Santa Clara County Emergency Medical Services

Trauma Data Dictionary 2022

Version
2-15-2022

Intro

The primary purpose of The Santa Clara County Trauma Data Dictionary is to assist Trauma registrars in reporting the appropriate trauma cases into the Santa Clara County Trauma Registry System in accordance with Santa Clara County EMS Policy 407.

This is the 2022 edition is designed to clarify data element requirements the Santa Clara County Emergency Medical Service Agency for quality improvement of the Trauma System and incorporates the most recent version of the National Trauma Data Bank (NTDB).

State Requirements

In 2017, California became the first state to transition state EMS Data to the National database. Now data from the California Emergency Medical Services Information System (CEMSIS) is collected by ensuring each Local Emergency Medical Services Agency collects data using the most recent version of the National Emergency Medical Services Information System (NEMSIS), version 3.4. California Health and Safety Code, Section 1797.227 requires that the local EMS agency collect and submit data electronic health record systems export data in a format that is compliant with the current version of NEMSIS.

California Title 22, Division 9, Chapter 7, further defines the Trauma Care System requirements. Article 2, Local EMS Agency Trauma System Requirements, provides the local EMS agency the authority to develop and implement a standardized data management system for trauma care. This system shall include the collection of both prehospital and hospital patient care data. All hospitals that receive trauma patients shall participate in the local EMS agency data collection efforts.

Trauma Registry Inclusion Criteria

Santa Clara County EMS will refer to the National Trauma Data Standard (NTDS) Patient Inclusion for entry into the Trauma Registry. All Level I, II, and III trauma centers verified in Santa Clara County will submit data from their trauma registries for patients meeting the following NTDS criteria.

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

1. **The patient must have sustained At least ONE of the following injury diagnostic codes defined as follows:**

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

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

- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome–initial encounter)

AND

2. **EXCLUDING the following isolated injuries (ICD-10CM):**
   - S00 (Superficial injuries of the head)
   - S10 (Superficial injuries of the neck)
   - S20 (Superficial injuries of the thorax)
   - S30 (Superficial injuries of the abdomen, pelvis, lower back, and external genitals)
   - S40 (Superficial injuries of shoulder and upper arm)
   - S50 (Superficial injuries of elbow and forearm)
   - S60 (Superficial injuries of wrist, hand, and fingers)
   - S70 (Superficial injuries of hip and thigh)
   - S80 (Superficial injuries of knee and lower leg)
   - S90 (Superficial injuries of ankle, foot, and toes)

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

AND

3. **AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION to steps 1 and 2** (ICD-10-CM S00-S99, T07, T14, and T79.A1-T79.A9):
   - Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status); OR
   - Patient transfer from one acute care hospital to another acute care hospital; **OR**

(Acute Care Hospital is defined as a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition)

• Patients 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.*

Additional Clarification Regarding Trauma Registry Data Entry

A. **Common Null Values**

Definitions: These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values.

Field Values:

1. Not applicable: NA

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

2. Not Documented: ND

   This null value applies if hospital documentation of an information system has an empty field, or nothing is recorded. This null value signifies that the hospital patient care record provides a "place holder" to document the specific data element but that no value for that element was recorded for the patient. For example, a hospital patient care record may request the date of birth, but none was recorded.

In certain fields, common Null values may be specified that are different from those outlined above. If such values are specified for some variables, those alternatives must be used instead of the common Null value.

Do not leave blank fields. Blank fields can cause errors in data reporting and jeopardize credibility. Ensure all data fields include the appropriate response or Null value.

B. All times shall be collected using the 24-hour clock format. **HH:MM**

C. Conversions. Please ensure data is entered per NTDB format defined in the data dictionary. This includes values for temperature, weight, height, and fluids. (Conversations can be calculated here: https://www.metric-conversions.org).

D. Pediatrics is defined as patients under 15 years of age.

E. Always use the highest level of reliability when abstracting data and resolving contradictory information. If there is ever a question about the severity of an injury, code the least severe code in that injury category.

Example (highest to lowest):

- Medical Examiner Report
- Hospital/Medical Records:
  - Operative Reports
  - Radiology Physician Notes/Reports
  - Nursing or ICU Notes
  - ED/Triage Records
  - Discharge Summary
- Field Records
  - EMS
  - Law Enforcement
- Bystanders
- Patient

F. **EMS Patient Care Report Universally Unique Identifier (UUID)**: Automated abstraction technology provided by registry product providers/vendors must be used for this data element. In the absence of automated technology, report the null value "Not Known/Not Recorded."

