New York State Trauma Registry

Data Dictionary

NEW YORK STATE | Department of Health

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Acknowledgements

New York State Registry Data Dictionary Workgroup 2023

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Introduction to NYSTR

In 2005, the New York State trauma registry was developed to identify key elements of traumatic injury trends statewide. In support of the development, assessment and ongoing monitoring of care outcomes, the collection of standardized data specific to the New York State trauma patient must be standardized and aggregated in a New York State trauma registry.

The data will be used to:

- Identify traumatic injury trends
- Evaluate the NYS Trauma System and EMS System
- Monitor trauma care outcomes and identify opportunities for improvement
- Establish uniformity of data collection and reporting processes

Section 1: NYSTR Basics

Case Definition

New York State Trauma Registry Inclusion Criteria

The New York State Trauma Registry (NYSTR) is intended to collect information on patients with traumatic injuries that were treated in New York State hospitals. To ensure standardized data collection across NYS hospitals, a trauma patient is defined as a patient sustaining a traumatic injury within 14 days of admission meeting the following criteria:

Admission or treatment in a NYS hospital with at least one of the injury codes:

ICD-10 code of: S00-S99 with 7th character modifiers of A, B, or C ONLY (Injuries to specific body parts-initial encounter); T07, T14, T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome-initial encounter only).

Superficial injuries are excluded: S00, S10, S20, S30, S40, S50, S60, S70, S80 and S90. Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded. (ICD-10 will be required beginning 1/1/16.)

Patients presenting with one of these preceding injury codes who:

Has been admitted or placed in observation status for 23 hours or more

OR

Presented to the hospital and died of their traumatic injuries

OR

Was transferred in from another acute care hospital or from your facility for the care of injury

OR

Was directly admitted to your hospital (excluding elective or planned surgical admissions)

Should be included in the trauma center registry and should be submitted to the New York State Trauma Registry.

Submission Guide

All hospitals in New York State (NYS) who care for traumatically injured patients are required to submit registry data electronically to the New York State Department of Health (NYSDOH) through Image Trend, the vendor that serves as the State repository (https://newyork.emsbridge.com/patientregistry), on the following schedule:

1st Quarter Submissions	Jan, Feb, March discharges	Jul 1 submission deadline
2nd Quarter Submissions	Apr, May, June discharges	Oct 1 submission deadline
3rd Quarter Submissions	Jul, Aug, Sept discharges	Jan 1 submission deadline
4th Quarter Submissions	Oct, Nov, Dec discharges	Apr 1 submission deadline

Inclusion Algorithm

New York State Trauma Registry Inclusion Criteria will follow the current NTDS patient inclusion criteria standard.

In keeping with the standards set forth by the American College of Surgeons Committee on Trauma (ACS-COT), the core data points in the National Trauma Data Set (NTDS) are required data elements in the NYSTR. Each year, there will be automatic inclusion in the NYSTR of any new data elements introduced in the new edition of the NTDS. The current data dictionary for the NTDS can be found at: https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb The NYSTR manual **only** describes the NYS-specific data elements that are in addition to those core NTDS data elements. **These are mandatory data elements that must be completed for each trauma patient**. Each field is detailed with definitions, constraints, value choices, source, type, etc.

The state-specific data elements, field choices and data collection instructions are the responsibility of the NYSDOH working in conjunction with the Registry Subcommittee of the New York State Trauma Advisory Committee (STAC).

Reconciling the SPARCS list and Vital Records Files list with data submission:

It is critical that all qualified records for each hospital be submitted to the NYSTR to ensure the NYSTR captures an accurate dataset. Hospitals in NYS submit information electronically regarding diagnosis and procedure codes to the Statewide Planning and Research Cooperative Systems database (SPARCS) and Vital Records files. The SPARCS database is queried for ICD-10 diagnosis codes that warrant inclusion in the NYSTR. Hospitals that submit cases to the NYSTR have their records checked against the inpatient and outpatient SPARCS datasets to ensure that all appropriate cases are entered into the trauma registry. This matching process looks at identifiers in both the referring hospital portion and the final hospital portion of the NYSTR record. Hospitals also have Vital Records Files queried for trauma cases. It is possible for a record to be submitted to the State registry that does not have a corresponding SPARCS record.

For a match to be valid, **the PFI number, medical record number and date of birth must match exactly**. In addition, either the admission or the discharge date must be within one day of the dates reported to SPARCS or the Vital Records File.

Process, Implementation and Evaluation:

- The Registry Subcommittee, or any member of STAC, proposes changes to the NYSTR (recommendations are made to the Chair of the Registry Subcommittee).

- Trauma Centers and members of STAC comment.

- Definitions are finalized and accepted for inclusion in the NYSTR dataset.

- Members of STAC vote on the proposed change(s) **no later than April 1st with implementation on January 1st of the following year.**

- The finalized change(s) are submitted to Image Trend in writing by the Department of Health Bureau of trauma and EMS. The technical aspects of the change(s) will be locked down by July 1st and will be communicated to all involved vendors.

- The Department notifies all hospitals of the change(s) and start date and with support of the STAC registry subcommittee educational materials for NYS trauma registrars and program staff will be developed and distributed no later than fall STAC meeting preceding Jan 1 of the subsequent year or prior to when changes take place.

- The Department confirms that the change(s) are downloading appropriately, and that the data appears valid. Any identified issues with a download will be communicated by the Department to the involved facility and vendor.

Guidelines for Inclusion and Exclusion

1. Appendix II contains the E-codes/External Cause codes that might make a case ineligible for the NYSTR. These **External Cause codes** include: V90, V92, W42, W46, W65-W69, W73-W74, W85-W90, W92-W94, W99, X10-X19, X30-X32, X38, X71, X75, X77, Y21, Y25, Y27, Y35-Y38, Y62-Y69, Y70-Y82, Y83-Y84, Y90-Y99.

2. Records with a principal diagnosis of V57 are excluded (unless the records reflect trauma deaths in the Emergency Department).

3. Every record that is "eligible" for inclusion in the registry should be reviewed.

In certain cases, the reviewer may determine that the record should not be included. In this case, the reviewer completes an Exclusion Report for the record (see section on "Who to Exclude") and submits these quarterly to the Department through the State's Health Commerce System (HCS).

Exclusions: (Also refer to Appendix III: Exclusion Format)

When a record is reported as an exclusion, that record must be recorded on the Exclusion Form located in Appendix III and submitted quarterly to the New York State Health Commerce System (HCS). Records excluded should be marked with a reason for exclusion. The standard list of exclusions below should be used for categorizing exclusions. Appendix III provides additional detail for each exclusion reason.

Reason for exclusion:

1. If the **injury occurred while in your acute care hospital**. For example, injuries related to a fall in hospital, birth trauma or intraoperative complication should be excluded.

2. Exclude the record if the injury occurred more than **14 days** prior to this hospitalization.

3. Exclude the record if this is a **re-admission for treatment of an injury already captured in the registry**. NOTE: These records may be combined into one.

4. The **ICD-10 code assigned is incorrect** and the correct code is not on the state inclusion list.

5. In rare instances, a record may be excluded because it cannot be located despite multiple attempts to locate it over several months.

6. Record was submitted to SPARCS in error, patient was **not admitted** to the hospital but was submitted to SPARCS.

7. Exclude patients admitted to same day surgery for the care of a previously diagnosed injury.

Identification of cases for inclusion:

1. Hospitals can generate a daily admission list of any patient with an ICD-10 code that may warrant inclusion in the NYSTR. The list is then reviewed and NYS cases based on ICD-10 codes and age are selected. Potential cases for the registry can also be identified by reviewing the ED log every day.

2. The SPARCS list is **not** the daily trauma census. The two will not match. The SPARCS list will include many patients with whom the trauma team may not have been involved. Each record on the SPARCS list must be reviewed and either collected or excluded.

3. **DO NOT** wait for a SPARCS list to begin the process of data collection. SPARCS lists are generated 12-18 months after patient discharge.

4. Identify the ED trauma deaths by either: reviewing the ED log or asking the ED Manager for a daily list of all deaths so you may select the trauma cases. Deaths occurring in the ED after traumatic injury **are included** in the NYSTR.

5. **Regardless of resuscitation or intervention**:

    - **DOA**: Defined as arrived **WITHOUT** recordable/reportable VS/signs of life, and never regained VS/signs of life, despite no or any intervention
    - **DIED in ED**: Defined as arrived **WITH** recordable/reportable VS/signs of life, **OR**, regained VS/signs of life after arrival, but subsequently lost VS/signs of life, and was pronounced

Common Null Values

Definition

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

Field Values

1 Not Applicable
2 Not Known/Not Recorded

Additional Information

For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data.

- **Not Applicable (NA)**: This null value code applies if, at the time of patient care documentation, the information requested was “Not Applicable” to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transports to the hospital.
- **Not Known/Not Recorded (NK/NR)**: This null value applies if, at the time of patient care documentation, information was “Not Known” (to the patient, family, health care provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as “Unknown”. Another example “Not Known/Not Recorded” should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for a patient transported by EMS).

Section 2: NYS Field Value Definitions

Section 2a: Demographic Data

Field: Medical Record Number

Definition

The medical record number that is reported to SPARCS by the final hospital for this patient.

