non-specialty unit bed)  2. Observation unit (unit that provides < 24 hour stays)  3. Telemetry/step-down unit (less acuity than ICU)  4. Home with services  5. Deceased/expired  6. Other (jail, institutional care, mental health, etc.)  7. Operating Room  8. Intensive Care Unit (ICU)  9. Home without services  10. Left against medical advice  11. Transferred to another hospital  88. Unknown  99. Not Applicable  Field cannot be Not Known/Not Recorded.  Field cannot not be Not Applicable when Hospital Discharge Date is Not Applicable.  Field cannot not be Not Applicable when Hospital Discharge Date is Not Known/Not Recorded.  Field cannot not be Not Applicable when Hospital Discharge Disposition is Not Applicable.  Field cannot not be Not Applicable when Hospital Discharge Disposition is Not  Known/Not Recorded.  Single entry max exceeded if entered more than once. | The disposition of the patient at the time of discharge from the ED.  The null value "Not Applicable" is used if the patient is directly admitted to the hospital.  If ED Discharge Disposition is 4, 5, 6,9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable". | A |
| 76 | Signs of life | X |  | Yes | Signsoflife | Xs:integer | No | R | Must be coded as:  1. Arrived with NO signs of life  2. Arrived with signs of life  99. Unknown  Field cannot be Not Applicable  Field is 1 (Arrived with NO signs of life) when Initial ED/Hospital SBP = 0, Pulse = 0, AND GCS Motor = 1. Please verify.  Field is 2 (Arrived with signs of life) when Initial ED/Hospital SBP > 0, Pulse > 0, OR GCS Motor > 1. Please verify.  Single entry max exceeded if entered more than once. | Indication of whether patient arrived at ED/Hospital with signs of life.  A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress. | **B** |
| 77 | Total ICU Length of Stay | X |  | Yes | TotalICULengthofStay | Xs:integer | No | R | Must be a valid 3 digit entry not less than 1 or more than 575.  Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date  If Total ICU Length of Stay is Not Applicable then enter ‘888’.  Single entry max exceeded if entered more than once. | The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.  Recorded in full day increments with any partial calendar day counted as a full calendar day.  The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient’s chart.  If any dates are missing then a LOS cannot be calculated.  If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.  At no time should the ICU LOS exceed the Hospital LOS.  The null value "Not Applicable" is used if the patient had no ICU days according to the above definition.  Must be a valid 3 digit entry not less than 1 or more than 575. | B |
| 78 | Total Ventilator Days | X |  | Yes | TotalVentilatorDays | Xs:integer | No | R | Must be a valid 3 digit entry not less than 1 or more than 575.  Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date.  If Total Ventilator Days is Not Applicable then enter ‘888’.  Single entry max exceeded if entered more than once. | The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.  Excludes mechanical ventilation time associated with OR procedures.  Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.  Recorded in full day increments with any partial calendar day counted as a full calendar day.  The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart.  If any dates are missing then a Total Vent Days cannot be calculated.  At no time should the Total Vent Days exceed the Hospital LOS.  The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.  Must be a valid 3 digit entry not less than 1 or more than 575. | B |
| 79 | Hospital Discharge Date | X | X | Yes | HospitalDischargeDate | Xs:date | No | R | Must be a valid date format (CCYYMMDD).  If date is unknown/not applicable then enter ‘99999999’.  Hospital Discharge Date cannot be earlier than EMS Dispatch Date.  Hospital Discharge Date cannot be earlier than EMS Unit Arrival on Scene Date.  Hospital Discharge Date cannot be earlier than EMS Unit Scene Departure Date.  Hospital Discharge Date cannot be earlier than ED/Hospital Arrival Date  Hospital Discharge Date cannot be earlier than ED Discharge Date.  Hospital Discharge Date cannot be earlier than Date of Birth  Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11.  Field must be Not Applicable when ED Discharge Disposition= 5 (Died).  Single entry max exceeded if entered more than once. | The date the order was written for the patient to be discharged from the hospital.  The null value "Not Applicable" is used If ED Discharge Disposition = 5 Deceased/Expired.  The null value "Not Applicable" is used If ED Discharge Disposition = 4,6,9,10, or 11.  If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Date is the date of death as indicated on the patient’s death certificate. | B |
| 80 | Hospital Discharge Time | X |  | Yes | HospitalDischargeTime | Xs:time | No | C | Collected as HH:MM military time from 00:00 to 23:59.  If time is unknown/not applicable then enter ’99:99’.  Hospital Discharge Time cannot be earlier than EMS Dispatch Time.  Hospital Discharge Time cannot be earlier than EMS Unit Arrival on Scene Time.  Hospital Discharge Time cannot be earlier than EMS Unit Scene Departure Time.  Hospital Discharge Time cannot be earlier than ED/Hospital Arrival Time.  Hospital Discharge Time cannot be earlier than ED Discharge Time.  Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11.  Field must be Not Applicable when ED Discharge Disposition= 5 (Died).  Single entry max exceeded if entered more than once. | The time the order was written for the patient to be discharged from the hospital.  The null value "Not Applicable" is used If ED Discharge Disposition = 5 (Deceased/expired).  The null value "Not Applicable" is used If ED Discharge Disposition = 4,6,9,10, or 11.  If Hospital Discharge Disposition is 5 Deceased/Expired, then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate. | B |
| 81 | Hospital Discharge Disposition | X | X | Yes | HospitalDischargeDisposition | Xs:integer | No | R | Must be coded as:  1. Discharged/Transferred to a short-term general hospital for inpatient care  2. Discharged/Transferred to an Intermediate Care Facility (ICF)  3. Discharge/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 rehab or designated unit  12. Discharged/Transferred to Long Term Care Hospital (LTCH)  13. Discharged/Transferred to a psychiatric hospital  or psychiatric distinct part unit of a hospital  14. Discharged/Transferred to another type of institution not defined elsewhere  99. Not Applicable  Field must be Not Applicable when ED Discharge Disposition= 5 (Died).  Field must be Not Applicable when ED Discharge Disposition= 4,6,9,10, or 11.  Field cannot be Not Known/Not Recorded when Hospital Arrival Date and Hospital Discharge Date are not:(1)blank, (2) Not Applicable, or (3) Not Known/Not Recorded.  Single entry max exceeded if entered more than once. | The disposition of the patient when discharged from the hospital.  Field value = 6,"home" refers to the patient's current place of residence (e.g., prison, Child Protective Services etc.)  Field values based upon UB-04 disposition coding.  Disposition to any other non-medical facility should be coded as 6.  Disposition to any other medical facility should be coded as 14.  The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/expired).  The null value "Not Applicable" is used if ED Discharge Disposition = 4,6,9,10, or 11. | B |
| 82 | Primary Method of Payment | X | X | Yes | PrimaryMethodofPayment | Xs:integer | No | R | Must be coded as:  1. Medicaid  2. Not Billed (for any reason)  3. Self-Pay  4. Private/Commercial Insurance  6. Medicare  7. Other Government  10. Other  99. Unknown  Field cannot be Not Applicable.  Single entry max exceeded if entered more than once. | Primary source of payment for hospital care.  No Fault Automobile, Workers Compensation, and Blue Cross/BlueShield should be captured as Private/Commercial Insurance. | B |
| 83 | Race1 | X | X | Yes | Race1 | Xs:integer | No | R | Must be coded as:  1. Asian  2. Native Hawaiian or Other Pacific Islander  3. Other Race  4. American Indian  5. Black or African American  6. White  9. Unknown/Not Applicable  If any Field Value is reported, neither "Not Applicable" or "Not Known/Not Recorded" can also be reported.  Multiple entry max exceeded if entered more than twice. | The patient's race.  Patient race should be based upon self-report or identified by a family member. | B |
