2024 Definition Updates

M·TQIP

Key

Indicator	Meaning
Yellow Highlight	New change
Red Text	Variability compared to NTDS
~~Strike~~	Deleted verbiage
	Vendor flag
	Analyst flag

Key

Indicator	Meaning
Yellow Highlight	New change
Red Text	Variability compared to NTDS
~~Strike~~	Deleted verbiage
	Vendor flag
	Analyst flag

Key

Indicator	Meaning
Yellow Highlight	New change
Red Text	Variability compared to NTDS
~~Strike~~	Deleted verbiage
	Vendor flag
	Analyst flag

Key

Indicator	Meaning
Yellow Highlight	New change
Red Text	Variability compared to NTDS
~~Strike~~	Deleted verbiage
	Vendor flag
	Analyst flag

Key

Indicator	Meaning
Yellow Highlight	New change
Red Text	Variability compared to NTDS
~~Strike~~	Deleted verbiage
	Vendor flag
	Analyst flag

INTER-FACILITY TRANSFER	ADDED: INCLUDE: Patients who require physical transfer from a free-standing emergency department (ED) to an affiliated trauma center. ADDED: 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).
Rational – NTDS update	
2023	2024
INTER-FACILITY TRANSFER **Description** Was the patient transferred to your facility from another acute care facility? **Element Values** 1. Yes 2. No **Additional Information** • Patients transferred from a private doctor's office or stand-alone ambulatory surgery center are not considered inter-facility transfers. • Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities. **Resources** • Orientation	**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

CIRRHOSIS (Pre-Existing Condition)	ADDED: EXCLUDE patients who no longer have cirrhosis due to a successful liver transplant.
Rational – NTDS update	
2023	2024
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. **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.	**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

DEMENTIA (Pre-Existing Condition)	REMOVED: A diagnosis of dementia including Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) **and** vascular dementia must be documented in the patient's medical record. ADDED: 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.
Rational – NTDS update	
2023	2024
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), ~~and~~ vascular dementia, must be documented in the patient's medical record. • The minimum required written documentation to report is "dementia" or equivalent.	**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.

TRAUMA CENTER	UPDATED: Beaumont and Spectrum hospital names > now Corewell Health REMOVED: McLaren Northern Michigan Hospital
Rational – MTQIP Member request	
2023	2024
TRAUMA 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 OW ~~Beaumont Hospital - Dearborn~~ BF ~~Beaumont Hospital - Farmington Hills~~ WB ~~Beaumont Hospital - Royal Oak~~ OS ~~Beaumont Hospital - Trenton~~ TB ~~Beaumont Hospital - Troy~~ 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 NO ~~McLaren Northern Michigan Hospital~~ PO McLaren Oakland UM Michigan Medicine MI MidMichigan Medical Center - Midland MU Munson Medical Center SG Sinai-Grace Hospital SP Sparrow Hospital SH ~~Spectrum Health~~ 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	**TRAUMA 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 BM Bronson Methodist 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 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

DRUG SCREEN	ADDED: Report positive drug screen results documented in autopsy report if capture criteria are met.
Rational – MTQIP Member request	
2023	2024
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.	**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).

ICD-10 HOSPITAL PROCEDURES	REMOVED: For patients on warfarin, direct thrombin inhibitor, or factor Xa inhibitor pre-injury and sustain a traumatic brain injury and are not transferred in a referring hospital or direct admit, report pre-hospital head/brain CT code, date, and time REMOVED: Procedures marked with a double dagger (‡) indicate a pre-hospital exception to this reporting rule.

Rational – MTQIP Member request

2023	2024
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. ~~Procedures marked with a double dagger (‡) indicate a pre-hospital exception to this reporting rule.~~ • 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. • ~~For patients on warfarin, direct thrombin inhibitor, or factor Xa inhibitor pre-injury and sustain a traumatic brain injury and are not transferred in a referring hospital or direct admit, report pre-hospital head/brain CT code, date, and time.~~ • Note that the hospital may report additional procedures.	**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.