Field Values

Numeric Value of Medical Record Number

Additional Information

- This field is used for linking purposes only and will not be made public
- This field is crucial for matching against SPARCS and Vital Records files

Data Hierarchy: Hospital Admission (Face) Sheet

Data Type: Numeric value

History: Reviewed 7/2015, 4/2019

Field: Patient's Last Name

Definition

The last name of the patient.

Field Values

Relevant for this data element.

Additional Information

- This field is used to create a unique identifier that will be used for matching purposes.

Data Hierarchy: ACR/PCR, Hospital Admission (Face) Sheet, Emergency Department Notes, Discharge Summary

Data Type: Alpha Text

History: Added 1/2013; Reviewed 7/2015, 4/2019

Field: Patient's First Name

Definition

The first name of the patient.

Field Values

Relevant for this data element.

Additional Information

- This field is used to create a unique identifier that will be used for matching purposes.

Data Hierarchy: ACR/PCR, Hospital Admission (Face) Sheet, Emergency Department Notes, Discharge Summary

Data Type: Alpha Text

Field: Social Security Number

Definition

The last four (4) digits of the patient's Social Security number.

Field Values

Relevant for this data element.

Additional Information

- If the patient's social security number is unknown, enter "0000".
- The last four (4) digits of the patient's Social Security number is used to create a unique identifier that will be used for matching purposes. This will not be made public.

Data Hierarchy: Hospital Admission (Face) Sheet

Data Type: Numeric

Data History: Added 1/2013; Reviewed 7/2015, 4/2019

Section 2b: Injury Information

Field: Height of Fall

Definition

The distance in feet the patient fell, measured from the lowest point of the patient to the ground.

Field Values

- 0-200 ft
- Not Applicable
- Not Known/Not recorded

Additional Information

- Fall height should be recorded as documented or estimated as 1 foot per step, 10 feet per story.
- A fall from standing is considered a level surface fall, enter 0 for fall height
- Use whole numbers, round conservatively. If documentation has a range of fall height, i.e. 10 – 20 feet, code conservatively at 10 feet.
- If the mechanism of injury is not a fall, enter "Not Applicable"

Data Hierarchy: ACR/PCR, Trauma Flow Sheet, Triage notes, Emergency Department Notes, H/P

Data History: Added 1/2013; Reviewed 7/2015, 4/2019, 1/2022

Height of Fall Reference Table		
Item	*Standard Height*	*Range Height*
Chair (standard)	18 inches	(17 -20 inches)
Stool (counter)	24 inches	(24-27 inches)
Stool (bar)	30 inches	(28- 33 inches)
Highchair	35-45 inches	
Wheelchair	18 inches	(18-20 inches)
Toilet/Commode	15 inches	(14-19 inches)
Bed (standard)	24 inches	(18 -25 inches)
Platform	18 inches	
Antique	36 inches	
Futon	18 inches	

Field: Trauma Type

Definition

The type of injury.

Field Values

- Blunt
- Penetrating
- Burn

Additional Information

- Vendor autofill based on ICD-10 code is the best practice
- Registrars should follow NTDS logic rules

Data Hierarchy: ICD-10 E Code based on E-code cause of injury.

Data Type: Alpha Character

Data History: Added 1/2013; Reviewed 7/2015, 4/2019

Section 2c: Pre-hospital Information

Field: Service

Definition

The EMS agency that provided the care documented in the first ACR/PCR.

Field Values

- Relevant for the data element
- Not Applicable
- Not Known/Not Recorded

Additional Information

- Four (4-digit) PCR field 'Agency Code'. Up to date listings can be found at: http://www.health.ny.gov/professionals/ems/State_trauma_registry_data_dictionary.htm
- If the patient is a transfer, use the ACR/PCR into your facility
- "Not applicable" should be used if the patient arrived via transportation other than ambulance/air medical

Data Hierarchy: ACR/PCR

Data Type: Alpha Character

Data History: Added 1/2013; Reviewed 7/2015, 4/2019, 10/2022

Field: Arrived From

Definition

The location the patient arrived from.

Field Values: **(Picklist)**

- Scene
- Referring hospital/facility
- Clinic/MD Office
- Jail
- Home
- Nursing Home
- Supervised Living
- Not Applicable
- Not Known/Not Recorded

Additional Information

- Use **scene** if the patient arrives directly from the scene of injury to your facility or occurred at a residence that is not the patient's primary residence.
- **Referring Hospital/Facility** means either an acute care hospital or a facility providing acute nursing care including acute rehab & psychiatric facilities, includes standalone Emergency Department. Includes facilities subject to **EMTALA** rules.
- **Clinic/M.D. Office** means any outpatient clinic or private physician's office, **urgent care**
- Use **Home** if the scene of the accident is the patient's current primary residence.
- **Nursing Home** means any Skilled Nursing Facility where the patient permanently resides.
- **Supervised Living** means foster care, group homes or Assisted Living Facilities.

Data Hierarchy: ACR/PCR, Trauma Flow Sheet, Triage Note, Emergency Department Notes, H/P, Case management notes

Data Type: Alpha Character

Data History: Added 1/2013; Reviewed 7/2015, 4/2019

Field: Pre-hospital Treatments: Chest Decompression

Definition

Record of chest decompression, relief of pressure within the chest, performed by EMS personnel

Field Values

- Needle Thoracostomy
- Not performed
- Not Applicable
- Not Known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Pre-hospital Treatments: Airway Management

Definition

Record of airway intervention by EMS personnel

Field Values [Picklist used]

- Oxygen by Nasal Cannula
- Oxygen by mask
- Bag-Valve Mask
- Endotracheal intubation
- Bipap/cpap
- Alternative airway device (retroglottic/supraglottic airway)
- Not performed
- Not applicable
- Not known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR. Multiselect field, select all that apply.
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes, H/P, consult notes

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Pre-hospital Treatments: Pre-hospital IV/IO fluids

Definition

Record of pre-hospital administration of intravenous/intraosseous fluids

Field Values [Picklist used]

- IV fluids administered
- I/O fluids administered
- Not performed
- Not applicable
- Not known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR.
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes, H/P, consult notes

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Pre-hospital Treatments: Pre-hospital Blood Administration

Definition

Record of pre-hospital administration of blood products

Field Values [Picklist used]

- EMS blood administration during transport
- Air Medical blood initiation/administration
- Not performed
- Not applicable
- Not known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR.
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes, H/P, consult notes

History: Added 4/2019

Field: Pre-hospital treatments: Pre-hospital Hemorrhage Control

Definition

Record of pre-hospital hemorrhage control procedures

Field Values [Picklist used, select all that apply]

- Direct pressure
- Tourniquet applied
- Hemostatic dressing
- Pelvic Binder
- Patient or bystander-initiated bleeding control measures
- Not performed
- Not applicable
- Not known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR.
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle
- Hemostatic dressing refers to a coated dressing applied to control bleeding.

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes, H/P, consult notes

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Pre-hospital treatments: Pre-hospital immobilization

Definition

Record of pre-hospital immobilization

Field Values [Picklist used, select all that apply]

- C Spine
- Long board
- Limb
- Not performed
- Not applicable
- Not known/Not recorded

Additional Information

- Record treatments documented in the ACR/PCR.
- If documentation exists in the medical record this may be used **if** the PCR is not available
- Use “Not applicable” for patients arriving by private vehicle

Data Source: ACR/PCR, Trauma Flow Sheet, Triage note, Emergency Department notes, H/P, consult notes

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: EMS Dispatch Date

Definition

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

Field Values

- Relevant value for data element

Additional Information

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

Data Source: ACR/PCR

Field: EMS Dispatch Time

Definition

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

Field Values

- Relevant value for data element

Additional Information

- Reported as military time HH:MM
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched.
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Unit Arrival Date: Scene/Referring Facility

Definition

The date the unit transporting to your hospital arrived on the scene/transferring facility.

Field Values

- Relevant value for data element

Additional Information

- Reported as MM-DD-YYYY
- For inter-facility transfer patients, this is the date at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility arrived at the scene
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Arrival Time: Scene/Referring Facility

Definition

The time the unit transporting to your hospital arrived at the scene/transferring facility

Field Values

- Relevant value for data element

Additional Information

- Reported as HH:MM
- For inter-facility transfer patients, this is the time which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility arrived at the transferring facility
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Unit Patient Contact Date

Definition

The date the unit transporting to your hospital made patient contact on scene.

Field Values

- Relevant value for data element

Additional Information

- Reported as MM-DD-YYYY
- For inter-facility transfer patients, this is the date at which the unit transporting the patient to your facility from the transferring facility made contact with the patient at the referring facility
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility made patient contact with the patient at the referring facility
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Unit Patient Contact Time

Definition

The time the unit transporting to your hospital made contact with the patient on scene

Field Values

- Relevant value for data element

Additional Information

- Reported as HH:MM
- For inter-facility transfer patients, this is the time which the unit transporting the patient to your facility from the transferring facility made contact with the patient at the referring facility
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility made contact with the patient
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Unit Departure Date: Scene/Referring Facility

Definition

The date the unit transporting to your hospital departed from the scene/transferring facility

Field Values

- Relevant value for data element

Additional Information

- Reported as MM-DD-YYYY
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility departed at the transferring facility
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: EMS Unit Departure Time: Scene/Referring Facility

Definition

The time the unit transporting to your hospital departed from the scene/transferring facility

Field Values

- Relevant value for data element

Additional Information

- Reported as HH:MM
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility departed at the transferring facility
- The null value “Not applicable” is reported for patient who were not transported by EMS.

