M·TQIP

2024 Data Dictionary

CONTENTS

SECTION 1 - INTRODUCTION

1.1 PATIENT INCLUSION CRITERIA

Description

To ensure consistent data reporting across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of initial hospital encounter and meeting the following criteria*:

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

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

- S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)

Excluding the following 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 and T79.A1-T79.A9):

- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status);
  OR
- Patient transfer from one acute care hospital** to another acute care hospital;
  OR
- Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention);
  OR
- Patients who were an in-patient admission and/or observed.

Element Values

- Not applicable.

Additional Information

- * In-house traumatic injuries sustained after ED/hospital arrival and before discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded from NTDS Inclusion Criteria.
    - If an inpatient rehabilitation, geropsychiatry, or similar unit are separately licensed facilities from your hospital, then it's not considered an in-house trauma.
    - If an inpatient rehabilitation, geropsychiatry, or similar unit are part of the hospital (i.e., under the same license), then it would qualify as an in-house trauma.
- ** Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).
- Patients entered into the trauma registry will then be selected for analysis using TQIP and/or MTQIP inclusion and exclusion criteria.

Resources

- CMS Data Navigator Glossary of Terms
- National Trauma Data Dictionary
- Orientation

Codebook

Source: NTDS
Data Base Column Name: Not applicable
Type of Element: Not appliable
Length: Not applicable
Report: #1-8

1.2 CASE NUMBER

Description

Registry number from commercial registry software.

Element Values

- Relevant value for data element.

Additional Information

- This number is automatically assigned by the registry program.
- We will use only the initial admission (xxxxxx.000) record.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: TRAUMA_NUM
Type of Element: Numeric
Length: 30
Report: #1-8

1.3TRAUMA CENTER

Description

A two-letter code that identifies each trauma center.

Element Values

BO	Ascension Borgess Hospital
GH	Ascension Genesys Hospital
PN	Ascension Providence Hospital - Novi Campus
VH	Ascension Providence Hospital - Southfield Campus
JO	Ascension St. John Hospital
SM	Ascension St. Mary's Hospital
TB	Corewell Health Beaumont Troy Hospital
SH	Corewell Health Butterworth Hospital
OW	Corewell Health Dearborn Hospital
BF	Corewell Health Farmington Hills Hospital
OS	Corewell Health Trenton Hospital
WB	Corewell Health William Beaumont University Hospital
BM	Bronson Methodist Hospital
CO	Covenant HealthCare
DR	Detroit Receiving Hospital
AL	Henry Ford Allegiance
HF	Henry Ford Hospital
HM	Henry Ford Macomb Hospital
HU	Hurley Medical Center
ML	McLaren Lapeer Regional Medical Center
MC	McLaren Macomb
PO	McLaren Oakland
UM	Michigan Medicine
MI	MidMichigan Medical Center - Midland
MU	Munson Medical Center
SG	Sinai-Grace Hospital
SP	Sparrow Hospital
SJ	Trinity Health Ann Arbor Hospital
LM	Trinity Health Livonia Hospital
MK	Trinity Health Muskegon Hospital
SO	Trinity Health Oakland Hospital
MM	Trinity Health Saint Mary's - Grand Rapids
MH	University of Michigan Health - West
MG	UP Health System Marquette

Additional Information

- Assigned by the data coordinating center.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: TRAUMACTR (CDM), FACILITY_NUM (DI)
Type of Element: String
Length: 2
Report: #1-8

SECTION 2 - DEMOGRAPHIC INFORMATION

2.1 PATIENT'S FIRST NAME

Description

The first name of the patient.

Element Values

- Relevant value for data element.

Additional Information

- Report the legal name provided by the patient.
- Report "Unknown" if the legal name is never documented.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_NAME_F
Type of Element: String
Length:
Report: #1

2.2 PATIENT'S LAST NAME

Description

The last name of the patient.

Element Values

- Relevant value for data element.

Additional Information

- Report the legal name provided by the patient, including suffix if applicable.
- Report "Unknown" if the legal name is never documented.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_NAME_L
Type of Element: String
Length:
Report: #1

2.3 PATIENT'S MIDDLE INITIAL

Description

The first initial of the middle name of the patient.

Element Values

- Relevant value for data element.

Additional Information

- Report the legal name first initial provided by the patient.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_NAME_MI
Type of Element: String
Length: 1
Report: #1

2.4 PATIENT'S HOME STREET 1

Description

The house number and street of the patient.

Element Values

- Relevant value for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_ADR_S01
Type of Element: String
Length:
Report: #1

2.5 PATIENT'S HOME STREET 2

Description

The house number and street of the patient if additional information is necessary to find the patient's home destination.

Element Values

- Relevant value for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_ADR_S02
Type of Element: String
Length:
Report: #1

2.6 PATIENT'S HOME CITY

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_FCI
Type of Element: String
Length:
Report: #1

2.7 PATIENT'S HOME STATE

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_ST
Type of Element: Numeric
Length:
Report: #1

2.8 PATIENT'S HOME ZIP/POSTAL CODE

Description

The patient's home ZIP/postal code of primary residence.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_ZIP
Type of Element: Numeric
Length:
Report: #1

2.9 PATIENT'S HOME COUNTRY

Description

The country where the patient resides.

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_CY_S
Type of Element: String
Length:
Report: #1

2.10 PATIENT'S HOME COUNTY

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_FCO
Type of Element: Numeric
Length: 3
Report: #1

2.11 ALTERNATE HOME RESIDENCE

Description

Documentation of the type of patient without a home ZIP/postal code.

Element Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_ADR_ALT1, PAT_ADR_ALT2, PAT_ADR_ALT3
Type of Element:
Length:
Report: #1

2.12 PATIENT'S TELEPHONE NUMBER

Description

The patient's telephone number.

Element Values

- Relevant value for data element.

Additional Information

Resource

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PATIENT_PHONE
Type of Element: Numeric
Length:
Report: #1
Vendor edit check: A populated element must be 10 characters in length. A populated element cannot contain non-numeric values.

2.13 PATIENT'S EMAIL ADDRESS

Description

The email address of the patient.

Element Values

- Relevant value for data element.

Additional Information

- If the patient does not have an email address, a proxy email used by the patient or surrogate may be entered.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: EMAIL_ADDRES
Type of Element: String (Email Format)
Length:
Report: #1

2.14 PATIENT'S MEDICAL RECORD NUMBER

Description

The medical record number of the patient at your hospital.

Element Values

- Relevant value for data element.

Additional Information

- This number should be the unique identifier to the patient at your hospital.
- This identifier should be able to identify the patient across all their care visits at your center and should not be unique for a single encounter.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PAT_REC_NUM
Type of Element:
Length:
Report: #1

2.15 DATE OF BIRTH

Description

The patient's date of birth.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- If Date of Birth is "Not Known/Not Recorded," report Age and Age Units.
- If Date of Birth is the same as the Injury Incident Date, then the Age and Age Units data elements must be reported.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: DOB_DATE
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1

2.16 AGE

Description

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

Element Values

- Relevant value for data element.

Additional Information

- Must also report variable: Age Units.
- If an age cannot be found after referencing all available documentation, including the medical examiner report, then enter an age of 50.
- Report Age and Age Units if Date of Birth is reported the same as the ED/Hospital Arrival Date.
- The null value "Not Applicable" is reported if Date of Birth is documented.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: CALCULATED_AGE
Type of Element: Numeric
Length: 5
Report: #1

2.17 AGE UNITS

Description

The units used to report the patient's age.

Element Values

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

Additional Information

- Must also report variable: Age.
- Report Age Units and Age if Date of Birth is "Not Known/Not Recorded."
- Report Age Units and Age if Date of Birth is the same as the ED/Hospital Arrival Date.
- The null value "Not Applicable" is reported if Date of Birth is reported.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: AGE_UNIT, AGE_UNIT_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1

2.18 RACE

Description

The patient's race.

Element Values

1. Asian (A)
2. Native Hawaiian or Other Pacific Islander (P)
3. Other Race (O)
4. American Indian (I)
5. Black or African American (B)
6. White (W)

Additional Information

- Report all that apply.
- Patient race should be based upon self-report or identified by a family member.

Resources

- Orientation

Codebook

Source: NTDS, US Census Bureau 2010
Data Base Column Name: RACE, RACE2, RACE3, RACE4, RACE5, RACE6
Type of Element: String
Length: 2
Report: #1

2.19 ETHNICITY

Description

The patient's ethnicity.

Element Values

1. Hispanic or Latino
2. 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.

Resources

- Orientation

Codebook

Source: NTDS, US Census Bureau 2010
Data Base Column Name: ETHNICITY
Type of Element: Numeric
Length: 1
Report: #1

2.20 SEX

Description

The patient's sex.

Element Values

1. Male (M)
2. Female (F)
3. Non-binary (N)

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: SEX
Type of Element: String
Length: 1
Report: #1

SECTION 3 - INJURY INFORMATION

3.1 INJURY INCIDENT DATE

Description

The date the injury occurred.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- Estimated injury date must be based on patient, witness, family, or healthcare provider report.
- Other proxy measures (e.g., 911 call times) must not be reported.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_DT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

3.2 INJURY INCIDENT TIME

Description

The time the injury occurred.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- Estimated injury time must be based on patient, witness, family, or healthcare provider report.
- Other proxy measures (e.g., 911 call times) must not be reported.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_TM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1

3.3 WORK-RELATED

Description

Indication of whether the injury occurred during paid employment.

Element Values

1. Yes
2. No

Additional Information

- If work-related, Patient's Occupational Industry and Patient's Occupation must be reported.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_WORK_YN
Type of Element: Numeric
Length: 1
Report: #1

3.4 PATIENT'S OCCUPATIONAL INDUSTRY

Description

The occupational industry associated with the patient's work environment.

Element 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, Patient's Occupation must be reported.
- The null value "Not Applicable" is reported if Work-Related is Element Value “2. No.”

Resources

- Orientation

Codebook

Source: NTDS, US Bureau of Labor Statistics Industry Classification
Data Base Column Name: PAT_JOB_TYPE
Type of Element: Numeric
Length:
Report: #1

3.5 PATIENT'S OCCUPATION

Description

The occupation of the patient.

Element Values

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

Additional Information

- Only reported if injury is work-related.
- If work-related, Patient's Occupational Industry must also be reported.
- The null value "Not Applicable" is reported if Work-Related is Element Value “2. No.”

Resources

- Orientation

Codebook

Source: NTDS, 1999 US Bureau of Labor Statistics Standard Occupational Classification
Data Base Column Name: PAT_JOB
Type of Element: Numeric
Length:
Report: #1

3.6 ICD-10 PRIMARY EXTERNAL CAUSE CODE

Description

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

Element Values

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

Additional Information

- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- ICD-10-CM codes are accepted for this data element.
- Activity codes are not reported under the NTDS.
- 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.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ECODE_ICD10_01
Type of Element: String
Length: 5
Report: #1

3.7ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Description

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

Element Values

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

Additional Information

- Only ICD-10-CM codes are accepted.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_PLC_ICD10
Type of Element: String
Length:
Report: #1

3.8ICD-10 ADDITIONAL EXTERNAL CAUSE CODE

Description

Additional external cause code used in conjunction with the ICD-10 Primary External Cause Code if multiple external cause codes are required to describe the injury event.

Element Values

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

Additional Information

- Report all that apply (maximum 2).
- Only ICD-10-CM codes are accepted.
- Activity codes are not reported under the NTDS and should not be reported for this data element.
- The null value "Not Applicable" is reported 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.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ECODE_ICD10_02
Type of Element: String
Length: 5
Report: #1

3.9 INCIDENT CITY

Description

The city or township where the patient was found or to which the unit responded.

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ADR_FCI
Type of Element: Numeric
Length: 5
Report: #1

3.10 INCIDENT STATE

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ADR_ST
Type of Element: Numeric
Length:
Report: #1

3.11 INCIDENT LOCATION ZIP/POSTAL CODE

Description

The ZIP/postal code of the incident location.

Element Values

- Relevant value for data element.

Additional Information

- Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US and Canada or can be stored in the postal code format of the applicable country.
- If Incident Location ZIP/Postal Code is reported, report Incident Country.
- If "Not Known/Not Recorded," report Incident Country, Incident State (US only), Incident County (US only), and Incident City (US only).
- May require adherence to HIPAA regulations.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ADR_ZIP
Type of Element: Numeric
Length:
Report: #1

3.12 INCIDENT COUNTY

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ADR_FCO
Type of Element: Numeric
Length: 3
Report: #1

3.13 INCIDENT COUNTRY

Description

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

Element Values

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

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: INJ_ADR_CY_S
Type of Element: String
Length: 2
Report: #1

3.14 PROTECTIVE DEVICES

Description

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

Element Values

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

Additional Information

- Report all that apply.
- Evidence of the use of safety equipment may be reported or observed.
- If Element Value "6. Child Restraint" is reported, report Child Specific Restraint.
- If Element Value "8. Airbag" is reported, report Airbag Deployment.
- Lap Belt should be reported to include those patients that are restrained but not further specified.
- If the documentation indicates "3-point-restraint," report Element Values “2. Lap Belt” and “10. Shoulder Belt.”
- If documented that a “Child Restraint (booster seat or child/infant car seat)” was used or worn but not properly fastened, either on the child or in the car, report Element Value “1. None.”

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: SAFETY01, SAFETY02, SAFETY03
Type of Element: Numeric
Length:
Report: #7

3.15 AIRBAG DEPLOYMENT

Description

Indication of airbag deployment during a motor vehicle crash.

Element Values

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

Additional Information

- Report all that apply.
- Evidence of the use of airbag deployment may be reported or observed.
- Only report when Protective Devices include "8. Airbag Present."
- Report Element Value “2. Airbag Deployed Front” for patients with documented airbag deployments but are not further specified.
- Report the null value "Not Applicable" if Element Value "8. Airbag Present" is not reported for Protective Devices.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: AIRBAG01, AIRBAG02, AIRBAG03, AIRBAG04
Type of Element: Numeric
Length:
Report: #1

3.16 MECHANISM

Description

Enter the mechanism that caused the injury event.

Element Values

1. Blunt
2. Penetrating

Additional Information

- Blunt injuries are the result of an external force exerted onto the body.
- Penetrating injuries result from the puncturing of the skin, creating a wound.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: INJ_TYPE
Type of Element: String
Length: 15
Report: #1

SECTION 4 - PRE-HOSPITAL INFORMATION

4.1 TRANSPORT MODE

Description

The mode of transport delivering the patient to your hospital.

Element Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private/Public Vehicle/Walk-in
5. Police
6. Other

Additional Information

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PAT_A_MODE
Type of Element: Numeric
Length:
Report: #1

4.2 EMS PATIENT CARE REPORT UNIQUE IDENTIFIER (UUID)

Description

The universally unique identifier (UUID) of the patient care report (PCR) of each emergency medical service (EMS) unit treating the patient from the time of injury to arrival at your ED/hospital.

Element Values

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

Additional Information

- Report all that apply (maximum 20).
- A sample UUID is: e48cd734-01cc-4da4-ae6a-915b0b1290f6
- Automated abstraction technology provided by registry product providers/vendors must be used for this data element. In the absence of automated technology, report the null value "Not Known/Not Recorded."
- The null value "Not Known/Not Recorded" must be reported if the UUID is not documented on the EMS Run Report. The UUID will not be documented on EMS Run Reports in NEMSIS versions lower than 3.5.0. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is widely implemented.
- The null value "Not Applicable" must be reported if the patient was never transported via EMS prior to arrival at your hospital.
- Assigned by any applicable transporting EMS agency in accordance with the IETF RFC 4122 standard.

Resources

- Orientation

Codebook

Source: NTDS, NEMSIS v3.5.0
Data Base Column Name: LINKAGERECORDID
Type of Element: String
Length:
Report: #1

4.3 INTER-FACILITY TRANSFER

Description

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

INCLUDE

- Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center.

EXCLUDE

- Patients transferred from a private doctor's office or stand-alone ambulatory surgery center.

Element Values

1. Yes
2. No

Additional Information

- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities.
- Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition). "CMS Data Navigator Glossary of Terms" (accessed January 15, 2019).

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: HOSPTRF_L
Type of Element: String
Length: 1(CDM), 3 (DI)
Report: #1

4.4 PRE-HOSPITAL CARDIAC ARREST

Description

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

Element Values

1. Yes
2. No

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: MTQIP_PRECPR
Type of Element: Numeric
Length: 1

SECTION 5 - EMERGENCY DEPARTMENT INFORMATION

5.1 ED TRAUMA RESPONSE

Description

Enter the final level of response listed on the trauma flowsheet or similar documentation.

