Present: Robin Nikkel, Voncille Dirks, Jan Miller, Karen Holly, Sonya Foos, Me’Chell Helton, Rachel Reimer, Jaime Richling, Paula Mills, Margaret Gillen, Amy Bucholtz, Janelle Dimond, Rita Demeter, Stacey Ary, Sharon Gehring, Alvina Fant, Debby Trujillo

Welcome & Trauma Program Update: Rosanne Rutkowski
Rosanne started the program update by reporting on the KEMSIS/Collector Bridge. The project is moving smoothly and is projected for testing in November with actual roll out in January 2011. Rosanne reiterated the bridge will only work if the registrar’s EMS service uses ImageTrend.

NHTSA has chosen Kansas to participate in a data program to analyze what research questions can be answered from trauma registry data. Utah, North Carolina, and Alaska are also participating in the program.

Kansas was awarded funding from the CDC for a field triage guideline pilot project that will be held in the Southeast region, which will also include St. Joplin and Freeman. Massachusetts and Wisconsin were also granted funding by the CDC for a field triage guideline project.

The Dana and Christopher Reeve Foundation awarded the trauma program with a grant to help deliver TNCC training through the state.

The regional trauma councils are very interested in starting regional PI. The preliminary infrastructure has been developed to perform regional PI. A PI workshop will be held at Stormont-Vail HealthCare on October 29th.

Dee Vernberg’s article, “Sustaining an Inclusive Trauma System in a Rural State: The Role of Regional Care Systems, Partnerships, and Quality of Care,” was accepted for publication by the Journal of Trauma Nursing and should be published within a couple of months.

Jan Miller stated she is having problems obtaining information through KEMSIS for some of the EMS services. Jan explained Kansas City has a separate service and she has access to those records. Rosanne informed Jan she needs to speak with Joe Moreland at the Board of EMS.
Registry Update

Dan Russell

Dan started by discussing last month’s server problems at KDHE which affected almost every bureau in the agency and how those problems related to the registry. Dan explained he has searched the registry’s data thoroughly and did not find any problems with it.

Dan gave a presentation on all the software changes in the latest patch. The central site was updated and all the local users should have received the patch by now.

Dan mentioned some of the registrars may have received an email indicating that some of the data elements were coded with an invalid option. Please edit the records with these errors. Dan explained the patch should fix these problems by preventing the entry of any option other than the available options.

Dan reported that local users should send all queued data before installing the patch. There are some structural differences in the software which may cause problems if the queued records are not first sent.

During the QA/QI mapping portion, Dee pointed out that the “comp” tab (meaning the comprehensive QA/QI tab) has moved to the first position before the “core” QA/QI tab. The reason the tabs moved is to correlate with the flow of data structured through the mapping: QA/QI comp to QA/QI core to QA/QI tracking.

Data Collection Issues: Dee Vernberg/ Dan Robinson

Dan Robinson reviewed how to appropriately code prehospital providers. These fields are for only transport providers that transport a patient from the scene of injury to the initial hospital. Prehospital providers involved in inter-facility transfers should not be coded in the prehospital tab (this information can be coded in the Intermediate tab if a registrar is a local user and collects variables in the comprehensive dataset). He also explained every facility involved in a patient’s care should enter the pre-hospital data even if that facility is the secondary or tertiary facility.

Dee asked the group if retrieving EMS run-sheets for the initial run is difficult for the secondary and tertiary facilities. Janelle Dimond from Via Christi-Pittsburg stated she does not get both run sheets. Janelle explained that she had a patient who was injured in Missouri, treated in a Kansas hospital and then transferred to Via Christi-Pittsburg. Janelle does not know which Missouri service picked up this patient in Missouri making it impossible for her to track down the run sheet. Janelle said they try to get more information from pre-hospital providers, but it is difficult.

Dee asked how often the registrars see these types of cases. Jan Miller said about 10% of the time. Jan said they only get information from the agency that transports the patient to their facility, and the only way to know which agency was the initial transport is to call the referring facility.
Amy Bucholtz said they used to have problems getting reports but it has gotten better due to the KEMSIS system that allows them to pull up run sheets online. Amy echoed Jan’s remarks about contacting the initial facility for transfer cases to get the initial transport’s information. Dee asked who Amy calls. Amy explained she calls the main number and asks for medical records. They have not had problems obtaining scene run sheets from the transferring facility because the run sheet is considered to be part of the transferred patient’s records.

Sharon Gehring said the one issue she sees in secondary and tertiary facilities obtaining the initial EMS run sheet is most medical record departments are only encouraged to collect and send the documents generated by their facilities. Some discussion arose over whether this practice is due to legal reasons. Sharon did say her facility encourages this behavior because the facility can only vouch for their documents. All outside documents, generated from other facilities, are viewed as potentially incomplete documents.