Data Source: ACR/PCR

Field: Initial Field Systolic B/P

Definition

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

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded’ is reported if the patient is transferred to yourfacility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- Measure reported must be without the assistance of CPR or any time of mechanical chest compression device.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initialfield systolic blood pressure was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field Diastolic B/P

Definition

First recorded diastolic blood pressure measured at the scene of injury.

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to yourfacility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- Measure reported must be without the assistance of CPR or any time of mechanical chest compression device.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initialfield diastolic blood pressure was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field Heart Rate

Definition

First recorded heart rate measured at the scene of injury, expressed as a number per minute.

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to yourfacility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of Not known/Not recorded for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- Measure reported must be without the assistance of CPR or any time of mechanical chest compression device.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initialfield heart rate was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field Respiratory Rate

Definition

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

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to yourfacility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- Measure reported must be without the assistance of CPR or any time of mechanical chest compression device.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initialfield respiratory rate was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field Oxygen Saturation

Definition

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

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to yourfacility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- Value should be based upon assessment before administration of supplemental oxygen.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in.
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initialfield oxygen saturation was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field GCS – Eye Opening

Definition

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

Field Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Open eyes spontaneously

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to your facility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: “patient’s pupils are PERRL,” an Eye GCS of 4 may be reported, IF there is no other contradicting documentation.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in.
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initial field GCS - Eye was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field GCS – Verbal

Definition

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

Field Values

Pediatric (≤ 2 years):

1. No vocal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but is consolable
5. Smiles, oriented to sounds, follows objects, interacts

Adult

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to your facility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: “patient withdraws from a painful stimulus,” a Motor GCS of 4 may be report, IF there is no other contradicting documentation.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in.
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initial field GCS - Verbal was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field GCS – Motor

Definition

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

Field Values

Pediatric (≤ 2 years):

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Appropriate response to stimulation

Adult

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Obeys commands

Additional Information

- The null value of "Not known/Not recorded" is reported if the patient is transferred to your facility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of "Not known/Not recorded" for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be reported. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be report, IF there is no other contradicting documentation.
- The null value of "Not applicable" is reported for patients who arrive via public/private vehicle or walk in.
- The null value of "Not known/Not recorded" is reported if the patient's first recorded initial field GCS - Motor was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Field: Initial Field GCS – Total

Definition

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

Field Values

- Relevant value for data element

Additional Information

- The null value of “Not known/Not recorded” is reported if the patient is transferred to your facility with no EMS run report from the scene of injury
- Collect VS collected prior to EMS departing the scene and < 30 minutes from EMS arrival, record null value of “Not known/Not recorded” for VS not collected prior to departing the scene or < 30 minus from arrival on scene
- If a patient does not have a numeric GCS score recorded, but there is documentation related to their level of consciousness such as “AAOx3”, “awake alert and oriented”, or “patient with normal mental status”, report this as GCS of 15 IF there is no other contradicting documentation.
- The null value of “Not applicable” is reported for patients who arrive via public/private vehicle or walk in.
- The null value of “Not known/Not recorded” is reported if the patient’s first recorded initial field GCS - Total was NOT measured prior to departure from the scene.

Data Source: ACR/PCR

Section 2d: Referring Hospital Information

Field: Medical Record Number

Definition

The medical record number that is reported to SPARCS by the referring hospital for this patient.

Field Values [Picklist used]

- Relevant value for data element
- Not applicable
- Not known/Not recorded

Additional Information

- This field is for linking purposes only and will not be made public.
- This field is crucial for matching against SPARCS and Vital Records Files.

Data Source: Hospital admission (Face) sheet.

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Transport Mode

Definition

The mode of transport used to deliver the patient to the referring hospital.

Field Values [Picklist used]

- Ground ambulance
- Helicopter ambulance
- Fixed-wing ambulance
- Private/public vehicle/walk-in
- Police
- Other
- Not known/Not recorded

Additional Information

- If EMS response times are provided, transport mode cannot be Private/Public vehicle/walk-in.

Data Source: ACR/PCR, Trauma flow sheet, Triage note, Emergency Department notes

Data Type: Text

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital PFI Number

Definition

The Permanent Facility ID number (PFI) of the referring acute care hospital.

Field Values

- Four (4-) digit code assigned to each hospital by New York State (listed in Appendix IV).

Additional Information

- The hospital PFI number is different from the three (3)-digit EMS number that EMS agencies use to indicate the hospital to which the patient was transported.
- A referring hospital is defined for this section as an acute care hospital and does not include acute psychiatric or rehabilitation facilities.

Data Source: Hospital Admission (Face) Sheet

Data Type: Text

History: Added 1/2013, Revised 7/2015, Reviewed 4/2019

Field: Referring Hospital: Arrival Date

Definition

The date the patient arrived at the referring hospital.

Field Values

- Relevant value for the data element.

Additional Information

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

Data Source: Hospital Admission (Face) Sheet, Emergency Department notes, Trauma flow sheet, Triage note

Data Type: Text

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital: Arrival Time

Definition

The time the patient arrived at the referring hospital.

Field Values

- Relevant value for the data element.

Additional Information

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

Data Source: Trauma flow sheet, Triage note, Hospital Admission (Face) Sheet, Emergency Department notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital: Discharge Date

Definition

The date the patient was discharged from or transferred out of the referring hospital.

Field Values

- Relevant value for the data element.

Additional Information

- Collected as YYYY-MM-DD
- This field is used to calculate the length of stay (time from ED arrival to hospital discharge) at the referring facility.
- This field is crucial for matching.

Data Source: Hospital Admission (face) Sheet, Billing Sheet/Medical Records Coding Summary Sheet, Physician Discharge Summary, Emergency Department Notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital: Discharge Time

Definition

The time the patient was discharged from or transferred out of the referring hospital.

Field Values

- Relevant value for the data element.

Additional Information

- Collected as HH:MM military time
- This field is used to calculate the length of stay (time from ED arrival to hospital discharge) at the referring facility.

Data Source: Hospital Admission (face) Sheet, Physician Discharge Summary, Emergency Department Notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital GCS – Eye

Definition

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

Field Values [Picklist]

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously.
5. Not known/not recorded

Additional Information

- Used to calculate overall GCS
- GCS is the best response at maximal arousal after resuscitation
- If numeric GCS values were not recorded in the record, the documentation of assessment may be used to apply a numeric score, i.e. the ED provider notes: alert and oriented x 3, moving all extremities spontaneously" the score for eye opening can be recorded as 4.
- If the eyes are swollen shut prohibiting assessment, the score should be (1).
- "Not applicable" applies to patients not transferred.
- The eye component of the GCS is valid for patients of all ages.

Data Source: Hospital Admission (face) Sheet, Billing Sheet/Medical Records Coding Summary Sheet, Physician Discharge Summary, Emergency Department Notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital GCS – Verbal

Definition

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

Field Values

Adult

1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Oriented
6. Not known/Not recorded

Peds (< or = 2 years of age)

1. No verbal response
2. Inconsolable, agitated
3. Inconsistently consolable, moaning
4. Cries but consolable, inappropriate interactions
5. Smiles, oriented to sounds follows objects interacts

Additional Information

- Used to calculate overall GCS
- If the patient is intubated, then the GCS verbal score is equal to one (1).
- If the notes reflect a patient who is moaning, enter a score of two (2).

Data Source: Trauma flow sheet**,** ED Department notes, Physician notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital GCS – Motor

Definition

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

Field Values (picklist)

Adult

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localizing pain
6. Following commands

Peds (< or = 2 years of age)

1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal form pain
5. Localizing pain
6. Appropriate response to stimulation

Additional Information

- Used to calculate overall GCS
- If the GCS is not documented but the record reflects “Alert and orientated x 3, moving all extremities then the motor score should be entered as six (6).
- If GCS is not specified but documents notes “decerebrate” movement, enter a score of two (2).
- If GCS is not specified but documents notes “decorticate” movement, enter a score of three (3).
- If GCS is not specified but documentation for purposeful movement is noted, enter a score of four (4).
- If the patient is intubated then the GCS verbal score is equal to one (1).

Data Source: Trauma flow sheet**,** ED Department notes, Physician notes

Data Type: Numeric

History: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Calculated Glasgow Coma Score

Definition

Total Glasgow Coma Score at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- Auto-calculated from scores for eye, verbal and motor GCS scores
- GCS range is 3-15

Data Source: Trauma flow sheet, Emergency Department Notes, Physician notes

Date last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital GCS Assessment Qualifiers

Definition

Documentation of factures potentially affecting the first assessment of GCS within 30 minutes of arrival at the referring hospital.