"The UUID will not be documented on EMS Run Reports until NEMSIS version 3.5.0. is released. In collaboration with NEMSIS, the ACS will communicate when NEMSIS 3.5.0 is released."

Once Santa Clara County switches to NEMSIS version 3.5.0, the UUID will be required for all EMS patients. When this upgrade occurs, Pre-hospital data elements will automatically link to the NTDB and the need to enter these data elements will no longer be required (reference: NTDB Q&A section).

G. It is not the intent of the Santa Clara County EMS Agency to hinder or restrict trauma data collected internally at each trauma center. Instead, the intent is to clearly define the criteria for standardized reporting of trauma patients to the local EMS Agency trauma registry as required by California legislation. Trauma Centers may collect additional data elements not defined below to meet their individual needs; this data may be removed from aggregated reports utilized by the EMS Agency.

Data Due Dates

Data must be submitted into the Trauma Data Registry System on a quarterly basis. All cases should be entered based on Hospital Arrival Date so that it can be mapped appropriately with the State registry. The quarters and due dates are listed below.

Quarter 1: Hospital arrival dates from January 1 through March 31; Data submission due on June 2, 2022

Quarter 2: Hospital arrival dates from April 1 through June 30; Data submission due on September 1, 2022

Quarter 3: Hospital arrival dates from July 1 through September 30; Data submission due on December 1, 2022

Quarter 4: Hospital arrival dates from October 1 through December 31; Data submission due on March 1, 2023

*Trauma centers are not restricted to submitting quarterly, they may adhere to internal practice of submitting data as long as quarterly data is received by the dates listed above for the SCC EMS agency to aggregate and produce reports locally and for state submission.

2022 Trauma Data Base Collection Elements

All of data elements listed in the accompanying table are to be collected for 2022. The dictionary element name and description are listed for each element. The Reference Column will indicate the page number of the most recent data dictionary in which the data element corresponds to for further details.

The 2022 NTDB data dictionary can be accessed at: https://www.facs.org/-/media/files/quality-programs/trauma/ntdb/ntds/data-dictionaries/ntds_data_dictionary_2022.ashx

Elements specific to Santa Clara County EMS and no longer collected by NTDB are defined in the most recent Santa Clara County Trauma Data Dictionary that can be accessed at: https://emsagency.sccgov.org/sites/g/files/exjcpb266/files/General/TRUG%20Data%20Dictionary%20.pdf

Please access these documents for field values, additional information, data sources and notes. Any data values that need further clarification will be addressed and documented in Santa Clara County Trauma Registry User Group meetings.

Required Entities Key: National Trauma Data Base, NTDB: National Emergency Medical Services Information System, NEMSIS:

Santa Clara County EMS, XSC:

Required Entity			Dictionary Element	Description	Reference
1. Demographic Section					
			Abstractor	The person who abstracts the data into the registry.	XSC pg. 13
			Abstractor Start Date	The date the abstractor performs the abstraction of the chart.	XSC pg. 14
			Trauma Center Code	This number is assigned to each participating facility that collects trauma data. This facility number is assigned by the Santa Clara County EMS Agency	This is assigned
			Medical Record Number	The patient's medical record number as assigned by the facility treating the trauma.	XSC pg. 21
			Patient Number	The patient's account number assigned by the facility treating the trauma.	XSC pg. 23
			Patient Last Name	The patient's last name.	XSC pg. 24
			Patient First Name	The patient's first name.	XSC pg. 25
			Patient Middle Initial	The patient's middle initial (M.I.)	XSC pg. 26
			Social Security Number (last 4)	Number used for patient identification.	XSC pg. 22
			Date of Birth	The patient's date of birth reported as YYYY-MM-DD.	NTDB pg. 7
			Age	The patients age at the time of injury (best approximation).	NTDB pg. 8
			Age Units	The units used to report the patient's age.	NTDB pg. 9
			Race	The patient's race.	NTDB pg. 10
			Ethnicity	The patient's ethnicity.	NTDB pg. 11
			Gender/Sex	The patient's identified gender/sex.	NTDB pg. 12
			Patient's Home Zip Code	The patient's home Zip/Postal code of primary residence.	NTDB pg. 1
			Patient's Home Country	The country where the patient resides.	NTDB pg. 2
			Patient's Home State	The state (territory, province, or District of Columbia) where the patient resides.	NTDB pg. 3
			Patient's Home County	The patient's count (or parish) of residence.	NTDB pg. 4
			Patient's Home City	The patient's city (or township, or village) of residence.	NTDB pg. 5