Element Values

1. Full activation
2. Partial activation
3. Trauma consult
4. None

Additional Information

- Trauma is called by the ED to see a patient, report as consult.
- Patient arrives as a full activation but is downgraded to a partial activation, report as a partial activation.
- Patient arrives as partial activation but is upgraded to a full activation, report as a full activation.
- Include patients with an order entered. For example, an ED provider enters a consult order for trauma consultation, report as trauma consult.
- Report direct admits (e.g., no ED care provision) as Element Value "4. None."

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: ED_TTA_TYPE, ED_TTA_TYPE_AS_TEXT
Type of Element: Numeric, String
Length: 1,8
Report: #1

5.2 HIGHEST ACTIVATION

Description

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

INCLUDE:

- Patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- Patients who received the highest level of trauma activation initiated by EMS or by ED personnel at your hospital and were downgraded after arrival to your center.
- Patients who received a lower level of trauma activation initiated by EMS or by ED personnel at your hospital and were upgraded to the highest level of trauma activation.

EXCLUDE:

- Patients who received the highest level of trauma activation after ED discharge.

Element Values

1. Yes
2. No

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: HIGHESTTRAUMAACTIVATION
Type of Element: Numeric
Length: 1
Report: #1

5.3TRAUMA SURGEON

Description

Report the name and National Provider Identifier (NPI) of the trauma surgeon providing initial care to the patient in the ED and on admission.

Element Values

- Relevant value for data element.

Additional Information

Resources

- NPI Registry
- Orientation

Codebook

Source: MTQIP
Data Base Column Name (Resus Trauma Surgeons): EDP_MD_LNK01, EDP_MD_LNK01_AS_TEXT, EDP_MD_LNK01_NPI
Data Base Column Name (Admitting Trauma Surgeons): TSPHCODE, TSPHCODE_AS_TEXT, TSPHCODE_NPI
Type of Element: String, String, Numeric
Length:
Report: #1
Vendor edit check: A populated NPI element must be 10 characters in length. A populated NPI element cannot contain non-numeric values.

5.4TRAUMA SURGEON ARRIVAL DATE

Description

The date the first trauma surgeon arrived at the patient's bedside.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- Limit reporting to 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- Report for all full and partial activations. Trauma center discretion for consults.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: EDP_A_DATE01
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1
Vendor mapping: Map partial activations to null value "Not Applicable" for NTDS submission.

5.5TRAUMA SURGEON ARRIVAL TIME

Description

The time the first trauma surgeon arrived at the patient's bedside.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- Limit reporting to 24 hours after ED/Hospital arrival.
- The trauma surgeon leads the trauma team and is responsible for the overall care of trauma patient, including coordinating care with other specialties and maintaining continuity of care.
- The null value "Not Applicable" is reported for those patients who were not evaluated by a trauma surgeon within 24 hours of ED/Hospital arrival.
- Report for all full and partial activations. Trauma center discretion for consults.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: EDP_A_TIME01
Type of Element: Time (HH:MM Format)
Length:
Report: #1
Vendor mapping: Map partial activations to null value "Not Applicable" for NTDS submission.

5.6 ELAPSED MINUTES FROM ED ARRIVAL TO PROVIDER ARRIVAL

Description

The time in minutes from ED arrival of patient to ED arrival of trauma surgeon for highest level activations.

Element Values

- Relevant value for data element.

Additional Information

- This element is auto calculated by the registry software.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: EDP_ELAPSED_MIN01
Type of Element: Numeric
Length:
Report: #1

5.7 ED/HOSPITAL ARRIVAL DATE

Description

The date the patient arrived at the ED/hospital.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- 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.
- Used to auto-generate two additional calculated elements: 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).

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ED_ARRDT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

5.8 ED/HOSPITAL ARRIVAL TIME

Description

The time the patient arrived at the ED/hospital.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ED_ARRTM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1

5.9 INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Description

First recorded systolic blood pressure in the ED/hospital within 30 minutes of ED/hospital arrival.

Element 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 reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no BP is ever able to be obtained, then report BP as 0.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_BP
Type of Element: Numeric
Length: 3
Report: #1

5.10 INITIAL ED/HOSPITAL PULSE

Description

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

Element 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 reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no pulse is ever able to be obtained, then report pulse as 0.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_PULSE
Type of Element: Numeric
Length: 3
Report: #1

5.11 INITIAL ED/HOSPITAL TEMPERATURE

Description

First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes of ED/hospital arrival.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ED_TEMP
Type of Element: Numeric
Length: 5
Report: #1

5.12 INITIAL ED/HOSPITAL RESPIRATORY RATE

Description

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

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_URR (ED ASSESS UNASSISTED), EDAS_ARR (ED ASSESS ASSISTED)
Type of Element: Numeric
Length:
Report: #1

5.13 INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Description

Determination of respiratory assistance associated with the initial ED/Hospital Respiratory Rate within 30 minutes of ED/hospital arrival.

Element Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_ARR_YN
Type of Element: Numeric
Length: 1
Report: #1

5.14 INITIAL ED/HOSPITAL OXYGEN SATURATION

Description

First recorded oxygen saturation in the ED/hospital within 30 minutes of ED/hospital arrival (expressed as a percentage).

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_SAO2
Type of Element: Numeric
Length: 3
Report: #1

5.15 INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Description

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

Element Values

1. No Supplemental Oxygen
2. Supplemental Oxygen

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_SO2_YN
Type of Element: Numeric
Length: 1
Report: #1

5.16 INITIAL ED/HOSPITAL GCS-EYE

Description

First recorded Glasgow Coma Scale (GCS) Eye in the ED/hospital within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- If a patient does not have a numeric GCS documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported (e.g., the chart indicates: "opens eyes spontaneously," or "alert," an Eye GCS of 4 may be recorded, if there is no other contradicting documentation).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Eye is documented.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Eye was not measured within 30 minutes or less of ED/hospital arrival.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no GCS is ever able to be obtained, then report this GCS variable as 1.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_EYE
Type of Element: Numeric
Length: 2
Report: #1

5.17 INITIAL ED/HOSPITAL GCS-VERBAL

Description

First recorded Glasgow Coma Scale (GCS) Verbal within 30 minutes of ED/hospital arrival.

Element Values

1. No verbal 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 documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be reported (e.g., the chart indicates: "patient is oriented to person place and time," a GCS Verbal of 5 may be recorded, if there is no other contradicting documentation).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS - Verbal was not measured within 30 minutes or less of ED/hospital arrival.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no GCS is ever able to be obtained, then report this GCS variable as 1.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_VRB
Type of Element: Numeric
Length: 2
Report: #1

5.18 INITIAL ED/HOSPITAL GCS-MOTOR

Description

First recorded Glasgow Coma Scale (GCS) Motor within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- If a patient does not have a numeric GCS documented, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS, the appropriate numeric score may be listed (e.g., the chart indicates: "patient withdraws from a painful stimulus," a GCS Motor of 4 may be recorded, if there is no other contradicting documentation).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 – Motor is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS – Motor was not measured within 30 minutes of ED/hospital arrival.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no GCS is ever able to be obtained, then report this GCS variable as 1.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_MTR
Type of Element: Numeric
Length: 2
Report: #1

5.19 INITIAL ED/HOSPITAL GCS-TOTAL

Description

First recorded Glasgow Coma (GCS) Total Score within 30 minutes of ED/hospital arrival.

Element Values

- Relevant value for data element.

Additional Information

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 if there is no other contradicting documentation.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Eye, Initial ED/Hospital GCS – Motor, Initial ED/Hospital GCS – Verbal was not measured within 30 minutes of ED/Hospital arrival.
- If the patient has a cardiopulmonary arrest prior to arrival or within 15 minutes of arrival, and no GCS is ever able to be obtained, then report GCS total as 3.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_GCS
Type of Element: Numeric
Length: 2
Report: #1

5.20 INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Description

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes of ED/hospital arrival.

Element Values

- Patient Chemically Sedated (S)
- Patient Intubated (T)
- Patient Intubated and Chemically Paralyzed (TP)
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to eye (L)
- Unknown (V)
- Not Available (X)
- Inappropriate (Z)

Additional Information

- Identifies treatments given to the patient that may affect the first GCS assessment. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- Element value "Patient Intubated and Chemically Paralyzed (TP)" is reported if an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible.
- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS 40 is reported.
- The null value "Not Known/Not Recorded" is reported if the Initial ED/Hospital GCS Assessment Qualifiers are not documented within 30 minutes of ED/Hospital arrival.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_CALCAQ

Type of Element: Character
Length: 2
Report: #1

5.21 INITIAL ED/HOSPITAL GCS-40 – EYE

Description

First recorded Glasgow Coma Scale 40 (GCS-40) Eye score in the ED/hospital within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- If a patient does not have a numeric GCS-40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be reported (e.g., the chart indicates: "patient's eyes open spontaneously," or "alert" an Eye GCS-40 of 4 may be recorded, if there is no other contradicting documentation).
- Report Element Value "0. Not Testable" if unable to assess (e.g., swelling to eye(s)).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Eye is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS-40-Eye was not measured within 30 minutes of ED/hospital arrival.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: GCS40EYE
Type of Element: Numeric
Length: 1
Report: #1

5.22 INITIAL ED/HOSPITAL GCS-40 – VERBAL

Description

First recorded Glasgow Coma Scale 40 (GCS-40) Verbal score within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- If a patient does not have a numeric GCS-40 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be reported (e.g., the chart indicates: "patient correctly gives name, place, and date" a Verbal GCS-40 of 5 may be recorded, if there is no other contradicting documentation).
- Report Element Value "0. Not Testable" if unable to assess (e.g., patient is intubated).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial ED/Hospital GCS – Verbal is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS-40 - Verbal was not measured within 30 minutes of ED/hospital arrival.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: GCS40VERBAL
Type of Element: Numeric
Length: 1
Report: #1

5.23 INITIAL ED/HOSPITAL GCS-40 – MOTOR

Description

First recorded Glasgow Coma Scale 40 (GCS-40) Motor within 30 minutes of ED/hospital arrival.

Element Values

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

Additional Information

- If a patient does not have a numeric GCS-40 recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS-40, the appropriate numeric score may be reported (e.g., the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a GCS-40 Motor of 6 may be recorded if there is no other contradicting documentation).
- Report Element Value "0. Not Testable" if unable to assess (e.g., neuromuscular blockade).
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Known/Not Recorded" is reported if Initial Field GCS – Motor is reported.
- The null value "Not Known/Not Recorded" is reported if the patient's Initial ED/Hospital GCS-40 - Motor was not measured within 30 minutes of ED/hospital arrival.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: GCS40MOTOR
Type of Element: Numeric
Length: 1
Report: #1

5.24 INITIAL ED/HOSPITAL HEIGHT

Description

First recorded height after ED/hospital arrival.

Element Values

- Relevant value for data element.

Additional Information

- Recorded in centimeters.
- May be based on family or self-report.
- Report the null value "Not Known/Not Recorded" if the patient's Initial ED/Hospital Height was not measured prior to discharge.
- Please note the first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_HGT
Type of Element: Numeric
Length:
Report: #1

5.25 INITIAL ED/HOSPITAL WEIGHT

Description

First recorded weight within 24 hours of ED/hospital arrival.

Element Values

- Relevant value for data element.

Additional Information

- Report in kilograms.
- May be based on family or self-report.
- Report the null value "Not Known/Not Recorded" if the patient's Initial ED/Hospital Weight was not measured within 24 hours of ED/hospital arrival.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: EDAS_WGT
Type of Element: Numeric
Length:
Report: #1

5.26 DRUG SCREEN

Description

First recorded positive drug screen results within 24 hours after first hospital encounter.

Element Values

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

Additional Information

- Report all that apply.
- Report positive drug screen results within 24 hours after first hospital encounter at either your facility or the transferring facility.
- Report Element Value "14. None" 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.
- Report positive drug screen results documented in autopsy report if capture criteria are met (i.e., patient expires within 24 hours of first hospital encounter and there are autopsy-reported drugs not administered by health care providers).

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ED_DRGC01, ED_DRGC02, ED_DRGC03, ED_DRGC04, ED_DRGC05, ED_DRGC06, ED_DRGC07, ED_DRGC08, ED_DRGC90, ED_DRGC10, ED_DRGC11, ED_DRGC12, ED_DRGC13
Type of Element: Numeric
Length:

Report: #1

5.27 ALCOHOL SCREEN

Description

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

Element Values

1. Yes
2. No

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ETOH_BAC_SCRN_C
Type of Element: Numeric
Length:
Report: #1

5.28 ALCOHOL SCREEN RESULTS

Description

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

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: ETOH
Type of Element: Numeric
Length: 7
Report: #1

5.29 ED DISCHARGE DISPOSITION

Description

The care disposition, the order was written for the patient to be discharged to from the ED. If disposition is OR, no order is required.

Element Values

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

Additional Information

- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition should be "Not Applicable."
- For patients who require Interventional Radiology in the radiology procedure suite, report the patient's disposition location following this procedure.
- If multiple orders were written, report the actual care being delivered to the patient upon disposition from ED.
- Reporting should indicate the actual and highest acuity care being delivered to the patient.
- Example 1: The ICU provides floor, step-down, and ICU care. The patient is admitted to the ICU, and the documentation indicates the patient is provided floor care. Report as floor.
- Example 2: Floor beds can provide telemetry if patient need exists. The documentation indicates the patient receives telemetry monitoring on the floor. Report as telemetry (i.e., actual and highest acuity care).
- Example 3: Patient goes from ED to OR for airway management, then ED to ICU. Report the first disposition of OR.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ED_DISP, ED_DISP_AS_TEXT

Type of Element: Numeric, String
Length:
Report: #1

5.30 ED DISCHARGE DATE

Description

The date the patient was discharged from the ED.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: EDD_DATE
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1

5.31 ED DISCHARGE TIME

Description

The time the patient was discharged from the ED.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: EDD_TIME
Type of Element: Time (HH:MM Format)
Length: 5
Validation Range: +/- 1 hour
Report: #1

5.32 DIRECT ADMIT

Description

Report whether patient was directly admitted to MTQIP accepting facility without ED evaluation (i.e., direct admit to floor or ICU).

Element Values

- Yes (Y)
- No (N)

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: DIR_ADMIT
Type of Element: String
Length: 1
Report: #1

5.33 ARRIVED FROM

Description

The location where patient arrived from.

Element Values

1. Scene of injury
2. Home
3. Transfer from referring hospital ED

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: ARRIV_FROM
Type of Element: String
Length: 15
Report: #1

5.34 COMPLAINT

Description

The description of event that caused the injury.

Element Values

1. Fall (Fall)
2. Motor vehicle crash (MVC)
3. Motorcycle crash (MCC)
4. ATV crash (ATV)
5. Stab with object (Stab)
6. Gunshot wound (GSW)
7. Pedestrian vs. motor vehicle collision (MPC)
8. Bicycle (Injured while riding) (Bicycle)
9. Other

Additional Information

- If a matching description is not available, choose "other."

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: CHIEFCOMP
Type of Element: String
Length: 15
Report: #1

5.35 INTUBATION STATUS

Description

The location of first intubation.

Element Values

1. Never
2. Field/Scene/En route
3. ED
4. OR
5. ICU
6. Other

Additional Information

- Report Combitube, Hi-Lo, i-gel, King, and LMA airways, and tracheostomy as an intubation.
- Report the endoscopy suite, floor, and radiology as "6. Other."

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_INT_STAT
Type of Element: String
Length: 20
Report: #1

5.36 CPR

Description

CPR was performed at the ED of OSH or MTQIP hospital.

Element Values

- ED CPR (CPR Performed in ED)
- Not Performed (Not Performed)

Additional Information

- Report Element Value "ED CPR (CPR Performed in ED)" if the patient received chest compressions or external/internal cardioversion (defibrillation) in ED.
- Exclude respiratory arrest only requiring rescue breathing or intubation.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: CPR
Type of Element: String
Length: 15
Report: #1

5.37 PRIMARY TRAUMA SERVICE TYPE

Description

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

Element Values

1. Adult
2. Pediatric

Additional Information

- The primary service type responsible for trauma evaluation and care of the patient.
- This element will be used to determine which eligible Trauma Quality Programs report [adult or pediatric] the patient will appear; report age criteria will still apply.
- Adult trauma centers that do not have a separate pediatric service must report Element Value "1. Adult."
- Pediatric trauma centers that do not have a separate adult service must report Element Value "2. Pediatric."

