Kansas Collector Users Group Meeting
September 9, 2009
SRS Learning Center, Room 3
2600 SW East Circle Drive South
Topeka, KS

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

Present Via Conference Call: Debbie Trujillo, Terry Woodson, Amy Bucholtz, Sharon Gehring, Paula Mills, Rachel Reimer, Janelle Dimond, Lois Towster

Dee Vernberg called the meeting to order at 1:05pm.

Program Update: **Dee Vernberg**
Dee gave the program update in Rosanne Rutkowski's absence.

The trauma program and the Board of EMS are exploring options for how to download prehospital information from EMS directly into trauma's Collector. The Trauma Program participated in a conference call between the Board of EMS, DI, and ImageTrend, the vendor for KEMIS (EMS data that are submitted to the Board of EMS). where DI presented a proposal for an interface between the two programs. The solution DI presented is similar to the product the company uses in Mississippi. This work is still in the planning stages but will keep you informed of progress.

The six regional plans are complete and have been approved by the respective regions. These regional plans are currently awaiting review by an external subcommittee of the ACT. Dee suggested everyone look at the regional plans to see how they affect their particular regions when the reviews are complete. Dee also recommended attending a regional general meeting. You can find out when there is a regional meeting in your region by going to http://www.kstrauma.org/regional_council.htm or you can read the minutes to review activities and issues regarding trauma in your region.
The general meetings are an opportunity for individuals to take an active role in improving the trauma system in their area. Dee also gives a registry presentation at each general meeting. She thought it might be interesting for the registrars to see how she analyzes and presents these data. Dee asked if the registrars would like to see more presentations on findings at the meetings. The attendees agreed that a data presentation would be interesting to have in a future user's group meeting.

The statewide meeting of the executive councils is scheduled for November 6, 2009 at Wesley Medical Center in Wichita, Kansas. Dr. Sasser from the CDC will present on field triage guidelines.

Registry Update: **Dee Vernberg**

Registrar listserv. Dee informed the group that a new listserv has been established for registrars. Even though no discussion has yet crossed the listserv, the program is very

excited to have this resource available. Dee explained the listserv is intended for any questions related to the registry, how to code case scenarios, or how to use report writer to answer questions.

Online Collector Training. Dan Robinson described plans to develop online Collector training classes. These trainings will be comprised of instructional video segments. The first release will focus on core data entry and will be targeted for smaller facilities, which experience a much higher registrar attrition rate than larger facilities. Dan asked the group if they thought video instruction would be useful. The registrars in attendance replied they would find video instruction for report writer most beneficial. The program welcomes any suggestions from other registrars on what types of training they would like to have that might be offered as a video instruction module.

Trauma Program Newsletter. The next newsletter should hopefully be released in October. Dee identified and explained the various sections of the newsletter. She finished by stating the registry section in the October newsletter will examine registry data on teen driver injuries.

2010 Collector Update. The trauma program is working on the details for the major update scheduled for January 2010. Included in the January update is the AIS 2005 coder. Dee explained the program will not offer training in AIS 2005 until the update has been successfully implemented. Other changes that will be made in this update include: 1) New physician on-time field, 2) new EMS fields if EMS is involved in transporting a patient to another facility from your hospital, 3) new options for discharge to, 4) New options for non-injury related occurrences (core and comprehensive). More information and training will be offered when the update is complete.

Kansas Department of Transportation (KDOT) occupant protection group. The trauma program is working closely with KDOT on issues related to occupant protection. KDOT has been analyzing these issues and is interested in trauma registry data. Dee asked the attendees how they collect seat belt use data, where do they find this information recorded and what problems do they experience when collecting the data (i.e. which seat belts were used and if child seats were used). Jan explained the first responder will document belt usage. This documentation should follow the patient to the hospital. If the MVC occurred on the highway, then the information can be obtained from the highway patrol who collects information about whether or not a patient is restrained. Jan stated she uses the highway patrol web sites to access this information. The Kansas Highway Patrol crash logs are located at https://www.accesskansas.org/ssrv-khp-crashlogs/index.do. The majority of the attendees stated they obtain the information from the EMS run sheet, and the information is usually complete. The group discussed the various methods they use to obtain the EMS run sheet. Dee explained that she is interested in these data because the data elements for seat belt use are frequently missing and this affects the quality of the trauma data for looking at occupant restraint issues.

The group then discussed collecting airbag data. Some expressed concern in collecting data on the deployment of an airbag without collecting the location of the airbag. Only

collecting data on airbag deployment does not address the issue of whether or not the airbag provided any protection for the injured patient.

