NORTH DAKOTA TRAUMA REGISTRY DATA DICTIONARY

North Dakota Department of Health
Division of Emergency Medical Systems

2022 Revision

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ACKNOWLEDGEMENTS

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INTRODUCTION

A primary purpose of aggregating trauma related data across the nation and within a state, is to provide data for research purposes and to have evidence to direct and improve treatment, which can maximize positive outcome for the trauma population. Good data provides evidence for benchmarking and process improvement activities as well as a base from which to develop standards of care. In order to preserve data integrity, each data element must be collected, as close as possible, by the same definition and according to the same guidelines by each facility that contributes to a state or national database.

The integrity and value of data entered into a trauma registry database is directly affected by the training and expertise of the Trauma Registrar who abstracts, enters, and manages the data. Knowledge of medical terminology and human anatomy are also important. The focus of this manual is to provide clarity of definition and process guidance as the NTDB, National Trauma Databank, national elements are entered into facility trauma registries to upload to the state and national databases. Once the data has been entered into a facility trauma registry, the data will then be uploaded directly or be mapped to the corresponding fields at the state and national level; therefore, monitoring data mapping and understanding software functionality will be a necessary task for the Trauma registrar/Trauma Program Manager in every trauma department.

HIPAA Statement

The federal law known as “HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996. This law was passed to promote more standardization and efficiency in the health care industry. HIPAA directly impacts health care providers who transmit any health care information in electronic form in connection with a covered transaction, as well as indirectly impacting their business partners.

There are four parts to HIPAA’s Administrative Simplification:

1. Electronic transactions and code sets standards requirements
   National standards (for formats and data content) are the foundation of this requirement. HIPAA requires every provider who does business electronically to use the same health care transactions, code sets and identifiers. Transactions and code sets standards requirements were created to give the health care industry a common language to make it easier to transmit information electronically.
2. Privacy requirements
   The privacy requirements limit the release of patient protected health information without the patient’s knowledge and consent beyond that required for patient care. Patient’s personal information must be securely guarded and carefully handled when conducting the business of health care.
3. Security requirements
   The security regulation outlines the minimum administrative, technical and physical safeguards required to prevent unauthorized access to protected health care information. The general requirements of the security rule include:
   a. Ensuring confidentiality, integrity and availability of electronic protected health information that a covered entity creates, receives, maintains or transmits;
   b. Protecting against reasonably anticipated threats or hazards to the security or integrity of information;
   c. Protecting against reasonably anticipated uses and disclosures not permitted by privacy rules; ensuring compliance by the workforce.

   National identifier requirements
   HIPAA requires health care providers, health plans and employers to have standard national numbers that identify them on standard transactions.

The HIPAA law applies directly to three specific groups referred to as “covered entities”. The three groups include Health Care Providers who transmit any health information in electronic form in connection with a transaction for which standards requirements have been adopted; Health Plans; and Health Care Clearinghouses.

The NDDoH has been designated as a hybrid entity. A hybrid entity is a single legal covered entity whose business activities include both covered and noncovered functions. The NDDoH's covered functions are performed by the Division of Microbiology, however, the Department has chosen to operate under "best practices" as a single covered entity, and all divisions and programs of the Department operate under the privacy rule.

ND Trauma Registry Quarterly Submission Schedule

January 1 – March 31	June 30
April 1 - June 30	September 30
July 1 – September 30	December 31
October 1 – December 31	March 31

North Dakota Inclusion/Exclusion Criteria ICD-10
Patients to be downloaded to the state

Definition:

To ensure consistent data collection across the State and with the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

The patient must have incurred, **14 days prior to presentation for initial treatment**, at least one of the following injury diagnostic codes defined as follows:

INCLUDE:

- **ALL TRAUMA CODES/ALERTS OR ANY LEVEL OF TRAUMA TEAM ACTIVATION REGARDLESS OF ICD-10 INJURY.**
- Patient transfers from one acute care hospital to another acute care hospital.
- Death resulting from the traumatic injury.
- Patients admitted inpatient or observation with the following ICD-10 injuries (excluding superficial injuries as categorized below):

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

S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter)
T07 (unspecified multiple injuries)
T14 (injury of unspecified body region)
T20-T28 with 7th character modifier of A ONLY (burns by specific body parts – initial encounter)
T30-T34 (burn/frostbite by TBSA percentages)
T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)

EXCLUDE: isolated injuries:

ICD-10-CM:

S00 (Superficial injuries of the head)
S10 (Superficial injuries of the neck)
S20 (Superficial injuries of the thorax)
S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
S40 (Superficial injuries of shoulder and upper arm)

S50 (Superficial injuries of elbow and forearm)
S60 (Superficial injuries of wrist, hand and fingers)
S70 (Superficial injuries of hip and thigh)
S80 (Superficial injuries of knee and lower leg)
S90 (Superficial injuries of ankle, foot, and toes)

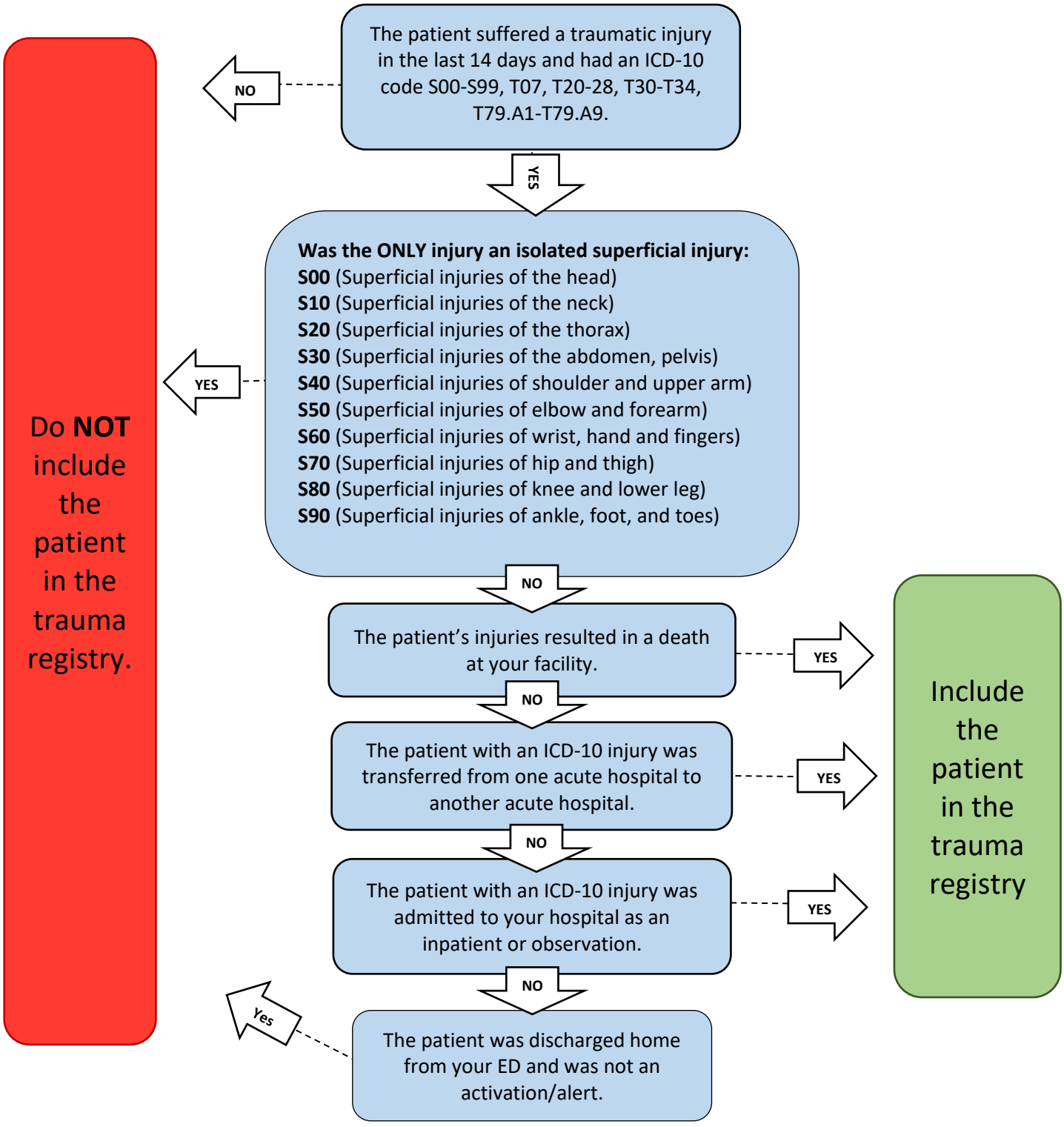
Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-10- CM S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9):

- Death resulting from the traumatic injury
- Patient transfer from one acute care hospital to another acute care hospital;
- Patients directly admitted to your hospital
- Patients who were an in-patient admission and/or observed.
- All trauma activations

North Dakota Patient Inclusion Criteria Decision Tree

ALL TRAUMA ALERTS AND ACTIVATIONS ARE INCLUDED IN THE TRAUMA REGISTRY!



Adopted from National Trauma Data Bank Reference Manual

REFERENCES

- International Classification of Diseases 2020 ICD-10-CM Professional and PCS
- National Trauma Data Bank Reference Manual, January 2020.
- Resources for Optimal Care of the Injured Patient 2014, American College of Surgeons, Chicago IL.
- The Abbreviated Injury Scale 2015 Revision; Association for the Advancement of Automotive Medicine, Barrington, IL.
- US Department of Labor Bureau of Labor Statistics, Occupational Outlook Handbook https://www.bls.gov/ooh/
- ESO eTraumaBase

DEMOGRAPHICS

Data Source for Demographic Information:

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

INSTITUTE NUMBER

Field Name: INSTITUTE_NUMBER

Definition: The hospital specific identifying number.

Field Values

- Relevant value for data element

Additional Information

National and State Data Element

INCIDENT TIME
Field Name: INJURY_TIME

Definition: The time the injury occurred

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM (collected as military time)
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used
- If time of injury is "Not Known / Not Recorded", the null value is unknown, do not use “NA”

National and State Data Element

INCIDENT DATE
Field Name: INJURY_DATE

Definition: The date the incident occurred

Field Values

• Relevant value for data element

Additional Information

- Collected as YYYY/MM/DD
- 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 times) should not be used
- If date of injury is "Not Known / Not Recorded", the null value is “Unknown” do not use “NA”

National and State Data Element

DATE OF BIRTH
Field Name: DOB

Definition: The patients date of birth

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY
- If Date of Birth equals Injury Date, then the Age and Age Units variables must be completed if date of birth is "Not Known / Not Recorded"
- Used to calculate patient age in days, months, or years

National and State Data Element

AGE (at date of incident)

Field Name: AGE_NUMBER

Definition: The patient's age at the time of injury

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated to patient's age in years when "Date of Birth" is entered
- Used to calculate patient age in hours, days, months, or years
- If date of birth is equal to the ED / Hospital Arrival date, then the “Age” and “Age Units” variables must be completed
- Must also complete: Age Units

National and State Data Element

Age:	

AGE UNITS
Field Name: AGE_UNITS

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

Field Values

- Hours
- Minutes
- Days
- Weeks
- Months
- Years

Additional Information

- If date of birth is equal to the ED / Hospital Arrival date, then the “Age” & “Age Units” variables must be completed

- Must also complete variable: “Age”

National and State Data Element

Sex
Field Name: SEX

Definition: The patient's (gender) sex at time of injury**.**

Field Values

Male

Female

Non-binary

Additional Information

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

National and State Data Element

Sex:	○ Male ○ Female ○ Non-binary

RACE

Field Name: RACE

Definition: The patient's race

Field Values

Asian
Native Hawaiian or Other Pacific Islander
Other Race
American Indian
Black or African American
White
UNK/Not Documented

Additional Information

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

National and State Data Element

ETHNICITY

Field Name: ETHNICITY

Definition: The patient's ethnicity

Field Values

Hispanic or Latino
Not Hispanic or Latino

Additional Information

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

National and State Data Element

PATIENT'S HOME COUNTY

Field Name: RES_COUNTY_STATE

Definition: The patient's county of residence

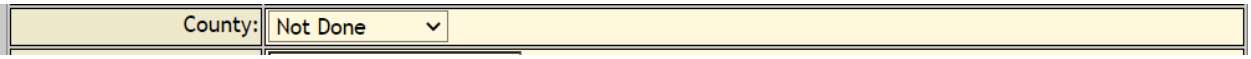
Field Values

- Relevant value for data element

Additional Information

- The null value "Not Applicable" if patient's home county is not available

National and State Data Element



PATIENT'S HOME CITY

Field Name: RES_CITY

Definition: The city the patient currently resides

Field Values

- Relevant value for data element

Additional Information

- The null value “Not Applicable” is reported if patient’s city is not available

National and State Data Element

City:	

PATIENT'S HOME STATE

Field Name: RES_STATE

Definition: The patient's state of residence

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Applicable" if patient's home state is not available

National and State Data Element

PATIENT'S HOME ZIP CODE

Field Name: ZIP_CODE

Definition: The patient's home Zip/Postal Code of primary residence

Field Values

- Relevant value for data element

Additional Information

- May require adherence to HIPAA regulations
- Can be stored as a 5 digit
- NA used if patient is not a U.S. resident.

National and State Data Element

Zip Code:	

PATIENT'S HOME COUNTRY

Field Name: COUNTRY

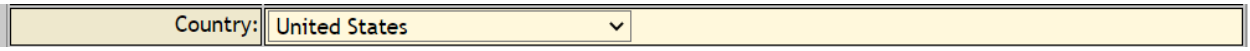
Definition: The country where the patient resides

Field Values

- Relevant value for data element

Additional Information

National and State Data Element



PATIENT'S ALTERNATE RESIDENCE

Field Name: HOME

Definition: Documentation of the type of patient without a home ZIP / Postal Code

Field Values

- HOME-Homeless
- UND-Undocumented Citizen
- MI-Migrant worker
- NA-Not Applicable

Additional Information

- Homeless 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 defined as a national of another country who has entered or stayed in another country without permission

National and State Data Element

EVENT/CAUSE CODE

Data Source For Event/Cause Code Information:

1. EMS Run Report
2. Triage Form / Trauma Flow Sheet
3. ED Nurses' Notes
4. History & Physical
5. Progress Notes

INCIDENT ZIP CODE
Field Name: INJURY_ZIP

Definition: The Zip / Postal Code of incident location

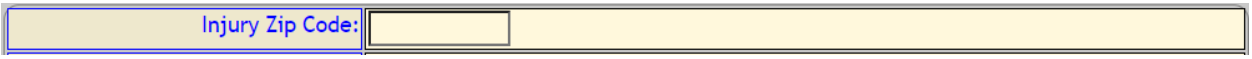
Field Values

- Relevant value for data element

Additional Information

- Can be stored as a 5 digit code

National and State Data Element



INCIDENT COUNTY
Field Name: COUNTY_STATE

Definition: The county where the patient was found or to which the EMS unit responded.

