

## HOSPITAL DISCHARGE DISPOSITION

O\_05

### Definition

The disposition of the patient when discharged from the hospital.

### Field Values

- |   |  |
|---|--|
| 1. Discharged/Transferred to a short-term general hospital for inpatient care | 8. Discharged/ Transferred to hospice care   |
| 2. Discharged/Transferred to an Intermediate Care Facility (ICF)              | <del>9. RETIRED 2014 Discharged/Transferred to another type of rehabilitation or long-term care facility</del> |
| 3. Discharge/Transferred to home under care of organized home health service  | 10. Discharged/Transferred to court/law enforcement.   |
| 4. Left against medical advice or discontinued care                           | 11. Discharged/Transferred to inpatient rehab or designated unit   |
| 5. Expired  | 12. Discharged/Transferred to Long Term Care Hospital (LTCH)   |
| 6. Discharged home with no home services                                      | 13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital           |
| 7. Discharged/Transferred to Skilled Nursing Facility (SNF)                   | 14. Discharged/Transferred to another type of institution not defined elsewhere                                |

### Additional Information

- Field value = 6, "home" refers to the patient's current place of residence (e.g., prison, Child Protective Services etc.)
- Field values based upon UB-04 disposition coding.
- Disposition to any other non-medical facility should be coded as 6.
- Disposition to any other medical facility should be coded as 14.
- The null value "Not Applicable" is used if ED Discharge Disposition = 5 (Died).
- The null value "Not Applicable" is used if If ED Discharge Disposition = 4,6,9,10, or 11.

### Data Source Hierarchy

1. Hospital Discharge Summary Sheet
2. Nurses' notes
3. Case Manager / Social Services' Notes

### Associated Edit Checks

Rule ID	Level	Message
7901	1	Invalid value
7902	2	Blank, required field
7903	2	If ED Discharge Disposition = 5 (Died) then Hospital Discharge Disposition should be NA (BIU=1)

## CO-MORBID CONDITIONS

### Definition

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

### Field Values

- |  |   |
|--|---|
| 1. Other                                       | 16. History of angina within 30 days  |
| 2. Alcoholism                                  | 17. History of myocardial infarction  |
| 3. Ascites within 30 days                      | 18. History of PVD  |
| 4. Bleeding disorder                           | 19. Hypertension requiring medication   |
| 5. Currently receiving chemotherapy for cancer | <del>20. RETIRED 2012 Impaired sensorium</del>                                    |
| 6. Congenital anomalies                        | 21. Prematurity   |
| 7. Congestive heart failure                    | 22. Obesity   |
| 8. Current smoker                              | 23. Respiratory disease   |
| 9. Chronic renal failure                       | 24. Steroid use   |
| 10. CVA/residual neurological deficit          | 25. Cirrhosis   |
| 11. Diabetes mellitus                          | 26. Dementia  |
| 12. Disseminated cancer                        | 27. Major psychiatric illness   |
| 13. Advanced directive limiting care           | 28. Drug or dependence  |
| 14. Esophageal varices                         | 29. Pre-hospital cardiac arrest with resuscitative efforts by healthcare provider |
| 15. Functionally dependent health status       |   |

### Additional Information

- The null value "Not Applicable" is used for patients with no known co-morbid conditions.
- Refer to Appendix 3: Glossary of Terms for definition of Co-Morbid Conditions.
- Check all that apply.

