Ohio Trauma Registry

2027

Trauma Acute Care Registry

Data Dictionary

This Data Dictionary is to be used by all Ohio Trauma Centers, all Ohio Region affiliated Acute-Care hospitals and all Ohio region affiliated Free Standing Emergency Departments.

Version 2027.0 (01/01/2027)
This edition is effective for all trauma patients presenting for treatment on or after January 1, 2027.

Department of Public Safety
Ohio Emergency Medical Services

EMFTS BOARD

ACKNOWLEDGEMENTS

The Ohio State Board of Emergency Medical, Fire and Transportation Services and the EMS Division of the Ohio Department of Public Safety would like to thank the myriad of people – too numerous to list here – who have worked tirelessly to create, expand and transform the Ohio Trauma Registry from its inception and embryonic beginnings in the late 1990s into the powerful research and policymaking tool it is today. This growth and development would not have been possible without the strength of their combined knowledge, wisdom and hard work.

Trauma Acute Care Registry (TACR) is a component of the Ohio Trauma Registry (OTR) and is maintained by the Ohio Department of Public Safety, 1970 W. Broad St., Columbus, Ohio 43223. For more information about the TACR, OTR and/or the State of Ohio's Trauma System, contact the Ohio Department of Public Safety, Division of EMS, Research and Analysis Section, at (800)233-0785, EMSdata@dps.ohio.gov or visit www.ems.ohio.gov.

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STATEMENT ABOUT ITDX / TECHNICAL STANDARDS VS. CLINICAL STANDARDS

The State of Ohio recognizes the ITDX as the transmission standard. The Ohio Trauma Acute Care Registry Data Dictionary reflects the American College of Surgeons (ACS) reporting requirements adopted by the State of Ohio for 2025. The manner of end-point collection is left to the trauma vendor(s) provided that these vendors are able to meet both State and ACS reporting requirements.

OHIO-TACR GLOBAL RULES

OHIO-TACR MINIMUM DATA SET

The OHIO-TACR defines the minimum required dataset for submission to theOhio Trauma Registry. Centers may collect additional data elements beyond those defined in the OHIO-TACR for local, region, research, or performance improvement purposes; however, all data submitted must conform to the OHIO-TACR Data Dictionary definitions, formats, and value sets for the associated admission year.

Submission files are validated for structural compliance through the OHIO-TACR Validator; however, successful validation does not ensure adherence to OHIO-TACR data definitions.

OHIO-TACR PATIENT INCLUSION CRITERIA

All centers submitting data must identify and report cases in accordance with the current OHIO-TACR Patient Inclusion Criteria for the applicable patient admission year.

Centers must not substitute local registry inclusion rules, , or institutional conventions in place of the OHIO-TACR Patient Inclusion Criteria.

ADMISSION REASON NEUTRALITY

Submissions must not consider or differentiate cases based on the stated reason for hospital admission. Eligibility for inclusion and reporting is determined solely by the OHIO-TACR Patient Inclusion Criteria and applicable diagnosis code definitions, regardless of the admission intent, admitting diagnosis narrative, or admitting service.

HOSPITAL SERVICE LINE NEUTRALITY

Submissions must not consider or differentiate cases based on the hospital service line responsible for admitting or treating the patient at any time during the hospitalization.

Eligibility for inclusion, data abstraction, and reporting are determined solely by the OHIO-TACR Patient Inclusion Criteria and data definitions, not by the admitting, consulting, or primary service line of record.

ICD-10 CODING CONVENTION

All centers submitting data must assign diagnosis, procedure and external cause codes in accordance with the official ICD10 coding conventions in effect for the applicable reporting year.

Centers must not modify, truncate, reinterpret, or locally redefine ICD-10 codes when abstracting injuries, procedures or external causes.

AIS CODING RULES AND GUIDELINES

All centers submitting data must assign Abbreviated Injury Scale (AIS) codes in accordance with the official AIS coding rules and guidelines for the version of AIS specified by OHIO-TACR for the applicable reporting year.

Centers must not modify, reinterpret, or locally redefine AIS codes, scoring conventions, or severity assignments when reporting injury data.

CURRENT MEDICAL ENCOUNTER DOCUMENTATION

Unless otherwise specified, OHIO-TACR data must be abstracted only from documentation within the medical encounter record for the current hospitalization.

Information sourced solely from prior encounters (e.g., historical problem lists, legacy registry records, previous discharge summaries) must not be used unless it is explicitly carried forward, reaffirmed, or documented in the current encounter record.

HOSPITAL EVENT REPORTING

OHIO-TACR data elements capturing hospital events (e.g., Pressure Ulcer, Unplanned Admission to the ICU, etc.) must represent only the first occurrence of that event during the initial hospitalization. Subsequent episodes are not reported.

POST -DISCHARGE DATA EXCLUSION

Submissions must include data collected during the initial hospitalization only. Information pertaining to hospital events, for example, occurring after the hospital discharge order was written, is not reported.

READMISSION REPORTING

Submissions must include data for the initial hospitalization only. Subsequent encounters occurring after the hospital discharge order was written from the initial encounter are not reported as part of the original record and must not be submitted as a separate record.

NATIONAL ELEMENTS THAT WILL NOT BE COLLECTED IN THE OHIO TRAUMA ACUTE CARE REGISTRY

The following elements will not be collected and should be defaulted to Not Applicable.

- Initial ED/Hospital GCS 40 – Eye
- Initial ED/Hospital GCS 40 – Verbal
- Initial ED/Hospital GCS 40 – Motor

OHIO SPECIFIC ELEMENTS

- Hospital Code
- Unique Admission Number
- Trauma Tracking Number
- Facility Type
- Transport Agency
- Other Transport Mode
- EMS Dispatch Date
- EMS Dispatch Time
- EMS Unit Arrival Date at Scene or Transferring Facility
- EMS Unit Arrival Time at Scene or Transferring Facility
- EMS Unit Departure Date From Scene or Transferring Facility
- EMS Unit Departure Time From Scene or Transferring Facility
- Initial Field Systolic Blood Pressure
- Initial Field Pulse Rate
- Initial Field Respiratory Rate
- Initial Field Oxygen Saturation
- Initial Field GCS Eye
- Initial Field GCS Verbal
- Initial Field GCS Motor
- Initial Field GCS Total
- Initial Field GCS Qualifier
- Scene Interventions
- Transferring Hospital Code
- ED Discharge Order Written Date
- ED Discharge Order Written Time
- ED Transfer to Hospital
- Procedure Episode
- DNR Status
- Injury Severity Score
- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
- Inpatient Transfer To Hospital
- Discharge Status
- Date of Death
- Autopsy Performed

DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)

Inclusion Criteria Differences

- Ohio follows NTDS Inclusion Criteria with exceptions:
    - Ohio INCLUDES: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in/ out (FOR TRAUMA EVALUATION)
    - TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in or died THAT WERE EVALUATED BY TRAUMA OR SURGICAL SERVICE)
    - Ohio EXCLUDES: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred out FOR TRAUMA EVALUATION
    - Ohio EXCLUDES: TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred in or died FOR EVALUATION BY TRAUMA OR SURGICAL SERVICE)
    - Ohio EXCLUDES: S09.8XXA and S09.90XA - Isolated closed head injuries without a headache
    - Ohio INCLUDES:
        - J70.5 (Respiratory conditions due to smoke inhalation)
        - T20-28 (Burns by specified body parts)
        - T30-32 (Burn by TBSA percentage)
        - T33 (Superficial frostbite)
        - T34 (Frostbite with tissue necrosis)
        - T59.81 (Toxic effect of smoke)
        - T67 (Effects of heat and light)
        - T68 (Hypothermia)
        - T69 (Other effects of reduced temperature)
        - T70.4 (Effects of high-pressure fluids)
        - T70.8 (Other effects of air pressure and water pressure)
        - T70.9 (Effect of air pressure and water pressure, unspecified)
        - T71 (Asphyxiation)
        - T74.1 (Physical abuse, confirmed)
        - T74.4 (Shaken infant syndrome)
        - T75 (Effects of lightning)
        - T75.1 (Unspecified effects of drowning and nonfatal submersion)
        - T75.4 (Electrocution)

OH Definition Is Different Than NTDS

- Weight
    - OH does not include “within 24 hours or less of ED/Hospital arrival” in definition

OH Additional Information Is Different Than NTDS

- Patient Home City
    - OH does not include “Only reported when patients home zip postal code is not known not recorded and country is US.”
    - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
- Patient Home State
    - OH does not include “Only reported when patient home zip / postal code is not known / not recorded and country is US.”
    - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”

- Patient Home County
    - OH does not include “Only reported when patient home zip / postal code is not known not recorded and country is US.”
    - OH does not include “Null value NA is reported if patients home zip / postal code is reported.”
- Patient Home Zip Code
    - OH does not include “May require adherence to HIPAA regulations.”
- Age
    - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Age Units
    - OH does not include the “Null value not applicable is reported if date of birth is reported.”
- Incident City
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident State
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip / postal code is reported.”
- Incident County
    - OH does not include “Only recorded when incident location zip / postal code is not known / not recorded and country is US.”
    - OH does not include the “Null value not applicable is reported if incident location zip postal code is reported.”
- Incident Zip Code
    - NTDS says “Can be stored as a 5 or 9-digit code (XXXXX-XXXX) for US or CA and can be stored in the postal code format of the applicable country.”
    - Ohio says “Stored as a five-digit code (XXXXX)”
- Transport mode for arrival at your hospital
    - OH added examples
- Other Transport Modes
    - OH added examples
    -
- Weight
    - OH does not include “…within 24 hours or less of ED/Hospital arrival” in the 4th bullet point
- Hospital Procedure Start Date
    - OH added “Linked to hospital procedures element”
- Hospital Procedure Start Time
    - OH added “Linked to hospital procedures element”
- Alcohol Screen Results
    - Conversion example
- Packed Red Blood Cells
    - OH Does not include “The null value "Not Known/Not Recorded " is reported by Level III centers that do not collect this data element.”
- Whole Blood
    - OH Does not include “The null value "Not Known/Not Recorded " is reported by Level III centers that do not collect this data element.”
- Plasma
    - OH Does not include “The null value "Not Known/Not Recorded " is reported by Level III centers that do not

collect this data element."

- Platelets
    - OH Does not include "The null value "Not Known/Not Recorded " is reported by Level III centers that do not collect this data element."
- Cryoprecipitate
    - OH Does not include "The null value "Not Known/Not Recorded " is reported by Level III centers that do not collect this data element."

Other Element Name and Definition Differences

- ED Discharge Order Written Date
- ED Discharge Order Written Time
    - These are Ohio specific elements. However, they match in definition to NTDS ED Discharge Date and ED Discharge Time

- ED Discharge Date
- ED Discharge Time
    - These are NTDS elements, however the Ohio definition is different

- Hospital Discharge Order Written Date
- Hospital Discharge Order Written Time
    - These are Ohio specific elements. However, they match in definition to NTDS Hospital Discharge Date and Hospital Discharge Time

- Hospital Discharge Date
- Hospital Discharge Time
    - These are NTDS elements, however the Ohio definition is different

Element Value Differences

- Other Mental / Personality Disorder
    - Ohio added "Intermittent Personality Disorder"
- Primary Method of Payment
    - Ohio added "8 Workers Compensation"

Edit Check Differences

- For element Hospital Procedure Start Date, the following edit check should not be present:
    - 6607 Hospital Procedure Start Date is later than Hospital Discharge Order Written Date. (Note: NTDS refers to this field as Hospital Discharge Date – Ohio has a different definition for this field.)
- For element Hospital Procedure Start Time, the following edit check should not be present:
    - 6707 Hospital Procedure Start Time is later than Hospital Discharge Order Written Time. (Note: NTDS refers to this field as Hospital Discharge Time – Ohio has a different definition for this field.)

Reporting Criterion

- **Not reported**

NOTE: Reference to this section is included on each individual element page that is affected by the differences listed.

TACR INCLUSION/EXCLUSION CRITERIA – ICD-10

TRAUMA PATIENT DEFINITION

To ensure consistent data collection across the State of Ohio and to follow 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:

PATIENT INCLUSION CRITERIA

To be included in the Trauma Acute Care Registry (TACR):

The patient must have incurred at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):

- **J70.5 with character modifier of A ONLY** (Respiratory conditions due to smoke inhalation – initial encounter)
- **S00-S99 with 7th character modifier of A, B or C ONLY** (Injuries to specific body parts – initial encounter):
- **T07** (Unspecified multiple injuries);
- **T14** (Injury of unspecified body region);
- **T20-T28 with 7th character modifier of A ONLY** (Burns by specified body parts – initial encounter);
- **T30-T32** (Burn by TBSA percentage);
- **T33 with character modifier of A ONLY** (Superficial frostbite – initial encounter)
- **T34 with character modifier of A ONLY** (Frostbite with tissue necrosis – initial encounter)
- **T59.81 with 7th character modifier of A ONLY** (Toxic effect of smoke - initial encounter)
- **T67 with character modifier of A ONLY** (Effects of heat and light – initial encounter)
- **T68 with character modifier of A ONLY** (Hypothermia – initial encounter)
- **T69 with character modifier of A ONLY** (Other effects of reduced temperature – initial encounter)
- **T70.4 with character modifier of A ONLY** (Effects of high-pressure fluids – initial encounter)
- **T70.8 with character modifier of A ONLY** (Other effects of air pressure and water pressure – initial encounter)
- **T70.9 with character modifier of A ONLY** (Effect of air pressure and water pressure, unspecified – initial encounter)
- **T71 with character modifier of A ONLY** (Asphyxiation – initial encounter)
- **T74.1 with character modifier of A ONLY** (Physical abuse, confirmed – initial encounter)
- **T74.4 with character modifier of A ONLY** (Shaken infant syndrome – initial encounter)
- **T75.0 with character modifier of A ONLY** (Effects of lightning – initial encounter)
- **T75.1 with character modifier of A ONLY** (Unspecified effects of drowning and nonfatal submersion – initial encounter)
- **T75.4 with character modifier of A ONLY** (Electrocution – initial encounter)
- **T79.A1-T79.A9 with 7th character modifier of A ONLY** (Traumatic compartment syndrome – initial encounter)

- **NON-TRAUMA CENTERS**: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in/ out (FOR TRAUMA EVALUATION)
- **TRAUMA CENTERS:** TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in or died THAT WERE EVALUATED BY TRAUMA OR SURGICAL SERVICE)

PATIENT EXCLUSION CRITERIA

Patients with the following isolated ICD-10-CM codes are **EXCLUDED** from the TACR:

- **NON-TRAUMA CENTERS**: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred out FOR TRAUMA EVALUATION
- **TRAUMA CENTERS:** TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred in or died FOR EVALUATION BY TRAUMA OR SURGICAL SERVICE)

    - Superficial Injuries with an ISS of 1 unless repaired in the operating room under anesthesia: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90
    - Lacerations Without Foreign Body with an ISS of 1 unless repaired in the operating room under anesthesia: S01, S11, S21, S31, S41, S51, S61, S64, S71, S81, S91
    - Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th character modifier of D through S.
    - S09.8XXA and S09.90XA - Isolated closed head injuries without a headache

THE PATIENT <u>MUST ALSO</u> IN ADDITION TO THE ABOVE INCLUSION CRITERIA

- 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 transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice)
  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.

*In-house traumatic injuries sustained after initial ED/Hospital arrival and before hospital discharge at the index hospital (the hospital reporting data), and all data associated with that injury event, are excluded.

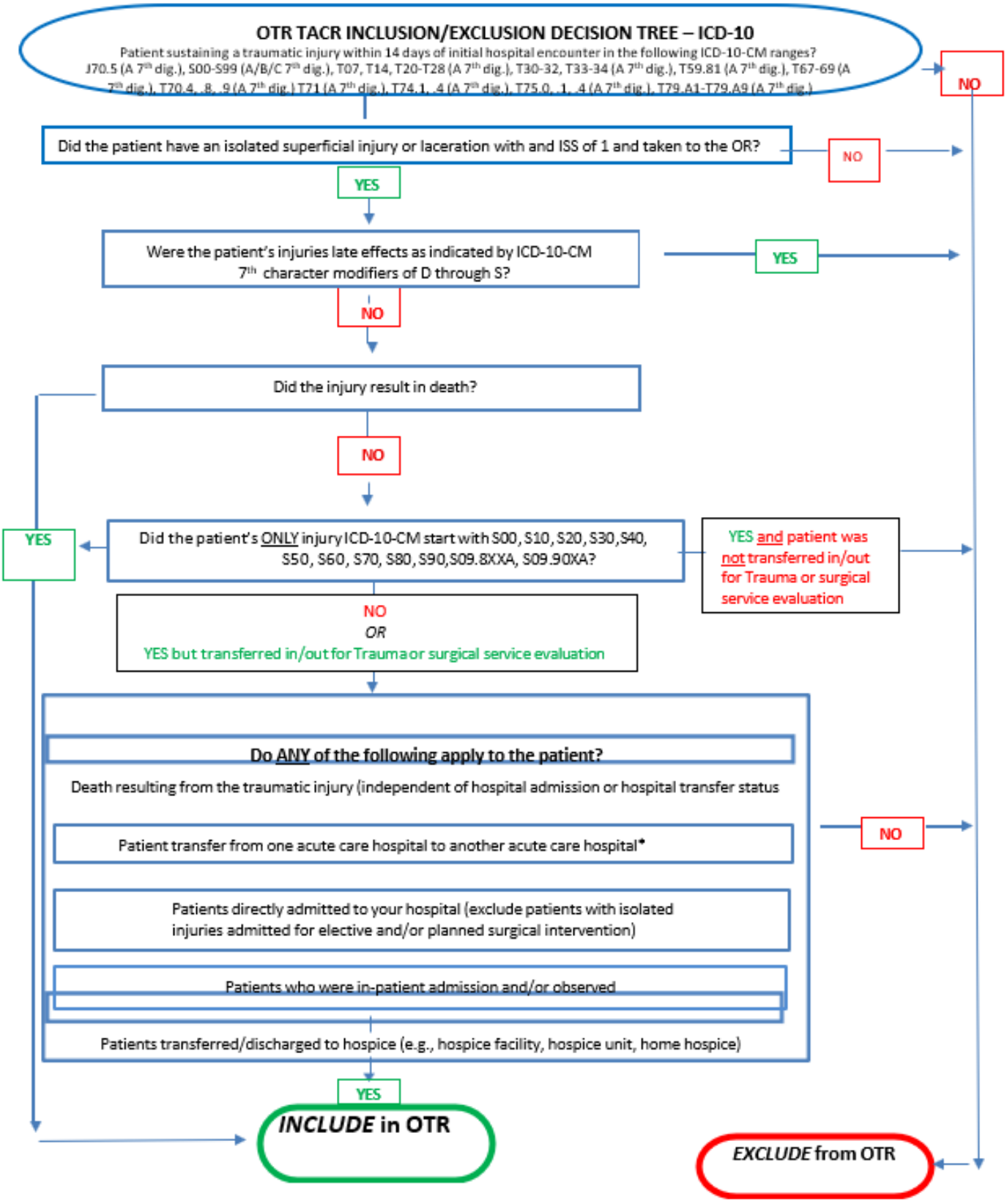
**Exclude patient injuries sustained at your facility after initial ED/Hospital arrival and before hospital discharge, and all data associated with that injury event.

**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 short-term illness or condition). “CMS Data Navigator Glossary of Terms”, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf .

*** Initial hospital encounter is referring to the patient’s first encounter for this injury event at your hospital.

****If the patient was transferred from another hospital, the injury must have occurred within 14 days prior to arrival at the referring hospital. If the patient’s initial hospital encounter occurred at the hospital reporting the data, the injury must have occurred within 14 days prior to arrival at the reporting hospital.

<u>NOTE</u>: INCLUSION / EXCLUSION CRITERIA differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.


OTR TACR INCLUSION/EXCLUSION DECISION TREE – ICD-10
Patient sustaining a traumatic injury within 14 days of initial hospital encounter in the following ICD-10-CM ranges? J70.5 (A 7th dig.), S00-S99 (A/B/C 7th dig.), T07, T14, T20-T28 (A 7th dig.), T30-32, T33-34 (A 7th dig.), T59.81 (A 7th dig.), T67-69 (A 7th dig.), T70.4, .8, .9 (A 7th dig.) T71 (A 7th dig.), T74.1, .4 (A 7th dig.), T75.0, .1, .4 (A 7th dig.), T79.A1-T79.A9 (A 7th dig.)
NO
Did the patient have an isolated superficial injury or laceration with and ISS of 1 and taken to the OR?
NO
YES
Were the patient's injuries late effects as indicated by ICD-10-CM 7th character modifiers of D through S?
YES
NO
Did the injury result in death?
NO
YES
Did the patient's ONLY injury ICD-10-CM start with S00, S10, S20, S30, S40, S50, S60, S70, S80, S90, S09.8XXA, S09.90XA?
YES and patient was not transferred in/out for Trauma or surgical service evaluation
NO
OR
YES but transferred in/out for Trauma or surgical service evaluation
Do ANY of the following apply to the patient?
Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status
Patient transfer from one acute care hospital to another acute care hospital*
NO
Patients directly admitted to your hospital (exclude patients with isolated injuries admitted for elective and/or planned surgical intervention)
Patients who were in-patient admission and/or observed
Patients transferred/discharged to hospice (e.g., hospice facility, hospice unit, home hospice)
YES
INCLUDE in OTR
EXCLUDE from OTR

COMMON NULL VALUES

Description

Common Null Values are terms to be used with OTR TACR Data Elements as described in this document for specifically-defined data fields when an answer cannot be provided.

Element Values

NA= Not Applicable
NK/NR = Not Known/Not Recorded (NK/NR)

Additional Information

- Although not written out on the following pages, these Common Null Values are included in the TACR dataset for every allowable data element. To ascertain their allowability by data field, see the "Accepts Null Value" notation on every data element descriptor page.

- *Not Applicable (Element Value NA):* This null value code applies if, at any time of patient care documentation, the information requested was "Not Applicable" *(NA)* to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be *NA* if a patient self-transports to the hospital.

- *Not Known/Not Recorded (Element Value NK/NR):* This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, healthcare provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown". Another example, Not Known/Not Recorded/Not Documented should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the TACR are to be electronically stored in a database or moved from one database to another, the indicated null values should be applied.

References to Other Databases

- NTDS 2027

HOSPITAL CODE

Element Intent

This identifies the facility where the patient was seen, which is helpful for data linkage purposes and for further clarifying the resources that were available to treat the patient.

Description

Hospital Code is a four-digit (4) hospital code assigned by the Ohio Department of Public Safety.

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Stored as a four-digit code (xxxx)

Data Source Hierarchy Guide

1 Ohio Department of Public Safety Hospital (Facility) Code List

References to Other Databases

- Not an NTDS element

UNIQUE ADMISSION NUMBER

Element Intent

This identifies the specific trauma injury incident, which can help with record identification and data linkage purposes.

Description

Unique Admission Number is a number assigned to the trauma patient at your facility. A patient encounter number or account number can be used.

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Use an identifiable number specific to your facility, e.g. patient encounter or account number

References to Other Databases

- Not an NTDS Element

TRAUMA TRACKING NUMBER

Element Intent

This identifies the specific trauma injury incident, which can help with record identification and data linkage purposes.

Description

Trauma Tracking Number is a number automatically generated by the trauma registry system.

Element Values

- Relevant value for data element

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

FACILITY TYPE

Element Intent

This is helpful for data linkage purposes and for further clarifying the resources that were available to treat the patient.

Description

Facility Type is the type of facility at time of admission, transfer in or transfer out for each patient.

Element Values

1 Free Standing Emergency Department
2 Acute Care Hospital
3 Adult Trauma 1
4 Adult Trauma 2
5 Adult Trauma 3
6 Pediatric Trauma 1
7 Pediatric Trauma 2
8 Adult Trauma 3 - N

Common Null Values

- Not Accepted

References to Other Databases

- Not an NTDS Element

PATIENT'S HOME CITY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Patient's Home City is the patient's city, township, or village of residence.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

NOTE: PATIENT HOME CITY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME STATE

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Patient's Home State is the state, territory, or province (or the District of Columbia) of the patient's residence.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

NOTE: PATIENT HOME STATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Patient's Home County is the patient's county (or parish) of residence.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- The null value "Not Applicable" is reported for non-US hospitals.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

NOTE: PATIENT HOME COUNTY differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME ZIP CODE

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Patient's Home Zip Code is the zip code of the patient's primary residence.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

NOTE: PATIENT HOME ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

PATIENT'S HOME COUNTRY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Patient's Home Country is the country where the patient resides.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing the country (e.g. U.S.)
- 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.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

ALTERNATE HOME RESIDENCE

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Alternate Home Residence is documentation of the residential status of a patient who has no home zip code.

Element Values

1 Homeless
2 Undocumented Resident
3 Migrant Worker

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form

References to Other Databases

- NTDS 2027

DATE OF BIRTH

Element Intent

To calculate the patient's age at the time of the injury event, which is used for reporting and as a predictor of adverse outcomes.

Description

Date of Birth is the patient's date of birth at time of injury.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage / Trauma Flow Sheet
5 EMS Run Report

References to Other Databases

- NTDS 2027

AGE

Element Intent

In the absence of the patient's date of birth, to calculate the patient's age at the time of the injury event, which is used for reporting and as a predictor of adverse outcomes.

Description

Age is the patient's age (or best approximation) at the time of injury.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage / Trauma Flow Sheet
5 EMS Run Report

References to Other Databases

- NTDS 2027

NOTE: AGE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

AGE UNITS

Element Intent

In the absence of the patient's date of birth, to calculate the patient's age at the time of the injury event, which is used for reporting and as a predictor of adverse outcomes.

Description

Age Units are the units used to document the patient's age (hours, days, months, years, minutes, weeks).

Element Values

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

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage / Trauma Flow Sheet
5 EMS Run Report

References to Other Databases

- NTDS 2027

NOTE: AGE UNITS differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

SEX ASSIGNED AT BIRTH

Element Intent

To analyze variations in injury patterns and outcomes.

Description

The patient's sex assigned at birth

Element Values

1 Male
2 Female
3 intersex

Additional Information

- Also referred to as birth sex, natal sex, biological sex.

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage/Trauma Flow Sheet
5 EMS Run report
6 History & Physical

References to Other Databases

- NTDS 2027

GENDER

Element Intent

To analyze variations in injury patterns and outcomes.

Description

The patient's gender identity

Element Values

1. Man
2. Woman
3. Non-binary, genderqueer, gender nonconforming
4. Non-disclosed

Additional Information

- Patient gender should be based upon self-report or identified by a family member.
- Report Element Value "4. Non-disclosed" if the patient was asked and declined to answer.
- The null value "Not Known/Not Recorded" is reported for patients who were not asked, or if there was no gender identity documented.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run report
6. History & Physical

References to Other Databases

- NTDS 2027

GENDER-AFFIRMING HORMONE THERAPY

Element Intent

To analyze variations in injury patterns and outcomes.

Description

Is the patient currently (i.e., within the past 30 days) taking gender-affirming hormone therapy?

Element Values

1. Yes
2. No
3. Non-disclosed

Additional Information

- Gender-affirming hormone therapy includes but is not limited to estrogen, antiandrogens, and testosterone.
- If unclear if medication was for gender-affirming hormone therapy, then consult TMD or relevant physician/physician extender.
- Report Element Value "3. Non-disclosed" if the patient was asked and declined to answer.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run report
6. History & Physical

References to Other Databases

- NTDS 2027

RACE

Element Intent

To analyze variations in injury patterns and outcomes.

Description

Race is the patient's race.

Element Values

1 Asian
2 Native Hawaiian or Other Pacific Islander
3 Other Race
4 American Indian
5 Black or African American
6 White

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage/Trauma Flow Sheet
5 EMS Run report
6 History & Physical

References to Other Databases

- NTDS 2027

ETHNICITY

Element Intent

To analyze variations in injury patterns and outcomes.

Description

Ethnicity is the patient's ethnicity in terms of Hispanic heritage.

Element Values

1 Hispanic or Latino
2 Not Hispanic or Latino

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Face Sheet
2 Billing Sheet
3 Admission Form
4 Triage/Trauma Flow Sheet
5 History & Physical
6 EMS Run Report

References to Other Databases

- NTDS 2027

PRIMARY ICD-10 EXTERNAL CAUSE CODE

Element Intent

To identify potential injuries and are used as predictors of adverse outcomes.

Description

Primary External Cause Code is a designation used to describe the mechanism (or external factor) that caused the injury event.

Element Values

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

Common Null Values

- Not Accepted

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 should not be reported for this data element.
- Activity codes should not be reported for this data element.
- 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.

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage Form/Trauma Flow Sheet
3 Nursing Notes/Flow Sheet
4 History & Physical
5 Progress Notes

References to Other Databases

- NTDS 2027

ADDITIONAL ICD-10 EXTERNAL CAUSE CODE

Element Intent

To identify potential injuries and are used as predictors of adverse outcomes.

Description

Additional External Cause Code is used in conjunction with the 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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is used if no additional external cause codes are used
- Activity codes should not be reported for this data element
- Report all that apply (maximum 2)
- 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 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 accident 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.

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage Form/Trauma Flow Sheet
3 Nursing Notes/ Flow Sheet
4 History & Physical
5 Progress Notes

References to Other Databases

- NTDS 2027

ICD-10 PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Element Intent

To provide geographic context to the injury and describes the nature, activity, and cause.

Description

ICD-10 Place of Occurrence external cause code is a Y92.x code used to describe the place, site or location of the injury event.

Element Values

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

Common Null Values

- Not Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage Form/Trauma Flow Sheet
3 Nursing Notes/ Flow Sheet
4 History & Physical
5 Progress Notes

References to Other Databases

- NTDS 2027

WORK-RELATED

Element Intent

To analyze variations in injury patterns and outcomes.

Description

Work-related is whether the injury occurred during paid employment.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet
3 History & Physical
4 Face Sheet
5 Billing Sheet

References to Other Databases

- NTDS 2027

INJURY INCIDENT DATE

Element Intent

To analyze the timeline of the care event and the timeliness of interventions.

Description

Injury Incident Date is the date that the injury occurred.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- Estimates of the date of injury should be based upon report by patient, witness, family or health care provider (onset date). Other proxy measures (e.g. 911 call-time) should NOT be used.

Data Source Hierarchy Guide

1 EMS Run report
2 Triage/Trauma Flow Sheet
3 History & Physical
4 Face Sheet

References to Other Databases

- NTDS 2027

INJURY INCIDENT TIME

Element Intent

To analyze the timeline of the care event and the timeliness of interventions.

Description

Injury Incident Time is the time of day that the injury occurred.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider (onset time). Other proxy measures (e.g. 911 call-time) should NOT be used.

Data Source Hierarchy Guide

1 EMS Run report
2 Triage/Trauma Flow Sheet
3 History & Physical
4 Face Sheet

References to Other Databases

- NTDS 2027

INCIDENT CITY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Incident City is the city or township where the incident occurred.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town.
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2027

NOTE: INCIDENT CITY differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

INCIDENT STATE

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Incident State is the state, territory or province where the incident occurred.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2027

NOTE: INCIDENT STATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

INCIDENT COUNTY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Incident County is the county or parish where the incident occurred.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code
- If Incident Country is not US, report the null value "Not Applicable."

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2027

NOTE: INCIDENT COUNTY differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

INCIDENT LOCATION ZIP CODE

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Incident Location Zip Code is the zip code of the location where the patient was injured.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Stored as a five-digit code (XXXXX).
- If "Not Known/Not Recorded," report variables: Incident Country, Incident State (US Only), Incident County (US Only) and Incident City (US Only).
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is documented, then must report Incident Country.

Data Source Hierarchy Guide

1 EMS Run Report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2027

NOTE: INCIDENT LOCATION ZIP CODE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

INCIDENT COUNTRY

Element Intent

To conduct geospatial analyses or for linkage with geographic data sources.

Description

Incident Country is the country where the incident occurred.

Element Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character FIPS codes representing a 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 Home City

Data Source Hierarchy Guide

1 EMS Run report
2 Triage/Trauma Flow Sheet

References to Other Databases

- NTDS 2027

PROTECTIVE DEVICES

Element Intent

To analyze the prevalence and effects of safety equipment.

Description

Protective Devices is the safety equipment in use or worn by the patient at the time of the injury.

Element Values

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

Common Null Values

- Accepted
- Element cannot be “Not Applicable”

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage/Trauma Flow Sheet
3 Nursing Notes / Flow Sheet
4 History & Physical

References to Other Databases

- NTDS 2027

CHILD SPECIFIC RESTRAINT

Element Intent

To analyze the prevalence and effects of safety equipment.

Description

Child Specific Restraint indicates protective child restraint devices used by the pediatric patient at the time of injury.

Element Values

1 Child Car Seat
2 Infant Car Seat
3 Child Booster Seat

Common Null Values

- Accepted

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only reported when *Protective Devices* include “6. Child Restraint (booster seat or child car seat).”
- The null value "Not Applicable" is reported if Element Value 6. "Child Restraint" is NOT reported for Protective Devices.
- Report Element Value “1. Child Car Seat” for forward-facing child seats.
- Report Element Value “2. Infant Car Seat” for rear-facing child seats.

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage/Trauma Flow Sheet
3 Nursing Notes / Flow Sheet
4 History & Physical

References to Other Databases

- NTDS 2027

AIRBAG DEPLOYMENT

Element Intent

To analyze the prevalence and effects of safety equipment.

Description

Airbag Deployment indicates whether an airbag deployed during a motor vehicle crash.

Element Values

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

Common Null Values

- Accepted

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."
- Airbag Deployed Front should be reported for patients with documented airbag deployments, but are not further specified.
- The null value "Not Applicable" is reported if Element Value 8. "Airbag Present" is NOT reported for Protective Devices.

Data Source Hierarchy Guide

1 EMS Run Sheet
2 Triage/Trauma Flow Sheet
3 Nursing Notes / Flow Sheet
4 History & Physical

References to Other Databases

- NTDS 2027

TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL

Element Intent

To analyze patterns between different transportation modes.

Description

Transport Mode for Arrival at Your Hospital is the manner of transport delivering the patient to your hospital.

Element Values

1 Ground Ambulance
2 Helicopter Ambulance
3 Fixed-wing Ambulance
4 Private or Public Vehicle or Walk-in
5 Police Transport
6 Other Transport Mode

Common Null Values

- Accepted

Additional Information

- Example of "Other Transport Mode" include boat
- Examples of "Public or Private or Walk-in" include: bus, bicycle or personal vehicle
- If a patient was a visitor/in-house patient at your facility and experienced an event to require admission to the ED select patient's mode of arrival as "4/Private or Public Vehicle or Walk-In".

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- NTDS 2027

NOTE: TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

TRANSPORT AGENCY

Element Intent

This identifies the EMS agency that treated the patient prior to arrival at the destination facility and provides vital information regarding the patient's prehospital care.

Description

Transport Agency is the EMS agency or air ambulance that delivered the patient to your hospital.

Element Values

- Relevant value for data element (ODPS-assigned EMS Agency ID)

Common Null Values

- Accepted

Additional Information

- "Non-applicable" (NA) is used to indicate that a patient arrived via "Private or Public Vehicle or Walk-in," "Police Transport," or "Other Transport Mode"
- Transport Agency information can be found at: https://ems.ohio.gov/ems-trauma-data/data-center-resources/ohio-ems-agency-list
- If identify agency not listed contact emsdata@dps.ohio.gov

Data Source Hierarchy Guide

1 EMS Run Report
2 ED Record

References to Other Databases

- Not an NTDS element

OTHER TRANSPORT MODES

Element Intent

To analyze patterns between different transportation modes.

Description

Other Transport Modes documents all other types of transport used during patient care prior to the patient arriving at your hospital, except the transport mode delivering the patient to your hospital.

Element Values

1 Ground Ambulance
2 Helicopter Ambulance
3 Fixed-wing Ambulance
4 Private or Public Vehicle or Walk-in
5 Police Transport
6 Other Transport Mode

Common Null Values

- Accepted

Additional Information

- For patients with an unspecified mode of transport, select 6, *Other*
- The null value "Not Applicable" is reported to indicate that a patient had a single mode of transport.
- Report all that apply with a maximum of 5.
- An example is an ambulance transporting the patient to the helicopter landing zone.

Data Source Hierarchy Guide

1. EMS Run Report
2. Transfer Facility Records

References to Other Databases

- NTDS 2027

NOTE: OTHER TRANSPORT MODES differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

EMS PATIENT CARE REPORT UNIQUE IDENTIFIER (UUID)

Element Intent

To link hospital and EMS data systems.

Description

The universally unique identifier (UUID) of the patient care report (PCR) of each emergency 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}-[afA-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."
- Consistent with NEMSIS v3.5.0.
- 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.

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- NTDS 2027

EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is reported for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

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

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

The date the unit *transporting to your hospital* arrived on the scene/transferring facility (the time the vehicle stopped moving).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

The time the unit *transporting to your hospital* arrived on the scene (the time the vehicle stopped moving).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

The date the unit *transporting to your hospital* left the scene (the time the vehicle started moving).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as YYYY-MM-DD
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Element Intent

This provides information regarding the patient's prehospital care in relation to how quickly the EMS agency was able to arrive at the patient, spend time at the scene, and transport the patient to a destination facility.

Description

The time the unit *transporting to your hospital* left the scene (the time the vehicle started moving).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM military time
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).
- The null value "Not Applicable" is used for patients who were not transported by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field *Systolic Blood Pressure* is the first recorded systolic blood pressure measured.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in."
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field systolic blood pressure was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD PULSE RATE

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field Pulse Rate is the first recorded pulse measured (palpated or auscultated), expressed as a number per minute.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in."
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field pulse rate was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD RESPIRATORY RATE

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field Respiratory Rate is the first recorded respiratory rate measured (expressed as a number per minute).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- The null value "Not Applicable" is reported for patients who arrive by "4. Private/Public Vehicle/Walk-in."
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field respiratory rate was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD OXYGEN SATURATION

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field Oxygen Saturation is the first recorded oxygen saturation measured (expressed as a percentage).

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- The null value "Not Applicable" is reported for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field oxygen saturation was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - EYE

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field GCS Eye Opening is the first recorded Glasgow Coma Score eye assessment done.

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

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient's pupils are PERRL," an Eye GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/ Walk-in
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS-Eye was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - VERBAL

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field GCS Verbal Response is the first recorded Glasgow Coma Score verbal assessment done.

Element Values

- Pediatric(<= 2 years of age)
  1. No vocal response
  2. Inconsolable, agitated
  3. Inconsistently consolable, moaning
  4. Cries but is consolable, inappropriate interactions
  5. Smiles, oriented to sounds, follows objects, interacts
- Adult
  1. No verbal response
  2. Incomprehensible sounds
  3. Inappropriate words
  4. Confused
  5. Oriented

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If patient is intubated, then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient is oriented to person place and time," a Verbal GCS of 5 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/ Walk-in
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Verbal was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - MOTOR

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field GCS Motor Response is the first recorded Glasgow Coma Score motor assessment done.

Element Values

• Pediatric (<= 2 years of age)	• Adult
1 No motor response	1 No motor response
2 Extension to pain	2 Extension to pain
3 Flexion to pain	3 Flexion to pain
4 Withdrawal from pain	4 Withdrawal from pain
5 Localizing pain	5 Localizing pain
6 Appropriate response to stimulation	6 Obeys commands

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS - TOTAL

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field GCS Total is the first recorded total Glasgow Coma Score done.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- 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 who arrive by "4. Private/Public Vehicle/Walk-in"
- The null value "Not Known/Not Recorded" is reported if the patient's first recorded initial field GCS - Total was NOT measured

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

INITIAL FIELD GCS QUALIFIER

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Initial Field GCS Qualifier documents circumstances related to the patient when or near the time that the *Initial Field GCS Total* was obtained.

Element Values

1 Patient is chemically sedated or paralyzed
2 Obstruction to the patient's eye(s) prevents accurate eye assessment
3 Patient is intubated
4 GCS is valid meaning that the patient is not sedated, not intubated and without eye obstruction

Common Null Values

- Accepted

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This element does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- Element Value "1. Patient Chemically Sedated or Paralyzed" 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 agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that the first recorded vitals do not need to be from the same assessment.
- Select *NA* if the patient was not transported to your hospital by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

SCENE INTERVENTIONS

Element Intent

This provides information regarding the patient's prehospital care and health status.

Description

Scene Interventions indicates whether a critical procedure was performed by EMS at the scene or en route to your hospital, and if so, the procedure that was performed.

Element Values

1 CPR
2 Needle Thoracostomy or Chest Tube
3 Nasal Endotracheal Tube
4 Oral Endotracheal Tube
5 Surgical Airway (i.e. surgical, needle or percutaneous cricothyrotomy, tracheostomy)
6 Other Non-Surgical Airway (Supraglottic Airway (e.g., Laryngeal Mask Airway, King, Combitube))
7 Tourniquet
8 Finger Thoracostomy
9 Packed Red Blood Cells (PRBC) Administration
10 Whole Blood Administration
11 Fresh Frozen Plasma (FFP)
12 Freeze dried Plasma (FDP)
13 Tranexamic Acid (TXA)

Common Null Values

- Accepted
- Do not include referring or inter-facility transport interventions

Additional Information

- Select *NA* If the patient was not treated at the scene by EMS

Data Source Hierarchy Guide

1 EMS Run Report

References to Other Databases

- Not an NTDS element

PREHOSPITAL CARDIAC ARREST

Element Intent

Pre-hospital cardiac arrest is associated with increased risk of mortality which could impact care decisions and increase the risk of adverse outcomes.

Description

Prehospital Cardiac Arrest is indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 EMS Run Report
2 Nursing Notes/Flow Sheet
3 History & Physical
4 Transfer Facility Records

References to Other Databases

- NTDS 2027

INTUBATION PRIOR TO ARRIVAL

Element Intent

To indicate respiratory compromise, which could increase the risk of adverse outcomes.

Description:

The patient is intubated with a definitive airway due to this injury prior to arrival at your hospital.

INCLUDE:

- Definitive airways placed below the vocal cords (e.g., endotracheal tube (ET), tracheostomy, cricothyroidotomy).

EXCLUDE:

- Airways not placed below the vocal cords (e.g., combitube, KING, laryngeal mask airway (LMA), I-Gel).

Element Values

1. Yes
2. No

Additional Information :

- **If Element Value "1. Yes" is reported, report Intubation Location.**
- **The Null value "Not Applicable" is reported for patients who had an established airway prior to this injury event (e.g., Chronic Ventilator Dependence).**

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

INTUBATION LOCATION

Element Intent

To determine if the patient was intubated inside or outside of a hospital setting, which can inform outreach and improve prehospital care strategies.

Description

The location the patient was intubated at prior to hospital arrival.

Element Values

1. Out of the Hospital Intubation
2. Transferring Facility

Additional Information

- Only reported if Intubation Prior to Arrival is Element Value "1. Yes".
- The null value "Not Applicable" is reported if Intubation Prior to Arrival is reported as Element Value "2. No"
- The null value "Not Applicable" is reported if Intubation Prior to Arrival is reported as "Not Applicable."
- The null value "Not Known/Not Recorded" is reported if Intubation Prior to Arrival is reported as "Not Known/Not Recorded."
- Element Value "1. Out of Hospital Intubation" included intubations performed in the field, during transport occurred, report the location of the first intubation.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

BLOOD PRESSURE SUPPORT

Element intent

To identify patients who arrived with blood pressure support, including blood transfusions, intravenous vasopresors or, inotropes. Blood pressure support agents suggest that the initial blood pressure in the ED might not represent the clinical
status of the patient and so might impact care decisions.

Description

Blood pressure support administered within 30 minutes prior to ED/hospital arrival.

Element values

1. None
2. Blood Transfusion
3. Intravenous Vasopressor

Additional information

- Report all that apply.
- Intravenous vasopressors include dopamine, epinephrine, norepinephrine, and vasopressin.
- If blood pressure support was initiated prior to arrival at your hospital and remained ongoing, it must have continued up to 30 minutes prior to arrival at your hospital.
- Element Value “2. Blood Transfusion” includes red blood cells and whole blood.
- Report Element Value “1. None” if the patient received blood pressure support that is not listed as an available Element Value or if the patient did not receive blood pressure support.

Data source hierarchy guide

1. EMS Run Report
2. Transferring Facility Records
3. History and Physical
4. Physician Notes/Flow Sheet
5. Progress Notes
6. Nursing Notes/Flow Sheet
7. Triage/Trauma Flow Sheet
8. Discharge Summary

INTER-FACILITY TRANSFER

Element Intent

To analyze system utilization and outcomes.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Include, patients who require physical transfer from a free-standing emergency department (ED) to an affiliated hospital.
- Patients transferred from a private doctor's office or stand-alone ambulatory surgery centers 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.
- 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", https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/Downloads/DataNav_Glossary_Alpha.pdf .

Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow sheet
3. History & Physical
4. Transfer Facility Records

References to Other Databases

- NTDS 2027

TRANSFERRING HOSPITAL CODE

Element Intent

If the patient was transferred from another hospital, this identifies that facility. This helps for data linkage purposes and to also track the level of care the patient received.

Description

Transferring Hospital Code documents the Ohio Department of Public Safety (ODPS) assigned-number for the acute care facility which transferred a trauma patient to your hospital.

Element Values

1. Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Additional Information

- Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
- If identify hospital not listed contact emsdata@dps.ohio.gov

Data Source Hierarchy Guide

1 ED Record
2 History & Physical

References to Other Databases

- Not an NTDS element

ED/HOSPITAL ARRIVAL DATE

Element Intent

To calculate metrics such as hospital length of stay, provider response times, and medical intervention start times.

Description

ED/Hospital Arrival Date is the date that the patient arrived at your ED/hospital.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

ED/HOSPITAL ARRIVAL TIME

Element Intent

To calculate metrics such as hospital length of stay, provider response times, and medical intervention start times.

Description

ED/Hospital Arrival Time is the time of day that the patient arrived to your ED/hospital.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

1. If the patient was brought to your hospital ED, enter the time patient arrived at the ED. If the patient was a directly admit to your hospital and bypassed the ED, enter that time that the patient was admitted to your hospital.
2. Collected as HHMM military time

Data Source Hierarchy Guide

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

References to Other Databases

1. NTDS 2027

HIGHEST ACTIVATION

Element Intent

To analyze response times, under/over triage, and resource utilization.

Description

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

INCLUDE:

1. Patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
2. 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.
3. 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:

1. 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.
- Non-Trauma Center Facilities report the null value "Not Applicable" (NA)

Data Source Hierarchy Guide

1 Triage/Trauma Flow Sheet
2 ED Record
3 History & Physical
4 Physician Notes
5 Discharge Summary

References to Other Databases

- NTDS 2027

TRAUMA SURGEON ARRIVAL DATE

Element Intent

To analyze provider response times.

Description

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

Element Values

1. Relevant value for data element

Additional Information

- Reported as YYYY-MM-DD.
- Limit reporting to the 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.
- The null value "Not Applicable" is reported if the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

1 Triage/Trauma Flow Sheet
2 History & Physical
3 Physician Notes
4 Nursing Notes

References to Other Databases

- NTDS 2027

TRAUMA SURGEON ARRIVAL TIME

Element Intent

To analyze provider response times.