			Alternate Home Residence	Documentation of the type of patient without a home ZIP/Postal code.	NTDB pg. 6
2. Injury Information					
			Injury Incident Date	The date the injury occurred.	NTDB pg. 13
			Injury Incident Time	The time the injury occurred.	NTDB pg. 14
			Trauma Type	The type of injury that occurred.	XSC pg. 48
			Details	Brief description of how the injury occurred.	XSC pg. 49
			Position (in Vehicle of applicable)	For documentation in a Motor Vehicle incident, related to location of patient in vehicle.	XSC pg. 50
			Work-Related -Patients Occupational Industry -Patients Occupation	Indication of whether the injury occurred during paid employment. -The occupational industry associated with the patient's work environment. -The occupation of the patient.	NTDB pg. 15-17
			XSC Cause Code	The Santa Clara County two-digit code describing the mechanism of the patient's injury.	XSC pg. 43
			ICD-10 Primary External Cause Code	External cause code used to describe the mechanism (or external factor) that caused the injury event.	NTDB p. g18
			ICD-10 Place of Occurrence External Cause Code	Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.X).	NTDB pg. 19
			ICD-10 Additional External Cause Code	Additional external cause code used in conjunctions the ICD-10 Primary External Cause Code if multiple external cause codes are required to describe the injury.	NTDB pg. 20
			Incident Location Zip Code	The ZIP/Postal code of the incident location.	NTDB pg. 21
			Incident Country	The country where the patient was found or to which the unit responded (or best approximation).	NTDB pg. 22
			Incident State	The state, territory, or province where the patient was found or to which the unit responded (or best approximation).	NTDB pg. 23
			Incident County	The county or parish where the patient was found or to which the unit responded (or best approximation).	NTDB pg. 24
			Incident City	The city or township where the patient was found or to which the unit responded.	NTDB pg. 25
			Protective Devices	Protective devices (safety equipment) in use or worn by the patient at the time of the injury.	NTDB pg. 26

			Child Specific Restraint	Protective child restraint devices used by the patient at the time of injury.	NTDB pg. 27
			Abuse Reported	A report of suspected physical abuse was made to law enforcement and/or protective services.	XSC pg. 58
			Airbag Deployment	Indication of airbag deployment during a motor vehicle crash.	NTDB pg. 28
3. Prehospital Information					
			Transport Mode	The mode of transport delivering the patient to your hospital.	NTDB pg. 29
			Other Transport Mode	All other modes of transport used during the patient care event (prior to arrival at your hospital), except the mode delivering the patient to your hospital.	NTDB pg. 30
			EMS Patient Care Report Universally Unique Identifier (UUID)	The patient's universally unique identifier (UUIS) as assigned by the emergency medical service (EMS) agency transporting the patient from the scene of injury to your hospital. Note: Please report "not Known/Not recorded" until database is updated to NESIS version 3.5	NTDB pg. 31
			Inter-facility Transfer	Was the patient transferred to your facility from another acute care facility?	NTDB pg. 32
			Pre-hospital Cardiac Arrest	Indication of whether the patient experienced cardiac arrest prior to ED/Hospital arrival.	NTDB pg. 33
			Agency	The code for Prehospital Provider Agency, who transported the patient to the hospital.	XSC pg. 70
			PCR Present	Input by the registrar to indicate the presence or absence of a PCR.	XSC pg. 71
			PCR Number	The number generated at County Communications related to the incident for which the Prehospital contact occurred.	XSC pg. 72
			Transport Type	The type of provider which responds to the incident.	XSC pg. 73
			EMS Dispatched Date	The time the unit transporting to your hospital was notified by dispatch.	XSC pg. 77
			EMS Dispatched Time	The date the unit transporting to your hospital was notified by dispatch.	XSC pg. 76
			EMS Unit arrived on Scene Date	The date the unit transporting to your hospital arrived on the scene/transferring facility.	XSC pg. 79
			EMS Unit Arrived on Scene Time	The time the unit transporting to your hospital arrived on the scene/transferring facility.	XSC pg. 78