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Applicable" if incident county is not available.
- If Incident Country is not US, report the null value "Not Applicable"

National and State Data Element

INCIDENT STATE

Field Name: INJURY_ST

Definition: The state where the patient was found or to which the unit responded

Field Values

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

Additional Information

- If Incident Country is not US, report the null value "Not Applicable"

National and State Data Element

INCIDENT CITY

Field Name: NEAREST_TOWN

Definition: The nearest city where the patient was found or to which the unit responded

Field Values

- Relevant value for data element

Additional Information

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

National and State Data Element

Nearest Town:	

INCIDENT COUNTRY

Field Name: INJURY_COUNTRY

Definition: The country where the patient was found or to which the unit responded

Field Values

- Relevant value for data element

Additional Information

National and State Data Element

ICD-10 LOCATION CODE

Field Name: LOCATION10 and LOCATION

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

HOME

- Private Garage
- Apartment
- Garden
- Boarding house
- Farm house
- Home premises
- House (residential)
- Non-institutional place of residence
- Swimming pool in private house or garden
- Home
- Yard of Home
- Driveway
- Walk

(Excludes: Home under construction and not yet occupied or an institutional place of residence)

FARM

Farm: buildings, land under cultivation
(Excludes: farm house and home premises of farm)

MINE & QUARRY

Gravel pit
Tunnel under construction
Sand pit

INDUSTRIAL PLACE AND PREMISES

Building under construction
Loading platform of factory or store
Dockyard/Plant industrial
Dry Dock/Railway yard
Factory buildings and premises

ICD-10 LOCATION CODE (continued)

Shop (place of work)
Garage (place of work)
Warehouse
Industrial yard Workhouse

PLACE OF RECREATION AND SPORT

Amusement park
Baseball field
Basketball court
Beach resort
Cricket ground
Fives court
Football field
Golf course
Gymnasium
Hockey rink
Holiday camp
Ice palace
Lake resort
Mountain resort
Public park
Racecourse
Resort NOS
Riding school
Rifle range
Seashore resort
Skating rink
Sports Palace
Stadium
Swimming pool (public)
Tennis court
Vacation resort
Playground including school playground
(Excludes: that in private house or garden)

STREET AND HIGHWAY

Maintained public roadways and their right of ways

PUBLIC BUILDING

Building (includes adjacent grounds) used by the general public or by a particular group of the public, such as:

Airport
Bank
Office
Casino
Theater
Courthouse
Dance hall
Nightclub
Opera house
Store
Post office
Clubhouse Public hall
Radio broadcasting station
Restaurant

ICD-10 LOCATION CODE (continued)

Garage building (for car storage)
Hotel Shop (commercial)
Station (bus or railway)
School (state, public or private)
Church
Bar is coded to Cafe
(**Excludes:** home garage, industrial building or workplace)

RESIDENTIAL INSTITUTION

Children's Home
Nursing Home
Dormitory
Orphanage
Hospital
Prison
Jail
Reform School
Assisted Living

OTHER SPECIFIED PLACES

Beach (NOS)
Canal
Caravan site (NOS)
Derelict house
Desert
Dock
Forest
Harbor
Hill
Lake (NOS)
Mountain
Parking lot
Pond or pool (natural)
Prairie (grassland, pasture)
Public place (NOS)
Railway line
Reservoir
River
Sea
Seashore (NOS)
Stream
Swamp
Trailer court
Sidewalk

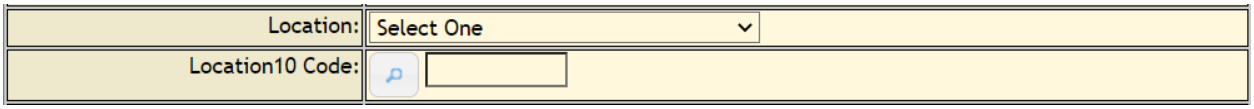
Y92.9 UNSPECIFIED PLACE

If location is not specifically listed above, then use unspecified place.

Additional Information

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

National and State Data Element



WORK RELATED
Field Name: INDUST_ACC

Definition: Indication of whether the injury occurred during paid employment

Field Values

- Yes Work Related
- No Not Work Related

Additional Information

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

National and State Data Element

PATIENT'S OCCUPATION
Field Name: OCCUPATION

Definition: The occupational industry associated with the patient's work environment

Field Values

1. Business and Financial Operations Occupations
2. Architecture and Engineering
3. Community and Social Services Occupations
4. Education, Training, and Library Occupations
5. Healthcare Practitioners and Technical
6. Protective Service Occupations
7. Building and Grounds Cleaning and Maintenance Occupations
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 Occupations
17. Healthcare Support Occupations
18. Food Preparation and Serving Related Occupations
19. Personal Care and Service Occupations
20. Office and Administrative Support Occupations
21. Construction and Extraction Occupations
22. Production Occupations
23. Military Specific Occupations

Additional Information

- 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)
- The null value "Not Applicable" is used if Work Related is (No)

National and State Data Element

Patient's Occupation: The occupation of the patient at the time of injury

Field Value Definitions*:*

Business and Financial Operations Occupations

Buyers and Purchasing
Agents Accountants and
Auditors
Claims Adjusters, Appraisers, Examiners, and Investigators
Human Resources Workers
Market Research Analysts and Marketing Specialists
Business Operations Specialists, All Other

Architecture and Engineering Occupations

Landscape Architects
Surveyors, Cartographers, and
Photogrammetrists Agricultural Engineers
Chemical Engineers
Civil Engineers
Electrical Engineers

Community and Social Services Occupations

Marriage and Family Therapists
Substance Abuse and Behavioral Disorder Counselors
Healthcare Social Workers
Probation Officers and Correctional Treatment Specialists
Clergy

Education, Training, and Library Occupations

Engineering and Architecture Teachers,
Postsecondary Math and Computer Teachers
Postsecondary
Nursing Instructors and Teachers, Postsecondary
Law, Criminal Justice, and Social Work Teachers, Postsecondary
Preschool and Kindergarten Teachers
Librarians

Healthcare Practitioners and Technical Occupations

Dentists, All Other
Specialists Dietitians and
Nutritionists Physicians and
Surgeons Nurse
Practitioners
Cardiovascular Technologists and Technicians
Emergency Medical Technicians and Paramedics

Protective Service Occupations

- Firefighters/Fire Inspectors
- Police Officers/Detectives
- Correctional Officers/Balliffs
- Animal Control Workers
- Security Guards
- Lifeguards, Ski Patrol, and Other Recreational Protective Service

Building and Grounds Cleaning and Maintenance

- Building Cleaning Workers
- Landscaping and Grounds keeping Workers Pest Control Workers
- Pesticide Handlers, Sprayers, and Applicators, Vegetation
- Tree Trimmers and Pruners

Sales and Related Occupations

- Advertising Sales Agents
- Cashiers
- Insurance Sales Agent
- Models
- Retail Salespersons
- Counter and Rental Clerks
- Door-to-Door Sales Workers, News and Street Vendors, and Related Workers
- Real Estate Brokers
- Travel Agents

Farming, Fishing, and Forestry Occupations

- Animal Breeders
- Fishers and Related Fishing Workers
- Agricultural Equipment Operators Hunters and Trappers
- Forest and Conservation Workers
- Logging Workers

Installation, Maintenance, and Repair Occupations

- Electric Motor, Power Tool, and Related Repairers
- Aircraft Mechanics and Service Technicians
- Automotive Glass Installers and Repairers
- Heating, Air Conditioning, and Refrigeration Mechanics and Installers
- Maintenance Workers, Machinery
- Industrial Machinery Installation, Repair, and Maintenance Workers

Transportation and Material Moving Occupations

- Air Traffic Controllers/Pilots
- Bus Drivers/Delivery Truck Drivers
- Flight Attendants
- Rail Transportation Workers, All Other

Subway and Streetcar Operators
Packers and Packagers, Hand
Refuse and Recyclable Material Collectors
Material Moving Workers,
Taxi Driver/Sales Workers
Water Transportation Worker

Management Occupations

Public Relations and Fundraising Managers
Advertising/Marketing and Sales Managers
Administrative Services Managers
Medical and Health Managers
Transportation, Storage, and Distribution Managers
Food Service Managers
Principals
Top Executives

Computer and Mathematical Occupations

Web Developers
Software Developers and Programmers
Database Administrators
Statisticians
Computer Occupations, All Other

Life, Physical, and Social Science Occupations

Psychologists Economists Foresters
Zoologists and Wildlife Biologists
Political Scientists
Agricultural and Food Science Technicians

Legal Occupations

Lawyers and Judicial Law Clerks
Paralegals and Legal Assistants
Court Reporters
Administrative Law Judges, Adjudicators, and Hearing Officers
Arbitrators, Mediators, and
Conciliators Title Examiners,
Abstractors, and Searchers

Arts, Design, Entertainment, Sports, and Media

Artists and Related Workers, All Other
Athletes, Coaches, Umpires, and Related Workers
Dancers and Choreographers Reporters and Correspondents
Interpreters and Translators
Photographers

Healthcare Support Occupations
- Nursing, Psychiatric, and Home Health Aides
- Physical Therapist Assistants and Aides
- Veterinary Assistants and Laboratory Animal Caretakers
- Healthcare Support Workers, All Other
- Medical Assistants

Food Preparation and Serving Related
- Bartenders
- Cooks, Institution and Cafeteria
- Cooks, Fast Food
- Counter Attendants, Cafeteria, Food Concession, and Coffee Shop
- Waiters and Waitresses
- Dishwashers

Personal Care and Service Occupations
- Animal Care and Service Workers
- Childcare Workers
- Amusement and Recreation Attendants
- Barbers, Hairdressers, Hairstylists and Cosmetologists, Mani/Pedi/Skin Care
- Baggage Porters, Bellhops, and Concierges
- Tour Guides and Escorts
- Recreation and Fitness Workers
- Funeral Service Workers
- Gaming Service Workers

Office and Administrative Support Occupations
- Bill and Account Collectors
- Bookkeeping, Accounting and Auditing Clerks
- Customer Service Representatives
- Dispatchers (fire, police, EMS)
- Office/Information/Material Recording Clerks
- Tellers
- Court, Municipal, and License Clerks
- Hotel, Motel, and Resort Desk Clerks
- Postal Service Workers
- Receptionist
- Secretaries and Administrative Assistants

Construction and Extraction Occupations
- Brick masons, Block masons, and Stonemasons
- Carpet, Floor, and Tile Installers and Finishers
- Construction Laborers
- Electricians
- Pipe layers, Plumbers, Pipefitters, and Steamfitters

Roofers

Production Occupations

Bakers
Boiler Operators
Water and Wastewater Treatment Plant and System Operators
Dental and Ophthalmic Lab Techs and Medical Appliance Techs
Food and Tobacco Processing Workers
Jewelers and Precious Stone/Metal Workers
Electrical, Electronics, and Electromechanical Assemblers
Engine and Other Machine Assemblers
Structural Metal Fabricators and Fitters
Butchers and Meat Cutters
Painting and Coating Workers
Power Plant Operators/Distributors/Dispatchers
Quality Control Inspectors
Machine Tool Cutting Setters, Operators, and Tenders, Metal and Plastic
Welding, Soldering, and Brazing Workers
Wood Workers

Military Specific Occupations

Air Crew Officers
Armored Assault Vehicle Officers
Artillery and Missile Officers
Infantry Officers
Military Officer Special and Tactical Operations Leader.

PATIENT'S OCCUPATIONAL INDUSTRY DESCRIPTION

Field Name: INDUSTRY_TYPE

Definition: The occupational industry associated with the patient's work environment

Field Values

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

Additional Information

- If work related, also complete Patient's Occupation
- Based upon US Bureau of Labor Statistics Industry Classification
- The null value "Not Applicable" is used if Work Related is (No)

National and State Data Element

Patient's Occupational Industry: The occupational history associated with the patient's work environment.

Field Value Definitions*:*

Finance and Insurance and Real Estate - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions.
Three principal types of activities are identified: 1.)Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
2.) Pooling of risk by underwriting insurance and annuities. 3.)Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.
Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.
Manufacturing - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials- handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.
Retail Trade - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers: 1)Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers. 2) Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.
Transportation and Public Utilities - The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.
Agriculture, Forestry, Fishing - The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising

animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.

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

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

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

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

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

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

Information Services - The Information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data.

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

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

Other Services - The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grantmaking, advocacy.

REPORT OF PHYSICAL ABUSE

Field Name: ABUSE_REPORTED

Definition: A report of suspected physical abuse was reported to law enforcement and/or protective services

Field Values

- Yes
- No

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse.

State Data Element

INVESTIGATION OF PHYSICAL ABUSE

Field Name: ABUSE_INVESTIGATION

Definition: An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse

Field Values

- Yes
- No
- Not Applicable

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse
- Only complete when Report of Physical Abuse is "Yes"
- The null value "Not Applicable" should be used for patients where Report of Physical Abuse is "No"

State Data Element

Abuse Investigation:	(●) NA ( ) Yes ( ) No

CAREGIVER AT DISCHARGE

Field Name: ABUSE_DC_CAREGIVER

Definition: The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse

Field Values

- Yes
- No
- Not Applicable

Additional Information

- Only complete when Report of Physical Abuse is "Yes"
- Only complete for minors as determined by state/local definition, excluding emancipated minors
- The null value "Not Applicable" should be used for patients if Report of Physical Abuse is "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

State Data Element

PROTECTIVE DEVICES

Field Name: PROTECTIVE_DEVICES

Definition: Protective devices in use or worn by the patient at the time of injury

Field Values

- None
- Seat Lap Belt
- Personal Floatation Device
- Gear Protective Non-Clothing (e.g., shin guard)
- Eye Protection
- Child Restraint (booster seat or child car seat)
- Helmet (e.g., bicycle, skiing, motorcycle)
- Airbag Present
- Protective Clothing (e.g., padded leather pants)
- Shoulder Belt
- Other

Additional Information

- Report all that apply
- If "Child Restraint" is present, complete variable "Child Specific Restraint"
- 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 (Lap Belt) and (Shoulder Belt)
- If documented that a “Child Restraint (booster seat or child care seat)” was used or worn, but not properly fastened, either on the child or in the car, report Field Value (None)

National and State Data Element

AIRBAG DEPLOYMENT

Field Name: AIRBAG

Definition: Indication of airbag deployment during a motor vehicle crash

Field Values

- Airbag not deployed
- Airbag deployed front
- Airbag deployed side
- Airbag deployed other (Knee, air belt, curtain, etc.)
- Airbag deployed unspecified Type
- Not applicable
- Unknown/Not Documented

Additional Information

- Check all that apply
- Evidence of the use of airbag deployment may be reported or observed.
- Only completed when Protective Devices include (8. Airbag Present)
- The null value "Not Applicable" is used if no "Airbag Present" is reported under Protective Devices

National and State Data Element

CHILD RESTRAINTS
Field Name: CHILD_RESTRAINT

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

Field Values

- Child Car Seat
- Infant Car Seat
- Child Booster Seat
- Used, Unspecified Type
- NA Not Applicable
- Unknown/Not Documented

Additional Information

- Evidence of the use of child restraint may be reported or observed.
- Only completed when Protective Devices include – (Child Restraint) - booster seat or child car seat
- The null value "Not Applicable" is used if no "Child Restraint" is reported under Protective Devices

National and State Data Element

TRIAGE CODES
Field Name: TRIAGE_CODE

Definition: Triage Codes for trauma centers

Field Values

- AMPUTATION - proximal to wrist and ankle
- CHEST - flail Chest
- DEFORM - auto deformity >20” documented by EMS
- EJECT - ejection for automobile
- FALL - fall >20 feet (PEDS 2-3x height of patient)
- FATAL - death in same passenger compartment
- FX - 2 or more proximal long bone fractures
- GCS <14
- HYPO - systolic BP <90
- IMPACT - auto-ped or auto-bike >5mph
- INTRUS - intrusion in passenger compartment >12” documented by EMS
- LIMB - limp paralysis
- MCYCLE - motorcycle>20mph or separation of bike rider
- NONE - none
- OTHER - other triage not listed i.e. snowmobile/ATV rider
- PEDES - pedestrian thrown or run over
- PELVFX - pelvic fracture
- PEN - penetrating injury to head, neck, torso, extremities proximal to elbow and knee
- RESP - respiratory rate <10 or >29
- ROLL - rollover
- SKULL - open or depressed skull fractures
- SPEED - initial speed >40mph
- TRAP - extrication >20minutes
- BURN - thermal, chemical, electrical

Additional Information

- May vary from facility to facility

State Data Element

INJURY DETAILS
Field Name: INJURY_DETAIL

Description: A brief description explaining the cause of injury

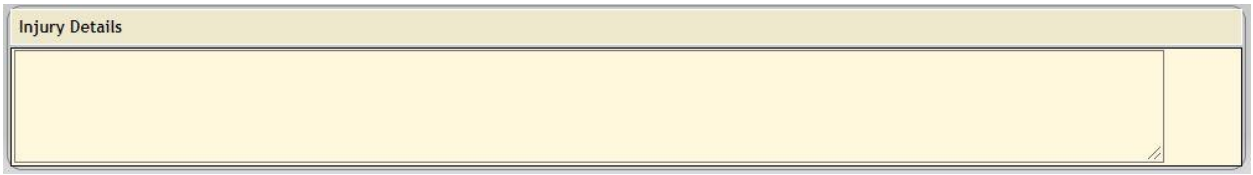
Field Values

Free text explaining the cause of injury

Additional Information

- Example: “Pt unrestrained driver of a motor vehicle that rolled at highway speeds”.