Janelle mentioned the Southeast regional trauma council performance improvement group is developing a form that would indicate salient patient information for the next facility.

Procedures:
Dee started her portion of the Data Collection Issues topic by opening with a discussion on procedures. Click here to see the presentation.

Dee asked what type of cases would have no procedures. Near drownings and patients who arrived dead on arrival would have no procedures listed in the trauma record. Dan Russell reported that he sees a significant number of patients in the registry who have a hospital length of stay greater than two days without any procedures recorded. He asked the registrars to take extra care and double check their procedures.

Dee asked where would be the best places to find what procedures were performed for a trauma case. (See PowerPoint for a hierarchy, as suggested by the NTDS). Debby at Via Christi Hospital-St. Francis said the trauma flow chart will contain most if not all the information needed for trauma patients. She also agreed the hierarchy is a good tool to find the needed data. Janelle commented registrars would miss a lot of data using only the medical records coding summary, an item identified in the hierarchy. Alvina Fant noticed the hierarchy lacked radiology report which is also a good source for procedures and other data elements in the registry.

During the presentation, Dee explained if a patient receives multiple CT scans for single body region during their stay at the hospital, the registrar is only required to enter the first scan for state purposes.

QA/QI:
Click here to see the QA/QI section of Dee’s presentation. Dee asked for examples of when a registrar would enter “bleeding” as the QA/QI option. Janelle said she had been
entering “bleeding” if a patient needed a blood transfusion after a hip fracture, but she stopped because she thought that was common place. Alvina asked for the NTDB definition for “bleeding.” Bleeding is considered “any transfusion (including autologous) of five or more units of packed red blood cells or whole blood given from the time the patient is injured up to and including 72 hours later. The blood may be given for any reason.

Concerning the hierarchy of sources for non-injury-related data, Amy commented that they get most of this information in their morning trauma staff meets every morning where they discuss their trauma patients. They also get some non-injury related information through progress reports.

During the injury diagnoses discussion, Dee stated that injury coding could be incomplete if no diagnostics were performed (e.g., a patient was transferred quickly, died quickly after arriving in hospital, or were (DOA) dead on arrival). In the cases where a patient dies, an autopsy report can provide detailed information about the injury so that a registrar can code the injuries sustained by a patient. Jan Miller mentioned that radiology reports are also a great source for injury diagnoses data.

With regard to comorbidities, Dee stated that, depending on the circumstances, pneumonia could be a comorbidity or a non-injury related occurrence. For example, if a patient had pneumonia before they were injured then pneumonia should be coded as a comorbidity. If a patient contracted pneumonia while being treated for an injury in the hospital, then the condition would be coded as a non-injury related occurrence.

The last part of Dee’s portion dealt with air ambulance personnel performing procedures such as airways in a hospital’s ED before transport. Jan said she collects that information under EMS because it is done with their supplies, people, and under their medical director. Janelle said she would just code air ambulance’s insertion of an airway under the airway data element then annotate the procedure was performed by the air ambulance team in the specify field.

**Scenarios:**

**Dan Robinson**

**Scenario 1:** A patient fell from a ladder and hit his head. After the incident, he didn’t feel like he injured anything and kept working. Two weeks later, he started experiencing a constant head ache. Another week later, he saw a doctor. At this time, he was diagnosed with a subdural hematoma and was transferred to higher level of care for surgery. Does this case belong in the registry?

This case does belong in the registry as it is a case of delayed diagnosis. The injury was sustained during the fall. The patient just did not seek medical attention until several weeks later.

**Scenario 2:** A patient came to your ED for a broken arm. Your facility is unable to treat the fracture and arranged EMS transport to transfer the patient to another acute care
facility. The patient refused the EMS transport and has a family member drive her to the accepting facility. Does this case belong in the registry?

In the status criteria of the Inclusion criteria (see slide below), patients are included if they meet the diagnosis criteria and are acutely transferred to another facility by EMS. In this case, your facility recommended that the patient be transported by EMS but they refused. Had the family not refused EMS transport, the patient would be in the registry; therefore, you should include this case in the registry.

![Trauma Definition Inclusion Criteria Diagram]

**Report Writer:** Dan Robinson

Dan mentioned the trauma registry web page contains some Report Writer manuals. Please visit the following link for a basic manual developed by the Kansas Trauma Program outlining step-by-step instructions on using Report Writer:


Please visit this link to view the DI Report Writer Guide:


There was no further discussion from the group during the presentation and no additional questions were asked at the end.

