VSTR 2025

Virginia State Trauma Registry Data Dictionary

For Patients Admitted On or After January 1, 2025

Table of Contents

PURPOSE

The purpose of the Virginia Statewide Trauma Registry is to provide a database of patients injured in Virginia and admitted to hospitals in Virginia or surrounding states.

Trauma registries are an integral part of the operations of a trauma center. Trauma registry data is of great importance to the overall success of trauma programs. It is used for performance improvement, research, injury prevention, resource utilization, and the creation of standards and benchmarks.

A key element in the performance improvement process is having data that accurately portray a trauma patient's injury, severity, process of care, outcome, type of trauma, and cause of injury. The trauma registry functions as the information resource driving this process. Collected information is used to:

- Study the epidemiology of injury in Virginia,
- Provide feedback to participating hospitals,
- Evaluate and improve the trauma care delivery system in Virginia,
- Develop injury prevention programs,
- Assist health care and social service agencies that provide services to the injured,
- Participate in regional and national injury databases, and
- Assist in the development of trauma system policy and legislation.

The big picture and ultimate goal are to create a powerful tool to prevent accidental injury and death and to promote better outcomes for injured patients throughout the Commonwealth.

DOCUMENT CONVENTIONS

- Data element names denoted by an asterisk (*) are Virginia-specific elements, not used by the National Trauma Data Bank (NTDB).

- Data element names followed by [Trauma Center only] are only required to be answered by designated trauma centers.

INCLUSION CRITERIA

Trauma Patient Definition

To ensure consistent data collection across the Commonwealth of Virginia, a trauma patient is defined as a person who sustained an injury within 14 days of their initial presentation for treatment and was either admitted to a hospital for treatment of their injury, transferred from a hospital or free-standing emergency department (FSED) for treatment of their injury, or who died at a hospital or FSED from their injury.

Inclusion Criteria

Patients to be included in VSTR are those who present for the initial treatment of an injury within 14 days of sustaining the injury. The patient must have at least one injury described by an ICD-10-CM code of:

- S00-S99, with 7th character modifiers of A, B, or C (Injuries to specific body parts, initial encounter)
- T07 (Unspecified multiple injuries)
- T14 (Injury of unspecified body region)
- T20-T28, with 7th character modifier of A only (Burns by specific body parts, initial encounter)
- T30-32 (Burns by TBSA percentage with 7th character modifier A)
- T79.A1-T79.A9, with 7th character modifier of A only (Traumatic compartment syndrome, initial encounter)

AND meet at least one of the following conditions:

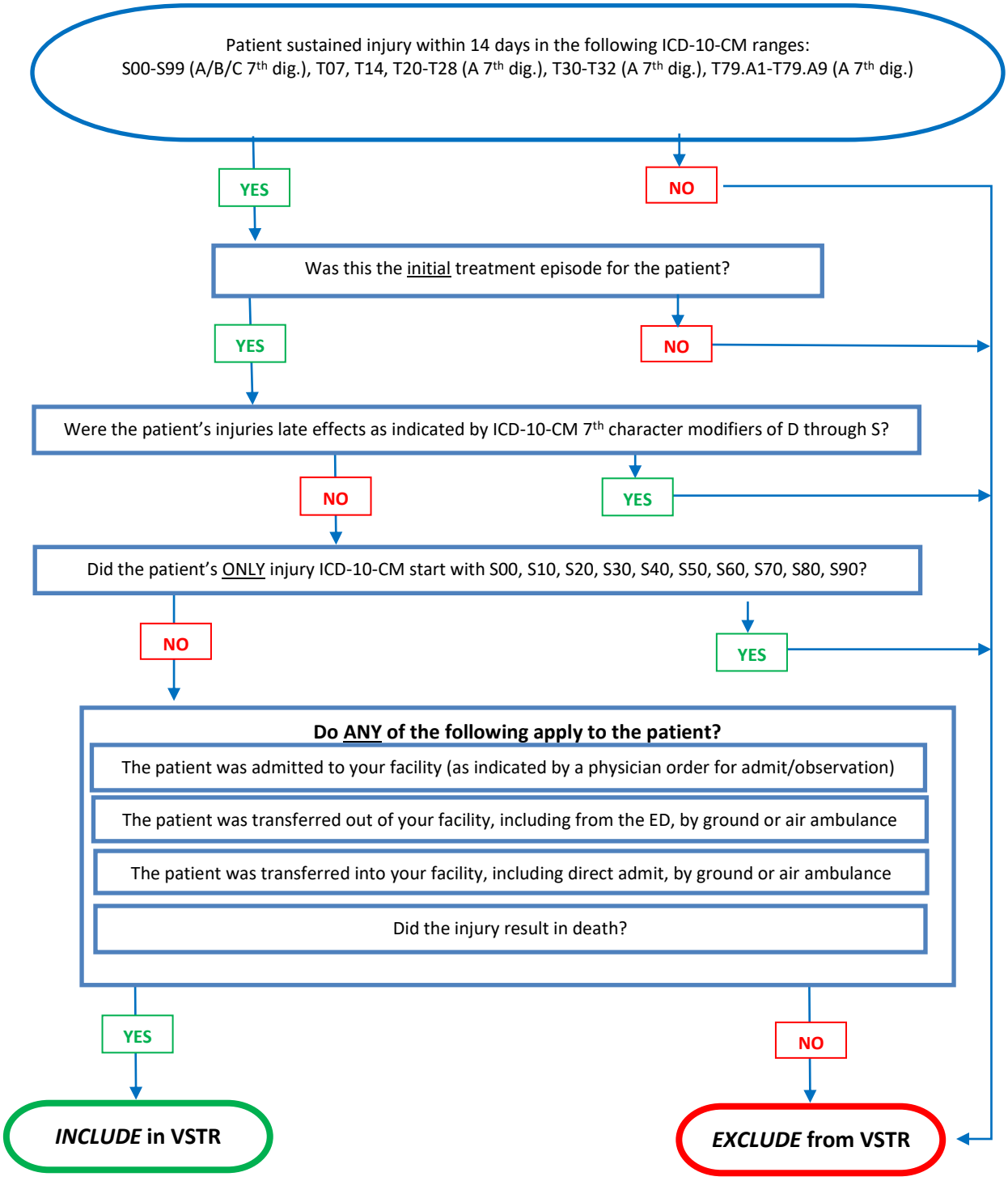
- Death resulting from the injury at any point during treatment;
  AND/OR
- Transfer by ambulance (ground or air) from an acute care hospital or free-standing ED to an acute care hospital for treatment of the injury;
  AND/OR
- Direct admission to a hospital for treatment of the injury;
  AND/OR
- Receipt of an order for admission for observation or treatment of the injury.

Exclusion Criteria

Patients with the following injuries are ***excluded*** from entry in VSTR:

- **Isolated superficial injuries** of the head (ICD-10-CM S00); neck (S10); thorax (S20); abdomen, pelvis, lower back, external genitalia (S30); shoulder and upper arm (S40); elbow and forearm (S50); wrist, hand, fingers (S60); hip, thigh (S70); knee, lower leg (S80); ankle, foot, toes (S90);
- **Injuries sustained greater than 14 days before initial presentation for treatment**;
- **Injuries with an ICD-10-CM 7th character modifiers of D through S** (late effects); and
- **Drownings** (Y21).
- For Trauma Centers: Patients with trauma activations who did not receive an order for admission, observation, or transfer and who are discharged alive from the emergency department are **excluded**.

VSTR Inclusion/Exclusion Decision Tree



DEMOGRAPHIC INFORMATION

MEDICAL RECORD NUMBER*

Definition
Unique alphanumeric number assigned and used by the hospital to identify a patient's health record at their institution.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

Validation Description
- Medical record number should not be blank.

ACCOUNT NUMBER*

Definition
A number assigned to the trauma patient at your facility. A patient encounter number or account number must be used.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- This number must be unique for each admission of an individual to avoid repeating a number if that patient suffers another injury later which also meets all inclusion criteria and no exclusion criteria for entry into VSTR.
- The use of a medical record number or trauma registry ID is not allowed.

Validation Description
- Patient encounter number should not be blank.

PATIENT LAST NAME*

Definition
The patient's family name or surname.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Pseudonyms (sometimes called 'trauma names' or 'John Doe names') are accepted.

Validation Description
- Patient last name should not be blank.

PATIENT FIRST NAME*

Definition
The patient's first or given name.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Pseudonyms (sometimes called 'trauma names' or 'John Doe names') are accepted.

Validation Description
- Patient first name should not be blank.

DATE OF BIRTH

Definition
The patient's date of birth.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- 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 ED/Hospital Arrival Date or Injury Date, then the Age and Age Units variables must be reported.

Validation Description
- Date of birth should not be blank.

AGE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- If Date of Birth is “Not known/Not recorded”, report variables: Age and Age Units.
- If Date of Birth equals ED/Hospital Arrival Date or injury date, then the Age and Age Units variables must be reported.
- The null value “Not known/Not recorded” must be reported when Age Units is “Not known/Not recorded”.
- Must also report variable: Age Units

Validation Description
- Age should not be blank.

AGE UNIT

Definition
The units used to document the patient's age.

Allowed Values
- Years
- Months
- Days
- Hours
- Minutes
- Weeks

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- If Date of Birth is “Not known/Not recorded”, report variables: Age and Age Units.
- If Date of Birth equals ED/Hospital Arrival Date or Injury Date, then the Age and Age Units variables must be reported.
- The null value “Not known/Not recorded” must be reported when Age Units is “Not known/Not recorded”.
- Must also report variable: Age

Validation Description
- Age unit should not be blank.

SEX

Definition
The patient's gender.

Allowed Values
- Male
- Female
- Non-binary

Null Values Allowed
- No

Multiple Entry
- No

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

Validation Description
- Sex should not be blank.

ETHNICITY

Definition
The patient's ethnicity.

Allowed Values
- Hispanic or Latino
- Not Hispanic or Latino

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- 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.
- The allowed values are based on the 2010 US Census Bureau.
- The null value “Not known/Not recorded” must be reported if the patient or family member refuse to identify ethnicity.

Validation Description
- Ethnicity should not be blank.

RACE

Definition
The patient's race.

Allowed Values
- American Indian
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- Yes

Notes
- Patient race should be based upon self-report or identified by a family member.
- The allowed values are based on the 2010 US Census Bureau.
- The null value “Not known/Not recorded” must be reported if the patient or family member refuse to identify race.
- Select all that apply.

Validation Description
- Race should not be blank.

PATIENT'S HOME ZIP/POSTAL CODE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- Can be stored as a 5 or 9-digit code (i.e., XXXXX or XXXXX-XXXX) for the US and Canada or can be stored in the postal code format of the applicable country.
- If zip/postal code is "Not Applicable", then report variable: Alternate Home Residence.

Validation Description
- Patient's home zip/postal code should not be blank.

PATIENT'S HOME ADDRESS

Definition
The street address of the patient's primary residence.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- If Patient Home Address is "Not Applicable" then report variable: Alternate Home Residence.

Validation Description
- Patient's home address should not be blank.

PATIENT'S HOME STATE

Definition
The state, territory, province, or district where the patient resides.

Allowed Values
- Two-digit numeric FIPS code. See Appendix A.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- If the patient's home country is not the US, report the null value "Not Applicable".

Validation Description
- Patient's home state should not be blank.

PATIENT'S HOME COUNTY

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

Allowed Values
- Three-digit numeric FIPS code. See Appendix B.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- If the patient's home country is not the US, report the null value "Not Applicable".

Validation Description
- Patient's home county should not be blank.

PATIENT'S HOME COUNTRY

Definition
The country where the patient resides.

Allowed Values
- Two-digit country code. See Appendix C.

Null Values Allowed
- No

Multiple Entry
- No

Validation Description
- Patient's home country should not be blank.

PATIENT'S HOME CITY/TOWN

Definition
The patient's city or town of residence.

Allowed Values
- Five-digit numeric FIPS code. See Appendix D.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- All home address elements are reported to VSTR.

Validation Description
- Patient's home city/town should not be blank.