### Data Source Hierarchy

1. History and Physical
2. Discharge Sheet
3. Billing Sheet

### Associated Edit Checks

Rule ID	Level	Message
6801	1	Invalid value
6802	2	Blank, required field

## HOSPITAL COMPLICATIONS

### Definition

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

### Field Values

1. Other	<del>17. RETIRED 2011 Intracranial pressure</del>
<del>2. RETIRED 2011 Abdominal compartment syndrome</del>	18. Myocardial infarction
<del>3. RETIRED 2011 Abdominal fascia left open</del>	19. Organ/space surgical site infection
4. Acute kidney injury	20. Pneumonia
5. Acute lung injury/Acute respiratory distress syndrome (ARDS)	21. Pulmonary embolism
<del>6. RETIRED 2011 Base deficit</del>	22. Stroke / CVA
<del>7. RETIRED 2011 Bleeding</del>	23. Superficial surgical site infection
8. Cardiac arrest with resuscitative efforts by healthcare provider	<del>24. RETIRED 2011 Systemic sepsis</del>
<del>9. RETIRED 2011 Coagulopathy</del>	25. Unplanned intubation
<del>10. RETIRED 2011 Coma</del>	<del>26. RETIRED 2011 Wound disruption</del>
11. Decubitus ulcer	27. Urinary tract infection
12. Deep surgical site infection	28. Catheter-related blood stream infection
13. Drug or alcohol withdrawal syndrome	29. Osteomyelitis
14. Deep Vein Thrombosis (DVT) / thrombophlebitis	30. Unplanned return to the OR
15. Extremity compartment syndrome	31. Unplanned return to the ICU
16. Graft/prosthesis/flap failure	32. Severe sepsis

### Additional Information

- The null value "Not Applicable" should be used for patients with no complications.
- Refer to Appendix 3: Glossary of Terms for definitions of Complications.
- Check all that apply.

### Data Source Hierarchy

1. Discharge Sheet
2. History and Physical
3. Billing Sheet

### Associated Edit Checks

Rule ID	Level	Message
8101	1	Invalid value
8102	2	Blank, required field

**Definition**

Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS run sheet.

**Field Values**

- |  |   |
|--|---|
| 1. Glasgow Coma Score < 14   | 7. Crushed, degloved, mangled, or pulseless extremity |
| 2. Systolic blood pressure < 90 mmHg   | 8. Amputation proximal to wrist or ankle              |
| 3. Respiratory rate <10 or > 29 breaths per minute (<20 in infants aged <1 year) or need for ventilatory support | 9. Pelvic fracture                                    |
| 4. All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee                      | 10. Open or depressed skull fracture                  |
| 5. Chest wall instability or deformity (e.g., flail chest)   | 11. Paralysis   |
| 6. Two or more proximal long-bone fractures  |   |

**Additional Information**

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Sheet indicates patient did not meet any Trauma Center Criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated on the EMS Run Sheet or if the EMS Run Sheet is not available.
- Check all that apply.

**Data Source Hierarchy**

1. EMS Run Sheet

**Associated Edit Checks**

Rule ID	Level	Message
9501	1	Invalid value

**Definition**

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS run sheet.

**Field Values**

- 1. Fall adults: > 20 ft. (one story is equal to 10 ft.)
- 2. Fall children: > 10 ft. or 2-3 times the height of the child
- 3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
- 4. Crash ejection (partial or complete) from vehicle
- 5. Crash death in same passenger compartment
- 6. Crash vehicle telemetry data (AACN) consistent with high risk injury
- 7. Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact
- 8. Motorcycle crash > 20 mph

**Additional Information**

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Sheet indicates patient did not meet any Vehicular, Pedestrian, Other Risk Injury criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated on the EMS Run Sheet or if the EMS Run Sheet is not available.
- Check all that apply.

**Data Source Hierarchy**

- 1. EMS Run Sheet

**Associated Edit Checks**

Rule ID	Level	Message
9601	1	Invalid value

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## Hospital Discharge Disposition (DC\_DISPOSITION\_CODE)

**Definition:** Where did the patient go after being discharged from trauma? (**Modified 2014**, replace hospital with trauma) (Applies only to patients who were admitted to the hospital; does not apply to ED-only patients)