Description

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

Element Values

1. Relevant value for data element

Additional Information

- Reported as HHMM.
- Limit reporting to the 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.
- The null value "Not Applicable" is reported if the data element *Highest Activation* is reported as *Element Value* "2. No."

Data Source Hierarchy Guide

1 Triage/Trauma Flow Sheet
2 History & Physical
3 Physician Notes
4 Nursing Notes

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Element Intent

A critical indicator of hemodynamic stability on arrival, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

ED/Hospital Initial Systolic Blood Pressure is the patient's first recorded systolic blood pressure within 30 minutes or less of ED/hospital arrival.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Physician Notes
4 History & Physical

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL PULSE RATE

Element Intent

A critical indicator of the body's response to injury and blood loss, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

ED/Hospital Initial Pulse Rate is the patient's first recorded pulse rate within 30 minutes or less of ED/hospital arrival (palpated or auscultated), expressed as a number per minute.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL RESPIRATORY RATE

Element Intent

A critical indicator of the body's overall physiological condition, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

ED/Hospital Initial Respiratory Rate is the patient's first recorded respiratory rate within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Respiratory Therapy Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Element Intent

A critical indicator of the patient's respiratory status on arrival, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

ED/Hospital Initial Respiratory Assistance documents whether the patient was receiving respiratory assistance within 30 minutes or less of ED/hospital arrival.

Element Values

1 Unassisted Respiratory Rate
2 Assisted Respiratory Rate

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Respiratory Therapy Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL OXYGEN SATURATION

Element Intent

A critical indicator of the patient's ability to deliver oxygen to tissues, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

ED/Hospital Initial Oxygen Saturation is the patient's first recorded oxygen saturation within 30 minutes or less of ED/hospital arrival, expressed as a percentage.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Respiratory Therapy Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Element Intent

To determine whether the recorded initial ED/Hospital Oxygen Saturation value reflects the underlying patient condition alone or was influenced by oxygen therapy.

Description

ED/Hospital Supplemental Oxygen is whether supplemental oxygen was provided to the patient during the assessment of *ED/Hospital Initial Oxygen Saturation Level* within 30 minutes or less of ED/hospital arrival.

Element Values

1 No Supplemental Oxygen
2 Supplemental Oxygen

Common Null Values

1. Accepted

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL TEMPERATURE

Element Intent

A critical indicator for the presence of hypothermia, which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

Initial ED/Hospital Temperature is the patient's first recorded temperature within 30 minutes or less of ED/hospital arrival, documented in degrees Fahrenheit.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL GCS - EYE

Element Intent

The GCS-Eye score is one component of the Total GCS and provider information on the severity of neurologic impairment. Collecting the initial provides identification of the patient's state on arrival.

Description

Initial ED/Hospital GCS Eye Opening is the patient's first recorded Glasgow Coma Score (GCS) eye assessment documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

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

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL GCS - VERBAL

Element Intent

The GCS-Verbal score is one component of the Total GCS and provider information on the severity of neurologic impairment. Collecting the initial provides identification of the patient's state on arrival.

Description

ED/Hospital Initial GCS Verbal Response is the patient's first recorded Glasgow Coma Score verbal assessment documented within 30 minutes or less of ED/hospital arrival.

Element Values

- Pediatric(<= 2 years of age)
  1. No vocal response
  2. Inconsolable, agitated
  3. Inconsistently consolable, moaning
  4. Cries but is consolable, inappropriate interactions
  5. Smiles, oriented to sounds, follows objects, interacts
- Adult
  1. No verbal response
  2. Incomprehensible sounds
  3. Inappropriate words
  4. Confused
  5. Oriented

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1. Triage/Trauma/ Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL GCS - MOTOR

Element Intent

The GCS-Motor score is one component of the Total GCS and provider information on the severity of neurologic impairment. Collecting the initial provides identification of the patient's state on arrival.

Description

ED/Hospital Initial GCS Motor Response is the patient's first recorded Glasgow Coma Score motor assessment documented within 30 minutes or less of ED/hospital arrival.

Element Values

- Pediatric(<= 2 years of age)
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Appropriate response to stimulation
- Adult
  1. No motor response
  2. Extension to pain
  3. Flexion to pain
  4. Withdrawal from pain
  5. Localizing pain
  6. Obeys commands

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1. Triage/Trauma/ Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL GCS - TOTAL

Element Intent

The GCS-Total score is used to gauge the severity of neurologic impairment. Collecting the initial provides identification of the patient's state on arrival.

Description

ED/Hospital Initial GCS Total Score is the patient's first recorded Glasgow Coma Score documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/ Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2027

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Element Intent

The GCS-Assessment Qualifier(s) indicate a GCS that might be altered due to a medical intervention.

Description

ED/Hospital Initial GCS Qualifiers are factors that potentially affected the patient's first Glasgow Coma Score assessment within 30 minutes or less of ED/hospital arrival.

Element Values

1 Patient Chemically Sedated or Paralyzed
2 Obstruction to the Patient's Eye
3 Patient Intubated
4 Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Common Null Values

- Accepted

Additional Information

- Report all that apply.
- 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* "1. Patient Chemically Sedated or Paralyzed" 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 agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that the first recorded hospital vitals do not need to be from the same assessment.
- The null value "Not Known/Not Recorded" is reported if ***Initial ED/Hospital GCS-40*** is reported.
- The null value "Not Known/Not Recorded" is reported if the ***Initial ED/Hospital GCS Assessment Qualifiers*** are not documented within 30 minutes of ED/hospital arrival.

Data Source Hierarchy Guide

1 Triage/Trauma/ Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Physician Notes/Flow Sheet

References to Other Databases

- NTDS 2027

HEIGHT

Element Intent

To calculate body mass index (BMI) which could impact care decisions and increase the risk of adverse outcomes.

Description

Height is the patient's height in centimeters.

Element Values

1. Height in centimeters

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Pharmacy Record

References to Other Databases

- NTDS 2027

NOTE: HEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

WEIGHT

Element Intent

To calculate body mass index (BMI) which could impact care decisions and increase the risk of adverse outcomes.

Description

Weight is the patient's weight in kilograms.

Element Values

1. Weight in kilograms

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Triage/Trauma/Hospital Flow Sheet
2 Nurses Notes/Flow Sheet
3 Pharmacy Record

References to Other Databases

- NTDS 2027

NOTE: WEIGHT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE ORDER WRITTEN DATE

Element Intent

Provides information about the patient's ED disposition, which helps track the level of care the patient received.

Description

ED Discharge Order Written Date is the date that the order was written for the patient to be discharged from your ED.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Hospital Discharge Summary
2 Billing Sheet/Medical Records Coding Summary Sheet
3 Physicians' Progress Notes

References to Other Databases

- Not an NTDS element

NOTE: ED DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE ORDER WRITTEN TIME

Element Intent

Provides information about the patient's ED disposition, which helps track the level of care the patient received.

Description

ED Discharge Order Written Time is the time that the order was written for the patient to be discharged from your ED.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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
- Collected as HHMM military time

Data Source Hierarchy Guide

1 Hospital Discharge Summary
2 Billing Sheet/Medical Records Coding Summary Sheet
3 Physicians' Progress Notes

References to Other Databases

- Not an NTDS element

NOTE: ED DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED DISCHARGE DATE

Element Intent

To calculate metrics such as hospital length of stay and to inform the care timeline.

Description

ED Discharge Date is the date that the patient was physically discharged from your ED.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected 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 death as indicated on the patient’s death certificate

Data Source Hierarchy Guide

1 Physician Order
2 ED Record
3 Triage/Trauma/Hospital Flow Sheet
4 Nursing Notes/Flow Sheet
5 Discharge Summary
6 Billing Sheet
7 Progress Notes

References to Other Databases

- NTDS 2027 (element name only)

NOTE: ED DISCHARGE DATE differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED DISCHARGE TIME

Element Intent

To calculate metrics such as hospital length of stay and to inform the care timeline.

Description

ED Discharge Time is the time that the patient was physically discharged from your ED.

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as HHMM 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

Data Source Hierarchy Guide

1 Physician Order
2 ED Record
3 Triage/Trauma/Hospital Flow Sheet
4 Nursing Notes/Flow Sheet
5 Discharge Summary
6 Billing Sheet
7 Progress Notes

References to Other Databases

- NTDS 2027 (element name only)

NOTE: ED DISCHARGE TIME differs from NTDS. Please refer to the section “DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)” starting on Page 12 for more information.

ED DISCHARGE DISPOSITION

Element Intent

To indicate the patient's medical needs after their ED phase of care is complete.

Description

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

Element Values

1 Floor bed (general admission, non-specialty unit bed)
2 Observation unit
3 Telemetry/step-down unit (less acuity than ICU)
5 Deceased/Expired
6 Other (jail, institutional care, mental health, etc.)
7 Operating Room (Hybrid OR)
8 Intensive Care Unit (ICU)
10 Left against medical advice
11 Transferred to another hospital
12 Interventional Radiology Suite
13 Hospice (e.g., hospice facility, hospice unit, Home hospice)
14 Home

Common Null Values

- Accepted

Additional Information

- Element Value "14. Home" refers to the patient's current place of residence (e.g., prison, child protective services, etc.), provided the patient's level of care at discharge is the same as it was prior to their injury event.
- The null value "Not Applicable" is reported if the patient is directly admitted to the hospital
- If ED Discharge Disposition is 5, 6, 10, 11, 13, or 14 then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be "Not Applicable."
- If the patient was boarded in the ED, the disposition must be the location the patient was ordered to go when their ED workup was complete.

Data Source Hierarchy Guide

1 Physician Order
2 Discharge Summary
3 Nursing Notes/Flow Sheet
4 Case Management/Social Services Notes
5 ED Record
6 History & Physical

References to Other Databases

- NTDS 2027

NOTE: ED DISCHARGE DISPOSITION differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ED TRANSFER TO HOSPITAL

Element Intent

Provides information about the patient's ED disposition, which helps track the level of care the patient received.

Description

ED Transfer to Hospital is a subsequent hospital destination of the patient upon discharge from your ED.

Element Values

1. Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

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 the Hospital Discharge date, Time, Disposition and Inpatient Transfer to Hospital should be "Not Applicable"
- Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
- If identify hospital not listed contact emsdata@dps.ohio.gov

Data Source Hierarchy Guide

1 ED Record
2 History & Physical

References to Other Databases

- Not an NTDS element

PRIMARY TRAUMA SERVICE TYPE

Element Intent

To indicate the service primarily responsible for the patient's care because physiological, psychological, and developmental needs differ based on age, which helps to analyze resource utilization and outcomes.

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."
- (OH Specific) Non-trauma facilities and Free-Standing Emergency Departments (FSEDs) should report *Element Value* "1. Adult" for patients age 16 and over; and *Element Value* "2. Pediatric" for patients age 15 and under.

Data Source Hierarch y Guide

1 Triage/Trauma Flow Sheet
2 History and Physical
3 Discharge Summary

References to Other Databases

- NTDS 2027

PRIMARY MEDICAL EVENT

Element Intent

To indicate pre-injury medical conditions that have a high risk of permanent disability or death which could impact care decisions and influence outcomes.

Description:

The patient experienced a documented primary medical event (stroke, myocardial infarction, cardiac arrest, intracranial bleeding, sepsis) that immediately preceded the traumatic injury.

Element Values

1. Yes
2. No

Additional Information :

- Element Value "1. Yes" is reported if the patient experienced a medical event immediately preceding the trauma.
- The null value "Not Known/Not Recorded" is reported if it is unknown the primary medical event immediately preceded the traumatic injury.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

ALCOHOL SCREEN

Element Intent

To identify potential risks that could impact care decisions, increase the risk of adverse outcomes, prolong the length of stay, and to identify those that may benefit from intervention programs.

Description

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

Element Values

1 Yes
2 No

Common Null Values

α. Not Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2027

ALCOHOL SCREEN RESULTS

Element Intent

To identify potential risks that could impact care decisions, increase the risk of adverse outcomes, prolong the length of stay, and to identify those that may benefit from intervention programs.

Description

Alcohol Screen Results is the first recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

Element Values

1. Relevant value for data element

Common Null Values

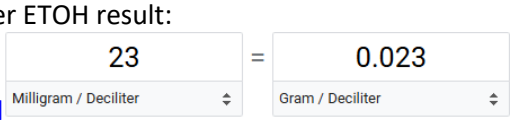
- Accepted

Additional Information

- Collect as X.XX grams per deciliter (g/dl)
- For facilities that report alcohol levels in mg/dL, refer to the example conversion table below to determine the g/dL value.
  - Conversion examples:
  - < 10 mg/dL = 0.00 g/dL
  - 10 mg/dL = 0.01 g/dL
  - 20 mg/dL = 0.02 g/dL
  - 50 mg/dL = 0.05 g/dL
  - 80 mg/dL = 0.08 g/dL
  - 100 mg/dL = 0.10 g/dL
  - 150 mg/dL = 0.15 g/dL
  - 200 mg/dL = 0.20 g/dL
  - 250 mg/dL = 0.25 g/dL
  - 300 mg/dL = 0.30 g/dL
  - 400 mg/dL = 0.40 g/dL

  - A result of “0.219” is reported as “0.21”
  - A result of “267” is reported as “0.26”
  - A result of “23” is reported as “0.02”
  - No rounding of results is done
  - Use this online calculator to convert a whole number ETOH result:

    https://www.convertunits.com/from/mg/dl/to/g/dl

- Record BAC results within 24 hours after first hospital encounter at either your facility or the transferring facility
- The null value “Not Applicable” is used for those patients who were not tested

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2027

DRUG SCREEN

Element Intent

To identify potential risks that could impact care decisions, increase the risk of adverse outcomes, prolong the length of stay, and to identify those that may benefit from intervention programs.

Description

Drug Screen is the first recorded positive drug screen within 24 hours after first hospital encounter (select all that apply).

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

Common Null Values

β. Not Accepted

Additional Information

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

Data Source Hierarchy Guide

1 Lab Results
2 Transferring Facility Records

References to Other Databases

- NTDS 2027

ICD-10 HOSPITAL PROCEDURES

Element Intent

To identify the types of hospital interventions.

Description

Hospital Procedures are all operative and selected non-operative procedures conducted during hospital stay. Operative and selected non- operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to the OTR.

Element Values

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

Common Null Values

- Accepted

Additional Information

- The null value "Not Applicable" is reported if the patient did not have procedures
- Include only procedures performed at your institution
- Report all procedure performed in the operating room
- Report all procures 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.
- Plain radiography of whole body, Plain radiography of whole skeleton, and Plain radiography of infant whole body to the Diagnostic and Therapeutic Imaging.
- Note that the hospital may capture additional procedures

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

PROCEDURE LIST FOR *HOSPITAL PROCEDURES* ELEMENT

DIAGNOSTIC & THERAPEUTIC IMAGING
Computerized tomographic studies* (Head, Chest, Abdomen, Pelvis, C-Spine, T-Spine, L-Spine)
Diagnostic ultrasound (includes FAST)*
Doppler ultrasound of extremities*
Angiography
Angioembolization
REBOA
Inferior vena cava (IVC) filter
Diagnostic imaging interventions on the total body
Plain radiography of whole body
Plain radiography of whole skeleton
Plain radiography of infant whole body

CARDIOVASCULAR
Open cardiac massage
Cardiopulmonary Resuscitation (CPR)

CENTRAL NERVOUS SYSTEM
Insertion of ICP monitor*
Ventriculostomy
Cerebral oxygen monitoring*

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

GENITOURINARY
Ureteric catheterization (i.e. ureteric stent)
Suprapubic cystostomy

MUSCULOSKELETAL
Soft tissue/bony debridement*
Closed reduction fractures
Skeletal (and halo) traction
Fasciotomy

RESPIRATORY
Insertion of endotracheal tube* (Exclude intubations performed in the OR)
Continuous invasive mechanical ventilation*
Chest tube*
Bronchoscopy*
Tracheostomy

TRANSFUSION
The following blood products should be captured over first 24 hours after hospital arrival:
Transfusion of red cells *
Transfusion of platelets *
Transfusion of plasma *

***May be performed multiple times during hospitalization**

PROCEDURE EPISODE

Element Intent

Provides information about patient's care in the hospital.

Description

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

Element Values

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

Common Null Values

- Accepted

Additional Information

- Include only those operative procedures performed at your hospital
- This element is linked to the *Hospital Procedures* element
- Leave element blank if procedure was not performed in the Operating Room
- All of the procedures done in the first OR visit would be Episode 1, all in visit 2 would be Episode 2, and so forth.

Data Source Hierarchy Guide

1 Operative Reports

References to Other Databases

- Not an NTDS element

HOSPITAL PROCEDURE START DATE

Element Intent

To determine the timeliness of hospital interventions.

Description

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

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This element is linked to the Hospital Procedures element
- Collected as YYYY-MM-DD

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

NOTE: HOSPITAL PROCEDURE START DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL PROCEDURE START TIME

Element Intent

To determine the timeliness of hospital interventions.

Description

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

Element Values

1. Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This element is linked to the Hospital Procedures element
- Collected as HHMM military time
- Procedure start time is defined as the time that the incision was made (or the procedure started).

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

NOTE: HOSPITAL PROCEDURE START TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

ADVANCE DIRECTIVE LIMITING CARE

Element Intent
Implementation of a previously signed advanced directive impacts care and influences outcomes.

Description
The patient had a written request to limit life-sustaining treatment that restricted the care for the patient during this patient care event.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

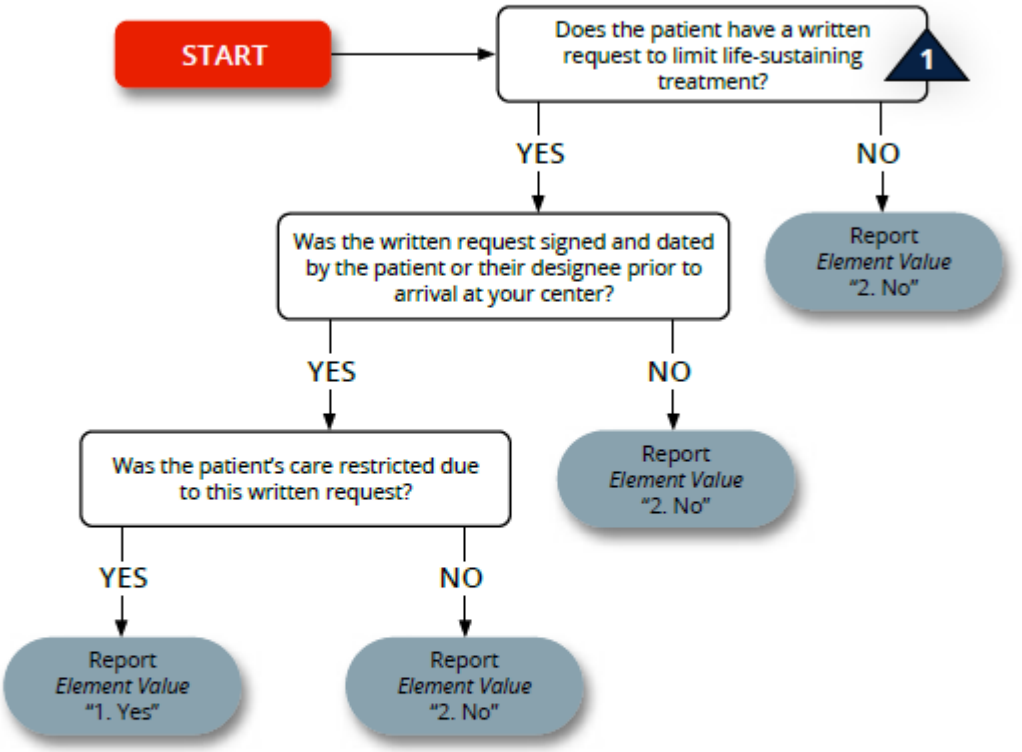
Additional Information
- The written request was signed/dated by the patient and/or his/her designee prior to arrival at your center
- Report Element Value "2. No" for patients with Advanced Directives that did not limit life-sustaining treatments during this patient care event.
- Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craiectomy, operation for hemorrhage control, angiography)
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary
8 Transfer Facility Records

References to Other Databases
- NTDS 2027

Advance Directive Limiting Care

***2026 NTDS Data Dictionary*, Released July 2025**



1 Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography).

ALCOHOL USE DISORDER

Element Intent

Consumption of high levels of alcohol can affect the immune system, negatively affect wound healing, and increase the risk of developing infection, which could impact care decisions, increase the risk of adverse outcomes and prolong length of stay.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

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.
- Consistent with American Psychiatric Association (APA) DSM 5, 2013.
- Based on the patient's age on the day of arrival at your hospital.

Data Source Hierarchy Guide

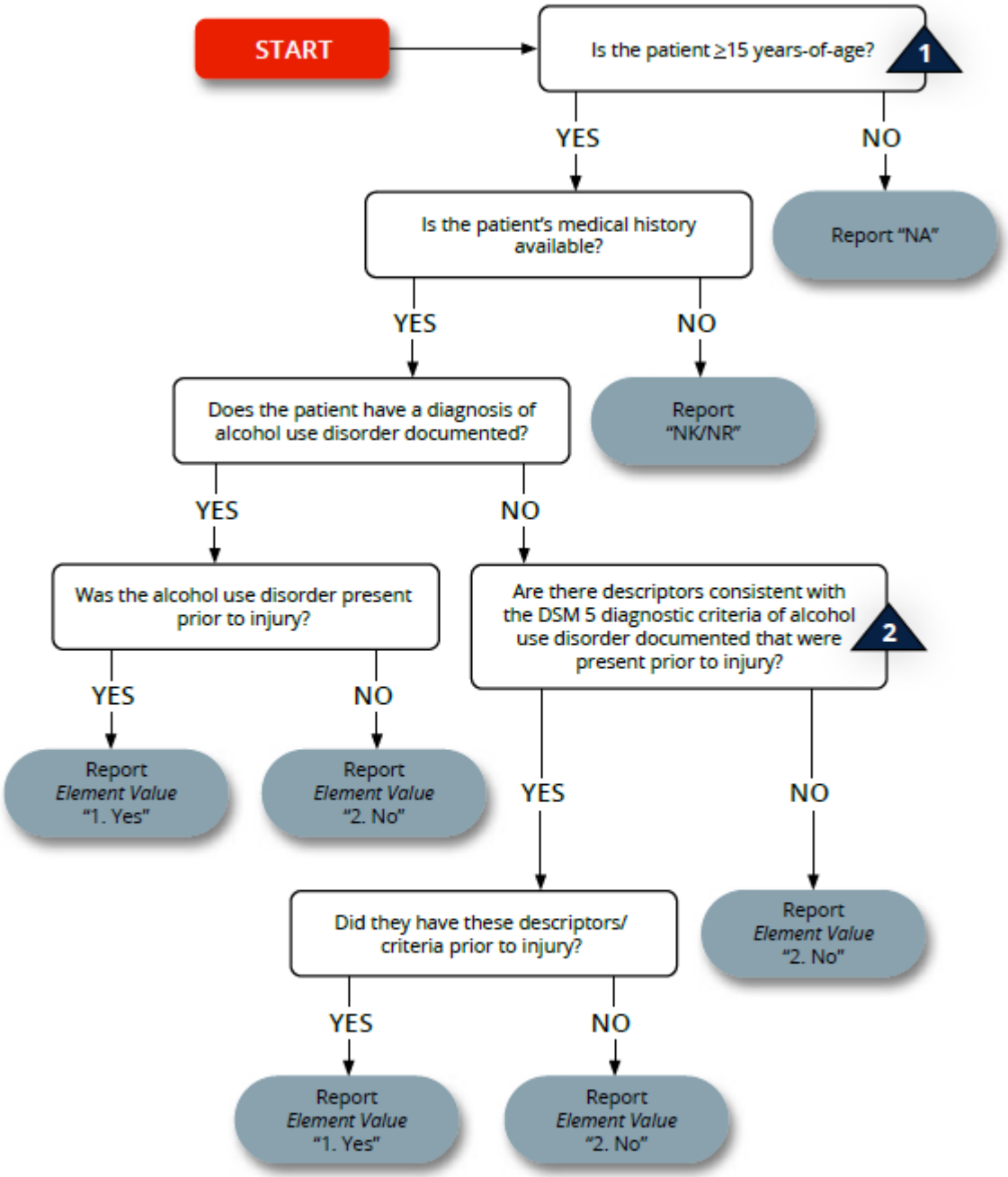
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Alcohol Use Disorder

2026 NTDS Data Dictionary, Released July 2025



1 Based on the patient's age on the day of arrival at your hospital.

2 The NTDS definition is consistent with the American Psychological Association (APA) DSM 5, 2013. Refer to the APA and/or the TPM/TMD for more information.

ANTICOAGULANT THERAPY

Element Intent

Anticoagulants could induce greater risk of bleeding and increase the risk of adverse outcomes.

Description

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

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- Anticoagulant must be part of the patient's active medication.
- Exclude patients whose only anticoagulant therapy is chronic Aspirin.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

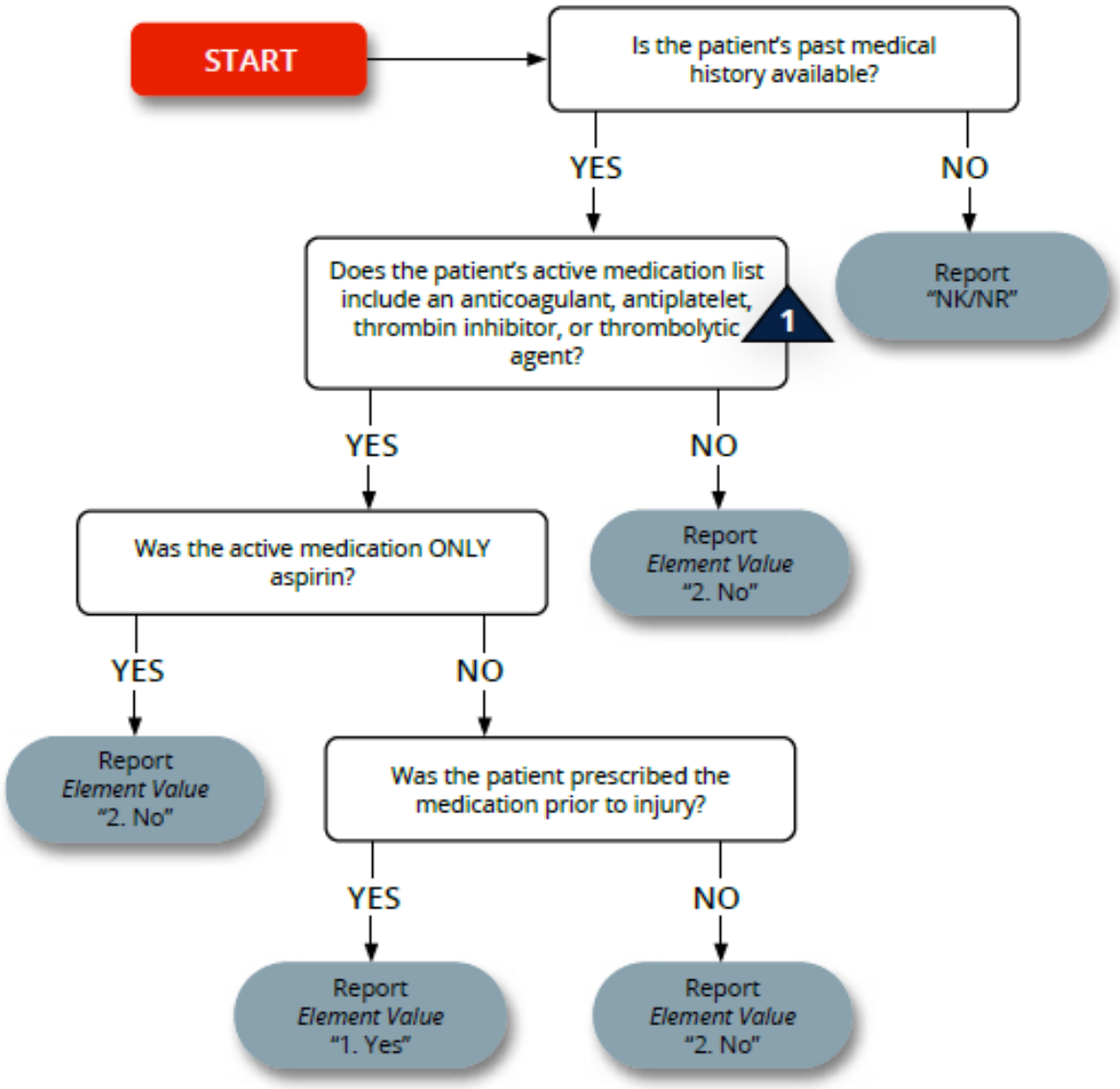
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Anticoagulant Therapy

2026 NTDS Data Dictionary, Released July 2025



1 Examples of commonly prescribed medications that interfere with blood clotting can be found on the definition page. This list is not all-inclusive. If medication meets the definition criteria and is not included in the list, report *Element Value* "1. Yes."

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

Element Intent

Patients with ADD/ADHD experience impulsiveness, restlessness, and difficulty focusing on tasks which could impact care decisions, increase the risk of adverse outcomes, and prolong the length of stay.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of ADD/ADHD must be documented in the patient's medical record.
- Report Element Value "1. Yes" for patients who were non-compliant with their prescribed ADD/ADHD medication.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

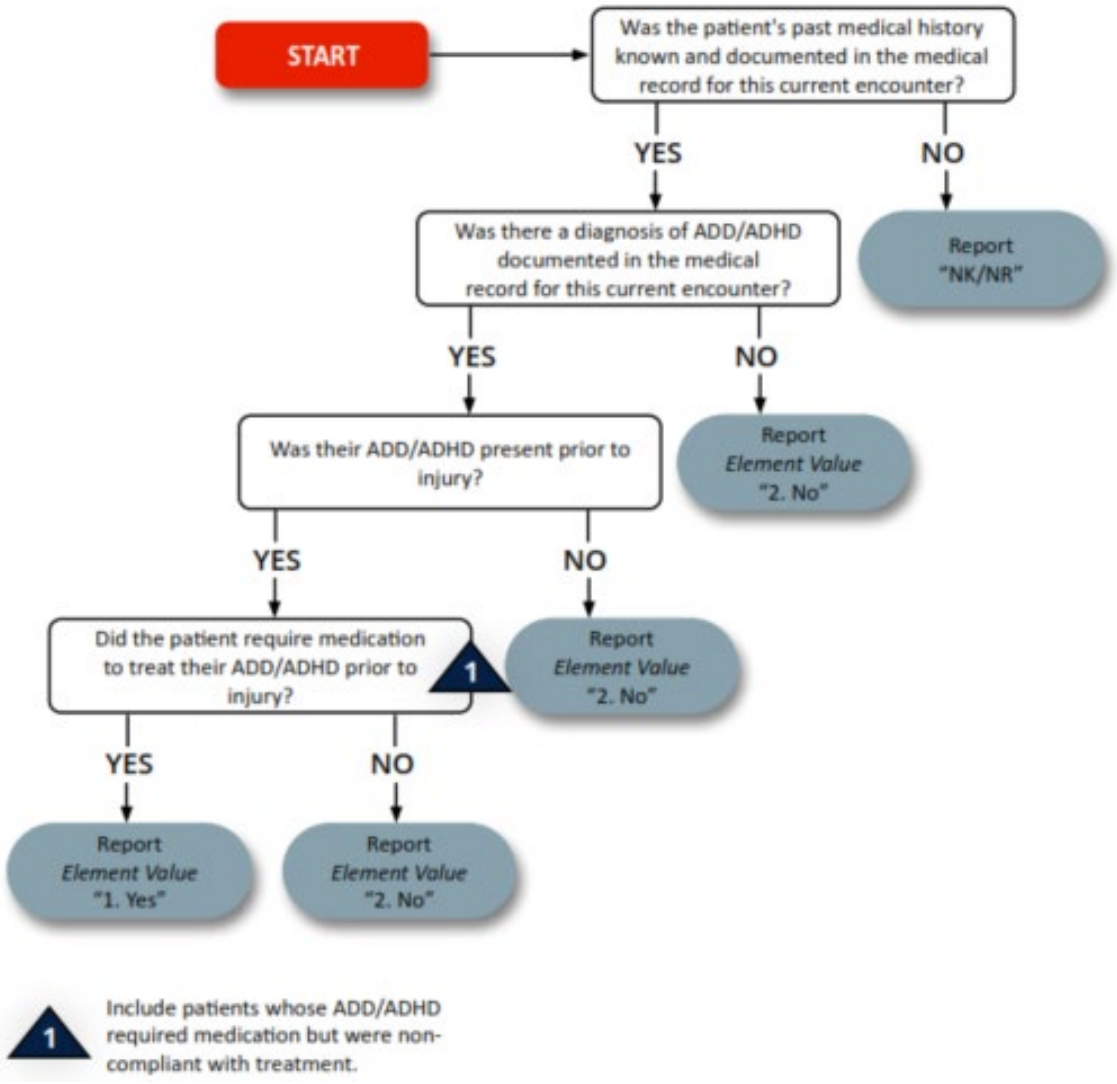
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

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

2027 NTDS Data Dictionary, Released July 2026



AUTISM SPECTRUM DISORDER (ASD) (PRE-EXISTING CONDITIONS)

Element Intent

Patients with ASD experience problems with social communications and interaction, restricted or repetitive behaviors or interest, and/or different ways of learning, moving, or paying attention, which could impact care decisions and increase the risk of adverse outcomes.

Description:

A disorder involving problems with social communication and interaction, and restricted or repetitive behaviors or interests as well as different ways of learning, moving, or paying attention.

Element Values

1. Yes
2. No

Additional Information :

- Present prior to injury.
- A diagnosis of ASD must be documented in the patient's medical record (e.g., autism, autism spectrum disorder, or Asperger's syndrome/disorder).
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

Data Source Hierarchy Guide

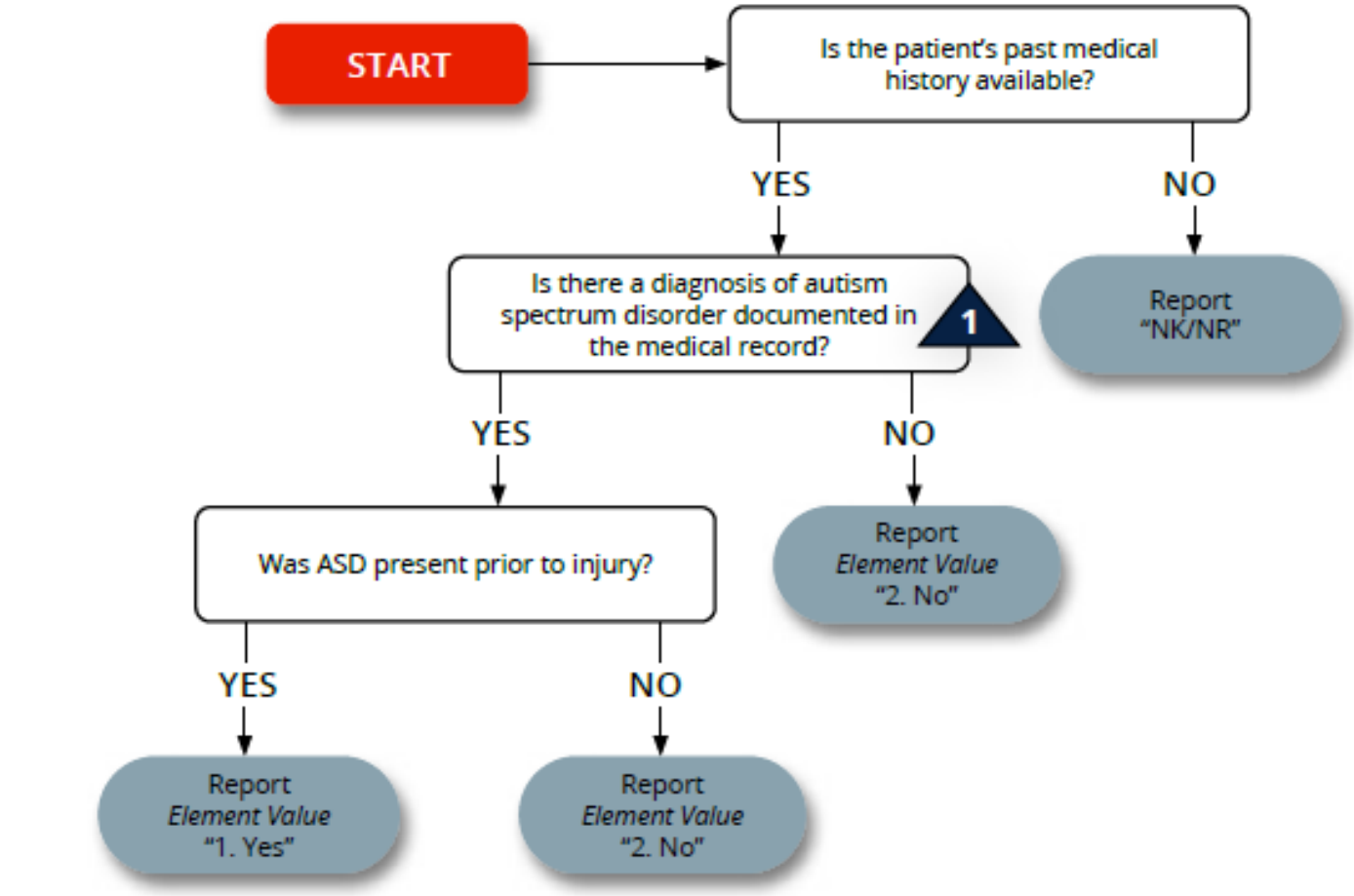
1. Physician Notes/Flow Sheet
2. History and Physical
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases

- NTDS 2027

Autism Spectrum Disorder (ASD)

***2026 NTDS Data Dictionary*, Released July 2025**



1 Might also be referred to as autism, ASD, or Asperger's syndrome/disorder.

BIPOLAR I/II DISORDER

Element Intent

Patients with Bipolar Disorder experience severe mood disturbances that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Description

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

Element Values

1 Yes
2 No

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.
- Based on patient's age on the day of arrival at your hospital.

Data Source Hierarch y Guide

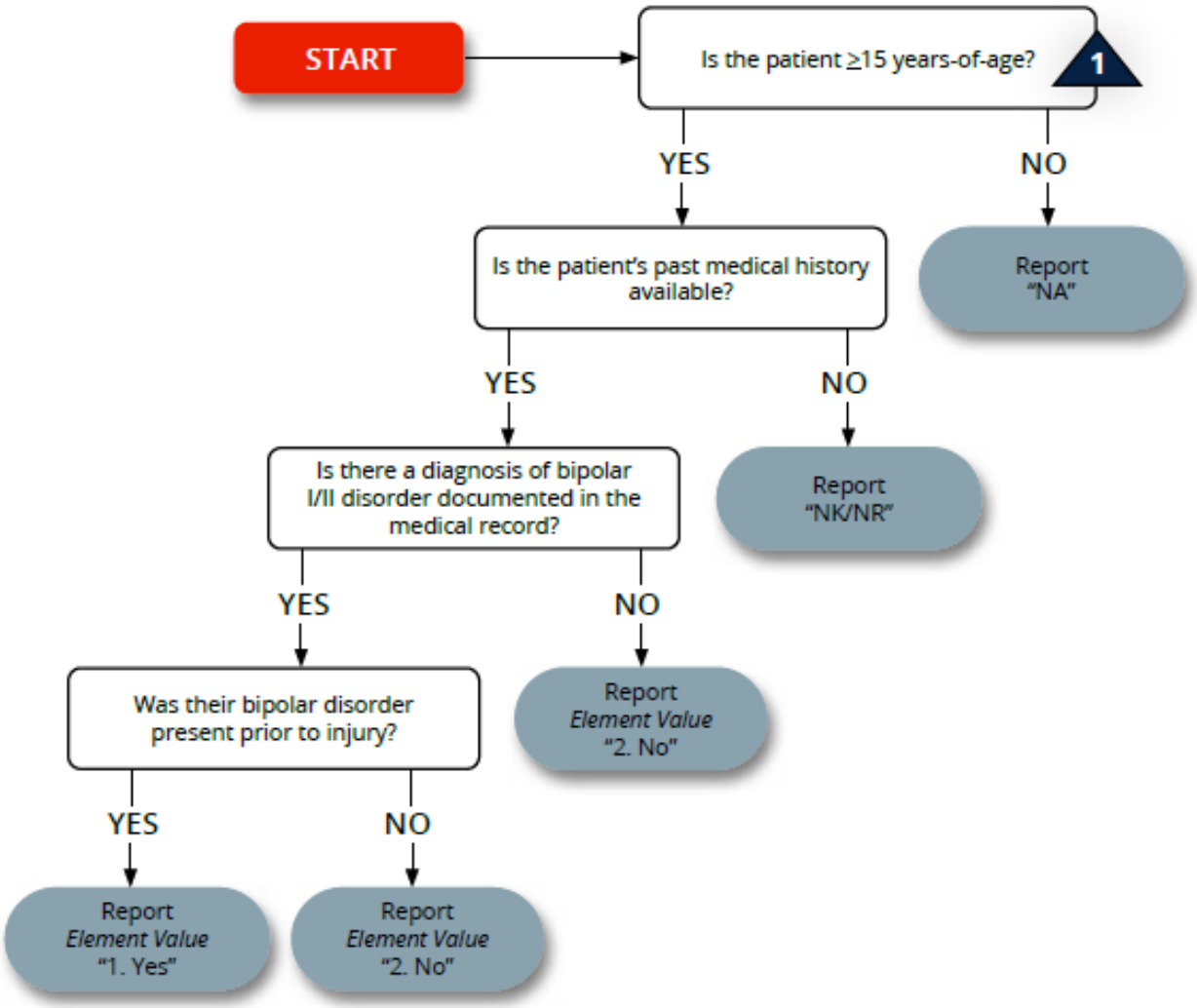
1 History and Physical
2 Physician Notes/Flow Sheet
3 Progress Notes
4 Case Management/Social Services Notes
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Bipolar I/II Disorder

***2026 NTDS Data Dictionary*, Released July 2025**



1 Based on the patient's age on the day of arrival at your hospital.

BLEEDING DISORDER

Element Intent

Underlying hematologic disorders result in a greater risk of bleeding which could increase the risk of adverse outcomes.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g., Hemophilia, von Willenbrand Disease, Factor V Leiden, Thrombocytopenia).
- Consistent with American Society of Hematology, 2015.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Data Source Hierarchy Guide

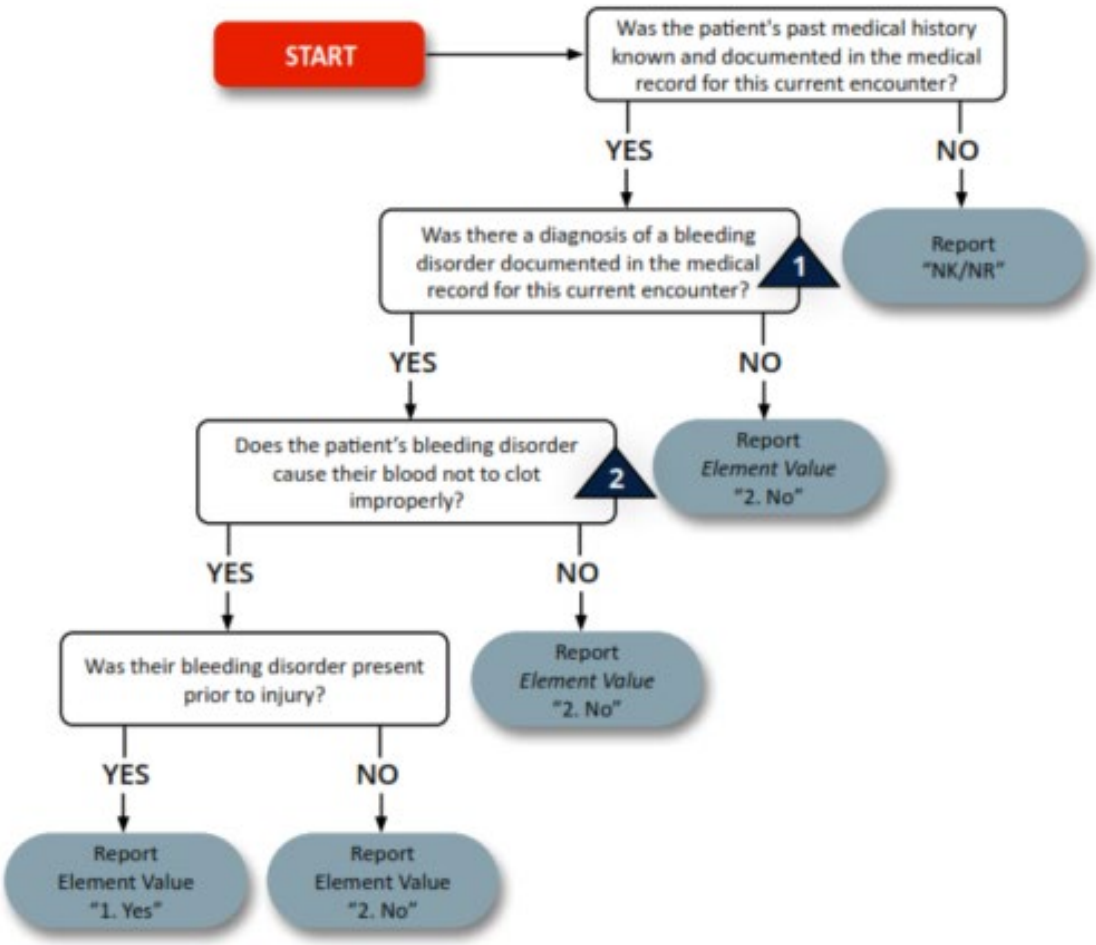
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

BLEEDING DISORDER

2027 NTDS Data Dictionary, Released July 2026



1 The NTDS definition is consistent with the American Society of Hematology, 2015.

2 Some examples of bleeding disorders that affect blood clotting are hemophilia, von Willebrand Disease, Factor V Leiden, and thrombocytopenia.

If the bleeding disorder does not cause the patient's blood to clot improperly, e.g., sickle cell disease, report *Element Value* "2. No." Consult with the TPM or TMD if questioning a specific diagnosis.

BRONCHOPULMONARY DYSPLASIA/CHRONIC LUNG DISEASE

Element Intent

Bronchopulmonary Dysplasia/Chronic Lung Disease could induce negative respiratory and pulmonary function, which could impact care decisions and increase the risk of adverse outcomes.

Description

The disorders which constitute Chronic Lung Disease (CLD) generally have a slow tempo of progression over many months or even years. The most common causes of CLD in children are Cystic Fibrosis (CF), and other causes of bronchiectasis (such as immunodeficiency, and in the third world, post -infective bronchiectasis (e.g., measles), Bronchopulmonary Dysplasia (BPD), or lung disease of prematurity).

INCLUDE:

- Patients with a diagnosis of Cystic Fibrosis with pulmonary involvement.

EXCLUDE:

- Patients with a diagnosis of Cystic Fibrosis with no documentation of lung disease.