ALTERNATE HOME RESIDENCE

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

Allowed Values
- Undocumented Citizen
- Migrant Worker
- Homeless

Null Values Allowed
- Not Applicable

Multiple Entry
- Yes

Notes
- Only reported when zip/postal code is "Not Applicable".
- Homeless is defined as a person who lacks housing, including a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- An undocumented citizen is defined as a national of another country who has entered or stayed in the US without permission.
- A migrant worker is defined as a person who temporarily leaves his/her principal country of residence to accept seasonal employment in a different country.
- The null value "Not Applicable" should be reported if Patient's Home zip/postal code is documented.

Validation Description
- Alternate home residence should not be blank.

INJURY INFORMATION

INJURY DATE

Definition
The date the injury occurred.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- Collected as YYYY-MM-DD.
- Estimates of date of injury should be based upon report by patient, witness, family, or healthcare provider. Other proxy measures (e.g., 911 call times) should not be reported.
- The null value "Not known/Not recorded" should be reported if an estimated date of injury is unavailable.

Validation Description
- Injury date should not be blank.

INJURY TIME

Definition
The time the injury occurred.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not known/Not recorded

Multiple Entry
- No

Notes
- Collected as HH:MM military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be reported.
- The null value "Not known/Not recorded" should be reported if an estimated time of injury is unavailable.

Validation Description
- Injury time should not be blank.

ICD-10 LOCATION CODE

Definition
Place of occurrence external cause code used to describe the place where the injury occurred (Y92.x).

Allowed Values
- Relevant ICD-10-CM code value for injury.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Only ICD-10-CM codes are accepted.

Validation Description
- ICD-10 location code should not be blank.

PROTECTIVE DEVICES

Definition
Protective devices (safety equipment) used by the patient at the time of injury during a motor vehicle incident.

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

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Evidence of the use of safety may be reported or observed.
- A motor vehicle incident is categorized as a traffic accident and/or non-traffic accident (i.e., a tree falling on an occupied vehicle while parked is considered a non-traffic accident).
- If "Child Restraint" is reported, report element "Child Specific Restraint".
- If "Airbag" is reported, report element "Airbag Deployment".
- Lap Belt must be reported to include those patients that are restrained but not further specified.
- If the documentation indicates "3-point-restraint," report Element Values "Lap Belt" and "Shoulder Belt".
- If documented that a "Child Restraint (booster or child/infant car seat)" was used or worn, but not properly fastened onto the child or into the car, report allowed value "none".
- If the ED/hospital chart indicates "3-point-restraint", report allowed value "seatbelt – lap and shoulder".

Validation Description
- Protective Devices should not be blank.

CHILD SPECIFIC RESTRAINT

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

Allowed Values
- Child Car seat
- Infant Car Seat
- Child Booster Seat

Null Values Allowed
- Not Applicable

Multiple Entry
- Yes

Notes
- Evidence of the use of a child restraint may be reported or observed.
- Only reported when element “Protective Devices” include “Child Restraint (booster seat or child car seat)”.
- The null value “Not Applicable” is reported if allowed value “Child Restraint” is not reported for element “Protective Devices”.

Validation Description
- Child Specific Restraint should not be blank.

AIRBAG DEPLOYMENT

Definition
Indication of airbag deployment during a motor vehicle crash.

Allowed Values
- Airbag Not Deployed
- Airbag Deployed Front
- Airbag Deployed Side
- Airbag Deployed Other (knee, airbelt, curtain, etc.)

Null Values Allowed
- Not Applicable

Multiple Entry
- Yes

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

Validation Description
- Airbag Deployment should not be blank.

INCIDENT ZIP CODE

Definition
The ZIP code of the incident location.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Can be stored as a 5- or 9-digit code (i.e., XXXXX or XXXXX-XXXX) for the US and Canada or can be stored in the postal code format of the applicable country.
- If the country in which the incident occurred is not the US, report the null value "not applicable".
- If patient is a “walk in” and cannot answer this question, please use null value “Not Known/Not Recorded”.

Validation Description
- Incident Zip Code should not be blank.

INCIDENT CITY/TOWN

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

Allowed Values
- Five-digit numeric FIPS code. See Appendix D.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- All incident location elements are reported to VSTR.
- If the patient's country is not the US, report the null value "not applicable".
- If patient is a "walk in" and cannot answer this question, please use null value "Not Known/Not Recorded".
- If incident location resides outside of formal city boundaries, report nearest city/town.

Validation Description
- Incident City should not be blank.

INCIDENT STATE

Definition
The state, territory, province, or district where the patient was found or to which the unit responded.

Allowed Values
- Two-digit numeric FIPS code. See Appendix A.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- If the country in which the incident occurred is not the US, report the null value "not applicable".
- If patient is a “walk in” and cannot answer this question, please use null value “Not Known/Not Recorded”.

Validation Description
- Incident State should not be blank.

INCIDENT COUNTY

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

Allowed Values
- Three-digit numeric FIPS code. See Appendix B.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- If the county in which the incident occurred is not the US, report the null value "not applicable".
- If patient is a “walk in” and cannot answer this question, please use null value “Not Known/Not Recorded”.

Validation Description
- Incident County should not be blank.

INCIDENT COUNTRY

Definition
The country where the incident occurred.

Allowed Values
- Two-digit alpha country code. See Appendix C.

Null Values Allowed
- No

Multiple Entry
- No

Validation Description
- Incident Country should not be blank.

WORK-RELATED

Definition
Indication of whether the injury occurred during paid employment.

Allowed Values
- Yes
- No

Null Values Allowed
- No

Multiple Entry
- No

Notes
- If work related = yes, “patient's occupational industry” and “patient's occupation” must be reported.

Validation Description
- Work-related should not be blank.

PATIENT'S OCCUPATION

Definition
The occupation of the patient.

Allowed Values
- Business and Financial Operations Occupations
- Architecture and Engineering Occupations
- Community and Social Services Occupations
- Education, Training and Library Occupations
- Healthcare Practitioners and Technical Occupations
- Protective Service Occupations
- Building and Grounds Cleaning Maintenance Occupations
- Sales and Related Occupations
- Farming, Fishing and Forestry Occupations
- Installation, Maintenance and Repair Occupations
- Transportation and Material Moving Occupations
- Management Occupations
- Computer and Mathematical Occupations
- Life, Physical and Social Science Occupations
- Legal Occupations
- Arts, Designs, Entertainment, Sports and Media Occupations
- Healthcare Support Occupations
- Food Preparation and Serving-Related Occupations
- Personal Care and Service Occupations
- Office and Administrative Support Occupations
- Construction and Extraction Occupations
- Production Occupations
- Military–Specific Occupations

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- Only reported if injury is work-related.
- If work related, also report "patient's occupational industry".
- The null value "Not Applicable" should be reported if "Work-related" value is "no".

Validation Description
- Patient's Occupation should not be blank.

PATIENT'S OCCUPATIONAL INDUSTRY

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

Allowed Values
- Finance, Insurance, and Real Estate
- Manufacturing
- Retail Trade
- Transportation and Public Utilities
- Agriculture, Forestry, Fishing
- Professional and Business Services
- Education and Health Services
- Construction
- Government
- Natural Resources and Mining
- Information Services
- Wholesale Trade
- Leisure and Hospitality
- Other services

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- If work related, also report Patient's Occupation.
- The null value "Not Applicable" should be reported if Work-Related value is "no".
- Based upon US Bureau of Labor Statistics Industry Classification.

Validation Description
- Patient's Occupational Industry should not be blank.

PRIMARY ICD-10-CM MECHANISM OF INJURY

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

Allowed Values
- Relevant ICD-10-CM code value for the injury event.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- The Primary ICD-10-CM Mechanism of Injury should describe the main reason a patient is seen for care.
- Activity codes should not be reported in this 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 should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm. 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, child and adult abuse, and terrorism.

Validation Description
- Primary ICD-10-CM Mechanism of Injury should not be blank.

SECONDARY ICD-10-CM MECHANISM OF INJURY

Definition
Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple External Cause Codes are required to describe the injury event.

Allowed Values
- Relevant ICD-10-CM code value for the cause of injury.

Null Values Allowed
- Not Applicable

Multiple Entry
- Yes

Notes
- Report all that apply (maximum 2).
- Activity codes should not be reported in this element.
- The null value "Not Applicable" should be reported if no additional external cause codes are documented.
- 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, 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.

Validation Description
- Secondary ICD-10-CM Mechanism of Injury should not be blank.

INJURY TYPE*

Definition
The primary source of the trauma injury sustained by the patient.

Allowed Values
- Blunt
- Penetrating
- Burn
- Other

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the source of the injury is unable to be identified.
- If more than one injury occurred, the injury type should correspond with the primary ICD-10 mechanism code chosen.

Validation Description
- Injury Type should not be blank.

INJURY MECHANISM*

Definition
The method by which damage (trauma) to the skin, muscles, organs, and bones happens.

Allowed Values
- Motor Vehicle Crash (MVC)
- Fall Under 1m (3.3 ft)
- Fall 1m – 6m (3.3 – 19.7 ft)
- Fall Over 6m (19.7 ft)
- Fall – Not Further Specified (NFS)
- Assault
- Motorcycle
- Pedestrian
- Bicycle
- Other Blunt Mechanism
- Knife
- Handgun
- Shotgun
- Other Gun
- Glass
- Biting
- Other Penetrating Mechanism
- Chemical Burn
- Inhalation Burn
- Thermal Burn
- Electrical Burn
- Other Burn Mechanism

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Notes
- The null value "Not Known/Not Recorded" should be reported if the method of injury is unable to be identified.
- The null value "Not Applicable" should be reported if there is no injury.

Multiple Entry
- Yes

Validation Description
- Injury Mechanism should not be blank.

PRE-HOSPITAL INFORMATION

TRANSPORT MODE

Definition
The method of transport delivering the patient to the hospital.

Allowed Values
- Ground Ambulance
- Helicopter Ambulance
- Fixed-wing Ambulance
- Water Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Other

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Other transport modes to the hospital (outside of the allowed values), should be listed as “other”.

Validation Description
- Transport Mode should not be blank.

OTHER TRANSPORT MODES TO YOUR HOSPITAL

Definition
All other methods of transport used during the patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital.

Allowed Values
- Ground Ambulance
- Helicopter Ambulance
- Fixed-wing Ambulance
- Water Ambulance
- Private/Public Vehicle/Walk-in
- Police
- Other

Null Values Allowed
- Not Applicable

Multiple Entry
- Yes

Notes
- Incidents with unspecified modes of transport reported should be documented as "other".
- The null value "Not Applicable" should be reported when the patient had a single method of transport.
- Report all that apply.

Validation Description
- Other Transport Methods to Your Hospital should not be blank.

TRANSPORTING EMS AGENCY*

Definition
The EMS Agency that delivered the patient to the hospital.

Allowed Values
- Appropriate Virginia EMS Agency code.

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.

Validation Description
- Transporting EMS Agency should not be blank.

PATIENT CARE REPORT NUMBER*

Definition
The EMS Agency patient care report number.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- The null value "Not Applicable" should be reported if the patient was not transported by an EMS agency.

Validation Description
- Patient Care Report Number should not be blank.

CALL DISPATCH DATE*

Definition
The date the EMS unit transporting the patient to the hospital was notified by dispatch.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as YYYY-MM-DD.
- For interfacility transfer patients, this is the date on which the EMS unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Call Dispatch Date should not be blank.

CALL DISPATCH TIME*

Definition
The time the EMS unit transporting the patient to the hospital was notified by dispatch.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as HH:MM military time.
- For interfacility transfer patients, this is the date on which the EMS unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Call Dispatch Time should not be blank.

ARRIVED AT LOCATION DATE*

Definition
The date the EMS unit transporting the patient to the hospital arrived on the scene/at the transferring facility.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as YYYY-MM-DD.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Arrived at Location Date should not be blank.

ARRIVED AT LOCATION TIME*

Definition
The time the EMS unit transporting the patient to the hospital arrived on the scene/at the transferring facility.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as HH:MM military time.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Arrived at Location Time should not be blank.

DEPARTED LOCATION DATE*

Definition
The date the EMS unit transporting the patient to the hospital left the scene/transferring facility.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as YYYY-MM-DD.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Departed Location Date should not be blank.