State Data Element



CAUSE OF INJURY

Field Name: CAUSE_CODE

Description: The cause or mechanism of injury

Field Values

- AIR (i.e. airplane, hang-gliders, helicopters, ultra-lights, hot air balloons, and skydivers)
- ANIMAL (i.e. struck by animal, animal bites, injured by animal/riding an animal /stepped on / crushed / mauled by animal)
- ASSAULT (physical blunt attack, abuse of pediatrics/elderly)
- ATV (definition of 3,4,5,6,7,8 “wheelers”)
- BIKE (bicycle and tricycle)
- BIOHAZ (intentional or non-intentional exposure to potentially hazardous materials, i.e. a mass casualty incident)
- BURN (thermal, chemical, electrical, includes frostbite)
- FALL (falls)
- GSW (gunshot wounds)
- MACH (machinery incidents)
- MC (motorcycle/includes dirt bike)
- MV (motor vehicle auto and truck, i.e. cars, pickup truck, SUV, van, bus, semi, etc.)
- OTHER (any other)
- OHV (golf cart, go-cart)
- PED (pedestrian)
- SKATE (i.e. ice skates, roller skates, roller blades, and skateboard)
- SKI (snow ski, snowboard, and sledding)
- SNOWMOBILE
- SPORT (organized football, soccer, etc.)
- STAB (point force or piercing injuries, i.e. knife, nail, tine.)
- WATER (water transport and activities)

Additional Information

- Only one value can be entered, select the cause code that is most relevant to the patient’s injuries

State Data Element

TRAUMA TYPE
Field Name: TRAUMA_TYPE

Definition: Trauma type and predominant injury type

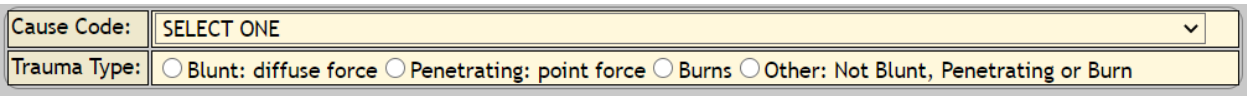
Field Values

- Burns-Burns
- B-Blunt injury: diffuse force, as in most MVC's
- P-Penetrating injury: point force
    - Examples: bullet / shell / BB
    - Fork Tine
    - Knife
    - Impaled object (nail, fish hook)
- O-Other,Not blunt, penetrating or Burn
    - Asphyxiation
    - Poisioning
    - Hanging

Additional Information

- If any of these causes a laceration/amputation type injury, the trauma type would be blunt

State Data Element



ICD-10 PRIMARY EXTERNAL CAUSE CODE

Field Name: CAUSE_E_CODES10

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

Field Values

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

Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital
- External cause codes are used to auto generate two calculated fields: Trauma Type (Blunt, Penetrating and 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.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault accident or self-harm, following the order of hierarchy listed above

National Element and State Element

ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Field Name: CAUSE_E_CODES10

Definition: Additional External Cause Code used in conjuction with the Primary External Cause Code if multiple external cause codes are required to describe the injury/event.

Field Values

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

Additional Information

- Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code. Activity codes should not be reported in this field.
- The null value "Not Applicable" is used if no additional external cause codes are used
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault accident or self-harm, following the order of hierarchy listed above

National and State Data Element

PRE EXISITING CONDITION

Field Name: RISK_TYPE

Data Source for Risk Factors/Comorbidities

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

ADVANCE DIRECTIVE LIMITING CARE

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

Additional Information

- The written request was signed or dated by the patient and/or his/her designee prior to arrival at your center.
- Report *Element Value* "2. No" for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography).

National and State Data Element

ALCOHOL USE DISORDER

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

Additional Information

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

National and State Data Element

ANGINA PECTORIS

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

Additional Information

- Present prior to injury
- A diagnosis of angina including microvascular angina, Prinzmetal's angina, stable angina, unstable angina, and variant angina must be documented in the patient's medical record.
- Consistent with American Heart Association (AHA), July 2015.

National and State Data Element

ANTICOAGULANT THERAPY

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

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

Additional Information

- Anticoagulation must be part of the patient's active medications.
- Present prior to injury.
- Exclude patients whose only anticoagulant therapy is chronic Aspirin.

National and State Data Element

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

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.

National and State Data Element

BLEEDING DISORDER

Definition: 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

National and State Data Element

CEREBRAL VASCULAR ACCIDENT (CVA)

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

Additional Information

- Present prior to injury
- A diagnosis of CVA must be documented in the patient's medical record

National and State Data Element

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Exclude patients whose only pulmonary disease is acute asthma.
- Exclude patients with diffuse interstitial fibrosis or sarcoidosis.
- Consistent with World Health Organization (WHO), 2019.

National and State Data Element

CHRONIC RENAL FAILURE

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

National and State Data Element

CIRRHOSIS

Definition: Documentation in the medical record of cirrhosis, which may 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.

National and State Data Element

CONGENITAL ANOMALIES

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

Additional Information

- Present prior to injury.
- Only report on patients < 18 years-of-age.
- A diagnosis of a congenital anomaly must be documented in the patient's medical record.

National and State Data Element

CONGESTIVE HEART FAILURE (CHF)

Definition: The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure.

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 or pulmonary edema with onset of increasing symptoms within 30 days prior to injury

  ***Common manifestations are:**
  - Abnormal limitation in exercise tolerance due to dyspnea or fatigue
  - Orthopnea (dyspnea or lying supine)
  - Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
  - Increased jugular venous pressure
  - Pulmonary rales on physical examination
  - Cardiomegaly
  - Pulmonary vascular engorgement

National and State Data Element

CURRENT SMOKER

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).

National and State Data Element

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

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.

National and State Data Element

DEMENTIA

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

National and State Data Element

DIABETES MELLITUS

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

National and State Data Element

DISSEMINATED CANCER

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

Additional Information

- Present prior to injury
- Another term describing disseminated cancer is “metastatic cancer.”
- A diagnosis of cancer that has spread to one or more sites must be documented in the patient’s medical record.

National and State Data Element

FUNCTIONALLY DEPENDENT HEALTH STATUS

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

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.

National and State Data Element

HYPERTENSION

Definition: History of persistent elevated blood pressure requiring antihypertensive medication

Additional Information

- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient's medical record.
- Report “Yes" for patients who were non-compliant with their prescribed antihypertensive medication.

National and State Data Element

MENTAL / PERSONALITY DISORDERS

Definition: History of a diagnosis and/or treatment for the following disorder(s) documented in the patient's medical record. Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Social Anxiety Disorder, PTSD, Antisocial Personality Disorder.

Additional Information

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

National and State Data Element

MYOCARDIAL INFARCTION (MI)

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

National and State Data Element

PERIPHERAL ARTERIAL DISEASE (PAD)

Definition: The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. Peripheral Arterial Disease (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 Peripheral Arterial Disease (PAD) must be documented in the patient's medical record.

National and State Data Element

PREGNANCY

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

Additional Information

- Present prior to ED / Hospital arrival

National and State Data Element

PREMATURITY

Definition: Babies born before 37 weeks of pregnancy are completed.

Additional Information

- Present prior to injury.
- Only report on patients ≤18 years-of-age.
- A diagnosis of Prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.

National and State Data Element

STEROID USE

Definition: 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.

National and State Data Element

SUBSTANCE USE DISORDER

Definition: Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders specifically cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and stimulants (e.g. patient has a history of drug use; patient has a history of opioid use) OR diagnosis of any of the following documented in the patient's medical record:

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

Additional Information

- Present prior to arrival at you center.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.

National and State Data Element

EMS/PREHOSPITAL

Data Source For Prehospital Information:

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

EMS PATIENT CARE REPORT UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Field Name: PREHOSPITAL_EMS_UUID

Definition: The patient's universally unique identifier (UUID) as assigned by the emergency medical service (EMS) agency transporting the patient from the scene of injury to your hospital.

Field Values

- Relevant value for data element
- Must be represented in canonical form, matching the following regular expression: [a-fA-F0-9]{8}-[a-fA-F0-9]{4}-[1-5][a-fA-F0-9]{3}-[89abAB][a-fA-F0-9]{3}-[a-fA-F0-9]{12}

Additional Information

- A sample UUID is: e48cd734-01cc-4da4-ae6a-915b0b1290f6
- Assigned by the transporting EMS agency in accordance with the IETF RFC 4122 standard
- The null value "Not Applicable" must be reported for all patients where Inter-facility Transfer is Element Value "Yes".
- The null value "Not Known/Not Recorded" should be reported if the UUID is not documented on the EMS Run Report or if the EMS provider is not NEMSIS v3.5.0 compliant.
- The null value "Not Applicable" must be reported for all patients where Transport Mode is Element Values "Private/Public Vehicle/Walk-in", "Police", "Other" or if patient is not transported from the scene of injury by EMS.
- For patients with multiple modes of transport from the scene of injury, report the UUID assigned by the EMS agency that delivered the patient to your hospital
- Consistent with NEMSIS v3.5.0.

National and State Data Element

THIS HAS NOT BEEN IMPLEMENTED AS OF 1/2001

NAME OF EMS SERVICE
Field Name: TRANSPORT_AGENCY_CODE

Definition: The name of the EMS service that transferred the patient**.**

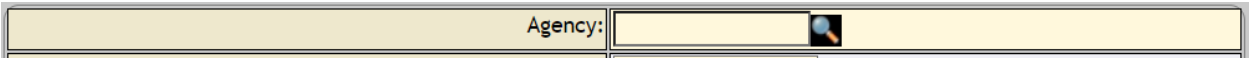
Field Values

- Relevant value for data element

Additional Information

- The null value “Not Applicable” must be reported for all patients where Transport Mode is Element Values “Private/Public Vehicle/Walk-in”, “Police”, “Other” or if patient is not transported from the scene of injury by EMS

State Data Element



EMS ORIGIN
Field Name: TRANSPORT_ORIGIN

Definition: The location the patient was transferred from to your facility**.**

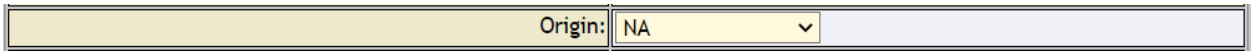
Field Values

- NA-Not Applicable
- Scene
- Referring Facility
- Intercept

Additional Information

- The null value “Not Applicable” must be reported for all patients where Transport Mode is Element Values “Private/Public Vehicle/Walk-in”, “Police”, “Other” or if patient is not transported by EMS

State Data Element



TRIP TICKET
Field Name:TRIP_FORM

Definition: EMS documentation was provided to your facility for patient event.

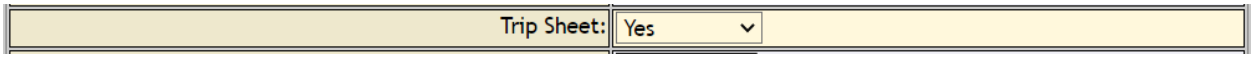
Field Values

- Yes
- No
- Incomplete

Additional Information

- The null value “Not Applicable” must be reported for all patients where Transport Mode is Element Values “Private/Public Vehicle/Walk-in”, “Police”, “Other” or if patient is not transported by EMS

State Data Element



EMS DISPATCH DATE
Field Name: NOTIFY_DATE

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

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- 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
- The null value "Not Applicable" is used for patients who were not transported by EMS

National and State Data Element

Notify/Dispatch Date:	

EMS DISPATCH TIME

Field Name: NOTIFY_TIME

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

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (collected in military time)
- The null value "Not Applicable" is used for patients not transported by EMS

National and State Data Element

Notify/Dispatch Time:	

EMS ARRIVAL DATE
Field Name: ARRIVAL_DATE

Definition: The date EMS arrived on scene/transferring facility.

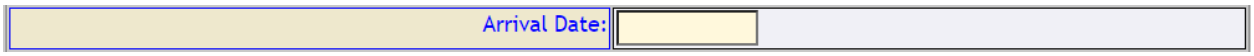
Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY/MM/DD
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched
- The date EMS arrives on scene, referral hospital, or point of intercept depending on the leg of transport defined
- The null value “Not Applicable” is reported for patients who were not transported by EMS

National and State Data Element



EMS ARRIVAL TIME
Field Name: ARRIVAL_TIME

Definition: The time EMS arrived on scene/transferring facility.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (collected in military time)
- The date EMS arrives on scene, referral hospital, or point of intercept depending on the leg of transport defined
- The null value “Not Applicable” is reported for patients who were not transported by EMS

National and State Data Element

Arrival Time:	

EMS DEPARTURE DATE
Field Name: DEPATURE_DATE

Definition: The date EMS departed from the scene/transferring facility with patient.

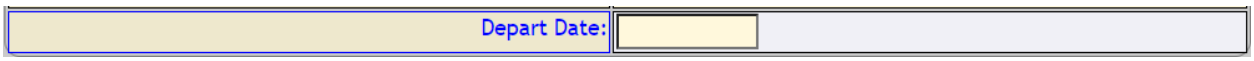
Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- This can be from the scene, referral hospital, intercept point or definitive care hospital
- The null value “Not Applicable” is reported for patients who were not transported by EMS

National and State Data Element



EMS DEPARTURE TIME
Field Name: DEPARTURE_TIME

Definition: The time the patient was discharged from the scene/referring hospital

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (collected in military time)
- This can be from the scene, referral hospital, intercept point or definitive care hospital
- The null value “Not Applicable” is reported for patients who were not transported by EMS

National and State Data Element

Depart Time:	

INTERFACILITY TRANSFER
Field Name: HOSPITAL_TRANSFER

Definition: Patient transferred from one acute care hospital to your facility

Field Values

- Yes
- No

Additional Information

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

National and State Data Element

Was the patient transfered from another facility? (If YES - answer remaining fields)	○ Yes ○ No

TRANSFER MODE
Field Name: TRANS_MODE

Definition: The mode of transport used from ***acute care referring facility*** to your facility.

Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- Private / Public Vehicle / Walk-in
- Police
- Other
- Not applicable

Additional Information

- The null value "Not Applicable" is used if “Hospital_Transfer” equals “No”.

National and State Data Element

ED/HOSPITAL INFORMATION

Data Source ED/Hospital Information:

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

Data Source For Procedures:

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

TRANSPORT MODE
Field Name: TRANS

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

Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- Private / Public Vehicle / Walk-in
- Police
- Other

Additional Information

- Include in "Other" unspecified modes of transport

National and State Data Element

Transport Mode To Your Hospital:	○ Ambulance ○ Fixed Wing ○ Helicopter ○ Police Vehicle ○ Private Vehicle ○ OTHER

OTHER TRANSPORT MODE
Field Name: TRANS_OTHER

Definition: All other modes of transport used during the patient care event.

Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- Private / Public Vehicle / Walk-in
- Police
- Other
- Not applicable

Additional Information

- Include in "Other" unspecified modes of transport
- The null value "Not Applicable" is used to indicate that a patient had a single mode of transport and therefore this field does not apply to the patient.
- Check all that apply with a maximum of 5

National and State Data Element

Other Transport Modes:	☑ NA ☐ Ambulance ☐ Fixed Wing ☐ Helicopter ☐ Police Vehicle ☐ Private Vehicle ☐ OTHER

ED / HOSPITAL ARRIVAL DATE
Field Name: ED_ADM_DATE

Definition: The date the patient arrived at the hospital / ED.

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- Collected as YYYY-MM-DD
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED / Hospital Arrival to ED / Hospital Discharge)

National and State Data Element

Hospital Arrival Date:	

ED / HOSPITAL ARRIVAL TIME
Field Name: ED_ADM_TIME

Definition: The time the patient arrived at the hospital / ED.

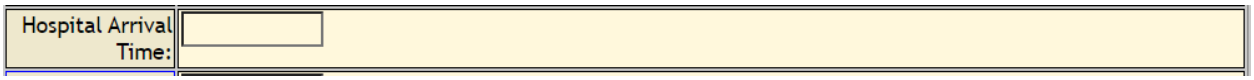
Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital
- Collected as HHMM (collected in military time)
- Used to auto-generate two additional calculated fields: Total EMS Time (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED / Hospital Arrival to ED / Hospital Discharge)

National and State Data Element



SIGNS OF LIFE
Field Name: ARRIVAL_CONDITION

Definition: Indication of whether patient arrived at hospital / ED with signs of life

Field Values

- Arrived with NO signs of life
- Arrived with signs of life

Additional Information

- A patient with no signs of life is defined as having none of the following: organize 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

State Data Element

Arrival Condition:	○ Arrived with NO Signs of Life ◉ Arrived with Signs of Life

PRE-HOSPITAL CARDIAC ARREST

Field Name: PREHOSPITAL_ARREST

Definition: Indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Field Values

- No
- Yes

Additional Information

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

National Data Element and State Element

TRAUMA TEAM READNIESS

Field Name: TEAM_NOTIFIED

Definition: The trauma team response.