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: PRIMARYSERVICETYPE
Type of Element: Numeric
Length:
Report: #1

5.38 ADMIT SERVICE

Description

The service that the patient was admitted to.

Element Values

1. Trauma
2. Neurosurgery
3. Orthopedics
4. General Surgery
5. Pediatric Surgery
6. Cardiothoracic Surgery
7. Burn Services
8. Emergency Medicine
9. Pediatrics
10. Anesthesiology
11. Cardiology
14. Critical Care
16. Documentation Recorder
19. ENT
20. Family Medicine
21. GI
23. Hospitalist
24. Infectious Disease
25. Internal Medicine
27. Nephrology
28. Neurology
29. Nurse Practitioner
30. Nursing
32. Ob-Gyn
34. Oncology
35. Ophthalmology
36. Oral Surgery
37. Oromaxillofacial
38. Ortho-Spine
43. Plastic Surgery
45. Pulmonary
46. Radiology
48. Respiratory Therapist
52. Thoracic Surgery
53. Trauma Resuscitation Nurse
54. Triage Nurse
55. Urology
56. Vascular Surgery
98. Other Surgical

99. Other Non-Surgical
? Unknown

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: ADMSERVICE
Type of Element: Numeric
Length:
Report: #1

SECTION 6 - HOSPITAL PROCEDURE INFORMATION

6.1 ICD-10 HOSPITAL PROCEDURES

Description

Operative and selected non-operative procedures conducted during the 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 desired non-operative procedures that should be provided to NTDB.

Element Values

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

Additional Information

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

Diagnostic & Therapeutic Imaging

Computerized tomographic Head *, †
Computerized tomographic Brain *, †
Computerized tomographic Chest *
Computerized tomographic Abdomen *
Computerized tomographic Pelvis *
Computerized tomographic C-Spine *
Computerized tomographic T-Spine *
Computerized tomographic L-Spine *
Doppler ultrasound of extremities *
Diagnostic ultrasound (includes FAST) *
Angioembolization
Angiography
IVC filter *, †
REBOA
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton

Cardiovascular
Open cardiac massage
CPR

CNS
Insertion of ICP monitor *
Ventriculostomy *
Cerebral oxygen monitoring *

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

Musculoskeletal
Soft tissue/bony debridements *
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Transfusion
Transfusion of red cells * (only report the first 24 hours after hospital arrival)
Transfusion of platelets * (only report the first 24 hours after hospital arrival)
Transfusion of plasma * (only report the first 24 hours after hospital arrival)

Respiratory
Insertion of endotracheal tube * (exclude intubations performed in the OR)
Continuous mechanical ventilation *
Chest tube *
Bronchoscopy *
Tracheostomy

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

Other
TPN *, †

Resources

- Orientation

Codebook
Source: MTQIP, NTDS
Data Base Column Name: A_PR_ICD10

Type of Element: String
Length: 5
Report: #5

6.2 HOSPITAL PROCEDURE START DATE

Description

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

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_OPDT
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #5

6.3 HOSPITAL PROCEDURE START TIME

Description

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

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- Head CT start time is defined as the time the imaging started (i.e., image 1). This is found on the time stamp on the digital image.

Resources

- Examples
- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_OPTM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #5

6.4 ELAPSED TIME ED ARRIVAL TO PROCEDURE START

Description

The minutes elapsed between ED arrival and procedure start time.

Element Values

- Relevant value for data element.

Additional Information

- This variable is auto calculated by the registry from the time entered for an operation and ED arrival.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PR_A_ELAPSED_MINSSC_L
Type of Element: Numeric
Length:
Report: #5

6.5 SERVICE PERFORMING OPERATIVE PROCEDURE

Description

The service performing the operative procedure. Reporting of this element is only required for operations.

Element Values

- Relevant value for data element.

Additional Information

- Reporting for procedures (i.e., blood transfusions, CPR, radiology) is at the discretion of the center.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PR_SVCS_L_AS_TEXT, PR_SVCS_L
Type of Element: String
Length:
Report: #5

6.6 OPERATION

Description

Surgical procedure performed in the operating room after arrival to your hospital.

Element Values

- Yes (Y)
- No (N)

Additional Information

- Report Element Value "Yes (Y)" if the patient had a procedure performed elsewhere that is normally performed in the OR (e.g., bedside tracheostomy or IR PEG placement).
- May use the presence of an operative note as a guide to determine if the case was an operation for cases performed outside of the OR.
- Exclude simple laceration repairs, closed reductions performed under GETA, or cath lab procedures.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_OPERATE
Type of Element: String
Length: 1
Report: #1

6.7 EMERGENCY OPERATION

Description

An emergency case is commonly performed as soon as possible after the patient sustained an injury.

Element Values

- Yes (Y)
- No (N)

Additional Information

- This is identified as emergent by the American Society of Anesthesiologists (ASA) Class.
- The presence of an "E" after ASA Class indicates an emergent operation. Report Element Value "Yes (Y)" if the surgeon and/or anesthesiologist report the case as emergent after arrival to your hospital.

Resources

- ASA Physical Status Classification System
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_E_OPERATE
Type of Element: String
Length: 1
Report: #1

SECTION 7 - PRE-EXISTING CONDITIONS

7.1 INTRODUCTION

Description

Pre-existing co-morbid factors present before patient arrival at the MTQIP ED/hospital.

Element Values

- Relevant value for data element.

Additional Information

- Report all that apply.
- The null value "Not Known/Not Reported" is reported only if no past medical history is available.
- Comorbidities should be submitted using numeric or alpha-numeric code for each element.
- Recommended data resources for reporting include but are not limited to electronic medical record (EMR), emergency medical services (EMS) run sheet, and Care Everywhere.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.2 ADVANCE DIRECTIVE LIMITING CARE

Description

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.

Element Values

- Advance Directive Limiting Care (NTDS 13)

Additional Information

- The written request was signed or dated by the patient and/or his/her designee prior to arrival at your center.
- Exclude patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- The verbiage "present prior to arrival at your center" is not limited to documentation in hand or scanned from a previous admission. "Present prior to arrival at your center" is defined as the medical record indicates the patient has an advanced directive that limits care completed prior to arrival at your center.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.3 ALCOHOL USE DISORDER

Description

The patient admits to drinking > 2 ounces of hard liquor or > two 12 oz. cans of beer or > two 6 oz. glasses of wine per day in the two weeks prior to admission or meets criteria for Alcohol Withdrawal Syndrome during the same stay.

Element Values

- Alcohol Use Disorder (NTDS 2)

Additional Information

- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- If the patient is a binge drinker, divide out the number of drinks during the binge by seven days, then apply the Description.
- May determine inclusion based on the brief screening tool used at your institution.
- May use information provided by family members or friends.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.4 ANTICOAGULANT THERAPY

Description

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

EXCLUDE:

- Patients whose only anticoagulant therapy is chronic aspirin.

Element Values

- Anticoagulant Therapy (NTDS 31)

Additional Information

- Present prior to injury.
- Anticoagulant must be an active medication within provided time frames below.

Trade Names	Generic Names	Subclass	Time Frame
Aggrastat	tirofiban	Antiplatelet	4 hours
Agrylin	anagrelide	Antiplatelet	3 days
Coumadin	warfarin	Anticoagulant	5 days
Effient	prasugrel	Antiplatelet	10 days
Fragmin	dalteparin	Antiplatelet	24 hours
	heparin (IV only)	Anticoagulant	4 hours
Integrilin	eptifibatide	Antiplatelet	2 days
Lovenox	enoxaparin	Anticoagulant	12 hours
Plavix	clopidogrel	Antiplatelet	10 days
Pradaxa	dabigatran etexilate	Direct Thrombin Inhibitor	2 days
Reopro	abciximab	Antiplatelet	9 days
Ticlid	ticlopidine	Antiplatelet	14 days
Xarelto	rivaroxaban	Factor Xa Inhibitor	2 days

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.5 ANTIPLATELET

Description

Patients who report use of an antiplatelet agent within a 10-day time frame prior to injury.

EXCLUDE:

- Aspirin under this variable.

Element Values

- Antiplatelet (D.06)

Additional Information

- Include any antiplatelet subclass agent with the mechanism of action via irreversibly binding to the P2Y12 adenosine diphosphate receptors or suppression of cAMP degradation, or augmentation of cGMP production, reducing platelet aggregation.
- Common agents include Plavix, (clopidogrel), Effient (prasugrel), Pletal (cilostazol) Brilinta (ticagrelor), and dipyridamole.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.6 ASPIRIN

Description

Patients who report use of aspirin within a 7-day time frame prior to injury.

INCLUDE:

- Aspirin-containing drugs, e.g., Aggrenox (aspirin/dipyridamole).

Element Values

- Aspirin (D.05)

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

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

Description

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

Element Values

- Attention deficit disorder/attention deficit hyperactivity disorder (NTDS 30)

Additional Information

- Present prior to injury.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.8 BETA BLOCKER

Description

Patients who report use of beta blocker medication within a 2-week time frame prior to injury.

Element Values

- Beta Blocker (Z.02)

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.9 BIPOLAR I/II DISORDER

Description

A bipolar I/II disorder diagnosis documented in the medical record.

Element Values

- Bipolar I/II Disorder (NTDS 39)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The minimum required written documentation to report is "bipolar" or equivalent.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.10 BLEEDING DISORDER

Description

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

Element Values

- Bleeding Disorder (NTDS 4)

Additional Information

- Present prior to injury.
- Examples include Factor V Leiden, Hemophilia, thrombocytopenia, and von Willebrand Disease.
- Exclude unspecified bleeding disorders and sickle cell disease.

Resources

- Orientation

Codebook

Source: American Society of Hematology 2015, MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.11 CEREBROVASCULAR ACCIDENT (CVA)

Description

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

Element Values

- Cerebrovascular Accident (NTDS 10)

Additional Information

- Present prior to injury.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.12 CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Description

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used but are now included within the COPD diagnosis.

EXCLUDE:

- Patients whose only pulmonary disease is asthma.
- Patients with diffuse interstitial fibrosis or sarcoidosis.

Element Values

- Chronic Obstructive Pulmonary Disease (NTDS 23)

Additional Information

- Reporting criteria (1 or more required)
  - Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs])
  - Hospitalization in the past for treatment of COPD
  - Requires chronic scheduled or prn bronchodilator therapy with oral or inhaled agents
  - A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing
- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS, World Health Organization 2019
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.13 CHRONIC RENAL FAILURE

Description

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

Element Values

- Chronic Renal Failure (NTDS 9)

Additional Information

- Present prior to injury.
- Exclude patients who previously required dialysis or filtration but are not actively requiring dialysis or filtration.

Resources

- Orientation

Codebook

Source: NSQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.14 CIRRHOSIS

Description

Cirrhosis is the replacement of normal liver tissue with non-living scar tissue related to other liver diseases. Must have documentation in the medical record of cirrhosis, which might also be referred to as end-stage liver disease.

EXCLUDE

- Patients who no longer have cirrhosis due to a successful liver transplant.

Element Values

- Cirrhosis (NTDS 25)

Additional Information

- Present prior to injury.
- A diagnosis of cirrhosis, or documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.
- Documentation in the medical record may include CHILD or MELD scores that support evidence of cirrhosis.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.15 CONGESTIVE HEART FAILURE

Description

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

Element Values

- Congestive Heart Failure (NTDS 7)

Additional Information

- Present prior to injury.
- To be included, this condition must be noted in the medical record as CHF, congestive heart failure, pregnancy-induced congestive heart failure, heart failure, HF (i.e., HFrEF, HFpEF), or pulmonary edema with onset or increasing symptoms 30 days prior to injury. The 30-day interval criterion applies only to pulmonary edema.
- Common manifestations are:
    - Abnormal limitation in exercise tolerance due to dyspnea or fatigue
    - Orthopnea (dyspnea on lying supine)
    - Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
    - Increased jugular venous pressure
    - Pulmonary rales on physical examination
    - Cardiomegaly
    - Pulmonary vascular engorgement

Resources

- American College of Cardiology
- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.16 CURRENT SMOKER

Description

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

EXCLUDE:

- Patients who smoke cigars, pipes, use smokeless tobacco (chewing tobacco or snuff) or e-cigarettes.

Element Values

- Current Smoker (NTDS 8)

Additional Information

- Present prior to injury.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.17 CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Description

A patient who is currently receiving chemotherapy treatment for cancer.

EXCLUDE:

- Treatment consisting solely of hormonal therapy or cell cycle inhibitors.

Element Values

- Chemotherapy for Cancer (NTDS 5)

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 lymphomas, leukemia, and multiple myeloma.

Resources

- Drug search
- Therapy types
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.18 DEMENTIA

Description

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

Element Values

- Dementia (NTDS 26)

Additional Information

- Present prior to injury.
- A diagnosis of dementia, including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease), or vascular dementia, must be documented in the patient's medical record.
- The minimum required written documentation to report is "dementia" or equivalent.

Resources

- Orientation

Codebook

Source: MTQIP, National Institute on Aging December 2017, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.19 DIABETES MELLITUS

Description

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

INCLUDE:

- Patients with documented pre-diabetes requiring parenteral insulin or an oral hypoglycemic agent.

EXCLUDE:

- Patients with diabetes is controlled by diet alone.
- Patients with documentation reporting the patient has not been taking medication.

Element Values

- Diabetes Mellitus (NTDS 11)

Additional Information

- Present prior to injury.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.20 DIRECT THROMBIN INHIBITOR

Description

Patients who report use of direct thrombin inhibitor class medication within a 2-day time frame prior to injury.

Element Values

- Direct Thrombin Inhibitor (Z.04)

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.21 DISSEMINATED CANCER

Description

Cancer that has spread to one site 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.

INCLUDE:

- Acute Lymphocytic Leukemia (ALL)
- Acute Myelogenous Leukemia (AML)
- Stage IV Lymphoma.

EXCLUDE:

- Chronic Lymphocytic Leukemia (CLL)
- Chronic Myelogenous Leukemia (CML)
- Stages I through III Lymphoma
- Multiple Myeloma

Element Values

- Disseminated Cancer (NTDS 12)

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.

Resources

- Examples
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.22 FACTOR XA INHIBITOR

Description

Patients who report use of a factor Xa inhibitor class medication within a 2-day time frame prior to injury.

Element Values

- Factor Xa Inhibitor (Z.05)

Additional Information

Resources

- Drug search
- Examples
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.23 FUNCTIONALLY DEPENDENT HEALTH STATUS

Description

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

INCLUDE:

- Cane use (device = cane, ADL = walking).
- Chronic home oxygen use (device = oxygen, ADL = walking).

EXCLUDE:

- Dentures, glasses, hearing aids, or prosthetic limbs as these devices or tools are used but not necessarily ADL dependent.
- LVADs, intrathecal pain pumps, pacemakers, and equivalent implanted devices used for physiologic limitations.

Element Values

- Functionally Dependent Health Status (NTDS 15)

Additional Information

- Present prior to injury.
- Activities of daily living include bathing, feeding, dressing, toileting, and walking.
- Report 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.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.24 HYPERTENSION

Description

History of persistently elevated blood pressure requiring antihypertensive medication.

EXCLUDE:

- If documentation reports medication noncompliance.
- Hypertension controlled only with diet or exercise.

Element Values

- Hypertension (NTDS 19)

Additional Information

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

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.25 MAJOR DEPRESSIVE DISORDER

Description

A major depressive disorder diagnosis documented in the medical record.

Element Values

- Major Depressive Disorder (NTDS 40)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The minimum required written documentation to report is "depression" or equivalent.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.26 MYOCARDIAL INFARCTION

Description

The history of a non-Q-wave or a Q-wave myocardial infarction in the six months prior to injury.

Element Values

- Myocardial Infarction (NTDS 34)

Additional Information

- Present prior to injury.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.27 OTHER

Description
Enter other chronic co-morbid conditions.

Element Values
- Other (NTDS 1)

Additional Information
- Present prior to injury.

Resources
- Orientation

Codebook
Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.28 OTHER MENTAL/PERSONALITY DISORDERS

Description

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

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

Element Values

- Other Mental/Personality Disorders (NTDS 41)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The minimum required written documentation to report is disorder type (i.e., "anxiety", "antisocial", "personality disorder") or equivalent.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.29 PERIPHERAL ARTERIAL DISEASE (PAD)

Description

The narrowing or blockage of the vessels that carry blood from the heart to the legs. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms.