**Values:**

- ACUTE = Discharged/transferred to another acute care hospital (NTDS1)
- AMA = Patient left the hospital against medical advice (NTDS4)
- D = Patient died after admission to the hospital (NOT in the ED) (NTDS5)
- DSS = Discharged to the Department of Social Services (NTDS14)
- HH = Discharged to home under care of a Home Health Agency (any outside agency that provides services after discharge, such as visiting nurse services) (NTDS3)
- HOME = Discharged to home/any residence with no home health services (NTDS6)
- HOSPICE = Discharged/transferred to hospice care (NTDS8)
- ICF = Discharged/transferred to an Intermediate Care Facility (NTDS2)
- JAIL = Discharged to a jail, prison, or other detention facility (NTDS10)
- LTAC = ~~Discharged/transferred to a Long-term acute care (NX)~~  
Discharged/transferred from trauma to a long-term acute care (LTAC) facility or a unit of the initial hospital for inpatient care including disposition or placement. Not on a trauma or rehabilitation service. (**Modified 2014**) (NTDS12)
- NHOME = Patient was discharged to a nursing home or other long-term residential care facility (NTDS12)
- PSYCH = Discharged to inpatient psychiatric care. This may be another facility or a division of the same facility (NTDS13)
- REHAB = Discharged/transferred to rehabilitation facility (NTDS11)
- SNF = Discharged/transferred to a Skilled Nursing Facility (NTDS7)
- OTHER = Other (NTDS14)
- NA = Not applicable(patient was never admitted as an inpatient; patient was an ED-only patient)
- UNK = Unknown or not documented

**Related Variables:** Outcome  
Emergency Department Disposition  
Arrival at Trauma Center Date & Time, Admit Date & Time, Discharge Date & Time

**Examples:** If Outcome = "D" and the patient died after admission to the hospital, this value should be "D".  
If the ED\_Disposition indicates that the patient was not admitted, this value should be "NA".  
If a patient resided in a nursing home and returned to the nursing home after admission, the hospital discharge disposition should be NHOME, not HOME.  
If the patient came from a SNF and returned to the SNF after admission, the

## Co-morbid Conditions (RISK\_TYPE)

<b>Definition:</b>	Disease processes or conditions that existed in the patient PRIOR TO INJURY that could affect patient survivability and functional outcome	
<b>Values:</b>	ABUSE	= <del>Current abuse of prescription or illicit drugs</del> (MODIFIED, 2014, apply NTDS28 definition) With particular attention to opioid, sedative, amphetamine, cocaine, diazepam, alprazolam, or lorazepam dependence (excludes ADD/ADHD or chronic pain with medication use as prescribed) (NTDS28)
	ANGINA	= History of angina within past 1 month (NTDS16)
	ANOM	= Congenital anomalies (NTDS6)
	ASCITES	= Ascites within 30 days (NTDS3)
	ASTHMA	= Asthma
	CA	= Disseminated cancer (NTDS12)
	CARDIAC	= <del>Any history of cardiac disease (e.g., hx of MI more than 6 months ago, cardiac arrhythmias, a-fib, hx of CABG or stent placement, pacemaker)</del> (MODIFIED, 2014, apply NTDS29 definition). A sudden, abrupt loss of cardiac function which occurs outside of the hospital, prior to admission at the center in which the registry is maintained, that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support by a health care provider. (NTDS29)
	CHEMO	= Chemotherapy for cancer <del>within 30 days</del> (Modified, 2014) (NTDS5)
	CHF	= Congestive heart failure (NTDS7)
	CIRRH	= Cirrhosis (NTDS25)
	COAG	= Bleeding disorder <del>or on anticoagulants</del> (Modified, 2014) (NTDS4)
	COPD	= <del>Chronic obstructive pulmonary disease</del> (RETIRED, 2014; see RESP)
	CVA	= CVA/residual neurological deficit (NTDS10)
	DEM	= Dementia (NEW, 2014; see SENS; NTDS26)
	DEP	= Functionally dependent health status (NTDS15)
	DIAL	= <del>Currently requiring or on dialysis</del> (MODIFIED, 2014, apply NTDS9 definition) Acute or chronic, and prior to injury, requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration (NTDS9)
	DM	= Diabetes mellitus, MODIFIED, 2014, apply NTDS11 definition (NTDS11)
	DNR	= Do not resuscitate (DNR) status (NTDS13)
	ETOH	= <del>Alcohol abuse or</del> (Modified, 2014) Alcoholism (NTDS2)
	HTN	= Hypertension requiring medication (NTDS19)
	IDDM	= <del>Insulin dependent diabetes mellitus</del> (RETIRED, 2014, see DM)
	IMMUNE	= Immunocompromised excluding steroid use (NTDS1)
	LIVER	= Liver disease without ascites (NTDS1)
	MI	= History of myocardial infarction within past 6 months (NTDS17)
	NEURO	= Neurologic disorder (Parkinson's, seizures, multiple sclerosis, etc.) (NTDS1)