| 84 | Race2 | X | X | Yes | Race2 | Xs:integer | No | R | Must be coded as:  1. Asian  2. Native Hawaiian or Other Pacific Islander  3. Other Race  4. American Indian  5. Black or African American  6. White  9. Unknown/Not Applicable  If any Field Value is reported, neither "Not Applicable" or "Not Known/Not Recorded" can also be reported.  Mulitple entry max exceeded if entered more than twice. | The patient's race.  Patient race should be based upon self-report or identified by a family member. | B |
| 85 | OtherTransportMode | X |  | Yes | OtherTransportMode | Xs:integer | Yes Max 5 | C | When present must be coded as:  1. Ground Ambulance  2. Helicopter Ambulance  3. Fixed-wing Ambulance  4. Private/Public Vehicle/Walk-in  5. Police  6. Other  9. Unknown  Multiple entry max exceeded if entered more than five times. | All other modes of transport used during patient care event (prior to arrival at your hospital),except the mode delivering the patient to the hospital.  Include in "Other" unspecified modes of transport. | B |
| 86 | Injury Diagnosis | X | X | Yes | InjuryDiagnoses | Xs:string | Yes max 50. | R | Must be a valid value (ICD-10 CM only).  Multiple entry max exceeded if entered more than 50 times. | Diagnoses related to all identified injuries.  IInjury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, T30-T32, T79.A1 – T79.A19, T79.A2 - T79.A29, T75.1 and T71.  At least one code needs to meet the inclusion criteria as primary or principle code. The primary or principle code must be located in the first diagnostic data field for the record to be included in the submission.  ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field. These codes reside in the diagnostic data fields after the first diagnostic data field. If the other medical conditions are coded in the first diagnostic data field, the record will cause a submission error.  Must be valid up to 7 digit ICD-10-CM code (exclude decimal point). | A |
| 87 | AIS | X |  | No | AIS | Xs:String | Yes | R | Must be present.  Must be a valid AIS code.  Must consist of 6 numbers followed by a decimal point followed by 1 number.  The number following the decimal point must be coded as:  1. Minor Injury  2. Moderate Injury  3. Serious Injury  4. Severe Injury  5. Critical Injury  6. Maximum Injury, Virtually Un survivable  9. Not Possible to Assign  If predot and/or severity are not able to be coded then enter ‘999999.9’  Multiple entry max exceeded if entered more than 57 times. | The Abbreviated Injury Scale (AIS) Pre Dot codes that reflect the patient's injuries.  The pre dot code is the 6 digits preceding the decimal point in an associated AIS code.  The severity code is the value after the decimal. The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries.  The field value (9)"Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.  Cannot be Not Applicable. | W |
| 88 | AIS Version | X |  | No | AISVersion | Xs:integer | Yes | R | Must be present.  AIS 2005 update 2008 enter ‘08’. AIS 2015 enter ‘15’.  Single entry max exceeded is entered more than once. | The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.  Cannot be Not Applicable. | W |
| 89 | Protective Devices | X |  | Yes | ProtectiveDevices | Xs:integer | Yes unlimited. | R | Must be present.  Must be numeric.  Must be coded as:  1. None  2. Lap Belt  3. Personal Floatation Device  4. Protective Non-Clothing Gear (e.g., shin guard)  5. Eye Protection  6. Child Restraint (booster seat or child car seat)  7. Helmet (e.g., bicycle, skiing, motorcycle)  8. Airbag Present  9. Protective Clothing (e.g., padded leather pants)  10.Shoulder  Belt  11. Other  88. Not Recorded  99. Unknown  Protective Device should be 6 (Child Restraint) when Child Specific Restraint is not: (1) blank, (2)Not Applicable, or (3) Not Known/Not Recorded.  Protective Device should be 8 (Airbag Present) when Airbag Deployment is not:(1) blank, (2)Not Applicable, or (3) Not Known/Not Recorded.  Multiple entry max exceeded if entered more than five times. | Protective devices (safety equipment) in use or worn by the patient at the time of the injury.  If" Child Restraint" is present, complete variable "Child Specific Restraint."  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.”  If" Airbag" is present, complete variable" Airbag Deployment."  Evidence of the use of safety equipment may be reported or observed.  Lap Belt should be used to include those patients that are restrained,but not further specified.  If chart indicates "3-point-restraint",choose 2. Lap Belt and 10. Shoulder Belt. | W |
| 90 | Child Specific restraint | X |  | Yes | ChildSpecificRestraint | Xs:integer | Yes | C | Must be present if Protective Devices = 6 (Child Restraint).  Must be coded as:  1. Child Car Seat  2. Infant Car Seat  3. Child Booster Seat  Multiple entry max exceeded if entered more than five times. | Protective child restraint device used by patient at the time of injury.  Evidence of the use of child restraint maybe reported or observed.  Only completed when Protective Devices include "Child Restraint."  Or if Protective Devices = 6 (Child Restraint) in one field.  Field cannot be Not Applicable when Protective Device is 6 (Child Restraint) | A |
| 91 | Airbag Deployment | X |  | Yes | AirbagDeployment | Xs:integer | Yes | C | Must be present if Protective Devices = 8 (Airbag).  Must be coded as:  1. Airbag Not Deployed  2. Airbag Deployed Front  3. Airbag Deployed Side  4. Airbag Deployed Other (knee, air belt, curtain,  etc.)  8. Not Applicable  9. Unknown  Multiple entry max exceeded if entered more than three times. | Evidence of the use of airbag deployment maybe reported or observed.  Only completed when Protective Devices include "Airbag." Or if Protective Devices = 8 (Airbag) in one field.  Airbag Deployed Front should be used for patients with documented airbag deployments, but are not further specified.  The null value code for "Not Applicable" is used if NO "Airbag" is reported under Protective Devices.  Field cannot be "Not Applicable" when Protective Device is 8 Airbag Present. | A |
| 92 | ICD10 Hospital Procedure Code | X |  | Yes | ICD10HospitalProcedureCode | Xs:string | Yes Max 200. | R | Must be present if Record Type 60 is present.  Must be a valid value (ICD-10 PCS only).  Multiple entry max exceeded if entered more than 200 times. | See National Trauma Data Standard Data Dictionary 2019 Admissions for the list of procedures and description for entry. | W |
| 93 | Hospital Procedures Start Date | X |  | No | HospitalProcedureStartDate | Xs:date | Yes | R | Must be a valid date format (CCYYMMDD).  UNK = 99999999  If Hospital Procedure Start Date is unknown then enter the date code for unknown.  Hospital Procedure Start Date cannot be earlier than EMS Dispatch Date.  Hospital Procedure Start Date cannot be earlier than EMS Unit Arrival on Scene Date.  Hospital Procedure Start Date cannot be earlier than EMS Unit Scene Departure Date.  Hospital Procedure Start Date cannot be earlier than ED/Hospital Arrival Date.  Hospital Procedure Start Date cannot be later than Hospital Discharge Date.  Multiple entry max exceeded if entered more than 200 times. | The date operative and selected non-operative procedures were performed. | W |
| 94 | Hospital Procedures Start Time | X |  |  | HospitalProcedureStartTime | Xs:time | Yes | R | Collected as HH:MM military time between  00:00 to 23:59.  If time is unknown/not applicable then enter ’99:99’  Hospital Procedure Start Time cannot be earlier than EMS Dispatch Time.  Hospital Procedure Start Time cannot be earlier than EMS Unit Arrival on Scene Time.  Hospital Procedure Start Time cannot be earlier than EMS Unit Scene Departure Time.  Hospital Procedure Start Time cannot be earlier than ED/Hospital Arrival Time.  Hospital Procedure Start Time cannot be later than Hospital Discharge Time.  Multiple entry max exceeded if entered more than 200 times. | The time operative and selected non-operative procedures were performed.  Procedure start time is defined as the time the incision was made(or the procedure started).  If distinct procedures with the same procedure code are performed, their start times must be different. | W |