INCLUDE:

- Peripheral vascular disease (PVD) which is used interchangeably with PAD unless vein-only disease is specified.

EXCLUDE:

- Disease processes not caused by atherosclerosis, such as Raynaud's and Buerger's disease.
- Disease processes not in the peripheral vasculature, such as coronary artery disease.

Element Values

- Peripheral Arterial Disease (NTDS 35)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.

Resources

- Orientation

Codebook

Source: CDC 2014 Fact Sheet, MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.30 POST-TRAUMATIC STRESS DISORDER

Description

A post-traumatic stress disorder diagnosis documented in the medical record.

Element Values

- Post-Traumatic Stress Disorder (NTDS 42)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The minimum required written documentation to report is "PTSD" or equivalent.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.31 PREGNANCY

Description

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

Element Values

- Pregnancy (NTDS 38)

Additional Information

- Present prior to arrival at your center.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.32 SCHIZOAFFECTIVE DISORDER

Description

A schizoaffective disorder diagnosis documented in the medical record.

Element Values

- Schizoaffective Disorder (NTDS 43)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The minimum required written documentation to report is "schizoaffective" or equivalent.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.33 SCHIZOPHRENIA

Description

A schizophrenia diagnosis documented in the medical record.

Element Values

- Schizophrenia (NTDS 44)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.34 STATIN

Description

Patients who report use of statin-class medication within a 2-week time frame prior to injury.

Element Values

- Statin (Z.03)

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.35 STEROID USE

Description

Regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition.

Element Values

- Steroid Use (NTDS 24)

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 or corticosteroids administered by inhalation or rectally.

Resources

- Drug search
- Orientation

Codebook

Source: NSQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.36 SUBSTANCE USE DISORDER

Description

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

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

Element Values

- Substance Abuse Disorder (NTDS 36)

Additional Information

- Present prior to injury.
- Only report on patients ≥ 15 years of age.
- The null value "Not Applicable" must be reported for patients < 15 years of age.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥ 15 years of age.
- The word "disorder" is not required to be present for capture.
- Include patients who have a positive drug screen for a non-prescribed drug.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

7.37 WARFARIN

Description

Patients who report the use of Coumadin (warfarin) within a 5-day time frame prior to injury.

Element Values

- Warfarin (D.02)

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_COMORCODE
Type of Element: String
Length:
Report: #4

SECTION 8 - DIAGNOSES INFORMATION

8.1 ICD-10 INJURY DIAGNOSES

Description

Diagnoses related to all identified injuries.

Element Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T79.A1-T79.A9 or compatible ICD-10-CA code range.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_DCODE, A_DCODE_AS_TEXT
Type of Element: String
Length: 6
Report: #2

8.2 AIS SEVERITY

Description

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

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- The required resource is AIS 2005.
- The pre-dot code is the 6 digits preceding the decimal point in an associated AIS code.
- AIS code element output should be in the XXXXXX.X format with the pre-dot and post-dot codes in a single cell.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: A_AISCODES, A_AISCODE_AS_TEXT
Type of Element: Numeric, String
Length: 8
Report: #3

8.3ISS

Description

Calculated injury severity score from the trauma registry.

Element Values

- Relevant value for data element.

Additional Information

- Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis), and External). The 3 most severely injured body regions have their AIS score squared and added together to produce the ISS. Only the highest AIS score in each body region is used.
- The ISS takes values from 0 to 75.
- If an injury is assigned an AIS of 6 (unsurvivable injury), the ISS is automatically assigned to 75.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_ISS
Type of Element: Numeric
Length: 2
Report: #1

8.4 NISS

Description

Calculated new injury severity score from the trauma registry.

Element Values

- Relevant value for data element.

Additional Information

- Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis), and External). The 3 highest AIS scores, regardless of regions, are squared and added together to produce the nISS.
- The nISS takes values from 0 to 75.
- If an injury is assigned an AIS of 6 (unsurvivable injury), the nISS is automatically assigned to 75.

Resources

- Orientation

Codebook

Source:
Data Base Column Name: NISS
Type of Element: Numeric
Length: 2
Report: #1

8.5 MAX HEAD/NECK AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the head/neck region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- Head or neck injuries include injury to the brain or cervical spine, skull, or cervical spine fractures.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_HN
Type of Element: Numeric
Length: 2
Report: #1

8.6 MAX FACE AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the face region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- Facial injuries include those involving mouth, ears, nose, and facial bones.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_FAC
Type of Element: Numeric
Length: 2
Report: #1

8.7 MAX CHEST AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the chest region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- Chest injuries include all lesions to internal organs.
- Chest injuries also include those to the diaphragm, rib cage, and thoracic spine.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_CHS
Type of Element: Numeric
Length: 2
Report: #1

8.8 MAX ABDOMEN OR PELVIC CONTENTS AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the abdomen region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- Abdominal or pelvic contents injuries include all lesions to internal organs.
- Lumbar spine lesions are included in the abdominal or pelvic region.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_ABD
Type of Element: Numeric
Length: 2
Report: #1

8.9 MAX EXTREMITY OR PELVIC GIRDLE AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the extremity region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- Injuries to the extremities or the pelvic or shoulder girdle include sprains, fractures, dislocations, and amputations, except for the spinal column, skull, and rib cage.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_EXT
Type of Element: Numeric
Length: 2
Report: #1

8.10 MAX EXTERNAL AIS

Description

Maximum severity value of AIS from 0-6 of individual injuries as defined by the Abbreviated Injury Scale for all injuries in the external region.

Element Values

1. Minor Injury
2. Moderate Injury
3. Serious Injury
4. Severe Injury
5. Critical Injury
6. Maximum Injury, Virtually Unsurvivable
9. Not Possible to Assign

Additional Information

- External injuries include lacerations, contusions, abrasions, and burns, independent of their locations on the body surface.

Resources

- Orientation

Codebook

Source: AAAM
Data Base Column Name: USRAIS_ST
Type of Element: Numeric
Length: 2
Report: #1

SECTION 9 - HOSPITAL EVENTS

9.1 INTRODUCTION

Description

Any medical complication that occurred during the patient's stay at your hospital.

Element Values

- Relevant value for data element.

Additional Information

- The patient's stay begins on arrival to the emergency department.
- Do not include reported complications that are present prior to arrival. For example, a patient arrives with a urinary tract infection as indicated by symptoms present in documentation obtained on arrival and a culture obtained on arrival.
- Do not report contaminants that did not require treatment for infectious events. For example, a patient has a BAL or blood culture that demonstrates contaminant, and therapy is not provided. If a provider documents a contaminant, but treatment is provided, the event is reported.
- For hospitals with an inpatient hospice service/unit without transition indicators in the EMR (e.g., new encounter/visit number, discharge order, discharge summary, new admit order, new hospice service assignment, new hospice-specific attending provider, etc.) to signal the end of the patient's stay, the end of stay occurs when the acute phase of care ends. This does not include comfort care status during the acute phase of care or transfer to medicine services during the acute phase of care.
- The null value "Not Applicable" should be used for patients with no complications.
- Includes ED hold, ED boarded, or similar status patients.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: Not applicable
Type of Element: Not applicable
Length: Not applicable
Report: #6

9.2 COMPLICATION CODE

Description

All corresponding codes provided for complications.

Element Values

- Relevant value for data element.

Additional Information

- Retired NTDS variable codes are indicated below the variable for variables that the collaborative continues to report.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length: 4
Report: #6

9.3 COMPLICATION DATE

Description

The corresponding date when the complication was first recognized.

Element Values

- Relevant value for data element.

Additional Information

- Recognition of the condition is based on satisfying the criteria listed below.
- The specific term describing the condition does not necessarily have to be identified in the progress notes.
- Example: A progress note states that the patient's incision was red with purulent drainage, necessitating opening of the incision by staple removal. This is a positive result for superficial incisional SSI regardless if the note specifically mentions a wound infection.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_COMPOCDT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #6

9.4 ABDOMINAL COMPARTMENT SYNDROME

Description

Defined as a condition in which there is swelling and sudden increase in pressure within the abdominal space (a fascial compartment) that presses on and compromises blood vessels and end-organ function.

Element Values

- Abdominal Compartment Syndrome (NTDS 2)

Additional Information

- Alterations typically occur to the respiratory mechanism, hemodynamic parameters, and renal perfusion.
- Report if the abdomen must be opened or a percutaneous drain placed to lower the intra-abdominal pressure and relieve end-organ dysfunction.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.5 ABDOMINAL FASCIA LEFT OPEN

Description

The abdominal wall fascia was left open for any reason following the first exploratory laparotomy.

Element Values

- Abdominal Fascia Left Open (NTDS 3)

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.6 ACUTE KIDNEY INJURY

Description

A patient who did not require chronic renal replacement therapy prior to injury who has worsening renal dysfunction after injury requiring renal replacement therapy.

Element Values

- Acute Kidney Injury (NTDS 4)

Additional Information

- If the patient or family refuses treatment (e.g., dialysis), the condition is still considered present if a combination of renal function and urine output criteria are present.
    - Renal function criteria: Increase creatinine x 3 or GFR decrease > 75%.
    - Urine output criteria: Urine output < 0.3ml/kg/hr. x 24 hr. or anuria x 12 hrs.
- Exclude renal replacement therapy for the sole indication of drug clearance.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.7 ACUTE RENAL INSUFFICIENCY

Description

The reduced capacity of the kidney to perform its function as evidenced by a rise in creatinine of >2 mg/dl from baseline value, but with no requirement for dialysis.

Element Values

- Acute Renal Insufficiency (MTQIP 101)

Additional Information

- Assume a baseline value of 1.0 mg/dl in the absence of additional information regarding the patient's pre-injury renal function.
- If continued decline in renal function meeting the criteria for acute kidney injury, only report acute kidney injury.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.8 ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Description

Timing	Within 1 week of known clinical insult or new or worsening respiratory symptoms
Chest imaging	Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules
Origin of edema	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if one of the following risk factors are not present. Common risk factors: non-pulmonary sepsis, major trauma (ISS ≥ 20), pneumonia, pulmonary contusion, aspiration of gastric contents, non-cardiogenic shock, drug overdose, multiple transfusions, transfusion-associated acute lung injury (TRALI), pancreatitis, inhalation injury, pulmonary vasculitis, drowning, severe burns.
Oxygenation	Pa02/Fi02 ≤ 300 with PEEP or CPAP ≥ 5 cm H20

Element Values

- Acute Respiratory Distress Syndrome (NTDS 5)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- P/F Ratio Calculator
- Orientation

Codebook

Source: New Berlin 2012, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.9 ALCOHOL WITHDRAWAL SYNDROME

Description

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

Element Values

- Alcohol Withdrawal Syndrom (NTDS 36)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- Orientation

Codebook

Source: NTDS, 2019 World Health Organization (WHO)
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.10 C. DIFF COLITIS

Description

Defined as one of the following:

- Diarrhea plus stool test positive for presence of toxigenic C. difficile or its toxins.
- Colonoscopy findings demonstrating pseudomembranous colitis.
- Histopathologic findings demonstrating pseudomembranous colitis.

Element Values

- Yes (Y)
- No (N)

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_C_DIFF
Type of Element: String
Length:
Report: #1

9.11 CARDIAC ARREST WITH CPR

Description

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

INCLUDE:

- Patients who, after arrival at your hospital, had an episode of cardiac arrest evaluated by hospital personnel and received compressions or defibrillation or cardioversion, or cardiac pacing to restore circulation.

EXCLUDE:

- Patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.

Element Values

- Cardiac Arrest with CPR (NTDS 8)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Cardiac arrest must be documented in the patient's medical record.
- Enter date and location of CPR or similar advanced measures (e.g., open cardiac massage in the procedures section).

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.12 CATHETER-ASSOCIATED URINARY TRACT INFECTION

Description

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 > 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.

Patient must meet 1, 2, and 3 below:

1. Patient has an indwelling urinary catheter in place for more than 2 consecutive days in an inpatient location on the date of event AND was either:
    a. Present for any portion of the calendar day on the date of event, OR
    b. Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    a. Fever (>38C)
    b. Suprapubic tenderness
    c. Costovertebral angle pain or tenderness
    d. Urinary urgency
    e. Urinary frequency
    f. Dysuria
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacterium ≥10^5 CFU/ml.

Element Values

- Catheter-Associated Urinary Tract Infection (NTDS 33)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Only report patients who meet CDC NHSN Manual CAUTI Criterion SUTI 1a.
- Includes ED hold, ED boarded, or similar status patients.

Resources

- CDC NHSN Manual, Chapter 7
- Orientation

Codebook

Source: CDC, NTDS

Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.13 CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION

Description
A laboratory-confirmed bloodstream infection (LCBI) where a 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.

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.

CDC Criterion LCBI 2:
Patient has at least one of the following signs or symptoms: fever (>38C), 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.)

Element Values

- Central Line-Associated Bloodstream Infection (NTDS 34)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Only report patients who meet CDC NHSN Manual CLABSI Criterion LCBI 1 or LCBI 2.
- Criterion elements must occur within the Infection Window Period, the 7-day time period, which includes the reporting date of the positive blood, the 3 calendar days before, and the 3 calendar days after.

Resources

- CDC NHSN Manual, Chapter 4
- Orientation

Codebook

Source: CDC, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.14 DEEP INCISIONAL SURGICAL SITE INFECTION

Description

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

AND

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

AND

Patient has at least one of the following:

a. purulent drainage from the deep incision.
b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed AND patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.
c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

Comments

There are two specific types of deep incisional SSIs:

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

Selected NHSN Operative Procedures Table

30-day Surveillance	
Operative Procedure	Operative Procedure
Abdominal aortic aneurysm repair	Laminectomy
Limb amputation	Liver transplant

Appendix surgery	Neck surgery
Shunt for dialysis	Kidney surgery
Bile duct, liver or pancreatic	Ovarian surgery
Carotid endarterectomy	Prostate surgery
Gallbladder surgery	Rectal surgery
Colon surgery	Small bowel surgery
Cesarean section	Spleen surgery
Gastric surgery	Thoracic surgery
Heart transplant	Thyroid and/or parathyroid
Abdominal hysterectomy	Vaginal hysterectomy
Kidney transplant	Exploratory Laparotomy
90-day Surveillance	
Operative Procedure	
Breast surgery	
Cardiac surgery	
Coronary artery bypass graft with both chest and donor site incisions	
Coronary artery bypass graft with chest incision only	
Craniotomy	
Spinal fusion	
Open reduction of fracture	
Herniorrhaphy	
Hip prosthesis	
Knee prosthesis	
Pacemaker surgery	
Peripheral vascular bypass surgery	
Ventricular shunt	

Element Values

- Deep Incisional Surgical Site Infection (NTDS 12)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- CDC NHSN Manual, Chapter 9
- CDC FAQ SSI Events
- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.15 DEEP VEIN THROMBOSIS (DVT)

Description

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

Element Values

- Deep Vein Thrombosis (NTDS 14)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- The diagnosis may be confirmed by venogram, ultrasound, or CT scan.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- Patients with DVT where the attending physician documents therapeutic anticoagulation contraindication due to bleeding risk.
- Patients with gastrocnemius or soleus vein thromboses if the patient receives treatment or contraindication is documented.
- Include if positive for DVT but expired before treatment can be instituted.
- Patients with non-extremity deep vein thromboses such as portal or internal jugular vein if the patient receives treatment or contraindication is documented.
- Exclude thrombosis of superficial veins of the upper or lower extremities, such as the cephalic or greater saphenous vein.
- Exclude patients with no documented contraindication who only receive aspirin for treatment.

Resources

- Veins of the Lower Extremity
- Veins of the Upper Extremity
- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.16 DELIRIUM

Description

Acute onset of behaviors characterized by restlessness, delusions, 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 (e.g., low sodium), medication, infection, surgery, or drug withdrawal.

OR

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

OR

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

EXCLUDE:

- Exclude patients whose delirium is due to alcohol withdrawal.

Element Values

- Delirium (NTDS 39)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.17 ENTEROCUTANEOUS FISTULA OR GI LEAK

Description

Defined as a fistula of the gastrointestinal tract (stomach, duodenum, small bowel, or large bowel) to the skin, open wound, or body cavity resulting from injury, break down/leak of GI anastomosis.