Field Values: (Picklist)

1. Patient chemically sedated or paralyzed
2. Obstruction to the patient's eye
3. Patient intubated
4. Valid GCS: patient was not sedated, intubation or have any obstruction to the eye

Additional Information:

- Qualifies treatment given to the patient that may affect the GCS, does not apply to medications or intoxication caused by patient ingestion, i.e. ETOH, prescription drug misuse
- Chemical sedation modifier should be used for patients recently intubated with agents for sedation and/or neuromuscular blockage, i.e. succinylcholine, mivacurium, rocuronium, atracurium, vecuronium, pancuronium
- Select all that apply

Data Source: PCR, Trauma flow sheet, Emergency Department Notes, Physician notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Temperature

Definition

The first recorded temperature measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- Record in degrees Celsius (centigrade)
- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Systolic Blood Pressure

Definition

The first recorded systolic blood pressure measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Diastolic Blood Pressure

Definition

The first recorded diastolic blood pressure measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Pulse Rate

Definition

The first recorded pulse rate measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- Record as number per minute
- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Respiratory Rate

Definition

The first recorded respiratory rate measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- Record as number per minute
- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Oxygen Saturation

Definition

The first recorded oxygen saturation measured within 30 minutes or less of arrival at the referring hospital.

Field Values:

Relevant value for the data element

Additional Information:

- Record as number per minute
- All referring hospital vital signs, including Temp, HR, RR, B/P, oxygen saturation does not have to be measured at the same time to be included, but must be assessed within 30 minutes of referring hospital arrival

Data Source: Trauma flow sheet, Emergency Department Notes

Date last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Referring Hospital Procedures

Definition

All key intervention, diagnostic and therapeutic procedures related to the assessment, stabilization and treatment of traumatic injuries performed at the referring hospital.

Field Values: (ICD-10) Enter the key procedure codes applicable to assessment, stabilization and treatment of traumatic injuries performed at the referring hospital. **The following list should serve as a guideline but should not limit what is reported.**

Airway

- Intubation/Ventilator use
- Surgical airway

CPR

- Performed

Operative Interventions

- Thoracotomy
- Laparotomy
- External fixation
- Tracheostomy
- Chest tube placement

Radiology

- Cat scan chest
- Cat scan c-spine
- Cat scan abd/pelvis
- Cat scan head/neck
- Chest radiograph
- Pelvis radiograph
- Focused Assessment with sonography in trauma [FAST]
- Occlusion/Embolization procedures

Therapeutics

- Administration of anti-infective
- Administration of anticoagulation reversal agent
- Transfusion of blood products

Additional Information:

- Enter ICD-10 Codes for each surgical and therapeutic procedure and radiological study key to the evaluation of the trauma injury plan of care prior to patient transfer

Data Source: Trauma flow sheet, Emergency Department Notes, Imaging Reports, Operative notes, Discharge summary, Transfer summary

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Section 2e: ED Information

Field: Hospital PFI Number

Definition

The Permanent Facility ID number of the final hospital

Field Values: (Picklist)

Four (4)-digit code assigned to each hospital by New York State Department of Health.

Additional Information:

- The hospital PFI Number is different form the three (3)-digit EMS number used by agencies to indicate the hospital to which the patient was transported.

Data Source: Hospital Admission (face) sheet

Date Last Reviewed/Revised/Added: Added 1/2013, Reviewed 7/2015, 4/2019

Field: Trauma Team Activation

Definition

Trauma resuscitation team activation level of response at the final hospital

Field Values: (Picklist)

Not activated
Full Trauma Activation
Partial Trauma Activation
Consultation

Additional Information:

- Record the **highest level** of activation called at your facility
- Full Trauma Activation is the highest level of activation resulting in full trauma team response based on criteria defined by the trauma center
- Partial Trauma Activation is a partial trauma team response as defined by the trauma center
- A consultation is the lowest level of activation. The patient did not require trauma team activation but required trauma evaluation.

Data Source: Trauma flowsheet. Emergency department notes, progress notes, consult notes

Date Last Reviewed/Revised/Added: Revised 1/2013, Reviewed 7/2015, 4/2019, 1/2022, 10/2022

Field: Initial ED/hospital Diastolic Blood Pressure

Definition

The first recorded diastolic blood pressure in the final ED/Hospital, within 30 minutes or less of ED/Hospital arrival.

Field Values: (Picklist)

Relevant value for the data element

Additional Information:

None

Data Source: Trauma flowsheet. Triage note, Emergency department notes

Date Last Reviewed/Revised/Added: Reviewed 7/2015, 4/2019

Field: ED Hemorrhage Control Procedures

Definition

Procedures for hemorrhage control performed in the final ED

Field Values: [multi-select field]

Direct pressure
Tourniquet applied
Hemostatic dressing
Pelvic Binder
Not performed
Not known/Not recorded

Additional Information:

- Collect procedures **performed** in the final ED, not prearrival in referring hospital and/or by EMS

Data Source: Trauma flowsheet. Triage note, Emergency department notes, procedure notes, operative reports, discharge summary

Date Last Reviewed/Revised/Added: Added 4/2019, 10/2022

Field: Actual ED Discharge Time

Definition

The time the patient was discharged from the ED.

Field Values:

Relevant value for the data element

Additional Information:

- Collected as HH:MM military time
- Used to calculate the length of stay in the ED (time from the ED arrival to hospital admission/death if in the ED

Data Source: Trauma flowsheet. Emergency department notes

Date Last Reviewed/Revised/Added: Added 11/2015, Reviewed 4/2019

Field: Actual ED Discharge Date

Definition

The date the patient was discharged from the ED.

Field Values:

Relevant value for the data element

Additional Information:

- Collected as YYYY-MM-DD
- Used to calculate the length of stay in the ED (time from the ED arrival to hospital admission/death if in the ED

Data Source: Trauma flowsheet. Emergency department notes

Date Last Reviewed/Revised/Added: Added 11/2015, Reviewed 4/2019

Field: Location of Procedures

Definition

Location of procedures performed during trauma admission and treatment to diagnose, stabilize or assess traumatic injury.

Field Values:

- ED
- Radiology
- OR
- Floor
- Interventional Radiology
- ICU
- Hybrid OR
- Other

Additional Information:

-Record for each reported trauma related procedure submitted in NTDS field submissions.

-Hybrid OR – a surgical theatre that is equipped with advanced medical imaging devices such as fixed C-arms, X-ray CT scanners or MRI imaging scanners. Used for minimally invasive surgical and endovascular procedures.

-All procedure, including imaging used to diagnose, stabilize or treatment traumatic injuries should be submitted including procedures completed prior to transfer out of ED or CDU should be recorded as ED procedures.

Data Source:

Date Last Reviewed/Revised/Added: Added 1/2021, updated 1/2022

Section 2f: Outcome Information

Field: Actual Discharge Time

Definition

The time the patient was discharged from the final hospital.

Field Values:

Relevant value for data element

Additional Information:

- Collected as HH:MM military time
- Used to calculate hospital length of stay (time from admission to hospital discharge)

Data Source: Discharge instructions, Nursing notes, Admission (face) sheet

Date Last Reviewed/Revised/Added: Added 11/2015, Revised 7/2015, Reviewed 4/2019

Field: Actual Discharge Date

Definition

The date the patient was discharged from the final hospital.

Field Values:

Relevant value for data element

Additional Information:

- Collected as YYYY-MM-DD
- Used to calculate hospital length of stay (time from admission to hospital discharge)

Data Source: Discharge instructions, Nursing notes, Admission (face) sheet

Date Last Reviewed/Revised/Added: Added 11/2015, Revised 7/2015, Reviewed 4/2019

Field: Glasgow Coma Score Total at Discharge

Definition

The total Glasgow Comas Score at the time of discharge from the final hospital.

Field Values:

Relevant value for data element

Additional Information:

- GCS range is from 3-15

Data Source: Discharge summary, Nursing notes

Date last Reviewed/Revised/Added: Reviewed 7/2015, Reviewed 4/2019

Appendix I.
Explanation of Fields on the Data Dictionary Page

Sections: There are 6 sections of data in the trauma registry:

- **Demographic Information** (information unique to the patient)
- **Injury Information** (information related to the injury sustained)
- **Pre-Hospital Information** (information specific to the pre-hospital care provided to the patient);
- **Referring Hospital Information** (information detailing the care provided to the patient at the referring hospital)
- **Emergency Department Information** (information detailing the care and services provided to the patient in the emergency department of the final hospital)
- **Outcome Information** (information regarding the final outcome for the patient).

Data Element Specifications

Data elements in the New York State Data Dictionary are required to be included in the NYS Trauma registry uploads if applicable to the submitted patient. Additional data fields collected as part of the NTDS data set with also be included in the New York State upload as defined by the admission year NTDS dictionary guide.

Field: Descriptive name of the data element in the trauma registry.

Definition: The definition for the data element requested for this field.

Field Values: Prescribed choices (or pick lists) and acceptable values for this data element.

Additional Information: Additional information for this data element.

Data Hierarchy: Where the registrar may find the information in the medical record.

Data Type: Constraints on the types of values for the data element, i.e., dates must be DD/MM/YYYY, alpha, numeric

History: Documents when this data element was last reviewed, revised or when it was added to the data dictionary.

Appendix II.
Guidelines for E-Codes/
External Cause of Injury ICD-10 Codes

Visit*:* http://eicd.com/Guidelines/ECodes.htm for the hierarchy of e-code reporting.

In addition to selecting the **best e-code** to describe the injury, the following E-codes/External Cause of Injury codes are unlikely to generate an injury with ICD-10 injury codes on the NYSTR inclusion list. Should a case present with one of these E codes/Cause of Injury codes the registrar should give the case careful review. It is possible that such a record would qualify for exclusion, and in such case the registrar should complete an exclusion form. Or it is possible that a more accurate E code/External Cause of Injury code could be assigned, and in such case the registrar should change the E code/External Cause of Injury code prior to submission to the state registry.