Field Values

- Yes arrived <20 minutes from patient arrival.
- No, arrived >20 minutes from patient arrival.
- NA-No activation

Additional Information

State Data Element

Trauma Team Notified:	○ No ○ Yes ○ NA

TRAUMA TEAM ACTIVATED
Field Name: TEAM_ACTIVATED_BY

Definition: Trauma Team activated.

Field Values

- Prehospital-Prior to arrival
- On-Upon arrival (within 5 minutes of arrival time)
- Late-Late (Greater than 5 minutes after patient arrival)
- N-Missed Activation (not activated when criteria was met)
- NA (no activation)

Additional Information

- The null value “NA” used for non activation ICD-10 injuries entries.

State Data Element

Team Code/Alert Requested?	○ NA ○ Prior to arrival ○ On arrival or within 5 minutes, includes walk-ins and private vehicles ○ Greater then 5 minutes, includes walk-ins and private vehicles ○ Not done when appropriate

HIGHEST TRAUMA ACTIVATION
Field Name: HIGHEST_TRAUMA_ACTIVATION

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

Field Values

- Yes
- No

Additional Information

- Highest level of activation is defined by your hospital's criteria.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- INCLUDE: patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were upgraded to the highest level of trauma activation.
- EXCLUDE: patients who received the highest level of trauma activation after emergency department (ED) discharge.

National and State Data Element

Lead Provider Arrival Date
Field Name: TS_ARRIVAL_DATE_ACS

Definition: The date the LEAD PROVIDER arrived at the patient's bedside.

Field Values

- Relevant value for data element.

Additional Information

- Collected as YYYY-MM-DD.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The LEAD PROVIDER leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a LEAD PROVIDER within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if the data element ***Highest Activation*** is reported as "No."

National and State Data Element

Trauma Surg Arrival Date:	

Lead Provider Arrival Time
Field Name: TS_ARRIVAL_TIME_ACS

Definition: The time the LEAD PROVIDER arrived at the patient's bedside.

Field Values

- Relevant value for data element.

Additional Information

- Collected as HHMM military time.
- Limit reporting to the 24 hours after ED/Hospital arrival.
- The LEAD PROVIDER leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a LEAD PROVIDER within 24 hours of ED/Hospital arrival.
- The null value "Not Applicable" is reported if the data element ***Highest Activation*** is reported "No".

National and State Data Element

Trauma Surg Arrival Time:	

ED DISCHARGE DATE
Field Name: ED_DC_DATE

Definition: The date the patient discharged (physically left) the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital

State Data Element

ED DISCHARGE TIME
Field Name: ED_DC_TIME

Definition: The time the patient discharged (physically left) the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge)
- The null value "Not Applicable" is used if the patent is directly admitted to the hospital

State Data Element

ED Discharge Time:	

ED DISCHARGE DISPOSITION
Field Name: ED_DISPOSITION_CODE

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

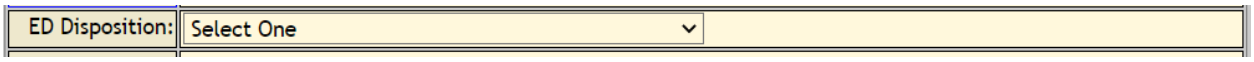
Field Values

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

Additional Information

- 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".
- If multiple orders were written, report the final disposition order.

National and State Data Element



ADMITTING SERVICE
Field Name: ADM_SVC

Definition: The service admitting the patient to the hospital.

Field Values

- Medicine (includes Neurology, Cardiology, Hospitalist, Pulmonology etc.)
- NA
- Neurosurgery
- Ortho Surgery (includes Podiatry)
- Plastic Surgery
- Ophthalmology
- Other
- Pediatric
- General Surgery
- Trauma Surgery
- Urology

Additional Information

- If patient is discharged home from the ED or transferred out from the ED, the null value “NA” is used.

State Data Element

ADMIT TYPE

Field Name: ADMIT_TYPE

Definition: Patient admit type to your facility.

Field Values

- Admitted through the Emergency Department
- Directly admitted to the hospital
- Seen in the ED and transferred to another facility
- Seen in the ED and discharged/released
- Died in the ED or DOA

Additional Information

- If directly admitted to facility the ED length of stay is “NA”

State Date Element

HOSPITAL DISCHARGE DATE

Field Name: DISCHARGE_DATE

Definition: The date the patient discharged (physically left) the hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total Hospital Time: (elapsed time from hospital admit to hospital discharge)
- The null value "Not Applicable" is used if the patient is not admitted to the hospital

State Data Element

Inpatient Discharge Date:	

HOSPITAL DISCHARGE TIME

Field Name: DISCHARGE_TIME

Definition: The time the patient discharged (physically left) the hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- Used to auto-generate an additional calculated field: Total Hospital Time: (elapsed time from hospital admit to hospital discharge)
- The null value "Not Applicable" is used if the patent is not admitted to the hospital.

State Data Element

Inpatient Discharge Time:	

HOSPITAL DISCHARGE DISPOSITION

Field Name: DC_DISPOSITION_CODE

Definition: The disposition of the patient when discharged from the hospital

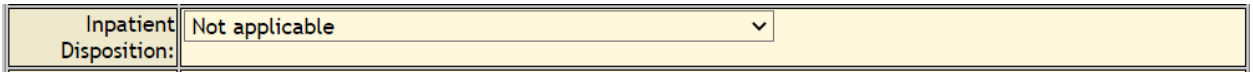
Field Values:

- HOSP-Discharged/Transferred to another hospital for inpatient care
- ICF-Discharged/Transferred to an Intermediate Care Facility
- AMA-Left against medical advice (AMA) or discontinued care
- D-Death
- HOME-Discharged to home or self-care
- NH-Discharged/Transferred to Skilled Nursing Facility (SNF)
- HOSPICE-Discharged/Transferred to hospice care
- JAIL-Discharged/Transferred to court/law enforcement
- REHAB-Discharged/Transferred to inpatient rehab or designated unit
- LTC-Discharged/Transferred to Long Term Care Hospital (LTCH)
- HH-Discharged/Transferred to home under care of organized home health service
- PSYCH-Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
- OTHER-Discharged/Transferred to another type of institution not defined elsewhere

Additional Information

- Field value “Home" refers to the patient's current place of residence (e.g., Prison, Child Protective Services, Nursing Home etc.).
- Disposition to any other non-medical facility should be coded as “Home”.
- Disposition to any other medical facility should be coded as “Other”.
- The null value "Not Applicable" is reported if ED Discharge Disposition is “DOA”, Deceased/Expired, AMA, Home, Jail, Rehab, Hospice.”

National and State Data Element



DISCHARGE TRANSPORT/TRANSFER MODE

Field Name: DC_TRANSFER_MODE

Definition: The mode of transport in which the patient was discharged from your hospital**.**

Field Values

- Ambulance
- Helicopter Ambulance
- Fixed Wing Ambulance
- POV-Private
- POL-Police
- OTHER-Other
- NA-Not Applicable

Additional Information

- If patient died, “NA” is the appropriate value

State Data Element

DECISION TO TRANSFER DATE

Field Name: DECISION_TX_DATE

Definition: The date the decision to transfer the patient to another facility was initiated.

Field Values

- The date the provider initiated the transfer of the patient to another acute care hospital by any mode of transport.

Additional Information

- Collected as MM/DD/YYYY
- The null value "Not Applicable" is used if the patient is not transferred to another acute care hospital

State Data Element

Decision Transfer Date:	

DECISION TO TRANSFER TIME
Field Name: DECISION_TX_TIME

Definition: The time the decision to transfer the patient to another facility was initiated.

Field Values

- The time the provider initiated the transfer of the patient to another acute care hospital by any mode of transport.

Additional Information

- Collected as HH:MM (military time)
- The null value "Not Applicable" is used if the patient is not transferred to another acute care hospital

State Data Element

Decision Transfer Time:	

OUTCOME
Field Name: OUTCOME

Definition: The patient's final outcome at hospital discharge.

Field Values

- Alive
- Death

Additional Information

- If "outcome" equals "D", additional data fields required: Death_Time, Death_Date, Autopsy_Completed, Autopsy_ID_NO, Donation_Status, Organs_Donated.

State Data Element

Outcome:	○ Alive ○ Dead

TOTAL ICU DAYS

Field Name: TOTAL_DAYS_ICU

Definition: The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.

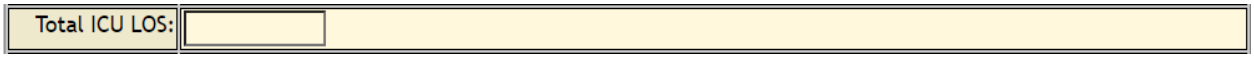
Field Values

- Relevant value for data element

Additional Information

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

National and State Data Element



TOTAL VENTILATOR DAYS
Field Name: VENTDAYS

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

Field Values

- Relevant value for data element

Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator hours
- Recorded in full day increments with any partial calendar day county as a full calendar day
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart
- The null value "Not Known/Not Recorded" is used if any dates are missing
- 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

National and State Data Element

Vent Days:	

eEMERGENCY
Field Name: eEMERGENCY

Definition: eEmergency was consulted during patient event at your facility.

Field Values

- Yes
- No
- Not applicable

Additional Information

- The null value “NA” is used if eEMERGENCY is not available at your facility**.**

State Data Element

eEmergency Consult:	○ Yes ○ No ○ Not Applicable

PRIMARY METHOD OF PAYMENT
Field Name: PAYMENT_SOURCE

Definition: Primary source of payment for hospital care

Field Values

1. Medicaid
2. Medicare
3. Not Billed (for any reason)
4. Private / Commercial Insurance
5. Indian Health Services (IHS)
6. Workman's Compensation
7. Other Government
8. Self Pay

Additional Information

- Primary insurance should be listed first.

National and State Data Element

TIME OF DEATH
Field Name: DEATH_TIME

Definition: The time of day the patient was pronounced dead or time of declaration of brain death confirmed.

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM(HH:MM should be collected as military time)
- If time of death is "Not Known/Not Recorded", the null value is unknown
- Only complete field when Discharge Status is completed as Dead
- This may differ from the time of discharge
- Time of Death must be ≤ Hospital Discharge Time
- The null value "Not Applicable" should be used for patients outcome A-Alive

State Data Element

Death Time:	NA

DATE OF DEATH
Field Name: DEATH_DATE

Definition: The date the patient was pronounced dead or time of brain death.

Field Values

- Relevant value for data element

Additional Information

- Collected as YYYY/MM/DD
- If date of death is "Not Known/Not Recorded", the null value is “Unknown”
- Only complete field when Discharge Status is completed as Dead
- This may differ from the date of discharge
- Date of Death must be ≤ Hospital Discharge Date
- The null value "Not Applicable" should be used for patients outcome A-Alive

State Data Element

Death Date:	NA

ORGAN DONATION
Field Name: DONATION_STATUS

Definition: Request to make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism.

Field Values

- REQ -Requested and Granted
- RNG-Requested Not Granted
- NR-Not Requested
- UNK/Not Documented
- NA

Additional Information

- Only completed if Hospital Disposition is “Death”

State Data Element

AUTOPSY PERFORMED
Field Name: AUTOPSY_COMPLETED

Definition: An examination of a body after death to determine the cause of death or the character and extent of changes produced by disease

Field Values

- Yes
- No

Additional Information

- Only completed if Hospital Disposition is "Death"

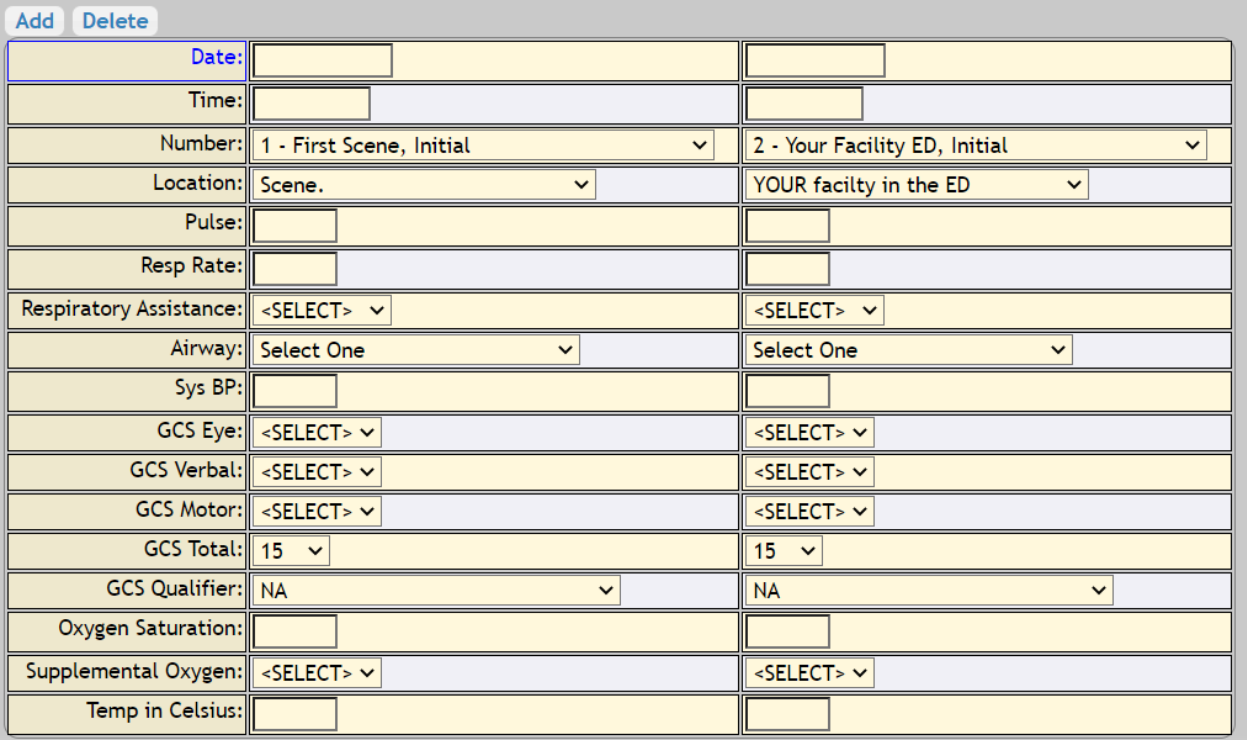
State Date Element

Autopsy Completed:	(●) NA ( ) Yes ( ) No

EMS/ED/INITIAL HOSPITAL VITAL SIGNS

Data Source EMS/ED/Hospital Information:

1. EMS Run Report
2. Triage / Trauma Flow Sheet
3. ED Record
4. Nursing Notes/Flow Sheet



VITAL SIGN DATE
Field Name: VS_DATE

Description: The date the vital signs were obtained.

Field Values

- Collected as YYYY/MM/DD

Additional Information

State Data Element

VITAL SIGN TIME
Field Name: VS_TIME

Description: The time the vital signs were obtained.

Field Values

- Collected as HH:MM (military time)

Additional Information

State Data Element

VITAL SIGN NUMBER
Field Name: VS_NUMBER

Description: Location number the vital signs were obtained.

Field Values

1.0 First Scene, Initial
1.1 Scene, 1 Hour
1.2 Scene, Last
1.3 Scene, Intercept Agency
1.4 Scene, Additional as Needed
2.0 Your Facility ED, Initial
2.1 Your Facility ED, 1 Hour
2.2 Your Facility ED, Additional as Needed
2.9 Your Facility ED, Last
3.0 First Interfacility Agency, Initial
3.1 First Interfacility Agency, 1 Hour
3.2 First Interfacility Agency, Last
3.3 Second Interfacility Agency, Initial
3.4 Second Interfacility Agency, 1 Hour
3.5 Second Interfacility Agency, Last
3.6 Interfacility, Additional as Needed
4.9 Referral Facility, Additional as Needed
5.0 Direct Admission

Additional Information

State Data Element

VITAL SIGN LOCATION
Field Name: VS_LOCATION_CODE

Description: Location the vital signs were obtained.