| 95 | Additional ICD10 External Cause Code | X |  | Yes | AdditionalICD10ExternalCauseCode | Xs:string | Yes Max 50. | R | E-Code is not a valid ICD-10-CM code (ICD-10CM only).  Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10.  Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long. (exclude decimal point) V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99  E-Code is not a valid ICD-10-CA code (ICD-10 CA only).  Multiple entry max exceeded if entered more than 50 times. | Should not be the same as the Primary External Cause Code.  Relevant ICD-10-CM code value for injury event.  Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code.  Activity codes should not be reported in this field.  Must be a valid ICD-10-CM Ecode 3 to 7 digits/characters long (exclude decimal point) V00-Y38, Y62-Y84, Y90-Y99, Z00-Z99 | W |
| 96 | Initial Field GCS 40 Eye | X |  | Yes | InitialFieldGCS40Eye | Xs:string | No | R | **Adults:**  1. None  2. To Pressure  3. To Sound  4. Spontaneous 5. Not Testable  **Pediatric <5 years:**  1. None  2. To Pain  3. To Sound  4. Spontaneous 5. Not Testable  0. Not Recorded | **Definition** First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury.  **Add Additional Information**: The null value "Not Known/Not Recorded" code is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.  • If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.  • The null value "Not Recorded" code is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.  • Report Field Value “5. Not Testable” if unable to assess (e.g. swelling to eye(s)).  • The null value “Not Known/Not Recorded” code is reported if the patient’s first recorded initial field GCS 40 – Eye was NOT measured at the scene of injury.  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Eye is reported.  **Add Edits**: 15001 1 Value is not a valid menu option  15003 2 Field cannot be blank  15005 2 Field must be “Not Recorded” code when Transport Mode is “4. Private/Public Vehicle/Walk-in”  15006 2 Field must be “Not Known/Not Recorded” code when Initial Field GCS – Eye is reported  15040 1 Single Entry Max exceeded | W |
| 97 | Initial Field GCS 40 Verbal | X |  | Yes | InitialFieldGCS40Verbal | Xs:string | No | R | **Adult:**  1. None  2. Sounds  3. Words  4. Confused  5. Oriented  6. Not Testable  **Pediatric < 5 years:**  1. None  2. Cries  3. Vocal Sounds  4. Words  5. Talks Normally  6. Not Testable  0. Not Recorded | **Definition**  First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury.  **Additional Information**:  The null value "Not Known/Not Recorded" code is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.  • If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.  • The null value "Not Recorded" code is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.  • Report Field Value “6. Not Testable” if unable to assess (e.g. patient is intubated).  • The null value “Not Known/Not Recorded” code is reported if the patient’s first recorded initial field GCS 40-Verbal was not measured at the scene of injury.  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Verbal is reported.  **Add Edits**:  15101 1 Value is not a valid menu option  15103 2 Field cannot be blank  15105 2 Field must be “Not Recorded” code when Transport Mode is “4. Private/Public Vehicle/Walk-in”  15106 2 Field must be “Not Known/Not Recorded” code when Initial Field GCS – Verbal is reported  15140 1 Single Entry Max exceeded | W |
| 98 | Initial Field GCS 40 Motor | X |  | Yes | InitialFieldGCS40Motor | Xs:string | No | R | **Adult:**  1. None 2. Extension 3. Abnormal Flexion  4. Normal Flexion  5. Localizing  6. Obeys Commands 7. Not Testable  **Pediatric < 5 years:**  1. None  2. Extension to Pain  3.Flexion to Pain  4.Localizes Pain 5. Obeys Commands  7. Not Testable  0. Not Recorded | **Definition**  First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury.  **Additional Information**:  The null value "Not Known/Not Recorded" code is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury.  • If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient’s, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.  • The null value "Not Recorded" code is reported for patients who arrive by “4. Private/Public Vehicle/Walk-in”.  • Report Field Value “7. Not Testable” if unable to assess (e.g. neuromuscular blockade).  • The null value “Not Known/Not Recorded” code is reported if the patient’s first recorded initial field GCS 40 – motor was NOT measured at the scene of injury.  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Motor is reported.  **Add Edits**:  15201 1 Value is not a valid menu option  15203 2 Field cannot be blank  15205 2 Field must be “Not Known/Not Recorded” code when Initial Field GCS – Motor is reported  15206 2 Field must be “Not Recorded” when Transport Mode is “4. Private/Public Vehicle/Walk-in”  15240 1 Single Entry Max exceeded | W |
| 99 | Initial ED Hospital GCS 40 Eye | X |  | Yes | InitialEDHospitalGCS40Eye | Xs:string | No | R | Adult:  1. None  2. To Pressure  3. To Sound 4. Spontaneous 5. Not Testable  Pediatric < 5 years:  1. None  2. To Pain  3. To Sound  4. Spontaneous 5. Not Testable  0. Not Recorded | **Definition** First recorded Glasgow Coma Score 40 (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.  **Additional Information**:  If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's eyes open spontaneously," an Eye GCS 40 of 4 may be recorded, IF there is no other contradicting documentation.  • Report Field Value “5. Not Testable” if unable to assess (e.g. swelling to eye(s)).  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Eye is reported.  • The null value “Not Known/Not Recorded” code is reported if the patient’s Initial ED/Hospital GCS 40- Eye was not measured within 30 minutes or less of ED/hospital arrival.  **Add Edits**:  15301 1 Value is not a valid menu option  15303 2 Field cannot be blank  15304 2 Field cannot be “Not Applicable”  15305 2 Field must be “Not Known/Not Recorded” coded when Initial ED/Hospital GCS – Eye is reported.  15340 1 Single Entry Max exceeded | W |
| 100 | Initial ED Hospital GCS 40 Verbal | X |  | Yes | InitialEDHospitalGCS40Verbal | Xs:string | No | R | Adult:  1. None  2. Sounds  3. Words  4. Confused  5. Oriented  6. Not Testable  Pediatric < 5 years:  1. None  2. Cries  3. Vocal Sounds  4. Words  5. Talks Normally  6. Not Testable  0. Not Recorded | **Definition**  First recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of ED/hospital arrival.  **Additional Information:**  If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS 40 scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient correctly gives name, place and date" a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation.  • Report Field Value “6. Not Testable” if unable to assess (e.g. patient is intubated).  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Verbal is reported.  • The null value “Not Known/Not Recorded” code is reported if the patient’s Initial ED/Hospital GCS 40 - Verbal was not measured within 30 minutes or less of ED/hospital arrival.  **Add Edits**:  15401 1 Value is not a valid menu option  15403 2 Field cannot be blank  15404 2 Field cannot be “Not Applicable”  15405 2 Field must be “Not Known/Not Recorded” code when Initial ED/Hospital GCS – Verbal is reported.  15440 1 Single Entry Max exceeded | W |
| 101 | Initial ED Hospital GCS 40 Motor | X |  | Yes | InitialEDHospitalGCS40Motor | Xs:string | No | R | Adult:  1. None  2. Extension  3. Abnormal Flexion  4. Normal Flexion  5. Localizing  6. Obeys Commands 7. Not Testable  Pediatric < 5 years:  1. None  2. Extension to Pain  3.Flexion to Pain  4.Localizes Pain  5. Obeys Commands  7. Not Testable  0. Not Recorded | **Definition** First recorded Glasgow Coma Score 40 (Verbal) within 30 minutes or less of ED/hospital arrival.  **Additional Information**:  If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient’s, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.  • Report Field Value “7. Not Testable” if unable to assess (e.g. neuromuscular blockade).  • The null value “Not Known/Not Recorded” code is reported if Initial Field GCS – Motor is reported.  • The null value “Not Known/Not Recorded” code is reported if the patient’s Initial ED/Hospital GCS 40 - Motor was not measured within 30 minutes or less of ED/hospital arrival.  **Add Edits**:  15501 1 Value is not a valid menu option  15503 2 Field cannot be blank  15504 2 Field cannot be “Not Applicable”  15505 2 Field must be “Not Known/Not Recorded” coded when Initial ED/Hospital GCS – Motor is reported.  15540 1 Single Entry Max exceeded | W |
