

Collector Users Group  
SRS Learning Center, Room 3  
Topeka, KS  
June 10, 2009

**Present:** Dee Vernberg, Dan Robinson, Rosanne Rutkowski, Amy Bucholtz, Julie Unruh

**Present Via Conference Call:** Alvina Fant, Leah Parks, Voncille Dirks, Lois Towster, Monica Smith, Vicki Richards, Sharon Gehring, Janelle Dimond, Paula Mills, Jan Miller, Rachel Reimer, Sharon Ball

Meeting Called to Order: 1:02pm

**Program Update:**

**Rosanne Rutkowski**

Rosanne welcomed everyone to the meeting. Currently the program has been busy working with trauma facility designations. Salina Regional Medical Center has committed to working toward being verified as a Level III Trauma Center. Rosanne informed the participants of the ACS verification report writer class on July 14 from 10am – 2pm at the SRS Learning Center. The class is geared toward preparing prospective trauma center registrars for their ACS verification visit. KDOT has convened an executive safety council, of which Rosanne is a member, to look at possible injury prevention methods. The Regional Trauma Councils have been busy developing new regional plans. All of the regional general memberships have met and discussed their respective regional plans except the Southeast and Southwest regions. The Southwest's general membership will meet on June 17<sup>th</sup> in Garden City, and the Southeast general membership will meet September 3 at Labette Health. Rosanne talked about KEMIS, the Board of EMS's pre-hospital data collection system. Currently, the state is working on a method to transfer data from KEMIS to the Trauma Registry.

**Registry Update:**

**Dee Vernberg**

Dee discussed the new variables in the registry: off-road vehicle (a core variable) and height (a comprehensive variable). The off-road vehicle variable was updated for the local users in January 2009, however, the variable was just added to the web version this month. The off-road field, under the prehospital tab, is only activated when ecodes E820-E829 and E919 are entered in either the primary, secondary, or tertiary ecode fields. The categories for the new off-road vehicle field are as follows: all terrain vehicle, off-road motorcycle, other off-road vehicle, farm implement, unknown, not applicable.

During the last users' group meeting, Dee was asked if motorcross motorcycles should be coded as an off-road vehicle. After careful consideration, Dee explained all motorcycles used in motorcross events should be coded as off-road vehicles.

Another question posed to Dee asked the correct coding for teenagers riding off-road motorcycles on the road. This incident should be coded by first coding the primary ecode as a traffic accident (off-road motorcycle collision with motor vehicle on the road), then coding the secondary ecode as a non-traffic accident to activate the off-road vehicle field

(E825.0 – other motor vehicle non-traffic accident of other unspecified nature), and finally using the specify field to describe the crash.

All the registrars said they are seeing these types of incidents at their hospitals. Amy asked about injuries involving riding horses. She said the appropriate codes for injuries while riding horses activate the off-road vehicle field. She was confused as to the correct response for the off-road field as horses do not fit any of the options offered by the field. Dee explained this is an error in the software. Injuries involving riding horses should not activate the off-road vehicle field. Dee said she will contact DI about the problem.

Julie Unruh asked if the state had any guidance on coding injuries involving the currently popular mini-motorcycles (also known as “pocket-rockets”) on public paved roads. The motorcycles do not necessarily fit the options listed in the off-road vehicle field and they are not licensed vehicles. Rosanne said the ecode should fall under “other off-road vehicles” because even-though the mini-motorcycles are ridden on the road, they are illegal to operate on public paved roads.

Dee discussed the KDHE transfer check box on the demographics tab. A record will not transfer to KDHE unless the check box has been marked with a “Y.” This option is to give the local users the ability to collect data on patients that do not meet the state criteria for trauma. To help mitigate some submission errors for the web users, the KDHE transfer patient check box in the web version has been defaulted to a “Y.” This change makes sense because web users only input cases that are required by KDHE. Dee asked the participants to change the KDHE transfer patient from an “N” to a “Y” if they know of records incorrectly marked; otherwise, KDHE will not receive those submissions.

The most significant future update for the registry is the implementation of the AIS 2005 coder. The AIS 2005 coder is planned for installation on January 2010 and will be used for 2010 data. It will not functionally change the way registrars code data if they use ICD9 codes. The state is currently working on a method to deliver training for AIS 2005. Dee referenced James Pou’s presentation on the AIS 2005 coder during the last users’ group meeting and told the group to contact her if they want the Powerpoint from James’ presentation.

