

Kansas Trauma Users Group Meeting
SRS Learning Center: Room 3
Topeka, KS
March 10, 2010
1pm to 3pm

Present via conference call: Brenda Messenger, Cheryl McDonald, Daniel Clark, Debra Summers, Erick Sallman, James Pou, Paula Mills, Rachel Reimer, Sharon Gehring, Susan Ramsey, Voncille Dirks, Daniel Clark, Marcia Holliday, Leslie Bedene, Jaime Richling, Lisa Chism

Present: Jan Miller, Alvina Fant, Dan Robinson, Dee Vernberg, Dan Russell

Dee called the meeting to order at 1pm.

Announcements:

Dee introduced Dan Russell to the group and explained that he brings a wealth of technical expertise to the program.

Welcome and trauma Program Update: Dan Russell

Dan Russell gave the program update in Rosanne's absence. KDOT has verbally approved the grant to fund the interface between the EMS data collection system and trauma's Collector.

NHTSA traffic records review has recommended that trauma registry data be added to KIC (Kansas Information for Communities) located on the KDHE web site. The program will work with vital statistics during the year to accomplish the recommendation.

The Trauma Program in collaboration with Kansas Emergency Nurse Association submitted a grant to the Christopher Reeves Foundation to fund trauma education.

The AIS 2005 coding module is scheduled for the 2011 update.

Registry Update: James Pou

James gave key rollout dates for the 2010 update which is grouped by local and web users.

Stand Alone Users:

- March 19 - installation software made available to hospitals for test installations.
- April 1 through May 1 - recommended date for installation of Kansas Collector 2010 update.
- May 14 - last day for submission of NTDS data.

Web users:

- April 2 – last date for entering 2009 cases for Kansas web collector.
- April 3 - Kansas web collector off-line while the installation of 2010 update commences.
- April 4 - updated Kansas web collector available for use on-line.

A question was asked if registrars can start preparing NTDS submissions once the update has been installed. James explained the update for the NTDS is included in the 2010

update; so registrars will be able to prepare NTDS submissions once the update has been installed. Another question was asked if the update maps the comprehensive codes in the QA/QI section to the core QA/QI codes for the NTDS. James was not sure but he thought it does. He said he would research the question.

James gave a demonstration of the new software highlighting three distinct areas: the diagnosis coding module, the NTDS module, and the trauma team leader element.

Listed are some points of interest in the demonstration:

- The diagnostic coding module allows users to use Tricode and AIS look up. A user can enter injuries using text to coding and add additional injuries using the AIS drill down menu.
- The updated NTDS module will allow users to manually override ICU days and vent days in the NTDS editor.
- The trauma team leader element features an automated calculation, based on the dates and times entered, which determines whether the team leader was timely.

James stated a training image of the local version will be available later this week if local users would like to review the software.

Registry Update Training:

Dan Robinson

Training videos describing the operation and functionality of the updated elements will be released a week before the update is released. There will be a group of videos for the web version and a group for the local version. We understand everyone's time is immensely valued so the whole group of videos for your version will take no longer than 25 minutes.

AIS Training Opportunity:

Dan Robinson

Columbia University in Missouri is planning to host an AIS course sometime this year in Columbia, MO. Funding is available for Kansas registrars to attend the course through the regional trauma councils. Kansas registrars who are interested in attending this AIS course should contact their regional trauma council for an application. Applications will be submitted to the registrar's respective regional trauma council for approval. If you have any questions regarding your regional trauma council, please call Jeanette Shipley at 785-296-0604.

Length of Stay (ACT decision):

Dee Vernberg

[Click here to view the handout pertaining to the ACT ruling on length of stay.](#) Dee described a purpose of the users' group meeting as a venue to discuss current trends in hospital practices and how those practices affect the registry, which was the case with length of stay as described in the handout.

A question was asked clarifying the new LOS criteria: a child who was placed in the nursing unit from the ER would be considered a trauma patient because the LOS is calculated from the time the child entered the ED even though they were not admitted. Dee explained this is correct. Dee asked the group if the new LOS criteria are different or similar to what they are already using in their hospitals. Most of the registrars said they already use LOS in this manner.

Scenarios:

Dee Vernberg

Dee walked through the scenarios.

Issue 1: Does this case belong in the registry?

An 85 year old was standing on a chair to change a light bulb on the ceiling and fell. (E884.2) and fell. He was brought to the hospital by a private vehicle and on assessment was found to have a GI bleed, chronic renal failure, and thrombocytopenia.