ALCOHOL USE DISORDER	REMOVED: Include evidence of chronic use, such as withdrawal episodes ADDED: May use information provided by family members or friends
Rational – MTQIP Member request	
2023	2024
ALCOHOL USE DISORDER **Description** ~~Evidence of chronic use, such as withdrawal episodes, or~~ 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. **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. • ~~Include evidence of chronic use, such as withdrawal episodes~~. • May determine inclusion based on the brief screening tool used at your institution. • Include patients who meet the criteria for Alcohol Withdrawal Syndrome during the same stay.	**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

ANTICOAGULANT THERAPY	ADDED: Time frame table for anticoagulant use that was present in the prior dictionaries; was left out of the 2023 version but still referenced under Additional Information
Rational – MTQIP Member request	
2023	2024

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.

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

CONGESTIVE HEART FAILURE	ADDED: Additional Information: Include: Heart failure or HF ADDED: Resources: Universal Definition and Classification of Heart Failure put out by American College of Cardiology(link)
Rational – MTQIP Member request	
2023	2024
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, 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: o Abnormal limitation in exercise tolerance due to dyspnea or fatigue o Orthopnea (dyspnea on lying supine) o Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea) o Increased jugular venous pressure o Pulmonary rales on physical examination o Cardiomegaly o Pulmonary vascular engorgement	**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: o Abnormal limitation in exercise tolerance due to dyspnea or fatigue o Orthopnea (dyspnea on lying supine) o Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea) o Increased jugular venous pressure o Pulmonary rales on physical examination o Cardiomegaly o Pulmonary vascular engorgement **Resources** • American College of Cardiology

HOSPITAL EVENTS: INTRODUCTION	ADDED: Includes ED hold, ED boarded, or similar status patients.
Rational – MTQIP Member request	
2023	2024
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. **Resources**	**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**

CATHETER-ASSOCIATED URINARY TRACT INFECTION	ADDED: Includes ED hold, ED boarded, or similar status patients.
Rational – MTQIP Member request	
2023	2024
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. **Resources** • CDC NHSN Manual, Chapter 7	**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

PNEUMONIA	REMOVED: VAP verbiage from Algorithm names UPDATED: CDC Algorithm versions from 2020 to 2023
Rational – MTQIP Member request	
2023	2024
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 (~~VAP~~ Algorithm PNU2) • Viral, Legionella, and other Bacterial Pneumonias (~~VAP~~ Algorithm PNU2) • Immunocompromised Patients (~~VAP~~ 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	**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

PRESSURE ULCER	REMOVED: Excludes intact skin with non-blanching redness (NPUAP Stage 1), present on arrival that progresses during hospital stay to NPUAP Stage > 1. ADDED: Excludes any stage pressure ulcer present on arrival that progresses during hospital stay to a greater NPUAP stage
Rational – MTQIP Member request	
2023	2024
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 intact skin with non-blanching redness (NPUAP Stage 1), present on arrival that progresses during hospital stay to NPUAP Stage > 1.~~ • Excludes medical device-related mucosal membrane pressure injury. **Resources** • NPUAP Pressure Injury Stages	**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

SEPSIS	ADDED: Criterion inclusion timeframe: 48 hours before and up to 24 hours after onset of infection
Rational – MTQIP Member request	
2023	2024
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. **Resources** • SCCM Sepsis 3	**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

UNPLANNED VISIT TO THE OPERATING ROOM	ADDED: Types of excluded OR definitions per NTDB January 2023 Educational Experience Review
Rational – MTQIP Member request	
2023	2024
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. • Inclusion Example o Patient has an acute loss of airway requiring emergent tracheostomy in the OR for airway establishment. • Exclusion Example o Patient is having difficulty weaning for the ventilator. Patient is scheduled and undergoes a tracheostomy. o 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. o 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**	**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 o Patient has an acute loss of airway requiring emergent tracheostomy in the OR for airway establishment. • Exclusion Example o Patient is having difficulty weaning for the ventilator. Patient is scheduled and undergoes a tracheostomy. o 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. o 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**