Dee remarked on the collection of financial data. Many facilities are collecting financial data and the state is working on a bridge for transferring financial data. 5% of the records entered into the registry have “Primary Payer Source” coded unknown. Dee asked the group if they had an explanation for the coding of unknown. Lois Towster said she has no issues collecting the data, but when a seriously injured patient is brought to the hospital primary payer is not a chief collection point. Most cases of this type that Lois experiences are transferred out before the data can be collected. She commented that sometimes the accounting department can track down the information but not always.

Dee started a discussion on the “Hospital Charges” data point. The “Hospital Charges” field is coded between \$1 and \$1,000 for more than 5% of the records entered into the registry. Dee explained she does not have much confidence in this dollar amount entered

for emergency care. She asked what type of coding convention the registrars are using for this data field. Are they using 10 to represent 10,000? Julie Unruh said she only enters dollar amounts and not cents. Dee asked if everyone was using hospital charges and not doctor charges. All the participants confirmed they use hospital charges and not doctor charges. Dee asked if anyone had problems finding financial information. Amy Bucholtz said she is not familiar with how Stormont handles financial data. She does not collect financial data because of the time and effort demanded in gathering the data from the appropriate departments. She claimed if she expended the effort to collect the financial data, she would not have the time to enter submissions into the registry by the submission due dates. Rosanne explained we need to work with the appropriate departments in collecting the financial data to develop reliable reports reflecting the cost of trauma in the great state of Kansas. Rosanne mentioned some of the methods currently employed by the larger centers to transfer financial data into collector. Maybe these methods could help Stormont gather financial data efficiently.

Sharon Gehring said the biggest issue they face is the lack or partial collection of financial data at the hospital level. Their registrars will search for the financial data over a course of two months, after which they will move on. Sharon also explained it is extremely difficult to collect the financial data for patients who are difficult cases due to the amount of time insurance takes to settle the case. Sharon discussed the use of Meditech with Janelle and suggested a further discussion off-line. Sharon said they do the best they can in collecting financial data as well as with all the other data in Collector. Rosanne said all the state asks and expects is for registrars to enter the best data they can gather

Dan Robinson discussed the implementation of a Kansas Trauma Registry specific listserv for registrars. All the participants agreed it would be a good idea. The trauma program will explore the idea further.

Dee said she hopes to send 2008 data reports to hospitals next month. Data reports are confidential reports sent to hospitals to give them descriptive information about trauma cases sent to the central site and performance review indicators.

Descriptive information includes what a hospital case mix looks like and how trauma in a hospital compares to trauma seen in region and in the state. Comparisons are made for 1) pediatric, adult and elderly cases; 2) % transfers; 3) age distribution of trauma patients, 4) gender, 5) injury type (blunt, penetrating, burn, drowning), and 5) motor vehicle crash, accidental falls, and other.

There are 10 performance review indicators on the data report. These are filters for identifying trauma cases that might need review. The report shows trauma numbers of cases so that registrars can go back and pull medical records if necessary.

Web users need to have a log with patient name, trauma registry number medical record number, ed admission date to use the information from the performance indicator part of the data report. Reviewing these records is part of hospital performance improvement.

The documentation part of the data report contains relevant information for registrars. It contains missing clinical measures; dates and times for injury, ED arrival, discharge, and procedures.

Dee covered the responsibility of the registrar concerning the data report. The first responsibility is to look at the report. They will come to you in an email. In the subject line of the email, it will say data report for xxx (hospital number used in the trauma registry). The second responsibility is to send these data reports to other relevant people in your hospital (your supervisor, Director of nursing, Director of ED, and Trauma Nurse Coordinator (if there is a trauma nurse coordinator). Dee said to contact her if there was anyone in particular who would like a copy of this report. Also, to contact her if you have never seen this report. The Trauma Program will only send the report to a work email address.

Dee discussed agendas for future meetings. Participants of earlier user group meetings expressed interest in case presentations and discussions over clinical issues. Lois Towster has volunteered to present a case presentation at the next meeting.

## **Case Scenarios/Group Discussion Issues**

### **Issue 1: Does this case belong in the registry?**

The 29 year old patient received a slash wound to the neck and was taken emergently to the OR for a rapidly expanding hematoma at the site. Intraoperatively, only a laceration to the left facial artery and one to the left submandibular gland were identified and repaired. When these injuries were coded, the result was:

900.89 Injury to other specified blood vessel of head and neck.

874.9 Open wound of other and unspecified parts of the neck, with injury to deeper structure, complicated

The patient has an ISS of 1. Does this patient belong in the registry?