Element Values

1. Yes
2. No

Additional Information

- Present prior to injury.
- Based on the patient's age on the day of arrival at your hospital.
- 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.
- Examples of evidence of Cystic Fibrosis-associated pulmonary disease included, but are not limited to:
- Use of Chest Physiotherapy (CPT) or other airway clearing techniques.
- Vest therapy or intrapulmonary percussive ventilator.
- Intravenous, inhaled, or oral antibiotics to treat chronic respiratory infections related to Cystic Fibrosis.
- Consistent with the ncbi.nlm.nih.gov.

Data Source Hierarchy Guide

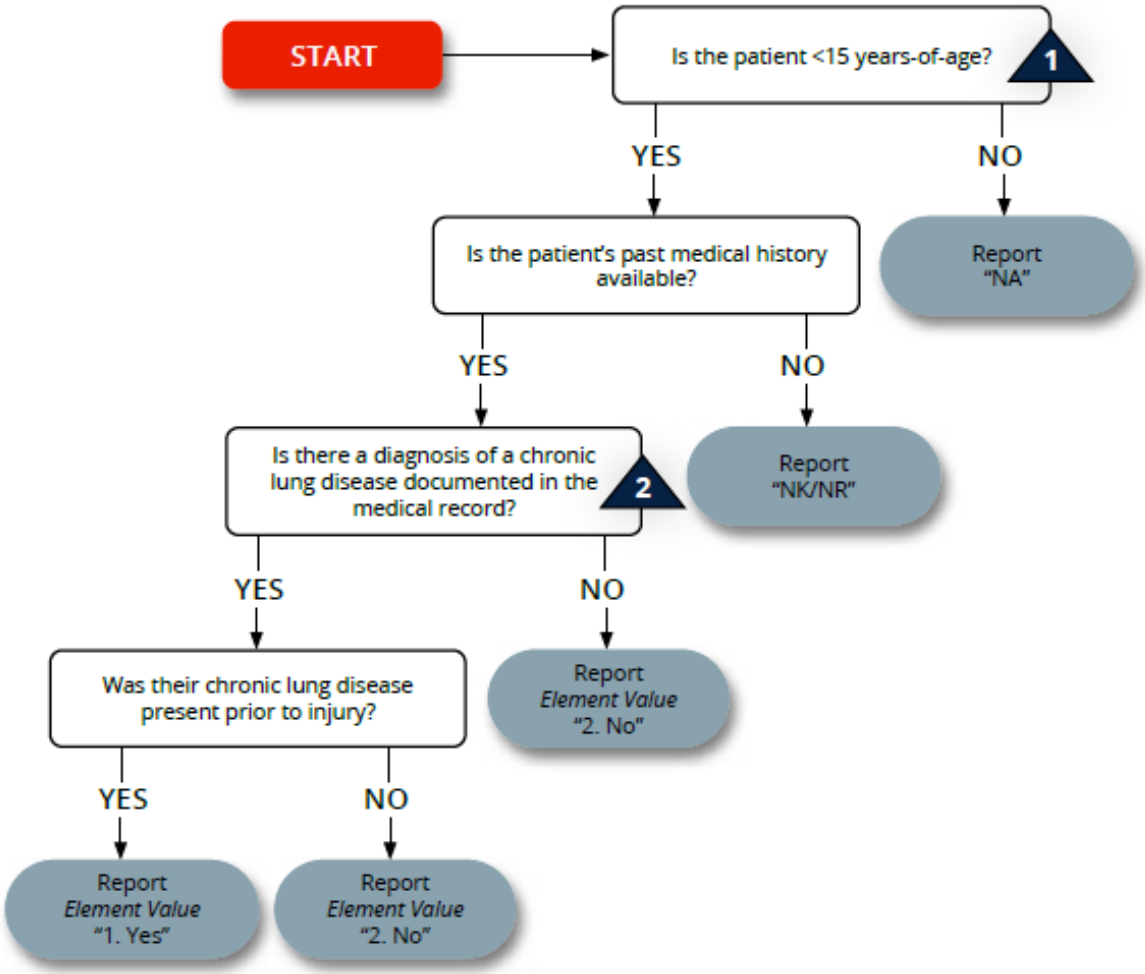
1. History and Physical
2. Physician Notes/Flow Sheet
3. Progress Notes
4. Case Management/Social Services Notes
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

References to Other Databases

- NTDS 2027

Bronchopulmonary Dysplasia/Chronic Lung Disease

2026 NTDS Data Dictionary, Released July 2025



1 Based on the patient's age on the day of arrival at your hospital.

2 Include patients with a diagnosis of Cystic Fibrosis with pulmonary involvement.

Exclude patients with a diagnosis of Cystic Fibrosis with no documentation of lung disease.

CEREBRAL VASCULAR ACCIDENT (CVA)

Element Intent

Persistent residual motor sensory or cognitive deficits could impact care decisions and increase the risk of adverse outcomes.

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

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

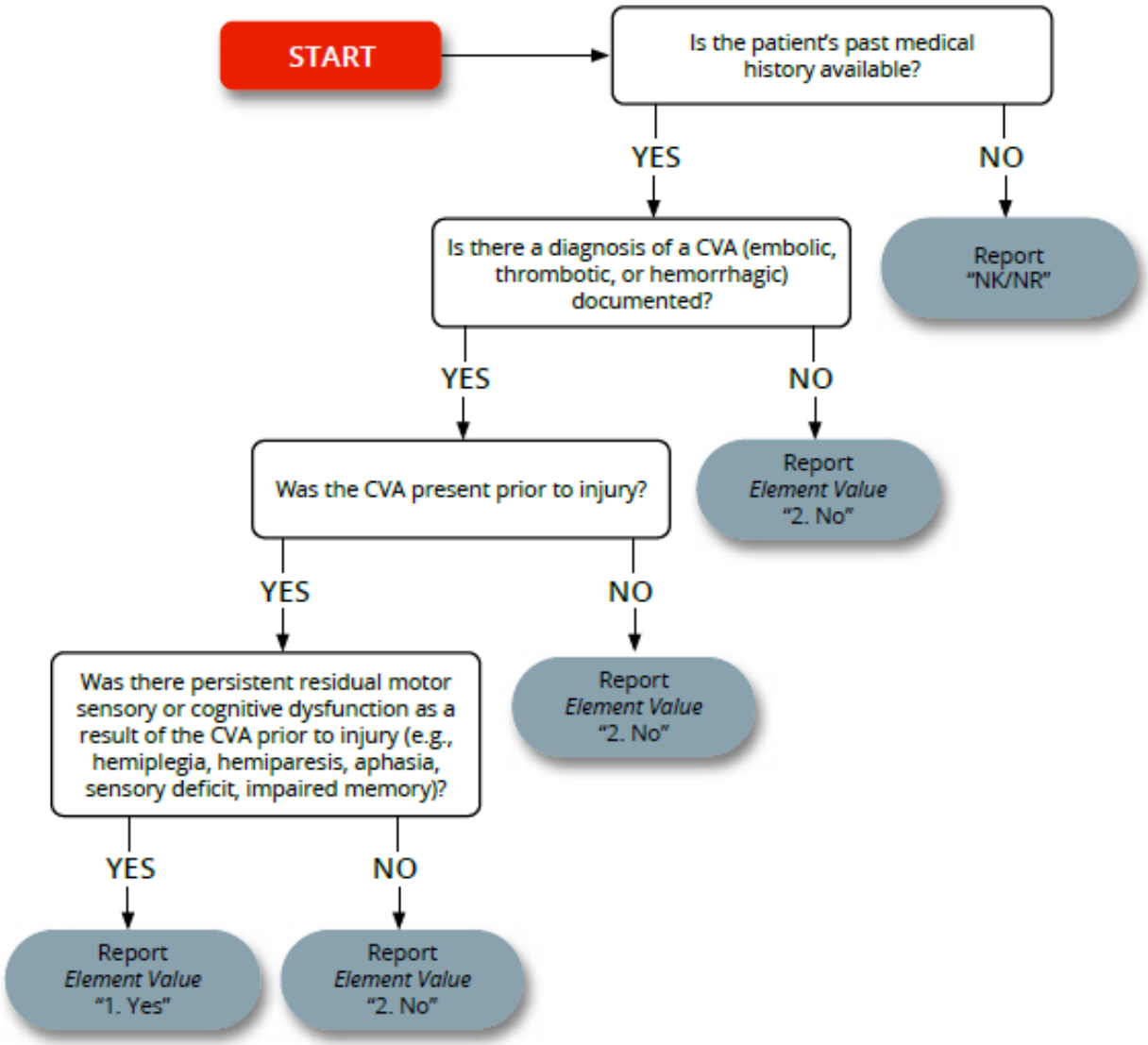
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Cerebral Vascular Accident (CVA)

***2026 NTDS Data Dictionary*, Released July 2025**



CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Element Intent
COPD limits respiratory reserve and prolongs the duration of mechanical ventilation, which could increase the risk of adverse outcomes.

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

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- 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.
- Consistent with World Health Organization (WHO), 2019.
- Based on the patient's age on the day of arrival at your hospital.

Data Source Hierarchy Guide

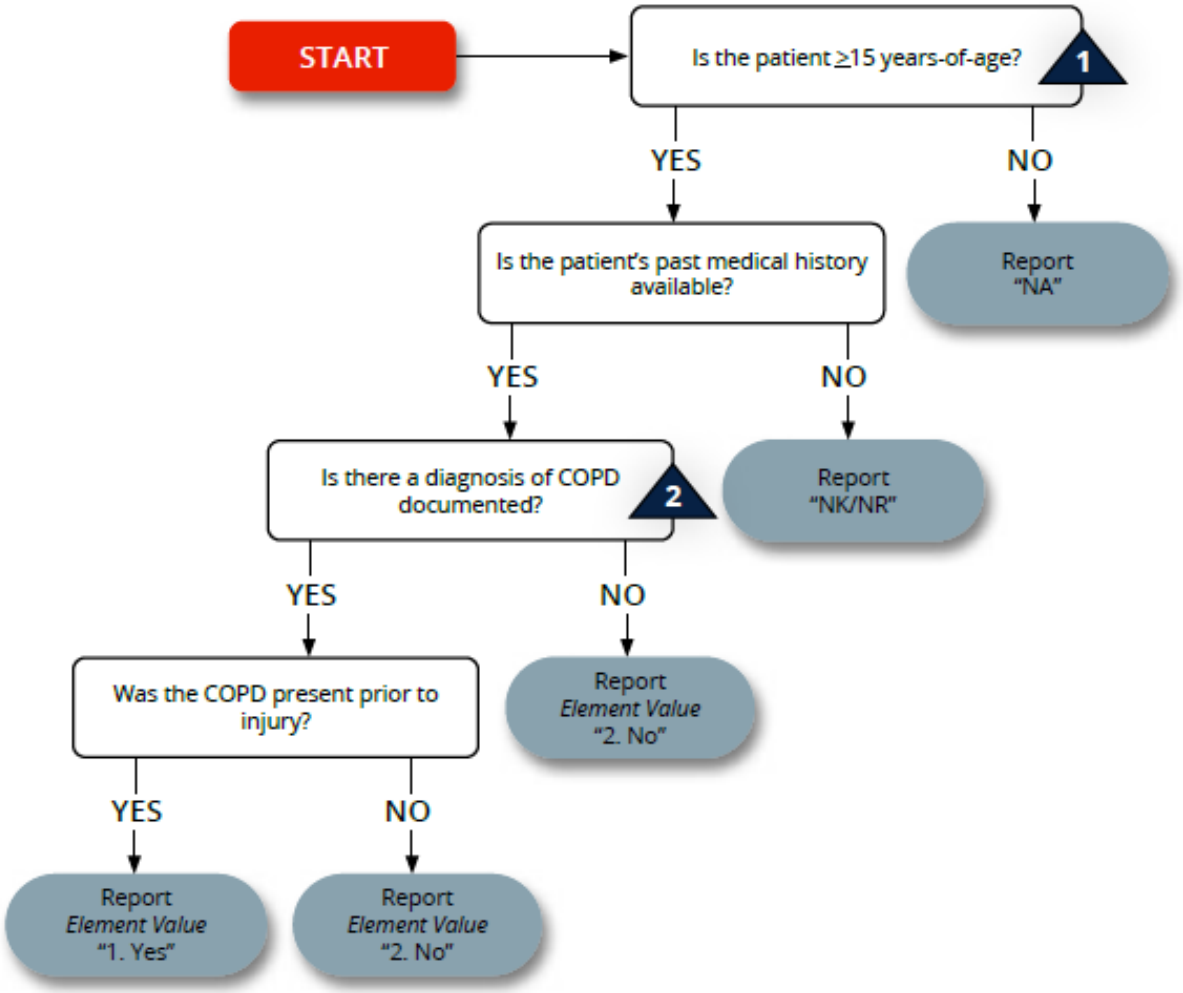
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Chronic Obstructive Pulmonary Disease (COPD)

2026 NTDS Data Dictionary, Released July 2025



1 Based on the patient's age on the day of arrival at your hospital.

2 The NTDS definition is consistent with the World Health Organization (WHO), 2019.

The terms 'chronic bronchitis' and 'emphysema' are included in the COPD diagnosis.

Asthma, diffuse interstitial fibrosis, and/or sarcoidosis are excluded from the NTDS definition.

CHRONIC RENAL FAILURE

Element Intent

Chronic renal failure reflects limited renal reserve, which increases the risk of adverse outcomes.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

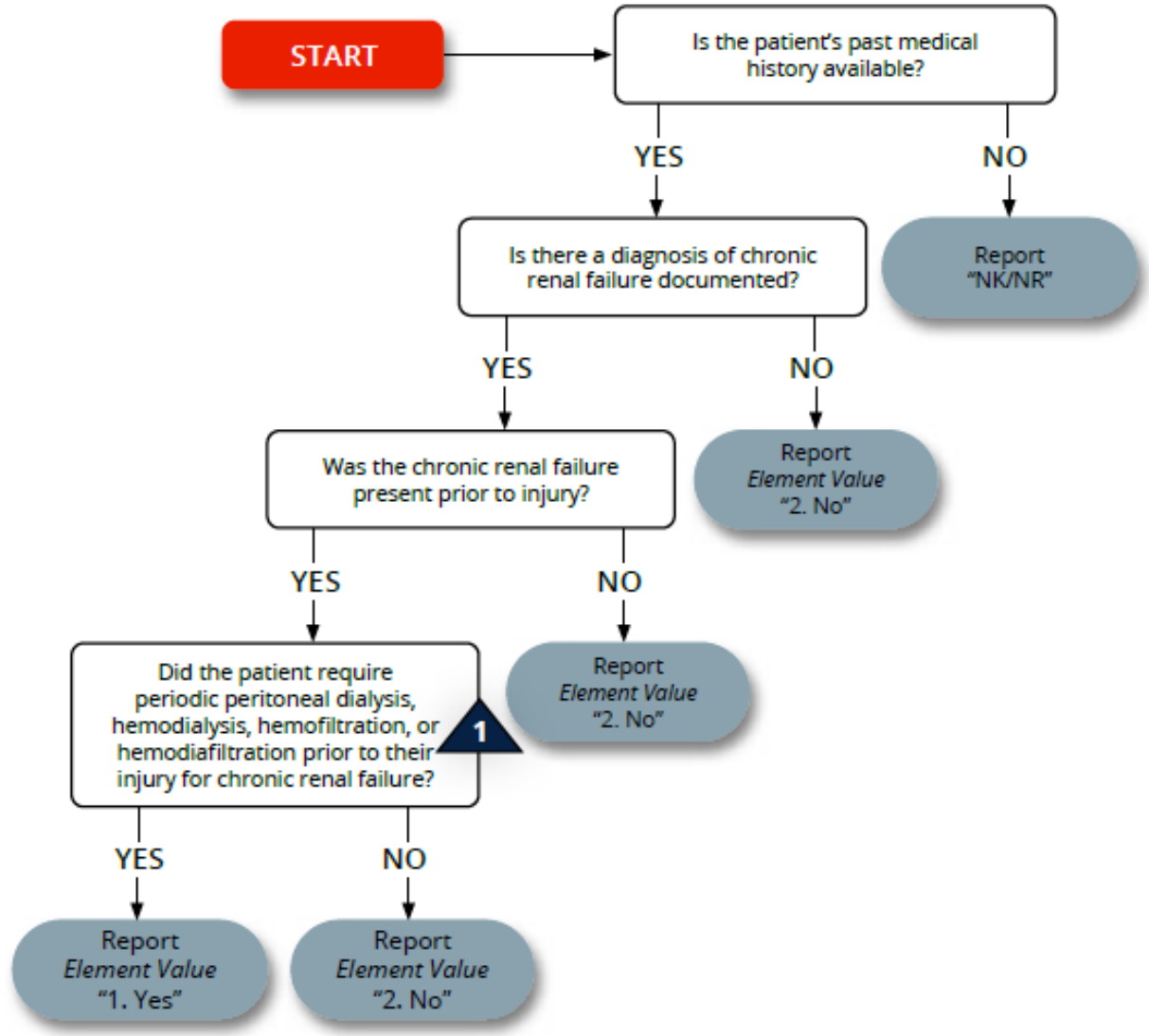
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Chronic Renal Failure

***2026 NTDS Data Dictionary*, Released July 2025**



1 Include patients with chronic renal failure that was present prior to injury that required renal replacement therapy but were not compliant or declined therapy.

CIRRHOSIS

Element Intent

Cirrhosis/end state liver disease reflects limited hepatic reserve, which could impact care decisions and increase the risk of adverse outcomes.

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

1 Yes
2 No

Common Null Values

- Accepted

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

Data Source Hierarchy Guide

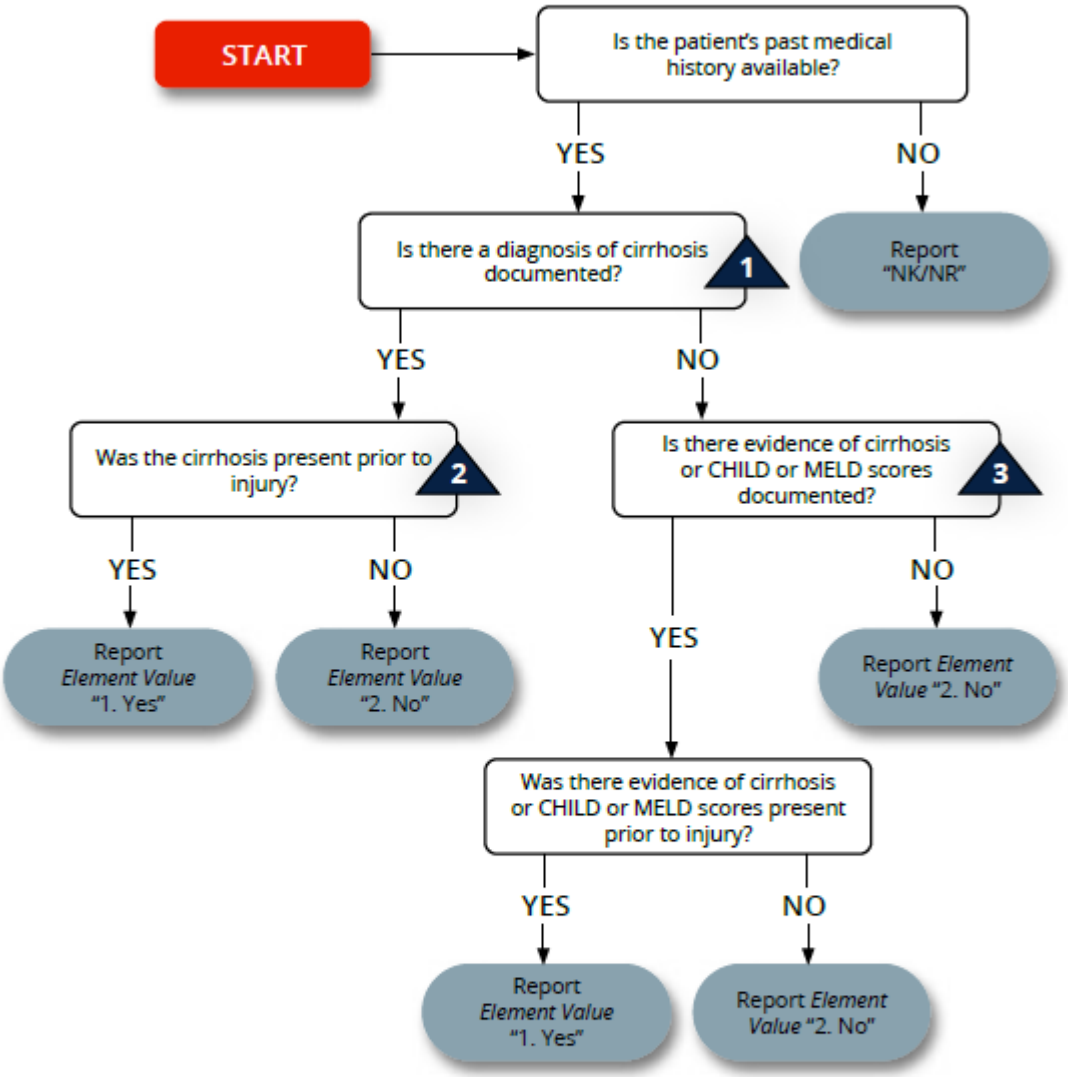
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Cirrhosis

***2026 NTDS Data Dictionary*, Released July 2025**



1. Might also be referred to as end-stage liver disease.
2. Exclude patients who no longer have cirrhosis due to a successful liver transplant.
3. In lieu of a diagnosis of cirrhosis, documentation of cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy may be used.

CONGENITAL ANOMALIES

Element Intent

Congenital anomalies have a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

Description

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

Element Values

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

- Present prior to injury.
- A diagnosis of a congenital anomaly must be documented in the patient's medical record.
- 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.
- Based on the patient's age on the day of arrival at your hospital.

Data Source Hierarchy Guide

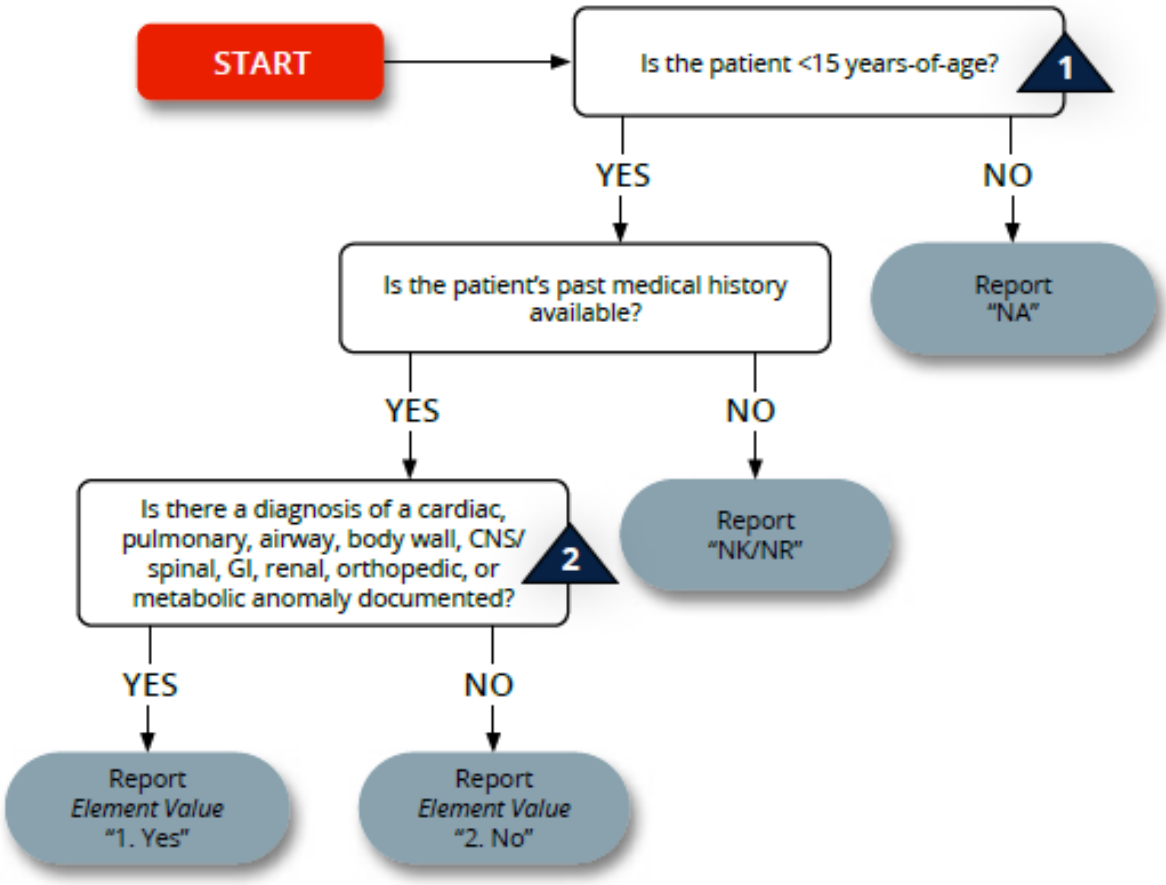
1 History & Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Congenital Anomalies

2026 NTDS Data Dictionary, Released July 2025



1 Based on the patient's age on the day of arrival at your hospital.

2 Congenital anomalies are limited to those listed in the *Description*. Consult with the TPM or TMD if questioning a specific diagnosis.

CONGESTIVE HEART FAILURE (CHF)

Element Intent

CHF reflects limited cardiac reserve, leading to a higher risk of adverse outcomes

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

1 Yes
2 No

Common Null Values

- Accepted

Additional Information

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

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- NTDS 2027

CONGSTIVE HEART FAILURE (CHF)

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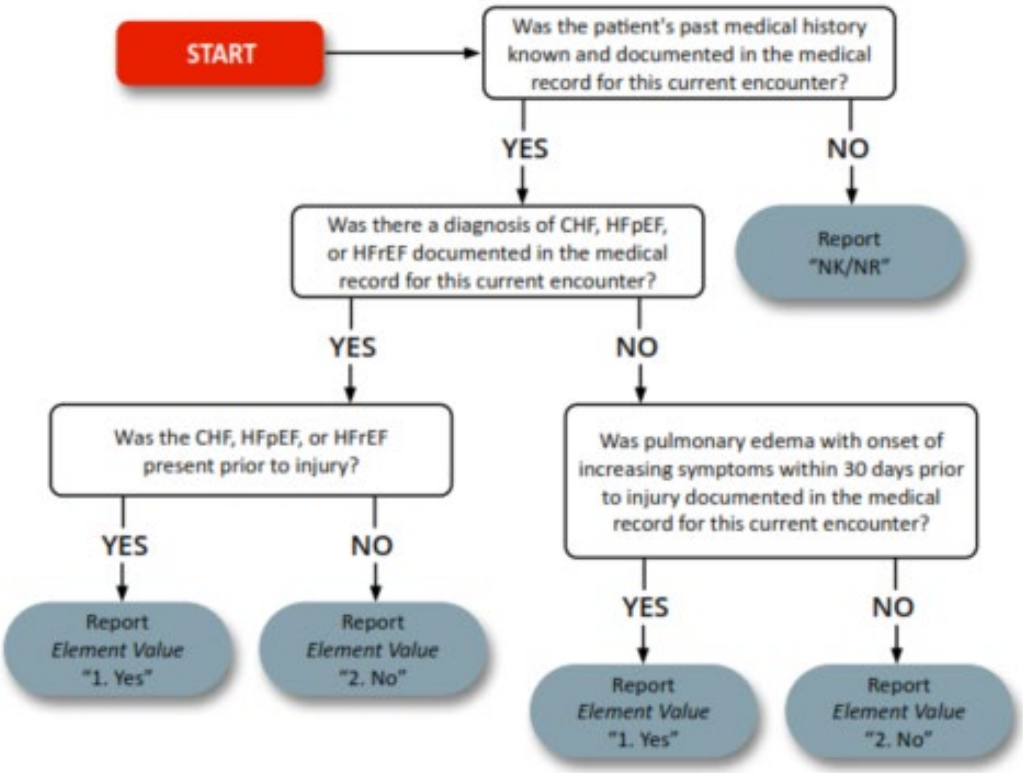

CURRENT SMOKER

Element Intent
Inhaling nicotine could induce negative cardiopulmonary effects, increase risk for stroke, negatively affect wound healing, increase anesthesia risk and the development of a venous thromboembolism (VTE), which could impact care decisions and increase the risk of adverse outcomes.

Description
A patient who reports inhaling nicotine by smoking cigars, pipes, cigarettes, e-cigarettes, vaping, or juuling every day or some days within the last 30-days.

EXCLUDE:
- Patients who chew tobacco or snuff.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Vaping and juuling includes vape pens, dab pens, dab rings, mods, pod-mods, or any other electronic delivery system used to inhale nicotine.

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References to Other Databases
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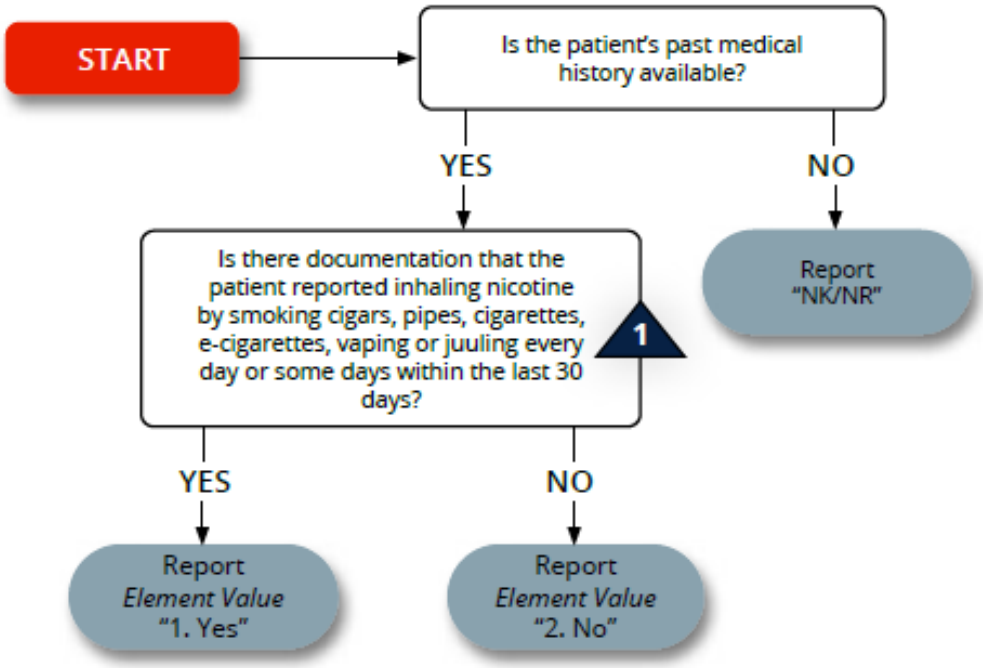
Current Smoker

2026 NTDS Data Dictionary, Released July 2025



1 Vaping and juuling includes vape pens, dab pens, dab rings, mods, pod-mods, or any other electronic delivery system used to inhale nicotine.

Exclude patients who chew tobacco or snuff.

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Element Intent
The effects of chemotherapy increase the risk of infection, and could limit physiologic reserve, which together increases the risk of adverse outcomes.

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

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Currently Receiving Chemotherapy for Cancer

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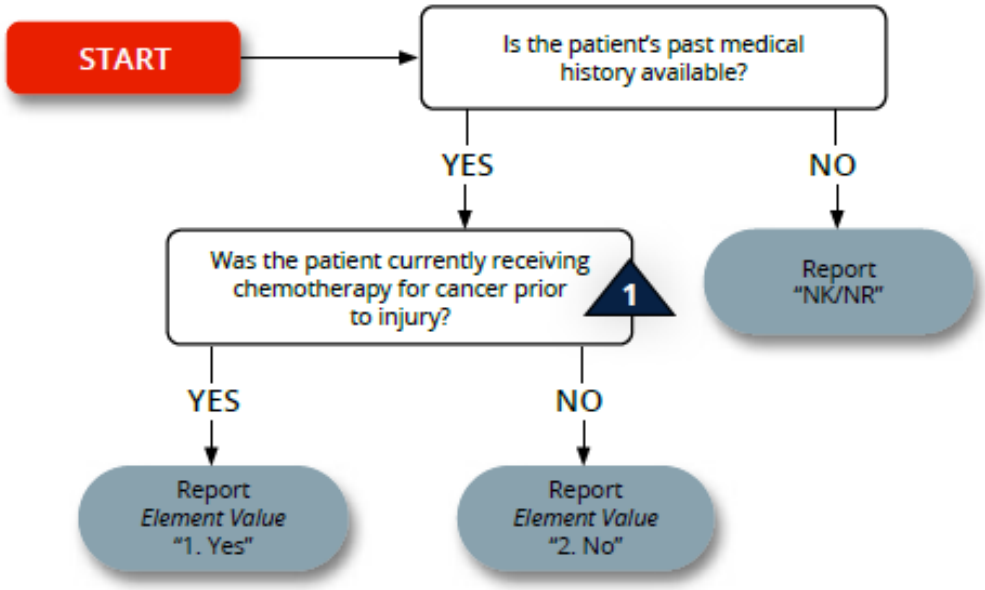

1 Limited to patients who were in active chemotherapy treatment for cancer and does not include patients with a history of receiving chemotherapy for cancer.

Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

DEMENTIA

Element Intent

Patients with dementia experience forgetfulness, limited social skills and impaired thinking that could impact care decisions and prolong the length of stay.

Description

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

Element Values

1 Yes
2 No

Common Null Values

1. Accepted

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 null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Consistent with the National Institute on Aging December 2017.

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Dementia

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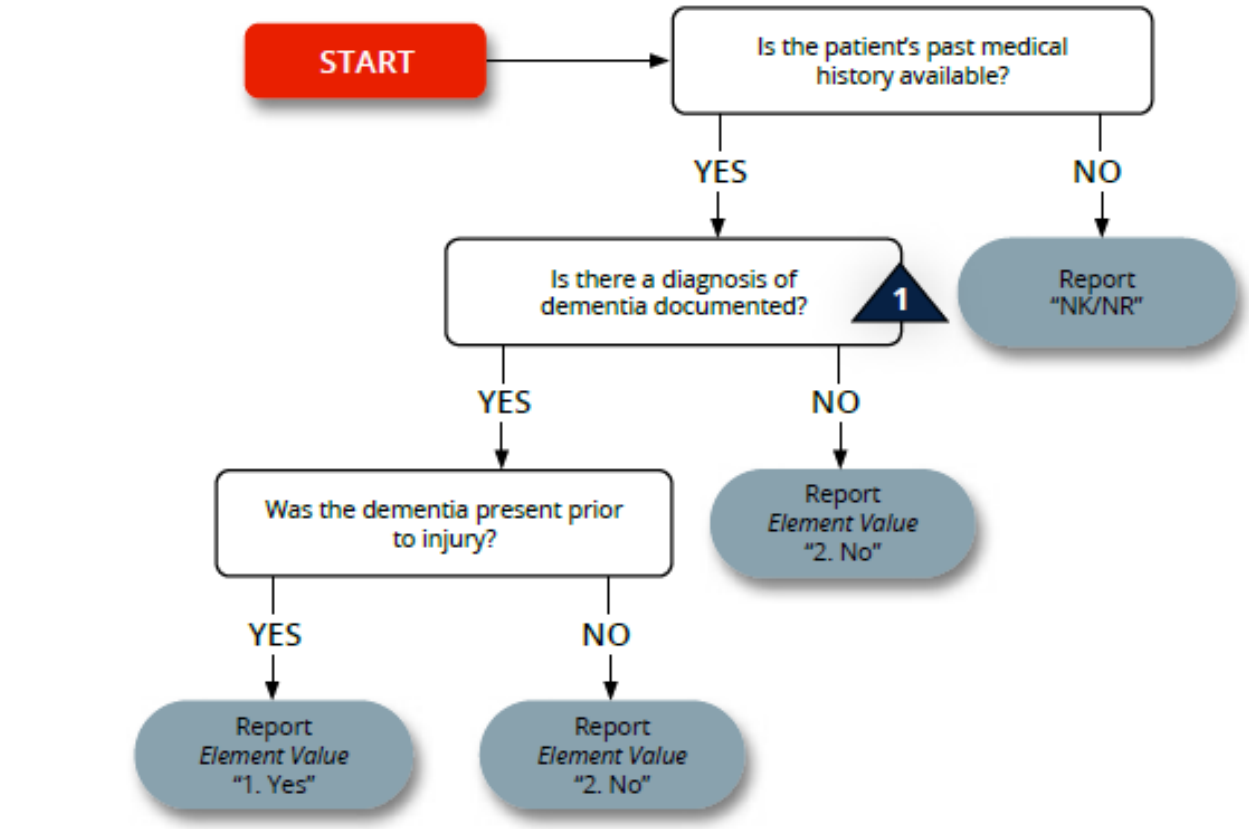

1 Documentation of Alzheimer's, Lewy Body Dementia, frontotemporal dementia (Pick's Disease) or vascular dementia.

DIABETES MELLITUS

Element Intent
Diabetes can increase risk for infection, negatively affect wound healing, and contribute to renal and cardiac dysfunction, which could impact care decisions and increase the risk of adverse outcomes.

Description
Diabetes mellitus that requires exogenous parenteral insulin, an oral hypoglycemic agent, or GLP-1 medications.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of diabetes mellitus must be documented in the patient's medical record.
- Report Element Value "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin, oral hypoglycemic agent, or GLP-1 medicationsThe null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Diabetes Mellitus

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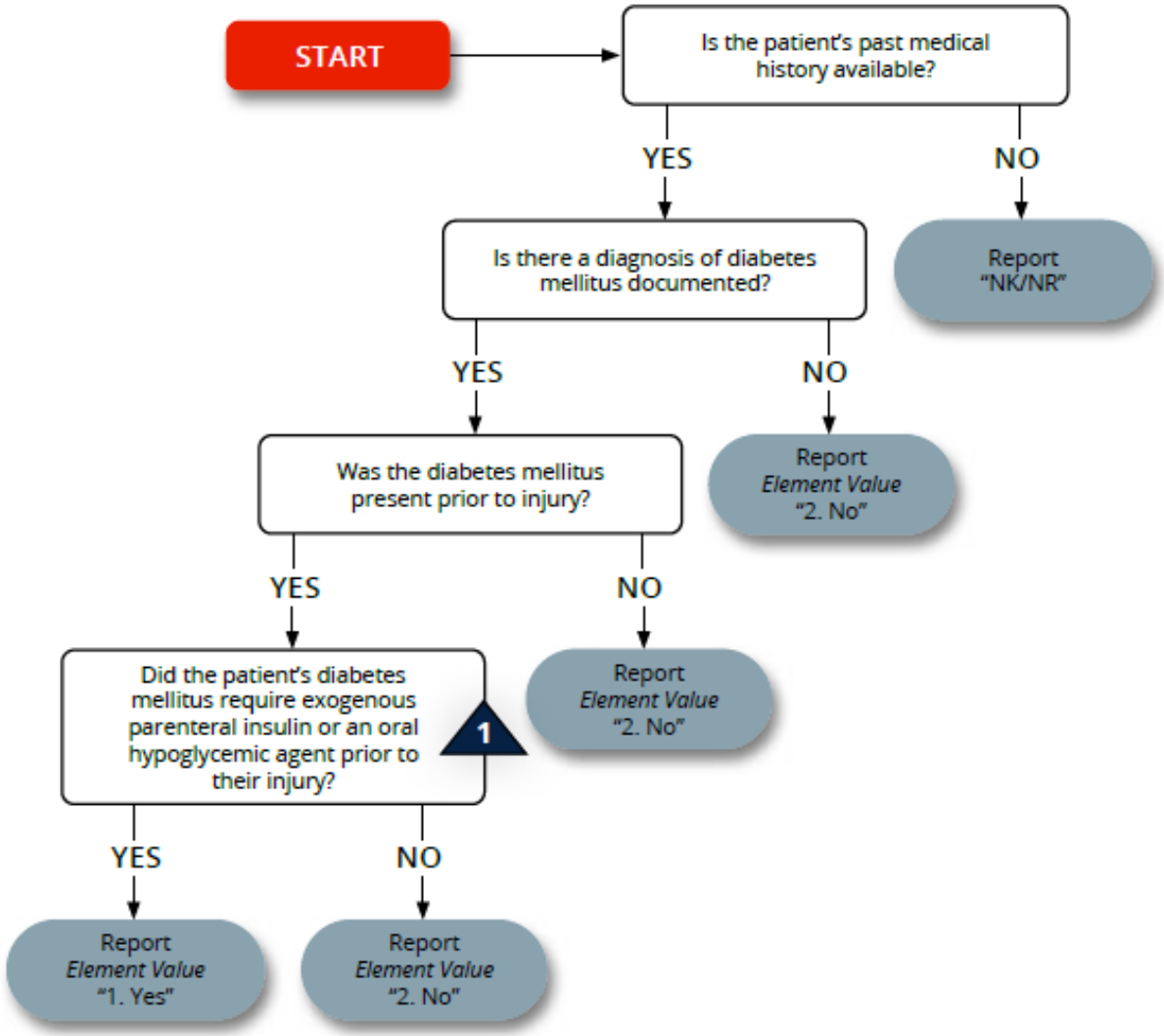

1 Include patients whose diabetes mellitus required exogenous parenteral insulin or an oral hypoglycemic agent but were non-compliant with treatment.

DISSEMINATED CANCER

Element Intent
Advanced malignancy reflecting serious physiologic compromise has a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

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

Element Values
1 Yes
2 No

Common Null Values
- Accepted

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.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

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Disseminated Cancer

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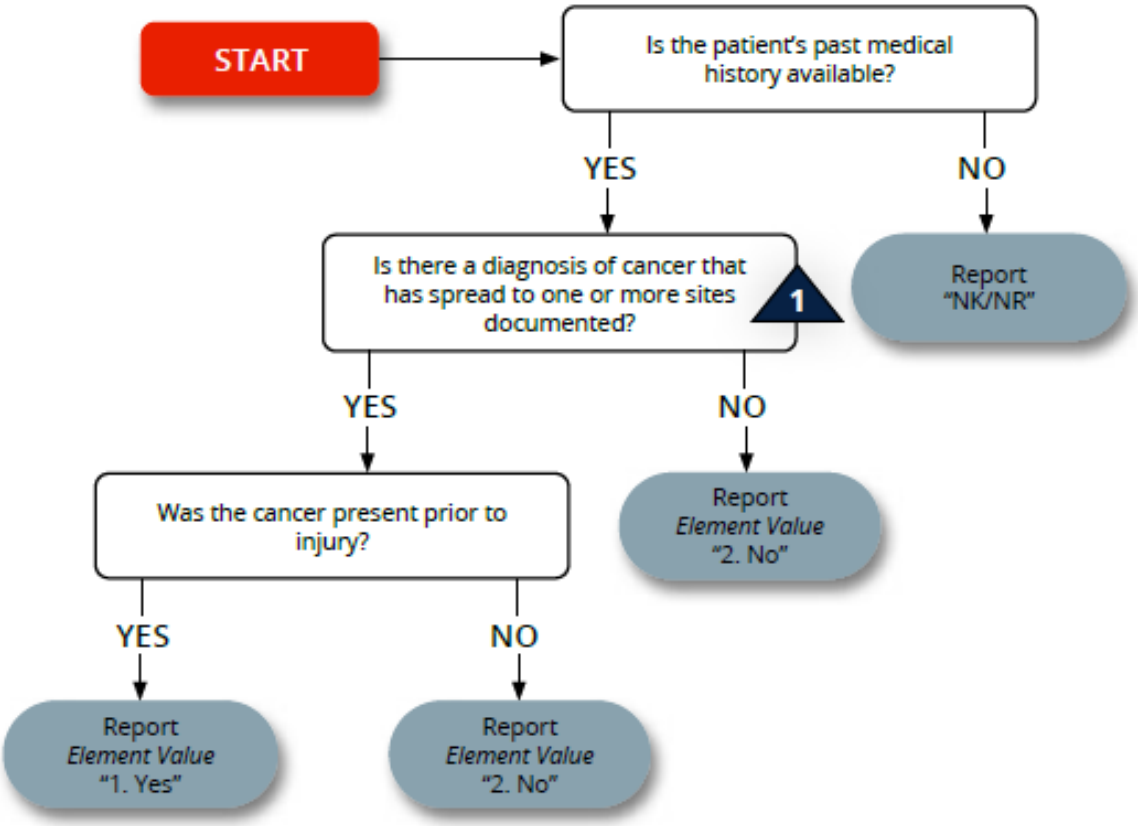

1 Include patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Another term describing disseminated cancer is "metastatic cancer."

FUNCTIONALLY DEPENDENT HEALTH STATUS

Element Intent
Pre-injury functional status could indicate a chronic/underlying disease state, which could impact care decisions and increase the risk of adverse outcomes.

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

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking.
- Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- If Ventilator Dependence is Element Value “1. Yes”, Functionally Dependent Health Status must be Element Value “1. Yes.”

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Functionally Dependent Health Status

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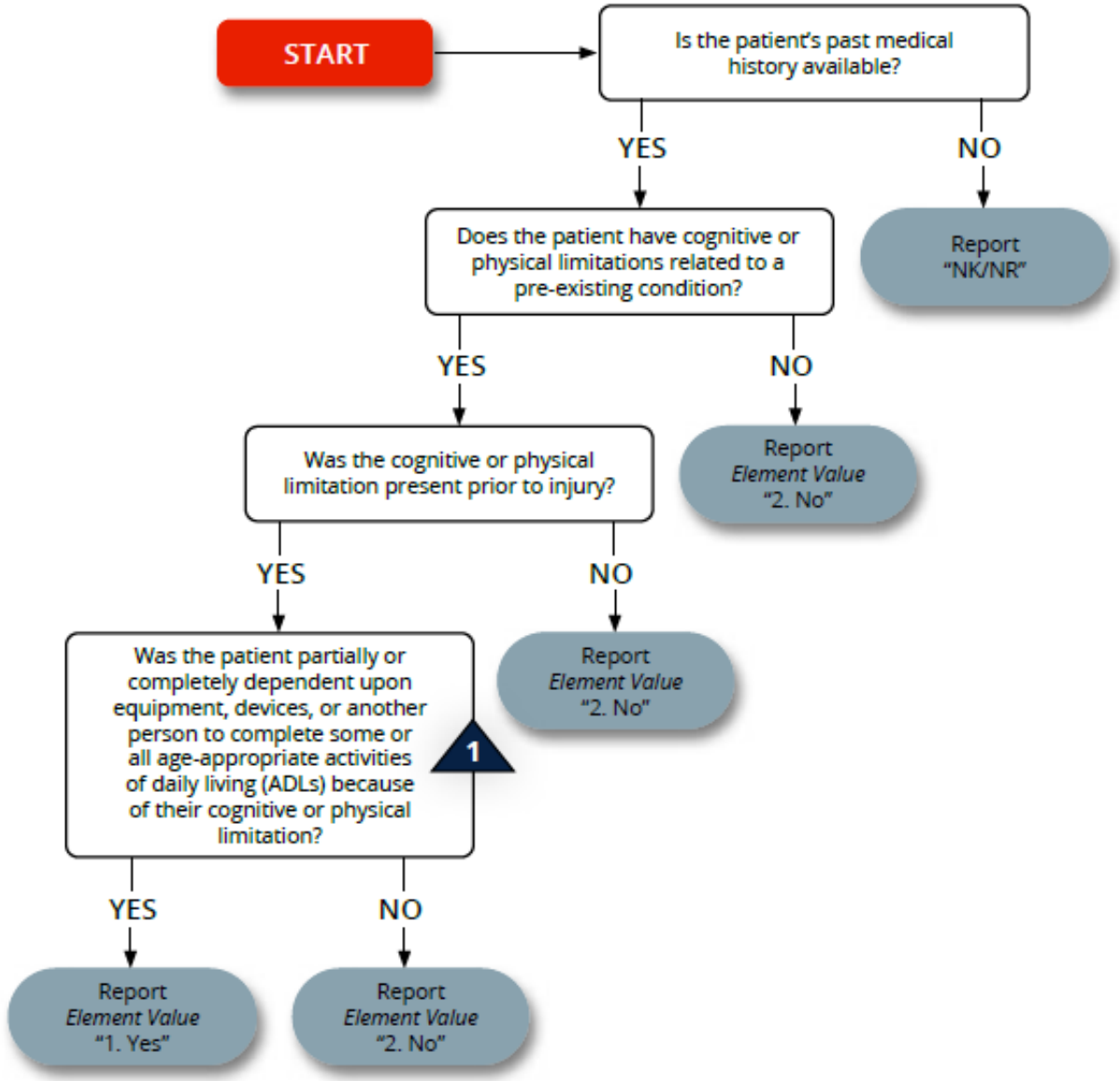

1 Activities of daily living include bathing, feeding, dressing, toileting, and walking.

Consult with the TPM or TMD if questioning a specific pre-injury functional status.