| 102 | Advanced Directive Limting Care | X |  | Yes | AdvancedDirectiveLimtingCare | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  The patient had a written request limiting life sustaining therapy, or similar advanced directive.  **Additional Information**:  Present prior to arrival at your center.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  **Add Edit**s:  16001 1 Value is not a valid menu option  16003 2 Field cannot be blank  16004 2 Field cannot be “Not Applicable”  16040 1 Single Entry Max exceeded | W |
| 103 | Alcohol Use Disorder | X |  | Yes | AlcoholUseDisorder | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Diagnosis of alcohol use disorder documented in the patient medical record.  **Additional Information**:  Present prior to injury.  • Consistent with American Psychiatric Association (APA) DSM 5, 2013.  • A diagnosis of Alcohol Use Disorder must be documented in the patient's medical record.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  **Add Edits**:  16101 1 Value is not a valid menu option  16103 2 Field cannot be blank  16104 2 Field cannot be “Not Applicable”  16140 1 Single Entry Max exceeded | W |
| 104 | Angina Pectoris | X |  | Yes | AnginaPectoris | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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” codes are only reported if no past medical history is available.  **Add Edits**:  16201 1 Value is not a valid menu option  16203 2 Field cannot be blank  16204 2 Field cannot be “Not Applicable”  16240 1 Single Entry Max exceeded | W |
| 105 | Anticoagulant Therapy | X |  | Yes | AnticoagulantTherapy | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting. **Additional Information**:    Present prior to injury.  • Exclude patients whose only anticoagulant therapy is chronic Aspirin.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  **Add Edits**:  16301 1 Value is not a valid menu option  16303 2 Field cannot be blank  16304 2 Field cannot be “Not Applicable”  16340 1 Single Entry Max exceeded | W |
| 106 | Attention Deficit Disorder Attention Deficit Hyperactivity Disorder (ADD/ADHD) | X |  | Yes | AttentionDeficitDisorderAttentionDeficitHyperactivityDisorderADDADHD | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  A disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.  **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” codes are only reported if no past medical history is available.  **Add Edits**: 16401 1 Value is not a valid menu option  16403 2 Field cannot be blank  16404 2 Field cannot be “Not Applicable”  16440 1 Single Entry Max exceeded | W |
| 107 | Bleeding Disorder | X |  | Yes | BleedingDisorder | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definitions**:  A group of conditions that result when the blood cannot clot properly.  **Additional Information**:  Present prior to injury.  • A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden).  • Consistent with American Society of Hematology, 2015.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available  **Add Edits**:  16501 1 Value is not a valid menu option  16503 2 Field cannot be blank  16504 2 Field cannot be “Not Applicable”  16540 1 Single Entry Max exceeded | W |
| 108 | Cerebral Vascular Accident CVA | X |  | Yes | CerebralVascularAccidentCVA | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**: A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).  **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” codes are only reported if no past medical history is available.  **Add Edits**:  16601 1 Value is not a valid menu option  16603 2 Field cannot be blank  16604 2 Field cannot be “Not Applicable”  16640 1 Single Entry Max exceeded | W |
| 109 | Chronic Obstructive Pulmonary Disease | X |  | Yes | ChronicObstructivePulmonaryDisease | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 (e.g., 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.  **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” codes are only reported if no past medical history is available.  **Add Edits**:  16701 1 Value is not a valid menu option  16703 2 Field cannot be blank  16704 2 Field cannot be “Not Applicable”  16740 1 Single Entry Max exceeded | W |
| 110 | Chronic Renal Failure | X |  | Yes | ChronicRenalFailure | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.  **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” codes are only reported if no past medical history is available.  **Add Edits**:  16801 1 Value is not a valid menu option  16803 2 Field cannot be blank  16804 2 Field cannot be “Not Applicable”  16840 1 Single Entry Max exceeded | W |
| 111 | Cirrhosis | X |  | Yes | Cirrhosis | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease.  **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” codes are only reported if no past medical history is available.  **Add Edits**:  16901 1 Value is not a valid menu option  16903 2 Field cannot be blank  16904 2 Field cannot be “Not Applicable”  16940 1 Single Entry Max exceeded | W |
| 112 | Congenital Anomalies | X |  | Yes | CongenitalAnomalies | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly.  **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” codes are only reported if no past medical history is available.  **Add Edits**:  17001 1 Value is not a valid menu option  17003 2 Field cannot be blank  17004 2 Field cannot be “Not Applicable”  17040 1 Single Entry Max exceeded | W |
| 113 | Congestive Heart Failure CHF | X |  | Yes | CongestiveHeartFailureCHF | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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:  o Abnormal limitation in exercise tolerance due to dyspnea or fatigue  o Orthopnea (dyspnea or lying supine)  o Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)  o Increased jugular venous pressure  o Pulmonary rales on physical examination  o Cardiomegaly  o Pulmonary vascular engorgement  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  **Add Edits**:  17101 1 Value is not a valid menu option  17103 2 Field cannot be blank  17104 2 Field cannot be “Not Applicable”  17140 1 Single Entry Max exceeded | W |
| 114 | Current Smoker | X |  | Yes | CurrentSmoker | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  A patient who reports smoking cigarettes every day or some days within the last 12 months.  **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” codes are only reported if no past medical history is available.  **Additional Information**:  17201 1 Value is not a valid menu option  17203 2 Field cannot be blank  17204 2 Field cannot be “Not Applicable”  17240 1 Single Entry Max exceeded | W |
| 115 | Currently Receiving Chemotherapy For Cancer | X |  | Yes | CurrentlyReceivingChemotherapyForCancer | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  A patient who is currently receiving any chemotherapy treatment for cancer prior to injury.  **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” codes are only reported if no past medical history is available.  **Add Edit**s:  17301 1 Value is not a valid menu option  17303 2 Field cannot be blank  17304 2 Field cannot be “Not Applicable”  17340 1 Single Entry Max exceeded | W |
| 116 | Dementia | X |  | Yes | Dementia | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition**:  Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's).  **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” codes are only reported if no past medical history is available.  **Add Edits**: 17401 1 Value is not a valid menu option  17403 2 Field cannot be blank  17404 2 Field cannot be “Not Applicable”  17440 1 Single Entry Max exceeded | W |
| 117 | Diabetes Mellitus | X |  | Yes | DiabetesMellitus | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  17501 1 Value is not a valid menu option  17503 2 Field cannot be blank  17504 2 Field cannot be “Not Applicable”  17540 1 Single Entry Max exceeded | W |
| 118 | Dissemenated Cancer | X |  | Yes | DissemenatedCancer | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **Additional Information:**  Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis."  • Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, 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” codes are only reported if no past medical history is available.  **Add Edits:**  17601 1 Value is not a valid menu option  17603 2 Field cannot be blank  17604 2 Field cannot be “Not Applicable”  17640 1 Single Entry Max exceeded | W |