Element Values

- Enterocutaneous Fistula (NTDS 4005, 4001)

Additional Information

- This is typically documented in the patient physical exam or by radiologic study with presence of leakage of gastrointestinal contents or contrast.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.18 EXTREMITY COMPARTMENT SYNDROME

Description

Documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndrome usually involves the leg but can also occur in the forearm, arm, thigh, and shoulder.

Element Values

- Extremity Compartment Syndrome (NTDS 15)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Report as a complication if it is originally missed leading to late recognition, a need for late intervention, and has threatened limb viability.
- Exclude if a fasciotomy is performed prophylactically without evidence of elevated compartment pressures (> 25mmHg).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.19 MYOCARDIAL INFARCTION

Description

An acute myocardial infarction (including NSTEMI type II) must be noted with documentation ECG changes indicative of an acute MI

AND

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

AND

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

Element Values

- Myocardial Infarction (NTDS 18)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.20 ORGAN/SPACE SURGICAL SITE INFECTION

Description

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

AND

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. organism(s) are identified from an aseptically obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

meets at least one criterion for a specific organ/space infection site listed in the Specified Sites of an Organ/Space SSI. These criteria are found in the Surveillance Descriptions for Specific Types of Infections chapter.

Specified Sites of an Organ/Space SSI

Site	Site
Osteomyelitis	Other infections of the
Breast abscess mastitis	Mediastinitis
Myocarditis or pericarditis	Meningitis or ventriculitis
Disc space	Oral cavity (mouth, tongue, or
Ear, mastoid	Other infections of the male or female reproductive tract
Endometritis	Periprosthetic Joint Infection
Endocarditis	Spinal abscess without
Eye, other than	Sinusitis
GI tract	Upper respiratory tract
Hepatitis	Urinary System Infection
Intra-abdominal, not	Arterial or venous infection
Intracranial, brain abscess	Vaginal cuff
Joint or bursa	

Element Values

- Organ/Space Surgical Site Infection (NTDS 19)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- An empyema is the result of accumulation or undrained fluid within the pleural cavity that becomes purulent. Enter "YES" for patients that had a chest tube placed and then developed an empyema that required management with placement of a new chest tube (empyema tube), VATS drainage, or thoracentesis with positive culture.

Resources

- CDC NHSN Manual, Chapter 9
- CDC FAQ SSI Events
- Orientation

Codebook

Source: CDC, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.21 OSTEOMYELITIS

Description

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organism(s) identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least two of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage*

And at least one of the following:

a. organism(s) identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.
b. imaging test evidence suggestive of infection (for example, x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation, specifically, physician documentation of antimicrobial treatment for osteomyelitis.

*With no other recognized cause

Element Values

- Osteomyelitis (NTDS 29)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- CDC NHSN Manual, Chapter 17-6
- Orientation

Codebook

Source: CDC, MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT

Type of Element: String
Length:
Report: #6

9.22 OTHER

Description

Report other complications post-injury present in physician documentation and requiring treatment, but not on NTDS list.

Element Values

- Other (NTDS 1)

Additional Information

- The entry "Not applicable" indicates no complications present at all.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.23 PNEUMONIA

Description

Patients with evidence of pneumonia that develops during hospitalization. Patients with pneumonia must meet at least one of the following two criteria:

Criterion 1

- Bacterial or Filamentous Fungal Pathogens (Algorithm PNU2)
- Viral, Legionella, and other Bacterial Pneumonias (Algorithm PNU2)
- Immunocompromised Patients (Algorithm PNU3)

Criterion 2

Patient meets criteria for Ventilator-Associated Pneumonia (report under both VAP and Pneumonia).

Element Values

- Pneumonia (NTDS 20)

Additional Information

- If no quantitative culture is performed, report if the culture is positive.

Resources

- CDC NHSN Excluded Organisms, Chapter 6-2
- CDC NHSN Immunocompromised Patients, Chapter 6-13
- CDC NHSN Manual, Chapter 6
- Orientation

Codebook

Source: MTQIP, CDC
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.24 PRESSURE ULCER

Description

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

Element Values

- Pressure Ulcer (NTDS 37)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Includes obscured full-thickness skin and tissues loss (NPUAP Unstageable).
- Excludes intact skin with non-blanching redness (NPUAP Stage 1), which is considered reversible tissue injury.
- Excludes any stage pressure ulcer present on arrival that progresses during hospital stay to a greater NPUAP stage.
- Excludes medical device-related mucosal membrane pressure injury.

Resources

- NPUAP Pressure Injury Stages
- Orientation

Codebook

Source: NPUAP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.25 PULMONARY EMBOLISM

Description

A lodging of a blood clot in the 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.

INCLUDE:

- Include segmental PE's.
- Include pulmonary imaging positive for fat embolism.

EXCLUDE:

- Exclude subsegmental PE's.

Element Values

- Pulmonary Embolism (NTDS 21)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.26 SEPSIS

Description

Sepsis is life-threatening organ dysfunction due to a dysregulated host response to infection. Septic shock is defined as a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities substantially increase mortality. The baseline SOFA score should be assumed to be zero unless the patient is known to have preexisting (acute or chronic) organ dysfunction before the onset of infection.

Presence of infection

1. Culture-confirmed infection

AND

Sepsis Quick Sequential Organ Failure Criteria (qSOFA) – 2 or more of the following are required:

1. Altered mentation (GCS < 15)
2. Systolic blood pressure ≤ 100 mmHg
3. Respiratory rate ≥ 22 breaths/min

OR

Septic Shock - all required

1. Persistent hypotension requiring vasopressors to maintain MAP ≥ 65 mmHg
2. Serum lactate level >2 mmol/L (18 mg/dL) despite adequate volume resuscitation

Element Values

- Sepsis (NTDS 32)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- Criterion inclusion timeframe: 48 hours before and up to 24 hours after onset of infection

Resources

- SCCM Sepsis 3
- Orientation

Codebook

Source: NTDS, SCCM
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.27 STROKE/CVA

Description

A focal or global neurological deficit of rapid onset and **NOT** present on admission.

- Duration of neurological deficit ≥24 h

AND

The patient must have at least one of the following symptoms:

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

OR

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

AND

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

AND

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

Element Values

- Stroke/CVA (NTDS 22)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- 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.

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.28 SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Description

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

Involves only skin and subcutaneous tissue of the incision

AND

Patient has at least one of the following:

a. purulent drainage from the superficial incision.
b. organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
c. Superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture-based testing is not performed. **AND** Patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture-based test that has a negative finding does not meet this criterion.
d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

** 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 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)

Element Values

- Superficial Incisional Surgical Site Infection (NTDS 38)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.

Resources

- CDC NHSN Manual, Chapter 9
- CDC NHSN Operative Procedures, Chapter 9-1
- CDC NHSN Exclusions, Chapter 9-9
- CDC FAQ SSI Events
- Orientation

Codebook

Source: CDC, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.29 UNPLANNED ADMISSION TO ICU

Description

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

INCLUDE:

- Patients who required ICU care due to an event that occurred during surgery or in the PACU.

EXCLUDE:

- Patients with a planned post-operative ICU stay.

Element Values

- Unplanned Admission to ICU (NTDS 31)

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.30 UNPLANNED INTUBATION

Description

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

Element Values

- Unplanned Intubation (NTDS 25)

Additional Information

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

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.31 UNPLANNED VISIT TO THE OPERATING ROOM

Description

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

EXCLUDE:

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

Element Values

- Unplanned Visit to OR (NTDS 40)

Additional Information

- Unplanned is defined as an acute clinical deterioration requiring operative intervention.
- Non-urgent is defined as a non-life-threatening procedure that could be deferred.
- Staged is defined as an operation undertaken in two or more separate parts, with a lull between the two stages.
- Incidental finding is defined as the discovery of a medical condition detected by CT, MRI, or other imaging modality performed for an unrelated reason.
- 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.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.32 VENTILATOR-ASSOCIATED PNEUMONIA

Description

A pneumonia where the patient is on mechanical ventilation for > 2 consecutive 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.

AND

- Bacterial or Filamentous Fungal Pathogens (VAP Algorithm PNU2)
- Viral, Legionella, and other Bacterial Pneumonias (VAP Algorithm PNU2)
- Immunocompromised Patients (VAP Algorithm PNU3)

Element Values

- Ventilator-Associated Pneumonia (NTDS 35)

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- If no quantitative culture is performed, report if the culture is positive.

Resources

- CDC NHSN Excluded Organisms, Chapter 6-2
- CDC NHSN Immunocompromised Patients, Chapter 6-13
- CDC NHSN Manual, Chapter 6
- Orientation

Codebook

Source: CDC, MTQIP, NTDS
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

9.33 WOUND DISRUPTION

Description

Separation of the layers of a surgical wound, which may be partial or complete, with disruption of the fascia.

Element Values

- Wound Disruption (NTDS 26)

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: A_TCODE, A_TCODE_AS_TEXT
Type of Element: String
Length:
Report: #6

SECTION 10 - OUTCOME INFORMATION

10.1 TOTAL ICU LENGTH OF STAY

Description

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

Element Values

- Relevant value for data element.

Additional Information

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

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

I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: ICUDAYS
Type of Element: Numeric
Length: 6
Report: #1
Validation Range: +/- 1 day

10.2 TOTAL VENTILATOR DAYS

Description

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

Element Values

- Relevant value for data element.

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 days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping ventilator episode are recorded in the patient's chart.
- At no time should the Total Vent Days exceed the hospital LOS.
- The null value "Not Known/Not Recorded" is reported if any dates are missing.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above description.

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

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
	01/02/11	18:00	01/02/11	20:00	2 days (patient was on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)

Resources

- Orientation

Codebook

Source: NTDS
Data Base Column Name: VSUP_DAYS
Type of Element: Numeric
Length: 3
Report: #1
Validation Range: +/- 1 day

10.3 HOSPITAL DISCHARGE DISPOSITION

Description

The disposition of the patient when discharged from the hospital.

Element Values

1. Discharged/Transferred to a short-term general hospital for inpatient care
2. Discharged/Transferred to an Intermediate Care Facility (ICF)
3. Discharged/Transferred to home under care of organized home health service
4. Left against medical advice or discontinued care
5. Deceased/Expired
6. Discharged to home or self-care (routine discharge)
7. Discharged/Transferred to Skilled Nursing Facility (SNF)
8. Discharged/Transferred to hospice care (home hospice or hospice facility)
10. Discharged/Transferred to court/law enforcement
11. Discharged/Transferred to inpatient rehab or designated unit (acute rehabilitation or subacute rehabilitation)
12. Discharged/Transferred to Long Term Care Hospital (LTCH, LTAC or Select Specialty)
13. Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
14. Discharged/Transferred to another type of institution not defined elsewhere

Additional Information

- Element values based upon UB-04 disposition coding.
- Element value = 6, "home" refers to the patient's current place of residence (e.g., prison, Child Protective Services etc.).
- Disposition to any other non-medical facility should be coded as Element Value "6. Discharged to home or self-care (routine discharge)."
- Disposition to any other medical facility should be coded as Element Value "14. Discharged/Transferred to another type of institution not defined elsewhere."
- The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 4, 5, 6, 9, 10, or 11.
- Hospital Discharge Dispositions which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Discharge Dispositions.
- Report the actual disposition of the patient as arranged and documented by discharge planning or case management at time of discharge. If no discharge planning or case management provided, report the final disposition order.

Resources

- CMS Clarification of Discharge Status Codes
- Orientation

Codebook

Source: CMS, MTQIP, NTDS
Data Base Column Name: HOSPDISP, HOSPDISP_AS_TEXT
Type of Element: Numeric, Character
Length: 30
Report: #1
Validation Range: Option 7 or 14 will be accepted for ECF disposition

10.4 HOSPITAL DISCHARGE DATE

Description

The date the patient was discharged from the hospital.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is Element Value "5. Deceased/Expired," then the Hospital Discharge Date is the date of death as indicated on the patient's death certificate.
- For hospitals with an inpatient hospice service/unit without transition indicators in the EMR (e.g., new encounter/visit number, discharge order, discharge summary, new admit order, new hospice service assignment, new hospice specific attending provider, etc.) to signal the end of the patient's stay, the hospital discharge date occurs when the acute phase of care ends. This does not include comfort care status during the acute phase of care or transfer to medicine services during the acute phase of care.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: DCDT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

10.5 HOSPITAL DISCHARGE TIME

Description

The time the patient was discharged from the hospital.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- The null value "Not Applicable" is reported if ED Discharge Disposition is 4, 5, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is Element Value "5. Deceased/Expired," then the Hospital Discharge Time is the time of death as indicated on the patient's death certificate.
- For hospitals with an inpatient hospice service/unit without transition indicators in the EMR (e.g., new encounter/visit number, discharge order, discharge summary, new admit order, new hospice service assignment, new hospice specific attending provider, etc.) to signal the end of the patient's stay, the hospital discharge time occurs when the acute phase of care ends. This does not include comfort care status during the acute phase of care or transfer to medicine services during the acute phase of care.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: DCTM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1

10.6 TOTAL DAYS IN HOSPITAL

Description

Total number of days spent in hospital.

Element Values

- Relevant value for data element.

Additional Information

- Calculated from admit and discharge date.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: HOSPDAYS
Type of Element: Numeric
Length: 4
Report: #1
Validation Range: +/- 1 day

10.7 DISCHARGE SERVICE

Description

The service that the patient was discharged from.

Element Values

1. Trauma
2. Neurosurgery
3. Orthopedics
4. General Surgery
5. Pediatric Surgery
6. Cardiothoracic Surgery
7. Burn Services
8. Emergency Medicine
9. Pediatrics
10. Anesthesiology
11. Cardiology
14. Critical Care
16. Documentation Recorder
19. ENT
20. Family Medicine
21. GI
23. Hospitalist
24. Infectious Disease
25. Internal Medicine
27. Nephrology
28. Neurology
29. Nurse Practitioner
30. Nursing
32. Ob-Gyn
34. Oncology
35. Ophthalmology
36. Oral Surgery
37. Oromaxillofacial
38. Ortho-Spine
43. Plastic Surgery
45. Pulmonary
46. Radiology
48. Respiratory Therapist
52. Thoracic Surgery
53. Trauma Resuscitation Nurse
54. Triage Nurse
55. Urology
56. Vascular Surgery
98. Other Surgical

99. Other Non-Surgical
? Unknown

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: HOSDISSERV
Type of Element: Numeric
Length:
Report: #1

10.8 DEATH LOCATION

Description

The location of patient death if death in the hospital occurred.

Element Values

- Emergency Department (ED)
- Floor (Floor)
- Intensive Care Unit (ICU)
- Operating Room (OR)
- Radiology (Radiology)

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: HODEATHLOC
Type of Element: Character
Length:
Report: #1

10.9 DEATH IN FIRST OR

Description

Report as "YES" if patient expired during first OR (emergent).

Element Values

- Yes (Y)
- No (N)

Additional Information

- OR start time (incision) must be within 12 hours of injury.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_DEATH_FIRST_OR
Type of Element: String
Length: 1
Report: #1

SECTION 11 - FINANCIAL INFORMATION

11.1 PRIMARY METHOD OF PAYMENT

Description

Primary source of payment for hospital care.

Element Values

1. Medicaid
2. Not Billed (for any reason)
3. Self-Pay
4. Private/Commercial Insurance
5. No Fault Automobile
6. Medicare
7. Other Government
8. Workers Compensation
9. Blue Cross/Blue Shield
10. Other

Additional Information

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should not be reported as Private/Commercial Insurance. These entities will remain available in your registry and will map to Private/Commercial for non-MTQIP submissions.

Resources

- Orientation

Codebook

Source: MTQIP, NTDS
Data Base Column Name: INSUR
Type of Element: Numeric
Length:

SECTION 12 - TRAUMATIC BRAIN INJURY PROCESSES OF CARE

12.1 HIGHEST GCS TOTAL

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Highest total GCS on calendar day after ED/hospital arrival.

Element Values

- Relevant value for data element.

Additional Information

- Refers to highest total GCS on calendar day after ED Hospital/Arrival to index hospital, where index hospital is the hospital abstracting the data.
- Requires review of all data sources to obtain the highest GCS total on the calendar day after ED/hospital arrival.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- If patient is intubated, then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" is reported for patients that do not meet reporting criteria.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_GCS_H
Type of Element: Numeric
Length: 2
Report: #1

12.2 HIGHEST GCS MOTOR

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Highest motor GCS on calendar day after ED/hospital arrival.