Field Values

- Scene
- Ambulance/EMS
- Helicopter
- Fixed Wing
- Emergency Department
- Floor
- OF-Outside Facility

Additional Information

State Data Element

EMS PULSE
Field Name: PULSE

Definition: The pulse by agency / EMS on scene.

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused
- The null value "Not Applicable" is reported for patients who arrive by (Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field pulse rate was NOT measured at the scene of injury

National and State Data Element

EMS RESPIRATORY RATE
Field Name: RESP_RATE

Definition: The respiratory rate by agency / EMS on scene.

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- The null value "Not Applicable" is reported for patients who arrive by (Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field respiratory rate was NOT measured at the scene of injury

National and State Data Element

EMS RESPIRATORY ASSISTANCE
Field Name: ASSISTING

Definition: Respiratory assistance associated with the initial agency / EMS respiratory rate on scene.

Field Values

- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- NA Not Applicable

Additional Information

- Respiratory Assistance is defined as mechanical and/or external support of respiration
- The null value "Not Applicable" is reported if Initial EMS Respiratory Rate is "Not Known / Not Recorded"

State Data Element

EMS AIRWAY
Field Name: AIRWAY

Definition: The type of airway used by EMS.

Field Values

- Bag and Mask
- Crichothyrotomy
- Nasal airway
- Oral Airway
- Nasal Cannula or Face Mask
- Nasal ETT
- No airway assistance
- Oral ETT
- Other
- TRACH-Tracheostomy

Additional Information

- Record the highest level of airway utilized by EMS.

State Data Element

EMS SUPPLEMENTAL OXYGEN

Field Name: VS_O2

Definition: Presence of supplemental oxygen during initial oxygen saturation level by agency / EMS on scene.

Field Values

- Yes supplemental oxygen
- No supplemental oxygen
- Not applicable
- UNK – Unknown/Not Documented

Additional Information

- Only completed if a value is reported for Initial Agency / EMS Oxygen Saturation, otherwise report as "Not Applicable"

State Data Element

EMS SYSTOLIC BLOOD PRESSURE
Field Name: SYS_BP

Definition: The systolic blood pressure by agency / EMS on scene.

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by (Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field systolic blood pressure was NOT measured at the scene of injury

National and State Data Element

EMS GCS EYE RESPONSE
Field Name: EYE_OPENING

Definition: The Glasgow Coma Score Eye Response from the transporting agency / EMS on scene.

Field Values

1. No eye movement when assesses
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed
- The null value "Not Applicable" is reported for patients who arrive by (4. Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field GCS - Eye was NOT measured at the scene of injury

National and State Data Element

EMS GCS VERBAL RESPONSE

Field Name: VERBAL_RESPONSE

Definition: The Glasgow Coma Score Verbal Response from the transporting agency / EMS on scene.

Field Values

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, follows objects, interacts

Adult:

1. No vocal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If patient is intubated, then the GCS Verbal score is equal to 1
- The null value "Not Applicable" is reported for patients who arrive by (4. Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured at 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 function within the GCS scale, the appropriate numeric score may be listed

National and State Data Element

EMS GCS MOTOR RESPONSE
Field Name: MOTOR_RESPONSE

Definition: The Glasgow Coma Score Motor Response from the transporting agency/ EMS on scene.

Field Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- The null value "Not Applicable" is reported for patients who arrive by (Private / Public Vehicle / Walk-in)
- The null value “Not Known/Not Recorded” is reported if the patient’s first recorded initial field GCS - Motor was NOT measured at the scene of injury.

National and State Data Element

EMS GCS TOTAL
Field Name: GLASGOW

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

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Known / Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such a "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 (Private / Public Vehicle / Walk-in)

National and State Data Element

EMS GCS ASSESSMENT QUALIFIERS
Field Name: PARALYTICS

Definition: Documentation of factors potentially affecting the first assessment of GCS by EMS on scene.

Field Values

- Patient chemically sedated
- Patient Intubated
- Valid GCS
- Patient chemically sedated and intubated
- Obstruction to the Patient's Eye

Additional Information

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

State Data Element

EMS OXYGEN SATURATION LEVEL
Field Name: OXIMETRY

Definition: The oxygen saturation level by EMS on scene.

Field Values

- Expressed as a percentage

Additional Information

- The null value "Not Known / Not Recorded" is reported if the patient is transferred to your facility with no EMS Run Report from the scene of injury
- Value should be based upon assessment before administration of supplemental oxygen
- The null value "Not Applicable" is reported for patients who arrive by (Private / Public Vehicle / Walk-in)
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial field oxygen saturation was NOT measured at the scene of injury

National and State Data Element

EMS SUPPLEMENTAL OXYGEN
Field Name: VS_O2

Definition: Presence of supplemental oxygen during initial oxygen saturation level by EMS on scene.

Field Values

- Yes supplemental oxygen
- No supplemental oxygen
- Not applicable
- UNK/Not Documented

Additional Information

- Only completed if a value is reported for EMS Oxygen Saturation, otherwise report as "Not Applicable"
- Please note that the first recorded EMS vitals do not need to be from the same assessment

National and State Data Element

EMS TEMPERATURE
Field Name: TEMPS

Definition: The temperature recorded in Celsius by EMS on scene.

Field Values

- Relevant value for data element
- Used to auto-generate an additional calculated field: Temperature in degrees Fahrenheit

Additional Information

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

National and State Data Element

INITIAL ED / HOSPITAL PULSE
Field Name: PULSE

Definition: The pulse from the initial hospital/ED (within 30 minutes of arrival).

Field Values

- Relevant value for data element

Additional Information

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

National and State Data Element

INITIAL ED / HOSPITAL RESPIRATORY RATE
Field Name: RESP_RATE

Definition: The respiratory rate from the initial hospital / ED (within 30 minutes of arrival).

Field Values

- Relevant value for data element

Additional Information

- If recorded, complete additional field: "Initial ED / Hospital Respiratory Assistance"
- Please note that first recorded hospital vitals do not need to be from the same assessment

National and State Data Element

INITIAL ED / HOSPITAL RESPIRATORY ASSISTANCE
Field Name: ASSISTING

Definition: Respiratory assistance associated with the initial hospital / ED respiratory rate (within 30 minutes of arrival.)

Field Values

- Yes assisted respiratory rate, bagged
- No, unassisted respiratory rate
- Not applicable
- UNK/Not documented

Additional Information

- Only completed if a value is provided for Initial ED / Hospital Respiratory Rate
- Respiratory Assistance is defined as mechanical and/or external support of respiration
- Please note that first recorded hospital vitals do not need to be from the same assessment
- The null value "Not Applicable" is used if "Initial ED / Hospital Respiratory Rate" is "Not Known / Not Recorded”

National and State Data Element

ED AIRWAY
Field Name: AIRWAY

Definition: The type of airway used in the ED.

Field Values

- Bag and Mask
- Crichothyrotomy
- Nasal airway
- Oral Airway
- Nasal Cannula or Face Mask
- Nasal ETT
- No airway assistance
- Oral ETT
- Other
- Tracheostomy

Additional Information

- Record the highest level of airway utilized during the ED stay.

State Data Element

INITIAL ED / HOSPITAL SYSTOLIC BLOOD PRESSURE

Field Name: SYS_BP

Definition: The systolic blood pressure from the initial hospital / ED (within 30 minutes of arrival).

Field Values

- Relevant value for data element

Additional Information

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

National and State Data Element

INITIAL ED / HOSPITAL GCS EYE RESPONSE
Field Name: EYE_OPENING

Definition: The Glascow Coma Score Eye Response in the hospital / ED (within 30 minutes of arrival).

Field Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously

Additional Information

- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed
- The null value “Not Known / Not Recorded” is reported if the patient’s first recorded initial ED / Hospital GCS –Eye was not measured within 30 minutes or less of ED/Hospital arrival

National and State Data Element

INITIAL ED/HOSPITAL GCS VERBAL RESPONSE

Field Name: VERBAL_RESPONSE

Definition: The Glasgow Coma Score Verbal Response from the initial hospital / ED (within 30 minutes of arrival).

Field Values

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, follows objects, interacts

Adult:

1-No vocal response
2-Incomprehensible sounds
3-Inappropriate words
4-Confused
5-Oriented

Additional Information

- If patient is intubated, then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed
- Please note that first recorded hospital vitals do not need to be from the same assessment

National and State Data Element

INITIAL ED/HOSPITAL GCS MOTOR RESPONSE
Field Name: MOTOR_RESPONSE

Definition: The Glasgow Coma Score Motor Response from the initial ED/Hospital (within 30 minutes of arrival).

Field Values

Pediatric (≤ 2 years):

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

Adult:

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

Additional Information

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

National and State Data Element

INITIAL ED/HOSPITAL GCS TOTAL
Field Name: GLASGOW

Definition: First recorded Glasgow Coma Score (total) (within 30 minutes of hospital/Ed arrival).

Field Values

- Relevant value for data element

Additional Information

- The null value "Not Known/Not Recorded" is used if Initial Hospital/ED GCS-Eyes, Motor, Verbal were not measured within 30 minutes or less of hospital arrival.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such a "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 first recorded/hospital vitals do not need to be from the same assessment.

National and State Data Element

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS
Field Name: PARALYTICS

Definition: Documentation of factors potentially affecting the first assessment of GCS (within 30 minutes of arrival to the hospital/ED).

Field Values

- Patient chemically sedated
- Patient Intubated
- Valid GCS
- Patient chemically sedated and intubated
- Obstruction to the Patient's Eye

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- 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.
- Check all that apply

National and State Data Element

INITIAL ED / HOSPITAL OXYGEN SATURATION LEVEL
Field Name: OXIMETRY

Definition: The oxygen saturation level from the ED (within 30 minutes of arrival).

Field Values
- Expressed as a percentage

Additional Information
- If reported, complete additional field: Initial ED / Hospital Supplemental Oxygen
- Please note that first recorded hospital vitals do not need to be from the same assessment

National and State Data Element

INITIAL ED / HOSPITAL SUPPLEMENTAL OXYGEN

Field Name: VS_O2

Definition: Presence of supplemental oxygen during initial oxygen saturation level in ED (within 30 minutes of arrival).

Field Values

- Yes supplemental oxygen
- No supplemental oxygen
- Not applicable
- UNK/Not documented

Additional Information

- Only completed if a value is reported for Initial ED / Hospital Oxygen Saturation, otherwise report as "Not Applicable"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

National and State Data Element

INITIAL ED / HOSPITAL TEMPERATURE
Field Name: TEMPS

Definition: The temperature recorded in Celsius from the initial hospital / ED (within 30 minutes of arrival).

Field Values

- Relevant value for data element
- Used to auto-generate an additional calculated field: Temperature in degrees Fahrenheit

Additional Information

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

National and State Data Element

CLINICAL

Data Source Clinical Information:

1. Lab Results
2. Transferring Facility Records

ALCOHOL SCREEN
Field Name: ETOH_SCREEN

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

Field Values

- Yes
- No

Additional Information

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

National and State Data Element

Alcohol Screen:	○ Yes ○ No

ALCOHOL SCREEN RESULTS
Field Name: ETOH

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

Field Values

- Relevant value for data element.

Additional Information

- Collect as X.XX standard lab value (e.g. 0.08).
- Record BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- The null value "Not Applicable" is used for those patient who were not tested.

National and State Data Element

ETOH - Blood Alcohol	

DRUG SCREEN

Field Name: TOX

Definition: First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

Field Values

AMP (Amphetamine)
OXY (Oxycodone)
BAR (Barbiturate)
PCP (Phencyclidine)
BEN (Benzodiazepines)
TCA (Tricyclic Antidepressant)
COC (Cocaine)
THC (Cannabinoid)
Methadone
Methamphetamine

Other
None/Negative
MTD (Methadone)
Not Tested
OPI (Opioid)

Additional Information

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

National and State Data Element

AUTOPSY IDENTIFICATION NUMBER

Field Name: AUTOPSY_ID_NO

Definition: The number assigned by the medical examiner's office identifying the patient.

Field Values

- Recorded as numeric/alphabetic combination

Additional Information

- Only completed if Hospital Disposition is "Death" and Autopsy Completed is "Yes"

State Data Element

Autopsy Id No.	

ORGANS DONATED

Field Name: ORGANS_DONATED

Definition: Organs donated.

Field Values

- Bone
- Cornea
- Ear
- Heart
- Kidney
- Liver
- Lung
- Marrow
- Other
- Pancreas
- Refused
- Skin
- Unk
- Unsuitable
- Heart Valves
- NA
- Not requested

Additional Information

- Only completed if Hospital Disposition is "Death" and Donation Status is “REQ” requested and granted.

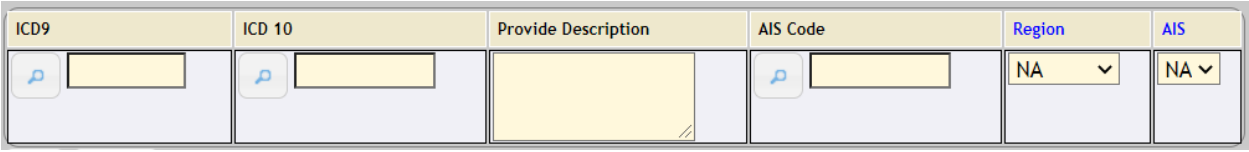
State Data Element

Organs Donated: check all that apply	☐ Not Applicable ☐ Not Requested ☐ Bone ☐ Cornea (Donated) ☐ Ear (Donated) ☐ Heart (Donated) ☐ Heart Valves ☐ Kidney (Donated) ☐ Liver (Donated) ☐ Lung (Donated) ☐ Marrow (Donated) ☐ Other (Donated) ☐ Pancreas (Donated) ☐ Refused ☐ Skin (Donated) ☐ Unsuitable ☐ Unknown ☐ Not Done

DIAGNOSES

Data Source Injury Information:

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



AIS CODING AND SCORING CONCEPTS

Guidelines:

A. **Basic Guideline**

Code conservatively if not clear, must have radiological, CT, MRI or other evidence of injury

1. Documentation Sources:
   Documentation of Injury- there are multiple sources with a data source hierarchy, but the entire medical record is to be reviewed. Code each injury to the most specific detail. Films and other radiological and diagnostic results from a referring facility can be referenced by the receiving facility, documented as present with evidence and, therefore can be coded as appropriate.
2. Ethical Constraints:
   Coding and Scoring Concepts: Do not code “rule out”, “suspected”, or “probable”. Do not over- code or up- code due to treatment required or performed. Take care not to code an injury as bilateral when it is unilateral.

B. **Abbreviated Injury Scale**

Abbreviated Injury Scale- originally developed by the AAAM, the Association for the Advancement of Automotive Medicine AIS is an anatomically based international injury scaling system.

According to the World Health Organization “It is the system of choice for coding single injuries and is the foundation for methods assessing multiple injuries or for assessing cumulative effects of more than one injury.” There is a strong correlation between AIS severity and survival (and mortality)

1. AIS Scoring.
   An AIS code follows a seven digit format. The first 6 digits are called the pre-dot code. The single digit after the dot is called the post-dot digit or severity number.
   The pre-dot code represents the body area of injury, the anatomical structure(s) involved, the level of injury.
   The AIS codes are grouped into 6 main body regions.
   - AIS region 1 = Head/Neck includes injuries to the brain, skull, cervical spine and neck organs. Asphyxia is also assigned to the Head region.
   - AIS region 2 = Face includes injuries to the mouth, ears, eyes, nose and facial bones.
   - AIS region 3 = Chest /Thorax includes injuries to the thorax, diaphragm, rib cage and thoracic spine. Drowning is assigned to the chest.
   - AIS region 4 = Abdomen or pelvic contents, include all lesions to the internal organs in those cavities and lumber spine
   - AIS region 5 = Extremities, include injuries to upper and lower extremities, shoulder and pelvic girdles, sprain, fractures, dislocations and amputation.

- AIS region 6 = External including burn, hypothermia, lacerations, contusions, abrasions, heat injuries, electrocution, explosion/full body.

The post-dot code is a numerical value that is assigned according to the severity of the injury:

1 -- Minor
2 – Moderate
.3 – Serious
.4 – Severe
.5 – Critical
.6 – Maximum (not fatal, currently untreatable) A .6 is automatically an

ISS = 75, code other injuries but don't add to this highest ISS total

Post dot "9" Unknown: Inadequate information exists for assigning an AIS severity.