| 119 | Functionally Dependent Health Status | X |  | Yes | FunctionallyDependentHealthStatus | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL).  **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” codes are only reported if no past medical history is available.  **Add Edits:**  17701 1 Value is not a valid menu option  17703 2 Field cannot be blank  17704 2 Field cannot be “Not Applicable”  17740 1 Single Entry Max exceeded | W |
| 120 | Hypertension | X |  | Yes | Hypertension | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  History of persistent elevated blood pressure requiring medical therapy.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  17801 1 Value is not a valid menu option  17803 2 Field cannot be blank  17804 2 Field cannot be “Not Applicable”  17840 1 Single Entry Max exceeded | W |
| 121 | Mental Personality Disorders | X |  | Yes | MentalPersonalityDisorders | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder.  **Additional Information:**  Present prior to injury.  • A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.  **•** Consistent with American Psychiatric Association (APA) DSM 5, 2013.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  **Add Edits:**  17901 1 Value is not a valid menu option  17903 2 Field cannot be blank  17904 2 Field cannot be “Not Applicable”  17940 1 Single Entry Max exceeded | W |
| 122 | Myocardial Infarction MI PreExisting | X |  | Yes | MyocardialInfarctionMIPreExisting | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  History of a MI in the six months prior to injury.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  18001 1 Value is not a valid menu option  18003 2 Field cannot be blank  18004 2 Field cannot be “Not Applicable”  18040 1 Single Entry Max exceeded | W |
| 123 | Peripheral Arterial Disease PAD | X |  | Yes | PeripheralArterialDiseasePAD | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  18101 1 Value is not a valid menu option  18103 2 Field cannot be blank  18104 2 Field cannot be “Not Applicable”  18140 1 Single Entry Max exceeded | W |
| 124 | Prematurity | X |  | Yes | Prematurity | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Babies born before 37 weeks of pregnancy are completed.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  18201 1 Value is not a valid menu option  18203 2 Field cannot be blank  18204 2 Field cannot be “Not Applicable”  18240 1 Single Entry Max exceeded | W |
| 125 | Steroid Use | X |  | Yes | SteroidUse | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.  **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” codes are only reported if no past medical history is available.  **Add Edits:**  18301 1 Value is not a valid menu option  18303 2 Field cannot be blank  18304 2 Field cannot be “Not Applicable”  18340 1 Single Entry Max exceeded | W |
| 126 | Substance Abuse Disorder | X |  | Yes | SubstanceAbuseDisorder | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Documentation of substance abuse disorder in the patient medical record.  **Additional Information:**  Present prior to injury.  • Consistent with the American Psychiatric Association (APA) DSM 5, 2013.  • A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.  • The null value “Not Known/Not Recorded” codes are only reported if no past medical history is available.  • EXCLUDE: Tobacco Use Disorder and Alcohol Use Disorder  **Add Edits:**  18401 1 Value is not a valid menu option  18403 2 Field cannot be blank  18404 2 Field cannot be “Not Applicable”  18440 1 Single Entry Max exceeded | W |
| 127 | Acute Kidney Injury | X |  | Yes | AcuteKidneyInjury | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function. KDIGO (Stage 3) Table: (SCr) 3 times baseline **OR** Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 μmol/l) **OR** Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m² **OR** Urine output <0.3 ml/kg/h for > 24 hours **OR** Anuria for > 12 hours  **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 (e.g., 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.  **•**The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  18501 1 Value is not a valid menu option  18503 2 Field cannot be blank  18504 2 Field cannot be “Not Applicable”  18540 1 Single Entry Max exceeded | W |
| 128 | Acute Respiratory Distress Syndrome ARDS | X |  | Yes | AcuteRespiratoryDistressSyndromeARDS | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.  Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules  Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present  Oxygenation: Mild 200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP >= 5 cm H2Oc Moderate 100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O Severe PaO2/FIO2 < 100 mm Hg With PEEP or CPAP >5 cm H2O  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available**.**  **Add Edits:**  18601 1 Value is not a valid menu option  18603 2 Field cannot be blank  18604 2 Field cannot be “Not Applicable”  18640 1 Single Entry Max exceeded | W |
| 129 | Alcohol Withdrawal Syndrome | X |  | Yes | AlcoholWithdrawalSyndrome | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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).  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  18701 1 Value is not a valid menu option  18703 2 Field cannot be blank  18704 2 Field cannot be “Not Applicable”  18740 1 Single Entry Max exceeded | W |
| 130 | Cardiac Arrest With CPR | X |  | Yes | CardiacArrestWithCPR | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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 who are receiving CPR on arrival to your hospital.  • INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  18801 1 Value is not a valid menu option  18803 2 Field cannot be blank  18804 2 Field cannot be “Not Applicable”  18840 1 Single Entry Max exceeded | W |
| 131 | Catheter Associated Urinary Tract Infection CAUTI | X |  | Yes | CatheterAssociatedUrinaryTractInfectionCAUTI | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 (>38⁰C) • 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 >10⁵ 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 (>38.0⁰C) • hypothermia (<36.0⁰C) • 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 ≥10⁵ CFU/ml.  **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.  • The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  18901 1 Value is not a valid menu option  18903 2 Field cannot be blank  18904 2 Field cannot be “Not Applicable”  18940 1 Single Entry Max exceeded | W |
| 132 | Central Line Associated Bloodstream Infection CLABSI | X |  | Yes | CentralLineAssociatedBloodstreamInfectionCLABSI | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1, **AND** The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient’s only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient’s removal from CLABSI surveillance. January 2016 CDC Criterion LCBI 1: Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). AND Organism(s) identified in blood is not related to an infection at another site. OR January 2016 CDC Criterion LCBI 2: Patient has at least one of the following signs or symptoms: fever (>38⁰C), chills, or hypotension AND Organism(s) identified from blood is not related to an infection at another site. AND the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after. OR January 2016 CDC Criterion LCBI 3: Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38⁰ C), hypothermia (<36⁰C), apnea, or bradycardia AND Organism(s) identified from blood is not related to an infection at another site AND the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.  **Additional Information:**  Must have occurred during the patient's initial stay at your hospital.  • A diagnosis of CLABSI must be documented in the patient's medical record.  • Consistent with the January 2016 CDC defined CLABSI.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19001 1 Value is not a valid menu option 19003 2 Field cannot be blank  19004 2 Field cannot be “Not Applicable”  19040 1 Single Entry Max exceeded | W |