Element Values

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

Additional Information

- Refers to highest GCS motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor on calendar day after ED/hospital arrival.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. For example, the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting Highest GCS Motor, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_GCS_MR

Type of Element: Numeric
Length: 2
Report: #1

12.3 GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

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

Element Values

- Legitimate without intervention (L)
- Obstruction to eye (E)
- Chemically sedated (S)
- Intubated (T)
- Intubated and chemically paralyzed (TP)
- Not applicable (/)

Additional Information

- Refers to highest GCS assessment qualifier score on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Requires review of all data sources to obtain the highest GCS motor score on calendar day after ED/hospital arrival, which might occur after the ED phase of care.
- Identifies medical treatments given to the patient that may affect the best assessment of GCS. This element does not apply to self-medication the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Must be the assessment qualifier for the Highest GCS Total on calendar day after ED/hospital arrival.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient 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.

- The null value "Not Known/Not Recorded" is reported if reporting Highest GCS Motor 40.
- If reporting GCS Assessment Qualifier Component of Highest GCS Total, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_GCS_Q
Type of Element: String
Length: 2
Report: #1

12.4 HIGHEST GCS 40 – MOTOR

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Highest GCS 40 motor on calendar day after ED/Hospital arrival.

Element Values

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

Additional Information

- Refers to highest GCS 40 motor on calendar day after arrival to index hospital, where index hospital is the hospital abstracting the data.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- Requires review of all data sources to obtain the highest GCS motor 40 score on the calendar day after ED/Hospital arrival.
- If a patient does not have a numeric GCS 40 score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. (E.g., the chart indicates: "patient opened mouth and stuck out tongue when asked" for adult patient's, a Motor GCS 40 of 6 may be recorded, IF there is no other contradicting documentation.)
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- Report Element Value "0. Not Testable" if unable to assess (e.g., neuromuscular blockade).
- The null value "Not Known/Not Recorded" is reported if Highest GCS – Motor is reported.
- If reporting Highest GCS-40 Motor, the null value "Not Applicable" is reported if the patient is discharged from your hospital prior to the next calendar day.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: TBIGCS40MOTOR
Type of Element: Numeric
Length: 2
Report: #1

12.5 INITIAL ED/HOSPITAL PUPILLARY RESPONSE

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

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

Element Values

1. Both Reactive
2. One Reactive
3. Neither Reactive

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment.
- The provider evaluation time, staff arrived time, and similar assessment time should be used when the specified provider's note documents this assessment.
- If a patient does not have a listed element value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light", both cranial nerves II & III intact, no cranial nerve deficit, no focal deficit, or neuro exam WNL report Element Value "1. Both reactive" if there is no other contradicting documentation.
- Documentation of a "blown pupil" indicates a non-reactive pupil.
- The null value "Not Known/Not Recorded" should be reported if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- Element value "2. One reactive" must be reported for patients who have a prosthetic eye.
- The null value "Not Applicable" is reported for patients who do not meet the reporting criterion.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: PUPILLARY_RESPONSE
Type of Element: Numeric
Length: 2
Report: #1

12.6 MIDLINE SHIFT

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

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

Element Values

1. Yes
2. No
3. Not Imaged (e.g., CT scan, MRI)

Additional Information

- If there is documentation of "massive" midline shift in lieu of > 5 mm shift measurement, report Element Value "1. Yes."
- Radiological and surgical documentation from transferring facilities should be considered for this data element.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- The null value "Not Known/Not Recorded" is reported if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24 hours of any CT measuring a > 5 mm shift, report the Element Value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the Element Value "3. Not Imaged (e.g., CT scan, MRI)".

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MIDLINE_SHIFT
Type of Element: Numeric
Length: 2
Report: #1

12.7 CEREBRAL MONITOR

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Indicate the first (TBIMON1), and if applicable second (TBIMON2), and third (TBIMON3) cerebral monitors that were placed.

Element Values

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

Additional Information

- Report single cerebral monitors with multi-value uses as separate monitors. For example, if a single brain tissue oxygen monitor is placed and used as both an ICP monitor and oxygen monitor, report value 2 and 3.
- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- Must also document under procedures if ICD 10 code available.
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_CMON1, MTQIP_TBI_CMON2, MTQIP_TBI_CMON3
Type of Element: Numeric
Length: 1
Report: #1

12.8 CEREBRAL MONITOR DATE

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Date of first (MON1DATE), and if applicable, second (MON2DATE) and third (MON3DATE) cerebral monitor placement.

Element Values

- Relevant value for data element.

Additional Information

- Reported as YYYY-MM-DD.
- Report single cerebral monitors with multi-value uses as separate monitors with the same placement date.
- The null value "Not Applicable" is reported if Cerebral Monitor is Element Value "5. None".
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor date must be the date of insertion at the referring facility.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_CMON1_DT, MTQIP_TBI_CMON2_DT, MTQIP_TBI_CMON3_DT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

12.9 CEREBRAL MONITOR TIME

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Time of first (MON1TIME), and if applicable, second (MON2TIME) and third (MON3TIME) cerebral monitor was placed.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- Report single cerebral monitors with multi-value uses as separate monitors with the same placement time.
- The null value "Not Applicable" is reported if Cerebral Monitor is Element Value "5. None."
- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the cerebral monitor was placed at the referring facility, cerebral monitor time must be the time of insertion at the referring facility.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_TBI_CMON1_TM, MTQIP_TBI_CMON2_TM, MTQIP_TBI_CMON3_TM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1

12.10 REASON CEREBRAL MONITOR WITHHELD

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

The reason for withholding cerebral monitor placement.

Element Values

0. Not Known/Not Recorded
1. Decision to withhold life sustaining measures
2. Death prior to correction of coagulopathy
3. Expected to improve within 8 hours due to effects of alcohol and/or drugs
4. Operative evacuation
5. No ICP because of coagulopathy
6. Attempt made, but unsuccessful due to technical issues
7. Neurosurgical discretion

Additional Information

- Coagulopathy refers to an elevated INR or low platelet count that might occur as a result of the injury or pre-existing conditions (e.g., Coumadin).
- Requires documentation in the medical record as to why cerebral monitor was withheld by a physician.
- If no reason documented, indicate Not Known/Not Recorded.
- If cerebral monitor was placed within 8 hours of ED/hospital arrival, then code as NA.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_CWITH
Type of Element: Numeric
Length: 1
Report: #1

12.11 BETA BLOCKER TREATMENT

Reporting Criterion

Report on patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

Report patients who receive scheduled administration of parenteral or oral beta blocker medication within 48 hours after admission to the index hospital.

Element Values

- Yes (Y)
- No (N)

Additional Information

- Exclude patients who receive prn or intermittent administration of beta blocker treatment.
- Example: Patient has one or intermittent orders for metoprolol 5 mg IV Q 15 min x 3. Report as "No."

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_BETA
Type of Element: String
Length: 1
Report: #1

12.12 FIRST ED/HOSPITAL INR

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

The first INR laboratory value obtained within 24 hours of admission to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

- Relevant value for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_INR
Type of Element: Numeric (Format XX.X)
Length:
Report: #1

12.13 FIRST ED/HOSPITAL PTT

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

The first PTT or APTT laboratory value obtained within 24 hours of admission to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

- Relevant value for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_PTT
Type of Element: Numeric (Format XXX.X)
Length:
Report: #1

12.14 FIRST ED/HOSPITAL ANTI-XA ACTIVITY

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

The first anti-Xa activity laboratory value obtained within 24 hours of admission to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

- Relevant value for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_ANTI_XA
Type of Element: Numeric (Format X.XX)
Length:
Report: #1

12.15 TYPE OF FIRST THERAPY

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

All the types of therapies given within 24 hours of admission time to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

1. FFP
2. PRBC
3. PLT
4. Vitamin K
5. 4 Factor PCC (e.g., Kcentra)
6. 3 Factor PCC
7. Antifibrinolytic (e.g., TXA, aminocaproic acid)
8. Desmopressin
9. Protamine
10. Dialysis / Continuous Renal Replacement
11. Charcoal
12. Monoclonal antibody fragment (e.g., Praxbind)
13. Modified recombinant factor Xa (e.g., andexanet)
14. Other

Additional Information

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_TYPE_FFP, MTQIP_TBI_TYPE_PR_BC, MTQIP_TBI_TYPE_PLT, MTQIP_TBI_TYPE_VITK, MTQIP_TBI_TYPE_4FPCC, MTQIP_TBI_TYPE_3FPCC, MTQIP_TBI_TYPE_ANTIFB, MTQIP_TBI_TYPE_DESMO, MTQIP_TBI_TYPE_PROT, MTQIP_TBI_TYPE_HD, MTQIP_TBI_TYPE_CHAR, MTQIP_TBI_TYPE_MONAB, MTQIP_TBI_TYPE_FXA, MTQIP_TBI_TYPE_OTHER
Type of Element: Logic for each operation (1=Yes/2=No)
Length:
Report: #1

12.16 DATE OF FIRST THERAPY

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

All the associated administration dates of therapies given within 24 hours of admission time to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

- Relevant values for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_DATE_FFP, MTQIP_TBI_DATE_PR_BC, MTQIP_TBI_DATE_PLT, MTQIP_TBI_DATE_VITK, MTQIP_TBI_DATE_4FPCC, MTQIP_TBI_DATE_3FPCC, MTQIP_TBI_DATE_ANTIFB, MTQIP_TBI_DATE_DESMO, MTQIP_TBI_DATE_PROT, MTQIP_TBI_DATE_HD, MTQIP_TBI_DATE_CHAR, MTQIP_TBI_DATE_MONAB, MTQIP_TBI_DATE_FXA, MTQIP_TBI_DATE_OTHER
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1

12.17 TIME OF FIRST THERAPY

Reporting Criterion

Report on all patients on anticoagulant therapy (NTDS 31) or aspirin with at least one injury in the AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and/or scalp avulsion(s). Exclude injuries where the code itself is not included in the AIS head region of the AAAM book such as isolated asphyxiation/suffocation injuries.

Description

All the associated administration times of therapies below given within 24 hours of admission time to the index hospital, where the index hospital is the hospital abstracting the data.

Element Values

- Relevant values for data element.

Additional Information

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_TBI_TIME_FFP, MTQIP_TBI_TIME_PR_BC, MTQIP_TBI_TIME_PLT, MTQIP_TBI_TIME_VITK, MTQIP_TBI_TIME_4FPCC, MTQIP_TBI_TIME_3FPCC, MTQIP_TBI_TIME_ANTIFB, MTQIP_TBI_TIME_DESMO, MTQIP_TBI_TIME_PROT, MTQIP_TBI_TIME_HD, MTQIP_TBI_TIME_CHAR, MTQIP_TBI_TIME_MONAB, MTQIP_TBI_TIME_FXA, MTQIP_TBI_TIME_OTHER
Type of Element: Time (HH:MM Format)
Length:
Report: #1

SECTION 13 - VENOUS THROMBOEMBOLISM PROCESSES OF CARE

13.1 VENOUS THROMBOEMBOLISM PROPHYLAXIS TYPE

Reporting Criterion

Report on all patients.

Description

Type of first dose of venous thromboembolism prophylaxis or treatment administered to patient at your hospital.

EXCLUDE:

- Sequential compression devices

Element Values

5. None
6. LMWH (Dalteparin, Enoxaparin, etc.)
7. Direct Thrombin Inhibitor (Dabigatran, etc.)
8. Xa Inhibitor (Rivaroxaban, etc.)
9. Coumadin
10. Other
11. Unfractionated Heparin (UH)
50. Aspirin

Additional Information

- Must be administered, not just ordered.
- Element Value "5. None" is reported if the patient refuses venous thromboembolism prophylaxis.
- Report heparin, LMWH, direct thrombin inhibitor and Xa inhibitor class agents regardless of the indication when it is administered first.
- Report aspirin and Coumadin and 'other' agents when the indication of VTE prevention is identified in the medical record documentation.
- Exclude non-prophylactic dosing of agents, such as heparin administered for line clearance purposes.
- Use drug search for agents and dosing outside these parameters to determine class and/or indicated use.
- Venous Thromboembolism Prophylaxis Types which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Venous Thromboembolism Prophylaxis Types.

Resources

- Drug search
- Orientation

Codebook

Source: TQIP

Data Base Column Name: MTQIP_VTE_PROP_TYPE
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: (9) Coumadin and (50) Aspirin maps to (10) Other for NTDS submission. If Hospital Discharge Date and Time Order is prior to VTE Prophylaxis Date and Time, convert VTE Prophylaxis Type to "5. None" for NTDS submission.

13.2 VENOUS THROMBOEMBOLISM PROPHYLAXIS DATE

Reporting Criterion

Report on all patients.

Description

Date of administration of first dose of venous thromboembolism prophylaxis or treatment administered to patient at your hospital.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_VTE_PROP_DT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1
Vendor Mapping: If Hospital Discharge Date and Time Order is prior to VTE Prophylaxis Date and Time, convert VTE Prophylaxis Date to "Not Applicable" for NTDS submission.

13.3 VENOUS THROMBOEMBOLISM PROPHYLAXIS TIME

Reporting Criterion

Report on all patients.

Description

Time of administration of first dose of venous thromboembolism prophylaxis or treatment administered to patient at your hospital.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_VTE_PROP_TM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1
Vendor Mapping: If Hospital Discharge Date and Time Order is prior to VTE Prophylaxis Date and Time, convert VTE Prophylaxis Time to "Not Applicable" for NTDS submission.

SECTION 14 - HEMORRHAGE CONTROL PROCESSES OF CARE

14.1 PACKED RED BLOOD CELLS UNITS (0-4 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number of units of packed red blood cells administered within first 4 hours after arrival to your hospital.

EXCLUDE:

- Exclude packed red blood cells transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 unit of PRBC = 350 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hanged, and initiated, even if not completely given.
- If no packed red blood cells were given, then the units are 0 (zero).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_PR_BC_4
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.2 PACKED RED BLOOD CELLS UNITS (0-24 HOURS)

Reporting Criterion
Report on all patients.

Description
The total number of units of packed red blood cells administered within first 24 hours after arrival to your hospital.

EXCLUDE:
- Exclude packed red blood cells transfusing upon patient arrival.

Element Values
- Relevant value for data element.

Additional Information
- 1 unit of PRBC = 350 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hanged, and initiated, even if not completely given.
- If no packed red blood cells were given, then the units are 0 (zero).

Resources
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_PR_BC_24
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.3 WHOLE BLOOD UNITS (0-4 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number of units of whole blood administered within first 4 hours after arrival to your hospital.

INCLUDE:

- Cell Saver blood
- Autotransfer blood

EXCLUDE:

- Exclude whole blood transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 unit of whole blood = 450 – 525 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not the aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hung and initiated, even if not completely given.
- If no whole blood was given, then the units are 0 (zero).
- For Cell Saver or autotransfuser blood, every 500 ml of blood re-infused into the patient will equal 1 unit of whole blood. If less than 250 ml of Cell Saver blood is re-infused, enter 0.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_WHOLE_BL_4
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.4 WHOLE BLOOD UNITS (0-24 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number of units of whole blood administered within first 24 hours after arrival to your hospital.

INCLUDE:

- Cell Saver blood
- Autotransfer blood

EXCLUDE:

- Exclude whole blood transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 unit of whole blood = 450 – 525 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not the aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hung and initiated, even if not completely given.
- If no whole blood was given, then the units are 0 (zero).
- Exclude whole blood transfusing upon patient arrival.
- For Cell Saver or autotransfuser blood, every 500 ml of blood re-infused into the patient will equal 1 unit of whole blood. If less than 250 ml of Cell Saver blood is re-infused, enter 0.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_WHOLE_BL_24
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml

Cryoprecipitate 1 unit = 10 ml

14.5 PLASMA UNITS (0-4 HOURS)

Reporting Criterion
Report on all patients.

Description
The total number units of plasma (fresh frozen, thawed, or never frozen) administered within first 4 hours after arrival to your hospital.

EXCLUDE:
- Exclude plasma transfusing upon patient arrival.

Element Values
- Relevant value for data element.

Additional Information
- 1 unit of FFP = 150-400 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hung, and initiated, even if not completely given.
- If no plasma was given, then the units are 0 (zero).

Resources
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_FFP_4
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.6 PLASMA UNITS (0-24 HOURS)

Reporting Criterion
Report on all patients.

Description
The total number units of plasma (fresh frozen, thawed, or never frozen) administered within first 24 hours after arrival to your hospital.

EXCLUDE:
- Exclude plasma transfusing upon patient arrival.