Coding transfers to Children's Mercy Hospital

In response to some confusion over coding patients who are transferred to Children's Mercy Hospital, Jan Miller clarified that Children's Mercy South, located in Overland Park, Kansas, does not have an ED at this time and therefore can not accept transferred patients. The other Children's Mercy is located in Kansas City, Missouri and is the facility that would accept trauma patients. For patients transferred to Children's Mercy Hospital, registrars should use the facility code for Children's Mercy found under the Missouri drop down box. If you need more information on the exact code to use, please contact Dee Vernberg at dvernberg@kdheks.gov

Case Presentations: **Dee Vernberg**

Issue 1: Does this case belong in the registry?

A patient is involved in a MVC accident and is pronounced dead at the scene. This patient is brought to your ED by EMS for body fluid collection (tests for ETOH and Drugs).

Does this patient belong in the registry? Why or why not?

Answer:

No, because this patient was not treated or assessed at the hospital. If a physician assessed the patient and pronounced them DOA, then they would be a case in the registry if they have a relevant ICD 9 diagnosis code.

Discussion:

Group agreed.

Issue 2: Does this case belong in the registry?

A patient is brought to your ED after being bitten by a venomous snake. Would you consider this injury a puncture wound and enter this patient in the registry? Why or why not?

Answer:

No, the ICD-9 diagnosis code for a venomous snakebite is 989.5, which is not in our list of valid diagnosis codes. (This assumes the patient was hospitalized due to the venom and not due to complications due to the puncture wounds from the snake bite.

Discussion:

Group agreed.

Issue 3: How would you code "discharge to"?

A patient is discharged to a skilled nursing facility in a hospital that is also considered to be an acute care hospital. For example, a patient is discharged to a skilled nursing unit at

Kansas General Hospital, Anywhere, Kansas. Kansas General Hospital, Anywhere, Kansas is also an acute care facility.

How would you code **discharge to?** (See screen shot below)
How would you code **Facility** (under discharge to)?

Answers:
The discharge to code should be 8 – skilled nursing facility NOT 7- acute care facility. The Facility code would be the number for the acute care facility – "Kansas General Hospital" – this is a fictitious center so there is no actual code.
Discussion:
Dee: I have noticed problems with the discharge to coding in the State Trauma Registry database. A question was asked how one should code discharge to another facility if the patient was first going to be admitted to a swing bed. It was decided that if the patient is being discharged for rehabilitation, for example, but is placed in a swing bed first that the field "discharge to" should be coded as rehabilitation not acute care facility.

Issue 4: How would you code this case?

On Monday, a patient was brought to your ED by EMS due to a fall where she hit her head on a concrete floor. The patient had been drinking all day at a bar. She was not seen by a physician, refused treatment and left AMA. During this visit, the patient did not receive a diagnosis so she did not meet criteria for the trauma registry. One week later, this same patient returned to the ED, ambulating, trouble with speech and tired. During this visit, she was transferred to another acute care facility with a subdural hematoma with mass effect.

In coding this patient,

> Would you report the second event with text indicating the first visit? It is suspected that there would have been an injury diagnosis during the first visit if the patient had not left AMA.

Answer:

Yes, you would code the second admission – subdural hematoma is a trauma diagnosis and you are acutely transferring this patient for definitive treatment.

Currently, there is no direct way to code the first event. Unless it is recorded in the chart that this subdural hematoma was due to the first fall, you can not put the injury date and time as the first fall. But if you have some evidence that the subdural hematoma is due to the first fall, then this patient is a **readmission.** There still remains a problem: there is no code for readmission in the core data set. However, in the next update, there will be a code for readmission in the non-injury related occurrences (core) under the QA/QI tab.

To indicate what happened to this patient, write a concise description of event in the "Specify" window. (See screen shot below). Note: this memo field is under the Prehospital tab and is found under the ecodes.

For example you could write in the specify memo field,

One week ago (Monday, 8/31/2009) the patient was brought to this hospital via EMS after falling on a concrete floor. She left AMA before seen by MD. She arrived today with symptoms due to fall. Readmission.

Trauma Data Editor

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

Incident | Location/Devices | Transport Provider 1 | Provider 1 - Vitals | Transport Provider 2 | Provider 2 - Vitals | Transport Provider 3 | Provider 3

Incident @ Primary Injury Type Work Related N

Causes of Injury:
Primary E
Secondary E
Tertiary E
Specify: One week ago (Monday, 8/31/2009) the patient was brought to this hospital via EMS after falling on a concrete floor. She left AMA before seen by MD. She arrived today

Off Road Vehicle
Places of Injury:
Primary E849.
Secondary E849.
Tertiary E849.
Specify

Custom

Check | NTDS | Save | Save and Exit | Print | Close | Prev | Next

Trauma Number: 11001768 | Last: Caudillo | First: Pat | Record Status: Closed - P | Arrival Date: 9/2/2002

Note: the information in the specify field has to be concise – DO NOT put in carriage returns. .