**Answer:** It just depends.... This patient has valid diagnosis codes. Although the trauma registry inclusion criteria excludes many mild injuries, there are lower ISS injuries in the registry. The key to deciding whether or not this patient should be in the registry lies in the status criteria for adults . It depends on whether or not the patient was admitted for 48 hours, transferred to or from another acute care facility via EMS, or died. If any of these three conditions exist then, the case should be included in your trauma registry for transfer to KDHE. If you are an ACS verified trauma center, then you may collect information on patients that may not be sent to the us(the state).

A Trauma Center should also include this patient if there was a trauma team activation. Otherwise the Trauma Center does not have a way to track appropriate utilization of the trauma team resources.

**Issue 2: What is the E-849 (place of occurrence code)?**

A patient lives in a homeless shelter and falls there. Is the place of occurrence home (E949.0)?

**Answer:** Yes, if this is the patient's current place of residence.

**Issue 3: What is considered a complication?**

Are complications coded only if they are unexpected? For example, compartment syndrome is a known complication of a tibial plateau fracture.

Is it coded as a complication or should this be entered into the registry as a complication?

**Answer.** Yes

Where are complications coded in Collector?

**Answer.** For those of you who collect minimal (core) data, this would be under the QA/QI tab in the Non-injury related occurrences. For those who collect comprehensive data, there is also a comprehensive non-injury related occurrence field that you can complete.

**Discussion**

Amy asked if a patient with pneumonia would fall under complications. Alvina clarified pneumonia is a comorbidity because it is a preexisting condition.

**Issue 4: Decreasing missing GCS scores**

Is it o.k. to imply a GCS total of 15 if the documentation in the hospital chart (or EMS record) says "AxOx3" and "MAE"?

**Answer:** At a recent national meeting, a physician speaker was describing the problem with GCS missing data in the National Trauma Data Bank. One of the strategies mentioned to help eliminate missing data was to code GCS 15 if there was documentation of AxOx3 and MAE. I think this is reasonable.

Can you imply a GCS score if the documentation says, *78 year old female with Parkinson's, dementia, IDDM, HTN. Reportedly fell yesterday. + femoral shaft fx, ortho consulted?*

*Answer: NO! This case does not have enough information to correctly code a GCS.*

### **Discussion**

Dee asked if the participants would record AxOx3 as a GCS 15. Amy said she does from the EMS reports but not from the hospital ED reports. Julie said there is some confusion in this area because there is not a standard. Some agencies use GCS and other agencies use trauma scale. She expressed her desire to see GCS as the standard of care. Dee asked if the participants use GCS or the trauma scale. Janelle said Mt. Carmel uses both. Many of the participants said their facilities use GCS. Rosanne said she agrees with Julie in trying to promote GCS as a standard of care. Concerning the case scenario, Dee said AxOx3 can equal GCS 15 depending on the situation.

**Issue 5: Where do you find .. transport provider- mode (mode of arrival) if the EMS record is not with the chart?**

**Answer:** Make every effort to get missing EMS records to make this determination.

**How much do you trust information on the ED registration sheet, triage note or physician ED notes?**

**Issue 6: Coding transport provider mode**

A patient was treated at the scene by a land ambulance provider (A) and transported the patient to Hospital 1. The patient was stabilized at Hospital 1 and transferred by land ambulance (B) to Hospital 2 (your hospital). (See next page for image of registry)

How would you code transport provider 1 in the registry?

**Answer:** 1. Land Ambulance

How would you code transport provider 2 in the registry?

**Answer:** / Inappropriate

### **Issue 7: Direct Admits**

When the patient is transferred in from another facility and is directly admitted to the unit, can you record the arrival date to your facility in the ED arrival date field?

**Answer:** Yes!

### **Issue 8: NTDB: National Trauma Data Standard User Group**

If you don't mind receiving a few more emails (sometimes a lot), this is an interesting group where you can pose questions or just learn from the answers to questions. Just remember, that sometimes coding rules for one state will not be valid for the State of Kansas. If in doubt, look at your data dictionary or call the Kansas Trauma Program.

Go to this link to sign up

**<http://groups.google.com/group/ntdbUserGroup?hl=en>**

Amy reiterated that it would be nice to have a listserv for Kansas trauma registrars.

### **Topics for future meetings:**

**Dee Vernberg**

Dee asked if all the participants could access Gotomeeting from their hospitals. Everyone said they could access Gotomeeting. Dee said if anyone is interested in presenting or speaking at a users' group meeting, they should contact her. She asked if there were any topics the participants would like to see covered during future meetings. Alvina suggested the topic of what is considered an invasive procedure for patients who die in the ED in ascertaining whether the patient was DOA or died under the care of the hospital. Amy explained Stormont decided they do not have DOA's and consider all patients who die in the ED as under their care. Lois said they do the same as Stormont.

Adjourned: 2:10pm