DEPARTED LOCATION TIME*

Definition
The time the EMS unit transporting the patient to the hospital left the scene/transferring facility.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Collected as HH:MM military time.
- Only required if the “Transport Mode” is “Ground Ambulance”, “Helicopter Ambulance”, “Fixed-Wing Ambulance” or “Water Ambulance”.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Departed Location Time should not be blank.

TRAUMA TRIAGE RED CRITERIA*

Definition

Physiologic and anatomic EMS trauma triage criteria for transport to a Level 1 or 2 trauma center available within the geographic constraints of the region, 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 EMS run report.

Allowed Values

- Injury Patterns
    - Penetrating injuries to head, neck, torso, and proximal extremities.
    - Skull deformity, suspected skull fracture.
    - Suspected spinal injury with new motor or sensory loss.
    - Chest wall instability or deformity, or suspected flail chest.
    - Suspected pelvic fracture.
    - Suspected fracture of two or more proximal long bones
    - Crushed, degloved, mangled or pulseless extremity
    - Amputation proximal to wrist or ankle
    - Active bleeding requiring a tourniquet or wound packing with continuous pressure
- Mental Status & Vital Signs
    - All Patients:
        - Unable to follow commands (motor GCS < 6)
        - RR < 10 or > 29 breaths/min
        - Respiratory distress or need for respiratory support
        - Room-air pulse oximetry < 90%
    - Age 0—9 Years:
        - SBP < 70mm Hg + (2 x age in years) OR tachycardia with signs of poor perfusion
    - Age 10—64 Years:
        - SBP < 90mm Hg or
        - HR > SBP
    - Age ≥ 65 years:
        - SBP < 110mm Hg or
        - HR > SBP

Null Values

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- Yes

Notes

- Allowed Values must be determined by the EMS provider and must not be assigned by the hospital.
- The null value "Not Applicable" should be reported if the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if the EMS Run Report indicates the patient did not meet any Trauma Triage Red Criteria.
- The null value "Not Known/Not Recorded" should be reported if the information captured on the EMS run report is not an exact match with one of the “allowed values” (above) or if the EMS run report is not available.
- Allowed values for this element are available in the “Trauma Center Criteria (einjury.03)” field of the EMS run report.
- Report all that apply.

Validation Description

- Trauma Triage Red Criteria should not be blank.

TRAUMA TRIAGE YELLOW CRITERIA*

Definition

EMS trauma triage mechanism of injury criteria for transport to a trauma center within the geographical constraints of the region, 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 EMS Run Report.

Allowed Values

- High-Risk Auto Crash
    - Partial or complete ejection
    - Significant intrusion (including roof)
        - > 12 inches occupant site OR
        - > 18 inches any site OR
        - Need for extrication for entrapped patient
    - Death in passenger compartment
    - Child (age 0-9 years) unrestrained or in unsecured child safety seat.
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, runover, or with significant impact.
- Fall from height > 10 feet (all ages)

Null Values

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- Yes

Notes

- Allowed Values must be determined by the EMS provider and must not be assigned by the hospital.
- The null value "Not Applicable" should be reported if the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if the EMS Run Report indicates the patient did not meet any Trauma Triage Yellow Criteria.
- The null value "Not Known/Not Recorded" should be reported if the information captured on the EMS run report is not an exact match with one of the “allowed values” (above) or if the EMS run report is not available.
- Allowed values for this element are available in the “Vehicular, Pedestrian, or Other Injury Risk Factor (einjury.04)” field of the EMS run report.
- Report all that apply.

Validation Description

- Trauma Triage Yellow Criteria should not be blank.

TRAUMA TRIAGE BURN CRITERIA*

Definition

EMS trauma triage mechanism of injury criteria for transport to a designated burn center available within the geographic constraints of the region, 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 EMS Run Report.

Allowed Values

- Partial thickness burns, greater than 10% TBSA
- Burns to the face, hands, feet, genitalia, perineum, or major joints
- Third degree burns in any age group
- Electrical burns, including lightning injury
- Chemical burns
- Inhalation injury
- Burn injury in patients with preexisting medical conditions
- Burn injuries involving children in hospitals without qualified personnel or equipment to care for children
- Burn injuries in patients that will require special social, emotional, or rehabilitative intervention
- Burn injuries with concomitant trauma injuries (i.e., fractures)

Null Values

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- Yes

Notes

- Allowed Values must be determined by the EMS provider and must not be assigned by the hospital.
- The null value "Not Applicable" should be reported if the patient did not arrive by EMS.
- The null value "Not Applicable" should be reported if the EMS Run Report indicates the patient did not meet any Trauma Triage Burn Criteria.
- The null value "Not Known/Not Recorded" should be reported if the information captured on the EMS run report is not an exact match with one of the “allowed values” (above) or if the EMS run report is not available.
- Report all that apply.

Validation Description

- Trauma Triage Burn Criteria should not be blank.

INTIAL FIELD SYSTOLIC BLOOD PRESSURE*

Definition
First recorded systolic blood pressure measured at the scene of injury.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who received CPR or any type of mechanical chest compressions, report the value obtained while compressions were paused.
- The null value "Not Applicable" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field systolic blood pressure was NOT measured at the scene of injury.

Validation Description
- Initial Field Systolic Blood Pressure should not be blank.

INITIAL FIELD PULSE RATE*

Definition
First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value “Not Applicable” should be reported for patients whom method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field pulse rate was NOT measured at the scene of injury.

Validation Description
- Initial Field Pulse Rate should not be blank.

INITIAL FIELD RESPIRATORY RATE*

Definition
First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- The null value “Not Applicable” should be reported for patients whom method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field respiratory rate was NOT measured at the scene of injury.

Validation Description
- Initial Field Respiratory Rate should not be blank.

INITIAL FIELD OXYGEN SATURATION*

Definition
First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value “Not Applicable” should be reported for patients whom method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field oxygen saturation was NOT measured at the scene of injury.

Validation Description
- Initial Field Oxygen Saturation should not be blank.

INITIAL FIELD GLASGOW COMA SCORE (GCS) – EYE*

Definition
First recorded Glasgow Coma Score (Eye) measured at the scene of injury.

Allowed Values
- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- If the patient does not have a numeric GCS (eye) 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., if 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” should be reported for patients whom method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field GCS – eye was NOT measured at the scene of injury.

Validation Description
- Initial Field Glasgow Coma Score (GCS) -- Eye should not be blank.

INITIAL FIELD GCS – VERBAL*

Definition
First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

Allowed Values

Pediatric (≤ 2 years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follows objects, interacts

Adult

- No verbal response
- Incomprehensible sounds
- Inappropriate words
- Confused
- Oriented

Null Values Allowed

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- No

Notes

- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- If the patient is intubated, then the GCS verbal is equal to 1.
- If the patient does not have a numeric GCS 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., if 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" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field GCS – verbal was NOT measured at the scene of injury.

Validation Description

- Initial Field GCS -- Verbal should not be blank.

INITIAL FIELD GCS – MOTOR*

Definition
First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

Allowed Values

Pediatric (≤ 2 years):

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Appropriate response to stimulation

Adult

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Obeys commands

Null Values Allowed

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- No

Notes

- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- If the patient does not have a numeric GCS (motor) 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., if 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" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field GCS – motor was NOT measured at the scene of injury.

Validation Description

- Initial Field GCS – Motor should not be blank.

INITIAL FIELD GCS – TOTAL*

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.
- If the patient does not have a numeric GCS (total), but there is documentation related to their level of consciousness (e.g., “AAOx3”, “awake alert and oriented”, “patient with normal mental status”), interpret this as GCS of 15 IF there is no other contradicting documentation.
- The null value "Not Applicable" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value “Not Known/Not Recorded” should be reported if the patient’s first recorded initial field GCS – total was NOT measured at the scene of injury.

Validation Description
- Initial Field GCS – Total should not be blank.

PREHOSPITAL PROCEDURES*

Definition
The procedures performed on the patient at the scene of injury.

Allowed Values

- None
- Airway – Nasal
- Airway Opened or Cleared
- Airway – Oral
- Arterial Line Maintenance
- Assisted Ventilation
- Bag Valve Mask
- Blood Draw
- Blood Glucose Analysis
- Cardiac Monitor
- Childbirth
- CNS Catheter
- Combitube
- CPR
- Cricothyrotomy
- Decontamination
- Defibrillation – Automated
- Defibrillation – Manual
- Defibrillation – NFS
- Endotracheal Tube – Nasal
- Endotracheal Tube – Oral
- Endotracheal Tube Route Not Recorded
- Esophageal Obturator Airway
- Extrication
- Intraosseous Access or Infusion
- Intravenous Fluids
- LT Blind Insertion Airway Device
- Nasogastric Tub
- Pericardiocentesis
- Pharmacological Restraints
- Physical Restraints
- Rapid Sequence Intubation
- Spinal Immobilization
- Splinting
- Thoracostomy – Needle
- Traction
- Venous Access
- Ventilator
- Wound Care
- Other
- Tourniquet

Null Values Allowed

- Not Applicable
- Not Known/Not Recorded

Multiple Entry

- Yes

Notes

- The null value "Not Applicable" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description

- Prehospital Procedures should not be blank.

PREHOSPITAL MEDICATIONS*

Definition
The medications administered to the patient at the scene of injury (See appendix E).

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not applicable
- Not Known/Not Recorded

Multiple Entry
- Yes

Notes
- The null value "Not Applicable" should be reported for patients whose method of transport is private/public vehicle/walk-in, police, public safety or other.
- The null value "Not Known/Not Recorded" should be reported if the patient is transported to the facility by EMS, but no EMS Run Report was available from the scene of injury.

Validation Description
- Prehospital Medications should not be blank.

PRE-ARRIVAL CARDIAC ARREST

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- 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 prior to arrival to your hospital, even if it occurred at a transferring institution.
- The null value “Not Known/Not Recorded” is only reported if it’s not indicated on the EMS report.

Validation Description
- Pre-Arrival Cardiac Arrest should not be blank.

REFERRING FACILITY INFORMATION

TRANSFER IN*

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

Allowed Values
- Yes
- No

Null Values Allowed
- No

Multiple Entry
- No

Notes
- Patients transferred from a private doctor's office, stand-alone ambulatory surgery center, urgent care center, or delivered to your hospital by a non-EMS transport are not considered interfacility transfers.
- Facilities providing emergency care services or utilized to stabilize a patient, such as freestanding Eds, are considered acute care facilities.

Validation Description
- Transfer In should not be blank.

FACILITY TRANSFERRED FROM*

Definition
The assigned code number of the hospital from which the patient was transferred to the hospital.

Allowed Values
- Hospital code assigned by VDH Office of EMS.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Validation Description
- Facility Transferred From should not be blank.

EMERGENCY DEPARTMENT INFORMATION

ED/HOSPITAL ADMITTED DATE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

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

Validation Description
- ED Departure/Admitted Date should not be blank.

ED/HOSPITAL ADMITTED TIME

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- No

Multiple Entry
- No

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

Validation Description
- ED Departure/Admitted Time should not be blank.

HIGHEST ACTIVATION [Trauma Center only] *

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

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

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- The null value “Not applicable” should only be used for non-trauma centers.

Validation Description
- Highest Activation should not be blank.

ED DISCHARGE DISPOSITION

Definition
Where the patient was discharged to from the ED.

Allowed Values
Inpatient

- Operating Room
- Intensive Care Unit (ICU)
- Floor bed (general admission, non-specialty unit bed)
- Telemetry/step-down unit (less acuity than ICU)
- Observation Unit
- Burn Unit
- Home without services
- Home with Services
- Left against medical advice
- Deceased/expired
- Other (jail, institutional care, mental health, etc.)
- Transferred to another hospital

Null Values Allowed

- Not Applicable

Multiple Entry

- No

Notes

- The null value "Not Applicable" should be reported if the patient is directly admitted to the hospital.
- If multiple orders were written, report the final disposition order.

Validation Description

- ED Discharge Disposition should not be blank or unknown.

ED DEPARTURE ORDER DATE

Definition
The date the order was written for the patient to be discharged from the ED.