Does this case meet the state criteria for a trauma? Why or why not?

Discussion: This case does not belong in the registry because it lacks the appropriate diagnosis codes for an injury to be considered a trauma patient as described in the inclusion criteria.

Issue 2: Coding CT Scan results

A patient was seen at your hospital with head trauma from a motor vehicle crash. A CT scan of the head was performed in the ED and showed a skull fracture but no space occupying lesion due to the trauma.

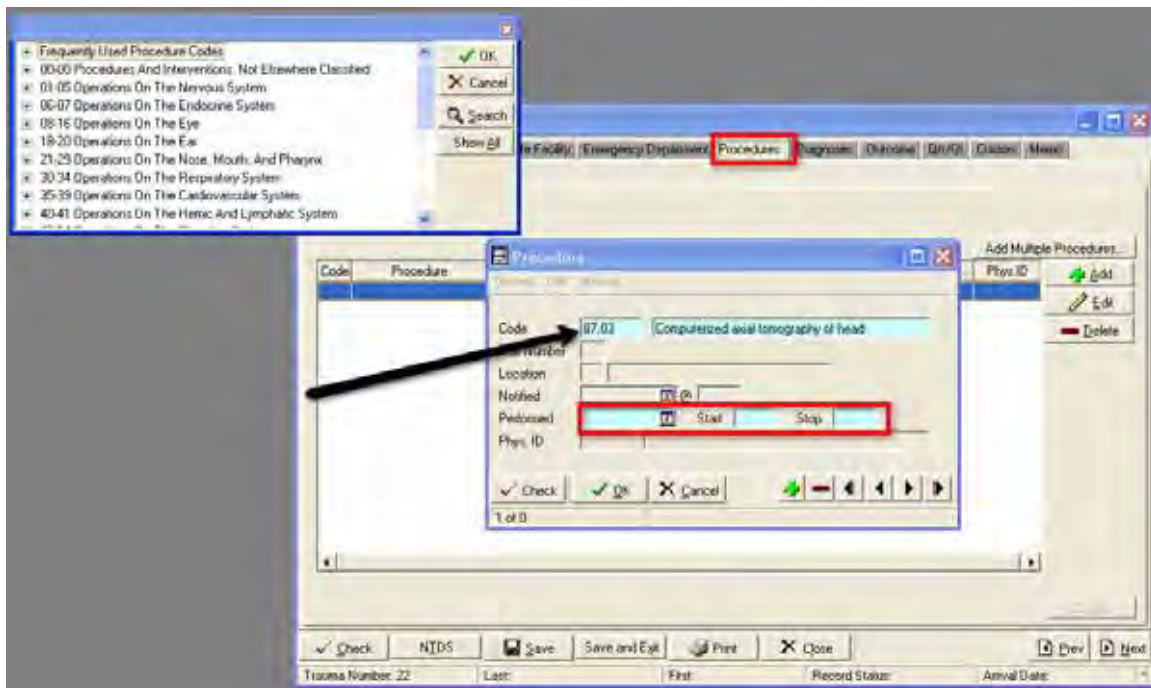
How would you code this finding?

Answer: The CT scan would be coded as “positive.”