ICD-10 E-code	Category of Injury
V90	Drowning and submersion due to accident to watercraft
V92	Drowning and submersion due to accident on board watercraft, without accident to watercraft
W42	Exposure to noise
W46	Contact with hypodermic needle
W65-W69	Accidental drowning and submersion while in bathtub, swimming pool or natural water
W73-W74	Other specified cause of accidental non-transport downing and submersion, unspecified cause of accidental drowning and submersion
X10-X19	Contact with heat and hot substances
X30-X32, X 38	Exposure to excessive natural heat, exposure to natural cold, exposure to sunlight; Flood
X71, X 75, X 77	Intentional self-harm by drowning and submersion; explosive material; smoke hot vapors and hot objects
Y21, Y25, Y27	Drowning/submersion; Contact with explosive material; Contact with steam, hot vapors, hot objects, undetermined intent
Y35-Y38	Legal intervention, operations of war, military operations, terrorism
Y62-Y69, Y70-Y82	Surgical/medical misadventures
Y90	Evidence of alcohol involvement determined by blood alcohol level
Y95	Nosocomial condition
Y92-93, Y99	Place of occurrence of the external cause; activity codes; external cause status

Appendix III.
NYS Trauma Registry Exclusion Report Format

Guidelines for Exclusion:

The NYSTR should be an accurate reporting of seriously injured patients during the acute phase of injury. Coding constraints, documentation limitations, and ICD-10 coding limitations can result in a case having an ICD-10 on the inclusion list but in fact is not a seriously injured trauma patient.

In general:

- Include or exclude based on clinical documentation in the record, not on admitting service, patient outcome, or the involvement of the trauma team.

- If there is any question in your mind as to the record being included or excluded, you should discuss the case with another registrar or your Trauma Program Manager.

- Incorrect ICD-10 codes should be brought to the attention of the hospital's Coding Department. Coding constraints may preclude changing the codes, but the opportunity should be offered.

Considerations:

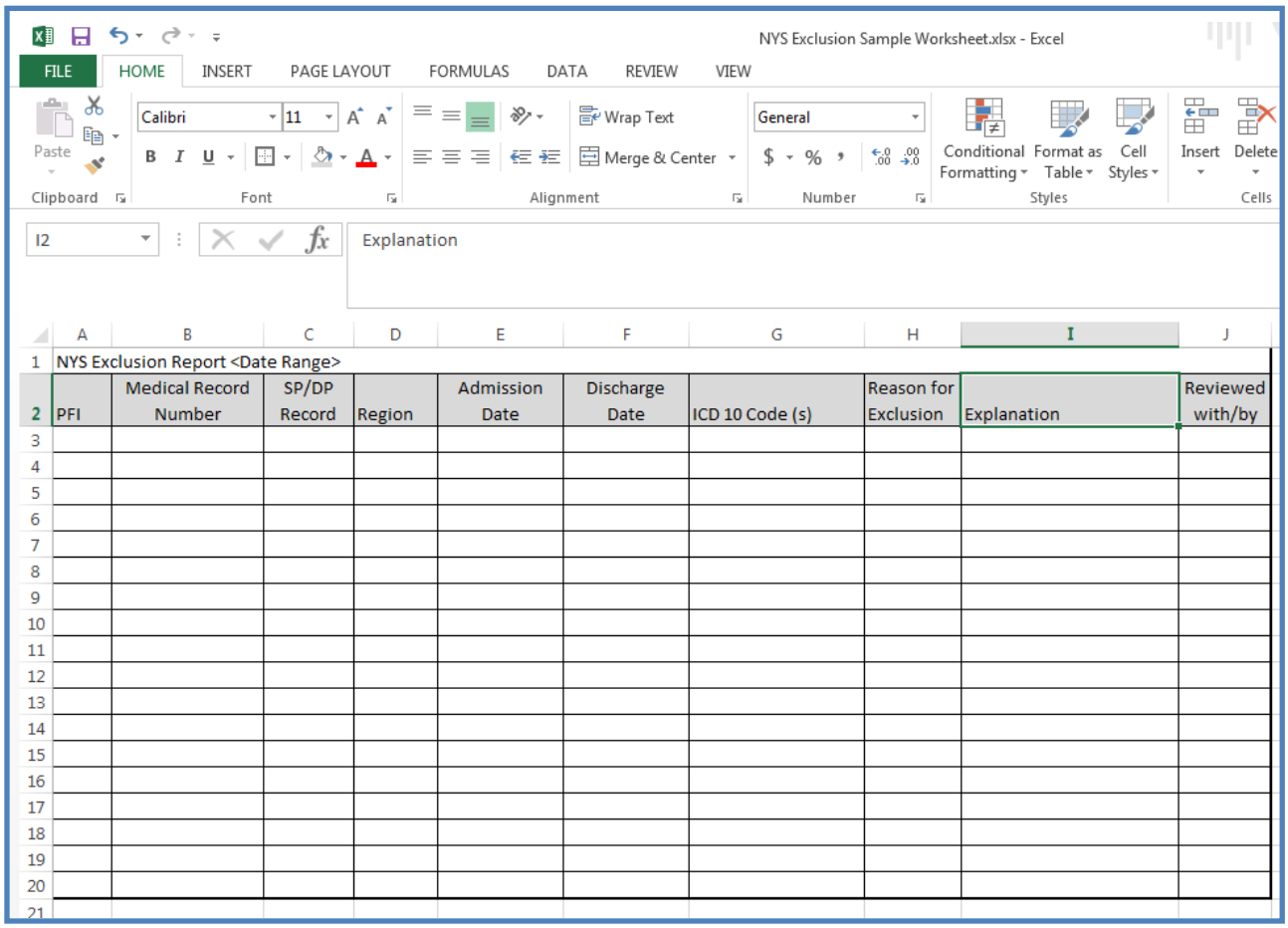
Admission to a hospital for an injury that was undiagnosed during the first hospitalization should be entered. If there were two admissions, combine them into one record. If there was an outpatient or emergency department visit, and the patient who had been sent home was then re-called for admission of a 'missed' injury, the record should be included in the registry.

Medical conditions that result in a fall and subsequent injury are eligible for inclusion in the State registry. For example, a patient with known seizure disorder who falls during a seizure and sustains a subdural hematoma is IN. A patient with Parkinson's disease who falls and sustains an open tib/fib fracture is IN.

Documentation can often be incomplete, confusing or even conflicting. It is important to review exclusions with a clinical person (such as the Trauma Program Manager or Trauma Medical Director) if there is any question as to the inclusion or exclusion of a particular case.

Reason for Exclusion

Reason	Definition	Example
1	Injury occurred while an inpatient in an acute care hospital.	Fall in hospital. Birth trauma. Intraoperative complication.
2	Injury occurred more than **14 days** prior to this admission.	Fell 8 weeks ago and now presents with ongoing pain. Do not use this for cases with 'history of multiple falls". Patient was in crash 4 years ago and now presents with herniated disc.
3	This is a readmission for further treatment of an injury already in the registry.	Readmission for infection or cellulitis, DVT, hardware removal etc., operative treatment of an injury originally treated non-operatively. Note: first admission should be in the registry, make note of MRN and discharge date for that admission.
4	The ICD-10 code is ***incorrect*****,** and the correct code is not on state list.	Patient had an intracerebral bleed and a fall, but the intracerebral bleed was the cause of the fall, not caused by the fall. Must have radiographic or neurology or neurosurgery documentation that the intracerebral bleed was not traumatic, or diagnosis was 'rule out' an injury, the patient was proven not to have that injury, but it was coded. **P**athologic fracture but coded as acute fracture. Injury was coded but radiographs and CT scan were negative.
5	Medical Record cannot be located.	Hospital closed. Hospital unable to locate medical record despite multiple attempts over many months. (This should be a rarely used exclusion.)
6	Record sent to SPARCS in error.	Occasionally a hospital submits a record to SPARCS for a patient who was not actually admitted to the hospital. Should this occur, use this reason for exclusion.
7	Exclude patients admitted to same day surgery for the care of a previously diagnosed injury.	Patients presenting to the facility for same day surgery procedures should not be included in the trauma registry.



	A	B	C	D	E	F	G	H	I	J
1	NYS Exclusion Report <Date Range>									
2	PFI	Medical Record Number	SP/DP Record	Region	Admission Date	Discharge Date	ICD 10 Code (s)	Reason for Exclusion	Explanation	Reviewed with/by
3										
4										
5										
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21										

Codes for Reviewed with/by

1 = Hospital Trauma Program Manager
2 = Regional Trauma Center Program Manager
3 = Trauma Medical Director
4 = Other
5 = None

Appendix IV.
Hospital PFI Numbers

Visit: http://www.health.state.ny.us/nysdoh/ems/counties/map.htm

The Bureau of Emergency Medical Services and Trauma Systems is implementing a new series of Hospital Identifiers for EMS to report on Monday, January 19, 2021 for all patient contact dispatches received after 00:00.