Allowed Values
- Relevant value for the data element.

Null Values
- Not Applicable

Multiple Entry Allowed
- No

Notes
- Collected as YYYY-MM-DD.
- The null value "Not Applicable" should be reported if the patient is directly admitted to the hospital.

Validation Description
- ED Departure Order Date should not be blank.

ED DEPARTURE ORDER TIME

Definition
The time the order was written for the patient to be discharged from the ED.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- Collected as HH:MM military time.
- The null value "Not Applicable" should be reported if the patient is directly admitted to the hospital.

Validation Description
- ED Departure Order Time should not be blank.

INITIAL ED/HOSPITAL TEMPERATURE

Definition
First recorded temperature in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Recorded in degrees Celsius/centigrade.
- The null value “Not Known/Not Recorded” should be reported if the patient temperature was not recorded within 30 minutes of arriving to the ED/hospital.
- Please note that the initial ED/hospital temperature does not have to be from the first recorded set of hospital vitals.

Validation Description
- Initial ED/Hospital Temperature should not be blank.

INITIAL ED/HOSPITAL WEIGHT

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Recorded in kilograms.
- May be based on family or self-report.
- Please note that the initial ED/hospital weight does not have to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient weight was not measured within 24 hours or less of ED/hospital arrival.

Validation Description
- Initial ED/Hospital Weight should not be blank.

INITIAL ED/HOSPITAL HEIGHT

Definition
The patient's recorded height.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Recorded in centimeters.
- The null value "Not Known/Not Recorded" should be reported if initial ED/hospital height was not documented.
- May be based on family or self-report.
- Please note that the initial ED/hospital height does not have to be from the first recorded set of hospital vitals.

Validation Description
- Initial ED/Hospital Height should not be blank.

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Please note that the Initial ED/Hospital Systolic Blood Pressure does not have to be from the first recorded set of hospital vitals.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who received CPR or any type of mechanical chest compressions, report the value obtained while compressions were paused.
- The null value “Not Known/Not Recorded” should be reported if the patient’s systolic blood pressure was not recorded within 30 minutes of arriving to the ED/hospital.

Validation Description
- Initial ED/Hospital Systolic Blood Pressure should not be blank.

INITIAL ED/HOSPITAL PULSE RATE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Please note that the Initial ED/Hospital Pulse Rate does not have to be from the first recorded set of hospital vitals.
- Measurement reported must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who received CPR or any type of mechanical chest compressions, report the value obtained while compressions were paused.
- The null value “Not Known/Not Recorded” should be reported if the patient’s pulse rate was not recorded within 30 minutes of arriving to the ED/hospital.

Validation Description
- Initial ED/Hospital Pulse Rate should not be blank.

INITIAL ED/HOSPITAL RESPIRATORY RATE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Only reported if Initial ED/Hospital Respiratory Rate is documented.
- Please note that the initial ED/hospital unassisted respiratory rate does not have to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient respiratory rate was not recorded within 30 minutes of arriving to the ED/hospital.

Validation Description
- Initial ED/Hospital Respiratory Rate should not be blank.

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition
Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.

Allowed Values
- Unassisted Respiratory Rate
- Assisted Respiratory Rate

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- 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 the initial ED/hospital assisted respiratory rate does not have to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient respiratory Assistance was not recorded within 30 minutes of arriving to the ED/hospital.

Validation Description
- Initial ED/Hospital Respiratory Assistance should not be blank.

INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition
First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- Initial ED/hospital oxygen saturation should be expressed as a percentage.
- If documented, report additional element: Initial ED/Hospital Supplemental Oxygen.
- The null value “Not Known/Not Recorded” should be reported if the patient’s oxygen saturation was not recorded within 30 minutes of arriving to the ED/hospital.
- Please note that the initial ED/hospital oxygen saturation does not need to be from the first recorded set of hospital vitals.

Validation Description
- Initial ED/Hospital Oxygen Saturation should not be blank.

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition
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.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if the patient supplemental oxygen was not recorded within 30 minutes of arriving to the ED/hospital.
- Please note that the initial ED/hospital supplemental oxygen does not need to be from the first recorded set of hospital vitals.

Validation Description
- Initial ED/Hospital Supplemental Oxygen should not be blank.

INITIAL ED/HOSPITAL GCS – EYE

Definition
First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

Allowed Values
- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- If the patient does not have a numeric GCS (eye) 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., if the chart indicates "patient's pupils are PERRL", an GCS Eye of 4 may be recorded IF there is no other contradicting documentation).
- Please note that the initial ED/hospital GCS – eye does not need to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient GCS (eye) was not measured within 30 minutes or less of ED/hospital arrival.

Validation Description
- Initial ED/Hospital GCS – Eye should not be blank.

INITIAL ED/HOSPITAL GCS – VERBAL

Definition
First recorded Glasgow Coma Score (Verbal) within 30 minutes or less of ED/hospital arrival.

Allowed Values

Pediatric (≤ 2 years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follows objects, interacts

Adult

- No verbal response
- Incomprehensible sounds
- Inappropriate words
- Confused
- Oriented

Null Values Allowed

- Not Known/Not Recorded

Multiple Entry

- No

Notes

- If the patient is intubated, then the GCS Verbal score is equal to 1.
- If the patient does not have a numeric GCS (verbal) 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., if the chart indicates "patient is oriented to person place and time", a GCS Verbal of 5 may be recorded IF there is no other contradicting documentation).
- Please note that the initial ED/hospital GCS – verbal does not need to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient GCS (verbal) was not measured within 30 minutes or less of ED/Hospital arrival.

Validation Description

- Initial ED/Hospital GCS – Verbal should not be blank.

INITIAL ED/HOSPITAL GCS – MOTOR

Definition
First recorded Glasgow Coma Score (Motor) within 30 minutes or less of ED/hospital arrival.

Allowed Values

Pediatric (≤ 2 years):

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Appropriate response to stimulation

Adult

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Obeys commands

Null Values Allowed

- Not Known/Not Recorded

Multiple Entry

- No

Notes

- If the patient does not have a numeric GCS (motor) 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., if the chart indicates "patient withdraws from a painful stimulus", a GCS Motor of 4 may be recorded IF there is no other contradicting documentation).
- Please note that the initial ED/hospital GCS – motor does not need to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if the patient GCS (motor) was not measured within 30 minutes or less of ED/Hospital arrival.

Validation Description

- Initial ED/hospital GCS – Motor should not be blank.

INITIAL ED/HOSPITAL GCS – TOTAL

Definition
First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- If the patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness (e.g., "AAOx3", "awake alert and oriented", "patient with normal mental status"), interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that the initial ED/hospital GCS – total does not need to be from the first recorded set of hospital vitals.
- The null value “Not Known/Not Recorded” should be reported if GCS (eye), GCS (motor), and GCS (verbal) were not measured within 30 minutes or less of ED/Hospital arrival.

Validation Description
- Initial ED/Hospital GCS – Total should not be blank.

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

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

Allowed Values
- Patient Chemically Sedated or Paralyzed
- Obstruction to the Patient's Eye
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- Yes

Notes
- 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 (e.g., ETOH, prescriptions).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis) atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that the initial ED/hospital GCS assessment qualifiers does not need to be from the first recorded set of hospital vitals.
- Report all that apply.
- The null value “Not Known/Not Recorded” should be reported if GCS assessment qualifiers are not documented within 30 minutes or less of ED/Hospital arrival.

Validation Description
- Initial ED/Hospital GCS Assessment Qualifiers should not be blank.

WARMING MEASURES*

Definition
Determine if warming measures were used.

Allowed Values
- No warming measures
- Warming Measures Applied

Null Values Allowed
- Not Known/Not Recorded

Multiple Entry
- No

Notes
- The null value "Not Known/Not Recorded" should be reported if warming measures were not documented.

Validation Description
- Warming Measures should not be blank.

ALCOHOL SCREEN

Definition

Did the patient test positive for alcohol consumption by a blood alcohol concentration test (BAC) within 24 hours of first hospital encounter?

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Multiple Entry

- No

Notes

- Report BAC results within 24 hours of first hospital encounter, at either your facility or the transferring facility.
- The null value "Not Applicable" should be reported for those patients who were not tested.

Validation Description

- Alcohol Screen should not be blank.

ALCOHOL SCREEN RESULTS (ETOH/BAC Level)

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- Collect as X.XX grams per deciliter (g/dl).
- Negative BAC results should be recorded as 0.00
- Report BAC results within 24 hours of first hospital encounter, at either your facility or the transferring facility.
- The null value “Not Applicable” should be reported for those patients who were not tested.

Validation Description
- Alcohol Screen Results (ETHOH/BAC Level) should not be blank.

DRUG SCREEN

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

Allowed Values
- AMP (Amphetamine)
- BAR (Barbiturate)
- BZO (Benzodiazepines)
- COC (Cocaine)
- mAMP (Methamphetamine)
- MDMA (Ecstasy)
- MTD (Methadone)
- OPI (Opioid)
- OXY (Oxycodone)
- PCP (Phencyclidine)
- TCA (Tricyclic Antidepressant)
- THC (Cannabinoid)
- Other
- None
- Not Tested

Null Values Allowed
- No

Multiple Entry
- Yes

Notes
- Select all that apply.
- Report drug screen results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- "None" should be reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating the patient during this event/incident, or for patients who were tested and had no positive results.
- If multiple drugs are detected, only report drugs that were NOT administered at any facility (or setting) treating the patient during this event/incident.

Validation Description
- Drug Screen should not be blank.

PRIMARY TRAUMA SERVICE TYPE

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

Allowed Values
- Adult
- Pediatric

Null Values Allowed
- No

Multiple Entry
- No

Notes
- The primary service type responsible for trauma evaluation and care of the patient.
- Adult trauma centers that do not have a separate pediatric service must report allowed value "Adult".
- Pediatric trauma centers that do not have a separate adult service must report allowed value "Pediatric".

Validation Description
- Primary Trauma Service Type should not be blank.

HOSPITAL PROCEDURE INFORMATION

ICD-10-CM HOSPITAL PROCEDURES

Definition

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 VSTR.

Allowed Values

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

Null Values Allowed

- Not Applicable

Multiple Entry

- Yes

Notes

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

DIAGNOSTIC AND THERAPEUTIC IMAGING

Computerized tomographic Head*
Computerized tomographic Chest*
Computerized tomographic Abdomen*
Computerized tomographic Pelvis*
Computerized tomographic C-Spine*
Computerized tomographic T-Spine*
Computerized tomographic L-Spine*
Ultrasound (includes FAST) *
Angioembolization
Angiography
IVC filter
REBOA

CARDIOVASCULAR

Open cardiac massage
CPR

CNS

Insertion of ICP monitor*
Ventriculostomy*
Cerebral oxygen monitoring*

GENITOURINARY

Ureteric catheterization (i.e., ureteric stent)
Suprapubic cyctostomy

MUSCULOSKELETAL

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

TRANSFUSION

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

RESPIRATORY

Insertion of endotracheal tube* (exclude intubations performed in the OR)

RESPIRATORY (continued)

Continuous mechanical ventilation*
Chest tube*
Bronchoscopy
Tracheostomy

GASTROINTESTINAL

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

Validation Description

- ICD-10-CM Hospital Procedures should not be blank.

HOSPITAL PROCEDURE START DATE

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

Multiple Entry
- Yes

Notes
- The null value "Not Applicable" should be reported if the patient did not have procedures.
- The null value "Not Known/Not Recorded" should be reported if the procedure date was not recorded.
- Collected as YYYY-MM-DD.

Validation Description
- Hospital Procedure Start Date should not be blank.

HOSPITAL PROCEDURE START TIME

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

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

Multiple Entry
- Yes

Notes
- The null value "Not Applicable" should be reported if the patient did not have procedures.
- The null value "Not Known/Not Recorded" should be reported if the procedure time was not recorded.
- Collected as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).

Validation Description
- Hospital Procedure Start Time should not be blank.