HYPERTENSION

Element Intent
Hypertension that requires medication increases risk for cerebrovascular, renal, and cardiac disease, which could impact care decisions and increase the risk of adverse outcomes.

Description
History of persistent elevated blood pressure requiring antihypertensive medication.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of Hypertension must be documented in the patient's medical record.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- Report Element Value ‘1. Yes’ for patients who were non-compliant with their prescribed antihypertensive medication.

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Hypertension

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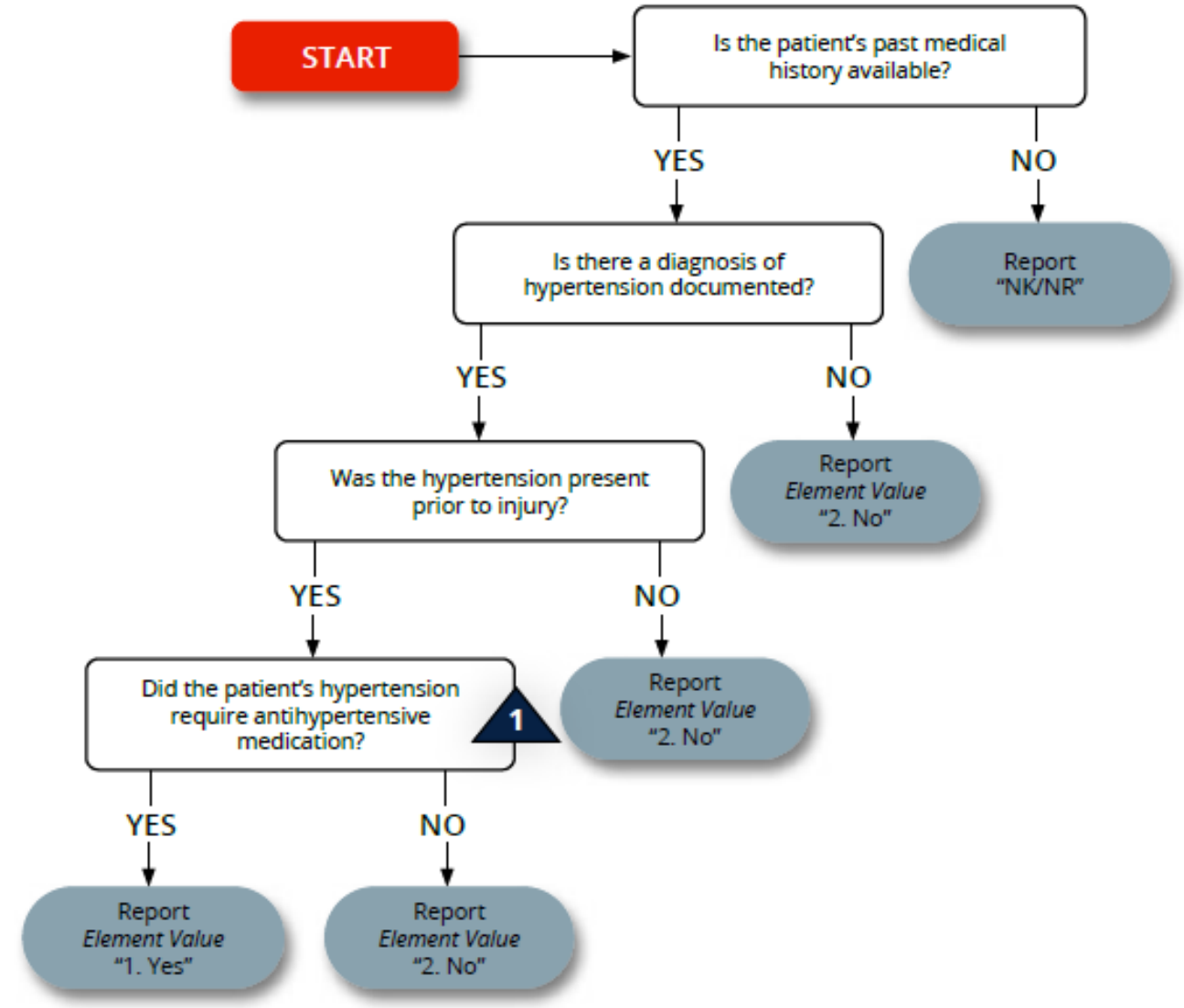

1 Include patients who were non-compliant with prescribed antihypertensive medication to treat their hypertension.

MAJOR DEPRESSIVE DISORDER

Element Intent

Patients with Major Depressive Disorder experience depressed mood, loss of interest/pleasure, weight issues, fatigue, insomnia or hypersomnia, psychomotor agitation or retardation, decreased concentration, delusional guilt, and suicidal ideation which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Description

A major depressive disorder diagnosis documented in the medical record.

Element Values

1 Yes
2 No

Additional Information

1. Present prior to injury.
2. Only report on patients ≥15 years-of-age.
3. The null value "Not Applicable" must be reported for patients <15 years-of-age.
4. The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years-of- age.
5. Based on the patient's age on the day of arrival at your hospital.

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Major Depressive Disorder

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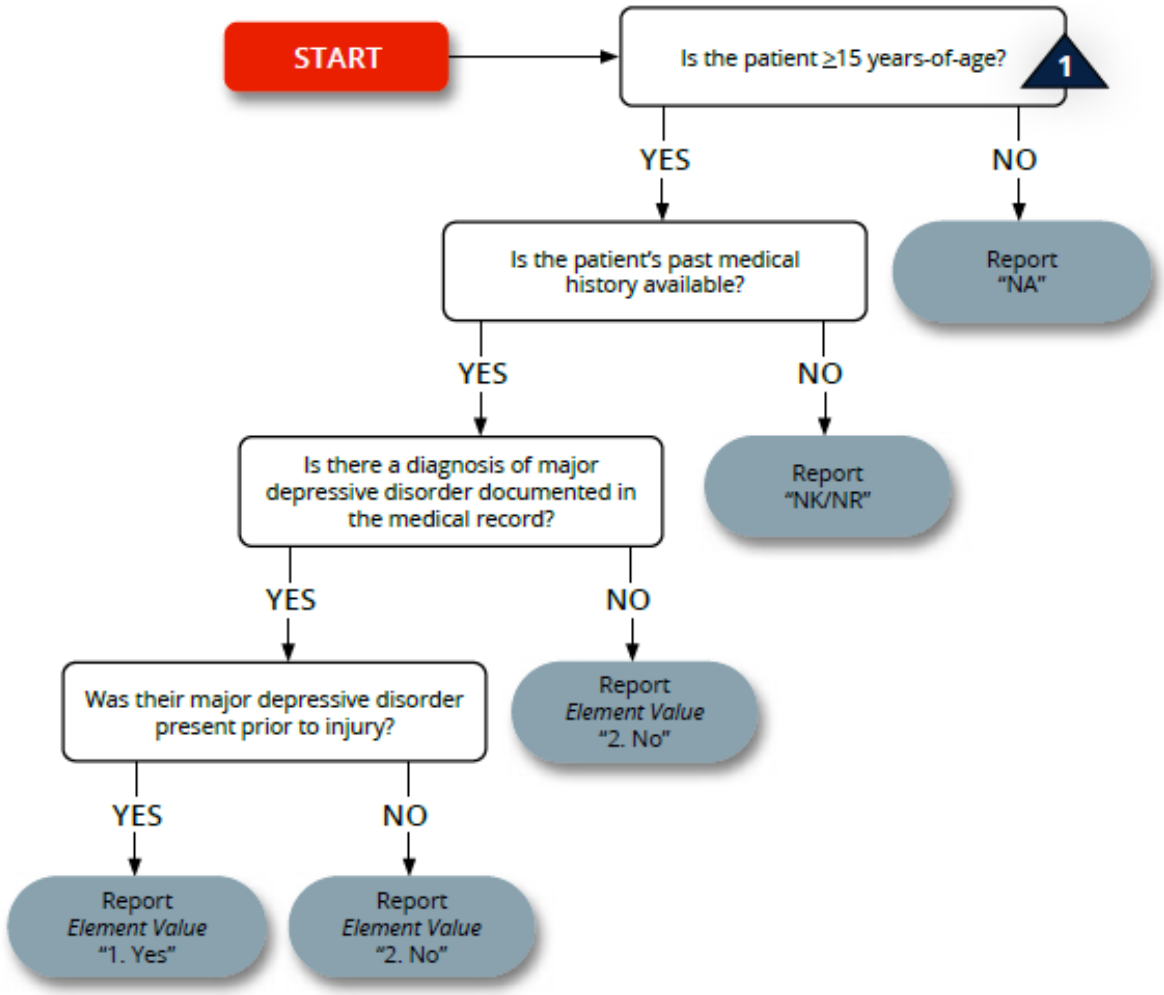

1 Based on the patient's age on the day of arrival at your hospital.

MYOCARDIAL INFARCTION (MI)

Element Intent
Myocardial infarction causes damage or death to the heart muscle, which could impact care decisions and increase the risk of adverse outcomes.

Description
History of a MI in the six months prior to injury.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

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

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Myocardial Infarction (MI)

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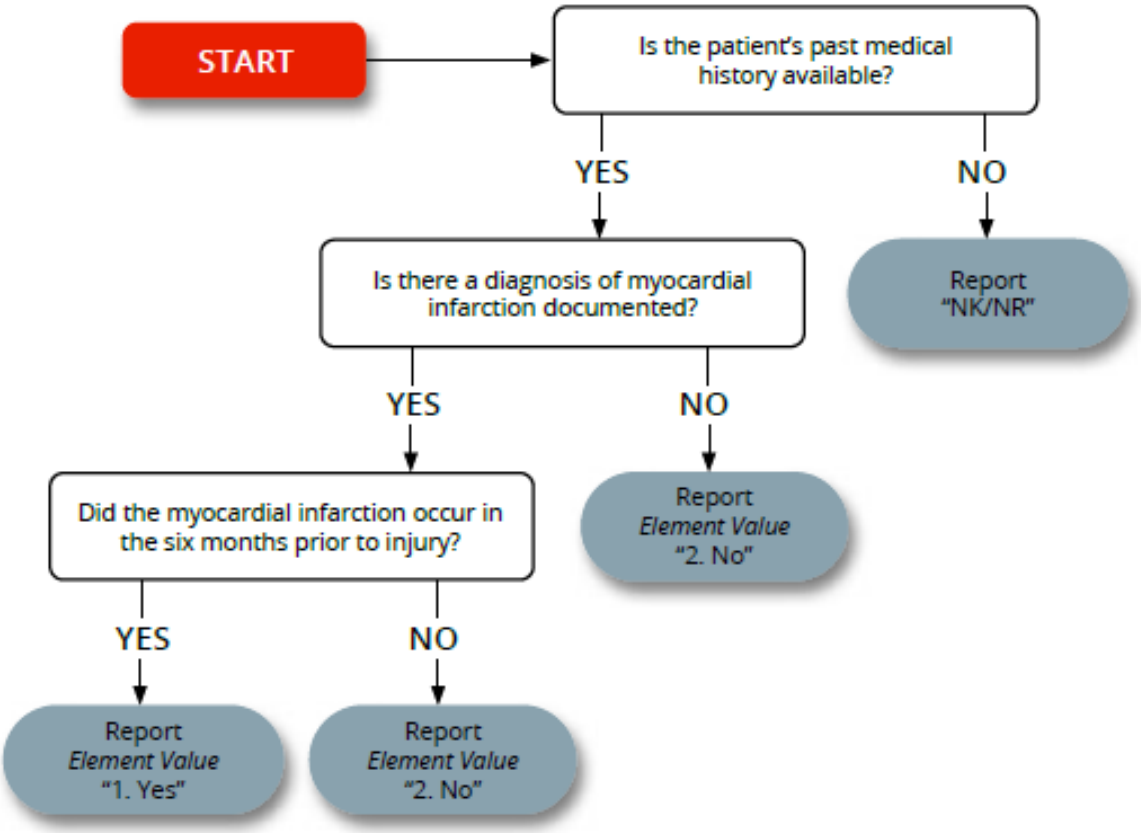

OTHER MENTAL/PERSONALITY DISORDERS

Element Intent

Patients with these disorders experience significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

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
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder

Element Values

1 Yes
2 No

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.
- Based on the patient's age on the day of arrival at your hospital.

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OTHER MENTAL/PERSONALITY DISORDERS

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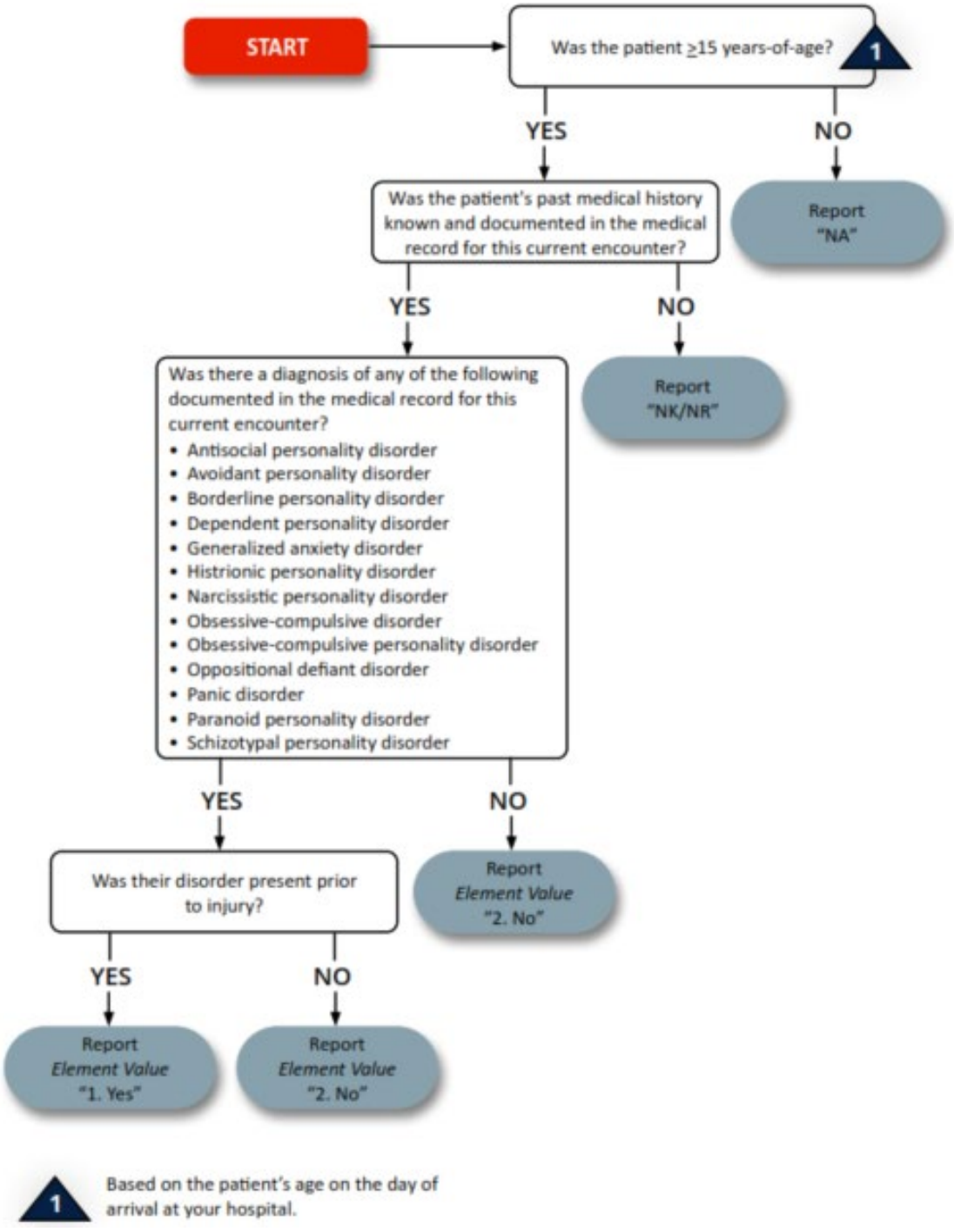

1 Based on the patient's age on the day of arrival at your hospital.

PERIPHERAL ARTERIAL DISEASE (PAD)

Element Intent
PAD reflects cardiovascular risk, which itself is associated with adverse outcomes.

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.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- A diagnosis of Peripheral Arterial Disease or Peripheral Vascular Disease must be documented in the patient's medical record.
- 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.
- Consistent with Centers for Disease Control, 2014 Fact Sheet.
- Based on the patient’s age on the day of arrival at your hospital.

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Peripheral Arterial Disease (PAD)

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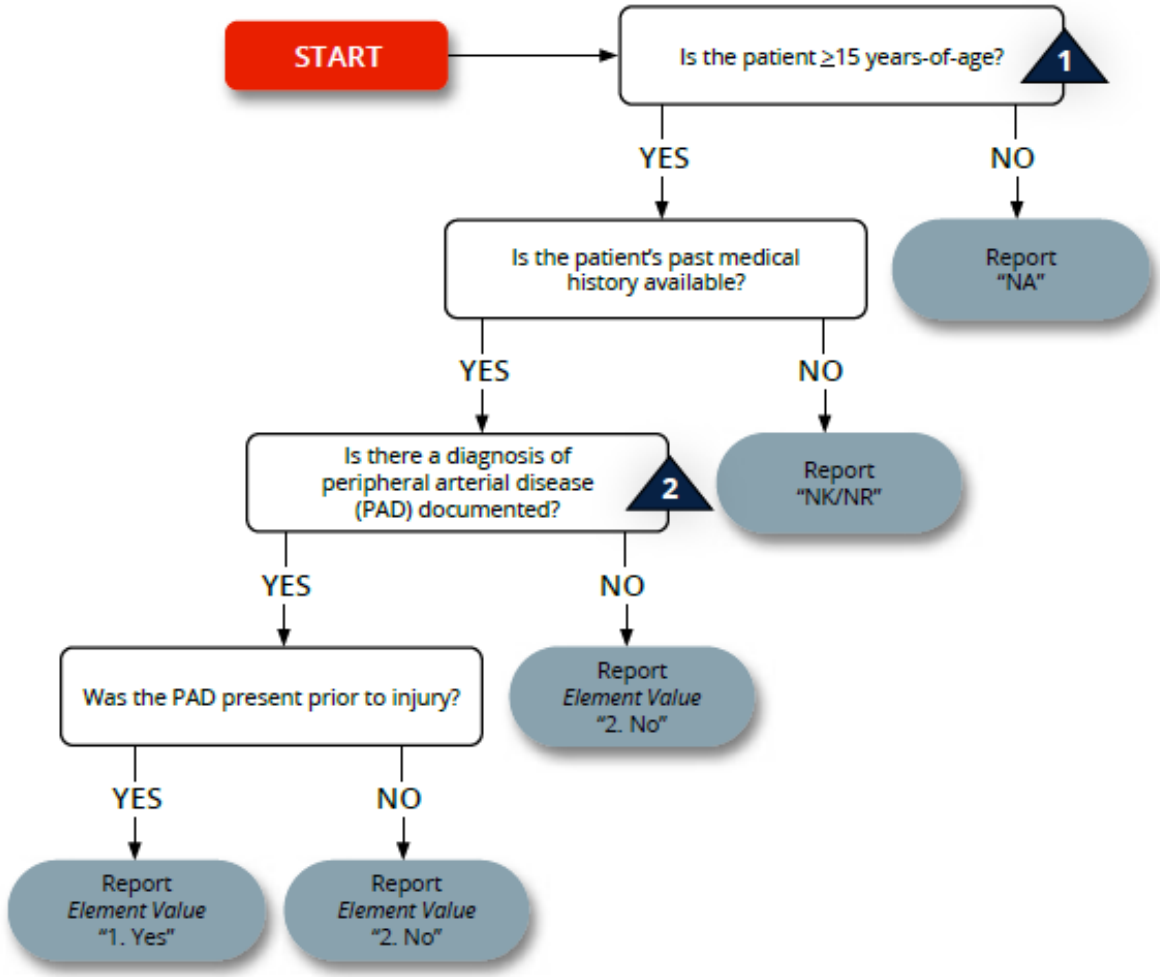

1 Based on the patient's age on the day of arrival at your hospital.

2 Consistent with the CDC 2014 Fact Sheet. The term "peripheral vascular disease (PVD)" can be used interchangeably with "PAD."

POST-TRAUMATIC STRESS DISORDER

Element Intent
Patients with PTSD experience intrusive symptoms, avoidance, altered mood, altered reactivity, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

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

Element Values
1 Yes
2 No

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.
- Based on the patient's age on the day of arrival at your hospital.

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Post-Traumatic Stress Disorder (PTSD)

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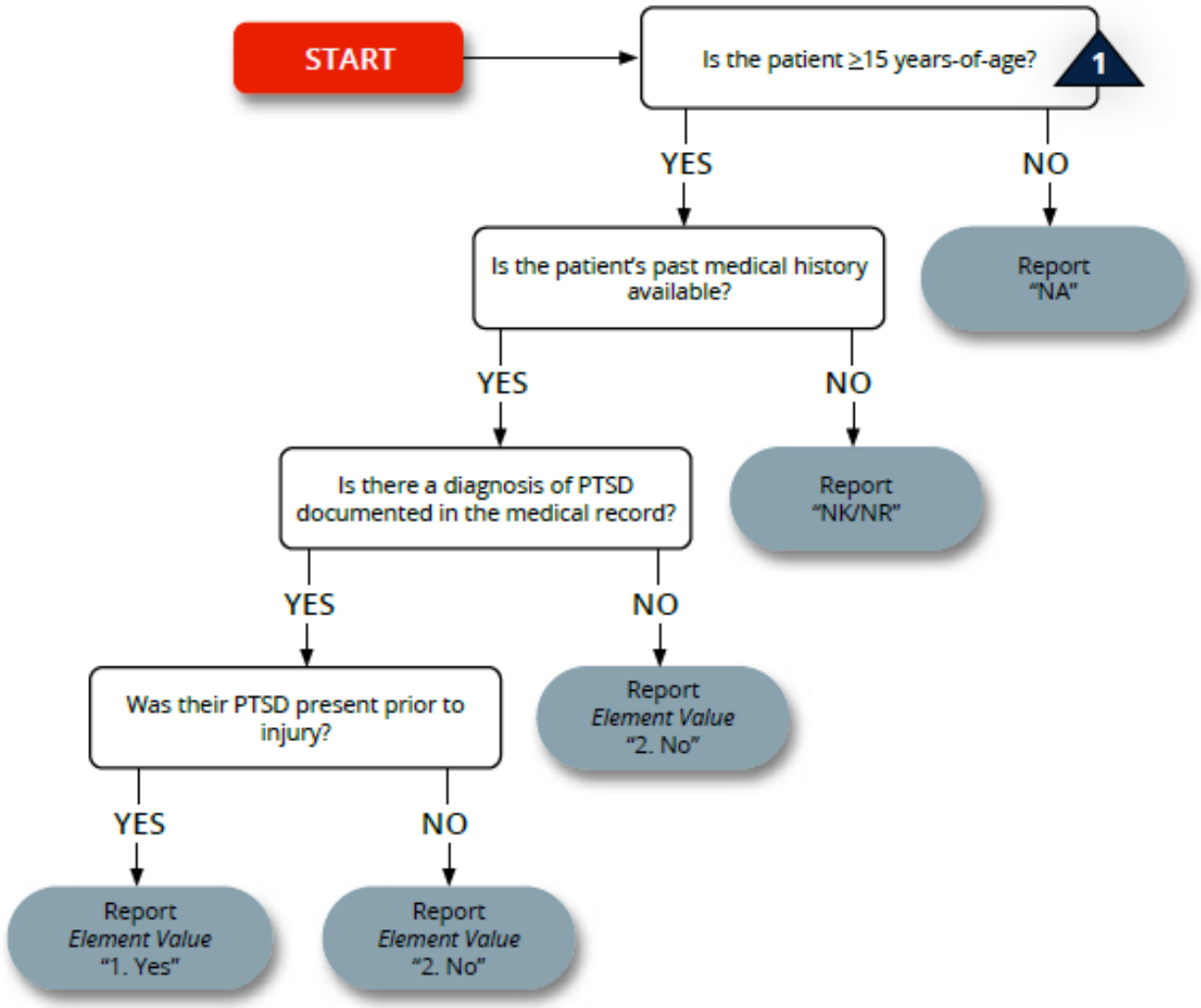

1 Based on the patient's age on the day of arrival at your hospital.

PREGNANCY

Element Intent
Trauma during pregnancy could cause pre-term labor and/or placental abruption, which could impact care decisions and increase the risk of adverse outcomes.

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

Element Values
1 Yes
2 No

Additional Information
- Present prior to arrival at your center
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available.

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Pregnancy

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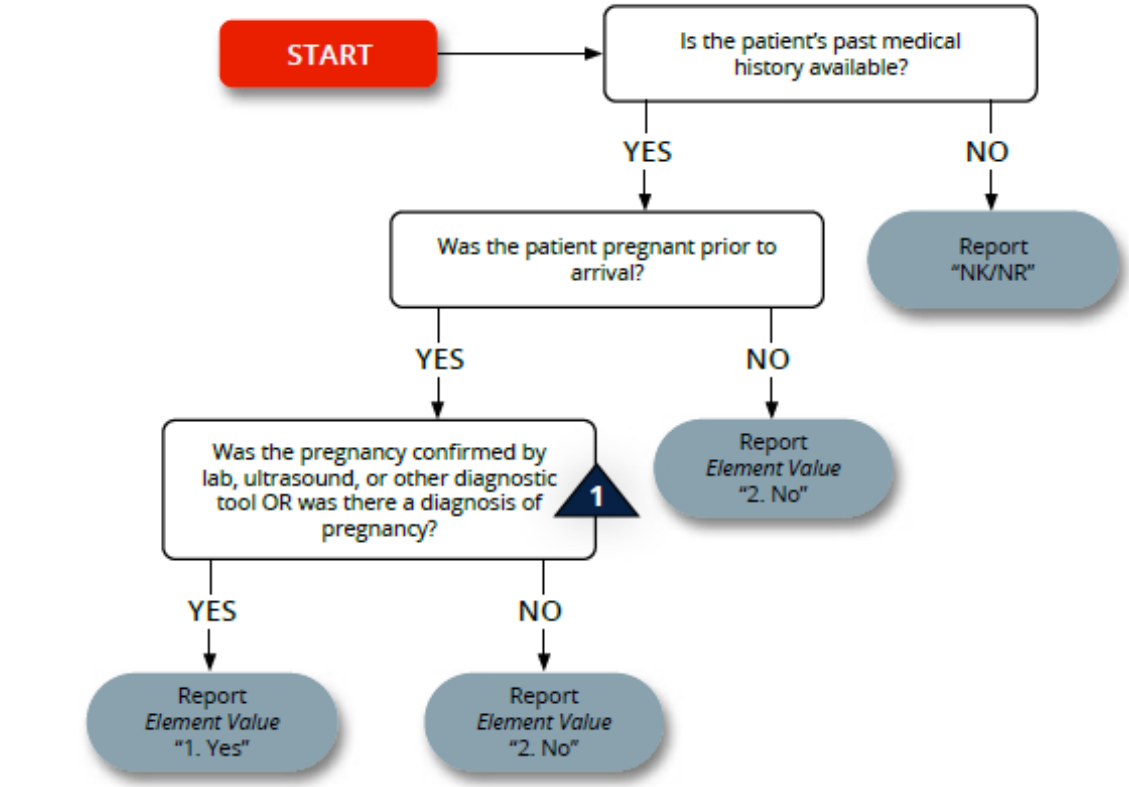

1 Pregnancy must be confirmed by lab, ultrasound, or other diagnostic tool if diagnosis was not documented.

This data element must be reported for all records submitted to TQIP, males and females.

PREMATURITY

Element Intent
Prematurity can induce a multitude of risks, which could impact care decisions and increase the risk of adverse outcomes.

Description
Babies born before 37 weeks of pregnancy are completed.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

Additional Information
- Present prior to injury.
- Only report on patients <15 years-of-age.
- A diagnosis of prematurity, or delivery before 37 weeks of pregnancy are completed, must be documented in the patient's medical record.
- 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.
- Based on the patient’s age on the day of arrival at your hospital.

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Prematurity

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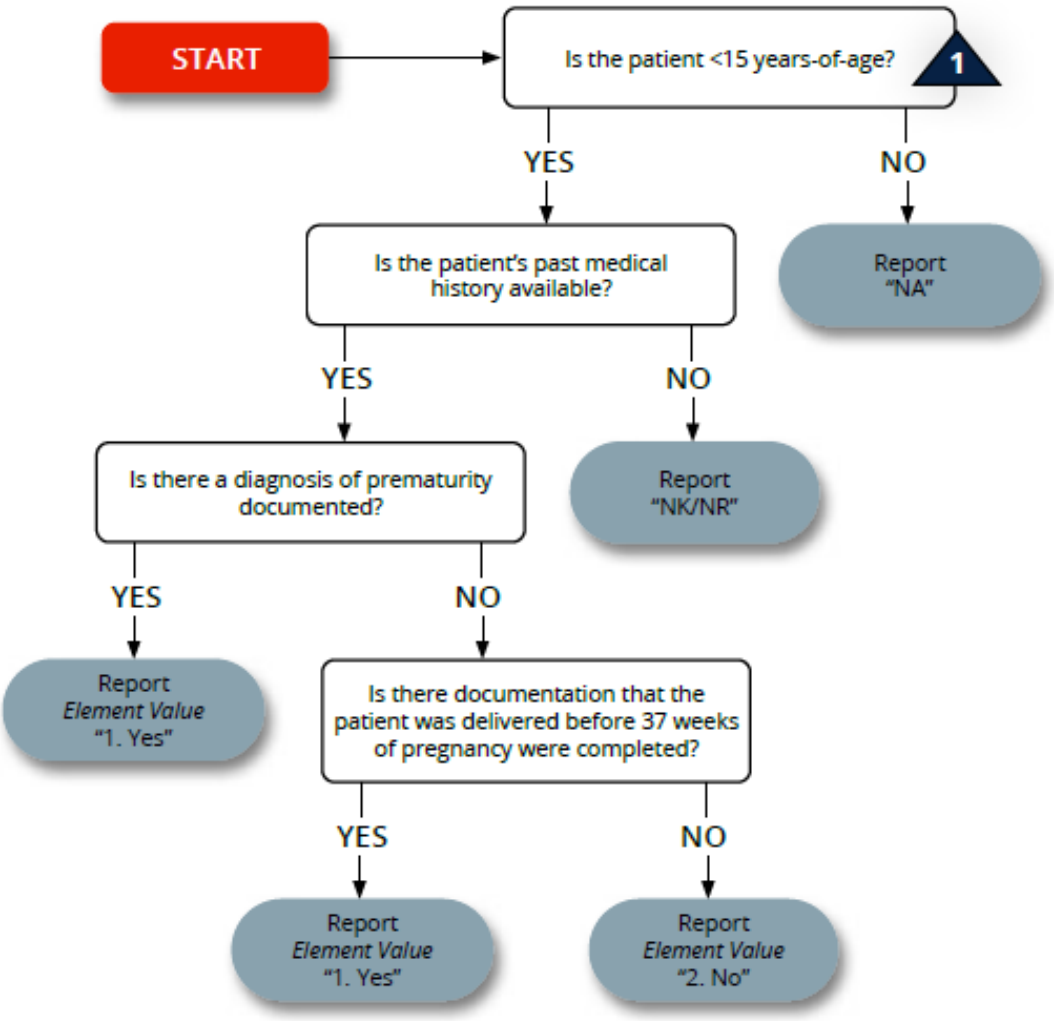

1 Based on the patient's age on the day of arrival at your hospital.

SCHIZOAFFECTIVE DISORDER

Element Intent

Patients with Schizoaffective Disorder experience hallucinations, delusions, mania, depression, and disorganized thinking causing clinically significant distress or impairment in social, occupational, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Description

A schizoaffective disorder diagnosis documented in the medical record.

Element Values

1 Yes
2 No

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.
- Based on the patient's age on the day of arrival at your hospital.

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Schizoaffective Disorder

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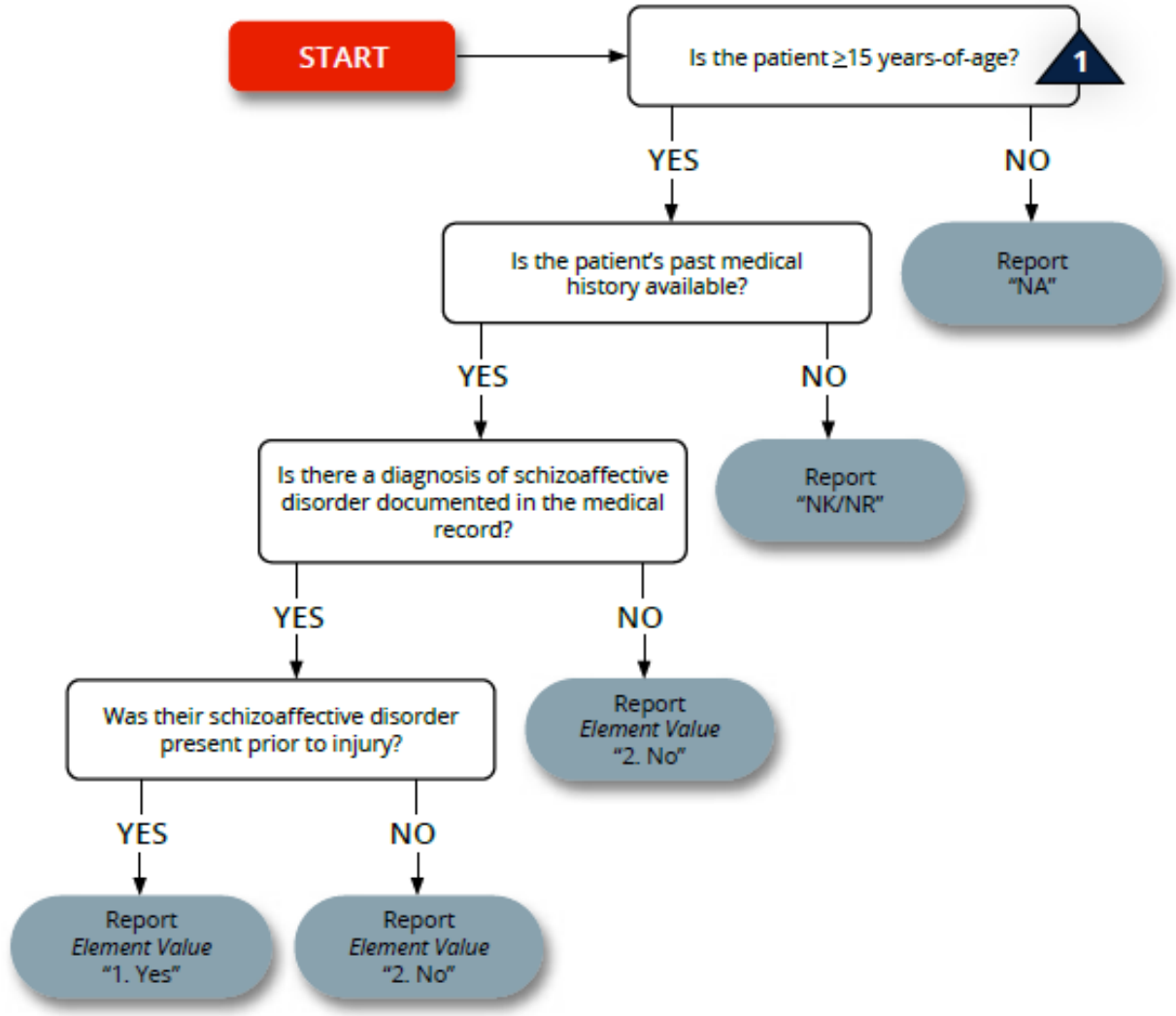

1 Based on the patient's age on the day of arrival at your hospital.

SCHIZOPHRENIA

Element Intent

Patients with Schizophrenia experience hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, diminished emotional expression or avolition causing clinically significant distress or impairment in social, occupation, or other important areas of functioning, which could impact care decisions and increase the risk of adverse outcomes.

Description

A schizophrenia diagnosis documented in the medical record.

Element Values

1 Yes
2 No

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.
- Based on the patient's age on the day of arrival at your hospital.

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Schizophrenia

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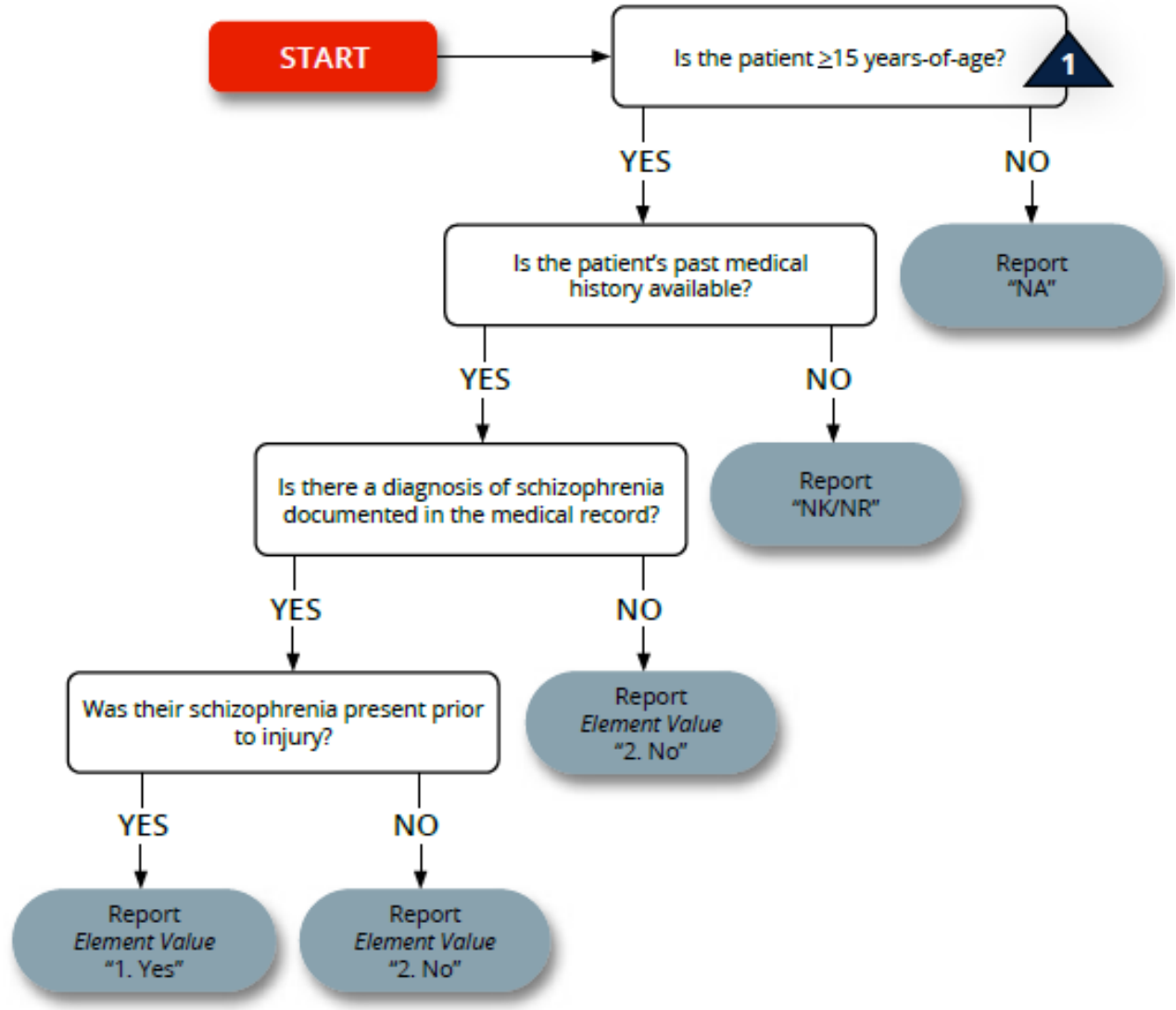

1 Based on the patient's age on the day of arrival at your hospital.

STEROID USE

Element Intent
Steroids negatively affect wound healing and increase the risk of infection, which could impact care decisions and increase the risk of adverse outcomes.

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

EXCLUDE:
- Topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

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.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

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Steroid Use

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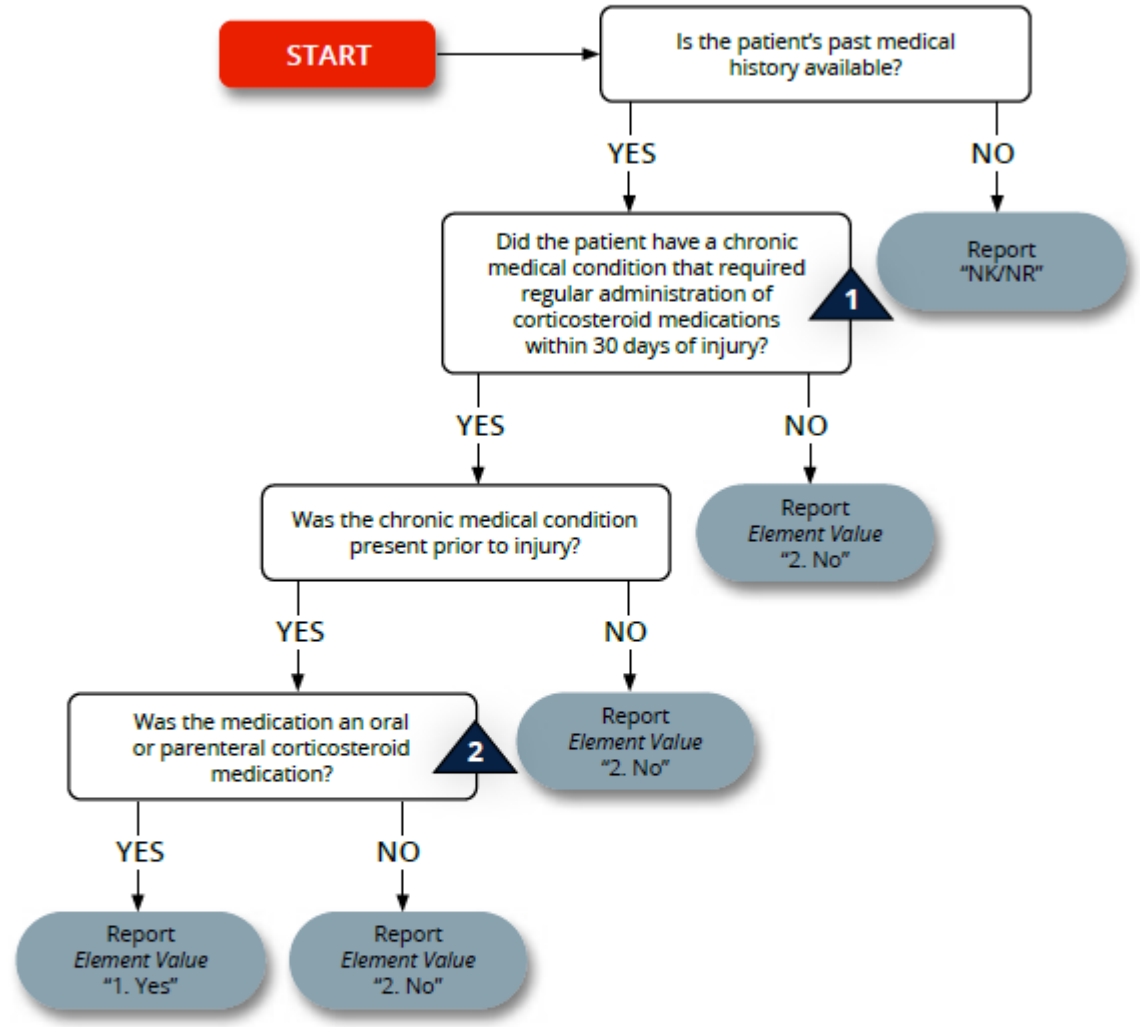


1 A few examples of chronic medical conditions that could require corticosteroids are COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.

2 Exclude corticosteroids that are administered by inhalation, topically, or rectally.

Examples of oral or parenteral steroid medications are prednisone and dexamethasone.

SUBSTANCE USE DISORDER

Element Intent
Patients with substance use disorder are at increased risk of heart, lung, liver, and kidney diseases, as well as stroke, cancer, and mental health conditions, which could impact care decisions and increase the risk of adverse outcomes.

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:

1. Cannabis Use Disorder; Other Cannabis-Induced Disorder; Unspecified Cannabis-Related Disorder
2. 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
3. Inhalant Use Disorder; Other Inhalant-Induced Disorder; Unspecified Inhalant-Related Disorder
4. Opioid Use Disorder; Other Opioid-Induced Disorder; Unspecified Opioid-Related Disorder
5. Sedative, Hypnotic, or Anxiolytic Use Disorder; Other Sedative, Hypnotic, or Anxiolytic-Induced Disorder; Unspecified Sedative, Hypnotic, or Anxiolytic-Related Disorder
6. Stimulant Use Disorder; Other Stimulant-Induced Disorder; Other Stimulant-Related Disorder
7. Based on the patient's age on the day of arrival at your hospital.