			Arrive at Patient Time	The time the unit transporting to your hospital arrived at the patient side.	XSC pg. 80
			Arrive at Patient Date	The date the unit transporting to your hospital arrived at the patient side.	XSC pg. 81
			EMS leave Scene Date	The date the unit transporting to your hospital left the scene/transferring facility.	XSC pg. 83
			EMS Leave Scene Time	The time the unit transporting to your hospital left the scene/transferring facility.	XSC pg. 82
			Initial field Systolic Blood Pressure	First recorded systolic blood pressure measured at the scene of the injury.	XSC pg. 157
			Initial field Diastolic Blood Pressure	First recorded diastolic blood pressure measured at the scene of the injury.	XSC pg. 158
			Initial Field Pulse Rate	First recorded pulse measured at the scene of the injury (palpated or auscultated), expressed as a number per minute.	XSC pg. 155
			Initial Field Respiratory Rate	First recorded respiratory rate measured at the scene of injury, expressed as a number per minute.	XSC pg. 156
			Initial field Oxygen Saturation	First recorded oxygen saturation measured at the scene of injury, expressed as a percentage.	XSC pg. 165
			Initial Field Vital Signs Date Initial Field Vital Signs Time	The date and time the vital signs were recorded in the field.	XSC pg. 168-169
			Respiratory Assistance (Initial Field Respiratory Assistance)	Determination of whether the respirations are self-sustaining or required assistance.	XSC pg. 166
			Supplemental Oxygen (Initial Field Supplemental Oxygen)	Determination of the presence of supplemental oxygen during assessment of oxygen saturation level.	XSC pg. 167
			Initial field GCS-Eye Initial Field GCS-Verbal Initial Field GCS-Motor Initial Field GCS-Total	-The first recorded Glasgow Coma Score (Eye) measured at the scene of the injury. - The first recorded Glasgow Coma Score (Verbal) measured at the scene of the injury. - The first recorded Glasgow Coma Score (Motor) measured at the scene of the injury. - The first recorded Glasgow Coma Score (Total) measured at the scene of the injury.	XSC pg. 159-162

			Initial Field GCS 40-Eye Initial Field GCS 40-Verbal Initial Field GCS 40-Motor	- First recorded Glasgow Coma Score 40 (Eye) measured at the scene of injury - First recorded Glasgow Coma Score 40 (Verbal) measured at the scene of injury - First recorded Glasgow Coma Score 40 (Motor) measured at the scene of injury	XSC pg. 174-176
			Paralytics (initial Field GCS Qualifier)	This is a description of the barriers to evaluation of the GCS.	XSC pg. 164
			Triage Data/Trauma Triage Criteria Steps 1-4	Physiological and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.	XSC pg. 64-66
			Transport Response Time (min)	Auto-calculated: the difference between time of *EMS Dispatch* and *EMS Arrived on Scene Time.*	XSC pg. 86
			Transport Scene Time (min)	Auto-calculated: the difference between the *EMS Arrived on Scene Time* and the *EMS Leave Scene Time*. (Need to confirm with ESO the correct values remain to do these calculations)	XSC pg. 87
			Transport Total Time (min)	Auto-calculated: the difference between the *EMS Departure Time* and time that the ambulance arrives at destination-your hospital.	XSC pg. 88
4. Emergency Department Information					
			Highest Activation	Patient received the highest level of trauma activation at your hospital.	NTDB pg. 34
			Trauma Level	The code used for the level of trauma team activation. Santa Clara Trauma Centers all use a tiered level of trauma team response.	XSC pg. 119
			Trauma Surgeon Arrival Date	The date the first trauma surgeon arrived at the patient's bedside	NTDB pg. 35
			Trauma Surgeon Arrival Time	The time the first trauma surgeon arrived at the patient's bedside	NTDB pg.36
			ED/Hospital Arrival Date	The date the patient arrived at the ED/Hospital.	NTDB pg. 37
			ED/Hospital Arrival Time	The time the patient arrived at the ED/Hospital.	NTDB pg. 38
			Signs of Life at Arrival	Indication of whether patient arrived at ED/Hospital with signs of life	XSC pg. 114
			Initial ED/Hospital Systolic Blood Pressure	The first recorded systolic blood pressure in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.	NTDB pg. 39
			Initial ED/Hospital Diastolic Blood Pressure	First recorded diastolic blood pressure in the ED/Hospital within 30 minutes or less of ED/Hospital arrival.	XSC pg. 182