PRE-EXISTING CONDITIONS

ADVANCED DIRECTIVE LIMITING CARE

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded

Notes

- The written request was signed/dated by the patient and/or the patient's designee prior to arrival at your center.
- 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).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).
- Report value “No” for patients with Advance Directives that did not limit life-sustaining treatments during this patient care event.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Validation Description

- Pre-existing conditions should not be blank.

ALCOHOL USE DISORDER

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded
- Not Applicable

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

ANTICOAGULANT THERAPY

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

See Appendix E for listing of medications used in anticoagulant therapy, by both generic and brand names.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

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

Validation Description
- Pre-existing conditions should not be blank.

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

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- Present prior to injury.
- A diagnosis of ADD/ADHD 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.

Validation Description
- Pre-existing conditions should not be blank.

BIPOLAR I/II DISORDER

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

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

Validation Description
- Pre-existing conditions should not be blank.

BLEEDING DISORDER

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

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

Validation Description
- Pre-existing conditions should not be blank.

CEREBRAL VASCULAR ACCIDENT (CVA)

Definition
A cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- 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.

Validation Description
- Pre-existing conditions should not be blank.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Definition

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.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded
- Not Applicable

Notes

- Present prior to injury.
- A diagnosis of COPD must be documented in the patient's medical record.
- Only report on patients ≥15 years old.
- The null value "Not Applicable" must be reported for patients <15 years old.
- The null value "Not Known/Not Recorded" is only reported if no past medical history is available for patients ≥15 years old.

Validation Description

- Pre-existing conditions should not be blank.

CHRONIC RENAL FAILURE

Definition
Chronic renal failure requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- 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.

Validation Description
- Pre-existing conditions should not be blank.

CIRRHOSIS

Definition

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.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

CONGENITAL ANOMALIES

Definition
Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly present at birth.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

Notes
- 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 old.
- The null value "Not Applicable" must be reported for patients ≥15 years old.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients <15 years old.

Validation Description
- Pre-existing conditions should not be blank.

CONGESTIVE HEART FAILURE (CHF)

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

CURRENT SMOKER

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- Present prior to injury.
- Exclude patients who only smoke cigars or pipes.
- Exclude patients who report only using smokeless tobacco (e.g., chewing tobacco, snuff), e-cigarettes/vape products, or other nicotine products.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Validation Description
- Pre-existing conditions should not be blank.

CURRENTLY RECEIVING CHEMOTHERAPY FOR CANCER

Definition
A patient who was receiving any chemotherapy treatment for cancer when injury occurred.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- 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.

Validation Description
- Pre-existing conditions should not be blank.

DEMENTIA

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- 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.

Validation Description
- Pre-existing conditions should not be blank.

DIABETES MELLITUS

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

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

Validation Description
- Pre-existing conditions should not be blank.

DISSEMINATED CANCER

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- 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.

Validation Description
- Pre-existing conditions should not be blank.

FUNCTIONALLY DEPENDENT HEALTH STATUS

Definition

Patients whom, because of cognitive or physical limitations relating to a pre-existing medical condition, are partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living. Pre-injury functional status may be represented by the ability of the patient to complete age-appropriate activities of daily living.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded

Notes

- Present prior to injury.
- Activities of Daily Living include bathing, feeding, dressing, toileting, and walking.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Validation Description

- Pre-existing conditions should not be blank.

HYPERTENSION

Definition
History of persistent elevated blood pressure requiring antihypertensive medication.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

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

Validation Description
- Pre-existing conditions should not be blank.

MAJOR DEPRESSIVE DISORDER

Definition
A major depressive disorder diagnosis documented in the medical record.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

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

Validation Description
- Pre-existing conditions should not be blank.

MYOCARDIAL INFRACTION (MI)

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- Present prior to injury.
- A diagnosis of myocardial infarction 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.

Validation Description
- Pre-existing conditions should not be blank.

OTHER MENTAL/PERSONALITY DISORDERS

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded
- Not Applicable

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

PERIPHERAL ARTERIAL DISEASE (PAD)

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded
- Not Applicable

Notes

- Present prior to injury.
- A diagnosis of Peripheral Arterial Disease must be documented in the patient's medical record.
- Only report on patients ≥15 years old.
- The null value "Not Applicable" must be reported for patients <15 years old.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients ≥15 years old.

Validation Description

- Pre-existing conditions should not be blank.

POST-TRAUMATIC STRESS DISORDER

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

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

Validation Description
- Pre-existing conditions should not be blank.

PREGNANCY

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

PREMATURITY

Definition
Babies born before 37 weeks of gestation.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

Notes
- Present prior to injury.
- Only report on patients <15 years old.
- A diagnosis of prematurity, or delivery before 37 weeks of gestation, must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients ≥15 years old.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available for patients <15 years old.

Validation Description
- Pre-existing conditions should not be blank.

SCHIZOAFFECTIVE DISORDER

Definition
A schizoaffective disorder diagnosis documented in the medical record.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

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

Validation Description
- Pre-existing conditions should not be blank.

SCHIZOPHRENIA

Definition
A schizophrenia diagnosis documented in the medical record.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded
- Not Applicable

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

Validation Description
- Pre-existing conditions should not be blank.

STEROID USE

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Known/Not Recorded

Notes
- Present prior to injury.
- Examples of oral or parenteral corticosteroid medications are prednisone and dexamethasone.
- Examples of chronic medical conditions are COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease.
- Exclude topical corticosteroids applied to the skin and corticosteroids administered by inhalation or rectally.
- The null value “Not Known/Not Recorded” is only reported if no past medical history is available.

Validation Description
- Pre-existing conditions should not be blank.

SUBSTANCE USE DISORDER

Definition

Descriptors documented in the patient's medical record consistent with the diagnostic criteria of substance use disorders (e.g., patient has a history of illicit drug use, patient has a history of treatment for substance use). Disorders may be related to the use of cannabis, hallucinogens, inhalants, opioids, sedative/hypnotics, and/or stimulants OR diagnosis of any of the following documented in the patient's medical record:

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Known/Not Recorded
- Not Applicable

Notes

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

Validation Description

- Pre-existing conditions should not be blank.

DIAGNOSIS INFORMATION

ICD-10 INJURY DIAGNOSES

Definition
Diagnoses related to all identified injuries.

Allowed Values
- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9, with 7th character A only (Traumatic compartment syndrome, initial encounter).
- The maximum number of diagnoses that may be reported for an individual patient is 50.

Null Values Allowed
- No

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

Validation Description
- ICD-10-CM Injury Diagnoses should not be blank.

AIS CODE [Trauma Center Only]

Definition
The Abbreviated Injury Scale (AIS) pre-dot codes that reflect the patient's injuries.

Allowed Values
- The pre-dot code is the 6 digits preceding the decimal point in an associated AIS code.

Null Values Allowed
- Not Applicable

Notes
- Only non-designated hospitals may enter “Not Applicable”.

Validation Description
- AIS Code should not be blank.

AIS VERSION [Trauma Center Only]

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

Allowed Values
- AIS 2015

Null Values Allowed
- Not Applicable

Notes
- Only non-designated hospitals may enter “Not Applicable”.

Validation Description
- AIS Version should not be blank.

HOSPITAL EVENTS

ACUTE KIDNEY INJURY (AKI)

Definition

Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function.

KDIGO (Kidney Disease Improving Global Outcome Guideline) Table:

STAGE	SERUM CREARININE	URINE OUTPUT
3	3.0 times baseline **OR** Increase in serum creatinine 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/1.73 m^2	<0.3 ml/kg/h for ≥ 24 hours **OR** Anuria for ≥ 12 hours

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of AKI must be documented in the patient's medical record.
- If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.
- EXCLUDE patients with renal failure that required chronic renal replacement therapy (e.g., periodic peritoneal dialysis, hemodialysis, hemofiltration, hemodiafiltration) prior to injury.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

ACUTE RESPIRATORY DISTRESS SYNDROME (ARDS)

Definition

Timing:	Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging:	Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules
Origin of edema:	Respiratory failure not fully explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if 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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of ARDS must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

ALCOHOL WITHDRAWAL SYNDROME

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- Documentation of alcohol withdrawal must be in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

CARDIAC ARREST WITH CPR

Definition

Cardiac arrest is the sudden cessation of cardiac activity. 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.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- Cardiac arrest must be documented in the patient's medical record.
- EXCLUDE patients whose ONLY episode of cardiac arrest with CPR was on arrival to your hospital.
- INCLUDE patients who, after arrival at your hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions, defibrillation, cardioversion, or cardiac pacing to restore circulation.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

CATHETER-ASSOCIATED URINARY TRACT INFECTION (CAUTI)

Definition

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

AND

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

January 2019 CDC CAUTI Criterion SUTI 1a:

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

1. Patient had an indwelling urinary catheter that had been in place for more than 2 consecutive days in an inpatient location on the date of event AND was either:
    - Present for any portion of the calendar day on the date of event, OR
    - Removed the day before the date of event
2. Patient has at least one of the following signs or symptoms:
    - Fever (>38^{o}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
    - Costovertebral angle pain or tenderness
    - Urinary urgency
    - Urinary frequency
    - Dysuria
3. Patient has a urine culture with no more than two species of organisms identified, at least one of which is a bacteria >10^{5} CFU/ml.

January 2016 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^{o}C)
    - hypothermia (<36.0^{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.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of UTI must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTION (CLABSI)

Definition

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

AND

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

January 2016 CDC Criterion LCBI 1:

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

AND

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

OR

January 2016 CDC Criterion LCBI 2:

Patient has at least one of the following signs or symptoms: fever (>38^{o}C), chills, or hypotension

AND

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

AND

The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not 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^{o} C), hypothermia (<36°C), apnea, or bradycardia

AND

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

AND

The same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not 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).

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of CLABSI must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

DEEP SURGICAL SITE INFECTION

Definition
Must meet the following criteria:

Infection occurs within 30 or 90 days after the National Healthcare Safety Network (NHSN) operative procedure (where day 1 = the procedure date) according to list in Table 2
AND
Involves deep soft tissues of the incision (e.g., fascial and muscle layers)
AND
Patient has at least **one** of the following:

- 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 purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)) or culture or non-culture based microbiologic testing method is not performed)

AND
Organism(s) identified from the deep soft tissues of the incision by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST)) or culture or non-culture based microbiologic testing method is not performed). A culture or non-culture-based test from the deep soft tissues of the incision that has a negative finding does not meet this criterion.
AND
Patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture-based test that has a negative finding does not meet this criterion.

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

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

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

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

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
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	**Operative Procedure**		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

DEEP VEIN THROMBOSIS (DVT)

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
- A diagnosis of DVT must be documented in the patient's medical record, which may be confirmed by venogram, ultrasound, or CT.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

DELIRIUM

Definition
Acute onset of behaviors characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.
OR
Patient tests positive after using an objective screening tool like the Confusion Assessment Method (CAM) or the Intensive Care Delirium Screening Checklist (ICDSC).
OR
A diagnosis of delirium documented in the patient's medical record.

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients whose delirium is due to alcohol withdrawal.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

MYOCARDIAL INFARCTION (MI)

Definition

An acute myocardial infarction must be noted with documentation of ECG changes indicative of an 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 after arrival at your center.

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

Definition

Must meet the following criteria:

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

AND

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

AND

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

a. Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
b. Organisms are identified from fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
c. An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test evidence suggestive of infection.