To code accurately and successfully using the AIS codes, it is necessary to know detailed anatomy and be able to apply the AIS coding rules and guidelines.
AAAM offers AIS courses both face to face and online.
Website: www.aaam.org

General Definitions

Pediatric - refers to patients younger than 15 years. (referenced from *Resources for Optimal Care of the Injured Patient 2014*).

Readmission – admission to the hospital within 72 hours of previous hospital discharge because of missed diagnosis or complications from original injuries (not late effects of). (i.e. infected wound, subacute or chronic subdural)

Extra-Articular- a fracture with NO joint involvement

Partial Articular- (Intra-Articular) refers to at least one fracture through the joint surface and part of the articular surface is still in continuity with the diaphysis
Complete Articular- a fracture where the articular surface is fractured AND there is no continuity with the diaphysis
Vessel Dissection- should be coded to intimal tear for all vessels including descriptors for carotid artery common/internal, carotid artery external and vertebral artery
Internal Carotid Artery- May refer to either Head or Neck. AIS Head codes 121099.3 to 121006.3 "Internal Carotid Artery" and 320099.9 to 320223.4 "Carotid Artery". When the exact location of the injury is not specified as to head or neck, code to the neck region with applicable associated detail (laceration, thrombosis, occlusion, etc.)
Vertebral Artery- May refer to either AIS Head or Neck Chapters. When the exact location of the injury is not specified as to head or neck, code to the neck region with applicable associated detail (laceration, thrombosis, occlusion, etc.)
Perforation- a hole or break or opening made through the entire thickness of a membrane, wall or other tissue of an organ or structure of the body
Rupture- the process or instance of breaking open or bursting to forcibly disrupt tissue resulting in a hole, break or opening with stellate edges or devitalized/fragmented tissue made through the entire thickness of a membrane or other tissue of an organ or structure.
Arch/Ring- may be used interchangeably when describing a portion of the vertebra or pelvis
Neurological Deficit- a loss or deficit in function of the nervous system that was not present pre-injury and lasts for more than a transient period (more than a few minutes).
Laceration: Major (Complex)- an injury in which the tissues are torn from a blunt or penetrating force. It must involve deeper tissues (subcutaneous tissue and possibly muscle) causing jagged or irregular edges. This type of wound, in the surviving victim, would generally require a layered closure, revision of the jagged edges or extensive cleaning or removal of debris.
Branches of Vessels- are not coded unless the branch has a specific anatomical name or it is included within a vessel descriptor. To assign the injury code with the descriptor 'and its named branches', the branch must be a direct tributary of that vessel. For other specifically named vessels use the categories "other named arteries" or "other named veins".
Flail Chest- three or more adjacent ribs, each fractured in more than one location (e.g. posterolateral and anterolateral) to create a free floating segment which may or may not result in paradoxical chest movement.
Penetrating Injury to Bone- Gunshot wounds resulting in bony fractures or "lodged in" the bone are coded as open fractures.
Penetrating Injuries – if deeper structures are injured, code the injury under the appropriate organ or vessel. (i.e. liver laceration). Always code the deepest structure injured. **DO NOT** code the overlying skin injury, as entry and exit wounds are in the score of the deepest structure

Skin/subcutaneous/muscle injuries : Degloving- should be coded as avulsion.
Amputation-is defined as "traumatic" not surgical.
Morel Lavalle Lesion- internal shearing or degloving injury of an extremity is coded as a degloving injury in the appropriate extremity chapter.(In the new 2015 AIS version there is a specific code)
Micro Fractures-not a codable injury.
Bone Contusions-not a codable injury.

Bone Edema-not a codable injury.
Hemarthrosis-not a codable injury.
Superficial Penetrating Injury-skin/subcutaneous/muscle only without underlying organ or bony involvement. For penetrating injuries to the extremities that do not involve bone or vascular structures, code as minor injury.

Asphyxia- is a condition arising when the body is deprived of oxygen, causing unconsciousness or death. This is a codeable sequela. This should be coded under Head.

Drowning-coded under the chest.

Puncture Wound-is caused by spearing or impalement type injuries. These should be coded as Penetrating NFS or Penetrating minor superficial.

Palsy/Paresis- coded as nerve contusion.

Paralysis/Total Loss of Function-coded as nerve laceration.

Incomplete Transection- is the same as incomplete circumferential involvement.

Pseudoaneurysm- coded as a minor artery laceration.
Carbon Monoxide Poisoning-is not an injury and not codable.
Burns- Sunburn and radiation burns are currently not a codeable injury. If a burn related amputation occurs a the time of injury, code as an amputation, do not code the burn separately. If an amputation is required, code only the burn.
Skin Tears- are coded as a laceration to the appropriate location on the patient and assigned to the External ISS body region for calculating an ISS.

HEAD/NECK

Blood Along Tentorium- Supratentorial codes to Cerebrum; Interpeduncular fossa (cistern) basal cisterns code as injury involving hemorrhage in the brainstem; "Along" the tentorium, code to supratentorial = Cerebrum.
Skull Fracture- The temporal bone consists of three portions, the squamous, shell-like portion that is part of the skull vault, and the mastoid and petrous portions which make up part of the skull base. In the rule box describing skull base the word "squamous" should be deleted. In the rule box describing the skull vault, the words "squamous portion only" should be inserted after the word temporal.
DAI Rule- The directions state "If coma exceeds 24 hours and diagnosis meets coding rules for DAI, use 161011.5…" The intention is to direct the coder to the Concussive Injury section on p. 51 and, if information about
brainstem signs is available, any of three codes may be used 161001.5 or 161012.5 or 161013.5.

Concussion/LOC- LOC must be documented by a physician, or by a Nurse Practitioner or Physician Assistant or other recognized physician extender acting on the behalf of the physician.

24 Hour Statement- Within the first 24 hours post injury, patients with transient signs and symptoms should be coded even if they are resolved within the 24 hour period.

Amnesia- One symptom that can exist without a closed head injury, no AIS code.

Occipital Condyles- Occipital condyles are coded to the skull base

Coma Modifiers- For codes with coma modifiers, "not associated with coma…" = means there was documentation of coma, but it was not greater than 6 hours in duration. "Associated with coma…." = means there was documentation of coma, and it was greater than 6 hours in duration. The NFS code should be used when there is no documentation of coma with an injury that has a coma modifier.

Acute on Chronic Bleeds- If the clinician does not differentiate and document the acute from chronic bleed, code as NFS in the appropriate section.

Pterygoid Plates- part of the sphenoid bone and are coded to the base of the skull if injured in isolation. If the pterygoid plates are part of a LeFort fracture, they are NOT coded additionally as skull base fractures.

Multiple hematomas/SDH small or Large, same hemisphere- When multiple small (140640.4) or large (140648.5) hematomas OR when multiple small (140652.4) or large (140656.5) SDH are diagnosed, code each individually IF they are separate and individual hematomas/bleeds of the same (unilateral) hemisphere. If both hemispheres are involved use the bilateral code.

DAI Rule-"If coma exceeds 24 hours and diagnosis meets coding rules for DAI, use 161011.5…" The intention is to direct the coder to the Concussive Injury section and, if information about brainstem signs is available, any of three codes may be used 161001.5 or 161012.5 or 161013.5.
Vascular injuries- Vasospasm is a transient occurrence that may or may not show up on imaging. It is the result of injury or insult to the artery and is not an injury in and of itself. Vasospasm cannot be coded. If the injury is described only as a "dissection" and there is no disruption to the vessel code to intimal tear, no disruption.
Hypoxic Brain Damage- may be coded in instances where such conditions as hypovolemia or hypoxia lead to this damage and the hypoxic brain damage is not directly related to a lesion in the brain. It is possible to have hypoxic brain damage in addition to a lesion within the brain when such lesion would not cause hypoxic brain damage. (e.g. small contusions in addition to hypovolemic shock leading to hypoxic brain damage).
Penetrating injury to Skull- Any penetrating injury involving the brain stem should be coded to 140216.6 no matter how many other regions of the brain are also involved.

Carotid Artery Injury- not specified should be coded to Common Carotid Artery.
Jugular Vein Injury- not specified should be coded to Internal Jugular Vein.
Caustic injury to pharynx is coded as 340699.2
Thrombosis (occlusion) secondary to trauma from any lesion but laceration (under carotid artery, internal and external, and vertebral artery) refers to the sequela of blunt trauma to neck, i.e. seatbelt injury.

FACE

LeFort Fractures- must be specified in the medical documentation to use the LeFort fracture codes, otherwise, code individual fractured bones.
Palate Perforation- Soft palate perforation code as laceration; hard palate perforation code as fracture. If palate is not specified as soft or hard, code as fracture.
Caustic Injury- to the mouth is coded as 243099.1.
Retrobulbar hemorrhage- should be coded to 240499.1 - Eye, NFS.
Nose amputation- is coded as skin avulsion according to its level of severity.
Nasal Fractures, displaced- if documented as "minimally displaced" are coded as non-displaced. Displacement must be significant.
Mandible Fractures, displaced- if documented as "minimally displaced" are coded as non-displaced. Displacement must be significant.
Panfacial Fracture- Multiple and complex bilateral fractures of the face not conforming to the standard classifications of LeFort but resulting in significant deformation and meeting the panfacial fracture definition should be coded using the panfacial codes 251900.3/251902.4. Frontal bone fractures may sometimes be included in the panfacial code and if so, should not be coded separately
Iris- The uvea is part of the eye, consisting collectively of the iris, choroid of the eye, and the ciliary body, therefore code iris under uvea.
Mandible Fractures- Multiple mandible fractures receive only one AIS code. The fracture should be assigned to the largest mass area of the mandible that is involved.
Orbit- Lamina papyracea is part of the medial wall of the orbit.
Complex Zygoma Fractures- The anatomic area which includes the zygoma is frequently referred to as the "zygomaticomaxillary complex (ZMC)" or the "zygomatic complex". The correct code for this is 251800.1.

THORAX

Persistent Air Leak--described as an air leak in the thorax that lasts for more than 48 hours, which represents a more severe injury than a simple pneumothorax. (442203.4)
Intracardiac Septum- may also be identified as "intraventricular" septum.
Flail Chest- Flail chest with additional but separate rib fractures on the same side is coded to the more severe injury, the flail chest, and the additional rib fractures on the same side are not coded.
Thoracic injuries-The 1,000cc blood loss descriptor is meant to indicate blood loss of 20% in the individual. When coding pediatric or other individuals with smaller blood volumes, use 20% blood loss parameter instead of 1,000cc.
Heart- Code 441012.5 "perforation, ventricular or atrial, with or without tamponade" should read "perforation, either ventricular or atrial, with or without tamponade".
Inhalation Injury- include all airway burns from mouth and nose to lungs. Do not code mouth or pharynx separately.
Hemomediastinum- includes mediastinal contusion.

ABDOMEN

Hemoperitoneum- is a sequela and is not a codeable injury.
Serosal Tear- coded as a partial thickness injury.
Bladder-Urinary- Lacerations to the bladder wall that occur outside the peritoneal cavity (extraperitoneal) are commonly associated with a fracture of the pelvis.Lacerations to the bladder wall that occur within the

peritoneal cavity (intraperitoneal) usually involve the dome of the bladder and the injury generally follows a blow to the abdomen.
Colon- These codes include injuries to the cecum.
Pars Interarticularis- located between the lamina and the pedicle anatomically and should be coded as pedicle.

SPINE

Cauda equina laceration- injuries described as laceration should be coded under cauda equina contusion.
Lateral mass fracture- Lateral mass fractures should be coded as pedicle fractures.
Spinal Cord Injury with Associated Fracture, no deficit- such as compression, epidural or subdural hemorrhage associated with a fracture AND there is NO neurologic deficit, the coder must choose to either code the cord injury OR the fracture. Current rules prohibit coding both.
Pars interarticularis is located between the lamina and the pedicle anatomically and should be coded as pedicle

EXTREMITIES

Foot Dislocations- include talonavicular, calcaneocuboid, talocalcaneal and metatarsal-phalangeal dislocations.
Knee Joint Dislocation- includes patellar dislocation (knee joint consists of proximal tibia, distal femur and patella).
Distal Tibia Fracture- includes isolated or associated posterior malleolus.
Pelvic Ring Fracture- includes "pelvic ring dislocation".
Muscle Laceration- occurring from a penetrating/external injury (from the skin down to and including the muscle) are coded to the Skin/subcutaneous/muscle section.
Muscle Tears/Avulsions- occurring from blunt, stretching-type trauma (sports injury) without an overlying laceration are coded to the Muscles, Tendon, Ligaments section.
Ligament injuries- should be coded as a sprain in the associated joint.
Acromion- should be coded as 750900.2 Scapula Fracture.
Humerus- The surgical neck of the humerus is located at the junction of the proximal section and the shaft. It should be coded as 751151.2 Proximal Humerus - Extra-Articular.
Subtrochanteric Fracture- should be coded to femur shaft fracture.
Posterior Malleolus- Code posterior malleolus to distal tibia.
Hip Fracture- simply stated with no other description is coded as a proximal femur fracture (853111.3).
Slipped Epiphysis- in children is coded as a femur neck fracture (853161.3).
Digital Vessels- included in "other named vessels".
Rotator Cuff- should be assigned to Shoulder, Glenohumeral Joint

ICD-10 Injury Diagnosis
Field Name: ICD10

Definition: Diagnoses related to all identified injuries. Injury diagnoses as defined by (ICD-10-CM) codes.

Field Values

- Injury diagnoses as defined by ICD-10-CM code range: S00-S99, T07, T14, T20-T28, T30-T34, and T79.A1-T79.A9 code range.
- The maximum number of diagnoses that may be reported for an individual patient is 50

Additional Information

- Used to auto-generate eight additional calculated fields: Abbreviated Injury Scale (six body regions) and Injury Severity Score

National and State Data Element

INJURY DIAGNOSIS
Field Name: DIAGNOSIS

Definition: Diagnoses related to all identified injuries.

Field Values

- Anatomic diagnoses, narratives should mention the severity of the injury, such as comminuted fx or compound fx.
- The maximum number of diagnoses that may be reported for an individual patient is 50

Additional Information

State Data Element

Basic Guideline- code conservatively if not clear, must have radiological, CT, MRI or other evidence of injury

Documentation Sources:

Documentation of Injury- there are multiple sources with a data source hierarchy, but the entire medical record is to be reviewed. Code each injury to the most specific detail. Films and other radiological and diagnostic results from a referring facility can be referenced by the receiving facility, documented as present with evidence and, therefore can be coded as appropriate.

Ethical Constraints:

Coding and Scoring Concepts: Do not code “rule out”, “suspected”, or “probable”. Do not over- code or up- code due to treatment required or performed. Take care not to code an injury as bilateral when it is unilateral.

AIS CODE
Field Name: AIS_CODE

Definition: The Abbreviated Injury Scale (AIS) codes that reflect the patient's injuries, first hospital encounter

Field Values

- The code assigned based on the identified patient injuries.

Additional Information

Data Source

- AIS Coding Manual

National and State Data Element

AIS Scoring.

An AIS code follows a seven digit format. The first 6 digits are called the pre-dot code. The single digit after the dot is called the post-dot digit or severity number.

The pre-dot code represents the body area of injury, the anatomical structure(s) involved, the level of injury.

The AIS codes are grouped into 6 main body regions.

- AIS region 1 = Head/Neck includes injuries to the brain, skull, cervical spine and neck organs. Asphyxia is also assigned to the Head region.
- AIS region 2 = Face includes injuries to the mouth, ears, eyes, nose and facial bones.
- AIS region 3 = Chest /Thorax includes injuries to the thorax, diaphragm, rib cage and thoracic spine. Drowning is assigned to the chest.
- AIS region 4 = Abdomen or pelvic contents, include all lesions to the internal organs in those cavities and lumber spine
- AIS region 5 = Extremities, include injuries to upper and lower extremities, shoulder and pelvic girdles, sprain, fractures, dislocations and amputation.
- AIS region 6 = External including burn, hypothermia, lacerations, contusions, abrasions, heat injuries, electrocution, explosion/full body.

REGION

Field Name: REGION

Definition: The region of the body the diagnosis was identified.