			Initial ED/Hospital Pulse Rate	First recorded pulse in the ED/Hospital (palpated or auscultated) within 30 minutes of ED/Hospital arrival (expressed as a number per minute).	NTDB pg. 40
			Initial ED/Hospital Temperature	First recorded temperature (in degrees Celsius {centigrade}) in the ED/Hospital within 30 minutes of ED/Hospital arrival/	NTDB pg. 41
			Initial ED/Hospital Respiratory Rate	First recorded respiratory rate in the ED/Hospital within 30 minutes of ED/Hospital arrival (expressed as a number per minute).	NTDB pg. 42
			Initial ED/Hospital Respiratory Assistance	Determination of respiratory assistance with the *Initial ED/Hospital Respiratory Rate* within 30 minutes of ED/Hospital arrival	NTDB pg. 43
			Initial ED/Hospital Oxygen Saturation	First recorded oxygen saturation in the ED/Hospital within 30 minutes of ED/Hospital arrival (expressed as a percentage).	NTDB pg. 44
			Initial ED/Hospital Supplemental Oxygen	Determination of the presence of supplemental oxygen during assessment of initial ED/Hospital Oxygen Saturation level within 30 minutes or less of ED/Hospital arrival.	NTDB pg. 45
			Initial ED/Hospital GCS-Eye Initial ED/Hospital GCS-Verbal Initial ED/Hospital GCS-Motor Initial ED/Hospital GCS-Total	-First recorded Glasgow Coma Score (Eye) in the ED/Hospital within 30 minutes of ED/Hospital arrival. -First recorded Glasgow Coma Score (Verbal) in the ED/Hospital within 30 minutes of ED/Hospital arrival. -First recorded Glasgow Coma Score (Motor) in the ED/Hospital within 30 minutes of ED/Hospital arrival. -First recorded Glasgow Coma Score (Total) in the ED/Hospital within 30 minutes of ED/Hospital arrival.	NTDB pg. 46-49
			Initial ED/Hospital GCS-Assessment Qualifiers	Documentation of factors potentially affecting the first assessment of GCS within 30 minutes of ED/Hospital arrival.	NTDB pg. 50
			Initial ED/Hospital GCS 40-Eye Initial ED/Hospital GCS 40-Verbal Initial ED/Hospital GCS 40-Motor	-First recorded Glasgow Coma Score 40 (Eye) in the ED/Hospital within 30 minutes of ED/Hospital arrival. -First recorded Glasgow Coma Score 40 (Verbal) in the ED/Hospital within 30 minutes of ED/Hospital arrival. -First recorded Glasgow Coma Score 40 (Motor) in the ED/Hospital within 30 minutes of ED/Hospital arrival.	NTDB pg. 50-53
			Initial ED/Hospital Height	First recorded height within 24 hours of ED/Hospital arrival (Recorded in inches).	NTDB pg. 54

			Initial ED/Hospital Weight	First recorded weight within 24 hours of ED/Hospital arrival (recorded in kilograms [kg]).	NTDB pg. 55
			Drug Screen	First recorded positive drug screen results within 24 hours after first hospital encounter (report all that apply).	NTDB pg. 56
			Alcohol Screen	A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after the first hospital encounter.	NTDB pg. 57
			Alcohol Screen Results	First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.	NTDB pg. 58
			ED Discharge Disposition	The disposition unit the order was written for the patient to discharge from the ED.	NTDB pg. 59
			ED Discharge Date	The date the order was written for the patient to be discharged from the ED.	NTDB pg. 60
			ED Discharge Time	The time the order was written for the patient to be discharged from the ED.	NTDB pg. 61
			ED Discharge Date ED Discharge Time	The time the patient left the ED, either home or to an inpatient area. The date the patient left the ED, either home or to an inpatient area.	XSC pg. 109-110
			Time in ED	The total time that the patient was in the Emergency Department	XSC pg. 113
			Consulting Provider	Facility code for name of consultant	XSC pg. 130
			Consulting Service	The consult service requested	XSC pg. 131
5. Transfers/Referring					
			Referring Facility Code	The code responding to the name of the acute facility which transferred the patient to your hospital.	XSC pg. 139
			Admit Service	Character Code from pick list for the in-house service on which the patient is admitted.	XSC pg. 142
			Admit Type	Differentiates as direct admit transfer from an interfacility transfer who goes to the ED.	XSC pg. 102
			Admit Unit	Which Unit the patient is admitted to.	XSC pg. 104
			Referring Arrival Time	This is the time the patient arrived at the referring facility.	XSC pg. 145
			Referring Arrival Date	This is the date the patient arrived at the referring facility.	XSC pg. 146
			Referring Discharge Time	This is the time the patient was discharged from the referring facility.	XSC pg. 147
			Referring Discharge Date	This is the date the patient was discharged from the referring facility.	XSC pg. 148
			Referring Facility Comments	Free text comments regarding the referring facility.	XSC pg. 149
			Referring LOS	The total time in minutes spent at the referring facility.	XSC pg. 150