AND

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

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
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	**Operative Procedure**		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		

90-day Surveillance (continued)	
Code	**Operative Procedure**
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	MED	Mediastinitis
BRST	Breast abscess mastitis	MEN	Meningitis or ventriculitis
CARD	Myocarditis or pericarditis	ORAL	Oral cavity infection (mouth, tongue, or gums)
DISC	Disc space infection	OREP	Deep pelvic tissue infection or other infection of the male or female reproductive tract
EAR	Ear, mastoid infection	PJI	Periprosthetic Joint Infection
EMET	Endometritis	SA	Spinal abscess/infection
ENDO	Endocarditis	SINU	Sinusitis
GIT	Gastrointestional GI tract infection	UR	Upper respiratory tract, pharyngitis, laryngitis, epiglottitis
IAB	Intraabdominal infection, not specified elsewhere	USI	Urinary System Infection
IC	Intracranial infection	VASC	Arterial or venous infection
JNT	Joint or bursa	VCUF	Vaginal cuff infection
LUNG	Other infection of the lower respiratory tract		

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

OSTEOMYELITIS

Definition

Osteomyelitis must meet at least one of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST))
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least ***two*** of the following localized signs or symptoms:
    - Fever (>38.0°C)
    - Swelling*
    - Pain or tenderness*
    - Heat*
    - Drainage*

And at least *one* of the following:

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

b. Imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which, if equivocal, is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

*With no other recognized cause

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of osteomyelitis must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

PRESSURE ULCER

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- Pressure ulcer documentation must be in the patient’s medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

PULMONARY EMBOLISM (PE)

Definition

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

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient’s medical record.
- Exclude sub segmental PEs.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

SEVERE SEPSIS

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

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of sepsis must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

STROKE/CVA

Definition

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

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke
  AND:
- Duration of neurological deficit ≥24 hours
  OR:
- Duration of deficit of <24 hours, 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).

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of stroke/CVA must be documented in the patient's medical record.
- Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

SUPERFICIAL INCISIONAL SURGICAL SITE INFECTION

Definition

Must meet the following criteria:

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

AND

Involves only skin and subcutaneous tissue of the incision

AND

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

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

   AND

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

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

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

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C- section incision, 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)

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of SSI must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

UNPLANNED ADMISSION TO ICU

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Patients with a planned post-operative ICU stay.
- INCLUDE: Patients who required ICU care due to an event that occurred during surgery or in the PACU.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

UNPLANNED INTUBATION

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- For patients who were intubated in the field or emergency department, or those intubated for surgery, an unplanned intubation occurs if they require reintubation > 24 hours after they were extubated.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

UNPLANNED VISIT TO THE OPERATING ROOM

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

Allowed Values
- Yes
- No

Null Values Allowed
- Not Applicable

Notes
- Must have occurred during the patient's initial stay at your hospital.
- EXCLUDE: Pre-planned, staged and/or procedures for incidental findings
- EXCLUDE: Operative management related to a procedure that was initially performed prior to arrival at your hospital
- EXCLUDE: Non-urgent tracheostomy and percutaneous endoscopic gastrostomy.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description
- Hospital Events should not be blank.

VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Definition

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

AND

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

VAP ALGORITHM (*PNU2* Bacterial or Filamentous Fungal Pathogens):		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm.) or leukocytosis (≥12,000 WBC/mm.) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• Organism identified from blood • Organism identified from pleural fluid • Positive quantitative culture or corresponding semi-quantitative culture result from minimally-contaminated lower respiratory tract (LRT) specimen (specifically, bronchoalveolar lavage (BAL), protected specimen brushing or endotracheal aspirate) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (for example: Gram's stain) • Positive quantitative culture or corresponding semi-quantitative culture result of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: - Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli - Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP Algorithm *(PNU2* Viral, Legionnella, and other Bacterial Pneumonias*):*		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following:	At least **one** of the following:	At least **one** of the following:
• New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	• Fever (>38°C or >100.4°F) • Leukopenia (<4000WBC/mm.) or leukocytosis (≥12,000 WBC/mm.) • For adults ≥70 years old, altered mental status with no other recognized cause AND at least **one** of the following: • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example: PaO2/FiO2 <240], increased oxygen requirements, or increased ventilator demand)	• 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 (for example: not Active Surveillance Culture/Testing (ASC/AST)). • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, *Chlamydia*) • Fourfold rise in *Legionella* pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect immunofluorescence assay. • Detection of L. *pneumophila* serogroup 1 antigens in urine by radioimmunoassay or enzyme immunoassay

VAP Algorithm *(PNU3* Immunocompromised Patients*):*		
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS**	**LABORATORY**
Two or more serial chest imaging test results with at least **one** of the following: • New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	Patient who is immunocompromised (see definition in footnote) 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 (for example: O2 desaturations • [for example: PaO2/FiO2<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 one of the following: sputum, endotracheal aspirate, BAL or protected specimen brushing. • Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: - Direct microscopic exam - Positive culture of fungi - Non-culture diagnostic laboratory test **OR** • Any of the following from: **LABORATORY CRITERIA DEFINED UNDER PNU2**

VAP Algorithm ALTERNATE CRITERIA *(PNU1),* for infant's ≤ 1 year old*:*	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/ LABORATORY**
Two or more serial chest imaging test results with at least **<u>one</u>** of the following: • New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	Worsening gas exchange (for example:2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) And at least ***three*** of the following: • Temperature instability • Leukopenia (≤4000 WBC/mm3) or leukocytosis (>15,000 WBC/mm3) and left shift (>10% band forms) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP Algorithm ALTERNATE CRITERIA *(PNU1)*, for children > 1 year old or ≤ 12 years old:	
IMAGING TEST EVIDENCE	**SIGNS/SYMPTOMS/ LABORATORY**
Two or more serial chest imaging test results with at least **<u>one</u>** of the following: • New and persistent **or** progressive and persistent • Infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1-year-old **NOTE:** In patients ***without*** underlying pulmonary or cardiac disease (for example: respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.	ALTERNATE CRITERIA, for child >1 year old or ≤12 years old, at least ***three*** of the following: • Fever (>38. 0°C or >100. 4°F) or hypothermia (<36.0°C or <96. 8°F) • Leukopenia (≤4000 WBC/mm3) or leukocytosis (≥15,000 WBC/mm3) • New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, or dyspnea, apnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (for example: O2 desaturations [for example pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

Allowed Values

- Yes
- No

Null Values Allowed

- Not Applicable

Notes

- Must have occurred during the patient's initial stay at your hospital.
- A diagnosis of pneumonia must be documented in the patient's medical record.
- The null value "Not Applicable" must be reported for patients that did not have a complication.

Validation Description

- Hospital Events should not be blank.

OUTCOME INFORMATION

DISCHARGE STATUS*

Definition
Whether the patient left your facility alive or dead.

Allowed Values
- Alive
- Dead

Null Values Allowed
- No

Notes
- Not an NTDS element.

Validation Description
- Discharge Status should not be blank.

DISCHARGE ORDERS WRITTEN DATE

Definition
The date the order was written for the patient to be discharged from the hospital.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Notes
- Collected as YYYY-MM-DD.
- The null value “Not Applicable” should be reported if ED Discharge Disposition is Home with services, child protective agency, hospice, morgue, law enforcement, skilled nursing facility, rehab, long-term care, psychiatric hospital, nursing home, another type of inpatient facility, home/self-care, left AMA, acute care facility, intermediate care facility or burn center.
- If Hospital Discharge Disposition is Element Value “morgue” then Hospital Discharge Date is the date of death, as indicated on the patient’s death certificate.

Validation Description
- Discharge Orders Written Date should not be blank.

DISCHARGE ORDERS WRITTEN TIME

Definition
The time the order was written for the patient to be discharged from the hospital.

Allowed Values
- Relevant value for the data element.

Null Values Allowed
- Not Applicable

Notes
- Collected as HH:MM military time.
- The null value "Not Applicable" should be reported if ED Discharge Disposition is home with services, child protective agency, hospice, morgue, law enforcement, skilled nursing facility, rehab, long-term care, psychiatric hospital, nursing home, another type of inpatient facility, home/self-care, left AMA, acute care facility, intermediate care facility or burn center.
- If Hospital Discharge Disposition is Element Value “morgue” then Hospital Discharge Time is the time of death as indicated on the patient’s death certificate.

Validation Description
- Discharge Orders Written Time should not be blank.

TOTAL ICU LENGTH OF STAY

Definition

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

Allowed Values

- Relevant value for the data element.

Null Values Allowed

- Not Applicable
- Not Known/Not Recorded

Notes

- 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" should be 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" should be reported if the patient had no ICU days according to the above definition.

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)

Validation Description

- Total ICU Length of Stay should not be blank.

TOTAL VENTILATOR DAYS

Definition

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

Allowed Values

- Relevant value for the data element.

Null Values Allowed

- Not Applicable
- Not Known/Not Recorded

Notes

- 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 dates, times and episodes with starting and stopping ventilator episodes are recorded in the patient's chart.
- The null value "Not Known/Not Recorded" should be reported if any dates are missing.
- At no time should the Total Vent Days exceed the Hospital LOS.
- The null value "Not Applicable" should be reported if the patient was not on the ventilator according to the above definition.

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 on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in on Vent 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 on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in on Vent on 3 separate calendar days)

Validation Description

- Total Ventilator Days should not be blank.

DISCHARGE DISPOSITION

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

Allowed Values
- Discharged/Transferred to a short-term general hospital for inpatient care
- Discharged/Transferred to an Intermediate Care Facility (ICF)
- Discharge/Transferred to home under care of organized home health service
- Left against medical advice or discontinued care
- Deceased/Expired
- Discharged to home or self-care (routine discharge)
- Discharged/Transferred to Skilled Nursing Facility (SNF)
- Discharged/Transferred to hospice care
- Discharged/Transferred to court/law enforcement
- Discharged/Transferred to inpatient rehab or designated unit
- Discharged/Transferred to Long Term Care Hospital (LTCH)
- Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- Discharged/Transferred to another type of institution not defined elsewhere

Null Values Allowed
- Not Applicable

Notes
- If multiple orders were written, report the final disposition order.
- Allowed values based upon UB-04 disposition coding.
- Allowed Value “Home or self-care (routine discharge)" refers to the patient's current place of residence (e.g., Prison, Child Protective Services etc.).
- The null value "Not Applicable" should be reported if ED Discharge Disposition is home with services, deceased/expired, other, transferred to another hospital, home/self-care or left AMA.

Validation Description
- Discharge Disposition should not be blank.

DISCHARGE DESTINATION*

Definition
The assigned code number of the acute care hospital or in-patient rehabilitation facility to which the patient was transferred from your hospital.

Allowed Values
- Hospital code or inpatient rehabilitation facility code assigned by VDH Office of EMS.

Null Values Allowed
- Not Applicable

Multiple Entry
- No

Notes
- Must be reported if ED Discharge Disposition is ‘Transferred to Another Hospital’.
- Must be reported if Hospital Discharge Disposition is ‘Discharged/Transferred to a short-term hospital for inpatient care’ or ‘Discharged/Transferred to inpatient rehab or designated unit’.
- The null value "Not Applicable" should be reported if the Discharge Disposition is home with services, hospice, deceased/expired, court/law enforcement, skilled nursing facility, long-term care, psychiatric hospital, another type of institution not defined elsewhere, home/self-care or left AMA.

Validation Description
- Discharge Destination should not be blank.

PRIMARY METHOD OF PAYMENT

Definition
Primary source of payment for hospital care.

Allowed Values

- Self-pay
- Medicare
- Medicaid
- Private/Commercial Insurance
- Not Billed (for any reason)
- Other
- Other government

Null Values Allowed

- No

Notes

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield must be reported as Allowed Value “Private/Commercial Insurance”.

Validation Description

- Primary Method of Payment should not be blank.