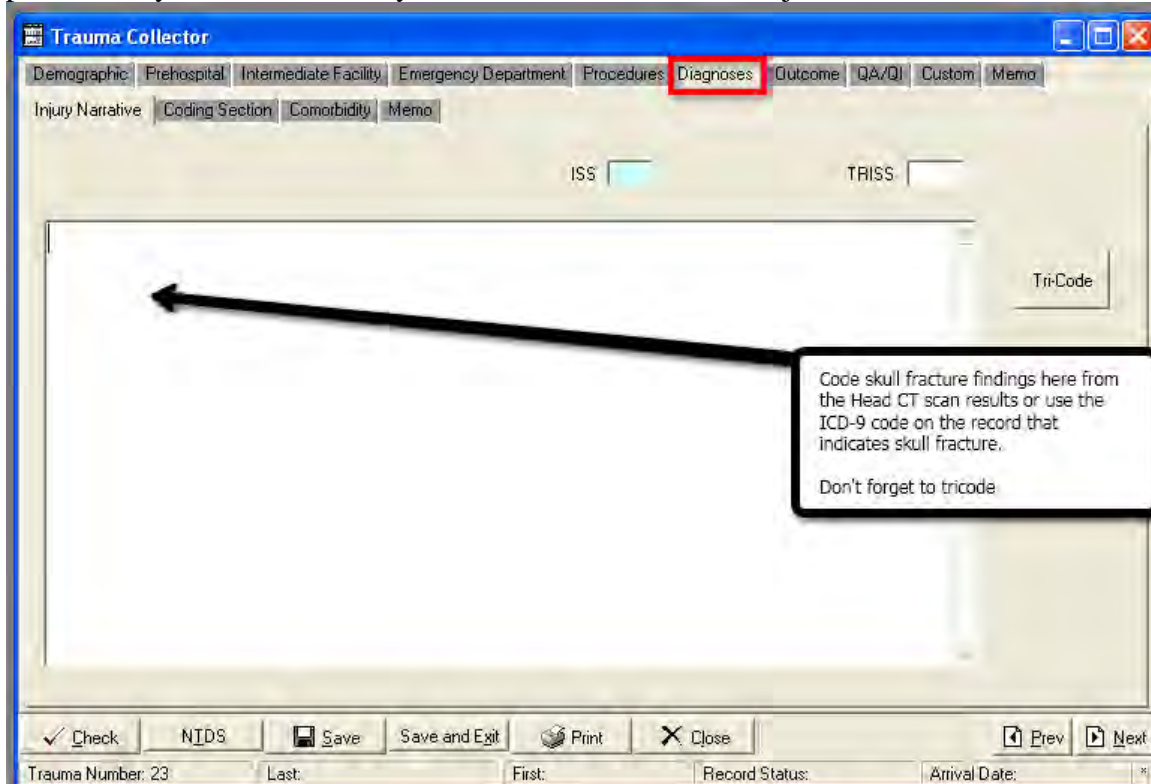
	Results	Date/Time
Abdominal CT		[?] @
Abdominal Ultrasound		[?] @
Aortogram/Arteriogram/Angiogram		[?] @
Chest CT		[?] @
Head CT	2 Positive	[?] @
Peritoneal Lavage		[?] @
Airway		
CPR		

Discussion: There were mix results from the participants on how they would code this CT scan. Most said they would code it as “positive.” Dee reported that the policy group and the ACT had recommended that registrars code CT scans as positive for fracture and/or space occupying lesions from trauma. If an injury can be diagnosed using a CT scan, then “positive” should be coded in Collector. A question was asked about patients

with a concussion. Dee explained that CT scans do not diagnose concussion. If there is reported loss of consciousness (LOC) in the medical record and a physician diagnoses a concussion, then concussion may be coded. Dee then reiterated CT scans would also be captured in the procedures section as illustrated below.



You should also code the skull fracture in the injury narrative. Since a CT scan was performed, you will most likely have more information than just skull fracture.



Issue 3:

A pedestrian is struck by a car and was found c at the scene with asystole. EMS begins CPR which continues in the ED. After 10 minutes in the ED, he is pronounced dead. No CT's or other diagnostics are performed. The trauma sheet indicates a flail chest, blood in nose and mouth, raccoon eyes, multiple facial lacerations and abrasions all over the body with extremity fractures.

The autopsy report states fractures of right femur and humerus, multiple bilateral rib fractures and fracture/dislocation at C1-2. There is no documentation of cord injury. Cause of death is listed as blunt cervicospinal trauma.

How would you code the diagnoses for this patient? Use text to coding.

Answer: This question is answered below in the screen shots.

The screenshot shows the 'Trauma Data Editor' software interface. The window title is 'Trauma Data Editor'. The interface includes a menu bar with options: Demographic, Prehospital, Intermediate Facility, Emergency Department, Procedures, Diagnoses, Outcome, QA/QI, Custom, and Memo. Below the menu bar, there are tabs for 'Injury Narrative', 'Coding Section', 'Comorbidity', and 'Memo'. The 'Coding Section' tab is active, displaying a list of injuries and their corresponding ISS and TRISS scores. The ISS score is 17, and the TRISS score is blank. The injuries listed are: fracture femur, fracture humerus, multiple bilateral rib fx, fx/dislocation c1-2, blunt trauma to head, multiple facial lacerations, abrasions on body, and blunt trauma to abdomen. A 'Tri-Code' button is visible on the right side of the list. The bottom of the window features a toolbar with buttons for Check, NIDS, Save, Save and Exit, Print, Close, Prev, and Next. At the very bottom, there are fields for Trauma Number (21), Last, First, Record Status, and Arrival Date.