Element Values
1 Yes
2 No

Common Null Values
- Accepted

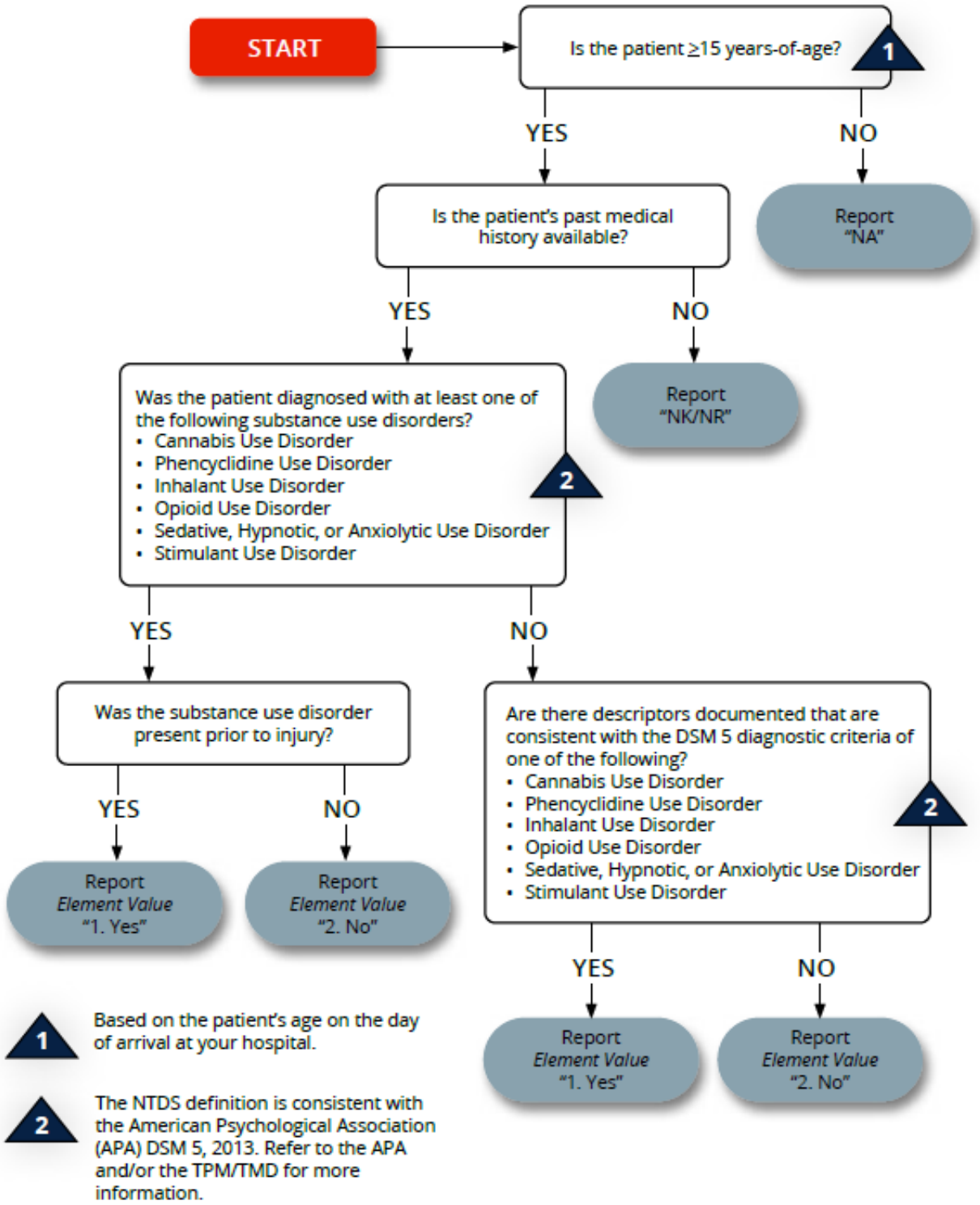
Additional Information
- Present prior to injury.
- Only report on patients ≥15-years-of-age.
- The null value "Not Applicable" must be reported for patients <15 years-of-age.
- The null value "Not Known/Not Recorded: is only reported if no past medical history is available for patients
- ≥15-years-of-age.
- Consistent with the American Psychiatric Association (APA) DSM 5, 2013.

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

References to Other Databases
- NTDS 2027

Substance Use Disorder

2026 NTDS Data Dictionary, Released July 2025



1 Based on the patient's age on the day of arrival at your hospital.

2 The NTDS definition is consistent with the American Psychological Association (APA) DSM 5, 2013. Refer to the APA and/or the TPM/TMD for more information.

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VENTILATOR DEPENDENCE

Element Intent
The need for ventilator-assisted respirations reflects limited pulmonary reserve, which increases the risk of adverse outcomes.

Description
Patients who are ventilator dependent with a tracheostomy prior to injury.

Element Values
1. Yes
2. No

Additional Information
- Present prior to injury.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.
- If Ventilator Dependence is Element Value “1. Yes”, Functionally Dependent Health Status must be Element Value “1. Yes.”

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

References to Other Databases
- NTDS 2027

Ventilator Dependence

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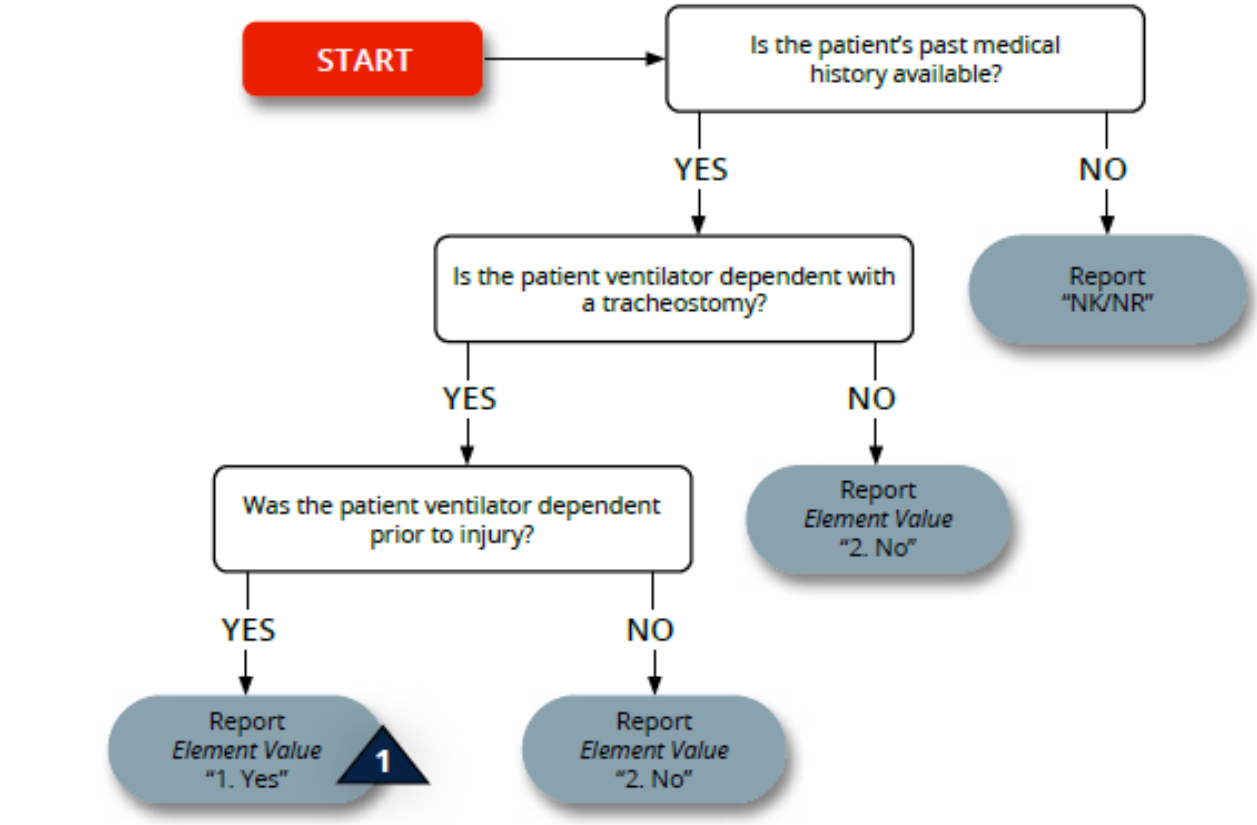


1 If ***Ventilator Dependence*** is *Element Value* "1. Yes," ***Functionally Dependent Health Status*** must be *Element Value* "1. Yes."

DNR STATUS

Element Intent
Provides information about patient's care in the hospital

Description
DNR Status documents the presence of signed DNR paperwork and/or written order from physician or mid-level provider to withhold select resuscitative efforts from the patient, and whether the order was issued prior to or during the patient's stay at your ED/hospital.

Element Values
1. Not a DNR patient (patient is to receive all resuscitative efforts if needed)
2. DNR status ordered prior to patient's arrival at your hospital
3. DNR status ordered after patient's arrival to your hospital

Common Null Values
- Not Accepted

Additional Information
- This element is completed for each patient.
- DNR status is typically ordered for a patient who does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing) near the end of life.
- A DNR status includes both *DNR-CC* (comfort care) and *DNR-CCA* (comfort care arrest) orders.
- DNR may also be referred to as Allow Natural Death (AND)
- Until DNR status is documented, the patient is considered to be "not a DNR patient".
- DNR Status is to be collected at time of discharge from Hospital.
- Refer to Ohio Department of Health for additional details: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/do-not-resuscitate-comfort-care.

Data Source Hierarchy Guide
1 Do Not Resuscitate Document
2 History and Physical
3 Discharge Sheet
4 Billing Sheet

References to Other Databases
- Not an NTDS element

ICD-10 INJURY DIAGNOSES

Element Intent
To classify and quantify the severity of individual injuries, which is used to understand injury patterns, care plans, and outcomes.

Description
Injury Diagnoses related to all identified injuries.

Exclude
Injuries that are iatrogenic in origin (injuries that occur as a direct result of medical treatment, diagnostic procedures, or surgical intervention) that are not attributable to an external traumatic mechanism.

Element Values
1. Injury diagnoses are defined by ICD-10-CM codes; refer to inclusion criteria
2. The maximum number of diagnoses that may be reported for an individual patient is 50.

Common Null Values
- Not Accepted

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
- Periprosthetic and osteoporotic/pathologic fractures must only be reported when there is documented evidence of a qualifying external mechanism of injury (MOI) and an assigned ICD-10-CM diagnosis code that falls within the NTDS-accepted code list.

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

References to Other Databases
- NTDS 2027

AIS CODE

Element Intent
To classify and quantify the severity of individual injuries, which is used to understand injury patterns, care plans, and outcomes.

Description
The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.

Element Values
1. The code is the 8-digit AIS code

Additional Information
None

Data Source Hierarchy Guide
1 AIS Coding Manual

References to Other Databases
- NTDS 2027

AIS VERSION

Element Intent
To indicate the AIS version used to code identified injuries.

Description
AIS version is the software version used to calculate Abbreviated Injury Scale (AIS) severity codes for the patient's current injury event.

Element Values
1. AIS 2015

Additional Information
None

Common Null Values
- Accepted

Data Source Hierarchy Guide
1 AIS Coding Manual

References to Other Databases
- NTDS 2027

INJURY SEVERITY SCORE

Element Intent
To classify and quantify the severity of individual injuries, which is used to understand injury patterns, care plans, and outcomes.

Description
Injury Severity Score (ISS) is a nationally-accepted scoring system that reflects the patient's injuries for this injury event.

Element Values
1. Relevant ISS value for the constellation of injuries

Additional Information
None

Common Null Values
- Accepted

Data Source Hierarchy Guide
1 AIS Coding Manual

References to Other Databases
- Not an NTDS element

TOTAL ICU LENGTH OF STAY

Element Intent
To indicate the patient's condition and the duration of their requirement for specialized monitoring and care.

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

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- The null value "Not Known / Not Recorded" is reported if any dates are missing.
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- The null value "Not applicable" is reported if the patient had no ICU days according to the above definition.
- A '0' (zero) in this field is not an acceptable value.
- See Appendix B for examples of ICU LOS calculations

Data Source Hierarchy Guide
1 ICU Flow Sheet
2 Nursing Notes/Flow Sheet

References to Other Databases
- NTDS 2027

TOTAL VENTILATOR DAYS

Element Intent
To indicate the patient's respiratory condition and the duration of their requirement for specialized monitoring and care.

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

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Reported in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart.
- The null value "Not known / Not Recorded" is reported if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS.
- The null value "Not Applicable" is reported if the patient was not on the ventilator according to the above definition.
- A '0' (zero) in this field is not an acceptable value.
- See Appendix B for examples of Total Ventilator Days calculations.

Data Source Hierarchy Guide
1 Respiratory Therapy Notes/Flow Sheet
2 ICU Flow Sheet
3 Progress Notes
4 Triage/ Trauma Flow Sheet

References to Other Databases
- NTDS 2027

HOSPITAL DISCHARGE ORDER WRITTEN DATE

Element Intent
Provides information about the patient's hospital disposition, which helps track the level of care the patient received.

Description
Hospital Discharge Order Written Date is the date that the order was written for the patient to be discharged from your hospital.

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as YYYY-MM-DD
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, 11 or 13
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is reported if ED Discharge Disposition is 5. Deceased/Expired.
- The null value "Not Applicable" is reported if Hospital Discharge Disposition is reported as "Not Applicable"

Data Source Hierarchy Guide
1 Physician Order
2 Discharge Instructions
3 Nursing Notes/Flow Sheet
4 Case Management/Social Services Notes
5 Discharge Summary

References to Other Databases
- Not an NTDS element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE ORDER WRITTEN TIME

Element Intent
Provides information about the patient's hospital disposition, which helps track the level of care the patient received.

Description
Hospital Discharge Order Written Time is the time that the order was written for the patient to be discharged from your hospital.

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as HHMM military time
- The null value "Not Applicable" is used if ED Discharge Disposition = 4, 6, 9, 10, 11 or 13.
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Deceased/ expired).
- The null value "Not Applicable" is reported if Hospital Discharge Disposition is reported as "Not Applicable"

Data Source Hierarchy Guide
1 Physician Order
2 Discharge Instructions
3 Nursing Notes/Flow Sheet
4 Case Management/Social Services Notes
5 Discharge Summary

References to Other Databases
- Not an NTDS element

NOTE: HOSPITAL DISCHARGE ORDER WRITTEN TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE DATE

Element Intent
To calculate metrics such as hospital length of stay and to inform the care timeline.

Description
Hospital Discharge Date is the date that the patient was physically discharged from your hospital.

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as YYYY-MM-DD
- The null value "Not Applicable" is reported if ED Discharge Disposition = 4, 6, 9, 10, 11 or 13
- The null value "Not Applicable" is reported if Hospital Discharge Disposition is reported as "Not Applicable"
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate

Data Source Hierarchy Guide
1. Discharge Instructions
2. Nursing Notes/Flow Sheet
3. Case Management/Social Services Notes
4. Discharge Summary

References to Other Databases
- NTDS 2027 (element name only)

NOTE: HOSPITAL DISCHARGE DATE differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE TIME

Element Intent
To calculate metrics such as hospital length of stay and to inform the care timeline.

Description
Hospital Discharge Time is the time of day that the patient was physically discharged from your hospital.

Element Values
1. Relevant value for data element

Common Null Values
- Accepted

Additional Information
- Collected as HHMM military time
- The null value "Not Applicable" is used if ED Discharge Disposition = 4, 6, 9, 10, 11 or 13.
- The null value "Not Applicable" is reported if Hospital Discharge Date is reported as "Not Applicable".
- If Hospital Discharge Disposition is "5. Deceased/Expired," then Hospital Discharge Date is the date of death as indicated on the patient's death certificate

Data Source Hierarchy Guide
1 Discharge Instructions
2 Nursing Notes/Flow Sheet
3 Case Management/Social Services Notes
4 Discharge Summary

References to Other Databases
- NTDS 2027 (element name only)

NOTE: HOSPITAL DISCHARGE TIME differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

HOSPITAL DISCHARGE DISPOSITION

Element Intent

To indicate the patient's medical and support needs after their acute care is complete, including functional dependence and ongoing medical requirements.

Description

Hospital Discharge Disposition documents in general terms where the patient went after discharge from your hospital.

Element Values

1 Discharged/Transferred to another hospital for ongoing acute inpatient care
2 Discharged to an intermediate care facility (ICF)/long term care facility (LTCF)
3 Discharged/Transferred to home under the care of an organized home health service
4 Left against medical advice (AMA) or discontinued care
5 Died
6 Discharged home or self-care (routine discharge)
7 Discharged to a skilled nursing facility (SNF)
8 Discharged to hospice care
9 [Value 9 not used]
10 Discharged to court/law enforcement/jail
11 Discharged to another type of inpatient rehabilitation facility (IRF)
12 Discharged to a long term acute care hospital (LTACH)
13 Discharged/transferred to psychiatric hospital/psychiatric unit
14 Discharged/transferred to other type of institution not listed here

Common Null Values

- Accepted

Additional Information

- Element Value "6. Home" refers to the patient's current place of residence (e.g., prison, child protective services, etc.), provided the patient's level of care at discharge is the same as it was prior to their injury event.Element values adapted from UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be coded as 14.
- The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 5, 6, 10, 11, 13, or 14.The null value "Not Applicable" is reported if ED Discharge Disposition is "5, Deceased/Expired."
- 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.
- Disposition to any Federal Health Care facility must be reported be selecting the option that most closely aligns to the needs of the patient (e.g., patients discharged to a Veteran's hospital skilled nursing facility must be reported as Element Value "7 Discharged/Transferred to Skilled Nursing Facility.")

Data Source Hierarchy Guide

1 Physician Order
2 Discharge Instructions
3 Nursing Notes/Flow Sheet
4 Case Management/Social Services Notes
5 Discharge Summary

References to Other Databases

- NTDS 2027

INPATIENT TRANSFER TO HOSPITAL

Element Intent
Provides information about the patient's hospital disposition, which helps track the level of care the patient received**.**

Description
Inpatient Transfer to Hospital documents a subsequent hospital destination for the patient after inpatient admission at your hospital. This includes transfers to inpatient rehabilitation facilities.

Element Values
1. Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values
- Accepted

Additional Information
- Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
- If identify hospital not listed contact emsdata@dps.ohio.gov

Data Source Hierarchy Guide
1 Discharge Summary
2 Progress Notes
3 Billing/Registration Sheet

References to Other Databases
- Not an NTDS element

DISCHARGE STATUS

Element Intent
Provides information about patient's vital status at the time of discharge

Description
Discharge Status is whether the patient left your hospital alive or dead.

Element Values
1 Alive
2 Dead

Common Null Values
- Not Accepted

Additional Information
None

Data Source Hierarchy Guide
1 Discharge Summary
2 Progress Notes
3 Billing Sheet

References to Other Databases
- Not an NTDS element

PRIMARY METHOD OF PAYMENT

Element Intent
to investigate disparities in care, access to services, and other relevant healthcare issues.

Description
Primary Method of Payment is the primary source of payment for hospital care.

Element Values
1 Medicaid
2 Not Billed (for any reason)
3 Self-Pay
4 Private/Commercial Insurance
6 Medicare
7 Other Government Payer Source
8 Workers Compensation
10 Other

Common Null Values
- Accepted

Additional Information
- No Fault Automobile, , and Blue Cross/Blue Shield should be reported as "4. Private/Commercial Insurance".
- Primary methods of payments which were retired greater than 2 years before the current NTDS version are no longer listed under Element Values. Refer to the NTDS Change Log for a full list of retired Primary Methods of Payments.
- Examples of "Other Government Payer Source": Veterans Affairs (VA), TRICARE, CHAMPVA
- Charity or HCAP should be coded under "Not Billed"

Data Source Hierarchy Guide
1 Billing Sheet
2 Admission Form
3 Face Sheet

References to Other Databases
- NTDS 2027

NOTE: PRIMARY METHOD OF PAYMENT differs from NTDS. Please refer to the section "DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)" starting on Page 12 for more information.

AUTOPSY PERFORMED

Element Intent
If the patient is deceased, provides additional information regarding the patient's disposition.

Description
Autopsy Performed documents whether an internal organ exam was performed on the patient by a trained pathologist.

Element Values
1 Yes, an autopsy was performed
2 No, an autopsy was not performed

Common Null Values
- Accepted

Additional Information
- Select *NA* if the patient is alive
- If only an external or visual-type exam was done and no internal organs were surgically explored, element value #2, *No, an autopsy was not performed,* should be selected.

Data Source Hierarchy Guide
1 Autopsy Report
2 Discharge Summary

References to Other Databases
- Not an NTDS element

ACUTE KIDNEY INJURY (AKI)

Element Intent

A potentially preventable event often induced by sepsis, hypotension, drug toxicity and/or renal trauma; advancement to stage 3 requires treatment which could increase the hospital stay and the likelihood of mortality.

Description

Acute kidney injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient's stay at your hospital.

EXCLUDE:

1. Patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

KDIGO (Stage 3) Table:

(SCr) 3 times baseline

OR

Increase in SCr to ≥ 4.0 mg/dl (≥ 353.6 µmol/l)

OR

Initiation of renal replacement therapy OR, in patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m^2

OR

Urine output <0.3 ml/kg/h for ≥ 24 hours

OR

Anuria for ≥ 12 hours

Element Values

1 Yes
2 No

Additional Information

- Onset of AKI stage 3 began after arrival to your ED/hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline.

Data Source Hierarchy Guide

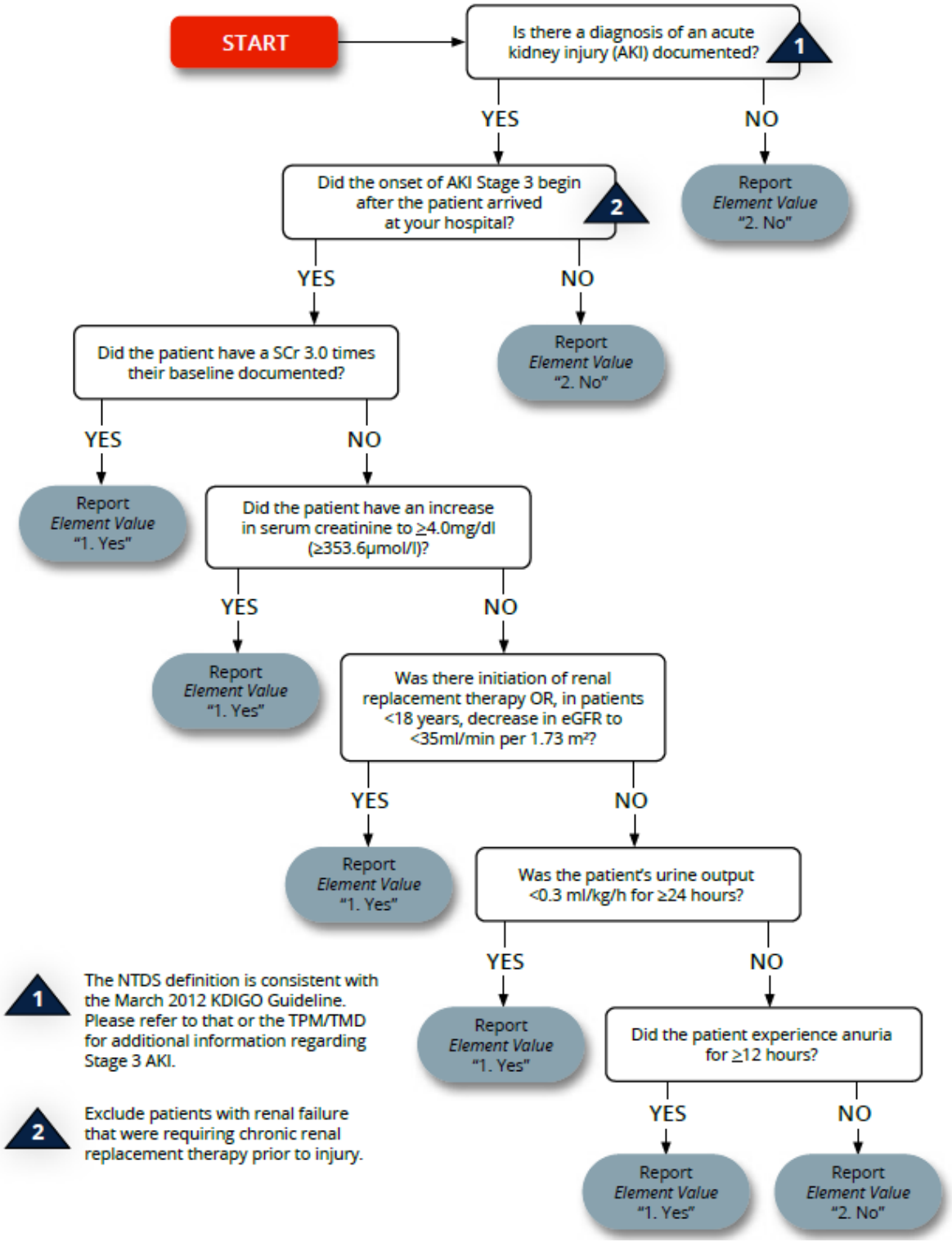
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Acute Kidney Injury (AKI)

2026 NTDS Data Dictionary, Released July 2025



ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Element Intent

A potentially preventable event often induced by pneumonia, viral infection, sepsis, blood transfusion, pancreatitis, fat emboli, trauma, or other injures, requiring treatment which could increase the hospital length of stay and likelihood of mortality.

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 collage, or nodules
Origin of edema:	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.
Oxygenation:	
Mild	200 mm Hg < PaO2/FIO2 < 300 mm Hg With PEEP or CPAP >= 5 cm H2Oc
Moderate	100 mm Hg < PaO2/FIO2 < 200 mm Hg With PEEP >5 cm H2O
Severe	PaO2/FIO2 < 100 mm Hg With PEEP or CPAP >5 cm H2O

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- Consistent with the 2012 New Berlin Definition.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

Acute Respiratory Distress Syndrome (ARDS)

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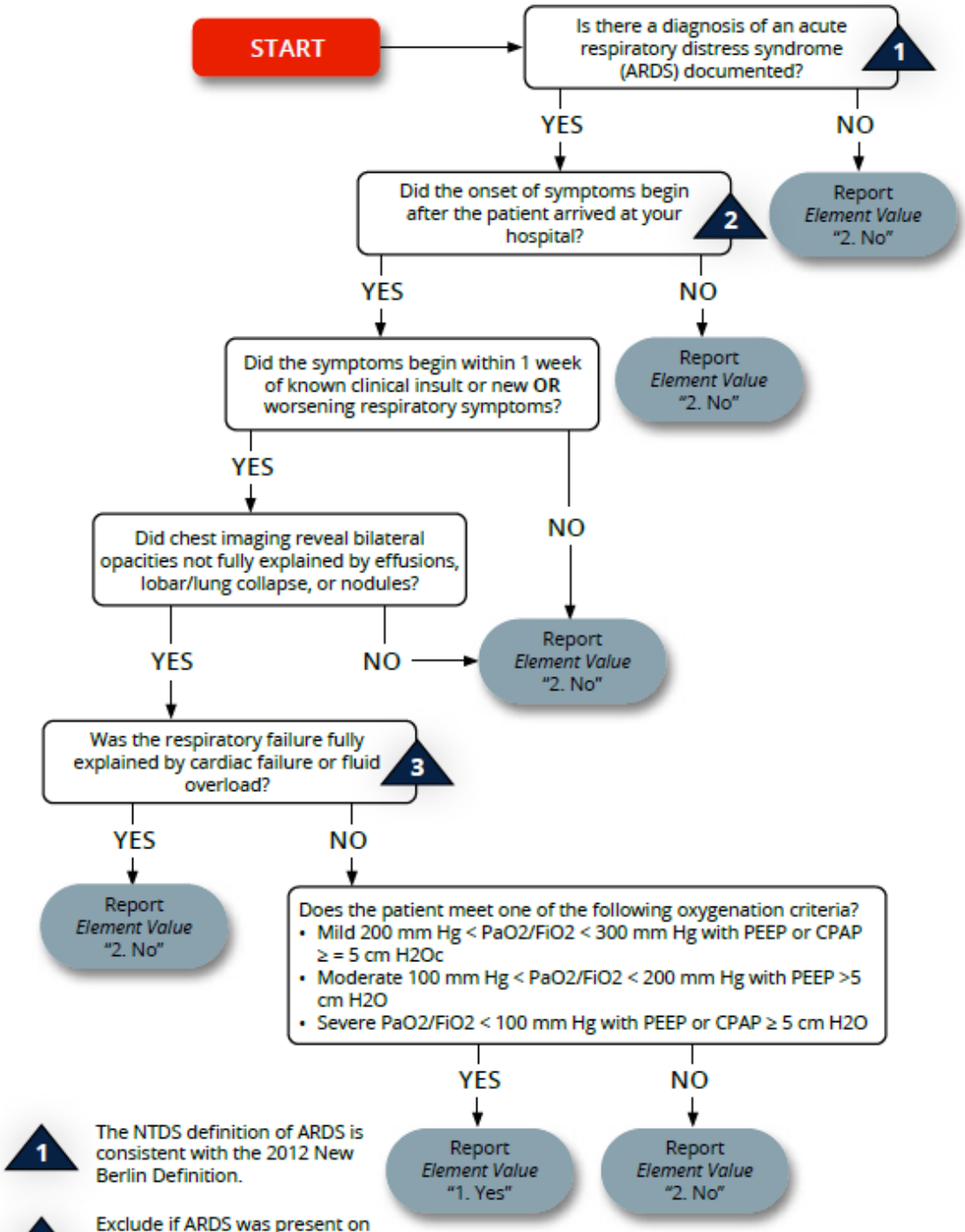

1. The NTDS definition of ARDS is consistent with the 2012 New Berlin Definition.
2. Exclude if ARDS was present on arrival at your hospital.
3. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.

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ALCOHOL WITHDRAWAL SYNDROME

Element Intent
A potentially preventable event often associated with infectious complications, requiring treatment which could increase the hospital length o stay and the likelihood or mortality.

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
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- Consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.

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

References to Other Databases
- NTDS 2027

Alcohol Withdrawal Syndrome

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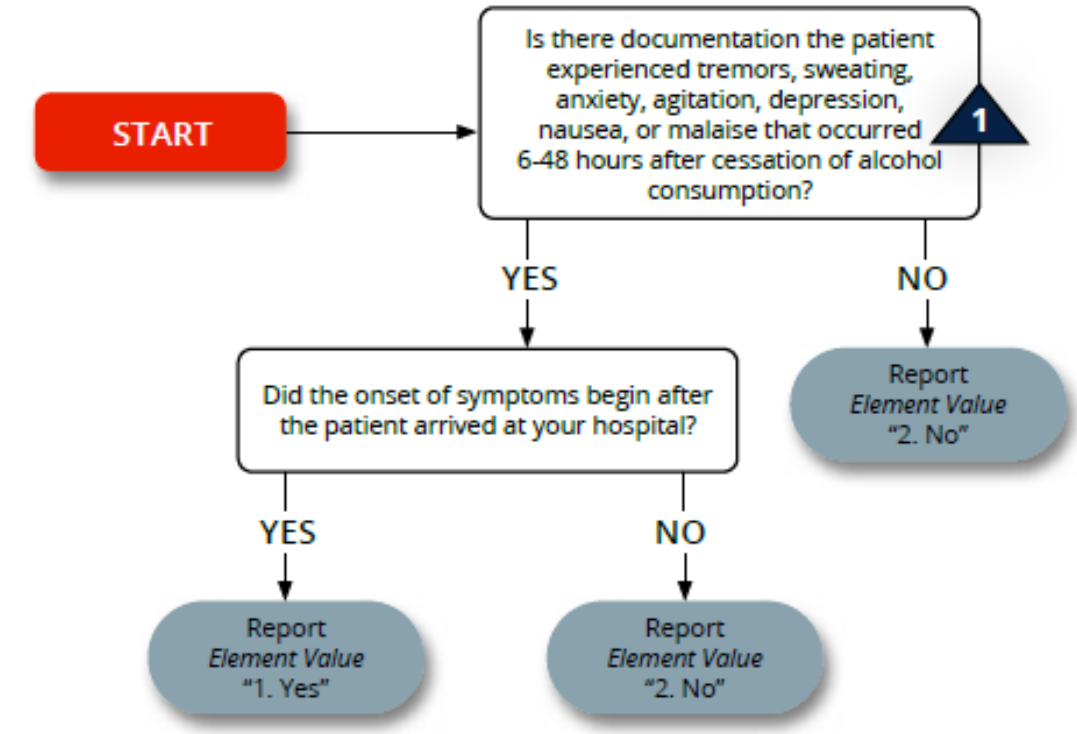

1 Note that a diagnosis of alcohol withdrawal syndrome is not required by the NTDS definition.

CARDIAC ARREST WITH CPR

Element Intent
A potentially preventable event often associated with either a medical or trauma-related condition, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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, have 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
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- Cardiac Arrest must be documented in the patient's medical record.

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

References to Other Databases
- NTDS 2027

Cardiac Arrest with CPR

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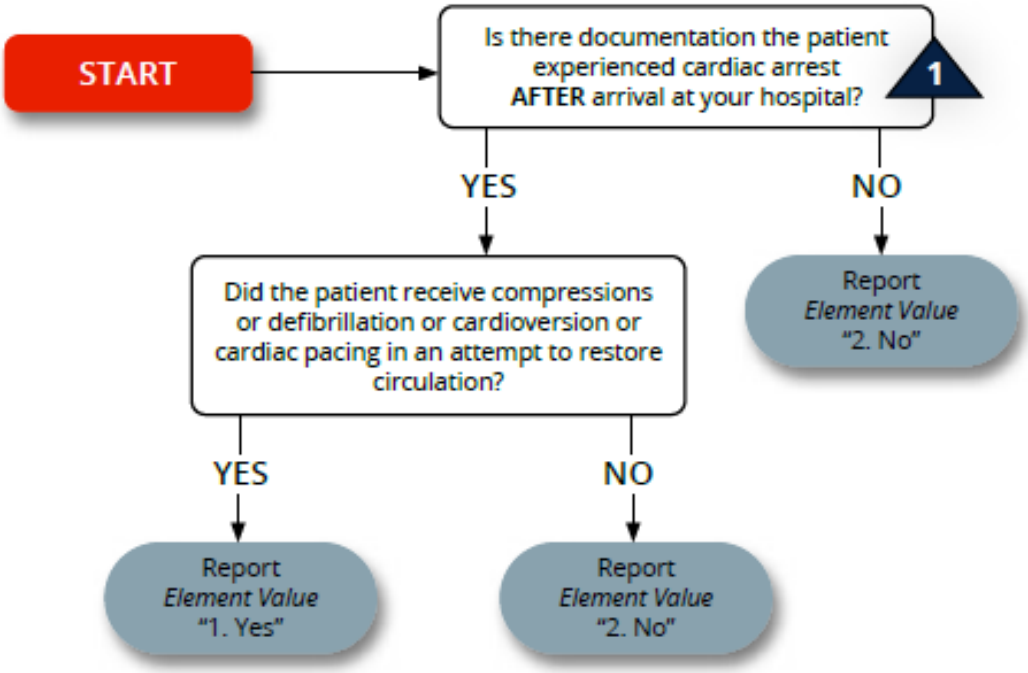


1

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.

EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Element Intent
A potentially preventable event often induced by bacteria entering the urinary tract through the catheter, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

AND

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

January 2019 CDC CAUTI Criterion SUTI 1a:

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

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

January 2019 CDC CAUTI Criterion SUTI 2:

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

1. Patient is ≤ 1 year of age
2. Patient has at least one of the following signs or symptoms:
    - Fever (> 38.0°C)
    - Hypothermia (<36.0°C)
    - Apnea
    - Bradycardia
    - Lethargy
    - Vomiting
    - Suprapubic tenderness

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

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined CAUTI.

Data Source Hierarchy Guide

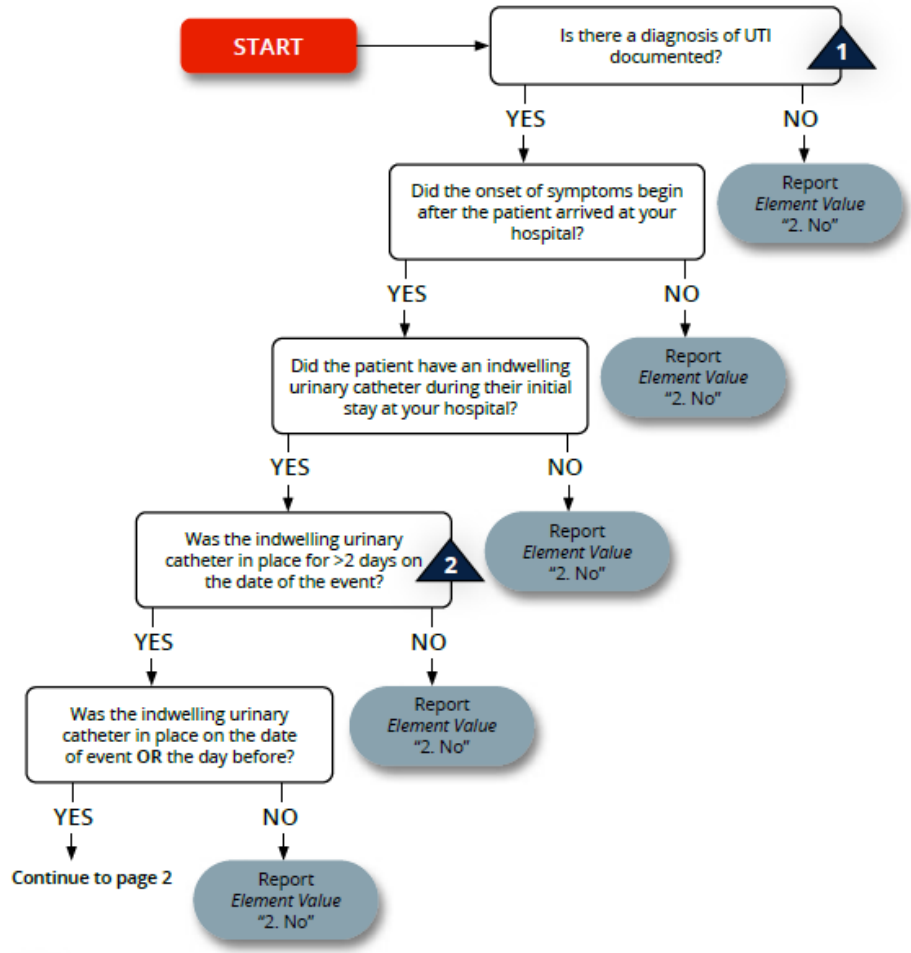
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

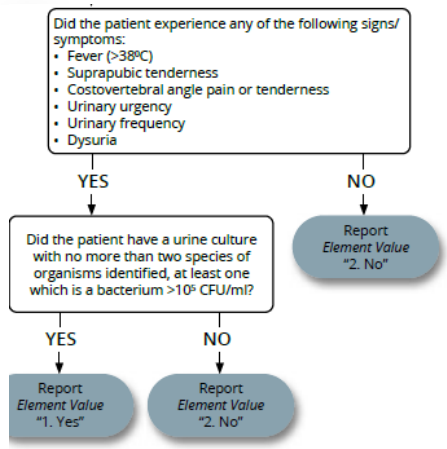
Catheter-Associated Urinary Tract Infection (CAUTI) SUTI 1a (Patients >1 year of age)

2026 NTDS Data Dictionary, Released July 2025



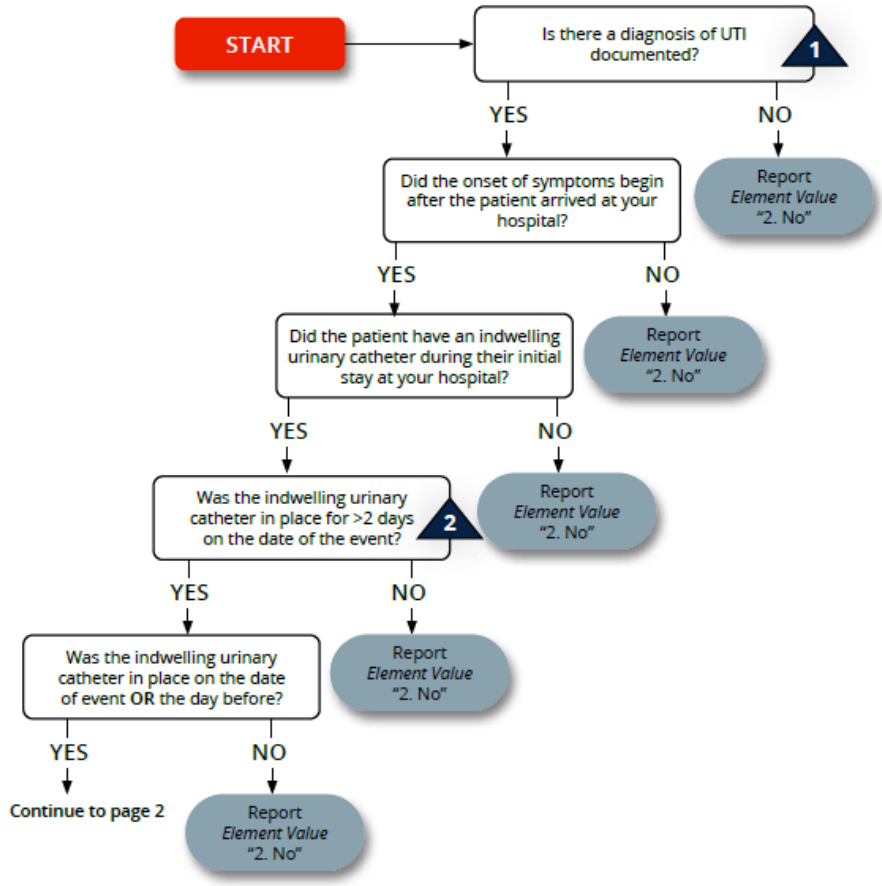
1 The NTDS definition is consistent with the January 2019 CDC CAUTI definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

2 The Date of Event is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period. The day of device placement is Day 1.



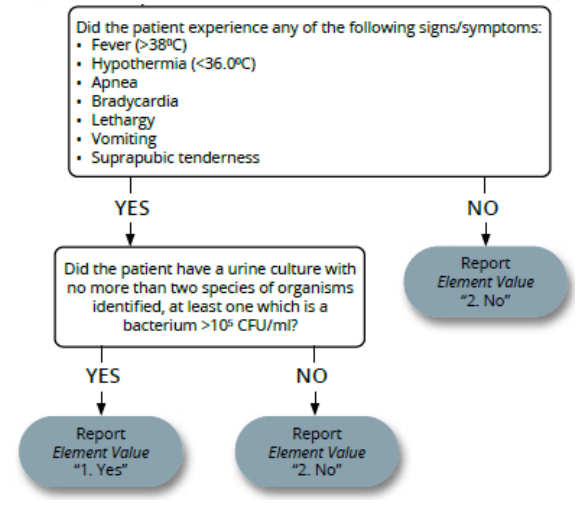
Catheter-Associated Urinary Tract Infection (CAUTI) SUTI 2 (Patients ≤1 year of age)

2026 NTDS Data Dictionary, Released July 2025



1 The NTDS definition is consistent with the January 2019 CDC CAUTI definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

2 The Date of Event is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period. The day of device placement is Day 1.



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI)

Element Intent
A potentially preventable event often induced by bacteria entering the bloodstream through the central line, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

AND

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

January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms:

- Fever (>38°C)
- Chills
- 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. diphtheria], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

OR

January 2016 CDC Criterion LCBI 3:

Patient ≤ 1 year of age has at least one of the following signs or symptoms:

- Fever (>38°C)
- Hypothermia (<36°C)
- Apnea
- Bradycardia

AND

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

AND

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

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of CLABSI must be documented in the patient's medical record.
- Consistent with the January 2016 CDC defined CLABSI.