			Transfer in for Higher Level of Care	This differentiates the patients who are sent to your facility because they need higher level of care.	XSC pg. 259
6. Hospital Procedure Information					
			ICD-10 Hospital Procedures	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.	NTDB pg. 62
			Hospital Procedures Start Date	The date operative and selected non-operative procedures were performed.	NTDB pg. 64
			Hospital Procedures Start Time	The time operative and selected non-operative procedures were performed.	NTDB pg. 65
7. Diagnosis Information					
			ICD-10 Injury Diagnoses	Diagnoses related to all identified injuries.	NTDB pg. 92
			AIS Code	The Abbreviated Injury Scale (AIS) code(s) that reflect the patient's injuries.	NTDB pg. 93
			AIS Version	The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes.	NTDB pg. 94
			Region	This is the region where the diagnosis was found.	XSC pg. 206
			ISS	Injury Severity Score	XSC pg. 208
8. Outcome Information					
			Total ICU Length of Stay	The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day.	NTDB pg. 130
			Total Ventilator Days	The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.	NTDB pg. 132
			Hospital Discharge Disposition	The disposition of the patient when discharged from the hospital.	NTDB pg. 134
			Hospital Discharge Date	The date the order was written for the patient to be discharged from the hospital.	NTDB pg. 135
			Hospital Discharge Time	The time the order was written for the patient to be discharged from the hospital.	NTDB pg. 136
			Readmission Outcome	Identifies the reason a trauma patient was readmitted.	Added to hospital list in 2020, EMS is working with ESO to map
9. Death Information					
			Autopsy Charted	Defines whether or not an autopsy was done.	XSC pg. 270

			Autopsy Type	Defines type of autopsy performed.	XSC pg. 271
			Autopsy ID	Coroner ID # found on autopsy report.	XSC pg. 272
			Place of Death	The location in the hospital where the patient died.	XSC pg. 276
			Organs Donated	The code for the organ/tissue donated.	XSC pg. 277
9. Financial Information					
			Primary Method of Payment	Primary source of payment for hospital care.	NTDB pg. 137
			Charge Total	The final billed amount charged for this admission; aggregate amount expressed in whole dollar figures.	XSC pg. 247
10. Surgeon Specific Reporting-Optional					
			National Provider Identifier (NPI)	The National Provider Identifier (NPI) of the admitting surgeon.	NTDB pg. 174

The following charts provides the 2022 list of Pre-Existing Health Conditions, Hospital Events, and Trauma Quality Improvement Measures that shall be collected by the NTDB and entered in the Trauma Registry System. Additional data entry details are provided in the 2022 NTDB Data Dictionary.

2022 NTDB Pre-Existing Conditions List (Reference pages 66-91)	2022 NTDB Hospital Events List (Reference pages 95-124)
Advanced Directives Limiting Care	Acute Kidney Injury (AKI)
Alcohol Use Disorder	Acute Respiratory Distress Syndrome (ARDS)
Angina Pectoris	Alcohol Withdrawal Syndrome
Anticoagulant Therapy	Cardiac Arrest with CPR
Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)	Catheter-Associated Urinary Tract Infection (CATI)
	Central Line-Associated Bloodstream Infection (CLABSI)
Bleeding Disorder	Deep Surgical Site Infection
Cerebral Vascular Accident (CVA)	Deep Vein Thrombosis (DVT)
Chronic Obstructive Pulmonary Disease (COPD)	Delirium
Chronic Renal Failure	Myocardial Infarction (NI)
Cirrhosis	Organ/Space Surgical Site Infection
Congenital Anomalies	Osteomyelitis
Congestive Heart Failure (CHF)	Pulmonary Embolism (PE)
Current Smoker)	Pressure Ulcer)
Currently Receiving Chemotherapy for cancer	Severe Sepsis