| 133 | Deep Surgical Site Infection | X |  | Yes | DeepSurgicalSiteInfection | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 4. **AND** involves deep soft tissues of the incision (e.g., fascial and muscle layers) **AND** patient has at least one of the following:  a. purulent drainage from the deep incision. b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician\*\* or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed **AND** 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 (e.g., C-section incision or chest incision for CBGB) 2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)  **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.  • The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19101 1 Value is not a valid menu option  19103 2 Field cannot be blank  19104 2 Field cannot be “Not Applicable”  19140 1 Single Entry Max exceeded | W |
| 134 | Deep Vein Thrombosis DVT | X |  | Yes | DeepVeinThrombosisDVT | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19201 1 Value is not a valid menu option  19203 2 Field cannot be blank  19204 2 Field cannot be “Not Applicable”  19240 1 Single Entry Max exceeded | W |
| 135 | Extremity Compartment Syndrome | X |  | Yes | ExtremityCompartment Sysndrome | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19301 1 Value is not a valid menu option 19303 2 Field cannot be blank  19304 2 Field cannot be “Not Applicable”  19340 1 Single Entry Max exceeded | W |
| 136 | Myocardial Infarction MI Hospital Event | X |  | Yes | MyocardialInfarctionMIHospitalEvent | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  An acute myocardial infarction must be noted with documentation of any of the following: Documentation of ECG changes indicative of acute MI (one or more of the following three): 1. ST elevation >1 mm in two or more contiguous leads 2. New left bundle branch block 3. New q-wave in two or more contiguous leads **OR** New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia **OR** Physician diagnosis of myocardial infarction  **Additional Information:**  Must have occurred during the patient's initial stay at your hospital.  • A diagnosis of MI must be documented in the patient's medical record.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19401 1 Value is not a valid menu option  19403 2 Field cannot be blank  19404 2 Field cannot be “Not Applicable”  19440 1 Single Entry Max exceeded | W |
| 137 | Organ Space Surgical Site Infection | X |  | Yes | OrganSpaceSurgicalSiteInfection | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 4. **AND** infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure according to the list in Table 5. **AND** patient has at least one of the following: a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage) b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test **AND** meets at least one criterion for a specific organ/space infection site listed in Table 5. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available**.**  **Add Edits:**  19501 1 Value is not a valid menu option  19503 2 Field cannot be blank  19504 2 Field cannot be “Not Applicable”  19540 1 Single Entry Max exceeded | W |
| 138 | Osteomyelitis | X |  | Yes | Osteomyelitis | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 (e.g., not Active Surveillance Culture/Testing (ASC/AST)). 2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam. 3. Patient has at least two of the following localized signs or symptoms: fever (>38.0°C), swelling\*, pain or tenderness\*, heat\*, 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 (e.g., not Active Surveillance Culture/Testing (ASC/AST)) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis). b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis). \* With no other recognized cause  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:** 19601 1 Value is not a valid menu option  19603 2 Field cannot be blank  19604 2 Field cannot be “Not Applicable”  19640 1 Single Entry Max exceeded | W |
| 139 | Pulmonary Embolism | X |  | Yes | PulmonaryEmbolism | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available. **Add Edits:**  19701 1 Value is not a valid menu option  19703 2 Field cannot be blank  19704 2 Field cannot be “Not Applicable”  19740 1 Single Entry Max exceeded | W |
| 140 | Pressure Ulcer | X |  | Yes | PressureUlcer | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  19801 1 Value is not a valid menu option  19803 2 Field cannot be blank  19804 2 Field cannot be “Not Applicable”  19840 1 Single Entry Max exceeded | W |
| 141 | Severe Sepsis | X |  | Yes | SevereSepsis | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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.  • The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:** 19901 1 Value is not a valid menu option  19903 2 Field cannot be blank  19904 2 Field cannot be “Not Applicable”  19940 1 Single Entry Max exceeded | W |
| 142 | Stroke / CVA | X |  | Yes | StrokeCVA | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 ≥24 h **OR**: • Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death **AND**: • No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified **AND**: • Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission).  **Additional Information:**  Must have occurred during the patient's initial stay at your hospital.  • A diagnosis of stroke/CVA must be documented in the patient's medical record.  • Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  20001 1 Value is not a valid menu option  20003 2 Field cannot be blank  20004 2 Field cannot be “Not Applicable”  20040 1 Single Entry Max exceeded | W |
| 143 | Superficial Incisional Surgical Site Infection | X |  | Yes | SuperficialIncisionalSurgicalSiteInfection | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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 (e.g., not Active Surveillance Culture/Testing (ASC/AST)). c. superficial incision that is deliberately opened by a surgeon, attending physician\*\* or other designee and culture or non-culture based testing is not performed. **AND** patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion. d. diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or other designee. COMMENTS: There are two specific types of superficial incisional SSIs: 1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C- section incision or chest incision for CBGB) 2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  20101 1 Value is not a valid menu option  20103 2 Field cannot be blank  20104 2 Field cannot be “Not Applicable”  20140 1 Single Entry Max exceeded | W |
| 144 | Unplanned Admission To ICU | X |  | Yes | UnplannedAdmissionToICU | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available**.**  **Add Edits:** 20201 1 Value is not a valid menu option  20203 2 Field cannot be blank  20204 2 Field cannot be “Not Applicable”  20240 1 Single Entry Max exceeded | W |
| 145 | Unplanned Intubation | X |  | Yes | UnplannedIntubation | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **Definition:**  Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:** 20301 1 Value is not a valid menu option  20303 2 Field cannot be blank  20304 2 Field cannot be “Not Applicable”  20340 1 Single Entry Max exceeded | W |
| 146 | Unplanned Return To The Operating Room | X |  | Yes | UnplannedReturnToTheOperatingRoom | Xs:string | No | R | 1. Yes  2. No  7. Not Applicable  8. Not Recorded  9. Unknown | **Definition:**  Unplanned return to the operating room after initial operation management for a similar or related previous procedure.  **Additional Information:**  Must have occurred during the patient's initial stay at your hospital.  • The null value "Not Applicable" is reported for patients who were never in the OR during their initial stay at your hospital.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available.  **Add Edits:**  20401 1 Value is not a valid menu option  20403 2 Field cannot be blank  20440 1 Single Entry Max exceeded | W |
| 147 | Ventilator Associated Pneumonia VAP | X |  | Yes | VentilatorAssociatedPneumoniaVAP | Xs:string | No | R | 1. Yes  2. No  8. Not Recorded  9. Unknown | **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.    See Tables 6 – 10 as reference information in Trauma Data Code Tables.  **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.  **•** The null value “Not Known/Not Recorded” codes are only reported if no medical history is available**.**  **Add Edits:**  20501 1 Value is not a valid menu option  20503 2 Field cannot be blank  20504 2 Field cannot be “Not Applicable”  20540 1 Single Entry Max exceeded | W |