Injury	ISS	TRISS
fracture femur	17	
fracture humerus		
multiple bilateral rib fx		
fx/dislocation c1-2		
blunt trauma to head		
multiple facial lacerations		
abrasions on body		
blunt trauma to abdomen		

Trauma Data Editor

Demographic Prehospital Intermediate Facility Emergency Department Procedures Diagnoses Outcome QA/QI Custom Memo

Injury Narrative Coding Section Comorbidity Memo

AIS Coder... ISS 17 TRISS

	ICD-9	AIS	ISS Body Region
1)	821.00 Fx femur - unspecified part closed	851800 . 3	5
2)	812.20 Fx humerus unspecified part closed	752600 . 2	5
3)	807.02 Rib fx closed, two ribs	450220 . 2	3
4)	805.02 Fx C2 vertebra, closed	650216 . 2	1
5)	805.01 Fx C1 vertebra, closed	650216 . 2	1
6)	854.00 Intracranial injury NOS closed	115099 . 9	1
7)	873.49 Open wound to face other and multiple sites	210600 . 1	6
8)	919.0 Abrasion in other, multiple or unspecified sites	910200 . 1	6
9)	959.1 TRUNK INJURY NOS*	515099 . 9	4
10)			
11)			
12)			
13)			
14)			

Check NIDS Save Save and Exit Print Close Prev Next

Trauma Number: 21 Last: First: Record Status: Arrival Date: *

Discussion: It was reported that if there is a court case, then the autopsy report will not be readily available to a hospital. Dee asked if it is clear where to call for the report. Most facilities said it was clear, however, others find the process more nebulous. Jan Miller explained when she is dealing with cases from small towns, she will call the Sheriff's office to get the ME's number. Dee explained that district coroners decide whether or not a trauma patient injured in their district will be autopsied. Dan Clark stated that Wesley reports all deaths to the Sedgwick County coroner who then follows up with the appropriate district coroner if the patient was injured outside their jurisdiction. Dee asked the registrars how they know if a patient who dies is autopsied or not. It was mentioned that the death form was a source indicating this information.

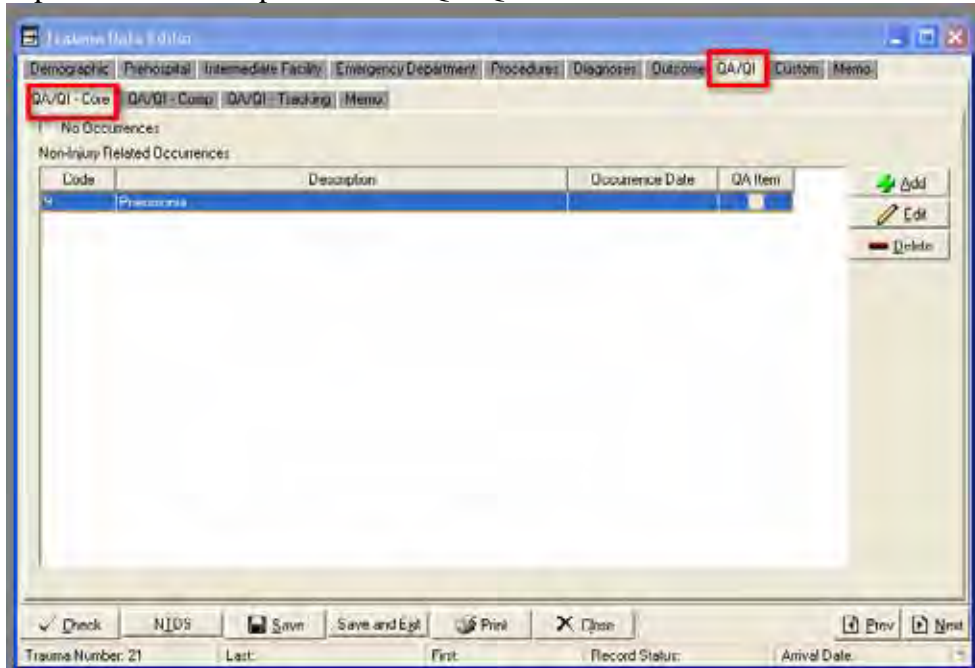
Dee said this case demonstrates a couple of points about coding patients who die suddenly in the ED. 1) the injuries coded from the medical record may produce low ISS scores, 2) more information about the extent and severity of injuries can be obtained from an autopsy report, if an autopsy is performed, and 3) how to use text to coding to code injuries found in the medical record or an autopsy report. Registrars who depend on ICD-9 codes in the medical record would have to use text to coding if they attempt to code injuries from an autopsy report.