Data Source Hierarchy Guide

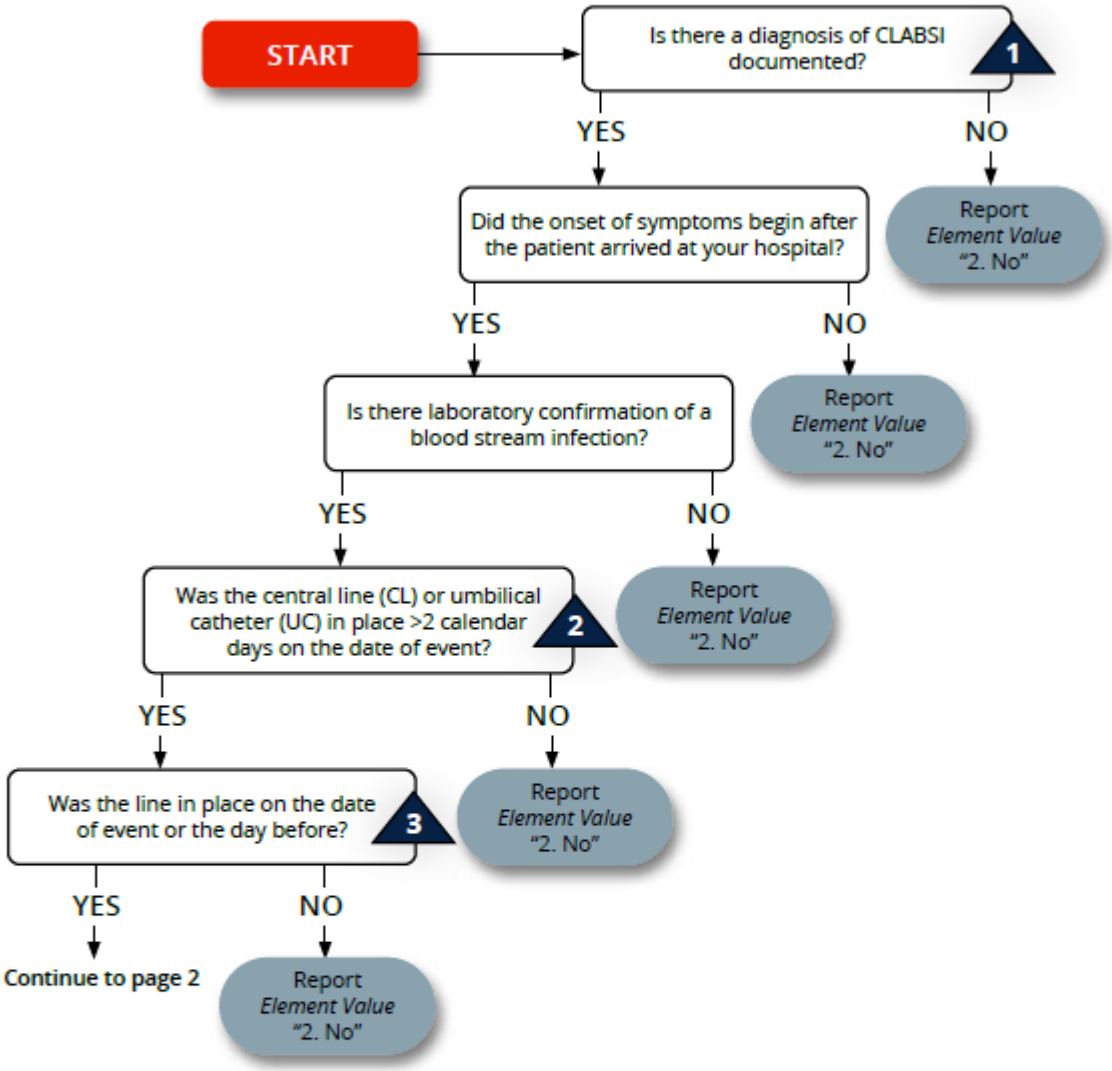
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Central Line-Associated Blood Stream Infection (CLABSI) (pg. 1 of 3)

2026 NTDS Data Dictionary, Released July 2025



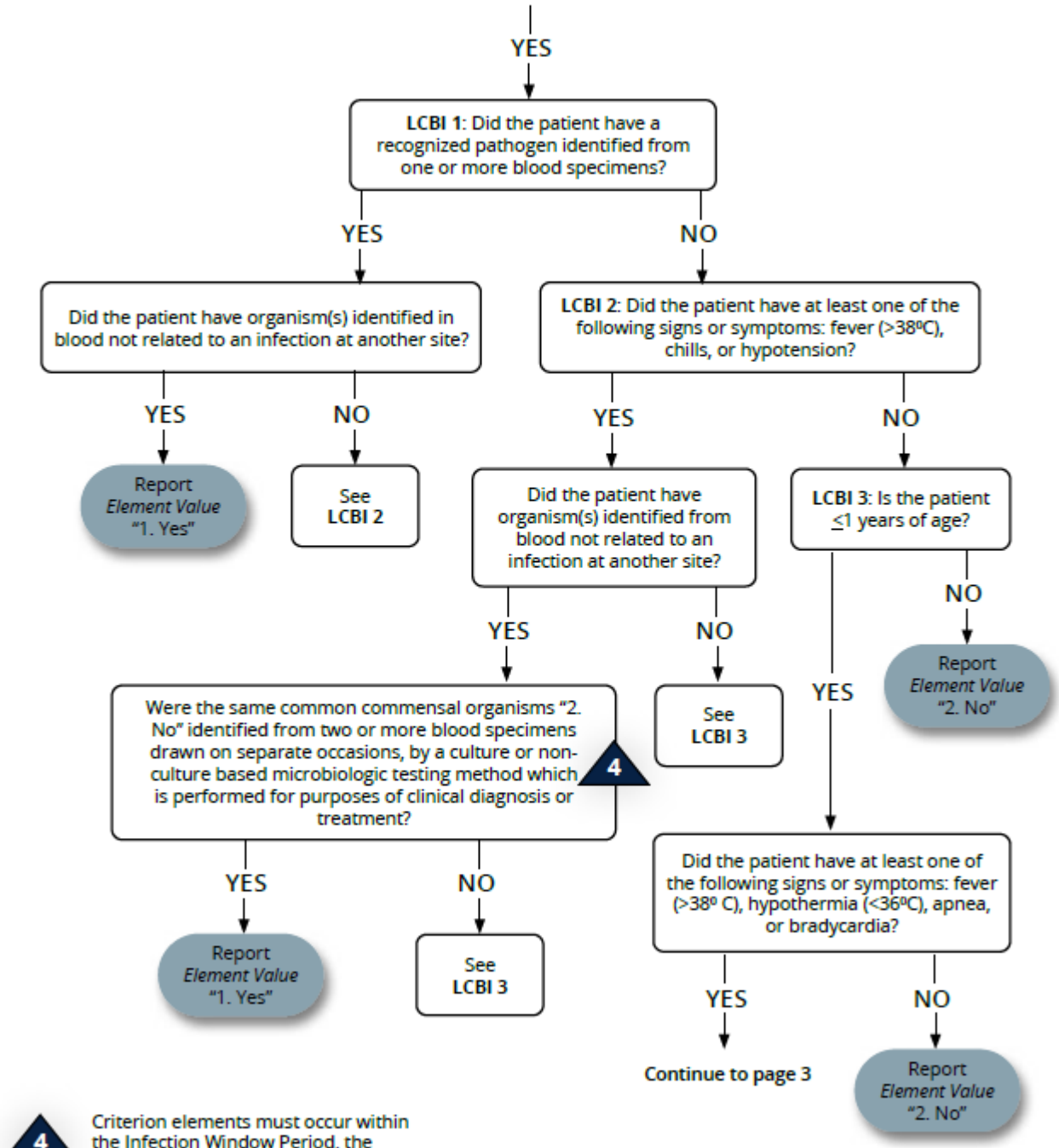
1 The NTDS definition is consistent with the January 2016 CDC CLABSI definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

2 The Date of Event is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period. The day of device placement is Day 1.

3 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.

Central Line-Associated Blood Stream Infection (CLABSI) (pg. 2 of 3)

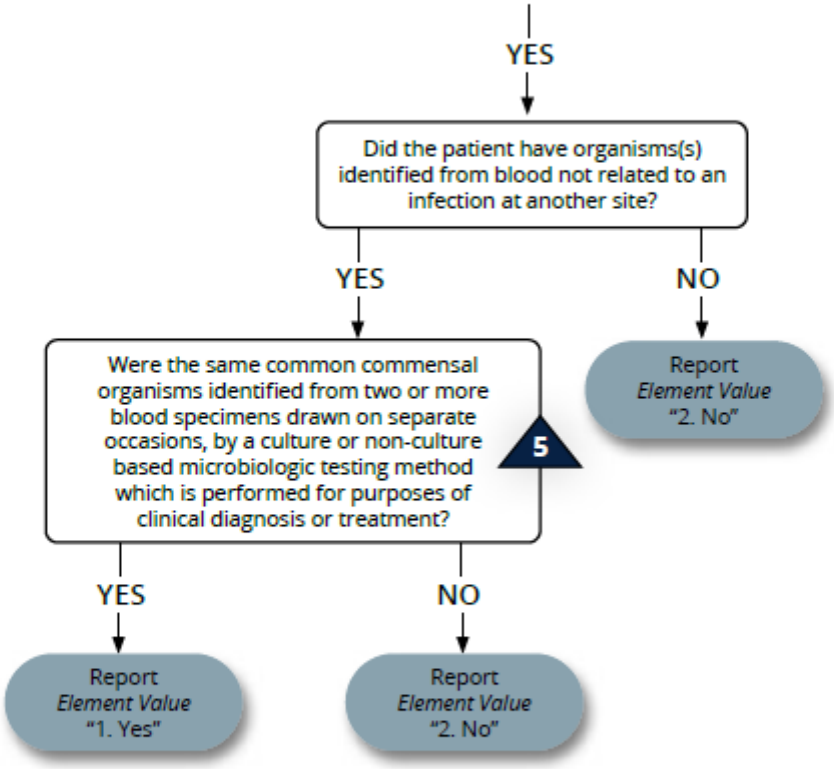
2026 NTDS Data Dictionary, Released July 2025



4 Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

Central Line-Associated Blood Stream Infection (CLABSI) (pg. 3 of 3)

***2026 NTDS Data Dictionary*, Released July 2025**



5 Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

Element Intent
A potentially preventable event often induced by bacteria, viruses, or endogenous flora contacting a surgical wound, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Description
Must meet the following criteria:

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

AND

Patient has at least one of the following:

- Purulent drainage from the deep incision
- 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 purposed of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ACS/AST) or culture or non-culture based microbiologic test 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
- An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

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

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

30- day Surveillance			
Code	**Operative Procedure**	**Code**	**Operative Procedure**
AAA	Abdominal Aortic Aneurysm repair	LAM	Laminectomy
AMP	Limb Amputation	LTP	Liver transplant
APPY	Appendix Surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BIBL	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder Surgery	REC	Rectal surgery

COLO	Colon Surgery	SB	Small bowel surgery
CSEC	Cesarean Section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery

HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90- day Surveillance			
Code	**Operative Procedure**		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with check incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the CDC January 2024 defined SSI.

Data Source Hierarchy Guide

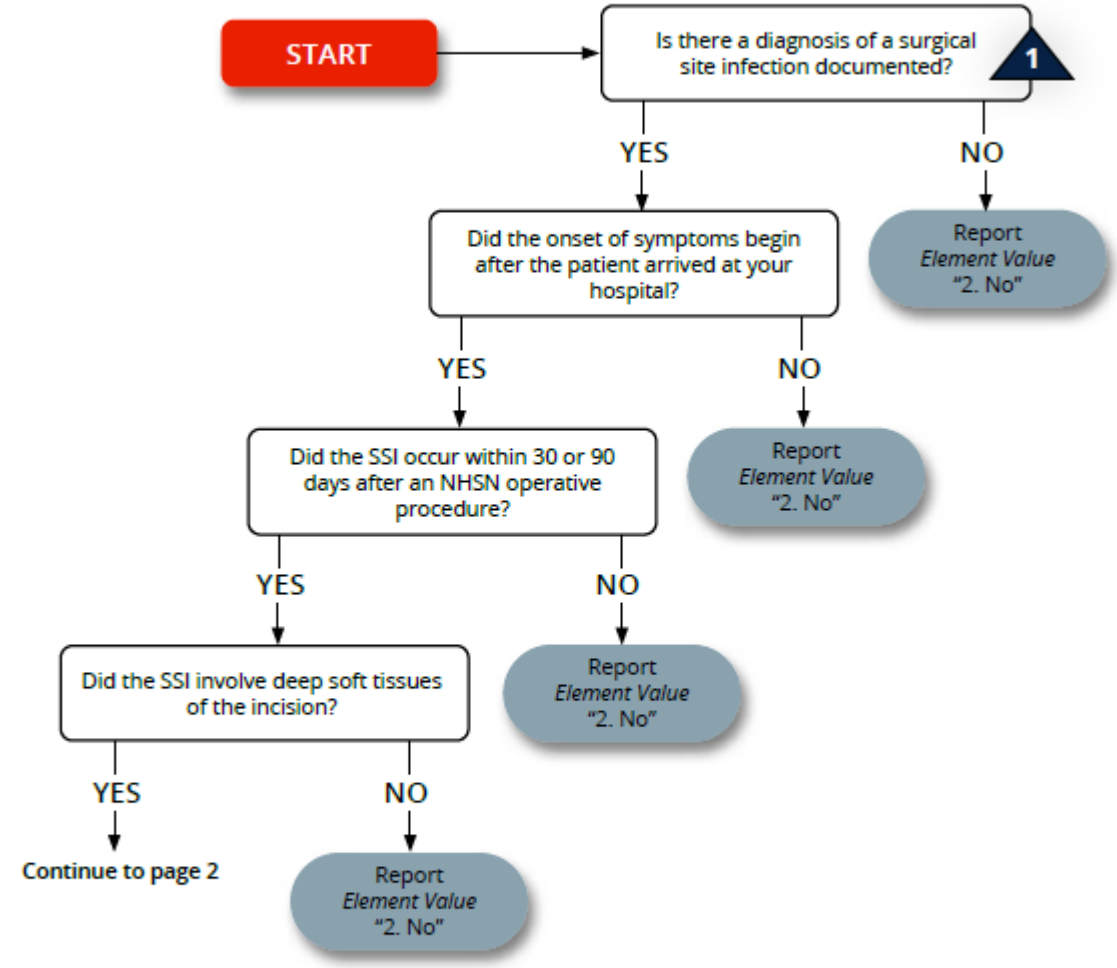
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Deep Surgical Site Infection (Deep SSI) (pg. 1 of 2)

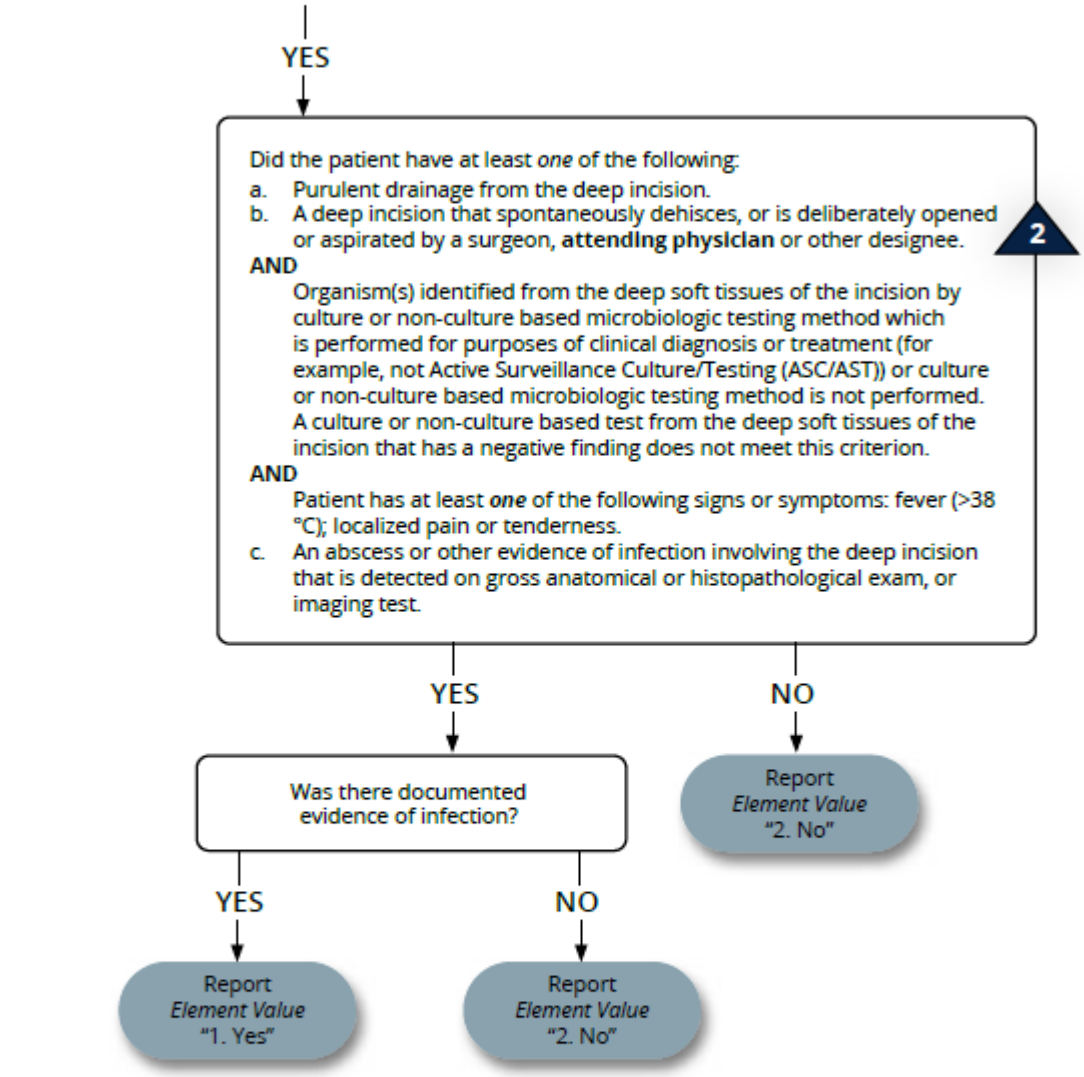
***2026 NTDS Data Dictionary*, Released July 2025**



1 The NTDS definition is consistent with the January 2024 CDC SSI definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

Deep Surgical Site Infection (Deep SSI) (pg. 2 of 2)

2026 NTDS Data Dictionary, Released July 2025



2 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).

DEEP VEIN THROMBOSIS (DVT)

Element Intent
A potentially preventable event often induced by immobility, anesthesia, stroke, venous catheters, dehydration, and/or thrombocytosis, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

Element Values
1 Yes
2 No

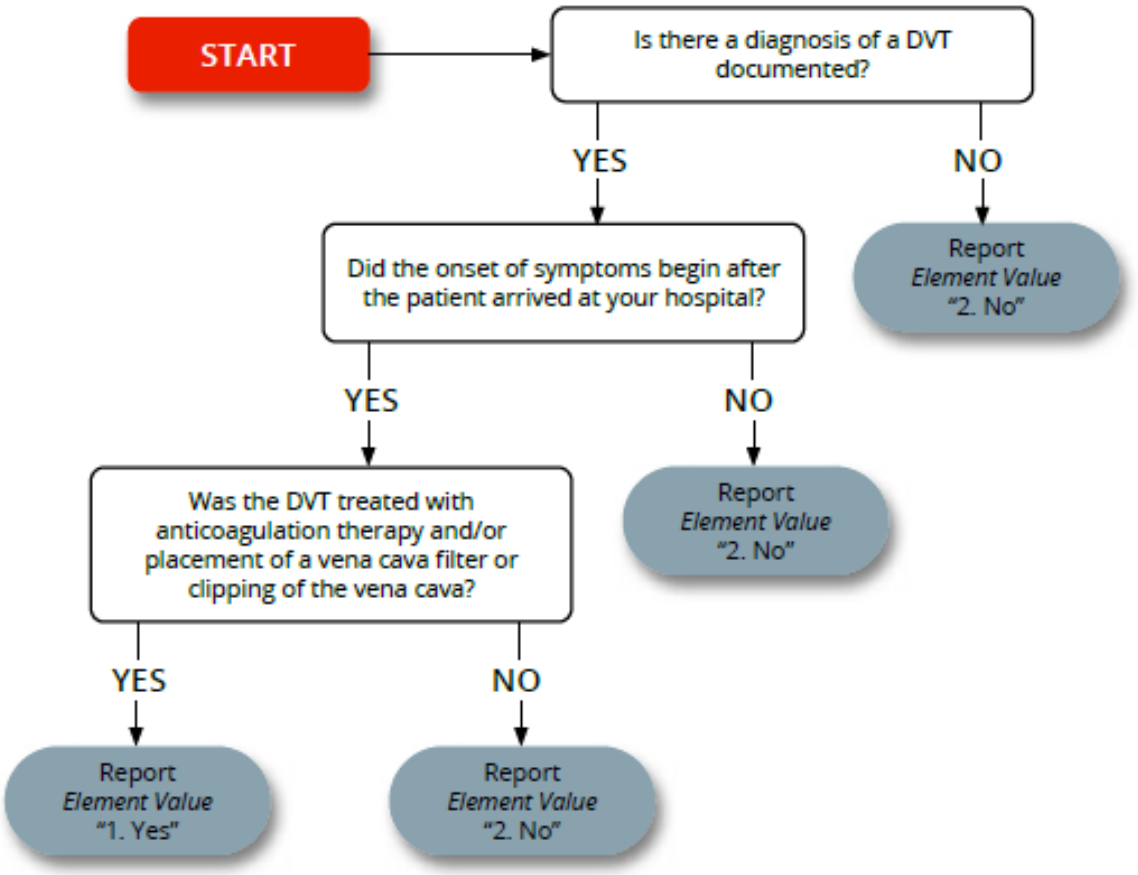
Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.

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

References to Other Databases
- NTDS 2027

Deep Vein Thrombosis (DVT)

2026 NTDS Data Dictionary, Released July 2025



DELIRIUM

Element Intent
A potentially preventable event often induced by infection, stroke, lung or liver disease, medications, low sodium, low blood sugar, urinary retention, dehydration, low oxygen, or an unfamiliar environment, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Description

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

OR

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

EXCLUDE:

- Patients whose delirium is due to alcohol withdrawal.

Element Values

1 Yes
2 No

Additional Information

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

Data Source Hierarchy Guide

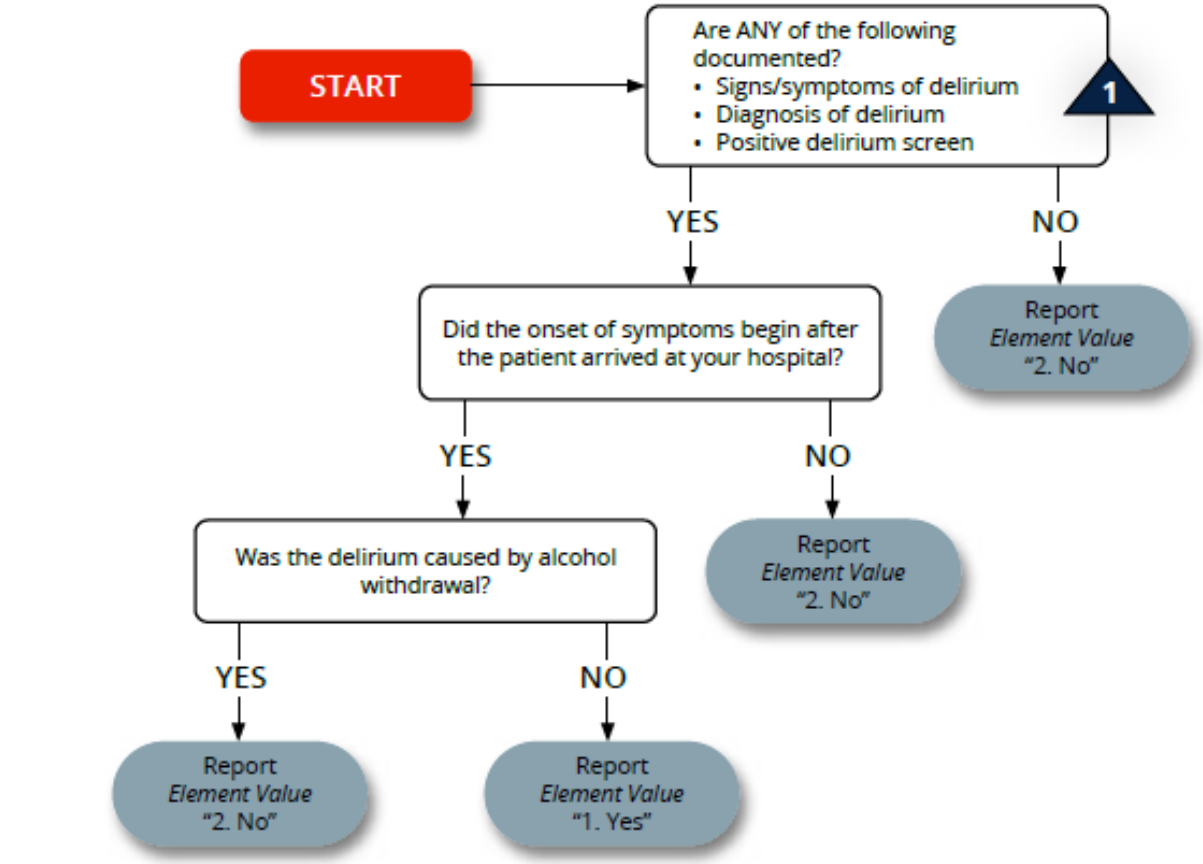
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Delirium

2026 NTDS Data Dictionary, Released July 2025



1 Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

MYOCARDIAL INFARCTION (MI)

Element Intent
A potentially preventable event often induced by coronary artery disease, medications, emotional stress, or pain, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

AND

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

AND

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

Element Values
1 Yes
2 No

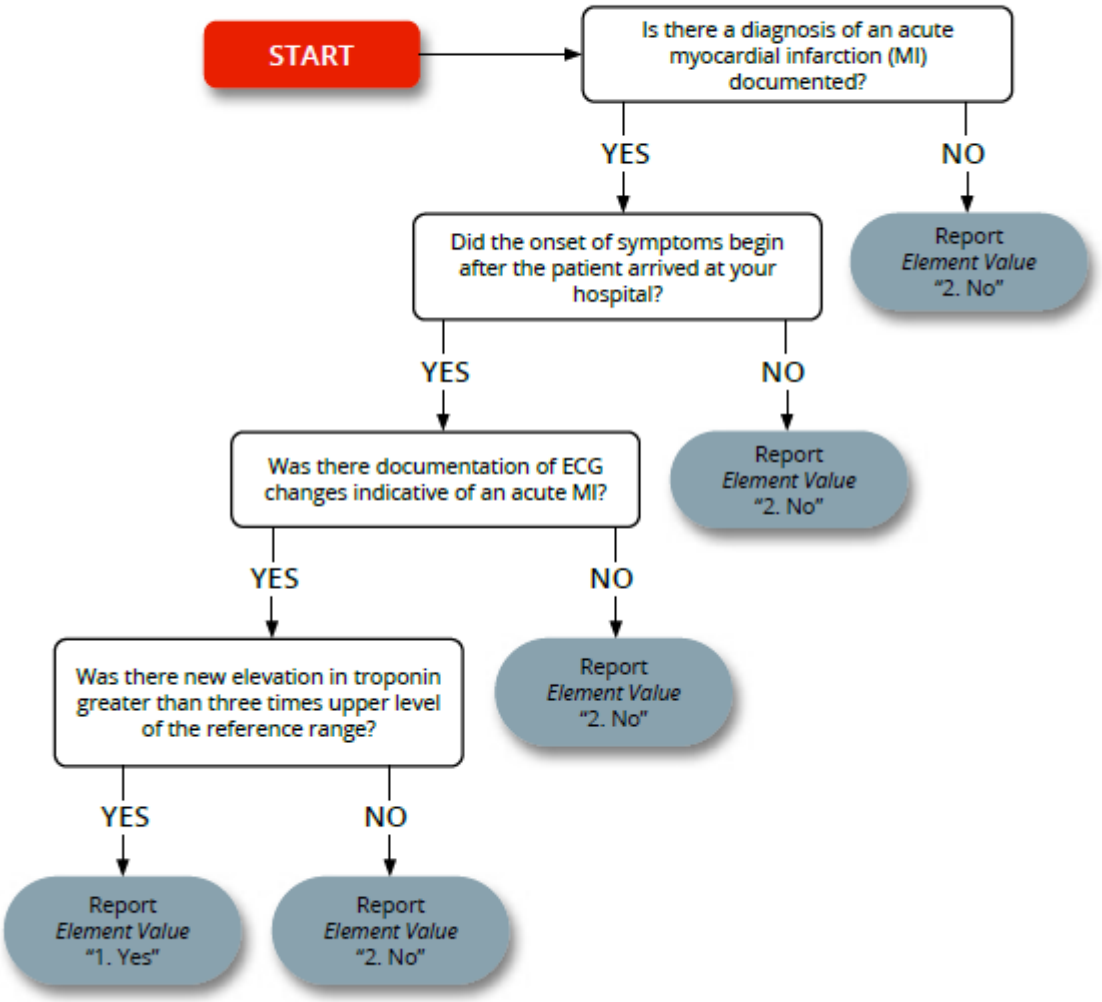
Additional Information
- Onset of symptoms began after arrival to your ED/hospital.

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

References to Other Databases
- NTDS 2027

Myocardial Infarction (MI)

***2026 NTDS Data Dictionary*, Released July 2025**



ORGAN/SPACE SURGICAL SITE INFECTION

Element Intent

A potentially preventable event often induced by bacteria or endogenous flora contacting a surgical wound, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Description

Must meet the following criteria:

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

AND

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

AND

Patient has at least **one** of the following:

a) Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)

b) Organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment) e.g., not Active Surveillance Culture/Testing (ASC/AST).

c) An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND

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

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

30- day Surveillance			
Code	**Operative Procedure**	**Code**	**Operative Procedure**
AAA	Abdominal Aortic Aneurysm repair	LAM	Laminectomy
AMP	Limb Amputation	LTP	Liver transplant
APPY	Appendix Surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BIBL	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder Surgery	REC	Rectal surgery
COLO	Colon Surgery	SB	Small bowel surgery
CSEC	Cesarean Section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90- day Surveillance			
Code	**Operative Procedure**		
BRST	Breast surgery		

CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions

CBGC	Coronary artery bypass graft with check incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI

Code	Site	Code	Site
BONE	Osteomyelitis	LUNG	Other infections of respiratory tract
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or Pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, Mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI Tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

Table 3. Specific Sites of an Organ/Space SSI

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2024 CDC defined SSI.

Data Source Hierarchy Guide

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

References to Other Databases

- NTDS 2027

Organ/Space Surgical Site Infection (O/S SSI)

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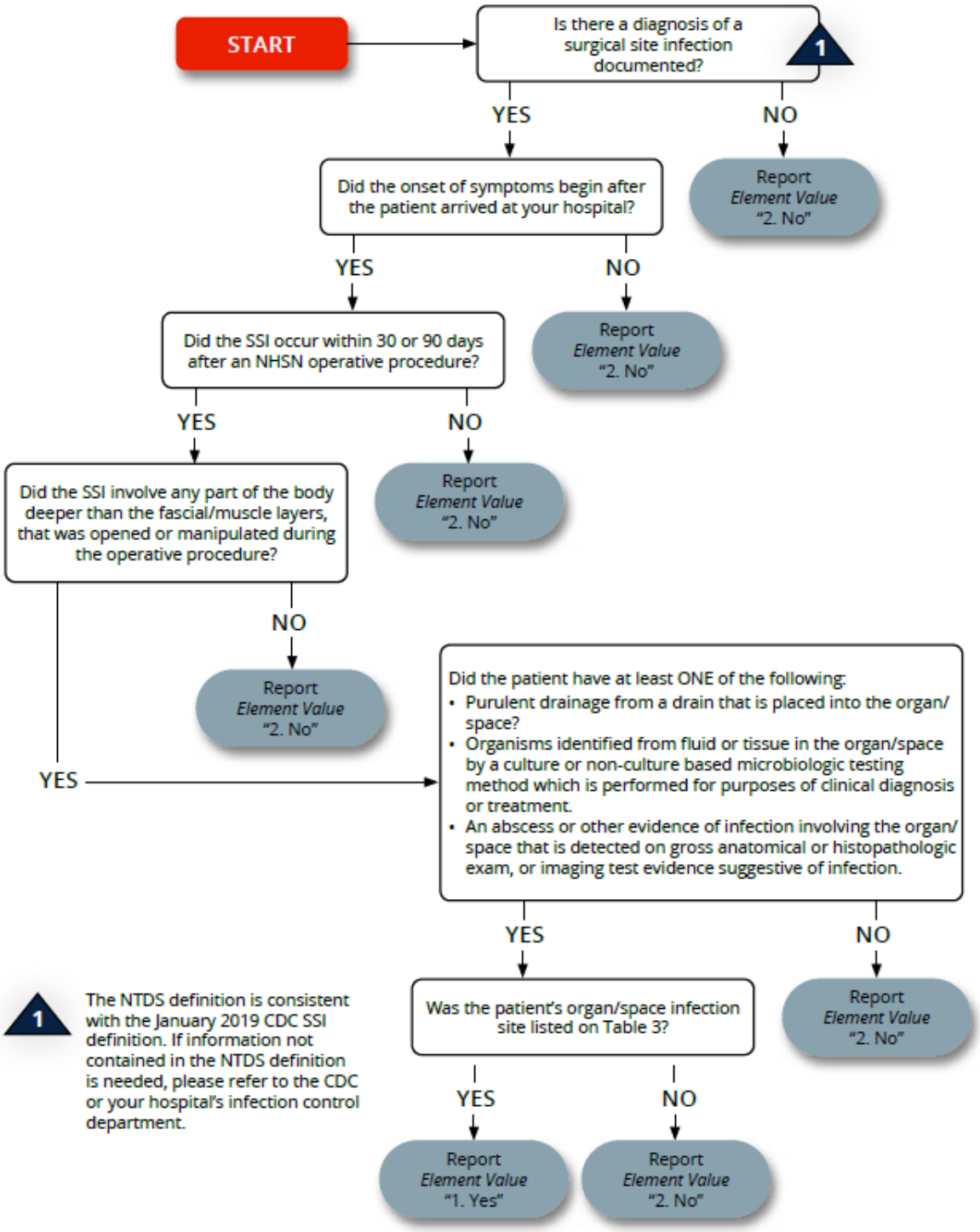


OSTEOMYELITIS

Element Intent

A potentially preventable event often induced by bacteria or fungi, diabetes, and/or a weakened immune system, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Description

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified by culture or non-cultured based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/ASST).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic examination.
3. Patient has at least two of the following localized signs or symptoms:
    - Fever (>38° C)
    - Swelling*
    - Pain or Tenderness*
    - Heat*
    - Drainage*

AND at least one of the following:

a. Organisms identified from blood by culture or non-culture based microbiologic testing method, which is performed for purposes of clinical diagnosis and treatment, for example, not Active Surveillance Culture/Testing (ASC/AST) AND 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

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- Consistent with the January 2020 CDC definition of Bone and Joint Infection.

Data Source Hierarchy Guide

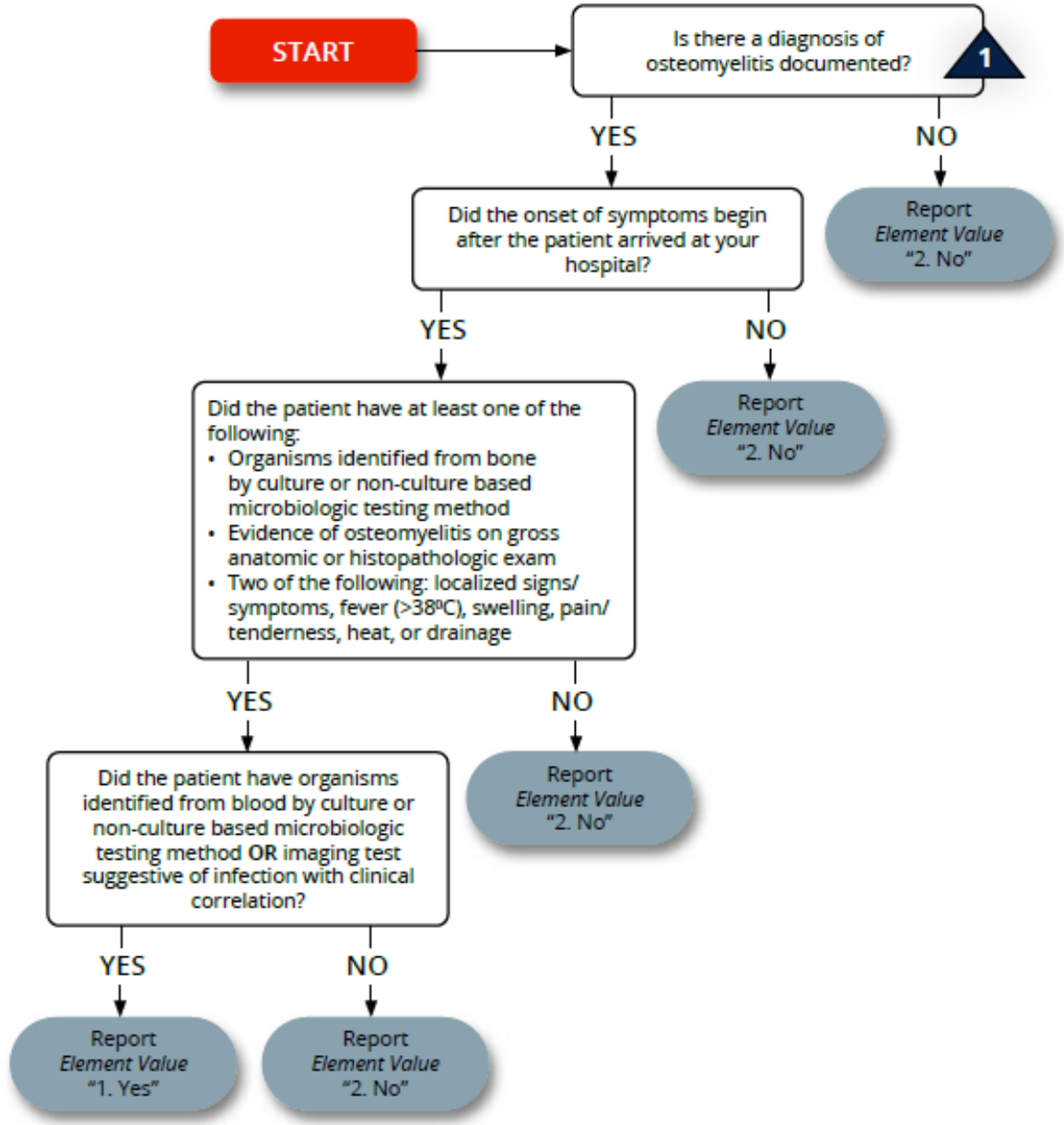
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Osteomyelitis

2026 NTDS Data Dictionary, Released July 2025



1 The NTDS definition is consistent with the January 2020 CDC Bone and Joint infection definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

PULMONARY EMBOLISM (PE)

Element Intent
A potentially preventable event requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

EXCLUDE:
- Subsegmental PEs.

Element Values
1 Yes
2 No

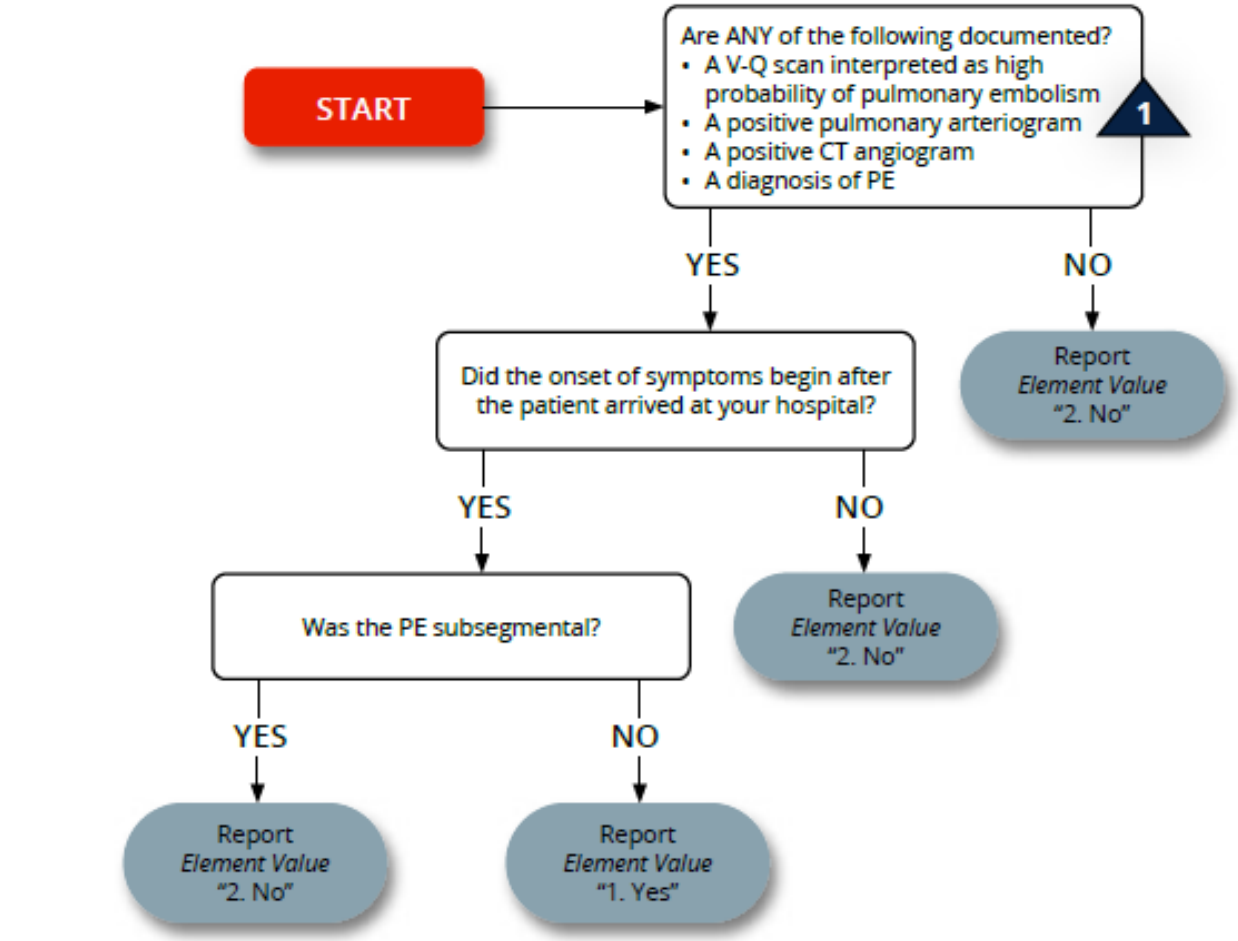
Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record.

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

References to Other Databases
- NTDS 2027

Pulmonary Embolism (PE)

2026 NTDS Data Dictionary, Released July 2025



1 Subsegmental PEs are excluded from the NTDS definition of PE.

PRESSURE ULCER

Element Intent
A potentially preventable event often induced by pressure or friction, moisture or other medical factors; advancement to stage II or greater requires treatment which could increase the hospital length of stay and the likelihood of mortality.

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
1 Yes
2 No

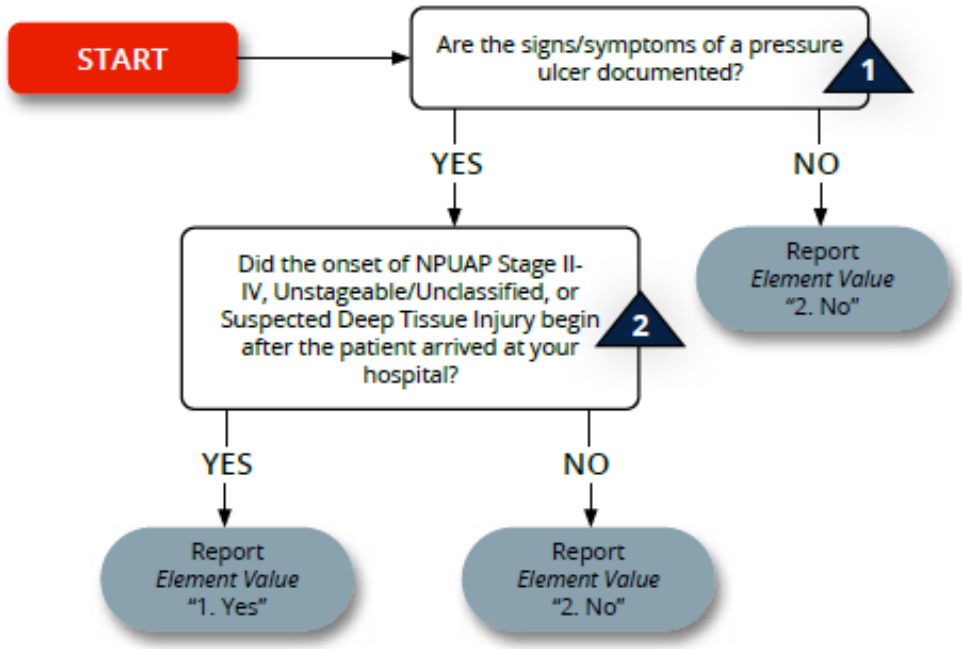
Additional Information
- Onset of NPUAP Stage II began after arrival to your ED/hospital.
- Pressure ulcer documentation must be in the patient's medical record.
- Consistent with the NPUAP 2014.

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

References to Other Databases
- NTDS 2027

Pressure Ulcer

***2026 NTDS Data Dictionary*, Released July 2025**



1 A pressure ulcer is 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.

2 The NTDS definition is consistent with the NPUAP 2014.

SEVERE SEPSIS

Element Intent
A potentially preventable event often induced by bacterial, viral or fungal infections, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

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

Element Values
1 Yes
2 No

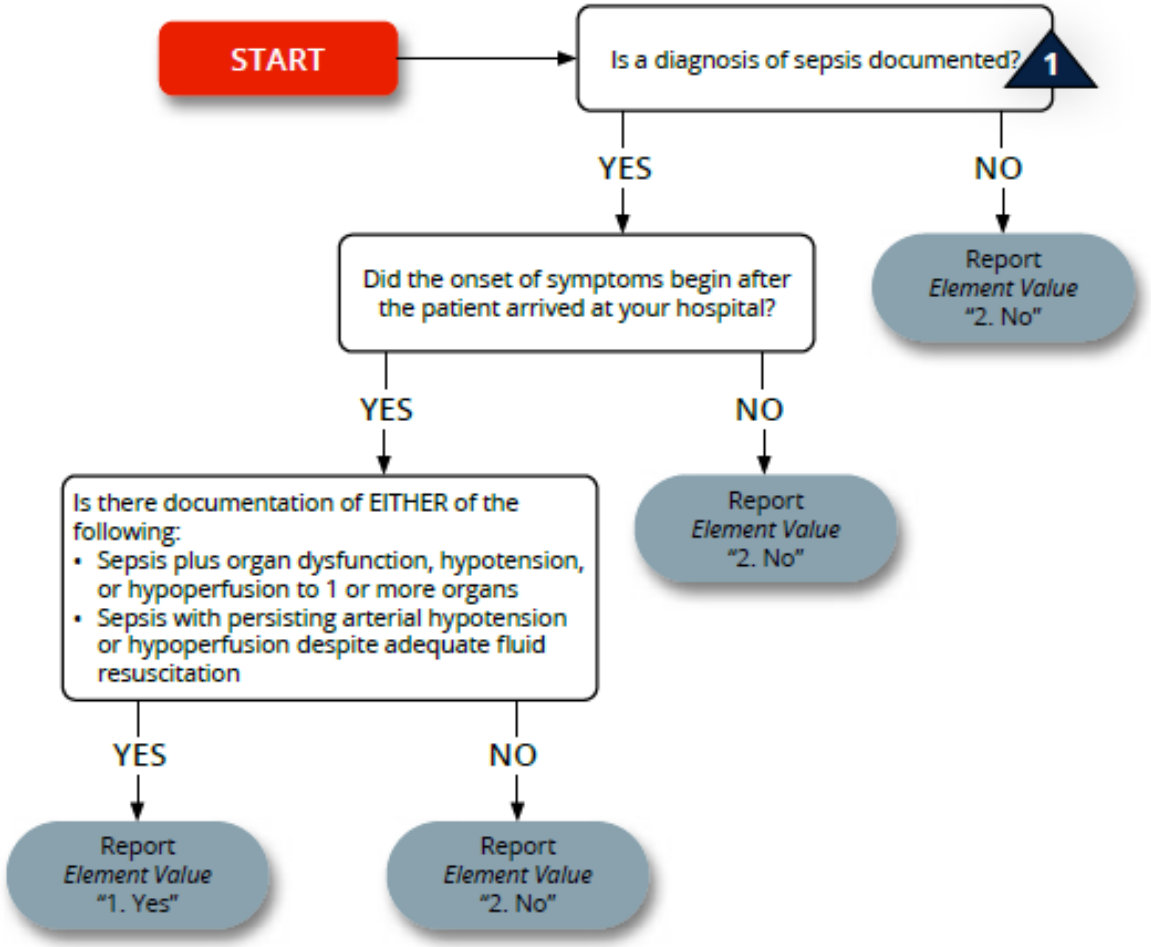
Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of sepsis must be documented in the patient's medical record.
- Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

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

References to Other Databases
- NTDS 2027

Severe Sepsis

2026 NTDS Data Dictionary, Released July 2025



1 The NTDS definition is consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010.

STROKE/CVA

Element Intent
A potentially preventable event often induced by obstruction of blood flow or a ruptured blood vessel in the brain, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

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

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

  AND

- Duration of neurological deficit ≥ 24 h

  OR

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

  AND

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

  AND

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

Element Values
1 Yes
2 No

Additional Information
- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

Data Source Hierarchy Guide
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services

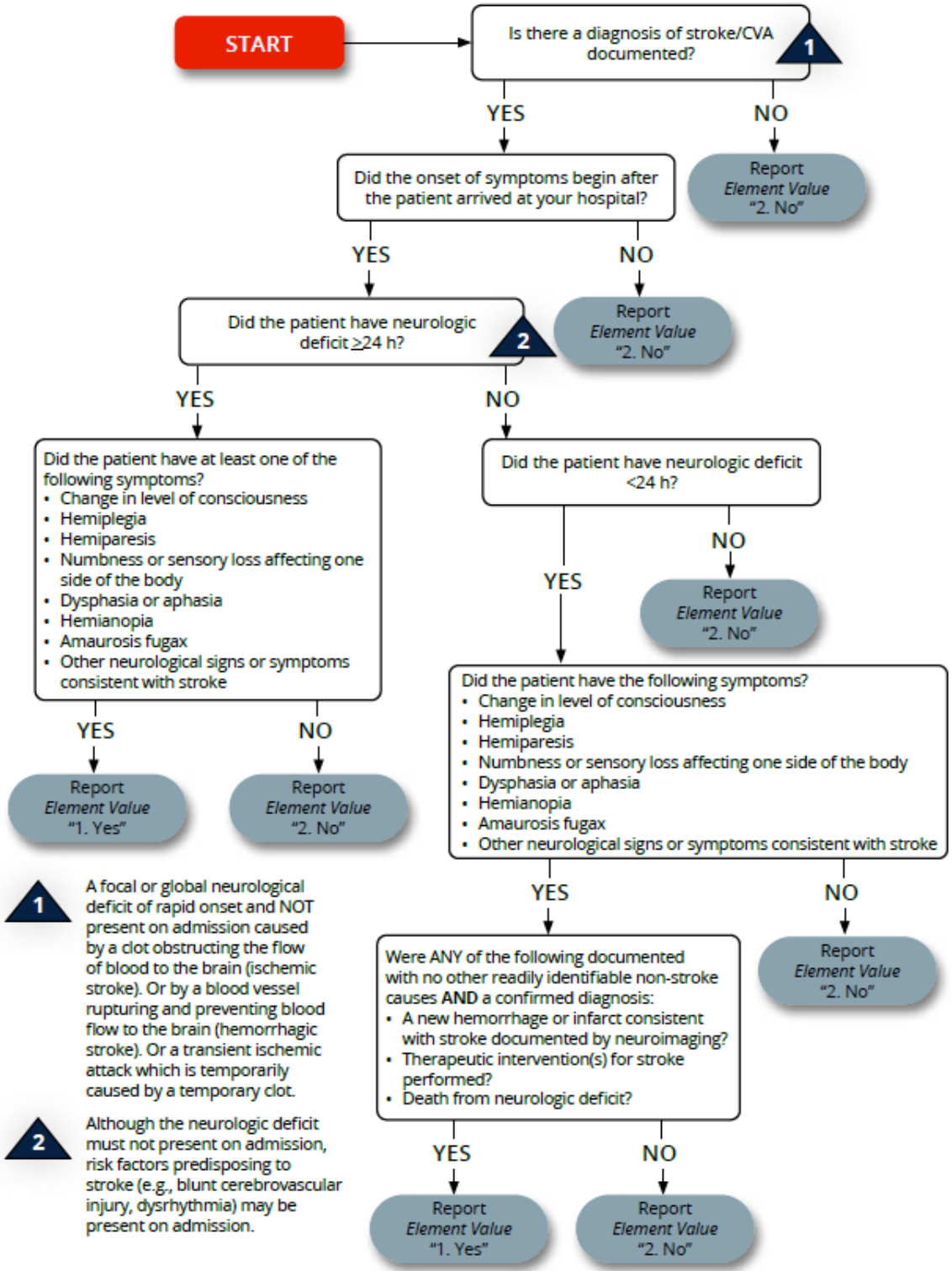
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Stroke/CVA

2026 NTDS Data Dictionary, Released July 2025



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SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Element Intent
A potentially preventable event often induced by endogenous flora or exogenous contamination contacting a surgical site, requiring treatment which could increase the hospital length of stay and the likelihood of mortality.