## Trauma Data Code Tables

|  |  |  |
| --- | --- | --- |
| **Table 1. DPH and CHIA Organization IDs for Hospitals** | | |
| **DPHOrg ID** | **CHIAOrgID** | **Organization Name** |
| 2006 | 1 | Anna Jaques Hospital |
| 2226 | 2 | Athol Memorial Hospital |
| 2120 | 5 | Baystate Franklin Medical Center |
| 2148 | 6 | Baystate Mary Lane Hospital |
| 2339 | 4 | Baystate Medical Center |
| 2181 | 139 | Baystate Wing Memorial Hospital |
| 2313 | 7 | Berkshire Medical Center ~~-~~ Berkshire Campus 725 North Street |
| 2227 | 98 | Beth Israel Deaconess Hospital - Milton |
| 2054 | 53 | Beth Israel Deaconess Hospital - Needham |
| 2082 | 79 | Beth Israel Deaconess Hospital - Plymouth |
| 2069 | 10 | Beth Israel Deaconess Medical Center - East Campus |
| 2092 | 140 | Beth Israel Deaconess Medical Center - West Campus |
| 2016 | 109 | Northeast Hospital - Addison Gilbert Campus |
| 2007 | 110 | Northeast Hospital – Beverly Campus |
| 2139 | 46 | Boston Children's Hospital |
| 2084 | 144 | Boston Medical Center – Newton Pavilion Campus |
| 2307 | 16 | Boston Medical Center - Menino Pavilion Campus |
| 2048 | 59 | Brigham and Women'sFaulkner Hospital |
| 2341 | 22 | Brigham and Women's Hospital |
| 2108 | 27 | Cambridge Health Alliance - Cambridge Campus |
| 2001 | 143 | Cambridge Health Alliance - Somerville Hospital Campus |
| 2046 | 142 | Cambridge Health Alliance – Everett Hospital Campus |
| 2135 | 39 | Cape Cod Hospital |
| 2003 | 42 | Steward Carney Hospital, Inc. |
| 2126 | 132 | Clinton Hospital |
| 2155 | 50 | Cooley Dickinson Hospital |
| 2335 | 51 | Dana-Farber Cancer Institute |
| 2018 | 57 | Emerson Hospital |
| 2052 | 8 | Fairview Hospital |
| 2289 | 40 | Falmouth Hospital |
| 2311 | 62 | Steward Good Samaritan Medical Center – Brockton Campus |
| 2038 | 66 | Melrose-Wakefield Hospital - Lawrence Memorial Hospital Campus |
| 2058 | 141 | Melrose-Wakefield Hospital |
| 2143 | 68 | Harrington Memorial Hospital |
| 2036 | 73 | Heywood Hospital |
| 2225 | 75 | Steward Holy Family Hospital, Inc. |
| 2131 | 11466 | Holy Family Hospital at Merrimack Valley – A Steward Family Hospital, Inc. (old number 70) |
| 2145 | 77 | Holyoke Medical Center |
| 2091 | 136 | Curahealth Boston, LLC |
| 2171 | 135 | Curahealth Boston North Shore, LLC |
| 2342 | 81 | Lahey Hospital & Medical Center, Burlington |
| 2161 | 4448 | Lahey Medical Center, Peabody |
| 2099 | 83 | Lawrence General Hospital |
| 2040 | 85 | Lowell General Hospital |
| 2029 | 115 | Saints Medical Center |
| 2103 | 133 | Marlborough Hospital |
| 2042 | 88 | Martha's Vineyard Hospital |
| 2167 | 89 | Massachusetts Eye and Ear Infirmary |
| 2168 | 91 | Massachusetts General Hospital |
| 2149 | 119 | Mercy Medical Center - Springfield Campus |
| 2020 | 49 | MetroWest Medical Center - Framingham Campus \* |
| 2039 | 457 | MetroWest Medical Center - Leonard Morse Campus \* |
| 2105 | 97 | Milford Regional Medical Center |
| 2022 | 99 | Morton Hospital, A Steward Family Hospital, Inc. |
| 2071 | 100 | Mount Auburn Hospital |
| 2044 | 101 | Nantucket Cottage Hospital |
| 2298 | 11467 | Nashoba Valley Medical Center, A Steward Family Hospital, Inc. (old number 52) |
| 2059 | 103 | New England Baptist Hospital |
| 2075 | 105 | Newton-Wellesley Hospital |
| 2076 | 106 | Baystate Noble Hospital |
| 2014 | 116 | North Shore Medical Center - Salem Campus |
| 2008 | 3 | North Shore Medical Center - Union Campus |
| 2114 | 41 | Steward Norwood Hospital, Inc. |
| 2011 | 114 | Steward Saint Anne's Hospital, Inc. |
| 2128 | 127 | Saint Vincent Hospital |
| 2118 | 25 | Signature Healthcare Brockton Hospital |
| 2107 | 122 | South Shore Hospital |
| 2337 | 123 | Southcoast Hospitals Group - Charlton Memorial Campus |
| 2010 | 124 | Southcoast Hospitals Group - St. Luke's Campus |
| 2106 | 145 | Southcoast Hospitals Group - Tobey Hospital Campus |
| 2085 | 126 | Steward St. Elizabeth's Medical Center |
| 2100 | 129 | Sturdy Memorial Hospital |
| 2299 | 104 | Tufts Medical Center and Floating Hospital for Children (Pediatric Trauma) |
| 2299 | 10177 | Tufts Medical Center (Adult Trauma Service) |
| 2127 | 8548 | Health Alliance Hospital - Burbank Campus |
| 2127 | 71 | Health Alliance Hospital - Leominster Campus |
| 2124 | 130 | UMass Memorial Medical Center - Memorial Campus |
| 2841 | 131 | UMass Memorial Medical Center - University Campus |
| 2094 | 138 | Winchester Hospital |

Note: \*# 457 MetroWest Medical Center – Leonard Morse / Natick records have been collected and sent under # 49 MetroWest Medical Center – Framingham Union Campus since the start of the trauma registry beginning with 2008 Q3. The filing org ID (provider filing the submission) and site org ID (provider of care for the trauma) is # 49 for both hospitals.

|  |  |
| --- | --- |
| **Table 2. Postal State Codes** | |
| **Valid Entries** | **Definition** |
|  |  |
| AL | Alabama |
| AK | Alaska |
| AZ | Arizona |
| AR | Arkansas |
| CA | California |
| CO | Colorado |
| CT | Connecticut |
| DE | Delaware |
| DC | District of Columbia |
| FL | Florida |
| GA | Georgia |
| HI | Hawaii |
| ID | Idaho |
| IL | Illinois |
| IN | Indiana |
| IA | Iowa |
| KS | Kansas |
| KY | Kentucky |
| LA | Louisiana |
| ME | Maine |
| MD | Maryland |
| MA | Massachusetts |
| MI | Michigan |
| MN | Minnesota |
| MS | Mississippi |
| MO | Missouri |
| MT | Montana |
| NE | Nebraska |
| NV | Nevada |
| NH | New Hampshire |
| NJ | New Jersey |
| NM | New Mexico |
| NY | New York |
| NC | North Carolina |
| ND | North Dakota |
| OH | Ohio |
| OK | Oklahoma |
| OR | Oregon |
| PA | Pennsylvania |
| RI | Rhode Island |
| SC | South Carolina |
| SD | South Dakota |
| TN | Tennessee |
| TX | Texas |
| UT | Utah |
| VT | Vermont |
| VA | Virginia |
| WA | Washington |
| WV | West Virginia |
| WI | Wisconsin |
| WY | Wyoming |

|  |  |
| --- | --- |
| **Table 3. Level of Service** | |
| **Valid Entries** | **Definition** |
| 1 | Outpatient Emergency Department Stay |
| 2 | Outpatient Observation Stay |
| 3 | Inpatient Stay |
| 4 | Death on Arrival |