Suffolk and Nassau

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
SUFFOLK			
UNIVERSITY HOSPITAL-SUNY STONY BROOK	0245	527	H00245
LONG ISLAND COMMUNITY HOSPITAL *(FORMERLY BROOKHAVEN MEM. HOSP. MED. CTR.)*	0885	525	H00845
SOUTHAMPTON HOSPITAL	0889	520	H00889
EASTERN LONG ISLAND HOSPITAL STONY BROOK	0891	514	H00891
JOHN T MATHER MEMORIAL HOSP OF PORT JEFFERSON	0895	517	H00895
ST. CHARLES HOSPITAL	0896	528	H00896
HUNTINGTON HOSPITAL	0913	516	H00913
SOUTHSIDE HOSPITAL	0924	521	H00924
GOOD SAMARITAN HOSPITAL	0925	515	H00925
PECONIC BAY MEDICAL CENTER	0938	513	H00938
ST. CATHERINE OF SIENNA HOSPITAL	0943	523	H00943
NORTHPORT VA		524	VA0005
NASSAU			
NORTH SHORE UNIVERSITY HOSPITAL AT GLEN COVE	0490	692	H00490
WINTHROP-UNIVERSITY HOSPITAL	0511	704	H00511
MERCY HOSPITAL (ROCKVILLE)	0513	945	H00513
LIJ – VALLEY STREAM (FRANKLIN GENERAL)	0518	694	H00518
SOUTH NASSAU COMMUNITIES HOSPITAL	0527	706	H00527
NASSAU UNIVERSITY MEDICAL CENTER EAST MEADOW	0528	702	H00528
NORTH SHORE UNIVERSITY HOSPITAL(MANHASSET)	0541	705	H00541
NORTHWELL HEALTH LIJ SYOSSETHOSPITAL	0550	703	H00550
ST. JOSEPH HOSPITAL	0551	701	H00551
NORTHWELL HEALTH PLAINVIEW HOSPITAL	0552	691	H00552
ST FRANCIS HOSPITAL (FLOWER HILL)	0563	707	H00563

New York City

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
New York City			
NEW YORK COUNTY			
NY PRESBYTERIAN / LOWER MANHATTAN HOSPITAL	1437	941	H01437
BELLEVUE HOSPITAL CENTER	1438	712	H01438
MT SINAI BETH ISRAEL MEDICAL CENTER	1439	713	H01439
HARLEM HOSPITAL CENTER	1445	721	H01445
NYU HOSPITAL FOR JOINT DISEASES	1446	735	H01446
HOSPITAL FOR SPECIAL SURGERY	1447	723	H01447
LENOX HILL HOSPITAL	1450	728	H01450
MANHATTAN EYE EAR AND THROAT HOSPITAL	1452	730	H09754
MEMORIAL HOSPITAL FOR CANCER & ALLIED DISEASES	1453	731	H01453
METROPOLITAN HOSPITAL CENTER	1454	732	H01454
MOUNT SINAI HOSPITAL	1456	734	H01456
NY PRESBYTERIAN HOSPITAL-WEIL CORNELL CAMPUS	1458	737	H01458
NY EYE AND EAR INFIRMARY	1460	736	H01460
NY UNIVERSITY MEDICAL CENTER	1463	739	H01463
NY PRESBYTERIAN HOSPITAL – MORGAN STANLEY CHILDREN'S HOSPITAL	1464	742	H01464
ROCKEFELLER UNIVERSITY HOSPITAL	1465	743	H01465
ST LUKES ROOSEVELT HOSP CTR-ROOSEVELT HOSP	1466	759	H01466
MOUNT SINAI ST LUKES	1469	745	H01469
HENRY J CARTER SPECIALTY HOSPITAL	1486	720	H01486
NY PRESBYTERIAN HOSPITAL – ALLEN PAVILLIAN	3975	749	H03975
MANHATTAN VA		724	VA0008
BRONX			
BRONX VA		634	VA0004
JACOBI MEDICAL CENTER	1165	621	H01165
MONTEFIORE MEDICAL CENTER-NORTH DIVISION	1168	627	H01168
MONTEFIORE MED CTR-HENRY & LUCY MOSES DIV	1169	637	H01169
LINCOLN MEDICAL & MENTAL HEALTH CENTER	1172	626	H01172
CALVARY HOSPITAL INC	1175	624	H01175
ST BARNABAS HOSPITAL	1176	629	H01176
BRONX-LEBANON HOSPITAL CENTER-CONCOURSE DIV	1178	635	H01178
MONTEFIORE WESTCHESTER SQUARE	1185	623	H01185
NORTH CENTRAL BRONX HOSPITAL	1186	628	H01186
MONTEFIORE MEDCTR-JACKDWEILER HOSP OF EINSTEIN	3058	639	H03058

KINGS			
BROOKDALE HOSPITAL MEDICAL CENTER	1286	902	H01286
NY COMMUNITY HOSPITAL OF BROOKLYN INC	1293	905	H01293
CONEY ISLAND HOSPITAL	1294	921	H01294
KINGS COUNTY HOSPITAL CENTER	1301	672	H01301
NYU LANGONE HOSPITAL - BROOKLYN	1304	913	H01304
MAIMONIDES MEDICAL CENTER	1305	914	H01305
NY PRESBYTERIAN BROOKLYN METHODIST HOSPITAL	1306	915	H01306
INTERFAITH MEDICAL CENTER	1309	916	H01309
KINGSBROOK JEWISH MEDICAL CENTER	1315	927	H01315
WYCKOFF HEIGHTS MEDICAL CENTER	1318	935	H01318
UNIVERSITY HOSPITAL OF BROOKLYN	1320	918	H01320
MT SINAI BETH ISRAEL MEDICAL CENTER	1324	926	H01324
WOODHULL MEDICAL & MENTAL HEALTH CENTER	1692	903	H01692
BROOKLYN VA		925	VA0007
QUEENS			
ELMHURST HOSPITAL CENTER	1626	764	H01626
FLUSHING HOSPITAL MEDICAL CENTER	1628	765	H01628
JAMAICA HOSPITAL	1629	768	H01629
STEVEN AND ALEXANDRA COHEN CHILDREN'S MEDICAL CENTER	1630	763	H01630
QUEENS HOSPITAL CENTER	1633	775	H01633
ST JOHNS EPISCOPAL HOSPITAL-SOUTH SHORE	1635	776	H01635
NY PRESBYTERIAN / QUEENS	1637	762	H01637
FOREST HILLS HOSPITAL	1638	769	H01638
MOUNT SINAI HOSPITAL-MOUNT SINAI HOSPITAL OF QUEENS	1639	761	H01639
RICHMOND			
STATEN ISLAND UNIVERSITY HOSP-SOUTH	1737	782	H01737
RICHMOND UNIVERSITY MEDICAL CENTER	1738	783	H01738
STATEN ISLAND UNIVERSITY HOSP-NORTH	1740	784	H01740

Western New York

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
Western New York			
ERIE			
BUFFALO VA		655	VA0013
BUFFALO GENERAL MEDICAL CENTER	0207	643	H00207
JOHN R. OISHEI CHILDREN'S HOSPITAL	0208	937	H00208
ERIE COUNTY MEDICAL CENTER	0210	646	H00210
MERCY HOSPITAL	0213	657	H00213
MILLARD FILLMORE HOSPITAL	0215	651	H03067
ROSWELL PARK CANCER INSTITUTE	0216	661	H00216
SISTERS OF CHARITY HOSPITAL	0218	654	H00218
KENMORE MERCY HOSPITAL	0267	648	H00267
BERTRAND CHAFFEE HOSPITAL	0280	641	H00280
SISTERS OF CHARITY HOSPITAL-ST JOSEPH CAMPUS	0292	656	H00292
MILLARD FILLMORE SUBURBAN HOSPITAL	3067	652	H03067
NIAGARA			
EASTERN NIAGARA HOSPITAL-LOCKPORT DIVISION / AND NEWFANE DIVISION	0565	313	H00565
NIAGARA FALLS MEMORIAL MEDICAL CENTER	0574	316	H00574
DEGRAFF MEMORIAL HOSPITAL	0581	317	H00581
MOUNT ST MARYS HOSPITAL & HEALTH CENTER	0583	314	H00583
WYOMING			
WYOMING COUNTY COMMUNITY HOSPITAL	1153	601	H01153
ALLEGANY			
CUBA MEMORIAL HOSPITAL INC	0037	021	H00037
MEMORIAL HSP OF WM F & GERTRUDE F JONES	0039	023	H00039
CATTARAUGUS			
OLEAN GENERAL HOSPITAL	0066	041	H00066
CHAUTAUQUA			
BROOKS MEMORIAL HOSPITAL	0098	061	H00098
WOMAN'S CHRISTIAN ASSOCIATION	0103	065	H00103
WESTFIELD MEMORIAL HOSPITAL INC	0111	064	H00111
TLC HEALTHCARE NETWORK LAKESHORE HOSPITAL	0114	063	H00114
ORLEANS			
MEDINA MEMORIAL HOSPITAL	0718	362	H00718
GENESEE			
UNITED MEMORIAL MEDICAL CENTER NORTH STREET CAMPUS	0339	181	H00339
BATAVIA VA		183	VA0012