Field Values

0 Other Trauma
1 Head
2 Face
3 Neck
4 Thorax
5 Abdomen
6 Spine
7 Upper Extremity
8 Lower Extremity
9 External

Additional Information

- The Region can be derived from the ICD10 injury code.
- Used to calculate the ISS

State Data Element

AIS VERSION

Field Name: SEVERITY_METHOD

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

Field Values

- AIS 05, Update 08
- AIS 2015

Additional Information

- AIS Coding Manual

National and State Data Element

- National Element DG_04 from the 2019 National Trauma Data Standard

Abbreviated Injury Scale

Abbreviated Injury Scale- originally developed by the AAAM, the Association for the Advancement of Automotive Medicine AIS is an anatomically based international injury scaling system.

According to the World Health Organization “It is the system of choice for coding single injuries and is the foundation for methods assessing multiple injuries or for assessing cumulative effects of more than one injury.” There is a strong correlation between AIS severity and survival (and mortality)

AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS

Field Name: AIS

Definition: The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries.

Field Values

- (1)Minor Injury
- (2)Moderate Injury
- (3)Serious Injury
- (4)Severe Injury
- (5)Critical Injury
- (6)Maximum Injury Virtually Non-Survivable
- (9)Not Possible to Assign

Additional Information

- The field value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury.

State Data Element

The post-dot code is a numerical value that is assigned according to the severity of the injury:

.1 -- Minor
.2 – Moderate
.3 – Serious
.4 – Severe
.5 – Critical
.6 – Maximum (not fatal, currently untreatable) A .6 is automatically an ISS = 75, code other injuries but don't add to this highest ISS total
Post dot "9" Unknown: Inadequate information exists for assigning an AIS severity.

To code accurately and successfully using the AIS codes, it is necessary to know detailed anatomy and be able to apply the AIS coding rules and guidelines. AAAM offers AIS courses both face to face and online. Website: www.aaam.org

INJURY SEVERITY SCORES
Field Name: ISS

Definition: The Injury Severity Score calculated.

Field Values

- Numbers from 1 up to 75
- Auto populated from the AIS_Code and Region

Additional Information

- If the AIS field value (9) is assigned, it would not be possible to assign a severity to an injury.

State Data Element

NATIONAL PROVIDER IDENTIFIER (NPI)
Field Name:

Definition: The National Provider Identifier (NPI) of the admitting surgeon.

Field Values

- Relevant value for data element.

Additional Information

- This variable is considered optional and is not required as part of the NTDS dataset.
- Must be stored as a 10-digit numeric value.
- The null value “Not Applicable” is reported if this optional element is not being reported.

National and State Data Element

***NOT CURRENTLY A DATA FIELD**

PROCEDURES

Data Source Procedure Information:

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

Procedure Code	Proc Place	Proc Episode	ICD9	ICD10	Start Time	Start Date
NONE	Not Applicable	Non Operative Procedure				

ICD-10 EMS/ED/HOSPITAL PROCEDURES

Field Name: PROCEDURE_ICD10

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

Field Values

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

Additional Information

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

National and State Data Element

***Include all procedures completed on scene, in ED and hospital course, ie: c-collar, spineboard, splinting, airway, IV access etc.**

EMS/ED/HOSPITAL PROCEDURES
Field Name: PROCEDURE_CODE

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

Field Values

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

Additional Information

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

Diagnostic & Therapetuic Imaging
Musculoskeletal

Computerized tomographic Head
Computerized tomographic Chest
Computerized tomographic Abdomen
Computerized tomographic Pelvis
Computerized tomographic C-Spine
Computerized tomographic T-Spine
Diagnostic imagine interventions on the total body
Computerized tomographic L-Spine

Soft tissue/bony debridement
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy
X-RAY/MRI whole body/whole skeleton

Cardiovascular

Doppler ultrasound of extremities
Diagnostic ultrasound (includes FAST)
IVC filter

Open cardiac massage
CPR
REBOA

Transfusion
Transfusion of red cells/WHOLE BLOOD
Transfusion of platelets
Transfusion of plasma

Respiratory
Insertion of oral/nasal airway
Insertion of endotracheal tube
Continuous mechanical ventilation
Chest tube
Bronchoscopy
Tracheostomy

CNS
Insertion of ICP monitor
Ventriculostomy
Cerebral oxygen monitoring

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

Genitourinary
Ureteric catheterization (i.e. Ureteric stent)
Suprapubic cystostomy

Other
Backboard/Spinal Immobilization/C-collar
Burn Care
Defibrillation
Fluid Administration
IV Access
Splinting
Other ED/Prehospital/Hospital/OR Procedure

State Data Element

***Include all procedures completed on scene, in ED and hospital course, ie: c-collar, spineboard, splinting, airway, IV access etc.**

PROCEDURE LOCATION

Field Name: PROCEDURE_LOCATION_CODE

Definition: Location the procedure takes place.

Field Values

- Ambulance/EMS
- Emergency Department
- Floor
- CT
- Xray
- IR
- OR
- ICU
- OF-Outside Facility

Additional Information

- Location codes may vary by facility.

State Data Element

PROCEDURE EPISODE

Field Name: PROCEDURE_EPISODE

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

Field Values

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

Additional Information

- Include only those operative procedures performed at your hospital
- If the procedure performed at your hospital was not done in the operating room, the Null Value Non Operative Procedure or NA is used.

State Data Element

EMS/ED/HOSPITAL PROCEDURE START DATE

Field Name: PROCEDURE_START_DATE

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

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

National and State Data Element

EMS/ED/HOSPITAL PROCEDURE START TIME

Field Name: PROCEDURE_START_TIME

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

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time
- 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

National and State Data Element

HOSPITAL EVENTS

Field Name: Critique_code
Field Name: Comp_type

Data Source Hospital Events Information:

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

HOSPITAL CRITIQUES

Field Name: CRITIQUE_CODE

Description: Documentation of critiques identified during the patient's course at your facility.

Field Values

- Trauma Code not activated when appropriate
- Hemo/Pneumo diagnosed and No Chest Tube placement
- >1 liters of Fluid Given
- GCS<=8 and Pt NOT Intubated
- Lead Provider Response Time >20 minutes
- No APP Chart Review within 2 weeks
- No State PI issues identified
- Antibiotics Administered within 1 hour from ED/Hospital arrival for ALL Open Fractures
- Other Reason Identified
- CT scan Done on Pediatric Case <=14 years old
- Transfer Time > 2 hours
- TXA

Additional Information

State Data Element

Hospital Events
Field Name: COMP_TYPE

Definition: Any medical condition that occurred during the patient's stay at your hospital.

Field Values

- Abdominal Compartment Syndrome
- Abdominal Fascia
- Acute Renal Failure
- Acute Respiratory Distress Syndrome
- Base Deficit
- Bleeding
- Cardiac Arrest with CPR
- Coagulopathy
- Coma
- Stroke/CVA
- Decubitus Ulcer
- Delayed Diagnosis
- Wound Disruption
- Deep Vein Thrombosis/Thrombophlebitis
- Extremity Compartment Syndrome
- Graft or Prosthetic or Flap failure
- Intracranial Pressure
- Unplanned Intubation
- Missed Diagnosis
- Myocardial Infarction
- No NTDS listed medical complication occurred
- Organ/Space Surgical Site Infection
- Pulmonary Embolism
- Pneumonia
- Systemic Sepsis
- Deep Surgical Infection
- Superficial Surgical Site Infection
- Drug or Alcohol Withdrawal
- Not Applicable
- Not Documented
- Unknown

Additional Information

- Must have occurred during the patient's initial hospital stay.
- Must be documented in the patient's chart

National and State Data Element

The following pages, outline the criteria for complications/hospital events. The patient has to meet the criteria in order to record the complication.

ACUTE KIDNEY INJURY

Definition: AKI (stage 3), is an abrupt decrease in kidney function.

KDIGO Staging of AKI:

SERUM CREATININE:

- 3.0 times baseline
  OR
- Increase in serum creatinine to >=4.0 mg/dl
  OR
- Initiation of renal replacement therapy
  OR
- Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to < 35ml/min per 1.73 m^2

URINE OUTPUT:

- >0.3ml/kg/hr 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 Acute Kidney Injury (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.

National and State Data Element

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Definition:

- Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.
- Chest imagine: Bilateral opacities not fully explained by effusions; lobar/lung collarge or nodules.
- Origin of edema: Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (echo) 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.

National and State Data Element

ALCOHOL WITHDRAWAL SYNDROME

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

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 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndome.

National and State Data Element

CARDIAC ARREST WITH CPR

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

Additional Information

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

National and State Data Element

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

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

AND

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

January 2019 CDC CAUTI Criterion SUTI 1a:

Patient must meet 1, 2, **and** 3 below:

1. Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event AND was either Present for any portion of the calendar day on the date of event,
   OR
   Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms.
   Fever (>38ºC): Reminder: To use fever in a patient >65 years of age, the IUC needs to be in place for more than 2 consecutive days in an inpatient location on date of event and is either still in place OR was removed the day before the DOE.
   Suprapubic tenderness
   Costovertebral angle pain or tenderness
   Urinary urgency
   Urinary frequency • dysuria
3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacterium >10^5 CFU/ml.

January 2019 CDC CAUTI Criterion SUTI 2:

Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   - fever (>38.0ºC)
   - hypothermia (<36.0ºC)
   - apnea
   - bradycardia
   - lethargy

- vomiting
- suprapubic tenderness

3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacterium of ≥10^5 CFU/ml.

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 2019 CDC defined CAUTI

National and State Data Element

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Definition: A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

AND

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

January 2016 CDC Criterion LCBI 2:

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

AND

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

AND

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

which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38º C), hypothermia (<36ºC), apnea, or bradycardia

AND

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

AND

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

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

National and State Data Element

DEEP SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) According to list in Table 2

AND

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

AND

patient has at least *one* of the following:

a. purulent drainage from the deep incision.
b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

AND

Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed. A culture or non-culture based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

* The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

- Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)

- Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

Surveillance Period for Deep Incisional or Organ/Space SSI following selected NHSN Operative Procedure Categories Day 1 = the day 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

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 2019 CDC defined SSI.

National and State Data Element

DEEP VEIN THROMBOSIS (DVT)

Definition: The formation, development, or existence of a blood clot or thrombus within the venous system, which may be coupled with inflammation.

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 Deep Vein Thrombosis (DVT) must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT

National and State Data Element

DELIRIUM

Definition: Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

OR

Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).

OR

A diagnosis of delirium documented in the patient's medical record.

Additional Information

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

National and State Data Element

EXTREMITY COMPARTMENT SYNDROME

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

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- Report as a hospital event 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.

National and State Data Element

MYOCARDIAL INFARCTION (MI)

Definition: An acute myocardial infarction must be noted with documentation of ECG changes indicative of an acute myocardial infarction (MI)

AND

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

AND

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

Additional Information

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

National and State Data Element

ORGAN/SPACE SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

AND

patient has at least *one* of the following:

a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
b. organisms are identified from fluid or tissue in the organ/space by a culture or 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 evidence suggestive of infection.

AND

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

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

30 DAY SURVEILLANCE	
Code	**Operative Procedure**
AAA	Abdominal aortic aneurysm repair
AMP	Limb amputation
APPY	Appendix surgery
AVSD	Shunt for dialysis
BILI	Bile duct, liver or pancreatic surgery
CEA	Carotid endarterectomy
CHOL	Gallbladder surgery
COLO	Colon surgery
CSEC	Cesarean section
GAST	Gastric surgery

HTP	Heart Transplant
HYST	Abdominal hysterectomy
KTP	Kidney Transplant
NEPH	Kidney surgery
OVRY	Ovarian surgery
PRST	Prostate surgery
REC	Rectal surgery
SB	Small bowel surgery
SPLE	Spleen surgery
THOR	Thoracic surgery
THUR	Thyroid and/or parathyroid surgey
VHYS	Vaginal hysterectomy
XLAP	Exploratory/Lapartomy

90 DAY SURVEILLANCE	
Code	**Operative Procedure**
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI.

Code	Site	Code	Site
BRST	Limb amputation	MED	Mediastinitis
CARD	Appendix surgery	MEN	Meningitis or ventriculitis
DISC	Shunt for dialysis	EMET	Carotid endarterectomy
ENDO	Gallbladder surgery	EYE	Colon surgery
SINU	Sinusitis	UR	Upper Respiratory Tract

PJI	Periprosthetic Joint Infection	USI	Urinary System Infection
SA	Spinal Abcess without meningitis	GIT	Cesarean section
EAR	Bile duct, liver or pancreatic surgery	HEP	Hepatitis
IAB	Intrabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal Cuff
LUNG	Other infections of the respiratory tract		
ORAL	Oral Cavity (mouth, tongue, or gums)		
OREP	Other infections of the male or female reproductive tract		

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 2019 CDC defined SSI

National and State Data Element

OSTEOMYELITIS

Definition: Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (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

National and State Data Element

PULMONARY EMBOLISM (PE)

Definition: A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system.

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 subsegmental PEs

National and State Data Element

PRESSURE ULCER

Definition: A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury.

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.

National and State Data Element

SEVERE SEPSIS

Definition: Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.

Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation

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.

National and State Data Element

STROKE/CVA

Definition: A focal or global neurological deficit of rapid onset and NOT present on admission caused by a clot obstructing the flow of blood flow to the brain (ischemic stroke). Or by a blood vessel rupturing and preventing blood flow to the brain (hemorrhagic stroke). Or a transient ischemic attack which is temporary caused by a temporary clot. The patient must have at least one of the following symptoms:

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

AND

Duration of neurological deficit ≥24 h

OR

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

AND

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

AND

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

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.

National and State Data Element

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition: Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)
AND
involves only skin and subcutaneous tissue of the incision
AND
patient has at least one of the following:

a. purulent drainage from the superficial incision.
b. organisms identified from an aseptically-obtained specimen from the superficial incision or sub cutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
c. superficial incision that is deliberately opened by a surgeon, attending physician**or other designee and culture or non-culture based testing is not performed.

   AND

   patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

*The term attending physician for the purposes of application of the NHSN SSI criteria may be interpreted to mean the surgeon(s), infectious disease, other physician on the case, emergency physician, or physician's designee (nurse practitioner or physician's assistant).

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

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

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 2019 CDC defined SSI.

National and State Data Element

UNPLANNED ADMISSION TO ICU

Definition: Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge.

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

National and State Data Element

UNPLANNED INTUBATION

Definition: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis

Additional Information

- Must have occurred during the patient's initial stay at your hospital.
- For patients who were intubated in the field or emergency department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.

National and State Data Element

UNPLANNED VISIT TO THE OPERATING ROOM

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

Additional Information

- Unplanned is defined as an acute clinical deterioration requiring operative intervention. • Exclude non-urgent tracheostomy and gastrostomy.
- Exclude pre-planned, staged and/or procedures for incidental findings.
- Exclude operative management related to a procedure that was initially performed prior to arrival at your center.
- Inclusion Example
    - Patient has an acute loss of airway requiring emergent tracheostomy in the OR for airway establishment. •
- Exclusion Example
    - Patient is having difficulty weaning for the ventilator. Patient is scheduled and undergoes a tracheostomy.
    - Patient is initially managed non-operatively for a fracture. Pain control is unable to be achieved with non-operative management. Patient is scheduled and undergoes an ORIF.
    - Patient is initially managed non-operatively for a fracture. Post-ambulation imaging to confirm stability demonstrates increased malalignment. Patient is scheduled and undergoes an ORIF.

National and State Data Element

VENTILATOR ASSISTED PNEUMONIA (VAP)

Definition: A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

AND

The ventilator was in place on the date of event or the day before

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
-New and persistent **or** progressive and persistent -Infiltrate -Consolidation -Cavitation -Pneumatoceles, in infants <= 1 year old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	-Fever (>38ºC or >100.4ºF) -Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) -For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: -New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements -New onset or worsening cough, or dyspnea, or tachypnea -Rales or bronchial breath sounds -Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen	-Organism identified from blood -Organism identified from pleural fluid -Positive quantitative culture or corresponding semi-quantitative culture result from minimally contaminated LRT specimen (specifically, BAL, protected specimen brushing or endotracheal aspirate) -≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain) -Positive quantitative culture or corresponding semi-quantitative culture result of lung tissue -Histopathologic exam shows at least **one** of the following evidences of pneumonia: − Abscess formation or foci of consolidation with intense PMN

	requirements, or increased ventilator demand)	accumulation in bronchioles and alveoli − Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae.