## 

Discuss the use of the tables again after updating them

**Table 4. Surveillance Period for Deep Incisional or Organ/Space Surgical Site Infection (SSI) Following Selected National Healthcare Safety Network (NHSN) Operative Procedure Categories. Day 1 = the date of the procedure.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **30-day Surveillance** | | | | |
| **Code** | | **Operative Procedure** | **Code** | **Operative Procedure** |
| AAA | | Abdominal aortic aneurysm repair | LAM | Laminectomy |
| AMP | | Limb amputation | LTP | Liver transplant |
| APPY | | Appendix surgery | NECK | Neck surgery |
| AVSD | | Shunt for dialysis | NEPH | Kidney surgery |
| BILI | | Bile duct, liver or pancreatic surgery | OVRY | Ovarian surgery |
| CEA | | Carotid endarterectomy | PRST | Prostate surgery |
| CHOL | | Gallbladder surgery | REC | Rectal surgery |
| COLO | | Colon surgery | SB | Small bowel surgery |
| CSEC | | Cesarean section | SPLE | Spleen surgery |
| GAST | | Gastric surgery | THOR | Thoracic surgery |
| HTP | | Heart transplant | THUR | Thyroid and/or parathyroid surgery |
| HYST | | Abdominal hysterectomy | VHYS | Vaginal hysterectomy |
| KTP | | Kidney transplant | XLAP | Exploratory Laparotomy |
| **90-day Surveillance** | | | | |
| **Code** | **Operative Procedure** | | | |
| BRST | Breast surgery | | | |
| CARD | Cardiac surgery | | | |
| CBGB | Coronary artery bypass graft with both chest and donor site incisions | | | |
| CBGC | Coronary artery bypass graft with chest incision only | | | |
| CRAN | Craniotomy | | | |
| FUSN | Spinal fusion | | | |
| 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 5. 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 | Mediastinitis |
| CARD | Myocarditis or pericarditis | MEN | Meningitis or ventriculitis |
| DISC | Disc space | ORAL | Oral cavity (mouth, tongue, or gums) |
| EAR | Ear, mastoid | OREP | Other infections of the male or female reproductive tract |
| EMET | Endometritis | PJI | Periprosthetic Joint Infection |
| ENDO | Endocarditis | SA | Spinal abscess without meningitis |
| EYE | Eye , other than conjunctivitis | SINU | Sinusitis |
| GIT | GI tract | UR | Upper respiratory tract |
| HEP | Hepatitis | USI | Urinary System Infection |
| IAB | Intraabdominal, not specified | VASC | Arterial or venous infection |
| IC | Intracranial, brain abscess or dura | VCUF | Vaginal cuff |
| JNT | Joint or bursa |  |  |

**Table 6 VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):**

|  |  |  |
| --- | --- | --- |
| IMAGING TEST EVIDENCE | SIGNS/SYMPTOMS | LABORATORY |
| Two or more serial chest imaging test results with at least one of the following: | At least one of the following: | At least one of the following: |
| • New or progressive and persistent infiltrate | • Fever (>38⁰C or >100.4⁰F) | •Organism identified from blood |
| • Consolidation | • Leukopenia (<4000 WBC/mmᵌ) or leukocytosis (≥12,000 WBC/mmᵌ) | • Organism identified from pleural fluid |
| • Cavitation | • For adults ≥70 years old, altered mental status with no other recognized cause | • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.) |
| • Pneumatoceles, in infants ≤1 year old | AND at least one of the following: | • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram’s stain) |
| NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable. | • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements | • Positive quantitative culture of lung tissue |
|  | • New onset or worsening cough, or dyspnea, or tachypnea | • Histopathologic exam shows at least **one** of the following evidences of pneumonia: |
|  | • Rales or bronchial breath sounds | o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli |
|  | • Worsening gas exchange (e.g., 0₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand) | o Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae |

**Table 7 VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

|  |  |  |
| --- | --- | --- |
| IMAGING TEST EVIDENCE | SIGNS/SYMPTOMS | LABORATORY |
| Two or more serial chest imaging test results with at least **one** of the following: | At least one of the following: | At least one of the following: |
| • New or progressive and persistent infiltrate | • Fever (>38⁰C or >100.4⁰F) | • Virus, *Bordetella*, *Legionella*, *Chlamydia* or *Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). |
| • Consolidation | • Leukopenia (<4000 WBC/mmᵌ) or leukocytosis (≥12,000 WBC/mmᵌ) | • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) |
| • Cavitation | • For adults ≥70 years old, altered mental status with no other recognized cause | • Fourfold rise in *Legionella pneumophila* serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. |
| • Pneumatoceles, in infants ≤1 year old | AND at least one of the following: | • Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA |
| NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable. | • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements |  |
|  | • New onset or worsening cough, or dyspnea, or tachypnea |  |
|  | • Rales or bronchial breath sounds |  |
|  | • Worsening gas exchange (e.g., 0₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand) |  |

**Table 8 VAP Algorithm (PNU3 Immunocompromised Patients):**

|  |  |  |
| --- | --- | --- |
| IMAGING TEST EVIDENCE | SIGNS/SYMPTOMS | LABORATORY |
| Two or more serial chest imaging test results with at least one of the following: | Patient who is immunocompromised has at least one of the following: | At least one of the following: |
| • New or progressive and persistent infiltrate | • Fever (>38⁰C or >100.4⁰F) | • Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13 |
| • Consolidation | • For adults ≥70 years old, altered mental status with no other recognized cause | • Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: |
| • Cavitation | • New onset of purulent sputum3, or change in character of sputum4, or increased respiratory secretions, or increased suctioning requirements | − Direct microscopic exam − Positive culture of fungi − Non-culture diagnostic laboratory test |
| • Pneumatoceles, in infants ≤1 year old | • New onset or worsening cough, or dyspnea, or tachypnea5 | Any of the following from: |
| NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable. | • Rales6 or bronchial breath sounds | **LABORATORY CRITERIA DEFINED UNDER PNU2** |
|  | • Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240]7, increased oxygen requirements, or increased ventilator demand) |  |
|  | • Hemoptysis |  |
|  | • Pleuritic chest pain |  |

**Table 9 VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant’s ≤ 1 year old:**

|  |  |
| --- | --- |
| IMAGING TEST EVIDENCE | SIGNS/SYMPTOMS/LABORATORY |
| Two or more serial chest imaging test results with at least **one** of the following: | Worsening gas exchange (e.g., O₂ desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) |
| • New or progressive **and** persistent infiltrate | **AND** at least three of the following: |
| • Consolidation | • Temperature instability |
| • Cavitation | • Leukopenia (<4000 WBC/mmᵌ) or leukocytosis (≥15,000 WBC/mmᵌ) and left shift (≥10% band forms) |
| • Pneumatoceles, in infants ≤1 year old | • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements |
| NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable. | • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting |
|  | • Wheezing, rales, or rhonchi |
|  | • Cough |
|  | • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min) |

**Table 10 VAP Algorithm ALTERNATE CRITERIA (PNU1), for children > 1 year old or ≤ 12 years old:**

|  |  |
| --- | --- |
| IMAGING TEST EVIDENCE | SIGNS/SYMPTOMS/LABORATORY |
| Two or more serial chest imaging test results with at least one of the following: | At least **three** of the following: |
| • New or progressive and persistent infiltrate | • Fever (>38.0⁰C or >100.4⁰F) or hypothermia (<36.0⁰C or <96.8⁰F) |
| • Consolidation | • Leukopenia (<4000 WBC/mmᵌ) or leukocytosis (≥15,000 WBC/mmᵌ) |
| • Cavitation | • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements |
| • Pneumatoceles, in infants ≤1 year old | • New onset or worsening cough, or dyspnea, apnea, or tachypnea |
| NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable. | • Rales or bronchial breath sounds |
|  | • Worsening gas exchange (e.g., O₂ desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) |

# Massachusetts Trauma Sample XML File

Please note that the purpose of this sample is to show sample XML formatting. It is not meant to show realistic data.

**Note:** When writing up the XML element tags, the coding should not include "biu=" . For example, HomeCity should be coded as <HomeCity>76678</HomeCity> rather than something like <HomeCity biu=’76678’/>.

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| <InitialEDHospitalGCS40Verbal>1</InitialEDHospitalGCS40Verbal> |
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