VENTILATOR-ASSOCIATED PNEUMONIA	UPDATED: CDC VAP Algorithm versions from 2020 to 2023
Rational – MTQIP Member request	
2023	2024
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	**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

GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL	ADDED: 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.
Rational – MTQIP Member request	
2023	2024
GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL • 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 the next calendar day. **Resources 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 (/)	**GCS ASSESSMENT QUALIFIER COMPONENT OF HIGHEST GCS TOTAL** • 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 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 (/)

TABLET TYPE 1	ADDED: Do not report if patient elopes and prescribed status is unclear
Rational – MTQIP Member request	
2023	2024
TABLET TYPE 1 **Reporting Criterion** Report on all patients. **Description** The type of opioid tablet prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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). **Resources** • Drug search	**TABLET TYPE 1** **Reporting Criterion** Report on all patients. **Description** The type of opioid tablet prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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

TABLET TYPE 2	ADDED: Do not report if patient elopes and prescribed status is unclear
Rational – MTQIP Member request	
2023	2024
TABLET TYPE 2 **Reporting Criterion** Report on all patients. **Description** The additional type of opioid tablet prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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). **Resources** • Drug search	**TABLET TYPE 2** **Reporting Criterion** Report on all patients. **Description** The additional type of opioid tablet prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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

SOLUTION TYPE 1	ADDED: Do not report if patient elopes and prescribed status is unclear
Rational – MTQIP Member request	
2023	2024
SOLUTION TYPE 1 **Reporting Criterion** Report on all patients. **Description** The type of opioid solution prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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, report oxycodone). **Resources** • Drug search	**SOLUTION TYPE 1** **Reporting Criterion** Report on all patients. **Description** The type of opioid solution prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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, report oxycodone). • Do not report if the patient elopes and prescribed status is unclear. **Resources** • Drug search

OTHER TYPE 1	ADDED: Do not report if patient elopes and prescribed status is unclear
Rational – MTQIP Member request	
2023	2024
OTHER TYPE 1 **Reporting Criterion** Report on all patients. **Description** The type of opioid other prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. Other **Additional Information** • Only report the opioid component of the prescription. **Resources** • Drug search	**OTHER TYPE 1** **Reporting Criterion** Report on all patients. **Description** The type of opioid other prescribed at discharge. **Element Values** 1. None 2. Buprenorphine 3. Codeine 4. Dihydrocodeine 5. Fentanyl 6. Hydrocodone 7. Hydromorphone 8. Meperidine 9. Methadone 10. Morphine 11. Oxycodone 12. Pentazocine 13. Tapentadol 14. Tramadol 15. 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

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE	ADDED: For brain dead patients, report the brain death date
Rational – MTQIP Member request	
2023	2024
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." **Resources** **Codebook** Source: TQIP Data Base Column Name: MTQIP_WD_CARE_DT Type of Element: Date (MM/DD/YYYY Format) Length: Report: #1	**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** **Codebook** Source: TQIP Data Base Column Name: MTQIP_WD_CARE_DT Type of Element: Date (MM/DD/YYYY Format) Length: Report: #1

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME	ADDED: For brain dead patients, report the brain death time
Rational – MTQIP Member request	
2023	2024
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." **Resources** **Codebook** Source: TQIP Data Base Column Name: MTQIP_WD_CARE_DT Type of Element: Date (MM/DD/YYYY Format) Length: Report: #1	**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** **Codebook** Source: TQIP Data Base Column Name: MTQIP_WD_CARE_DT Type of Element: Date (MM/DD/YYYY Format) Length: Report: #1

M·TQIP