**Adjourn 3:00pm**
Users Group

September, 2010

Our Vision - Healthy Kansans living in safe and sustainable environments
Procedure/Injury/Co-morbid/QA/QI

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Procedures

• Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient’s specific injuries.

• Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

• Include only procedures performed at your institution.
  - No CT scan at hospital – send to another hospital for CT scan before transfer
Procedures

• (ICD-9-CM) IP codes.

• Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient’s specific injuries.

• Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

• Include only procedures performed at your institution.

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Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Memo</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Procedures</td>
<td></td>
</tr>
</tbody>
</table>

Be sure and check if no procedures
Where do you find procedures?

Data Source Hierarchy

1. Operative Reports
2. ER and ICU Records
3. Trauma Flow Sheet
4. Anesthesia Record
5. Radiology Report
6. Billing Sheet / Medical Records Coding Summary Sheet
7. Hospital Discharge Summary

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What does Trauma Program do with procedures?

- Data report
  - Splenectomy
  - Chest tube
  - Reduction of dislocation
  - Laparatomy
- Reviewing cases for Regional PI
- Hospitals conduct own reports
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QA/QI
Non-injury related occurrences

• Different tabs for comprehensive & core
  – Web users only one tab – no problem

• Two parts to this variable/field
  – Any occurrences (Y/N)
  – If Yes, what occurrences

• Should you have NI RO?
  – Usually don’t have before 24 hours post injury
  – May not have this on all patients
Non injury related occurrences

An event that is not an expected sequela of a disease, illness or injury

1. Bleeding
2. Coagulopathy
3. Decubitus
4. Deep surgical site infection
5. Organ/space surgical site infection
6. Superficial surgical site infection
7. Wound Disruption
8. Systemic sepsis
9. Pneumonia
10. Extremity compartment syndrome
11. Graft/prosthesis/flap failure
12. Abdominal compartment syndrome
13. Acute renal failure
14. Acute respiratory distress syndrome ARDS
15. Coma
16. Cardiac arrest with CPR
17. Deep Vein Thrombosis (DVT)/Thrombopylebitis
18. Pulmonary Embolism
19. Stroke/CVA
20. Myocardial infarction
21. Unplanned intubation
22. Unplanned readmission

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Non-injury related occurrences are in QA/QI tab

Separate tab for comp. users (reason for mapping)

Code here if leave no occurrences
Non-injury related occurrences

Data Source Hierarchy

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

Uses

• Allows data to be used to characterize patients and hospital outcomes based upon the presence (and type) of hospital complication.
Injuries versus Comorbidities

To code diagnoses

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Injury DX- Coding Module

Overall severity

Individual injury severity
Injury Diagnosis

Data Source Hierarchy

- 1. Hospital Discharge Summary
- 2. Billing Sheet / Medical Records Coding Summary Sheet
- 3. Trauma Flow Sheet
- 4. ER and ICU Records
- 5. Radiology Reports

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon the presence, severity and type of injury.
- Data report (low grade splenic laceration; hip, knee, shoulder, elbow, ankle dislocation; pneumothorax/ hemopneumothorax)
When would **injury coding** not be complete?

- **DOA or Died quickly in ED**
  - Did patient get an autopsy?
  - If so, try to get autopsy report so you can code injuries from this?
  - Problems determining this?

- **Quick Transfer (limited or no diagnostics)**
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Comorbidity

Be sure and check if no comorbidities

- Code 486: Pneumonia organism unspecified
- Code 584.9: Acute kidney failure, unspecified
Non-injury related occurrences vs comorbidity

1. Bleeding
2. Coagulopathy
3. Decubitus
4. Deep surgical site infection
5. Organ/space surgical site infection
6. Superficial surgical site infection
7. Wound Disruption
8. Systemic sepsis
9. Pneumonia
10. Extremity compartment syndrome
11. Graft/prosthesis/flap failure
12. Abdominal compartment syndrome
13. Acute renal failure
14. Acute respiratory distress syndrome (ARDS)
15. Coma
16. Cardiac arrest with CPR
17. Deep Vein Thrombosis (DVT)/Thromboprophylaxis
18. Pulmonary Embolism
19. Stroke/CVA
20. Myocardial infarction
21. Unplanned intubation
22. Unplanned readmission

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Comorbidities

Data Source Hierarchy

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

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon the presence (and type) of co-morbid condition.

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Procedures performed by EMS before transfer

• Airway
  – Oral Endotracheal Tube
  – Other?

• Chest tubes
Procedures performed by EMS in ED before transfer

Are invasive airways coded in procedures?

Definitive airway established before transfer of comatose patient