OBESE	= Obesity based on BMI $\geq$ 30 ( <b>Modified, 2014; from 40;</b> NTDS22)
PAIN	= Chronic pain (NTDS1)
PREG	= Pregnancy (NTDS1)
PREM	= Prematurity (NTDS21)
PSYILL	= Major psychiatric illness ( <b>NEW, 2014;</b> see SENS; NTDS27)
RAP	= History of revascularization or amputation for PVD (NTDS18)
RENAL	= Renal disease/insufficiency not requiring dialysis or hemofiltration ( <b>Modified, 2014; add hemofiltration;</b> NTDS1)
RESP	= Respiratory disease (e.g., severe chronic lung disease, such as COPD, emphysema, chronic bronchitis or COPD, cystic fibrosis) (NTDS23)
SCI	= Pre-existing spinal cord injury (NTDS1)
SENS	= <del>Impaired sensorium, including dementia, Alzheimer's, chronic mental illness, mental retardation, attention disorders (RET, 2014; see DEM and PSYILL)</del>
SMOKER	= Current smoker (i.e., smoked cigarettes in the year prior to admission) (NTDS8)
STEROID	= Steroid use, oral or parenteral, in the 30 days prior to injury for a chronic medical condition. Does not include steroids received topically or by inhalation (NTDS24)
SURG	= History of any type of surgery in the past 3 weeks (NTDS1)
VAR	= Esophageal varices (NTDS14)
OTHER	= Other (a co-morbidity not mentioned above) (NTDS1)
NA	= For patients with no known co-morbid conditions (NTDSNull/NA)

### Examples:

CHF = Congestive Heart Failure  
Includes congestive heart failure, left heart failure and pulmonary edema associated with heart disease. This category DOES NOT INCLUDE patients who develop heart failure or pulmonary edema after injury.

RESP = Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis. Include severe chronic lung disease, chronic obstructive pulmonary disease (COPD) such as emphysema and/or chronic bronchitis resulting in any one of more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living[ADLs].)
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.

COAG = Coagulation defects resulting from a congenital bleeding disorder (hemophilia), liver disease or anti-coagulant medications. Includes any pre-existing condition resulting in a prolonged PT, PTT or bleeding time (twice the normal value as the individual facility's lab standard). This includes congenital coagulation defects/deficiencies (hemophilia A, hemophilia B, factor VIII, IX, XI or other clotting factor disorders, von