Description
Must meet the following criteria:
Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

AND

Involves only skin or 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 is deliberately opened by the 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
- Heat
- A culture or non-culture based test hat has a negative finding does not meet this criterion

d. Diagnosis of Superficial incisional SSI by the surgeon or attending physician** or other designee.

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

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

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- Consistent with the January 2024 CDC defined SSI.

Data Source Hierarchy Guide

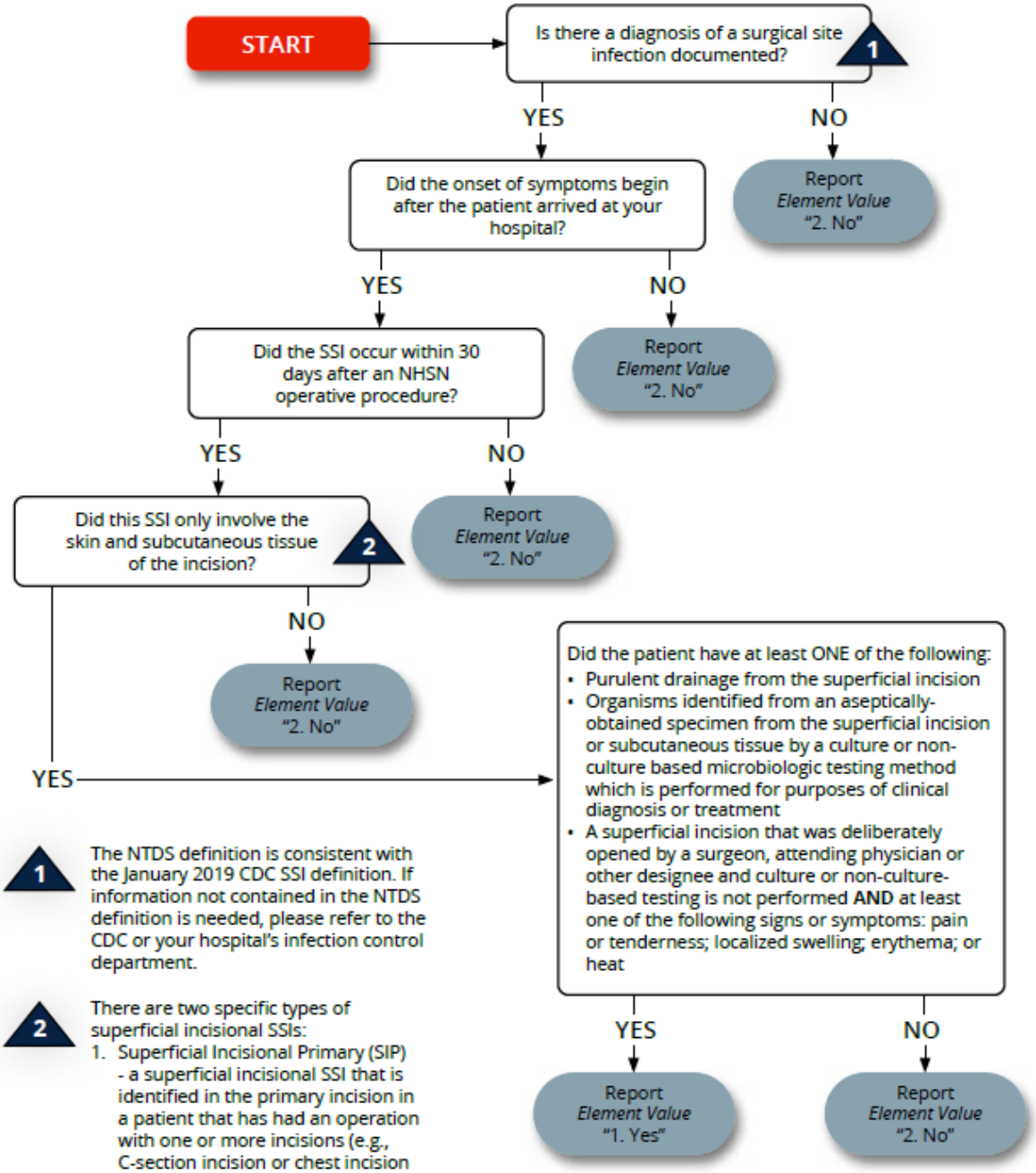
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Superficial Incisional Surgical Site Infection (S/I SSI)

***2026 NTDS Data Dictionary*, Released July 2025**



1 The NTDS definition is consistent with the January 2019 CDC SSI definition. If information not contained in the NTDS definition is needed, please refer to the CDC or your hospital's infection control department.

2 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 CBGC).

UNPLANNED ADMISSION TO ICU

Element Intent
A potentially preventable event that highlights possible gaps in the assessment of the severity of the patient's condition or the application of appropriate treatment plans.

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
1 Yes
2 No

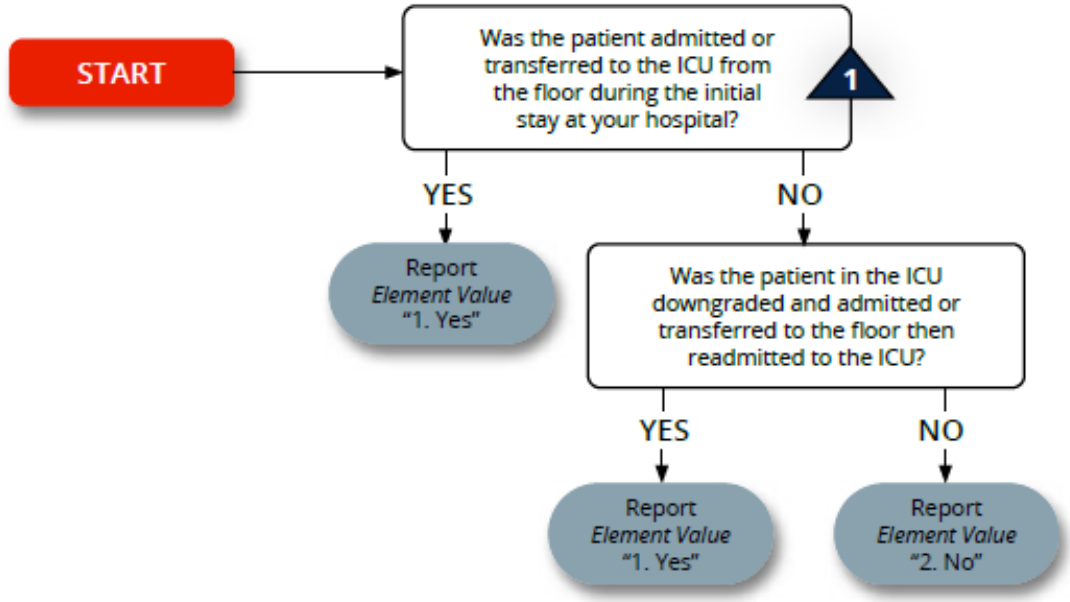
Additional Information
- Must have occurred during the patient's initial stay at your hospital.

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

References to Other Databases
- NTDS 2027

Unplanned Admission to the ICU

2026 NTDS Data Dictionary, Released July 2025



1 Floor is defined as any other ward that is not an ICU. "Floor" also includes step-down units and the operating room for the purposes of this definition.

EXCLUDE: Patients with a planned post-operative ICU stay. This means that it was known prior to surgery that the patient would require postoperative ICU care.

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

UNPLANNED INTUBATION

Element Intent
A potentially preventable event that highlights possible gaps in the assessment of the severity of the patient's condition or the application of appropriate treatment plans.

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
1 Yes
2 No

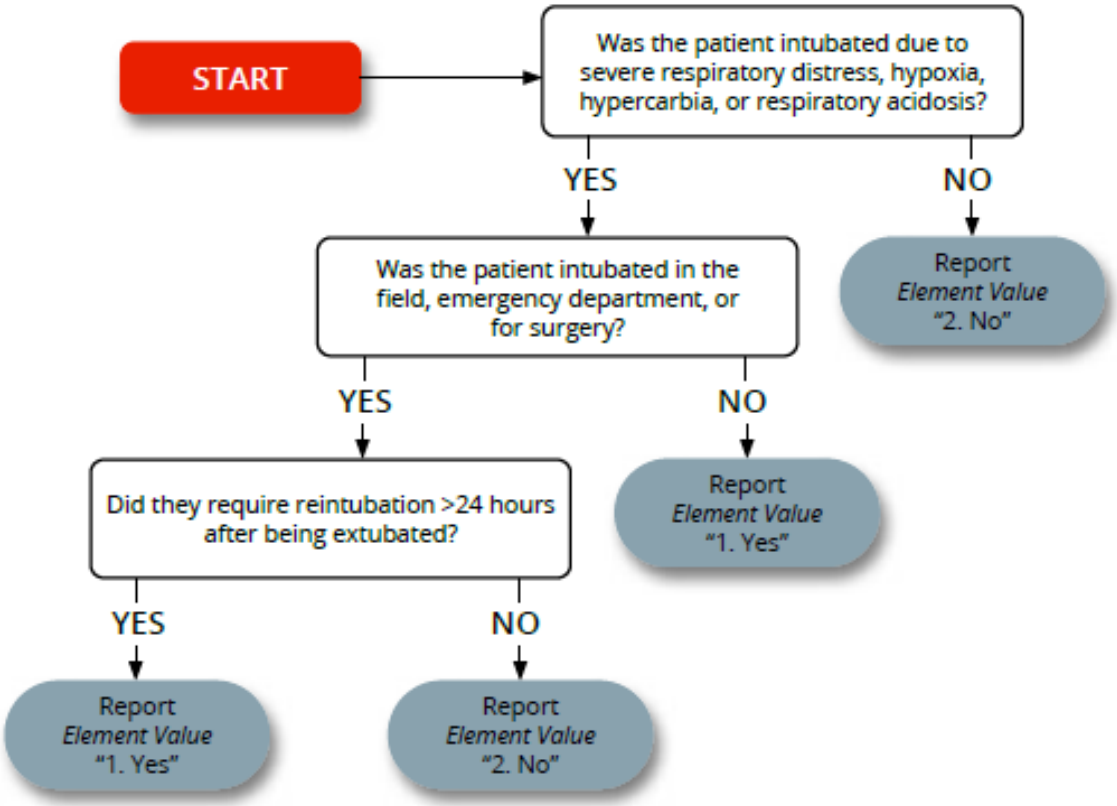
Additional Information
- Must have occurred during the patient's initial stay at your hospital.
- In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

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

References to Other Databases
- NTDS 2027

Unplanned Intubation

2026 NTDS Data Dictionary, Released July 2025



UNPLANNED RETURN TO THE OPERATING ROOM

Element Intent
A potentially preventable event that highlights possible opportunities for improvements in care.

Description
The patient underwent a subsequent operative procedure at the same operative site as the initial operative procedure. Both procedures must have been performed in the operating room at your center.

EXCLUDE:

- Planned return to the operating room after damage control surgery or staged surgical interventions.
- Procedures performed in an interventional radiology suite.
- Procedures performed in a hybrid operating room where the intervention is limited to a percutaneous approach.
- Pre-planned multiple-stage approach procedures.

Element Values
1 Yes
2 No

Additional Information

- The same operative site usually (but not exclusively) implies there was a need to re-open the previous incision.
- *Element Value* "1. Yes" is reported whether the initial intervention was related to the injuries (e.g., anastomotic leak after laparotomy, hardware failure/infection after ORIF of fractures) OR if there is a return to the operating room for an unplanned intervention related to a secondary procedure (e.g., return to the OR for bleeding after tracheostomy).
- *Element Value* "2. No" is reported if there is intent to return to the operating room for a two-stage approach.

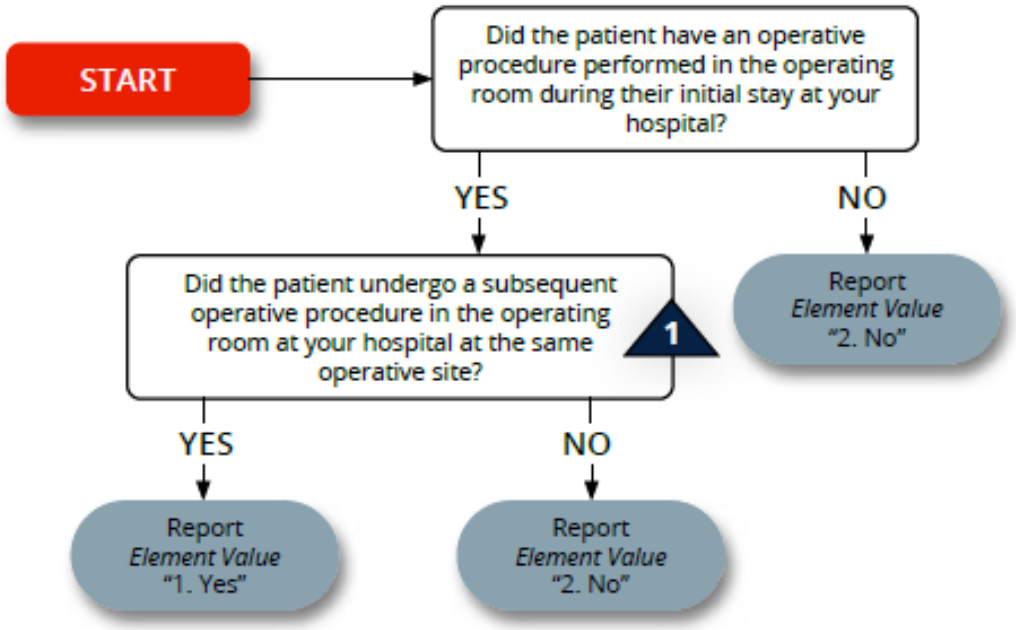
Data Source Hierarchy Guide
1 Operative Report
2 Physician Notes/Flow Sheet
3 Progress Notes
4 Nursing Notes/Flow Sheet
5 Discharge Summary

References to Other Databases

- NTDS 2027

Unplanned Return to the Operating Room

***2026 NTDS Data Dictionary*, Released July 2025**



1 The same operative site usually (but not exclusively) implies there was the need to re-open the previous incision.

EXCLUDE:

- Planned return to the operating room after damage control surgery or staged surgical interventions.
- Procedures performed in an interventional radiology suite.
- Procedures performed in a hybrid operating room where the intervention is limited to a percutaneous approach.
- Pre-planned multiple-stage approach procedures.

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Element Intent
A potentially preventable event often induced by bacteria or virus entering the lungs, requiring treatment which could increase the hospital length of stay and the likelihood or mortality.

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

AND

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

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable.	At least **one** of the following: • Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause **AND at least two of the following**: • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli o Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable	At least **one** of the following: • Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause **AND at least two of the following:** • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Virus, *Bordetella, Legionella, Chlamydia or Mycoplasma* identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). • Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in Legionella. pneumophila serogroup 1 antibody titer to ≥1:128 in pared acute and convalescent sera by indirect IFA. • Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP Algorithm (PNU3 Immunocompromised Patients):

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest imaging test result is acceptable	Patient who is immunocompromised has at least **one** of the following: • Fever (>38°C or >100.4°F) • For adults ≥70 years old, altered mental status with no other recognized cause • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., 0_2 desaturations (e.g., $PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand) • Hemoptysis • Pleuritic chest pain	At least **one** of the following: • Identification of matching *Candida* spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13 • Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: o Direct microscopic exam o Positive culture of fungi o Non-culture diagnostic laboratory test Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP Algorithm ALTERNATE CRITERIA (PNU1), for infants ≤1 year old:

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** imaging test result is acceptable.	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

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

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
Two or more serial chest imaging test results with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable	At least **three** of the following: • Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F) • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000 WBC/mm³) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Element Values

1 Yes
2 No

Additional Information

- Onset of symptoms began after arrival to your ED/hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- Consistent with the January 2019 CDC defined VAP.

Data Source Hierarchy Guide

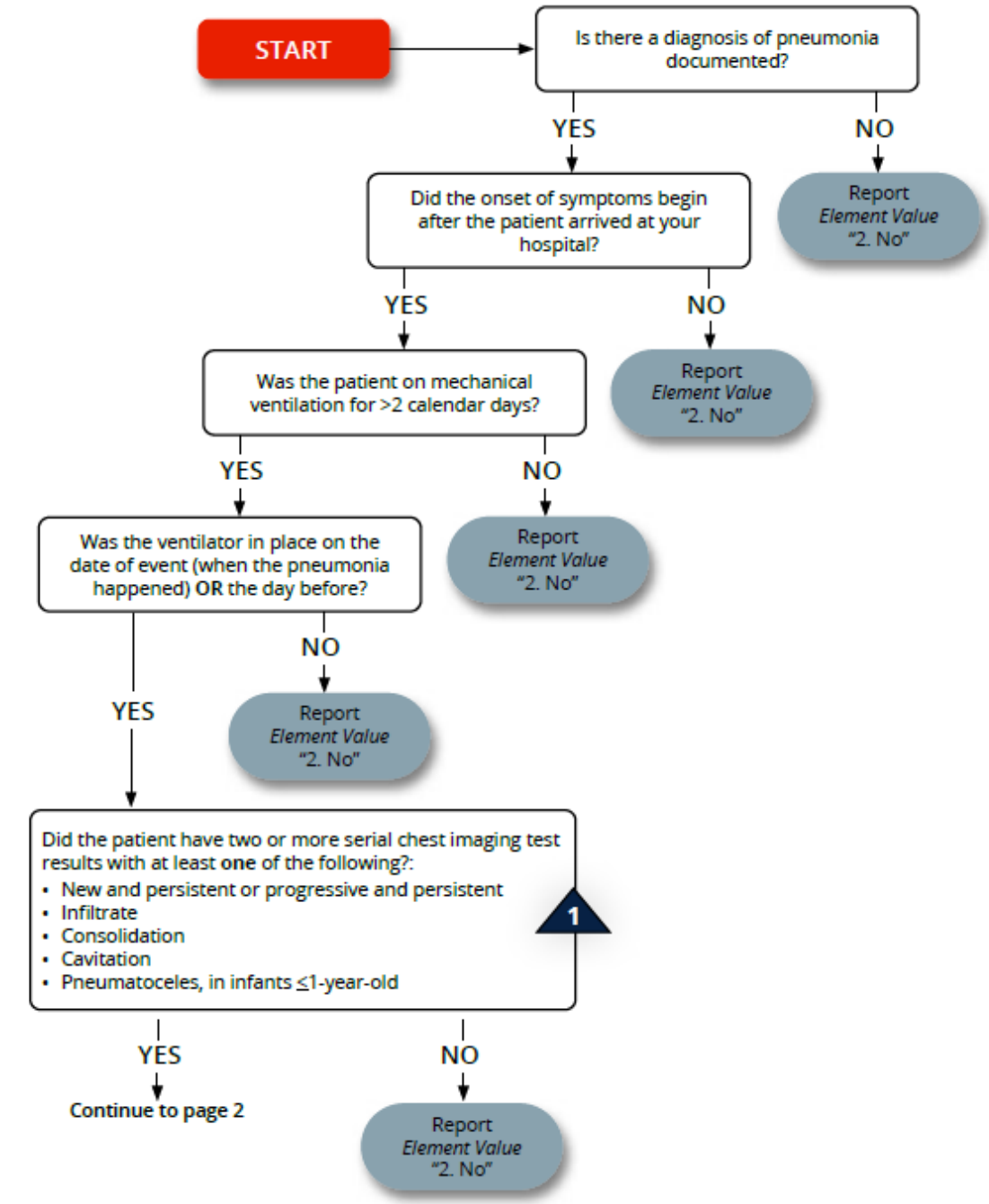
1 History and Physical
2 Physician's Notes
3 Progress Notes
4 Case Management/Social Services
5 Nursing Notes/Flow Sheet
6 Triage/Trauma Flow Sheet
7 Discharge Summary

References to Other Databases

- NTDS 2027

Ventilator-Associated Pneumonia (VAP) PNU2 Bacterial of Filamentous Fungal Pathogens (pg. 1 of 2)

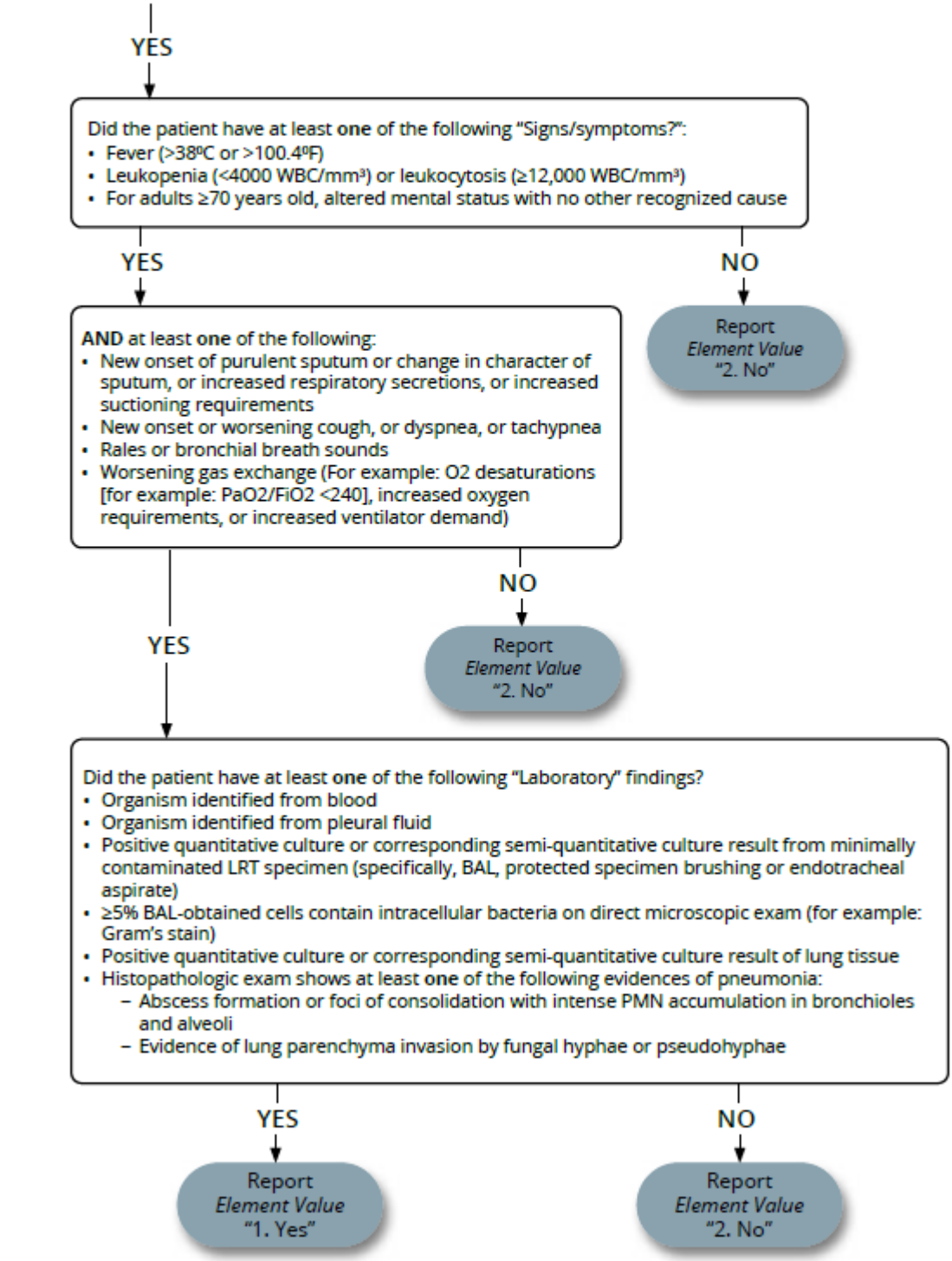
***2026 NTDS Data Dictionary*, Released July 2025**



1 NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.

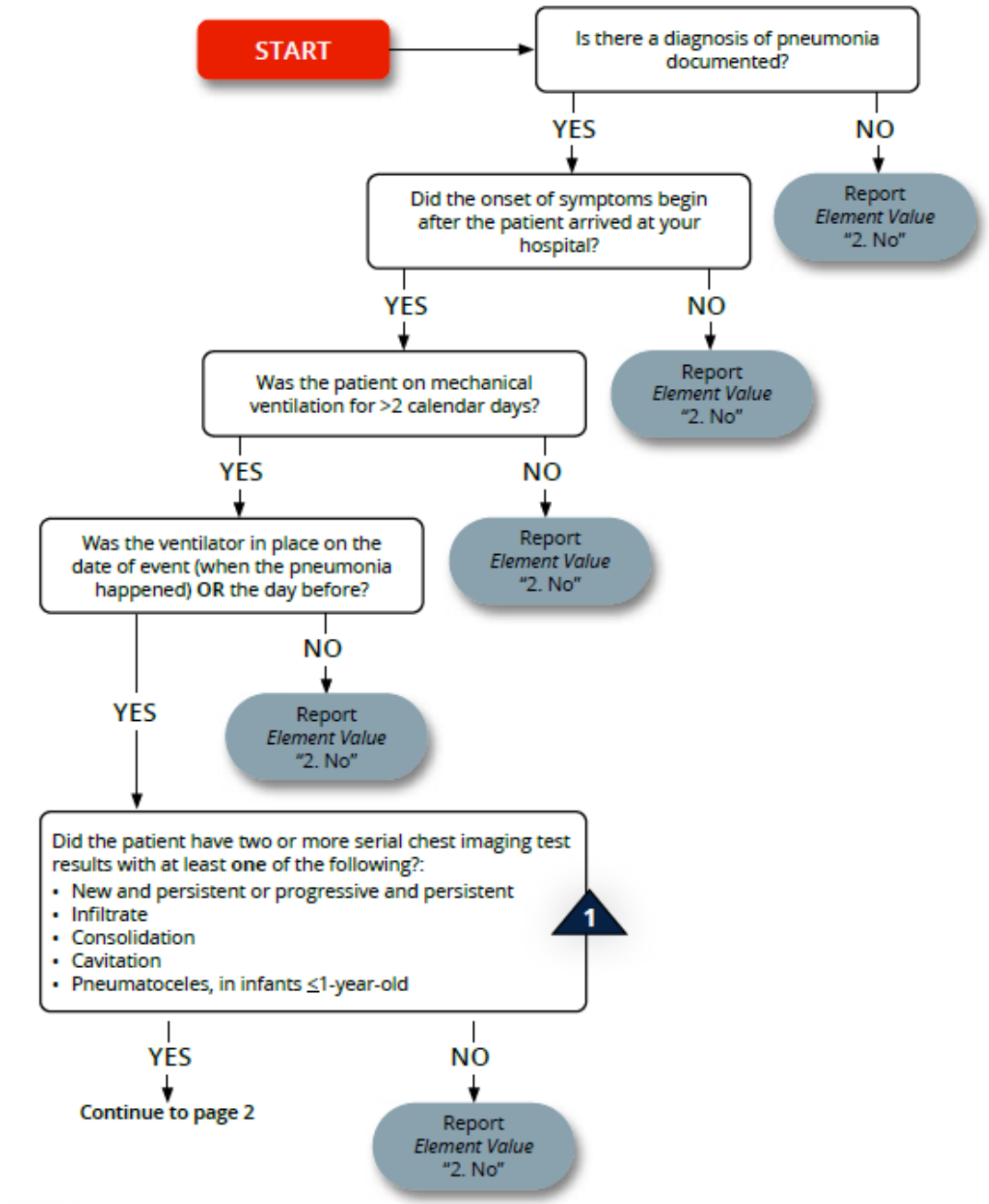
Ventilator-Associated Pneumonia (VAP) PNU2 Bacterial of Filamentous Fungal Pathogens (pg. 2 of 2)

2026 NTDS Data Dictionary, Released July 2025



Ventilator-Associated Pneumonia (VAP) PNU2 Viral, Legionella, and other Bacterial Pneumonias (pg. 1 of 2)

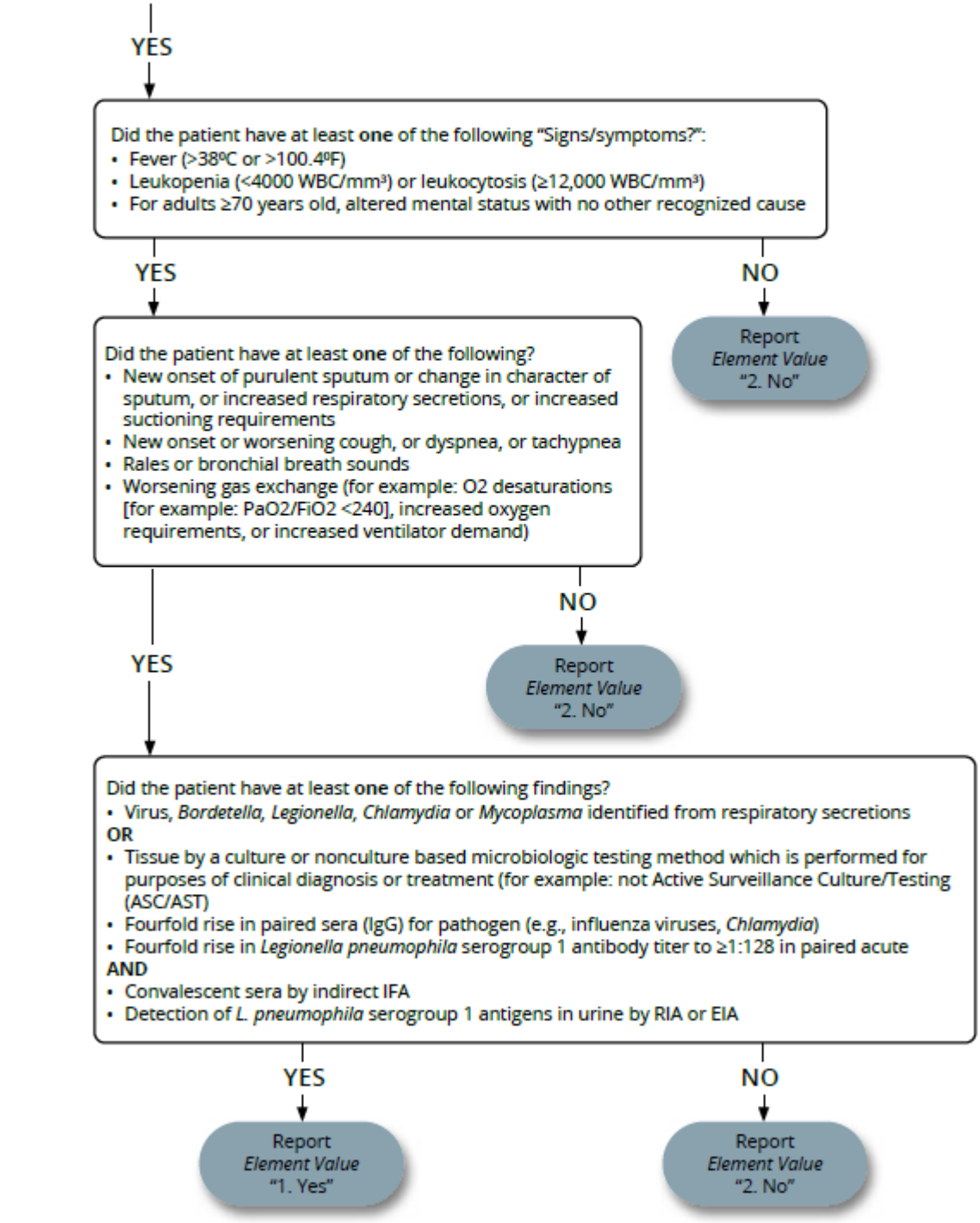
2026 NTDS Data Dictionary, Released July 2025



1 NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.

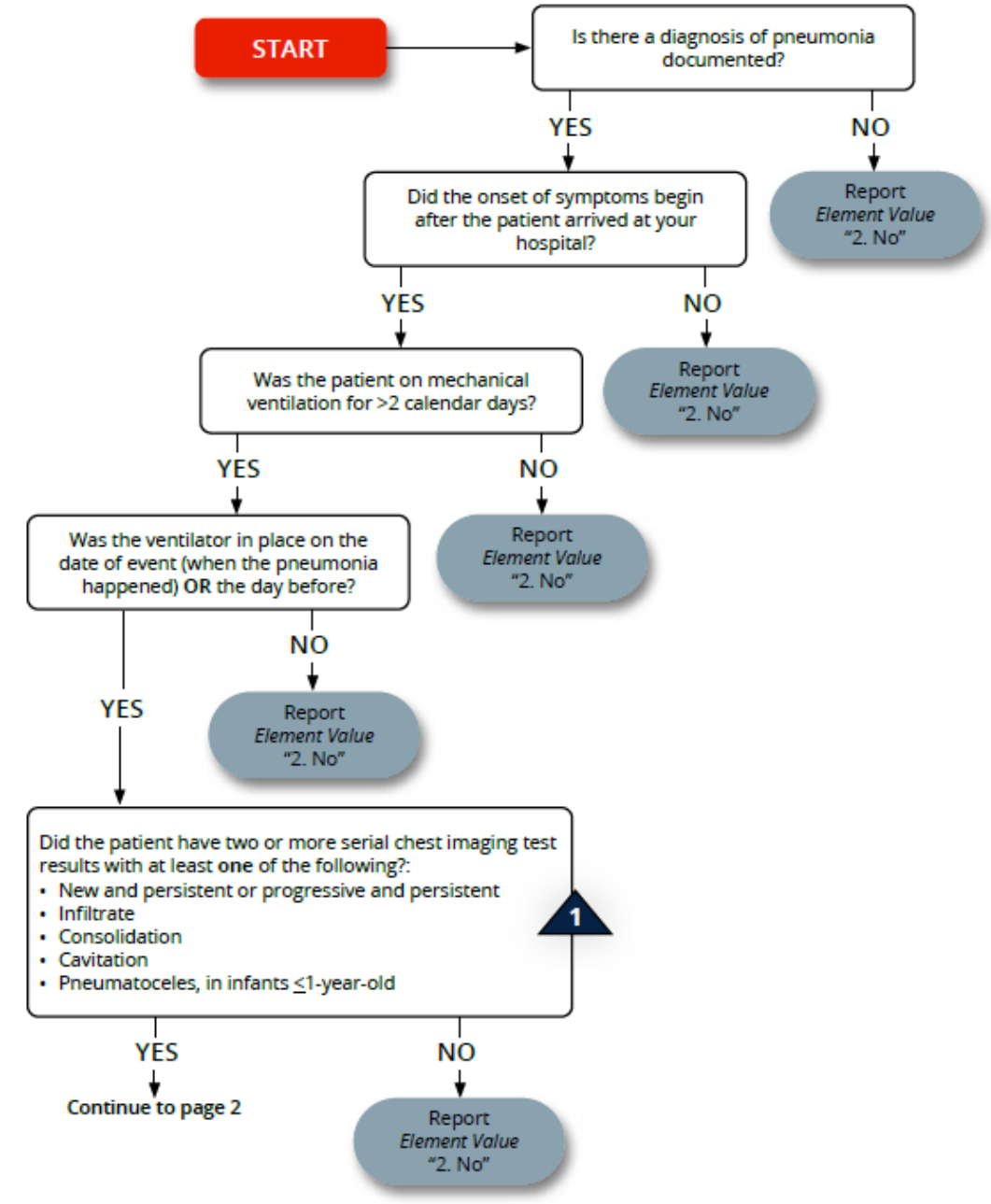
Ventilator-Associated Pneumonia (VAP) PNU2 Viral, Legionella, and other Bacterial Pneumonias (pg. 2 of 2)

***2026 NTDS Data Dictionary*, Released July 2025**



Ventilator-Associated Pneumonia (VAP) PNU3 Immunocompromised Patients (pg. 1 of 2)

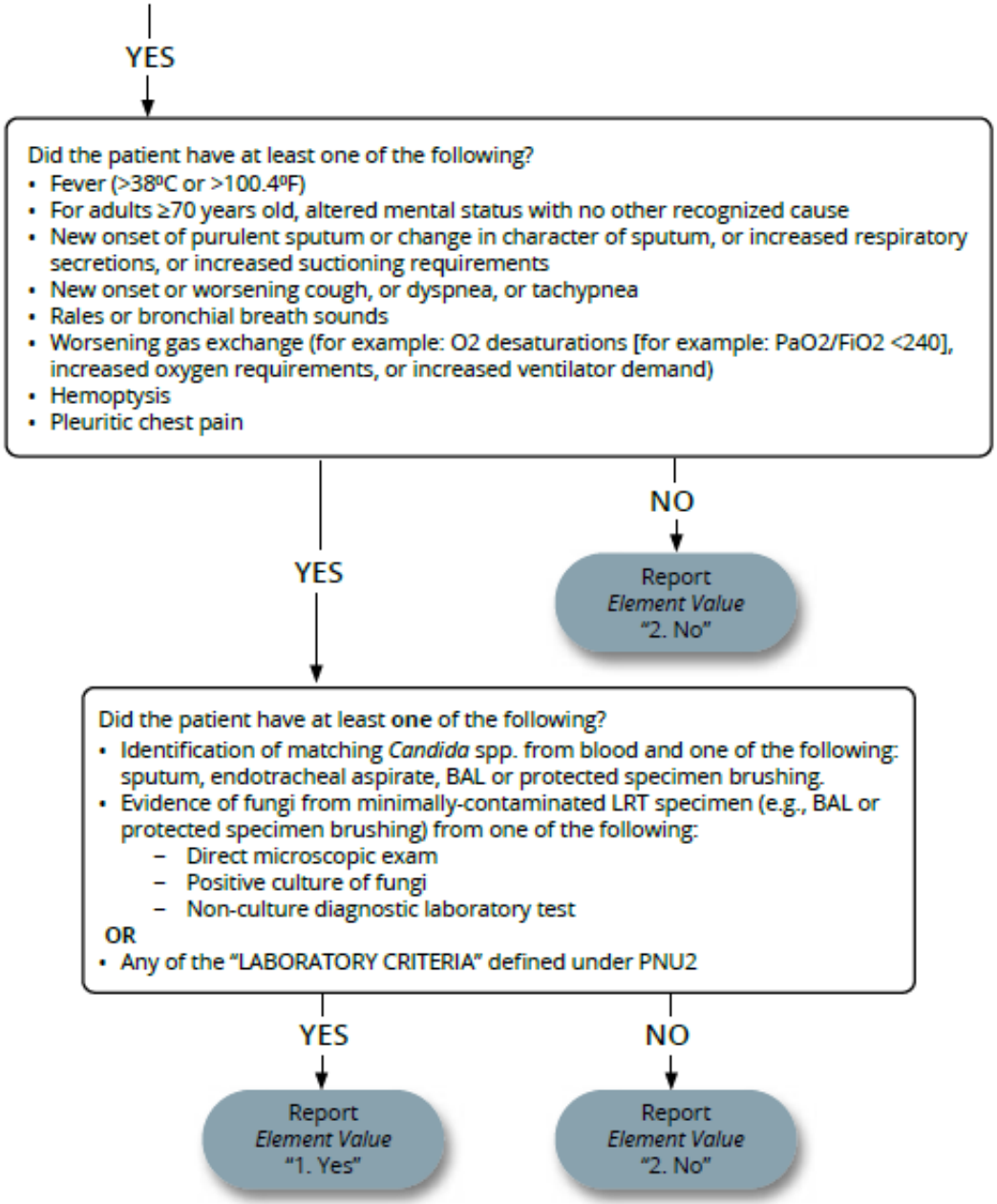
2026 NTDS Data Dictionary, Released July 2025



1 NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.

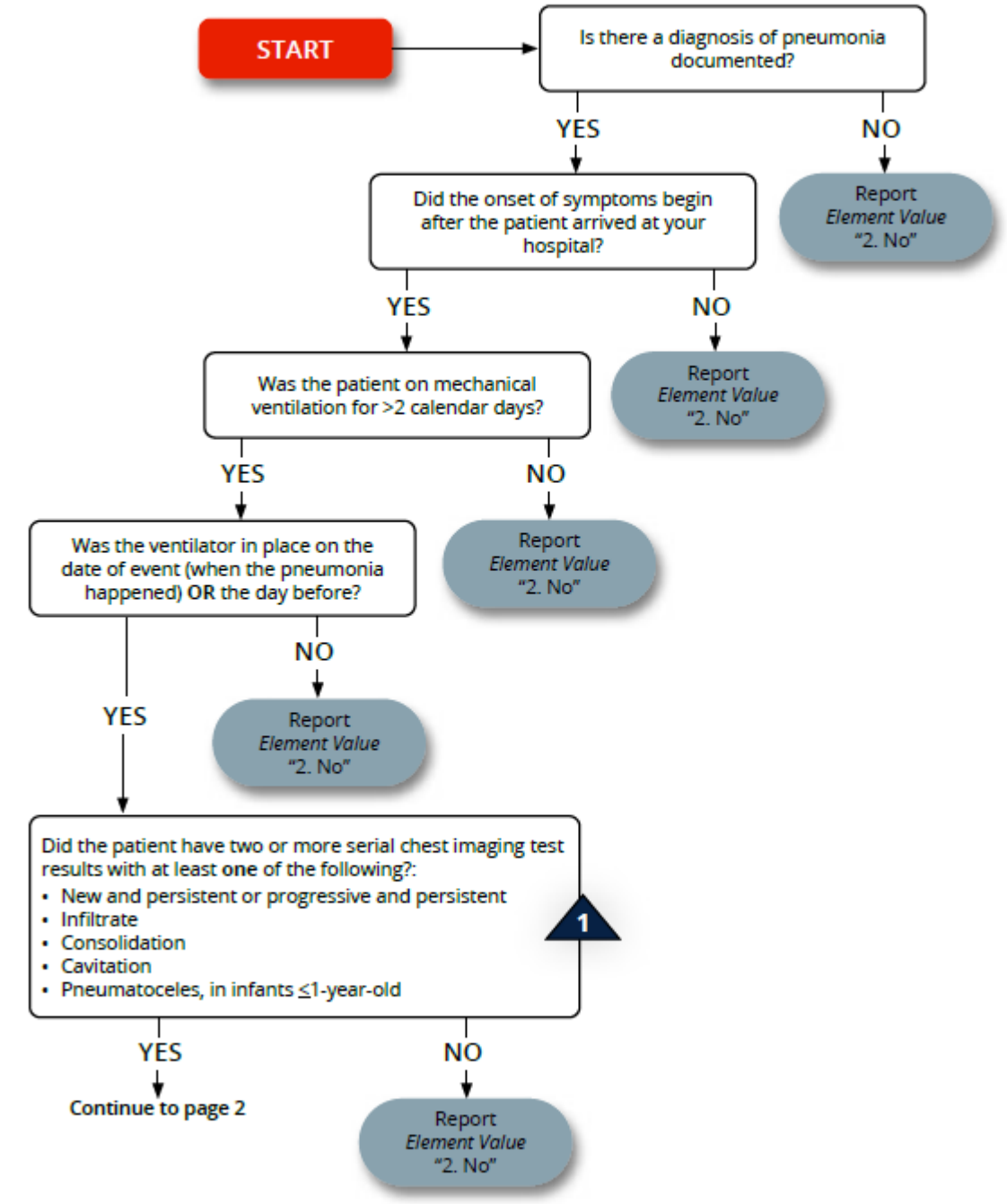
Ventilator-Associated Pneumonia (VAP) PNU3
Immunocompromised Patients (pg. 2 of 2)