Element Values
- Relevant value for data element.

Additional Information
- 1 unit of FFP = 150-400 ml
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- Count all units spiked, hung, and initiated, even if not completely given.
- If no plasma was given, then the units are 0 (zero).

Resources
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_FFP_24
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.7 PLATELETS UNITS (0-4 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number individual units (i.e., individual units within the pool) of platelets administered within first 4 hours after arrival to your hospital.

EXCLUDE:

- Exclude platelets transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 individual unit of PLT = 50 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- This blood product is pooled (grouped in batch with multiple single units).
- Count all units spiked, hung, and initiated, even if not completely given.
- If no platelets were given, then the units are 0 (zero).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_PLT_4
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.8 PLATELETS UNITS (0-24 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number individual units (i.e., individual units within the pool) of platelets administered within first 24 hours after arrival to your hospital.

EXCLUDE:

- Exclude platelets transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 individual unit of PLT = 50 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- This blood product is pooled (grouped in batch with multiple single units).
- Count all units spiked, hung, and initiated, even if not completely given.
- If no platelets were given, then the units are 0 (zero).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_PLT_24
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.9 CRYOPRECIPITATE UNITS (0-4 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number of individual units ((i.e., individual units within the pool) of cryoprecipitate administered within first 4 hours after arrival to your hospital.

EXCLUDE:

- Exclude cryoprecipitate transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 individual unit of cryoprecipitate = 10 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- This blood product is pooled (grouped in batch with multiple single units).
- Count all units spiked, hung, and initiated, even if not completely given.
- If no cryoprecipitate was given, then the units is 0 (zero).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_CRYO_4
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.10 CRYOPRECIPITATE UNITS (0-24 HOURS)

Reporting Criterion

Report on all patients.

Description

The total number of individual units ((i.e., individual units within the pool) of cryoprecipitate administered within first 24 hours after arrival to your hospital.

EXCLUDE:

- Exclude cryoprecipitate transfusing upon patient arrival.

Element Values

- Relevant value for data element.

Additional Information

- 1 individual unit of cryoprecipitate = 10 ml.
- Unit conversion provided for reference purposes only. Count by units if available.
- If converting a volume to a unit, the individual amounts should be used not aggregated sums of all products given to avoid marginal bias.
- This blood product is pooled (grouped in batch with multiple single units).
- Count all units spiked, hung, and initiated, even if not completely given.
- If no cryoprecipitate was given, then the units is 0 (zero).

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_CRYO_24
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Conversion logic for NTDS reporting
PRBC 1 unit = 350 ml
Whole Blood 1 unit = 500 ml
Plasma 1 unit = 200 ml
Platelets 1 unit = 50 ml
Cryoprecipitate 1 unit = 10 ml

14.11 IV FLUID LITERS PRE-HOSPITAL and FIRST 4 HOURS (0-4 HOURS)

Reporting Criterion

Report on all patients transfused with ≥ 5 units packed red blood cells within first 4 hours after ED/hospital arrival.

Description

The total number of liters of IV fluid administered starting from the time of injury through 4 hours after documented arrival time of first ED.

Element Values

- Relevant value for data element.

Additional Information

- Count all bags spiked and hung, even if not completely given.
- Exclude fluids provided for medication administration.
- Crystalloid: Crystalloid IV fluids are solutions of mineral salts or other water-soluble molecules.
- Common crystalloid IV fluids include normal saline and Lactated Ringer's, D5LR, D5W and PlasmaLyte. Examples provided in table below for rounding to the nearest 1,000.
- Colloid: Colloid IV fluids contain insoluble molecules.
- Common colloids include albumin, hydroxyethyl starch (Hespan, Voluven), gelofusine.

Calculation Instructions

1. Combine similar fluid types together (i.e., albumin combined with starch, and NS combined with LR)
2. Add the total mL administered for each fluid type over 4 hours
3. Round each total to the nearest one hundred
4. Covert mL to L (see table below)
5. Add the rounded total of each fluid type together to obtain final total volume for all fluids given
6. Examples provided in table below for rounding.

Colloid		Crystalloid	
Hypertonic Saline (mL)	Albumin, Hydroxyethyl Starch, Other (mL)	Normal saline, Lactated Ringer's (mL)	MTQIP Volume (L)
0-124	0-249	0-499	0
125-249	250-499	500-999	1
250-374	500-749	1000-1499	1
375-499	750-999	1500-1999	2
500-624	1000-1249	2000-2499	2
625-749	1250-1499	2500-2999	3
750-874	1500-1749	3000-3499	3
875-999	1750-1999	3500-3999	4

1000-1124	2000-2249	4000-4499	4
1125-1249	2250-2499	4500-4999	5
1250-1374	2500-2749	5000-5499	5
1375-1499	2750-2999	5500-5999	6
1500-1624	3000-3249	6000-6499	6

Resources

- IV Fluid Calculator
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_IVF_4
Type of Element: Numeric
Length: 2
Report: #1
Validation Range: +/- 1 L

14.12 IV FLUID LITERS IN FIRST 24 HOURS (0-24 HOURS)

Reporting Criterion

Report on all patients transfused with ≥ 5 units packed red blood cells within first 4 hours after ED/hospital arrival.

Description

The total number of liters of IV fluid administered starting from the time of injury through 24 hours after documented arrival time of first ED.

Element Values

- Relevant value for data element.

Additional Information

- Count all bags spiked and hung, even if not completely given.
- Exclude fluids provided for medication administration.
- Crystalloid: Crystalloid IV fluids are solutions of mineral salts or other water-soluble molecules.
- Common crystalloid IV fluids include normal saline and Lactated Ringer's, D5LR, D5W and PlasmaLyte. Examples provided in table below for rounding to the nearest 1,000.
- Colloid: Colloid IV fluids contain insoluble molecules.
- Common colloids include albumin, hydroxyethyl starch (Hespan, Voluven), gelofusine.

Calculation Instructions

1. Combine similar fluid types together (i.e., albumin combined with starch, and NS combined with LR)
2. Add the total mL administered for each fluid type over 4 hours
3. Round each total to the nearest one hundred
4. Covert mL to L (see table below)
5. Add the rounded total of each fluid type together to obtain final total volume for all fluids given
6. Examples provided in table below for rounding.

Colloid		Crystalloid	
Hypertonic Saline (mL)	Albumin, Hydroxyethyl Starch, Other (mL)	Normal saline, Lactated Ringer's (mL)	MTQIP Volume (L)
0-124	0-249	0-499	0
125-249	250-499	500-999	1
250-374	500-749	1000-1499	1
375-499	750-999	1500-1999	2
500-624	1000-1249	2000-2499	2
625-749	1250-1499	2500-2999	3
750-874	1500-1749	3000-3499	3
875-999	1750-1999	3500-3999	4

1000-1124	2000-2249	4000-4499	4
1125-1249	2250-2499	4500-4999	5
1250-1374	2500-2749	5000-5499	5
1375-1499	2750-2999	5500-5999	6
1500-1624	3000-3249	6000-6499	6

Resources

- IV Fluid Calculator
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_IVF_24
Type of Element: Numeric
Length: 2
Report: #1
Validation Range: +/- 1 L

14.13 TRANEXAMIC ACID ADMINISTRATION TYPE (DOSE 1-3)

Reporting Criterion

Report on all patients.

Description

The administration type of each of the tranexamic acid (TXA) doses.

Element Values

1. IV drip
2. IV bolus

Additional Information

- Report up to 3 doses.
- Report ordered doses to be given over <= 1 hour as a bolus.
- Reported ordered doses to be given over multiple hours as a drip.
- Exclude doses administered via non-IV routes.
- Literature-supported administration: 1 gram loading (bolus) dose given over 10 minutes followed by an infusion (drip) of 1 gram given over 8 hours or until the bleeding stops.

Resources

- Orientation

Codebook

Source: MTQIP, CRASH-2
Data Base Column Name: MTQIP_TXA_TYPE1, MTQIP_TXA_TYPE2, MTQIP_TXA_TYPE3
Type of Element: Numeric
Length: 1
Report: #1

14.14 TRANEXAMIC ACID DOSAGE (DOSE 1-3)

Reporting Criterion
Report on all patients.

Description
The administration dosage of each of the tranexamic acid (TXA) doses.

Element Values
1. 1 gram
2. 2 grams
3. 3 grams

Additional Information
- Report up to 3 doses.
- Literature-supported administration: 1 gram loading (bolus) dose given over 10 minutes followed by an infusion (drip) of 1 gram given over 8 hours or until the bleeding stops.
- Report doses separated by nursing as single doses. Example: physician orders 1 gram IV bolus x 1. Nursing administers this dose as two 0.5-gram doses. Report 1 gram IV bolus.
- Round doses following below table.

Dose (grams)	Report (grams)
0.0 – 0.499	Unknown
0.5 – 1.499	1
1.5 – 2.499	2
2.5 – 3.499	3

Resources
- Orientation

Codebook
Source: MTQIP, CRASH-2
Data Base Column Name: MTQIP_TXA_DOSAGE1, MTQIP_TXA_DOSAGE2, MTQIP_TXA_DOSAGE3
Type of Element: Numeric
Length: 1
Report: #1

14.15 TRANEXAMIC ACID DATE (DOSE 1-3)

Reporting Criterion
Report on all patients.

Description
The administration date of each of the tranexamic acid (TXA) doses.

Element Values
- Relevant value for data element.

Additional Information
- Report up to 3 doses.
- Literature-supported administration: 1 gram loading (bolus) dose given over 10 minutes followed by an infusion (drip) of 1 gram given over 8 hours or until the bleeding stops.
- Report doses separated by nursing as single doses. Example: physician orders 1 gram IV bolus x 1. Nursing administers this dose as two 0.5-gram doses. Report 1 gram IV bolus.

Resources
- Orientation

Codebook
Source: MTQIP, CRASH-2
Data Base Column Name: MTQIP_TXA_DATE1, MTQIP_TXA_DATE2, MTQIP_TXA_DATE3
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1

14.16 TRANEXAMIC ACID TIME (DOSE 1-3)

Reporting Criterion
Report on all patients.

Description
The administration time of each of the tranexamic acid (TXA) doses.

Element Values
- Relevant value for data element.

Additional Information
- Report up to 3 doses.
- Literature-supported administration: 1 gram loading (bolus) dose given over 10 minutes followed by an infusion (drip) of 1 gram given over 8 hours or until the bleeding stops.
- Report doses separated by nursing as single doses. Example: physician orders 1 gram IV bolus x 1. Nursing administers this dose as two 0.5-gram doses. Report 1 gram IV bolus.

Resources
- Orientation

Codebook
Source: MTQIP, CRASH-2
Data Base Column Name: MTQIP_TXA_TIME1, MTQIP_TXA_TIME2, MTQIP_TXA_TIME3
Type of Element: Time (HH:MM Format)
Length:
Report: #1

14.17 TRANEXAMIC ACID PRE-HOSPITAL (DOSE 1-3)

Reporting Criterion
Report on all patients.

Description
The administration of each of the tranexamic acid (TXA) doses in the pre-hospital setting when pre-hospital date/time is not documented.

Element Values
1. Yes
2. No

Additional Information
- Report up to 3 doses.
- Only reported when the pre-hospital date/time is not documented.

Resources
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TXA_PH1, MTQIP_TXA_PH2, MTQIP_TXA_PH3
Type of Element: Numeric
Length: 1
Report: #1

14.18 LOWEST ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Reporting Criterion

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

Description

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

Element Values

- Relevant value for data element.

Additional Information

- The null value "Not Applicable" is reported for patients that do not meet the reporting criterion.
- If the patient has a cardiopulmonary arrest within 1 hour of arrival, then report BP as 0.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_L_ED_SBP
Type of Element: Numeric
Length: 3
Report: #1

14.19 ANGIOGRAPHY

Reporting Criterion

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

Description

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

EXCLUDE:

- Computerized tomographic angiography (CTA)

Element Values

1. None
2. Angiogram only
3. Angiogram with embolization
4. Angiogram with stenting
5. Angiogram with embolization and stent graft

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_ANGIO
Type of Element: Numeric
Length: 2
Report: #1
Vendor Mapping: Value (5) Angiogram with embolization maps (3) Angiogram with embolization for NTDS Submission

14.20 EMBOLIZATION SITE

Reporting Criterion

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

Description

Organ/site of embolization for hemorrhage control.

Element Values

1. Liver
2. Spleen
3. Kidneys
4. Pelvic (iliac, gluteal, obturator)
5. Retroperitoneum (lumbar, sacral)
6. Peripheral vascular (neck, extremities)
7. Aorta (thoracic or abdominal)
8. Other

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_EMB_SITE_L, MTQIP_EMB_SITE_S, MTQIP_EMB_SITE_K, MTQIP_EMB_SITE_P, MTQIP_EMB_SITE_R, MTQIP_EMB_SITE_NE
Type of Element: Logic for each region (Yes/No)
Length: 3
Report: #1

14.21 ANGIOGRAPHY DATE

Reporting Criterion

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

Description

Date the first angiogram with or without embolization was performed.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_ANGIO_DT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

14.22 ANGIOGRAPHY TIME

Reporting Criterion

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

Description

Time the first angiogram with or without embolization was performed.

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_ANGIO_TM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1
Validation Range: +/- 1 hour

14.23 SURGERY FOR HEMORRHAGE CONTROL TYPE

Reporting Criterion

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

Description

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

Element Values

1. None
2. Laparotomy
3. Thoracotomy
4. Sternotomy
5. Extremity
6. Neck
7. Mangled extremity/traumatic amputation
8. Other skin/soft tissue
9. Extraperitoneal pelvic packing

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_SURG_TYPE_L, MTQIP_SURG_TYPE_T, MTQIP_SURG_TYPE_S, MTQIP_SURG_TYPE_E, MTQIP_SURG_TYPE_N, MTQIP_SURG_TYPE_A, MTQIP_SURG_TYPE_O, MTQIP_SURG_TYPE_P
Type of Element: Logic for each operation (Yes/No)
Length: 3
Report: #1

14.24 SURGERY FOR HEMORRHAGE CONTROL DATE

Reporting Criterion

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

Description

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

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_SURG_DT
Type of Element: Date (MM/DD/YYYY Format)
Length: 8
Report: #1

14.25 SURGERY FOR HEMORRHAGE CONTROL TIME

Reporting Criterion

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

Description

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

Element Values

- Relevant value for data element.

Additional Information

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

Resources

- Orientation

Codebook

Source: TQIP
Data Base Column Name: MTQIP_SURG_TM
Type of Element: Time (HH:MM Format)
Length: 5
Report: #1

SECTION 15 - INFECTIOUS DISEASE PROCESSES OF CARE

15.1 ANTIBIOTIC DAYS

Reporting Criterion

Report on all patients.

Description

The cumulative number of days the patient received antibiotics administered intravenously at the index hospital.

Element Values

- Relevant value for data element.

Additional Information

- Calendar day is assigned to the date the administered dose was started. Do not count a dose that continues onto the next calendar day as two days.
- Each partial or full day of drug or multiple drugs should be measured as one calendar day.
- Reported in full days' increments with any partial day listed as a full day regardless of purpose of administration.
- Do not include antifungal, antiviral or antiparasitic agents.

Resources

- Drug search
- Orientation

Codebook

Source: MTQIP
Data Base Column Name: MTQIP_ABX_DAYS
Type of Element: Numeric
Length:
Report: #1
Validation Range: +/- 1 day

15.2 ANTIBIOTIC 1 TYPE

Reporting Criterion

Report on all patients with open fractures.

Description

The first IV antibiotic class administered to the patient during EMS transfer from scene through 24 hours of arrival at your hospital.

Element Values

0. None
1. Penicillin
2. Monobactam
3. Carbapenem
4. Macrolide
5. Lincosamide
6. Aminoglycoside
7. Quinolone
8. Sulfonamide
9. Tetracycline
10. Cephalosporin
11. Other

Additional Information

- Must be administered, not just ordered.
- Exclude antibiotics administered by a transferring hospital.
- Exclude antibiotics administered for indications other than open fracture.

Resources

- Antibiotic Classes
- Drug search
- Open Fracture Codebook
- Orientation

Codebook

Source: MTQIP, Resources for Optimal Care of the Injured Patient
Data Base Column Name: MTQIP_ABX_TYPE1
Type of Element: Numeric
Length: 2
Report: #1

15.3 ANTIBIOTIC 2 TYPE

Reporting Criterion

Report on all patients with open fractures.