Dee asked if a fail chest can be determined without diagnostics. The group replied most of the time "no," however, you can palpate for it.

Issue 4: Complications

A 62 year old patient fell from a roof and received multiple extremity fractures including a skull fracture. While hospitalized, this patient developed pneumonia. Where would you code pneumonia for this case in Collector?

Answer: Because this case is most likely hospital acquired pneumonia, it should be captured in the complications or QA/QI section of Collector.



Retiring Fields: MAST in Future Update:

Dee Vernberg

Dee explained because MAST trousers are rarely used and have all but been discontinued, the MAST field will be retired in 2011's update.

Further questions/discussions:

Dee Vernberg

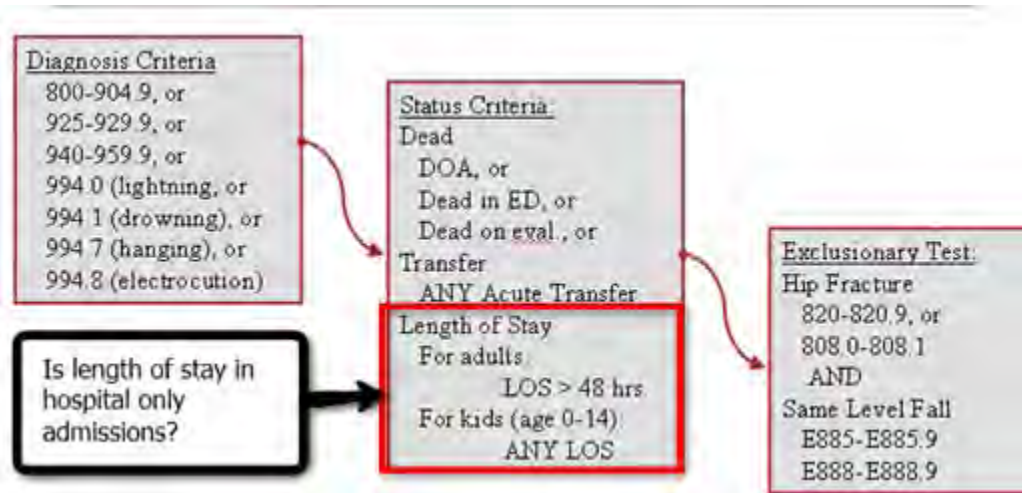
A question was asked about the medication section in the comprehensive version of Collector. Dee said she would like to form a committee to work on the medication list because it is a comprehensive issue. She will keep everyone informed of the committee's status as it is formed. Dee made a call for scenarios from the participants. If anyone has a scenario to share, please contact Dee Vernberg at 785-296-0613.

Meeting was adjourned 2:20pm.

Length of Stay Issue (Dee Vernberg)

Nature of Issue

Currently, the trauma registry inclusion criteria contain a length of stay (LOS) status criteria that is associated with admission to the hospital. The intent is to exclude patients who are treated and release from the ED (unless they are transferred from another acute care hospital).



Sometimes, patients are discharged from the ED to a hospital floor bed or to the ICU but for billing purposes are considered to be out-patients.

In training, the trauma program has considered admission to be **in-patient status** but we may be missing an important group of trauma patients (many trauma centers consider the in-patients who are treated on hospital floors to be trauma patients that should be sent to the state).

What changes are proposed?

In training, patients transferred from the ED to a hospital floor or ICU for observation and billed as an out-patient will meet State trauma registry inclusion criteria.

January, 2010 Policy Group recommendation:

Agree with propose change:

In training, patients transferred from the ED to a hospital floor or ICU for observation and billed as an out-patient will meet State trauma registry inclusion criteria.

February, 2010 ACT decision

Agree – Length of stay is a amount of time the patient spends in the hospital regardless of whether or not the patient is admitted (for billing purposes).

In training, patients transferred from the ED to a hospital floor or ICU for observation and billed as an out-patient will meet the inclusion criteria for the State trauma registry. If a patient stays in the ED if there are no hospital beds, then this patient should meet the inclusion criteria for the State.