VAP Algorithm (PNU2 Viral, Legionnella, and other Bacterial Pneumonias): imaging test evidence signs/symptoms laboratory

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 and persistent **or** progressive and persistent -Infiltrate -Consolidation -Cavitation -Pneumatoceles, in infants <= 1 year old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	-Fever (>38ºC or >100.4ºF) -Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) -For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: -New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements -New onset or worsening cough, or dyspnea, or tachypnea -Rales or bronchial breath sounds -Worsening gas exchange (for example: O2 desaturations [for	-Virus, *Bordetella*, *Legionella*, *Chlamydia* or *Mycoplasma* identified from respiratory secretions or tissue by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example: not Active Surveillance Culture/ Testing (ASC/AST). -Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) -Fourfold rise in *Legionella* pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. -Detection of L. *pneumophila* serogroup 1

	example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand	antigens in urine by RIA or EIA.

VAP Algorithm (PNU3 Immunocompromised Patients): imaging test evidence signs/symptoms laboratory.

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 and persistent **or** progressive and persistent -Infiltrate -Consolidation -Cavitation -Pneumatoceles, in infants <= 1 year old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	-Fever (>38ºC or >100.4ºF) -For adults ≥70 years old, altered mental status with no other recognized cause. -New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements. -New onset or worsening cough, or dyspnea, or tachypnea. -Rales or bronchial breath sounds. -Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand.	- Identification of matching *Candida* spp. from blood and one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing. -Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: -Direct microscopic exam -Positive culture of fungi -Non culture diagnostic lab test **OR** Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

	-Hemoptysis -Pleuritic chest pain	

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤ 1 year old:

IMAGINE TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with a least **one** of the following:	
New and persistent or progressive and persistent: -Infiltrate -Consolidation -Cavitation - Pneumatoceles, in infants <= 1 year old **NOTE:** In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, brochopulmonary dysplasia, pulmonary edema or chronic obstructive pulmonary disease), one definitive chest imagine test result is acceptable.	Worsening gas exchange (for example:2 desaturations [for example pulse oximetry <94%], increased oxygen requirements or increased ventilator demand). And at least ***three*** of the following: -Temperature instability -Leukopenia (≤4000 WBC/mm3) or leukocytosis (>15,000 WBC/mm3) and left shift (>10% band forms) -New onset of purulent sputum or change in character of sputum, or increased respiratory secretions or increased suctioning requirements -Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting -Wheezing, rales, or rhonchi -cough -Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

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

IMAGINE TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with a least **one** of the following:	

New and persistent or progressive and persistent: -Infiltrate -Consolidation -Cavitation - Pneumatoceles, in infants <= 1 year old **NOTE:** In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, brochopulmonary dysplasia, pulmonary edema or chronic obstructive pulmonary disease), one definitive chest imagine test result is acceptable.	ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least ***three*** of the following: -Fever (>38. 0°C or >100. 4°F) or hypothermia (<36. 0°C or <96. 8°F) -Leukopenia (≤4000 WBC/mm3) or leukocytosis (≥15,000 WBC/mm3) -New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements -New onset or worsening cough, or dyspnea, apnea and tachypnea -Rales or bronchial breath sounds -Worsening gas exchange (for example: O2 desaturations [example pulse oximetry <94%], increased oxygen requirements o rincreased ventilator demand).

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 2019 CDC defined VAP

National and State Data Element

NORTH DAKOTA

CITIES

COUNTIES

ZIP CODES

Abercrombie	Richland	58001
Absaraka	Cass	58002
Adams	Walsh	58210
Agate	Rolette	58310
Alamo	Williams	58830
Alexander	Mckenzie	58831
Almont	Morton	58520
Alsen	Cavalier	58311
Ambrose	Divide	58833
Amenia	Cass	58004
Amidon	Slope	58620
Anamoose	Mchenry	58710
Aneta	Nelson	58212
Antler	Bottineau	58711
Argusville	Cass	58005
Arnegard	Mckenzie	58835
Arthur	Cass	58006
Arvilla	Grand Forks	58214
Ashley	Mcintosh	58413
Ayr	Cass	58007
Baldwin	Burleigh	58521
Balfour	Mchenry	58712
Balta	Pierce	58313
Bantry	Mchenry	58713
Barney	Richland	58008
Bathgate	Pembina	58216
Beach	Golden Valley	58621
Belcourt	Rolette	58316
Belfield	Stark	58622
Benedict	Mclean	58716
Berlin	Lamoure	58415
Berthold	Ward	58718
Beulah	Mercer	58523
Binford	Griggs	58416
Bisbee	Towner	58317
Bismarck	Burleigh	58501
Bismarck	Burleigh	58502
Bismarck	Burleigh	58503
Bismarck	Burleigh	58504
Bismarck	Burleigh	58505
Bismarck	Burleigh	58506
Bismarck	Burleigh	58507
Blanchard	Traill	58009

Bottineau	Bottineau	58318
Bowbells	Burke	58721
Bowdon	Wells	58418
Bowman	Bowman	58623
Braddock	Emmons	58524
Bremen	Wells	58319
Brocket	Ramsey	58321
Buchanan	Stutsman	58420
Buffalo	Cass	58011
Burlington	Ward	58722
Butte	Mclean	58723
Buxton	Traill	58218
Caledonia	Traill	58219
Calvin	Cavalier	58323
Cando	Towner	58324
Cannon Ball	Sioux	58528
Carpio	Ward	58725
Carrington	Foster	58421
Carson	Grant	58529
Cartwright	Mckenzie	58838
Casselton	Cass	58012
Cathay	Wells	58422
Cavalier	Pembina	58220
Cayuga	Sargent	58013
Center	Oliver	58530
Chaseley	Wells	58423
Christine	Richland	58015
Churchs Ferry	Ramsey	58325
Cleveland	Stutsman	58424
Clifford	Traill	58016
Cogswell	Sargent	58017
Coleharbor	Mclean	58531
Colfax	Richland	58018
Columbus	Burke	58727
Cooperstown	Griggs	58425
Courtenay	Stutsman	58426
Crary	Ramsey	58327
Crosby	Divide	58730
Crystal	Pembina	58222
Cummings	Traill	58223
Dahlen	Nelson	58224
Davenport	Cass	58021
Dawson	Kidder	58428

Dazey	Barnes	58429
Deering	Mchenry	58731
Denhoff	Sheridan	58430
Des Lacs	Ward	58733
Devils Lake	Ramsey	58301
Dickey	Lamoure	58431
Dickinson	Stark	58601
Dickinson	Stark	58602
Dodge	Dunn	58625
Donnybrook	Ward	58734
Douglas	Ward	58735
Drake	Mchenry	58736
Drayton	Pembina	58225
Driscoll	Burleigh	58532
Dunn Center	Dunn	58626
Dunseith	Rolette	58329
Edgeley	Lamoure	58433
Edinburg	Walsh	58227
Edmore	Ramsey	58330
Egeland	Towner	58331
Elgin	Grant	58533
Ellendale	Dickey	58436
Emerado	Grand Forks	58228
Enderlin	Ransom	58027
Epping	Williams	58843
Erie	Cass	58029
Esmond	Benson	58332
Fairdale	Walsh	58229
Fairfield	Billings	58627
Fairmount	Richland	58030
Fargo	Cass	58102
Fargo	Cass	58103
Fargo	Cass	58104
Fargo	Cass	58105
Fargo	Cass	58106
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Fargo	Cass	58108
Fargo	Cass	58109
Fargo	Cass	58121
Fargo	Cass	58122
Fargo	Cass	58124
Fargo	Cass	58125
Fargo	Cass	58126

Fessenden	Wells	58438
Fingal	Barnes	58031
Finley	Steele	58230
Flasher	Morton	58535
Flaxton	Burke	58737
Forbes	Dickey	58439
Fordville	Walsh	58231
Forest River	Walsh	58233
Forman	Sargent	58032
Fort Ransom	Ransom	58033
Fort Totten	Benson	58335
Fort Yates	Sioux	58538
Fortuna	Divide	58844
Fredonia	Logan	58440
Fullerton	Dickey	58441
Gackle	Logan	58442
Galesburg	Traill	58035
Gardner	Cass	58036
Garrison	Mclean	58540
Gilby	Grand Forks	58235
Gladstone	Stark	58630
Glasston	Pembina	58236
Glen Ullin	Morton	58631
Glenburn	Renville	58740
Glenfield	Foster	58443
Golden Valley	Mercer	58541
Golva	Golden Valley	58632
Goodrich	Sheridan	58444
Grace City	Foster	58445
Grafton	Walsh	58237
Grand Forks	Grand Forks	58201
Grand Forks	Grand Forks	58202
Grand Forks	Grand Forks	58203
Grand Forks	Grand Forks	58206
Grand Forks	Grand Forks	58207
Grand Forks	Grand Forks	58208
Grand Forks Afb	Grand Forks	58204
Grand Forks Afb	Grand Forks	58205
Grandin	Cass	58038
Granville	Mchenry	58741
Grassy Butte	Mckenzie	58634

Grenora	Williams	58845
Gwinner	Sargent	58040
Hague	Emmons	58542
Halliday	Dunn	58636
Hamilton	Pembina	58238
Hampden	Ramsey	58338
Hankinson	Richland	58041
Hannaford	Griggs	58448
Hannah	Cavalier	58239
Hansboro	Towner	58339
Harvey	Wells	58341
Harwood	Cass	58042
Hatton	Traill	58240
Havana	Sargent	58043
Hazelton	Emmons	58544
Hazen	Mercer	58545
Hebron	Morton	58638
Hensel	Pembina	58241
Hettinger	Adams	58639
Hillsboro	Traill	58045
Hoople	Walsh	58243
Hope	Steele	58046
Horace	Cass	58047
Hunter	Cass	58048
Hurdsfield	Wells	58451
Inkster	Grand Forks	58244
Jamestown	Stutsman	58401
Jamestown	Stutsman	58402
Jamestown	Stutsman	58405
Jessie	Griggs	58452
Jud	Lamoure	58454
Karlsruhe	Mchenry	58744
Kathryn	Barnes	58049
Keene	Mckenzie	58847
Kenmare	Ward	58746
Kensal	Stutsman	58455
Killdeer	Dunn	58640
Kindred	Cass	58051
Kintyre	Emmons	58549
Knox	Benson	58343
Kramer	Bottineau	58748
Kulm	Lamoure	58456
Lakota	Nelson	58344

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Langdon	Cavalier	58249
Lankin	Walsh	58250
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Larimore	Grand Forks	58251
Lawton	Ramsey	58345
Leeds	Benson	58346
Lefor	Stark	58641
Lehr	Mcintosh	58460
Leonard	Cass	58052
Lidgerwood	Richland	58053
Lignite	Burke	58752
Linton	Emmons	58552
Lisbon	Ransom	58054
Litchville	Barnes	58461
Luverne	Steele	58056
Maddock	Benson	58348
Maida	Cavalier	58255
Makoti	Ward	58756
Mandan	Morton	58554
Mandaree	Mckenzie	58757
Manning	Dunn	58642
Mantador	Richland	58058
Manvel	Grand Forks	58256
Mapleton	Cass	58059
Marion	Lamoure	58466
Marmarth	Slope	58643
Marshall	Dunn	58644
Martin	Sheridan	58758
Max	Mclean	58759
Maxbass	Bottineau	58760
Mayville	Traill	58257
Mcclusky	Sheridan	58463
Mcgregor	Williams	58755
Mchenry	Foster	58464
Mcleod	Richland	58057
Mcville	Nelson	58254
Medina	Stutsman	58467
Medora	Billings	58645
Mekinock	Grand Forks	58258
Menoken	Burleigh	58558
Mercer	Mclean	58559
Michigan	Nelson	58259

Milnor	Sargent	58060
Milton	Cavalier	58260
Minnewaukan	Benson	58351
Minot	Ward	58701
Minot	Ward	58702
Minot	Ward	58703
Minot	Ward	58707
Minot Afb	Ward	58704
Minot Afb	Ward	58705
Minto	Walsh	58261
Moffit	Burleigh	58560
Mohall	Renville	58761
Montpelier	Stutsman	58472
Mooreton	Richland	58061
Mott	Hettinger	58646
Mountain	Pembina	58262
Munich	Cavalier	58352
Mylo	Rolette	58353
Napoleon	Logan	58561
Neche	Pembina	58265
Nekoma	Cavalier	58355
New England	Hettinger	58647
New Leipzig	Grant	58562
New Rockford	Eddy	58356
New Salem	Morton	58563
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Niagara	Grand Forks	58266
Nome	Barnes	58062
Noonan	Divide	58765
Northwood	Grand Forks	58267
Norwich	Mchenry	58768
Oakes	Dickey	58474
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Oriska	Barnes	58063
Osnabrock	Cavalier	58269
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Palermo	Mountrail	58769
Park River	Walsh	58270
Parshall	Mountrail	58770
Pekin	Nelson	58361
Pembina	Pembina	58271
Penn	Ramsey	58362

Perth	Towner	58363
Petersburg	Nelson	58272
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Pingree	Stutsman	58476
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Plaza	Mountrail	58771
Portal	Burke	58772
Portland	Traill	58274
Powers Lake	Burke	58773
Raleigh	Grant	58564
Ray	Williams	58849
Reeder	Adams	58649
Regan	Burleigh	58477
Regent	Hettinger	58650
Reynolds	Grand Forks	58275
Rhame	Bowman	58651
Richardton	Stark	58652
Riverdale	Mclean	58565
Robinson	Kidder	58478
Rocklake	Towner	58365
Rogers	Barnes	58479
Rolette	Rolette	58366
Rolla	Rolette	58367
Roseglen	Mclean	58775
Ross	Mountrail	58776
Rugby	Pierce	58368
Ruso	Mclean	58778
Rutland	Sargent	58067
Ryder	Ward	58779
Saint Anthony	Morton	58566
Saint John	Rolette	58369
Saint Michael	Benson	58370
Saint Thomas	Pembina	58276
Sanborn	Barnes	58480
Sarles	Cavalier	58372
Sawyer	Ward	58781
Scranton	Bowman	58653
Selfridge	Sioux	58568
Sentinel Butte	Golden Valley	58654
Sharon	Steele	58277
Sheldon	Ransom	58068
Sherwood	Renville	58782

Sheyenne	Eddy	58374
Shields	Grant	58569
Solen	Sioux	58570
Souris	Bottineau	58783
South Heart	Stark	58655
Spiritwood	Barnes	58481
Stanley	Mountrail	58784
Stanton	Mercer	58571
Starkweather	Ramsey	58377
Steele	Kidder	58482
Sterling	Burleigh	58572
Stirum	Sargent	58069
Strasburg	Emmons	58573
Streeter	Stutsman	58483
Surrey	Ward	58785
Sutton	Griggs	58484
Sykeston	Wells	58486
Tappen	Kidder	58487
Taylor	Stark	58656
Thompson	Grand Forks	58278
Tioga	Williams	58852
Tokio	Benson	58379
Tolley	Renville	58787
Tolna	Nelson	58380
Tower City	Cass	58071
Towner	Mchenry	58788
Trenton	Williams	58853
Turtle Lake	Mclean	58575
Tuttle	Kidder	58488
Underwood	Mclean	58576
Upham	Mchenry	58789
Valley City	Barnes	58072
Velva	Mchenry	58790
Verona	Lamoure	58490
Voltaire	Mchenry	58792
Wahpeton	Richland	58074
Wahpeton	Richland	58075
Wahpeton	Richland	58076
Walcott	Richland	58077
Wales	Cavalier	58281
Walhalla	Pembina	58282
Warwick	Benson	58381
Washburn	Mclean	58577

Watford City	Mckenzie	58854
Webster	Ramsey	58382
West Fargo	Cass	58078
Westhope	Bottineau	58793
Wheatland	Cass	58079
White Earth	Mountrail	58794
Wildrose	Williams	58795
Williston	Williams	58801
Williston	Williams	58802
Willow City	Bottineau	58384
Wilton	Mclean	58579
Wimbledon	Barnes	58492
Wing	Burleigh	58494
Wishek	Mcintosh	58495
Wolford	Pierce	58385
Woodworth	Stutsman	58496
Wyndmere	Richland	58081
York	Benson	58386
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Zahl	Williams	58856
Zap	Mercer	58580
Zeeland	Mcintosh	58581