## Hospital Complications (COMP\_TYPE)

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

<b>Values:</b>	ACS	= Abdominal compartment syndrome (NTDS1)
	ABD	= Abdominal fascia left open (NTDS1)
	ARF	= <del>Acute renal failure</del> (Modified 2014, apply NTDS4 definition) Acute kidney Injury (NTDS4)
	ARDS	= <del>Acute respiratory distress syndrome</del> (Modified 2014, apply NTDS5 definition) Acute lung injury (ALI)/Adult (acute) respiratory distress syndrome (ARDS) (NTDS5)
	BLD	= Bleeding (NTDS1)
	CATH	= Catheter-related bloodstream infection (NTDS28)
	CPR	= Cardiac arrest with CPR (NTDS8)
	COAG	= Coagulopathy (NTDS1)
	COMA	= Coma (NTDS1)
	CVA	= Stroke or CVA (NTDS22)
	DECUB	= Decubitus ulcer (NTDS11)
	DISRUPT	= Wound disruption (NTDS1)
	DVT	= Deep vein thrombosis (DVT) or thrombophlebitis (NTDS14)
	ECS	= Extremity compartment syndrome (NTDS15)
	FAIL	= Graft or prosthesis or flap failure (NTDS16)
	ICP	= Intracranial pressure (NTDS1)
	ICU	= Unplanned return to the ICU (NTDS31)
	INTUB	= Unplanned intubation (NTDS25)
	MI	= Myocardial infarction (NTDS18)
	OR	= Unplanned return to the OR (NTDS30)
	ORGAN	= Organ or space surgical site infection (NTDS19)
	OSTEO	= Osteomyelitis (NTDS29)
	PNEU	= Pneumonia (NTDS20)
	PE	= Pulmonary embolism (NTDS21)
	SEPSIS	= <del>Systemic sepsis (RETIRE, 2014, see SEVSEP)</del>
	SEVSEP	= Severe sepsis (NTDS32)
	SUP	= Superficial surgical site infection (NTDS23)
	SURGINF	= Deep surgical site infection (NTDS12)
	UTI	= Urinary Tract Infection (NTDS27)
	WITH	= Drug or alcohol withdrawal syndrome (NTDS13)
	OTHER	= Other complication not listed above (NTDS1)
	NA	= Not applicable (use for patients with no complications) (NTDS Null/NA)
	UNK	= Unknown or not documented (NTDS Null/NA)



**Notes:** Allows data to be used to characterize patients and hospital outcomes based upon the presence (and type) or hospital complication.

Definitions for some of these co-morbidities can be found in the 2011 National Trauma Data Standard data dictionary in Appendix 4: Glossary of Terms (see pages 133-140 at

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## Triage Codes (TRIAGE\_CODES) – IN PROGRESS

**Definition:** The triage criteria USED BY THE PREHOSPITAL CARE PROVIDER to decide where (which facility) the patient should be taken.

**Values:** NONE = No triage criteria met

AMPUT = Amputation or near amputation above the wrist or ankle.

Amputations of the finger do not meet these criteria. (NTDS Trauma Center Criteria, 2014, pg55; N8)

BLAST = High energy dissipation from explosion, high pressure, etc. (CO)

BLUNT = Significant blunt trauma. Defined as blunt trauma with physiologic compromise as evidenced by Systolic BP <90 or Pulse >120 or respiratory rate <10 or >29 or requiring endotracheal intubation. For children under age 15, physiologic compromise is evidenced by BP < lower limits for age or tachycardia for age and signs of poor perfusion (capillary refill time >2 seconds, cool extremities, decreased pulses, altered mental status, poor color or respiratory compromise).

BURNS =  $\geq$  20% total body surface area burn or burns involving the face, airway, hands, feet or genitalia (CO)

CHEST = Flail chest. ~~This code is NOT for all chest injuries, only for flail chest. If this triage code is selected, one of the diagnoses should be flail chest (807.4).~~ (MODIFIED, 2014; apply NTDS5) Chest wall instability or deformity (e.g., flail chest) (NTDS Trauma Center Criteria, 2014, pg55; NTDS5)

CRASH = High energy transfer situations such as an MVA with significant vehicle body damage (e.g., bent steering wheel, structural damage) or any motorcycle, ATV or bicycle crash. Also includes a skier hitting a tree.

DEATH = Death of an occupant in the same car

EXTRIC = Prolonged extrication time (>20 minutes)

FALL = A fall from a height  $\geq$  20 feet or for pediatric patients from a level more than or equal to twice the height of the child. Falls from the same level, from furniture, from a horse/bike etc. do not meet these criteria.

ELEC = High energy electrical injury

EXTREM = Crushed, degloved or mangled, or pulseless extremity (MODIFIED, 2014; add 'pulseless') (NTDS Trauma Center Criteria, 2014, pg55; NTDS7)

FX = Fracture of a long bone, in conjunction with an injury to another region. Long bones include femur, tibia/fib, and humerus. An isolated long bone fracture does not meet these criteria. This triage code should only be used when there is a long bone fx in addition to at least one other area of injury (CHEST, HEAD, ABDOMEN, etc). The AIS of the injuries to the other areas should be 2 or greater.