APPENDICES

APPENDIX A: STATE/TERRITORY CODES

Source: US Census Bureau, 2020 FIPS Codes,
https://www.census.gov/library/reference/code-lists/ansi.html

Name	Alpha code	FIPS code
Alabama	AL	01
Alaska	AK	02
American Samoa	AS	60
Arizona	AZ	04
Arkansas	AR	05
California	CA	06
Colorado	CO	08
Connecticut	CT	09
Delaware	DE	10
District of Columbia	DC	11
Florida	FL	12
Federated States of Micronesia	FM	64
Georgia	GA	13
Guam	GU	66
Hawaii	HI	15
Idaho	ID	16
Illinois	IL	17
Indiana	IN	18
Iowa	IA	19
Kansas	KS	20
Kentucky	KY	21
Louisiana	LA	22
Maine	ME	23
Marshall Islands	MH	68
Maryland	MD	24
Massachusetts	MA	25
Michigan	MI	26
Minnesota	MN	27
Mississippi	MS	28

Name	Alpha code	FIPS code
Montana	MT	30
Nebraska	NE	31
Nevada	NV	32
New Hampshire	NH	33
New Jersey	NJ	34
New Mexico	NM	35
New York	NY	36
North Carolina	NC	37
North Dakota	ND	38
Northern Mariana Islands	MP	69
Ohio	OH	39
Oklahoma	OK	40
Oregon	OR	41
Palau	PW	70
Pennsylvania	PA	42
Puerto Rico	PR	72
Rhode Island	RI	44
South Carolina	SC	45
South Dakota	SD	46
Tennessee	TN	47
Texas	TX	48
Utah	UT	49
Vermont	VT	50
Virginia	VA	51
Washington	WA	53
West Virginia	WV	54
Wisconsin	WI	55
Wyoming	WY	56
Virgin Islands (U.S)	VI	78

APPENDIX B: VIRGINIA COUNTY CODES

Source: US Census Bureau, 2010 FIPS Codes,
https://www.census.gov/library/reference/code-lists/ansi.html

****FIPS codes for counties outside of Virginia can also be found at the link above under the "County and County Equivalent Entities" section**.**

County	FIPS Code
Accomack	001
Albemarle	003
Alleghany	005
Amelia	007
Amherst	009
Appomattox	011
Arlington	013
Augusta	015
Bath	017
Bedford	019
Bland	021
Botetourt	023
Brunswick	025
Buchanan	027
Buckingham	029
Campbell	031
Caroline	033
Carroll	035
Charles City	036
Charlotte	037
Chesterfield	041
Clarke	043
Craig	045
Culpeper	047
Cumberland	049
Dickenson	051
Dinwiddie	053
Essex	057
Fairfax	059
Fauquier	061
Floyd	063
Fluvanna	065

County	FIPS Code
Franklin	067
Frederick	069
Giles	071
Gloucester	073
Goochland	075
Grayson	077
Greene	079
Greensville	081
Halifax	083
Hanover	085
Henrico	087
Henry	089
Highland	091
Isle of Wight	093
James City	095
King and Queen	097
King George	099
King William	101
Lancaster	103
Lee	105
Loudoun	107
Louisa	109
Lunenburg	111
Madison	113
Mathews	115
Mecklenburg	117
Middlesex	119
Montgomery	121
Nelson	125
New Kent	127
Northampton	131
Northumberland	133

County	FIPS Code
Nottoway	135
Orange	137
Page	139
Patrick	141
Pittsylvania	143
Powhatan	145
Prince Edward	147
Prince George	149
Prince William	153
Pulaski	155
Rappahannock	157
Richmond	159
Roanoke	161
Rockbridge	163
Rockingham	165
Russell	167
Scott	169
Shenandoah	171
Smyth	173
Southampton	175
Spotsylvania	177
Stafford	179
Surry	181
Sussex	183
Tazewell	185
Warren	187
Washington	191
Westmoreland	193
Wise	195
Wythe	197
York	199

APPENDIX C: COUNTRY CODES

Source: US Department of State, Bureau of Intelligence and Research, *Independent States in the World (Fact Sheet)*, https://www.state.gov/independent-states-in-the-world/

Country	Code
Afghanistan	AF
Albania	AL
Algeria	AG
American Samoa	AQ
Andorra	AN
Angola	AO
Antigua and Barbuda	AC
Argentina	AR
Armenia	AM
Australia	AS
Austria	AU
Azerbaijan	AJ
Bahamas	BF
Bahrain	BA
Bangladesh	BG
Barbados	BB
Belarus	BO
Belgium	BE
Belize	BH
Benin	BN
Bermuda	BD
Bhutan	BT
Bolivia	BL
Bosnia and Herzegovina	BK
Botswana	BC
Brazil	BR
British Virgin Islands	VI
Brunei	BX
Bulgaria	BU
Burkina Faso	UV
Burma	BM
Burundi	BY
Cambodia	CB
Cameroon	CM

Country	Code
Canada	CA
Cape (Cabo) Verde	CV
Cayman Islands	CJ
Central African Republic	CT
Chad	CD
Chile	CI
China	CH
Christmas Island	KT
Colombia	CO
Comoros	CN
Congo (Brazzaville)	CF
Congo (Kinshasa)	CG
Cook Islands	CW
Costa Rica	CS
Côte d'Ivoire	IV
Croatia	HR
Cuba	CU
Curaçao	UC
Cyprus	CY
Czechia / Czech Republic	EZ
Denmark	DK
Djibouti	DJ
Dominica	DO
Dominican Republic	DR
Ecuador	EC
Egypt	EG
El Salvador	ES
Equatorial Guinea	EK

Country	Code
Eritrea	ER
Estonia	EN
Eswatini	WZ
Ethiopia	ET
Faroe Islands	FO
Fiji	FJ
Finland	FI
France	FR
French Guiana	FG
French Polynesia	FP
Gabon	GB
Gambia, The	GA
Gaza Strip	GZ
Georgia	GG
Germany	GM
Ghana	GH
Gibraltar	GI
Greece	GR
Greenland	GL
Grenada	GJ
Guadeloupe	GP
Guam	GQ
Guatemala	GT
Guernsey	GK
Guinea	GV
Guinea-Bissau	PU
Guyana	GY
Haiti	HA
Honduras	HO
Hong Kong	HK
Hungary	HU
Iceland	IC
India	IN
Indonesia	ID
Iran	IR
Iraq	IZ

Country	Code
Ireland	EI
IM	Isle of Man
Israel	IS
Italy	IT
Jamaica	JM
Japan	JA
Jersey	JE
Jordan	JO
Kazakhstan	KZ
Kenya	KE
Kiribati	KR
Korea, North	KN
Korea, South	KS
Kosovo	KV
Kuwait	KU
Kyrgyzstan	KG
Laos	LA
Latvia	LG
Lebanon	LE
Lesotho	LT
Liberia	LI
Libya	LY
Liechtenstein	LS
Lithuania	LH
Luxembourg	LU
Madagascar	MA
Malawi	MI
Malaysia	MY
Maldives	MV
Mali	ML
Malta	MT
Marshall Islands	RM
Martinique	MB
Mauritania	MR
Mauritius	MP
Mexico	MX
Micronesia	FM
Midway Islands	MQ
Moldova	MD
Monaco	MN
Mongolia	MG

Country	Code
Montenegro	MJ
Montserrat	MH
Morocco	MO
Mozambique	MZ
Namibia	WA
Nauru	NR
Nepal	NP
Netherlands	NL
New Zealand	NZ
Nicaragua	NU
Niger	NG
Nigeria	NI
North Macedonia	MK
Northern Mariana Islands	CQ
Norway	NO
Oman	MU
Pakistan	PK
Palau	PS
Panama	PM
Papua New Guinea	PP
Paraguay	PA
Peru	PE
Philippines	RP
Pitcairn Islands	PC
Poland	PL
Portugal	PO
Puerto Rico	RQ
Qatar	QA
Romania	RO
Russia	RS
Rwanda	RW
Saint Helena, Ascension, and Tristan da Cunha	SH
Saint Kitts and Nevis	SC
Saint Lucia	ST
Saint Martin	RN

Country	Code
Saint Vincent and the Grenadines	VC
Samoa	WS
San Marino	SM
Sao Tome & Principe	TP
Saudi Arabia	SA
Senegal	SG
Serbia	RI
Seychelles	SE
Sierra Leone	SL
Singapore	SN
Sint Maarten	SX
Slovakia	LO
Slovenia	SI
Solomon Islands	BP
Somalia	SO
South Africa	SF
South Georgia and South Sandwich Islands	SX
South Sudan	OD
Spain	SP
Sri Lanka	CE
Sudan	SU
Suriname	NS
Svalbard	SV
Sweden	SW
Switzerland	SZ
Syria	SY
Taiwan	TW
Tajikistan	TI
Tanzania	TZ
Thailand	TH
Timor-Leste	TT
Togo	TO
Tokelau	TL
Tonga	TN
Trinidad and Tobago	TD
Tunisia	TS

Country	Code
Turkey	TU
Turkmenistan	TX
Turks & Caicos	TK
Tuvalu	TV
Uganda	UG
Ukraine	UP
United Arab Emirate	AE

Country	Code
United Kingdom	UK
United States	US
U.S. Virgin Islands	VQ
Uruguay	UY
Uzbekistan	UZ
Vanuatu	NH

Country	Code
Vatican City	VT
Venezuela	VE
Vietnam	VM
Wake Island	WQ
West Bank	WE
Yemen	YM
Zambia	ZA
Zimbabwe	ZI

APPENDIX D: VIRGINIA TOWN AND INDEPENDENT CITY CODES

Independent cities are listed in **bold type.**

Source: US Census Bureau, 2020 FIPS Codes,
https://www.census.gov/library/reference/code-lists/ansi.html

City or Town	FIPS Code
Abingdon town	00148
Accomac town	00180
Alberta town	00724
Alexandria	**01000**
Altavista town	01528
Amherst town	01672
Appalachia town	02040
Appomattox town	02072
Ashland town	03368
Bedford town	05544
Belle Haven town	05912
Berryville town	06968
Big Stone Gap town	07480
Blacksburg town	07784
Blackstone town	07832
Bloxom town	08120
Bluefield town	08152
Boones Mill town	08584
Bowling Green town	08888
Boyce town	08984
Boydton town	09016
Boykins town	09032
Branchville town	09208
Bridgewater town	09656
Bristol	**09816**
Broadway town	10040
Brodnax town	10072
Brookneal town	10296
Buchanan town	10744
Buena Vista	**11032**
Burkeville town	11560
Cape Charles town	12808
Capron town	12904
Cedar Bluff town	13784
Charlotte Court House town	14952
Charlottesville	**14968**
Chase City town	14984
Chatham town	15000
Cheriton town	15112
Chesapeake	**16000**

City or Town	FIPS Code
Chilhowie town	16480
Chincoteague town	16512
Christiansburg town	16608
Claremont town	16880
Clarksville town	16992
Cleveland town	17296
Clifton town	17376
Clifton Forge town	17440
Clinchco town	17504
Clinchport town	17536
Clintwood town	17552
Coeburn town	17952
Colonial Beach town	18400
Colonial Heights	**18448**
Courtland town	19600
Covington	**19728**
Craigsville town	19904
Crewe town	20160
Culpeper town	20752
Damascus town	21184
Danville	**21344**
Dayton town	21648
Dendron town	22160
Dillwyn town	22560
Drakes Branch town	23376
Dublin town	23648
Duffield town	23680
Dumfries town	23760
Dungannon town	23952
Eastville town	24752
Edinburg town	25008
Elkton town	25408
Emporia	**25808**
Exmore town	26416
Fairfax	**26496**
Falls Church	**27200**
Farmville town	27440
Fincastle town	27824
Floyd town	28544
Franklin city	29600
Fredericksburg	**29744**

City or Town	FIPS Code
Fries town	29920
Front Royal town	29968
Galax	**30208**
Gate City town	30496
Glade Spring town	31056
Glasgow town	31136
Glen Lyn town	31376
Gordonsville town	31936
Goshen town	31968
Gretna town	33232
Grottoes town	33488
Grundy town	33648
Halifax town	34064
Hallwood town	34176
Hamilton town	34240
Hampton	**35000**
Harrisonburg	**35624**
Haymarket town	35976
Haysi town	36008
Herndon town	36648
Hillsboro town	37288
Hillsville town	37336
Honaker town	38280
Hopewell	**38424**
Hurt town	39224
Independence town	39528
Iron Gate town	40024
Irvington town	40088
Ivor town	40232
Jarratt town	40536
Jonesville town	41272
Keller town	41656
Kenbridge town	41832
Keysville town	42264
Kilmarnock town	42424
La Crosse town	43176
Lawrenceville town	44520
Lebanon town	44696
Leesburg town	44984
Lexington	**45512**
Louisa town	47144