Central New York

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
Central New York			
OSWEGO			
OSWEGO HOSPITAL	0727	372	H00727
CAYUGA			
AUBURN COMMUNITY HOSPITAL	0085	053	H00085
ST LAWRENCE			
CLAXTON-HEPBURN MEDICAL CENTER	0798	441	H00798
MASSENA MEMORIAL HOSPITAL	0804	445	H00814
EDWARD JOHN NOBLE HOSPITAL OF GOUVERNEUR	0812	448	H00812
CANTON-POTSDAM HOSPITAL	0815	446	H00815
CLIFTON-FINE HOSPITAL	0817	442	H00817
JEFFERSON			
SAMARITAN MEDICAL CENTER	0367	223	H00367
RIVER HOSPITAL INC	0377	227	H00377
CARTHAGE AREA HOSPITAL INC	0379	221	H00379
HERKIMER			
LITTLE FALLS HOSPITAL	0362	212	H00362
ONEIDA			
ROME MEMORIAL HOSPITAL, INC	0589	324	H00589
FAXTON - ST. LUKES HEALTHCARE - FAXTON DIVISION	0597	322	
ST ELIZABETH CAMPUS - MVHS	0598	326	H00598
FAXTON - ST LUKES HEALTHCARE - ST. LUKES' DIVISION	0599	327	H00599
BROOME			
UNITED HEALTH SVCS HOSPITALS INC - BINGHAMTON GENERAL	0042	031	H00042
OUR LADY OF LOURDES MEMORIAL HOSPITAL INC	0043	034	H00043
UNITED HEALTH SVCS HOSPITALS INC - WILSON MEDICAL CENTER	0058	032	H00058
CHENANGO			
CHENANGO MEMORIAL HOSPITAL INC	0128	081	H00128
CORTLAND			
CORTLAND REGIONAL MEDICAL CENTER INC	0158	114	H00158
LEWIS			
LEWIS COUNTY GENERAL HOSPITAL	0383	241	H00383
MADISON			
ONEIDA HEALTHCARE CENTER	0397	262	H00397
COMMUNITY MEMORIAL HOSPITAL INC	0401	261	H00401
ONONDAGA			
SYRACUSE VA		338	VA0006
UPSTATE UNIVERSITY HOSPITAL AT COMMUNITY GENERAL	0628	331	H00628
ST JOSEPHS HOSPITAL HEALTH CENTER (SYRACUSE)	0630	334	H00630
UPSTATE UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	0635	336	H00635
CROUSE HOSPITAL	0636	332	H00636

Finger Lakes

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
Finger Lakes			
ONTARIO			
CANANDAIGUA VA		345	VA0003
GENEVA GENERAL HOSPITAL	0671	343	H00671
CLIFTON SPRINGS HOSPITAL AND CLINIC	0676	341	H00676
F F THOMPSON HOSPITAL	0678	342	H00678
STEUBEN			
BATH VA		505	VA0002
CORNING HOSPITAL	0866	502	H00866
ST JAMES MERCY HOSPITAL	0870	504	H00870
IRA DAVENPORT MEMORIAL HOSPITAL INC	0873	503	H00873
SCHUYLER			
SCHUYLER HOSPITAL	0858	481	H00858
YATES			
SOLDIERS AND SAILORS MEMORIAL HOSP OF YATES CO	1158	612	H01158
MONROE			
HIGHLAND HOSPITAL (ROCHESTER)	0409	272	H00409
ROCHESTER GENERAL HOSPITAL	0411	276	H00411
STRONG MEMORIAL HOSPITAL	0413	278	H00413
MONROE COMMUNITY HOSPITAL	0414	285	H00414
THE UNITY HOSPITAL OF ROCHESTER	0471	275	H00471
LIVINGSTON			
NICHOLAS H NOYES MEMORIAL HOSPITAL	0393	251	H00393
WAYNE			
NEWARK-WAYNE COMMUNITY HOSPITAL INC	1028	584	H01028
CHEMUNG			
ST JOSEPHS HOSPITAL (ELMIRA)	0118	072	H00118
ARNOT-OGDEN MEDICAL CENTER	0116	071	H00116
TOMPKINS			
Cayuga Medical Center at Ithaca	0977	542	H00977

Northeastern New York

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
Northeastern New York			
ALBANY			
ALBANY VA		016	VA0001
ALBANY MEDICAL CENTER HOSPITAL	0001	018	H00001
ALBANY MEMORIAL	0004	014	H00004
ST PETERS HOSPITAL	0005	015	H00005
CLINTON			
THE UNIVERSITY OF VERMONT HEALTH NETWORK - CHAMPLAIN VALLEY PHYSICIANS HOSPITAL	0135	091	H00135
COLUMBIA			
COLUMBIA MEMORIAL HOSPITAL	0146	101	H00146
ESSEX			
THE UNIVERSITY OF VERMONT HEALTH NETWORK - ELIZABETHTOWN COMMUNITY HOSPITAL	0303	151	H00303
ADIRONDACK MEDICAL CENTER-LAKE PLACID SITE	0306	154	H00306
MOSES-LUDINGTON HOSPITAL	0309	153	H00309
FRANKLIN			
ALICE HYDE MEDICAL CENTER	0325	161	H00325
DELAWARE			
O'CONNOR HOSPITAL	0165	125	H00165
MARGARETVILLE MEMORIAL HOSPITAL	0170	123	H00170
DELAWARE VALLEY HOSPITAL INC	0174	122	H00174
SCHENECTADY			
ELLIS HOSPITAL	0829	462	H00823
ELLIS HOSPITAL-BELLEVUE WOMEN'S CARE CENTER DIV	0848	465	H00848
WARREN			
GLENS FALLS HOSPITAL	1005	561	H01005
RENSSELAER			
SETON HEALTH SYSTEM-ST MARY'S CAMPUS	0755	413	H00755
SAMARITAN HOSPITAL	0756	412	H00756
SARATOGA			
SARATOGA HOSPITAL	0818	453	H00818
FULTON			
NATHAN LITTAUER HOSPITAL	0330	172	H00330
MONTGOMERY			
ST MARY'S HEALTHCARE-AMSTERDAM MEMORIAL CAMPUS	0482	281	H00482
ST MARYS HEALTHCARE	0484	282	H00484
OTSEGO			
AURELIA OSBORN FOX MEMORIAL HOSPITAL	0739	381	H00739
BASSETT MEDICAL CENTER	0746	383	H00746
SCHOHARIE			
COBLESKILL REGIONAL HOSPITAL – BASSETT HEALTHCARE NEWORK	0851	471	H00851

Hudson Valley

Hospital	PFI	EMS (1/1/21-1/18/21)	EMS (1/19/21 →)
Hudson Valley			
DUTCHESS			
NORTHERN DUTCHESS HOSPITAL	0192	132	H00192
MIDHUDSON REGIONAL HOSPITAL OF WESTCHESTER MEDICAL CENTER	0180	136	H00180
VASSAR BROTHERS MEDICAL CENTER	0181	134	H00181
CASTLE POINT VA HOSPITAL		135	VA0010
ORANGE			
BON SECOURS COMMUNITY HOSPITAL	0708	353	H00708
KELLER ARMY HOSPITAL		359	H00351
GARNET HEALTH MEDICAL CENTER (FORMERLY ORANGE REGIONAL MEDICAL CENTER)	0699	351	H00699
ST ANTHONY COMMUNITY HOSPITAL	0704	363	H00704
ST LUKES CORNWALL HOSPITAL/ CORNWALL	0698	352	H00698
MONTEFIORE - ST LUKES CORNWALL HOSPITAL/ NEWBURGH	0694	357	H00694
PUTNAM			
PUTNAM HOSPITAL CENTER	0752	392	H00752
ROCKLAND			
GOOD SAMARITAN HOSPITAL OF SUFFERN	0779	431	H00779
HELEN HAYES HOSPITAL	0775	437	H00775
MONTEFIORE - NYACK HOSPITAL	0776	436	H00776
SULLIVAN			
CATSKILL REGIONAL MEDICAL CENTER	0971	~~796~~	H00971
ULSTER			
HEALTH ALLIANCE HOSPITAL MARY'S AVE. CAMPUS	0989	551	H00989
ELLENVILLE REGIONAL HOSPITAL	1002	552	H01002
HEALTHALLIANCE HOSPITAL BROADWAY CAMPUS	0990	553	H00990
WESTCHESTER			
BLYTHEDALE CHILDRENS HOSPITAL	1138	821	H01138
WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL	1046	820	H01046
ST JOHNS RIVERSIDE HOSPITAL-DOBBS FERRY PAVILLION	1124	804	H01124
NY PRESBYTERIAN / HUDSON VALLEY HOSPITAL CENTER	1039	825	H01039
NY PRESBYTERIAN / LAWRENCE HOSPITAL CENTER	1122	806	H01122
MONTROSE VA HOSPITAL		805	VA0011
MONTEFIORE MOUNT VERNON HOSPITAL	1061	808	H01061
NORTHERN WESTCHESTER HOSPITAL	1117	810	H01117
PHELPS MEMORIAL HOSPITAL ASSN	1129	812	H01129
MONTEFIORE NEW ROCHELLE	1072	809	H01072
ST JOHNS RIVERSIDE HOSPITAL – ST JOHN'S DIVISION	1097	814	H01097
ST JOHNS RIVERSIDE HOSPITAL - PARK CARE PAVILION	1099	818	H01099
ST JOSEPHS MEDICAL CENTER	1098	815	H01098
ST JOSEPH'S MEDICAL CENTER – ST VINCENTS WESTCHESTER DIVISION	1133	824	H01133
WESTCHESTER MEDICAL CENTER	1139	803	H01139
WHITE PLAINS HOSPITAL CENTER	1045	817	H01045