Description

The second IV antibiotic class administered to patient during EMS transfer from scene through 24 hours of arrival at your hospital for patient's receiving combination therapy.

Element Values

1. None
2. Penicillin
3. Monobactam
4. Carbapenem
5. Macrolide
6. Lincosamide
7. Aminoglycoside
8. Quinolone
9. Sulfonamide
10. Tetracycline
11. Cephalosporin
12. Other

Additional Information

- Combination therapy is defined as the addition of an antibiotic that provides coverage against a wider spectrum of bacteria.
- Must be administered, not just ordered.
- Exclude antibiotics administered by a transferring hospital.
- Exclude antibiotics administered for indications other than open fracture.

Resources

- Antibiotic Classes
- Combination Therapy
- Drug search
- Open Fracture Codebook
- Orientation

Codebook

Source: MTQIP, Resources for Optimal Care of the Injured Patient
Data Base Column Name: MTQIP_ABX_TYPE2
Type of Element: Numeric
Length: 2
Report: #1

15.4 ANTIBIOTIC DATE

Reporting Criterion

Report on all patients with open fractures.

Description

The date of administration to patient of first IV dose of antibiotic administered to patient during EMS transfer from scene through 24 hours of arrival at your hospital.

Element Values

-

Additional Information

- Reported as MM/DD/YYYY.
- If administered during EMS transfer, report as index hospital ED/hospital arrival date to prevent negative calculations.

Resources

- Orientation

Codebook

Source: MTQIP, Resources for Optimal Care of the Injured Patient

Data Base Column Name: MTQIP_ABX_DATE

Type of Element: Date (MM/DD/YYYY Format)

Length:

Report: #1

Vendor Edit Check: Element date cannot be before ED/hospital arrival date/time.

15.5 ANTIBIOTIC TIME

Reporting Criterion

Report on all patients with open fractures.

Description

The time of administration to patient of first IV dose of antibiotic administered to patient during EMS transfer from scene through 24 hours of arrival at your hospital.

Element Values

- Relevant value for data element.

Additional Information

- Reported as HH:MM military time.
- If administered during EMS transfer, report as index hospital ED/hospital arrival time to prevent negative calculations.

Resources

- Orientation

Codebook

Source: MTQIP, Resources for Optimal Care of the Injured Patient

Data Base Column Name: MTQIP_ABX_TIME

Type of Element: Time (HH:MM Format)

Length: 5

Report: #1

Vendor Edit Check: Element date cannot be before ED/hospital arrival date/time.

SECTION 16 - OPIOID USE PROCESSES OF CARE

16.1 TABLET TYPE 1

Reporting Criterion
Report on all patients.

Description
The type of opioid tablet prescribed at discharge.

Element Values
0. None
1. Buprenorphine
2. Codeine
3. Dihydrocodeine
4. Fentanyl
5. Hydrocodone
6. Hydromorphone
7. Meperidine
8. Methadone
9. Morphine
10. Oxycodone
11. Pentazocine
12. Tapentadol
13. Tramadol
14. Other

Additional Information
- Report capsules in the tablet data fields.
- Only report the opioid component of the prescription (e.g., oxycodone/acetaminophen 5 mg/325 mg, report oxycodone).
- Do not report if the patient elopes and prescribed status is unclear.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_TYPE, MTQIP_TAB1_TYPE_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1
Default: 0. None
Validation Range: Reporting starting 7/1/22

16.2 TABLET TYPE 2

Reporting Criterion
Report on all patients.

Description
The additional type of opioid tablet prescribed at discharge.

Element Values
0. None
1. Buprenorphine
2. Codeine
3. Dihydrocodeine
4. Fentanyl
5. Hydrocodone
6. Hydromorphone
7. Meperidine
8. Methadone
9. Morphine
10. Oxycodone
11. Pentazocine
12. Tapentadol
13. Tramadol
14. Other

Additional Information
- Report capsules in the tablet data fields.
- Only report the opioid component of the prescription (e.g., oxycodone/acetaminophen 5 mg/325 mg, report oxycodone).
- Do not report if the patient elopes and prescribed status is unclear.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB2_TYPE, MTQIP_TAB2_TYPE_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1
Default: 0. None
Validation Range: Reporting starting 7/1/22

16.3 SOLUTION TYPE 1

Reporting Criterion
Report on all patients.

Description
The type of opioid solution prescribed at discharge.

Element Values
0. None
1. Buprenorphine
2. Codeine
3. Dihydrocodeine
4. Fentanyl
5. Hydrocodone
6. Hydromorphone
7. Meperidine
8. Methadone
9. Morphine
10. Oxycodone
11. Pentazocine
12. Tapentadol
13. Tramadol
14. Other

Additional Information
- Report cartridge, concentrate, elixir, liquid, pen injector, pump reservoir, syringe and other similar solution forms were prescribed as units/mL in the solution data fields.
- Only report the opioid component of the prescription (e.g., oxycodone/acetaminophen 5 mg/325 mg per 5 mL, report oxycodone).
- Do not report if the patient elopes and prescribed status is unclear.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_SOL1_TYPE, MTQIP_SOL1_TYPE_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1
Default: 0. None
Validation Range: Reporting starting 7/1/22

16.4 OTHER TYPE 1

Reporting Criterion
Report on all patients.

Description
The type of opioid other prescribed at discharge.

Element Values
0. None
1. Buprenorphine
2. Codeine
3. Dihydrocodeine
4. Fentanyl
5. Hydrocodone
6. Hydromorphone
7. Meperidine
8. Methadone
9. Morphine
10. Oxycodone
11. Pentazocine
12. Tapentadol
13. Tramadol
14. Other

Additional Information
- Only report the opioid component of the prescription.
- Do not report if the patient elopes and prescribed status is unclear.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_OTHER1_TYPE, MTQIP_OTHER1_TYPE_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1
Default: 0. None
Validation Range: Reporting starting 7/1/22

16.5 STRENGTH

Reporting Criterion
Report on all patients.

Description
The strength of opioid prescribed at discharge.

Element Values
- Relevant value for data element.

Additional Information
- Only report the opioid component of the prescription (e.g., oxycodone/acetaminophen 5 mg/325 mg, report the number 5).
- Round to the tenth decimal place where applicable (e.g., strength = 8.25 mg, report 8.3)

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_STGTH, MTQIP_TAB2_STGTH, MTQIP_SOL1_STGTH, MTQIP_OTHER1_STGTH
Type of Element: Numeric
Length:
Report: #1
Default: 0
Validation Range: Reporting starting 7/1/22

16.6 UNITS

Reporting Criterion
Report on all patients.

Description
The drug units of opioid prescribed at discharge.

Element Values
1. Milligrams (mg)
2. Micrograms (mcg)
3. Grams (g)
4. Percent (%)
5. Other (other)

Additional Information
- Only report the opioid component of the prescription.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_UNITS, MTQIP_TAB2_UNITS, MTQIP_SOL1_UNITS, MTQIP_OTHER1_UNITS
Type of Element: String
Length:
Report: #1
Default: mg (MTQIP_TAB1_UNITS, MTQIP_TAB2_UNITS, MTQIP_SOL1_UNITS), mcg (MTQIP_OTHER1_UNITS)
Validation Range: Reporting starting 7/1/22

16.7 MILLILITERS OF SOLUTION

Reporting Criterion
Report on all patients.

Description
The milliliters of solution (mL) of opioid prescribed at discharge.

Element Values
- Relevant value for data element.

Additional Information
- Example 1: acetaminophen/codeine solution 120 mg/12 mg per 5 mL is prescribed.
    - Report the numeric value 5.
- Round to the tenth decimal place where applicable.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_SOL1_ML
Type of Element: Numeric
Length:
Report: #1
Default: Blank
Validation Range: Reporting starting 7/1/22

16.8 FORM

Reporting Criterion
Report on all patients.

Description
The form of other opioid prescribed at discharge.

Element Values
0. None
1. Film
2. Lozenge
3. Nasal spray
4. Oral spray
5. Patch
6. Powder
7. Suppository
8. Other

Additional Information

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_OTHER1_FORM, MTQIP_OTHER1_FORM_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #1
Default: 0. None
Validation Range: Reporting starting 7/1/22

16.9 MAXIMUM PER DOSE

Reporting Criterion
Report on all patients.

Description
The maximum per dose opioid prescribed at discharge.

Element Values
- Relevant value for data element.

Additional Information
- Round to the tenth decimal place where applicable.
- Example 1 (Tablets): oxycodone 5 mg 1-2 tabs PO Q 4-6 h prn pain is prescribed.
    - The patient can take a maximum amount of 2 tabs for each dose.
    - Report the numeric value 2.
- Example 2 (Tablets): oxycodone 10 mg 1 tab PO Q 12 h pain is prescribed.
    - The patient can take a maximum amount of 1 tab for each dose.
    - Report the numeric value 1.
- Example 3 (Solution): acetaminophen/codeine solution 120 mg/12 mg per 5 mL take 5-10 mL Q 6 h prn pain.
    - The patient can take a maximum amount of 10 mL for each dose.
    - Report the numeric value 10.
- Example 4 (Other): fentanyl transdermal 50 mcg/h 1 patch Q 72 h is prescribed.
    - The patient can apply 1 patch for each dose.
    - Report the numeric value 1.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_MAXD, MTQIP_TAB2_MAXD, MTQIP_SOL1_MAXD, MTQIP_OTHER1_MAXD
Type of Element: Numeric
Length:
Report: #1
Default: Blank
Validation Range: Reporting starting 7/1/22

16.10 MAXIMUM FREQUENCY PER DAY

Reporting Criterion
Report on all patients.

Description
The maximum frequency opioid per day prescribed at discharge.

Element Values
- Relevant value for data element.

Additional Information
- Round to the tenth decimal place where applicable.
- Example 1 (Tablets): oxycodone 5 mg 1-2 tabs PO Q 4-6 h prn pain is prescribed.
    - The patient can take a maximum number of doses per day of 6.
    - Report the numeric value 6.
- Example 2 (Tablets): oxycodone 10 mg 1 tab PO Q 12 h pain is prescribed.
    - The patient can take a maximum number of doses per day of 2.
    - Report the numeric value 2.
- Example 3 (Solution): acetaminophen/codeine solution 120 mg/12 mg per 5 mL take 5-10 mL Q 6 h prn pain.
    - The patient can take a maximum number of doses per day of 4.
    - Report the numeric value 4.
- Example 4 (Other): fentanyl transdermal 50 mcg/h 1 patch Q 72 h is prescribed.
    - The patient can wear a maximum number of patches of 1 per day.
    - Report the numeric value 1.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_MAXF, MTQIP_TAB2_MAXF, MTQIP_SOL1_MAXF, MTQIP_OTHER1_MAXF
Type of Element: Numeric
Length:
Report: #1
Default: Blank
Validation Range: Reporting starting 7/1/22

16.11 QUANTITY

Reporting Criterion
Report on all patients.

Description
The quantity of opioids prescribed at discharge.

Element Values
- Relevant value for data element.

Additional Information
- Round to the tenth decimal place where applicable.
- For tablets, report the total number of tablets prescribed.
- For solution, report the total milliliters (mL) of solution prescribed.
- For other, report the total number of units (e.g., patches, lozenges, etc.) prescribed.
- Patients discharged to acute rehabilitation or facility may have an opioid prescription listed on their discharge summary, but no quantity listed because the providers at the facility will continue to dispense. For these scenarios, report the opioid listed with zero for the quantity.

Resources
- Drug search
- Orientation

Codebook
Source: MTQIP
Data Base Column Name: MTQIP_TAB1_QUANT, MTQIP_TAB2_ QUANT, MTQIP_SOL1_ QUANT, MTQIP_OTHER1_ QUANT
Type of Element: Numeric
Length: 10
Report: #1
Default: Blank
Validation Range: Reporting starting 7/1/22

SECTION 17 - END OF LIFE PROCESSES OF CARE

17.1 WITHDRAWAL OF LIFE SUPPORTING TREATMENT

Reporting Criterion

Report on all patients.

Description

Treatment was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Element Values

- Yes
- No

Additional Information

- DNR not a requirement.
- A note to limit escalation of treatment qualifies as a withdrawal of life supporting treatment. These interventions are limited to ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional, or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g., extubation) and a decision not to proceed with a life-saving intervention (e.g., intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of care.
- Element Value "No" must be reported for patients whose time of death, according to your hospital's definition, was prior to the removal of any interventions or escalation of care.
- Include brain dead patients where care is withdrawn in coordination with Gift of Life.
- Include patients changed to comfort care status, which may be documented in notes or orders.

Resources

- Orientation

Codebook

Source: MTQIP, TQIP
Data Base Column Name: MTQIP_WD_CARE
Type of Element: String (Yes/No)
Length: 3
Report: #1

17.2 WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Reporting Criterion
Report on all patients.

Description
The date treatment was withdrawn.

Element Values
- Relevant value for data element.

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

Resources
- Orientation

Codebook
Source: TQIP
Data Base Column Name: MTQIP_WD_CARE_DT
Type of Element: Date (MM/DD/YYYY Format)
Length:
Report: #1

17.3 WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Reporting Criterion
Report on all patients.

Description
The time treatment was withdrawn.

Element Values
- Relevant value for data element.

Additional Information
- Reported as HH:MM military time.
- Report the time the first of any existing life-sustaining intervention(s) is withdrawn (e.g., extubation). If no intervention(s) is in place, record the time the decision not to proceed with a lifesaving intervention(s) occurs (e.g., intubation).
- The null value "Not Applicable" is reported for patients where Withdrawal of Life Supporting Treatment is Element Value "2. No."
- For brain dead patients, report the brain death time.

Resources
- Orientation

Codebook
Source: TQIP
Data Base Column Name: MTQIP_WD_CARE_TM
Type of Element: Time (HH:MM Format)
Length:
Report: #1
Validation Range: +/- 6 hours

17.4 ORGAN DONATION REQUEST

Reporting Criterion
Report on all patients.

Description
The request for organ donation.

Element Values
- Yes
- No

Additional Information

Resources
- Orientation

Codebook
Source: MTQIP PRQ
Data Base Column Name: ORG_STAT_YN
Type of Element: String (Yes/No)
Length: 3
Report: #1

17.5 ORGANS PROCURED DATE/TIME

Reporting Criterion
Report on all patients.

Description
The date and time the organs were procured.

Element Values

Additional Information
- Report the incision date/time.

Resources
- Orientation

Codebook
Source: MTQIP PRQ
Data Base Column Name: ORG_PROCURE_DATE, ORG_PROCURE_TIME
Type of Element: Date (MM/DD/YYYY Format), Time (HH:MM Format)
Length:
Report: #8

17.6 ORGAN PROCURED

Reporting Criterion
Report on all patients.

Description
The organ(s) procured.

Element Values
0. None
1. Adrenal glands
2. Bone
3. Bone marrow
4. Cartilage
5. Corneas
6. Dura mater
7. Fascia lata
8. Heart
9. Heart valves
10. Intestine
11. Kidney
12. Liver
13. Lungs
14. Nerves
15. Pancreas
16. Skin
17. Stomach
18. Tendons
19. Whole eyes
20. Other

Additional Information

Resources
- Orientation

Codebook
Source: MTQIP PRQ
Data Base Column Name: ORG_DNRS_L, ORG_DNRS_L_AS_TEXT
Type of Element: Numeric, String
Length:
Report: #8

17.7 MORTALITY CLASSIFICATION

Reporting Criterion

Report on all deaths.

Description

The mortality classification is determined for all trauma deaths as part of the PIPS process at each trauma center.

Element Values

- Unanticipated mortality with opportunity for improvement (UNANTIC.QI.OPP)
- Mortality with opportunity for improvement (OPPORTUNITY)
- Mortality without opportunity for improvement (NO.OPPORTUNITY)
- Not done (NOT)

Additional Information

- Report the final mortality classification as determined by PIPS committee/attending review.
- An unanticipated mortality with opportunity for improvement is defined as patients whose death is unexpected in relation to their injuries and comorbid conditions. These deaths are considered to be potentially preventable and should have opportunities for improvement.
- A mortality with opportunity for improvement is defined as patients in whom death is anticipated, but where potential system or provider improvements/gaps in care could be identified.
- A mortality without opportunity is defined as patients in whom death is anticipated and no system provider improvements/gaps in care could be identified.

Resources

- Orientation

Codebook

Source: MTQIP
Data Base Column Name: PREVENTABLE
Type of Element: String
Length:
Report: #1