City or Town	FIPS Code
Lovettsville town	47208
Luray town	47528
Lynchburg	**47672**
McKenney town	48344
Madison town	48488
Manassas	**48952**
Manassas Park	**48968**
Marion town	49464
Martinsville	**49784**
Melfa town	50984
Middleburg town	51448
Middletown town	51512
Mineral town	52120
Monterey town	52680
Montross town	52952
Mount Crawford town	53864
Mount Jackson town	53992
Narrows town	54904
Nassawadox town	54984
New Castle town	55592
New Market town	55848
Newport News	**56000**
Newsoms town	56096
Nickelsville town	56304
Norfolk	**57000**
Norton	**57688**
Occoquan town	58696
Onancock town	59336
Onley town	59384
Orange town	59496
Painter town	60296
Pamplin City town	60488
Parksley town	60680
Pearisburg town	61208
Pembroke town	61336
Pennington Gap town	61560

City or Town	FIPS Code
Petersburg	**61832**
Phenix town	61896
Pocahontas town	63288
Poquoson	**63768**
Port Royal town	63928
Portsmouth	**64000**
Pound town	64272
Pulaski town	64880
Purcellville town	65008
Quantico town	65120
Radford	**65392**
Remington town	66512
Rich Creek town	66896
Richlands town	66928
Richmond	**67000**
Ridgeway town	67208
Roanoke	**68000**
Rocky Mount town	68496
Round Hill town	69168
Rural Retreat town	69456
St. Charles town	69792
St. Paul town	69936
Salem	**70000**
Saltville town	70096
Saxis town	70576
Scottsburg town	70752
Scottsville town	70800
Shenandoah town	71776
Smithfield town	73200
South Boston town	73712
South Hill town	73904
Stanardsville town	75008
Stanley town	75024
Staunton	**75216**
Stephens City town	75344
Stony Creek town	75840

City or Town	FIPS Code
Strasburg town	76000
Stuart town	76256
Suffolk	**76432**
Surry town	76880
Tangier town	77520
Tappahannock town	77568
Tazewell town	77792
The Plains town	78192
Timberville town	78736
Toms Brook town	79024
Troutdale town	79456
Troutville town	79472
Urbanna town	80272
Victoria town	81024
Vienna town	81072
Vinton town	81280
Virgilina town	81312
Virginia Beach	**82000**
Wachapreague town	82320
Wakefield town	82384
Warrenton town	83136
Warsaw town	83168
Washington town	83248
Waverly town	83600
Waynesboro	**83680**
Weber City town	83808
West Point town	84960
White Stone town	85600
Williamsburg	**86160**
Winchester	**86720**
Windsor town	86784
Wise town	87072
Woodstock town	87712
Wytheville town	88000

APPENDIX E: ANTICOAGULANT MEDICATION NAMES

The list of EMS agency medications can be found on the NEMSIS website at the link below:

Virginia | NEMSIS V3 State Data Set

APPENDIX F: VIRGINIA EMS AGENCIES AND FACILITIES NAMES

The list of EMS agencies and facility names can be found on the NEMSIS website at the link below:

Virginia | NEMSIS V3 State Data Set

APPENDIX G: CHANGE LOG

December 13, 2022

- Removed references of Appendix F, G and H (P
- age 192)
- Removed reference of Appendix E (Page 52)
- Removed reference of Appendix F and G (Page 75)
- Changed Appendix J name to Appendix E (Page 202)
- Changed Appendix K name to Appendix F (Page 203)
- Added Appendix G: Change Log (Page 204)
- Removed "Is the patient's ONLY injury in the ICD-10-CM range of S72.00-S72.14 (fracture of head/neck of femur)"? From the inclusion criteria tree. (Page 10)

January 5, 2023

- **Protective Devices-Equipment** – Removed notes (Page 35)
- **Protective Devices- Restraints** – Updated notes (Page 33)

March 17, 2023

- **Gender Identity** – Added element (page 21)
- **Patient's Home State** – Updated null values and notes (page 25)
- **Patient's Home County** – Updated null values and notes (page 26)
- **Protective Devices-Restraints** – Updated null values and notes (page 34)
- **Protective Devices-Airbags** – Updated null values and notes (page 35)
- **Protective Devices-Equipment** – Updated null values and notes (page 36)
- **Incident State** – Updated null values (page 39)
- **Incident County** – Updated null values (page 40)
- **Incident Country** – Updated definition (page 41)
- **Injury Type** – Updated null values and notes (page 47)
- **Activity Code-ICD 10** – Updated definition, null values and notes (page 48)
- **Alcohol Involvement** - Updated allowed values, null values and notes (page 49)
- **Injury Mechanism** - Updated allowed values, null values and notes (page 50)
- **Transport Mode** – Updated notes (page 52)
- **EMS Agency Incident Number** – Update null values and notes (page 54)
- **Other Transport Methods to Your Hospital** – Updated null values and notes (page 61)
- **Prehospital Procedures** – Updated allowed values and notes (page72)
- **Prehospital Medications** – Updated notes (page 73)
- Removed **"Mode of Arrival"**
- **Initial ED/Hospital Height** – Updated null values (page 86)
- **Initial ED/Hospital Unassisted Respiratory Rate** – Updated null values and notes (page 89)
- **Initial ED/Hospital Assisted Respiratory Rate** – Updated null values and notes (page 90)
- **Initial ED/Hospital Supplemental Oxygen** – Updated null values and notes (page 92)
- **Medications** – Updated null values and notes (page 101)
- **Warming Measures** – Updated null values and notes (page 102)

- **Alcohol Screen** – Updated definition (page 103)
- **Drug Screen** – Updated null values (page 105)
- **Advanced Directive Limiting Care** – Updated definition and notes (page 113)
- **Alcohol Use Disorder** – Updated null values and notes (page 114)
- **Bipolar I/II Disorder** – Updated null values and notes (page 117)
- **Chronic Obstructive Pulmonary Disease (COPD)** – Updated null values and notes (page 120)
- **Congenital Anomalies** – Updated null values and notes (page 123)
- **Major Depressive Disorder** – Updated null values and notes (page 132)
- **Other Mental/Personality Disorders** – Updated null values and notes (page 134)
- **Peripheral Arterial Disease (PAD)** – Updated null values and notes (page 135)
- **Post-Traumatic Stress Disorder** – Updated null values and notes (page 136)
- **Prematurity** – Updated definition, null values, and notes (page 138)
- **Schizoaffective Disorder** – Updated null values and notes (page 139)
- **Schizophrenia** – Updated null values and notes (page 140)
- **Substance Use Disorder** – Updated definition, null values, and notes (page 142)
- **Pre-Arrival Cardiac Arrest** – Updated null values and notes (page 147)
- **Acute Kidney Injury (AKI)** – Updated null values, notes and added validation description (page 149)
- **Acute Respiratory Distress Syndrome (ARDS)** – Updated null values, notes and added validation description (page 150)
- **Alcohol Withdrawal Syndrome** – Updated null values, notes and added validation description (page 151)
- **Cardiac Arrest with CPR** – Updated null values, notes and added validation description (page 152)
- **Catheter- Associated Urinary Tract Infection (CAUTI)** – Updated null values, notes and added validation description (page 153)
- **Central Line-Associated Blood Stream Infection (CLABSI) –** Updated null values, notes and added validation description (page 155)
- **Deep Surgical Site Infection** – Updated null values, notes and added validation description (page 157)
- **Deep Vein Thrombosis (DVT)** – Updated null values, notes and added validation description (page 159)
- **Delirium** – Updated null values, notes and added validation description (page 160)
- **Extremity Compartment Syndrome** – Updated null values, notes and added validation description (page 161)
- **Myocardial Infraction (MI)** – Updated null values, notes and added validation description (page 162)
- **Organ/Space Surgical Site Infection** – Updated null values, notes and added validation description (page 163)
- **Osteomyelitis** – Updated null values, notes and added validation description (page 165)
- **Pressure Ulcer** – Updated null values, notes and added validation description (page 166)
- **Pulmonary Embolism (PE)** – Updated null values, notes and added validation description (page 167)
- **Severe Sepsis** – Updated null values, notes and added validation description (page 168)
- **Stroke/CVA** – Updated definition, null values, notes and added validation description (page 169)
- **Superficial Incisional Surgical Site Infection** – Updated null values, notes and added validation description (page 170)
- **Unplanned Admission to ICU** – Updated null values, notes and added validation description (page 171)
- **Unplanned Intubation** – Updated null values, notes and added validation description (page 172)
- **Unplanned Visit to The Operating Room** – Updated null values, notes and added validation description (page 173)

- **Ventilator-Associated Pneumonia (VAP)** – Updated null values, notes and added validation description (page 174)
- **Discharge Orders Written Date** – Updated null values and notes (page 180)
- **Discharge Orders Written Time** – Updated null values and notes (page 181)

June 21, 2023

- **Age –** Updated notes (page 17)
- **Age Unit –** Updated notes (page 18)
- **Gender Identity** – Updated allowed values (page 20)
- **Alternate Home Residence** – Updated allowed values (page 29)
- **Protective Devices-Restraints** – Updated definition (page 34)
- **Protective Devices-Airbags** – Updated definition (page 35)
- **Patient's Occupation** – Updated allowed values (page 43)
- **Injury Mechanism** – Updated allowed values (page 50)
- Removed "**EMS Agency Incident Number**" and added "**Patient Care Report Number**" (page 55)
- **Arrived at Location Date** – Updated notes (page 58)
- **Arrived at Location Time** – Updated notes (page 59)
- **Departed Location Date** – Updated notes (page 60)
- **Departed Location Time** – Updated notes (page 61)
- **Trauma center Triage Red Criteria** – Updated element name, allowed values and validation description (page 62-63)
- **Trauma Center Triage Yellow Criteria** – Updated element name, allowed values and validation description (page 64)
- **Trauma Center Triage Burn Criteria** – New page (page 65)
- **Prehospital Procedures** – Updated allowed values (page 74)
- **Post ED Disposition** – Updated definition (page 83)
- **Functionally Dependent Health Status** – Updated definition (page 132)

June 3, 2024

- **Sex** – Updated element name and updated allowed values (page 19)
- Removed **Gender Identity**
- **Ethnicity** – Added null value (Page 20)
- **Race** – Added null value (page 21)
- **Alternate Home Residence** – Updated allowed values (page 28)
- Removed **Homeless**
- **Injury Date** – Updated null values (page 30)
- **Injury Time** – Updated null values (page 31)
- **Protective Devices** – Updated element name, allowed values and notes (page 33)
- **Child Specific Restraint** – Updated element name, allowed values and notes (page 34)
- **Airbag Deployment** – Updated element name, allowed values and notes (page 35)
- **Incident Zip Code** – Added null value (page 36)

- **Incident City/Town** – Added null value (page 37)
- **Incident State** – Added null value (page 38)
- **Incident County** – Added null value (page 39)
- **Incident Country** – Added null value (page 40)
- Removed **Activity Code**
- Removed **Alcohol Involvement**
- **Transport Mode** – Updated allowed values (page 49)
- **Other Transport Modes to Your Hospital** – Updated allowed values (page 50)
- **Call Dispatch Date** – Added null value (page 53)
- **Call Dispatch Time** - Added null value (page 54)
- **Arrived at Location Date** – Added null value (page 55)
- **Arrived at Location Time** – Added null value (page 56)
- **Departed Location Date** – Added null value (page 57)
- **Departed Location Time** – Added null value (page 58)
- **Prehospital Medications** – Added appendix for medications (page 72)
- **ED/Hospital Admitted date** – Updated element name (page 78)
- **ED/Hospital Admitted Time** – Updated element name (page 79)
- **Highest Activation** – Updated allowed values (page 80)
- **ED Discharge Disposition** – Updated allowed values (page 81)
- **Initial ED/Hospital Respiratory Assistance** – Updated element name and allowed values (page 90)
- Removed **GCS 40** fields
- **Warming Measures** – Updated notes (page 98)
- **Alcohol Screen** – Updated allowed values (page 99)
- **Hospital Procedure Start Date** – Added null values and updated notes (page 106)
- **Hospital Procedure Start Time** - Added null values and updated notes (page 107)
- **AIS Version –** Updated allowed values (page 142)
- **Discharge Disposition –** Updated allowed values and notes (page 179)
- **Primary Method of Payment –** Updated allowed values and notes (page 181)
- **Appendix E: Anticoagulant Medication Names** – Updated medication list (page 190)
- *Updated the null value **"Unknown"** to the null value **"Not Known/Not Recorded"** throughout the entire data dictionary*