Appendix V.
Summary of Field Changes

Data dictionary changes effective 1/1/2024

Change log key	
Red	Keep data element
Green	Eliminate data element
Blue	Revised or new data element

Section	Fieldname	Definition	State Status	NTDS Status	Field Values
NY Demographics	Medical Record Number	No change	Required	Not Required	
NY Demographics	Patient's Last Name	No change	Required	Not Required	
NY Demographics	Patient's First Name	No change	Required	Not Required	
NY Demographics	Social Security Number	No change	Required	Not Required	
Injury	Height of Fall	Revise definition	Required	Not Required	Numeric value in feet, 0-200
Injury	Trauma Type	No change	Required	Not Required	
NY Prehospital	Service	No change	Required	Not Required	
NY Prehospital	Arrived From	No change	Required	Not Required	
NY Prehospital	Initial Field Diastolic B/P	No change	Required	Not Required	
NY Prehospital	Chest Decompression	Revise definition, eliminate tube thoracostomy	Required	Not Required	
NY Prehospital	Prehospital CPR	No change	Required	Not Required	
NY Prehospital	Airway management	Updated picklist	Required	Not Required	Select all that apply
NY Prehospital	Prehospital fluids	No change	Required	Not Required	Eliminate numeric IV fluid volumes.

NY Prehospital	Prehospital Blood Administration	No change	Required	Not Required	
NY Prehospital	Hemorrhage Control	No change	Required	Not Required	
NY Prehospital	Oxygen administration	Eliminate field	Removed		Merged with Airway field
NY Prehospital	Prehospital Immobilization	Revised Definition, add c spine immobilization and long board immobilization	Required	Not Required	Select all that apply
NY Prehospital	EMS report status	Revised definition to clarify incomplete status data collection	Required	Not Required	
NY Prehospital	EMS dispatch date	Date of EMS dispatch	Required	Not required	MM/DD/YYYY
NY Prehospital	EMS dispatch time	Time of EMS dispatch	Required	Not Required	Military time
NY Prehospital	EMS unit arrival date at scene or transferring facility	Date of EMS arrival date at scene/transferring facility	Required	Not Required	MM/DD/YYYY
NY Prehospital	EMS unit arrival time at scene or transferring facility	Time of EMS arrival date at scene/transferring facility	Required	Not Required	Military time
NY Prehospital	EMS unit departure date from scene/transferring facility	Date of EMS departure from scene/transferring facility	Required	Not Required	MM/DD/YYYY
NY Prehospital	EMS unit departure time from scene/transferring facility	Time of EMS departure from scene/transferring facility	Required	Not Required	Military time
NY Prehospital	Initial field systolic B/P	Systolic B/P taken by EMS prior to departure from scene	Required	Not Required	record value 0 - 260 mmHg
NY Prehospital	Initial Field Diastolic BP	No change	Required	Not Required	

NY Prehospital	Initial field pulse rate	First HR recorded by EMS prior to departure from scene	Required	Not Required	Record value 0 - 200
NY Prehospital	Initial field respiratory rate	First respiratory rate recorded by EMS prior to departure from scene	Required	Not Required	0-100
NY Prehospital	Initial oxygen saturation	First pulse oximetry level recorded by EMS prior to departure from scene	Required	Not Required	0-100
NY Prehospital	Initial GCS Eye Opening	First GCS eye value recorded by EMS prior to departure from scene	Required	Not Required	0-4
NY Prehospital	Initial GCS Verbal	First GCS verbal value recorded by EMS prior to departure from scene	Required	Not Required	0-5
NY Prehospital	Initial GCS Motor	First GCS motor value recorded by EMS prior to departure from scene	Required	Not Required	0-6
NY Prehospital	Initial GCS Total	First total GCS value recorded by EMS prior to departure from scene	Required	Not Required	3-15
NY Referring Hospital	Medical Record Number	No Change	Required	Not Required	
NY Referring Hospital	Transport Mode	No Change	Required	Not Required	
NY Referring Hospital	Referring Hospital PFI #	No Change	Required	Not Required	
NY Referring Hospital	EMS dispatch date (From PCR to referring hospital)	Date of EMS dispatch	Required	Not required	MM/DD/YYYY
NY Referring Hospital	EMS dispatch time (From PCR to referring hospital)	Time of EMS dispatch	Required	Not Required	Military time
NY Referring Hospital	EMS unit arrival date at scene (From PCR to referring	Date of EMS arrival date at scene	Required	Not Required	MM/DD/YYYY

	hospital)				
NY Referring Hospital	EMS unit arrival time at scene	Time of EMS arrival date at scene	Required	Not Required	Military time
NY Referring Hospital	EMS unit departure date from scene (From PCR to referring hospital)	Date of EMS departure from scene/transferring facility	Required	Not Required	MM/DD/YYYY
NY Referring Hospital	EMS unit departure time from scene (From PCR to referring hospital)	Time of EMS departure from scene/transferring facility	Required	Not Required	Military time
NY Referring Hospital	Initial field systolic B/P (From PCR to referring hospital)	Systolic B/P taken by EMS prior to departure from scene	Required	Not Required	record value 0 - 260 mmHg
NY Referring Hospital	Initial Field Diastolic BP (From PCR to referring hospital)	No change	Required	Not Required	
NY Referring Hospital	Initial field pulserate (From PCR to referring hospital)	First HR recorded by EMS prior to departure from scene	Required	Not Required	Record value 0 - 200
NY Referring Hospital	Initial field respiratory rate (From PCR to referring hospital	First respiratory rate recorded by EMS prior to departure from scene	Required	Not Required	0-100
NY Referring Hospital	Initial oxygen saturation (From PCR to referring hospital)	First pulse oximetry level recorded by EMS prior to departure from scene	Required	Not Required	0-100
NY Referring Hospital	Initial GCS Eye Opening (From PCR to referring hospital)	First GCS eye value recorded by EMS prior to departure from scene	Required	Not Required	0-4
NY Referring Hospital	Initial GCS Verbal (From PCR to referring hospital)	First GCS verbal value recorded by EMS prior to departure from scene	Required	Not Required	0-5

NY Referring Hospital	Initial GCS Motor (From PCR to referring hospital)	First GCS motor value recorded by EMS prior to departure from scene	Required	Not Required	0-6
NY Referring Hospital	Initial GCS Total (From PCR to referring hospital)	First total GCS value recorded by EMS prior to departure from scene	Required	Not Required	3-15
NY Referring Hospital	Initial field pulse rate (From PCR to referring hospital)	First HR recorded by EMS prior to departure from scene	Required	Not Required	Record value 0 - 200
NY Referring Hospital	Initial field respiratory rate (From PCR to referring hospital)	First respiratory rate recorded by EMS prior to departure from scene	Required	Not Required	0-100
NY Referring Hospital	Arrival Date	No Change	Required	Not Required	
NY Referring Hospital	Arrival Time	No Change	Required	Not Required	
NY Referring Hospital	Discharge Date	No Change	Required	Not Required	
NY Referring Hospital	Discharge Time	No Change	Required	Not Required	
NY Referring Hospital	Referring Hospital GCS -Eye	No Change	Required	Not Required	
NY Referring Hospital	Referring Hospital GCS – Verbal	No Change	Required	Not Required	
NY Referring Hospital	Referring Hospital GCS – Motor	No Change	Required	Not Required	
NY Referring Hospital	Calculated Glasgow Coma Score	No Change	Required	Not Required	
NY Referring Hospital	Referring Hospital GCS assessment qualifiers	No Change	Required	Not Required	
NY Referring Hospital	Temperature	No Change	Required	Not Required	
NY Referring Hospital	Systolic Blood Pressure	No Change	Required	Not Required	
NY Referring Hospital	Diastolic Blood Pressure	No Change	Required	Not Required	

NY Referring Hospital	Pulse Rate	No Change	Required	Not Required	
NY Referring Hospital	Respiratory Rate	No Change	Required	Not Required	
NY Referring Hospital	Oxygen Saturation	No Change	Required	Not Required	
NY Referring Hospital	Procedures	Create procedures pick list	Required	Not Required	
NY ED	Hospital PFI #	No Change	Required	Not Required	
NY ED	Trauma Team Activation	No Change	Required	Not Required	
NY ED	Initial ED/Hospital Diastolic BP	No Change	Required	Not Required	
NY ED	ED hemorrhage control procedures	No Change	Required	Not Required	1. Tourniquet 2. Pelvic binder 2. Mass Transfusion Protocol
NY ED	Actual ED Discharge Time	No Change	Required	Not Required	
NY ED	Actual ED Discharge Date	No Change	Required	Not Required	
NY ED	Location of ICD10 Hospital Procedures	Map to ICD 10 collected for NTDS	Required	Not Required	1. ED 2. Radiology 3. OR 4. Floor 5. Interventional Radiology 6. ICU 7. Other
NY Outcome Information	Additional NY Hospital Discharge Dispositions	Eliminated			

NY Outcome Information	Actual Discharge Time	No Change	Required	Not Required	
NY Outcome Information	Actual Discharge Date	No Change	Required	Not Required	
NY Outcome Information	Glasgow Coma Score – Total at Discharge	No Change	Required	Not Required	