Dementia Diabetes Mellitus Disseminated Cancer Functionally Dependent Health Status Hypertension Mental/Personality Disorders Myocardial Infarction (MI) Peripheral Arterial Disease (PAD) Pregnancy Prematurity Steroid Use Substance Use Disorder	Stroke (CVA) Superficial Incisional Surgical Site Infection Unplanned Admission to ICUI Unplanned intubation Unplanned Visit to the Operating Room Ventilator-Associated Pneumonia (VAP) **Inappropriate Airway Management* (carry-over XSC would still like collected).

2022 National Trauma Quality Improvement Program (N-TQIP) Measures

2022 Performance Measures:	Criterion Description	NTDB pg.#
Highest GCS-Total	Report on the patients with at least one injury in AIS head region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp laceration(s) and or scalp avulsions. Highest total GCS on calendar day after ED/Hospital arrival.	139
Highest GCS-Motor	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s). Highest GCS on calendar day after ED/Hospital arrival.	140
GCS Assessment Qualifier Components of Highest GCS Total	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s). Documentation of factors potentially affecting the highest GCS on calendar day after ED/Hospital arrival.	142
Highest GCS 40-Motor	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s). Highest GCS on calendar day after ED/Hospital arrival.	144

Initial ED/Hospital Pupillary Response	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s).	146
	Physiological response of the pupil size within 30 minutes or less of ED/Hospital arrival.	
Midline Shift	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s).	147
	>5mm shift of the brain past its center line within 24-hours after time of injury.	
Cerebral Monitor - Cerebral Monitor date - Cerebral Monitor Time	Report on patients with at least one injury in AIS region, excluding patients with isolated scalp abrasion(s), scalp contusion(s), and/or scalp avulsion(s).	149-150
	Indicate all cerebral monitors that were placed, including any of the following: ventriculostomy, subarachnoid bolt, camino bolt, external ventricular drain (EVD), licox monitor, jugular venous bulb. Report date/time of first cerebral monitor placement.	
Venous Thromboembolism Prophylaxis Type - VTE date -VTE time	Report on all patients.	151-153
	Type of first dose of venous thromboembolism prophylaxis administered to patient at your hospital. Record date/time of administration of first dose.	
Packed Red Blood Cells	Report on all patients.	154
	Volume of packed red blood cells (mLs) within first 4 hours after ED/Hospital arrival.	
Whole Blood	Report on all patients.	155
	Volume of whole blood transfused (mLs) within first 4 hours after ED/Hospital arrival.	
Plasma	Report on all patients.	156
	Volume of plasma (mLs) transfused within first 4 hours after ED/Hospital arrival.	
Platelets	Report on all patients	157
	Volume of platelets (mLs) transfused within first 4 hours after ED/Hospital arrival.	
Cryoprecipitate	Report on all patients.	158
	Volume of solution enriched with clotting factors transferred (mLs) within first 4 hours after ED/Hospital arrival.	
Angiography	Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/Hospital arrival.	159
	First interventional angiogram for hemorrhage control within first 24 hours after ED/Hospital arrival.	
Embolization site -Embolization date	Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/Hospital arrival.	160-162

-Embolization time	Organ/site of embolization for hemorrhage control. Record date/time the first angiogram with or without embolization was performed.	
Surgery for hemorrhage control type -Surgery for hemorrhage control date -Surgery for hemorrhage control time	Report on all patients with transfused packed red blood cells or whole blood within first 4 hours after ED/Hospital arrival.	163-165
	First type of surgery for hemorrhage control within the first 24 hours of ED/Hospital arrival. Record the date/time of first surgery for hemorrhage control within first 24 hours of ED/Hospital arrival.	
Withdrawal of Life Supporting treatment -Withdrawal of life supporting treatment date -Withdrawal of life supporting treatment time	Report on all patients	166-168
	Treatment was withdrawn based on a decision to either remove or withhold further life supporting intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin. Record the date/time treatment was withdrawn.	
Antibiotic therapy -Antibiotic therapy date -Antibiotic therapy time	Report on all patients with any open fracture(s)	169-171
	Record the date/time of first recorded intravenous antibiotic therapy administered to the patient within 24 hours after first hospital encounter.	

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