***2026 NTDS Data Dictionary*, Released July 2025**



Ventilator-Associated Pneumonia (VAP) ALTERNATE CRITERIA (PNU1), for infants ≤1-year-old (pg. 1 of 2)

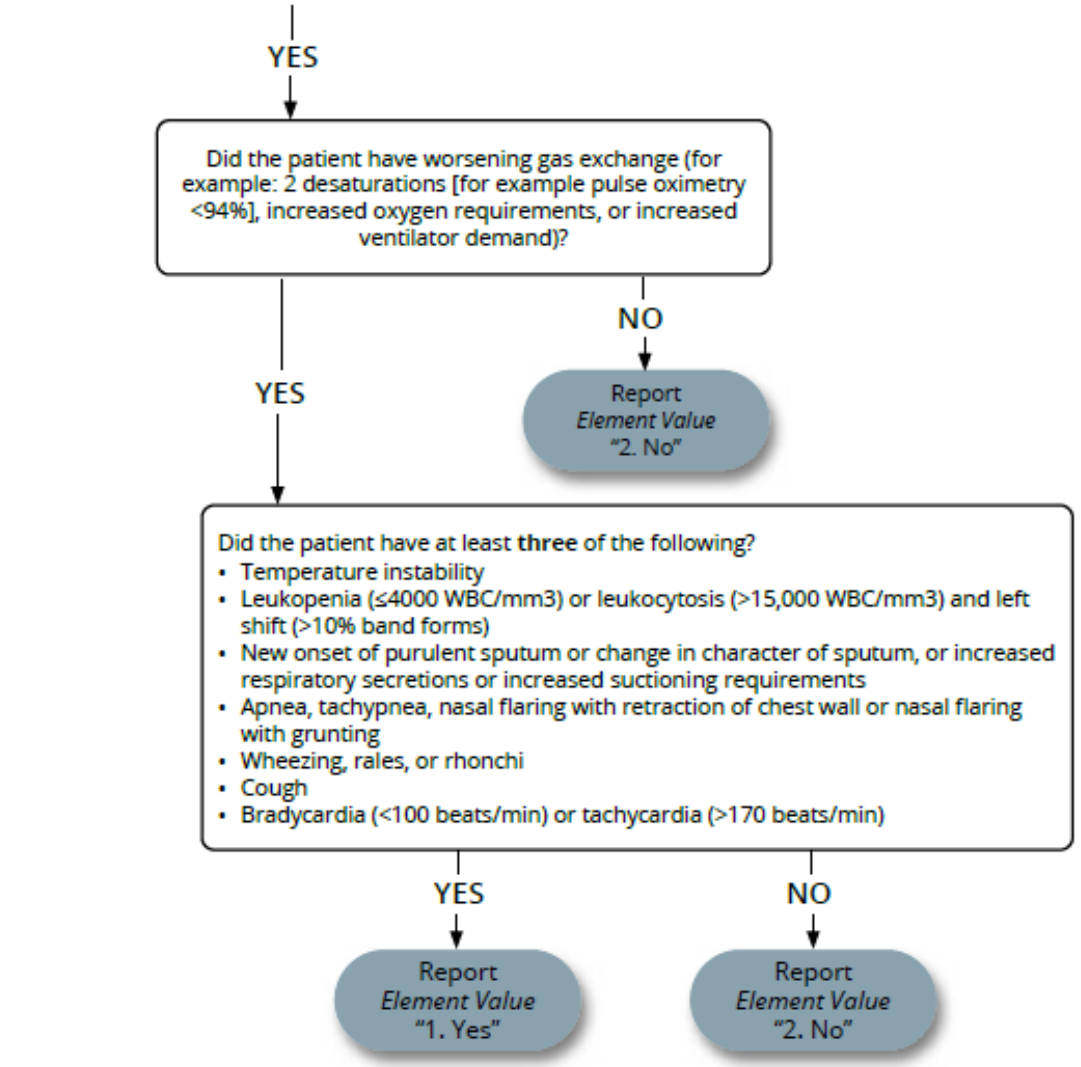
2026 NTDS Data Dictionary, Released July 2025



1 NOTE: In patients without underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.

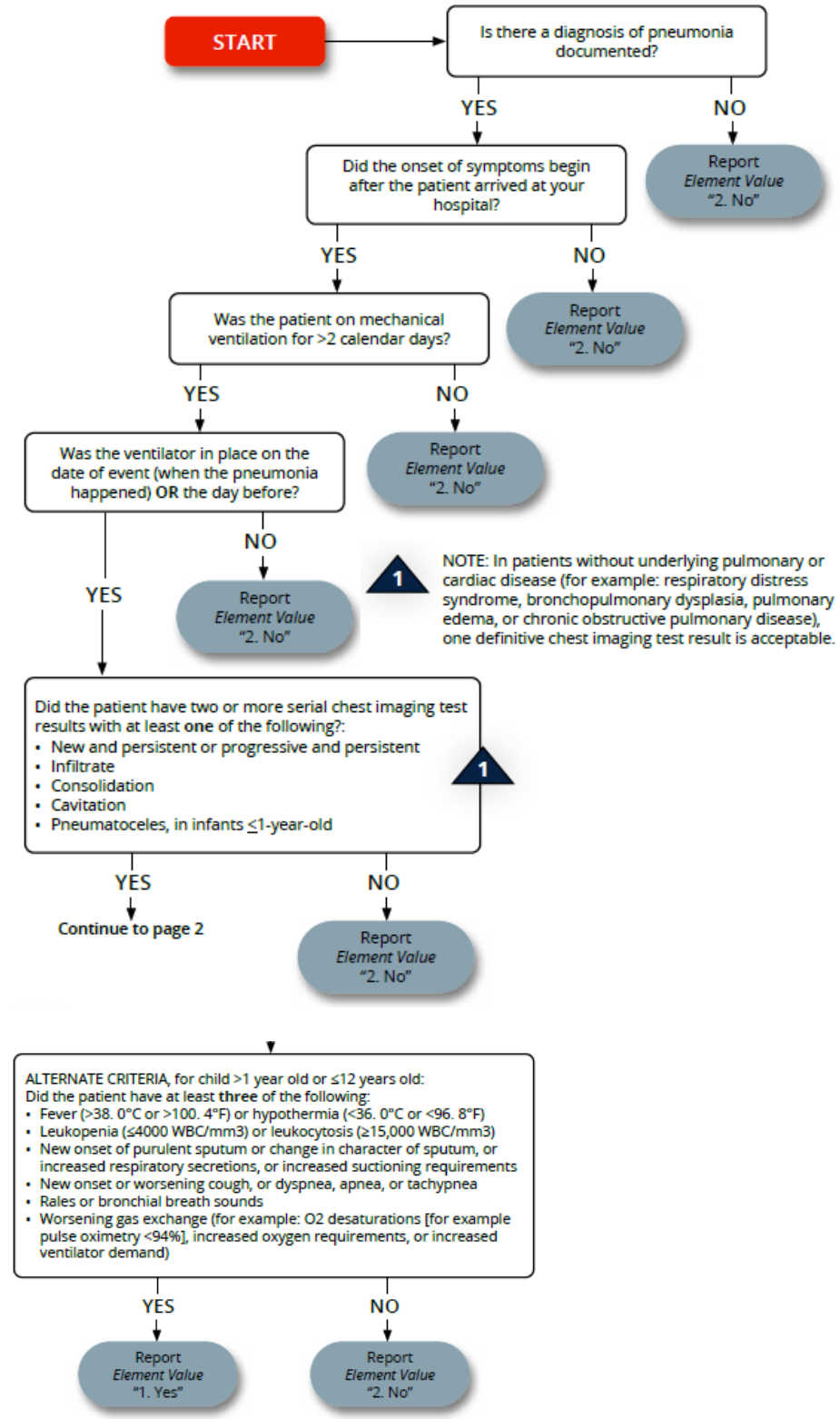
Ventilator-Associated Pneumonia (VAP) ALTERNATE CRITERIA (PNU1), for infants ≤1-year-old (pg. 2 of 2)

2026 NTDS Data Dictionary, Released July 2025



Ventilator-Associated Pneumonia (VAP) ALTERNATE CRITERIA (PNU1), for children >1-year-old or ≤12-years-old (pg. 1 of 2)

2026 NTDS Data Dictionary, Released July 2025



PACKED RED BLOOD CELLS

Element Intent
Transfusion volume and ratio might reflect severity of injury or practices which could highlight opportunities for improvement.

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

EXCLUDE:

- Packed red blood cells transfusing upon patient arrival.
- Cell saver blood.

Element Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy Guide

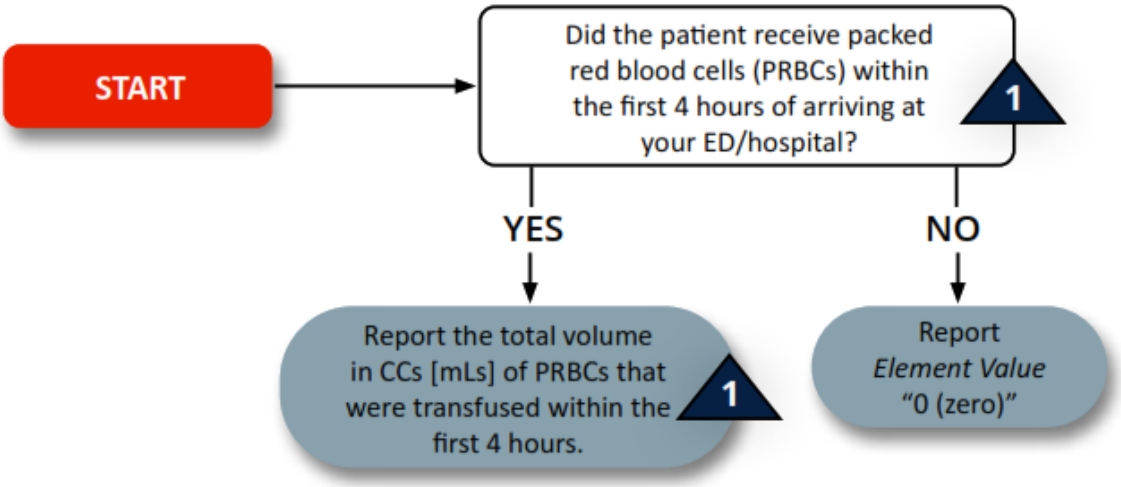
1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

References to Other Databases

- NTDS 2027

PACKED RED BLOOD CELLS

2027 NTDS Data Dictionary, Released July 2026



1 EXCLUDE: Packed red blood cells transfusing upon patient arrival.

EXCLUDE: Cell saver blood.

WHOLE BLOOD

Element Intent
Transfusion volume and ratio might reflect severity of injury or practices which could highlight opportunities for improvement.

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

EXCLUDE:
- Whole blood transfusing upon patient arrival.
- Cell saver blood.

Element Values
- Relevant value for data element

Common Null Values
- Accepted

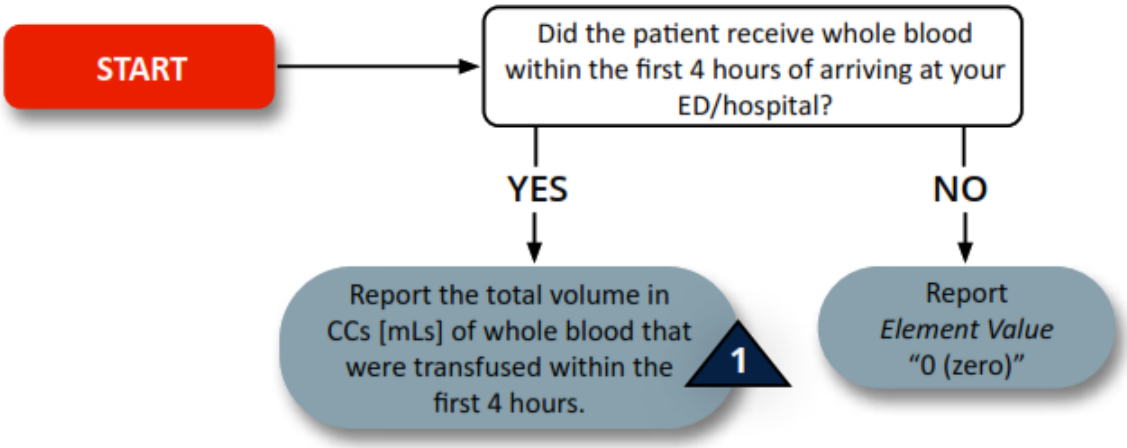
Additional Information
- Refers to amount of transfused whole blood (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no whole blood was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

References to Other Databases
- NTDS 2027

WHOLE BLOOD

2027 NTDS Data Dictionary, Released July 2026



1 EXCLUDE: Whole blood transfusing upon patient arrival.

EXCLUDE: Cell saver blood.

PLASMA

Element Intent
Transfusion volume and ratio might reflect severity of injury or practices which could highlight opportunities for improvement.

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

EXCLUDE:
- Plasma transfusing upon patient arrival.
- Cell saver blood.

Element Values
- Relevant value for data element

Common Null Values
- Accepted

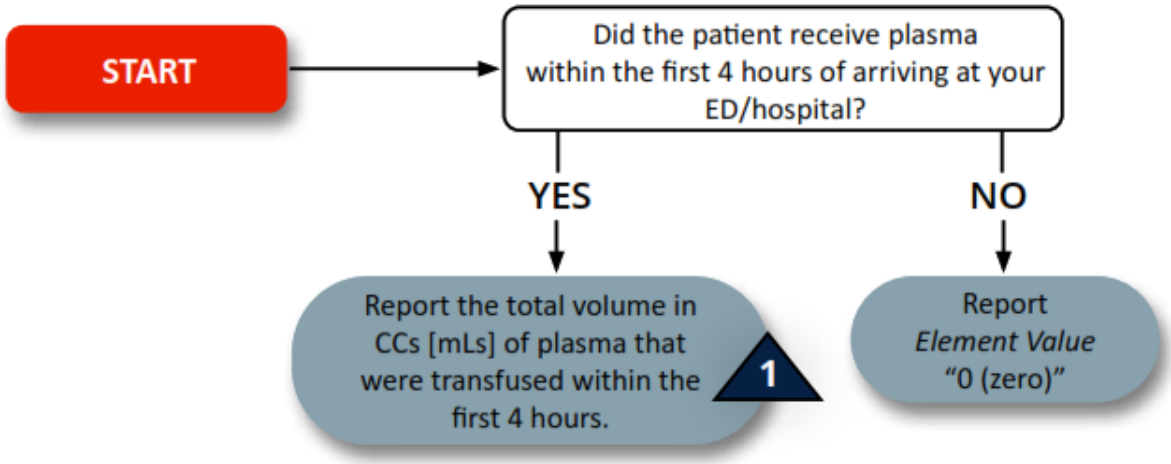
Additional Information
• Refers to amount of transfused fresh frozen, thawed, or never frozen plasma (CCs[mLs]) within first 4 hours after arrival to your hospital.
• If no plasma was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

References to Other Databases
- NTDS 2027

PLASMA

2027 NTDS Data Dictionary, Released July 2026



1 EXCLUDE: Plasma transfusing upon patient arrival.

EXCLUDE: Cell saver blood.

PLATELETS

Element Intent
Transfusion volume and ratio might reflect severity of injury or practices which could highlight opportunities for improvement.

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

EXCLUDE:
- Platelets transfusing upon patient arrival.
- Cell saver blood.

Element Values
- Relevant value for data element

Common Null Values
- Accepted

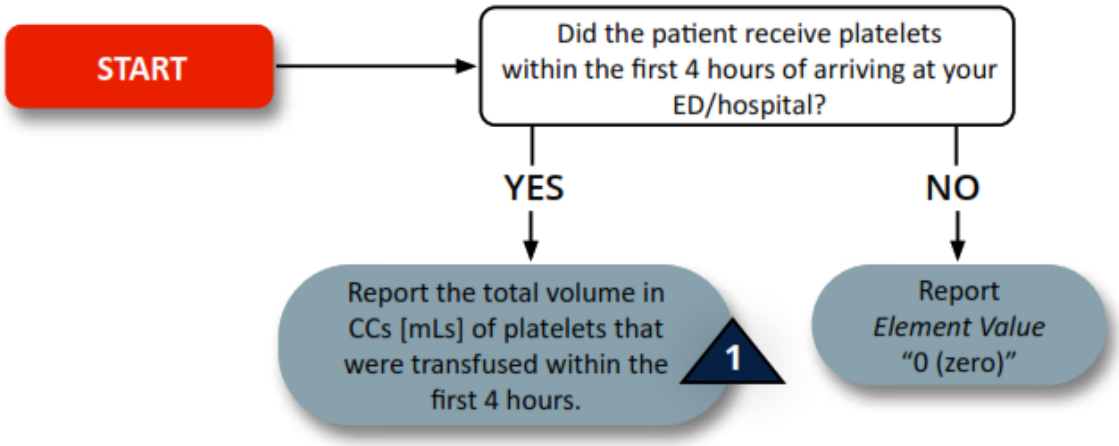
Additional Information
• Refers to amount of transfused platelets (CCs[mLs]) within first 4 hours after arrival to your hospital.
• If no platelets were given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

References to Other Databases
- NTDS 2027

PLATELETS

2027 NTDS Data Dictionary, Released July 2026



1 EXCLUDE: Platelets transfusing upon patient arrival.

EXCLUDE: Cell saver blood.

CRYOPRECIPITATE

Element Intent
Transfusion volume and ratio might reflect severity of injury or practices which could highlight opportunities for improvement.

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

EXCLUDE:
- Cryoprecipitate transfusing upon patient arrival.
- Cell saver blood.

Element Values
- Relevant value for data element

Common Null Values
- Accepted

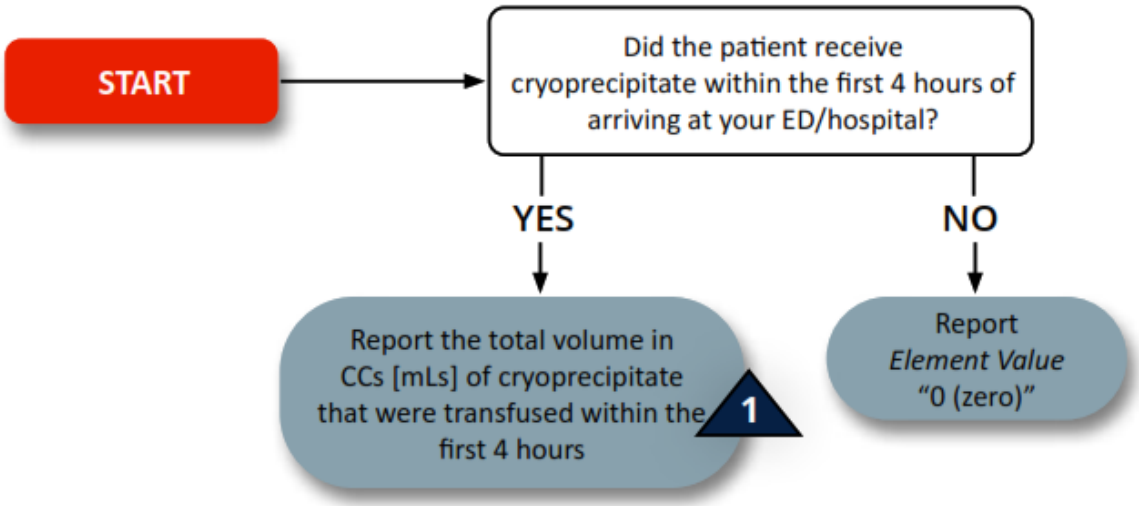
Additional Information
- Refers to amount of transfused cryoprecipitate (CCs [mLs]) within first 4 hours after arrival to your hospital.
- If no cryoprecipitate was given, then volume reported must be 0 (zero).

Data Source Hierarchy Guide
1. Trauma Flow Sheet
2. Anesthesia Record
3. Operative Reports
4. Nursing Notes/Flow Sheet
5. Blood Bank

References to Other Databases
- NTDS 2027

CRYOPRECIPITATE

2027 NTDS Data Dictionary, Released July 2026



1 EXCLUDE: Cryoprecipitate transfusing upon patient arrival.

EXCLUDE: Cell saver blood.

Appendix A - Discharge Disposition Definitions

Element Value	Variable	Definition
2	Intermediate Care Facility (ICF)	A nursing home providing long-term care less than a skilled level, usually custodial care only.
7	Skilled Nursing Facility (SNF)	A nursing home or unit which provides skilled nursing or rehabilitation care, less than the level of an inpatient rehabilitation facility.
8	Hospice	A special way of caring for persons who are terminally ill. Hospice services can be provided in the home or at a nursing facility.
9	Inpatient Rehabilitation Facility (IRF)	A hospital or part of a hospital which provides intensive (3 hours per day) of rehabilitation therapies to persons with disability from recent injury or illness.
10	Long Term Acute Care Hospital (LTACH)	A special hospital or part of a hospital that provides treatment for patients who stay, on average, more than 25 days for extended acute care. Most patients are transferred from an intensive or critical care unit.

Appendix B - Calculating ICU Length of Stay and Ventilator Days

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)

Appendix C - Glossary of Abbreviations

ACE	Angiotensin Converting Enzyme
ACS	Abdominal compartment syndrome; American College of Surgeons
ADL	Activities of daily living
AIS	Abbreviated Injury Scale
ARDS	Acute respiratory distress syndrome
ARF	Acute Renal Failure
BMI	Body mass index
BP	Blood pressure
CDC	Centers for Disease Control and Prevention
CHF	Congestive heart failure
CPAP/BIPAP	Continuous positive airway pressure/variable bi-level positive airway pressure
CT	Computerized topography
CVA	Cerebral vascular accident
DNR	Do not resuscitate
DNR-CC	Do not resuscitate; comfort care only
DNR-CCA	Do not resuscitate; comfort care arrest
DVT	Deep vein thrombosis
EOA	Esophageal Obturator Airway
ED	Emergency department
EMS	Emergency medical services
FAST	Focused assessment with sonography for trauma
FIPS	Federal Information Processing Standard codes
GCS	Glasgow Coma Score
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification IgG Immunoglobulin G
ISS	Injury Severity Score
LMA	Laryngeal Mask Airway
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NTDS	National Trauma Data Standard
OPO	Organ Procurement Organization
OR	Operating Room
OTR	Ohio Trauma Registry
PT	Prothrombin time
PTT	Partial thromboplastin time
PVD	Peripheral vascular disease
SaO2	Saturation of oxygen in arterial blood
TACR	Trauma Acute Care Registry
UB-04	Uniform Billing Form-04
XSD	XML (Extensible Markup Language) Schema definition

Appendix D – Acronyms

- AIS: Abbreviated Injury Scale
- CDC: Centers for Disease Control
- CPR: cardiopulmonary resuscitation
- CT: computerized tomography
- ED: emergency department
- EMS: emergency medical service
- GCS: Glasgow Coma Scale
- ICD-10: International Classification of Diseases, Tenth Revision
- ICD-10-CA: International Classification of Diseases, Tenth Revision, Canada
- ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
- ICD-10-PCS: International Classification of Diseases, Tenth Revision, Procedure Coding System
- ICU: intensive care unit
- LOS: length of stay
- NA: not applicable
- NEMSIS: National Emergency Medical Services Information System
- NK/NR: not known/not recorded
- NTDB: National Trauma Data Bank
- NTDS: National Trauma Data Standard
- OR: operating room
- PACU: post-anesthesia care unit
- TQIP: Trauma Quality Improvement Program
- TQP: Trauma Quality Programs

References to Other Databases

- NTDS 2027

Appendix E – Ohio Regional Trauma System Data Dictionary

Ohio contains several regional trauma systems. These are organized, coordinated efforts in a defined geographic area that deliver the full range of care to all injured patients and work together with emergency services and disaster preparedness making efficient use of health care resources to improve patient outcomes in the state of Ohio. Membership in a regional trauma system is voluntary and not generally restricted by a facility's location.

This "Ohio Regional Data Dictionary" is an effort to collapse individual regional dictionaries into a single unified regional dictionary to improve state, regional and vendor responsiveness during the annual reconciliation with the changes issued by the American College of Surgeons (ACS).

It has been included as a reference in the State of Ohio Trauma Acute Care Registry's data dictionary and intended as a shared reference and data set common to all regional trauma systems. Specific questions about its contents should be directed to the regional trauma system to which you are a member.

If you are not a member of a regional trauma system, then you are not required to collect the items in these appendices. These items are for regional trauma system use only and should not be submitted to the state unless otherwise directed by the Division of EMS.

Appendix F – Change LOG for the Ohio Trauma Acute Care Data (TACR)

STATE OF OHIO CHANGES:

Global Rules	Text	NEW
Common Null values	Text	CHANGED: ND: Not Known/Not Recorded/ Not Documented changed to NK/NR: Not Known/Not Recorded
INCLUSION	Reporting Criterion	CHANGED: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in/ out (FOR TRAUMA EVALUATION)
INCLUSION	Reporting Criterion	CHANGED: TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were transferred in or died THAT WERE EVALUATED BY TRAUMA OR SURGICAL SERVICE)
EXCLUSION	Reporting Criterion	CHANGED: NON-TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred out FOR TRAUMA EVALUATION
EXCLUSION	Reporting Criterion	CHANGED: TRAUMA CENTERS: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 (Patients with these isolated injuries that were NOT transferred in or died FOR EVALUATION BY TRAUMA OR SURGICAL SERVICE)
EXCLUSION	Reporting Criterion	CHANGED: S09.8XXA and S09.90XA - Isolated closed head injuries without a headache
DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)(Ohio)	Text	ADDED: Code Descriptions added to ICD10 codes
DIFFERENCES BETWEEN OHIO AND NATIONAL TRAUMA DATA STANDARD (NTDS)(Ohio)	Text - Height	REMOVED: OH does not include “within 24 hours or less of ED/Hospital arrival” in definition
Facility Type	Element Value	ADDED: 8 Adult Trauma 3 - N
Transport Agency	Additional Information	ADDED: Transport Agency information can be found at: https://ems.ohio.gov/ems-trauma-data/data-center-resources/ohio-ems-agency-list
Transport Agency	Additional Information	ADDED: If identify agency not listed contact emsdata@dps.ohio.gov
Scene Interventions	Element Value	ADDED: 8 Finger Thoracostomy; 9 Packed Red Blood Cells (PRBC) Administration; 10 Whole Blood Administration; 11 Fresh Frozen Plasma (FFP); 12 Freeze Dried Plasma (FDP); 13 TXA
Scene Interventions	Additional Information	ADDED: Do not include referring or inter-facility transport interventions
Inter-Facility Transfer	Additional Information	ADDED: Include, patients who require physical transfer from a free-standing emergency department (ED) to an affiliated hospital
Transferring Hospital Code	Additional Information	ADDED: Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
Transferring Hospital Code	Additional Information	ADDED: If identify hospital not listed contact

		emsdata@dps.ohio.gov
ED Transfer to Hospital	Additional Information	ADDED: Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
ED Transfer to Hospital	Additional Information	ADDED: If identify hospital not listed contact emsdata@dps.ohio.gov
Other mental/ Personality Disorder	Element Value	ADDED: Intermittent Explosive Disorder
Inpatient Transfer to Hospital	Additional Information	ADDED: Hospital information can be found at: https://ems.ohio.gov/programs-services/trauma-system/ohio-hospitals-list
Inpatient Transfer to Hospital	Additional Information	ADDED: If identify hospital not listed contact emsdata@dps.ohio.gov
Hospital Procedure Start Time	Additional Information	REMOVED: If distinct procedures with the same procedure code are performed, their start time must be different.
Hospital DC Order Written Date	Additional Information	CHANGED: The null value "Not Applicable" is reported if ED Discharge Disposition = 5, 6, 10, 11, 13, or 14.
Hospital DC Order Written Time	Additional Information	CHANGED: The null value "Not Applicable" is reported if ED Discharge Disposition = 5, 6, 10, 11, 13, or 14.
Hospital DC Time	Additional Information	CHANGED: The null value "Not Applicable" is reported if ED Discharge Disposition = 5, 6, 10, 11, 13, or 14.
Hospital DC Date	Additional Information	CHANGED: The null value "Not Applicable" is reported if ED Discharge Disposition = 5, 6, 10, 11, 13, or 14.
Date of Death	Element	RETIRED
Primary Method of Payment	Additional Information	CHANGED: No Fault Automobile and Blue Cross/Blue Shield should be reported as "4.Private/Commercial Insurance".
Packed Red Blood Cells	Element	NEW
Whole Blood	Element	NEW
Plasma	Element	NEW
Platelets	Element	NEW
Cryoprecipitate	Element	NEW

NTDS CHANGES ALSO IMPLEMENTED BY STATE OF OHIO:

Element Name	**Change Location**	**Change Text**
NTDS PATIENT INCLUSION CRITERIA	Text	CHANGED: Exclude any of the following isolated ICD-10-CM Codes: • Superficial Injuries with an ISS of 1 unless repaired in the operating room under anesthesia: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90 • Lacerations Without Foreign Body with an ISS of 1 unless repaired in the operating room under anesthesia: S01, S11, S21, S31, S41, S51, S61, S64, S71, S81, S91 • Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th character modifier of D through S.

NTDS PATIENT INCLUSION CRITERIA	Text	ADDED: *If the patient was transferred from another hospital, the injury must have occurred within 14 days prior to arrival at the referring hospital. If the patient's initial hospital encounter occurred at the hospital reporting the data, the injury must have occurred within 14 days prior to arrival at the reporting hospital.
GENDER	Additional Information	ADDED: Report Element Value "4. Non-disclosed" if the patient was asked and declined to answer.
GENDER	Additional Information	ADDED: The null value "Not Known/Not Recorded" is reported for patients who were not asked, or if there was no gender identity documented.
GENDER-AFFIRMING HORMONE THERAPY	Additional Information	ADDED: Report Element Value "3. Non-disclosed" if the patient was asked and declined to answer.
GENDER-AFFIRMING HORMONE THERAPY	Additional Information	ADDED: The null value "Not Known/Not Recorded" is only reported if no past medical history is available.
WORK-RELATED	Additional Information	REMOVED: If work-related, Patient's Occupational Industry and Patient's Occupation must be reported.
PATIENT'S OCCUPATIONAL INDUSTRY	ELEMENT	RETIRED
PATIENT'S OCCUPATION	ELEMENT	RETIRED
BLOOD PRESSURE SUPPORT	ELEMENT	NEW
ED DISCHARGE DISPOSITION	Element Value	ADDED: 14. Home
ED DISCHARGE DISPOSITION	Element Value	REMOVED: 4. Home with Services
ED DISCHARGE DISPOSITION	Element Value	REMOVED: 9. Home without Services
ED DISCHARGE DISPOSITION	Additional Information	ADDED: Element Value "14. Home" refers to the patient's current place of residence (e.g., prison, child protective services, etc.), provided the patient's level of care at discharge is the same as it was prior to their injury event.
ED DISCHARGE DISPOSITION	Additional Information	CHANGED: If ED Discharge Disposition is 5, 6, 10, 11, 13, or 14 then Hospital Discharge Date, Hospital Discharge Time, and Hospital Discharge Disposition must be "Not Applicable."
ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD) (Pre-Existing Condition)	Additional Information	ADDED: Report Element Value "1. Yes" for patients who were non-compliant with their prescribed ADD/ADHD medication.
BLEEDING DISORDER (Pre-Existing Condition)	Additional Information	CHANGED: A bleeding disorder diagnosis must be documented in the patient's medical record (e.g., hemophilia, von Willebrand disease, Factor V Leiden, thrombocytopenia).
CONGESTIVE HEART FAILURE (Pre-Existing Condition)	Additional Information	CHANGED: A diagnosis of CHF, HFrEF or HFpEF must be documented in the patient's medical record.

CONGESTIVE HEART FAILURE (Pre-Existing Condition)	Additional Information	CHANGED: To be included, this condition must be noted in the medical record as CHF, congestive heart failure, HFrEF, HFpEF, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury.
DIABETES MELLITUS (Pre-Existing Condition)	Description	CHANGED: Diabetes mellitus that requires exogenous parenteral insulin, an oral hypoglycemic agent, or GLP-1 medications.
DIABETES MELLITUS (Pre-Existing Condition)	Additional Information	CHANGED: Report Element Value "1. Yes" for patients who were non-compliant with their prescribed exogenous parenteral insulin, oral hypoglycemic agent, or GLP-1 medications
OTHER MENTAL/PERSONALITY DISORDER (Pre-Existing Condition)	Description	ADDED: Oppositional defiant disorder
ICD-10 INJURY DIAGNOSES	Description	CHANGED: EXCLUDE: Injuries that are iatrogenic in origin (injuries that occur as a direct result of medical treatment, diagnostic procedures, or surgical intervention) that are not attributable to an external traumatic mechanism.
ICD-10 INJURY DIAGNOSES	Additional Information	Periprosthetic and osteoporotic/pathologic fractures must only be reported when there is documented evidence of a qualifying external mechanism of injury (MOI) and an assigned ICD-10-CM diagnosis code that falls within the NTDS-accepted code list.
DELIRIUM (Hospital Event)	Description	REMOVED: Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).
ORGAN/SPACE SURGICAL SITE INFECTION	Additional Information	CHANGED: Consistent with the CDC January 2024 defined SSI.
SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION	Additional Information	CHANGED: Consistent with the CDC January 2024 defined SSI.
TOTAL VENTILATOR DAYS	Data Source Heierarchy Guide	ADDED: Triage/Trauma Flow Sheet
HOSPITAL DISCHARGE DISPOSITION	Additional Information	CHANGED: Element Value “6. Home” refers to the patient’s current place of residence (e.g., prison, child protective services, etc.), provided the patient’s level of care at discharge is the same as it was prior to their injury event.
HOSPITAL DISCHARGE DISPOSITION	Additional Information	CHANGED: The null value "Not Applicable" is reported if ED Discharge Disposition is reported as Element Value 5, 6, 10, 11, 13, or 14.

Ohio Regional Data Dictionary (ORDD) 2027

COTS, NORTN, NORTR, NOTS, SORTS, TRISTATE

INJURY DETAILS

Element intent
Provides additional details of injury event, utilized for E-Code validation processes

Description
Injury Details is a free text description that describes the circumstances of how the patient was injured.

Element Values
- Relevant value for data element

Additional Information
- Include as many details as possible
- Recommended examples:
    - 23- year old male, restrained driver, was T-boned by a tractor-trailer on the driver's side of the car, positive LOC, from Scene
    - 56- year old female fell down a flight of basement stairs and struck her head on the concrete floor, denies LOC, transfer by EMS from OSH

Data Source Hierarchy Guide
1 EMS Run Sheet
2 Triage Form/Trauma Flow Sheet
3 ED Documentation

TRAUMA ACTIVATION LEVEL*

Element Intent
Utilized for reporting and regional validation processes

Description
Trauma Activation Level is the highest level of trauma activation called for the patient when at your hospital emergency department.

Element Values
1 Highest Level of Activation
2 Intermediate Level of Activation
3 Lowest Level of Activation (includes consults)
4 No Trauma Activation
5 Direct Admission

Common Null Value
- Accepted

Additional Information
- Enter a common null value of "Not Applicable" if your facility does not have a trauma service and is NOT a verified trauma center.
- Highest level of activation is defined by your hospital's criteria.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital.
- INCLUDE: patients who received the highest level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were downgraded after arrival to your center.
- INCLUDE: patients who received a lower level of trauma activation initiated by emergency medical services (EMS) or by emergency department (ED) personnel at your hospital and were upgraded to the highest level of trauma activation.
- EXCLUDE: patients who received the highest level of trauma activation after emergency department (ED) discharge.

Data Source Hierarchy Guide
1 Triage/Trauma Flow Sheet
2 ED Record
3 History & Physical
4 Physician Notes
5 Discharge Summary

References to Other Databases
- NTDS 2022
- Ohio Trauma Registry, Trauma Acute Care Registry 2022

**Element Values* *different than NTDS and OTR*

ADMITTING SPECIALTY

Element Intent
Utilized for reporting

Description
Admitting Specialty is the medical specialty of the attending physician who admits the patient to your hospital.

Element Values

1	General Adult Surgery
2	Neurosurgery
3	Orthopedic Surgery
4	General Pediatric Surgery
5	Burn Service
6	Thoracic Surgery
7	Plastic Surgery
8	All Other Surgical Services
9	All Other Non-Surgical Services
10	Cardio Thoracic Surgery
11	Vascular Surgery
12	Hand Surgery
13	Microvascular Surgery
14	OBGYN Surgery
15	Ophthalmology
16	Otolaryngology
17	Urology
18	Intensivist/ Critical Care
19	Geriatrics
20	Endocrinology
21	Trauma - Pediatric
22	Trauma – Adult
23	Oral-Maxillofacial Surgery
24	Pediatrics

Additional Information
- This is not necessarily the service to which the patient is designated upon admission to the hospital, but the medical specialty of the patient's attending physician
- #9, All Other Non-Surgical Services would include specified observation service line if it pertains to your facility
- If patient is not admitted (Died/ Transferred to another facility or Discharged home from your ED) report null value Not applicable

Common Null Value
- Accepted

Data Source Hierarchy Guide
1 ED Record
2 Trauma Flow Sheet
3 Billing/Registration Sheet
4 History & Physical

PROCEDURE LOCATION

Element Intent
Utilized for reporting

Description
Procedure Location documents the location of the procedures performed while the patient was in your hospital.

Element Values
1 Emergency Department
2 Operating Room
3 ICU
4 Floor
5 Radiology
6 Other Specialty Area
7 Interventional radiology (IR)
8 Stepdown/Telemetry Unit
9 Observation Unit
10 Post Anesthesia Care Unit

Additional Information
Include only those procedures performed at your hospital.
This field is linked to the *Hospital Procedures* Field
Other Specialty Area includes: Endo, cardiac cath lab, dialysis, etc.
Scene Procedures are not part of this data variable but are collected elsewhere

Common Null Value
- Accepted

Data Source Hierarchy Guide
1 Operative Reports
2 Procedure Notes
3 ED and ICU Records
4 Trauma Flow Sheet
5 Nursing Notes
6 Radiology Reports
7 Anesthesia Record
8 Billing Sheet/Medical Records Coding Summary Sheet
9 Hospital Discharge Summary

ISS BODY REGION

Element Intent
Utilized for reporting and regional validation processes

Description
ISS Body Region is the Injury Severity Score assigned by body region codes that reflects the patient's injury(ies) diagnosed at your ED/hospital for this injury event.

Element Values

1 Head or Neck
2 Face
3 Chest
4 Abdominal or Pelvic Contents
5 Extremities or Pelvic Girdle
6 External

Additional Information
- Field value #1, *Head or Neck,* includes injury to the brain, skull, cervical spine and/or cervical spine fractures
- Field value #2, *Face,* includes those areas involving the mouth, ears, nose and/or facial bones
- Field value #3, *Chest,* includes all lesions to internal organs within the chest, diaphragm, rib cage and/or thoracic spine
- Field value #4, *Abdominal or Pelvic Contents*, includes all lesions to internal organs within the abdomen and lumbar spine
- Field value #5, *Extremities or Pelvic Girdle,* includes sprains, dislocations, fractures and amputations ***except for the spinal column, skull and rib cage***
- Field value #6, *External, includes* injuries such as lacerations, contusions, abrasions and burns independent of their location on the body surface

Common Null Values
- Accepted

Data Source Hierarchy Guide
Autopsy Report
Operative Report
Discharge Summary
Trauma Flow Sheet
Radiology Results
Billing Sheet/Medical Records Coding Summary Sheet
ED and ICU Records

LENGTH OF STAY

Element Intent
Utilized for reporting

Description
Length of Stay documents the total number of days that the patient occupied a bed while in your hospital.

Element Values
- Relevant value for data element

Additional Information
- This field is calculated from data in the “Hospital Arrival Date” and “Discharge Date” fields, automatically.
- Recorded in full day increments with any partial calendar day counted as a full calendar day.

Data Source Hierarchy Guide
1 Registration Form
2 Discharge Form

INJURY MECHANISM DEFINITION

APPENDIX E

Mechanism	Definition
ANIMAL	Animal Injury (Including but not limited to, bite, struck by) (rider of animal – see OV)
ASSAULT	Assault by person (blunt mechanism only)
BIKE	Any accident involving a bicyclist
BITING	Human bite only
BURN	Burn – Chemical, Thermal, Electrical, or Other
CRUSH	Crushing mechanism (when force or pressure is put onto the body)
CUT	Cut (includes cut by machine or chainsaw)
DROWN	Drowning/ Submersion
EXPOSURE	Exposure effects of heat and cold only Primary injury – environmental, not treatment related or sequela (AIS2015)
FALL.SL	Any fall from standing, may include subsequent strike against object
FALL.MINOR	Any fall <10 feet that is not a same level fall (Fall from object; chair; toilet)
FALL.MAJOR	Any fall >/= 10 feet.
FALL.NFS	Use only if no details stated about the fall, unwitnessed fall
GSW	Gunshot wound
INHAL	Smoke or chemical inhalation type injuries
MACHINE	Injury caused by machinery
MCC	Motorcycle related injuries (includes 2 wheel motor scooter and electric bike)
MVC	Cars, trucks, vans, SUV's on roads or parking lots etc.
OV	All off road and other vehicles not included elsewhere. (ATVs, snowmobiles, riding lawnmowers, 4-wheelers, golf carts, rider of animal, Dirt bike etc.)
OVEREX	Overexertion injuries (ie, heavy lifting). To be used for strains and sprains from improper lifting or repetitive motion. Do not include stress fractures here.
PED	Person walking (or using their typical mode of mobility) struck by motor vehicle. (If a person uses a wheelchair, mobility scooter, or other such conveyance to get around, they are still considered a pedestrian though they are not walking)
STAB	Stabbing/ Pierce/ Impalement
STRUCK	Struck by or against a person or object (not intentionally by someone)
SUFF	Suffocation, Hanging, or Asphyxiation
WATERCRAFT	Injury involving any boat (including jet skis), to include anything pulled behind watercraft (water skis, inner tubes, etc.)
UNK	Unknown (Found Down), No details to event

INJURY MECHANISM REFERENCES

Height Categories

House Story Height: The average height of 1, 2, and 3 story houses are respectively 10, 20, and 30 feet. A good rule of thumb when calculating the height of a house is to allocate approximately 10 feet per floor plus the height of the roof. (www.weekendbuilds.com)

Commercial building height: Average commercial building single story roof equals 12 feet

Office/ skyscraper building height: Building story height varies widely from just under the 14-foot average to well above it. That's because several factors affect the story's-to-feet standard for a building: building material, insulation type, and different height allowances for different levels. (theskydeck.com)

Step height: Standard should be between 7 or 7 ¾ inches at the most, and no less than 4 inches (www.stairsupplies.com)

ICD-10-PCS CODING REFERENCE

DIAGNOSTIC AND THERAPEUTIC IMAGING		
Computerized Tomography of Head	BW28	
Computerized Tomography of Chest	BW24	If wanting to combine CHEST/ABD/PELV- BW25
Computerized Tomography of Abdomen	BW20	If wanting to combine ABD/PELV- BW21
Computerized Tomography of Pelvis	BW2G	
Computerized Tomography of C-Spine	BR20	
Computerized Tomography of T-Spine	BR27	
Computerized Tomography of L-Spine	BR29	
Computerized Tomography Angiography	See Computerized Tomography Codes	
Doppler Ultrasound of extremities	RLE- B54B	
	LLE- B54C	
	BLE- B54D	
	RUE- B54M	
	LUE- B54N	
	BUE- B54P	
Diagnostic ultrasound (Includes FAST)	BW40ZZZ (abdomen), BW4GZZZ (pelvic), B24CZZZ (pericardium), BB4CZZZ (mediastinum)	
Angioembolization	Head, neck, upper arm artery- 03L	
	Aorta, abdominal, leg arteries- 04L	
	Head, neck, upper arm vein 05L	
	Leg veins- 06L	
Angiography	Upper arteries- B30	
	Lower arteries- B40	
IVC Filter	06H03DZ	
REBOA	Heart & Great Vessels- 02L	
	Lower Arteries- 04L	
Plain Radiography of Adult whole body	BW0KZZZ	
Plain Radiography of whole skeleton	BW0LZZZ	
Plain Radiography of infant whole body	BW0MZZZ	
CARDIOVASCULAR		
Open Cardiac Massage CPR	02QA0ZZ 5A12012 (manual) 5A1221J (mechanical)	

CNS		
Insertion of ICP Monitor	4A103BD	
Ventriculostomy	009630Z	
Cerebral Oxygen Monitor	4A103RD	
GENITOURINARY		
Ureteric Catheterization (Ureteric Stent)	0T7	
Suprapubic Cystostomy	0T1B0ZD	
MUSCULOSKETETAL		
Soft Tissue/Bony Debridement	Excisional Tissue Debridement- 0JB	
	Excisional Debridement- Upper Bone- 0PB	
	Excisional Debridement- Lower Bone- 0QB	
	Non Excisional Tissue Debridement- 0JD	
	Non Excisional Debridement- Upper Bone- 0PD	
	None Excisional Debridement- Lower Bone- 0QD	
Closed Reduction of Fractures	Upper Bones- 0PS	
	Lower Bones- 0QS	
Skeletal and Halo Traction	2W6	
Fasciotomy	0KN	
TRANSFUSION		
Transfusion of red blood cells (first 24 hours)	302_3N1	
Transfusion of platelets (first 24 hours)	302_3R1	
Transfusion of plasma (first 24 hours)	302_3K1	
RESPIRATORY		
Insertion of endotracheal tube	0BH17EZ	
Continuous mechanical ventilation	<24 HR- 5A1935Z	
	24-96HR- 5A1945Z	
	>96HR- 5A1955Z	
Chest Tube/ Thoracostomy	R- 0W9930Z	
	L- 0W9B30Z	
Bronchoscopy	Inspection- 0BJ	
	Drainage- 0B9	
	Excision- 0BB	
Thoracotomy	R-0WJ90ZZ	
	L- 0WJB0ZZ	

Tracheostomy	0B110F4	
GASTROINTESTINAL		
Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)	Gastroscopy- 0DJ68ZZ	
	Sigmoidoscopy- 0DJD8ZZ	
	Colonoscopy- 0DJD8ZZ	
Gastrostomy/jejunostomy (percutaneous or endoscopic)	Bypass- 0D1	
	Drainage- 0D9	
Percutaneous (endoscopic) gastrojejunoscopy	0DJ	

CHANGE LOG

2027 CHANGES

Cause Code	Retired
Trauma Type	Retired
Admitting Specialty	Retired Element Value 0 – Not Admitted (Died in your ED, Transferred to another facility or discharged home)
Admitting Specialty	Added to additional information: If patient is not admitted (Died/ Transferred to another facility or Discharged home from your ED) report null value Not applicable
Admitting Specialty	Common null values changed to accepted
Hospital Procedure Code	Retired
Injury Diagnosis Description	Retired
Injury Mechanism Definition Reference	FALL.SL - Removed Feet on Ground FALL.MINOR – Added (Fall from Object; chair; toilet) UNK – Added No details to event
ICD-10-PCS Coding Reference	Updated Fasciotomy code to 0KN
ICD-10-PCS Coding Reference	Updated Thoractomy codes to 0WJ90ZZ AND 0QJB0ZZ