Given the information you have, what E-code would this patient be given?
Answer:
The patient most likely would be given one of the two e-codes listed below:

E885.9 fall on same level from slipping, tripping or stumbling – from other slipping, tripping or stumbling.

E888.9 Other unspecified fall
Discussion:
The group discussed which visit of the patient is the more accurate to capture in the registry. Some capture the first visit for their own records, while the majority capture the second visit with a note in the specify line recounting the first visit.

Given the non-specificity of these-codes, you can see why a description of the fall in the specify memo field could be useful in understanding this injury.

Issue 5: How do you code insertion of a chest tube?

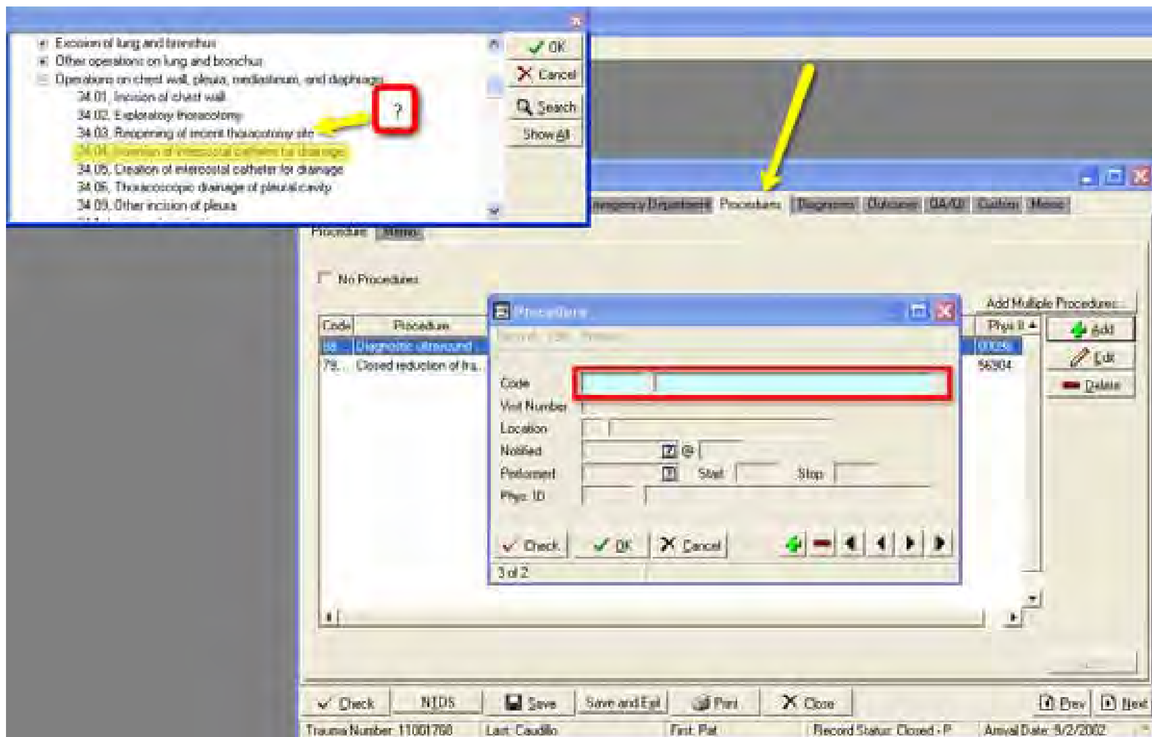
A patient comes to your ED with serious injuries and will be transferred to another acute care hospital with more resources to treat these injuries. Before transfer, the patient is diagnosed with a pneumothorax and your physician inserts a chest tube.

Where would you code insertion of a chest tube in Collector?
Answser:

Under the procedures tab (see screen shot below). ,
What code would you use to indicate insertion of a chest tube?
Answer:
The code is **34.04**. Click add, then under operations on respiratory system, click "operations on chest wall, pleura, mediastinum & diaphragm".
Highlight this code and click OK.

Be sure and record the date and time it was inserted (performed)!!!

Do you ever use the procedure code 34.03 – reopening of a recent thoracotomy site for a chest tube? (See screen shot below).
Answer:
The group at the meeting said No. You may use this code if this procedure is used, but it is rarely used. Most chest tube insertions are insertions only (34.04).



Issue 6: How would you code Head CT and intubation?

Suppose you had a patient in the ED who received a Head CT scan and was intubated. (e.g. received an airway intubation). Where in the registry would you code these procedures?

Answer:

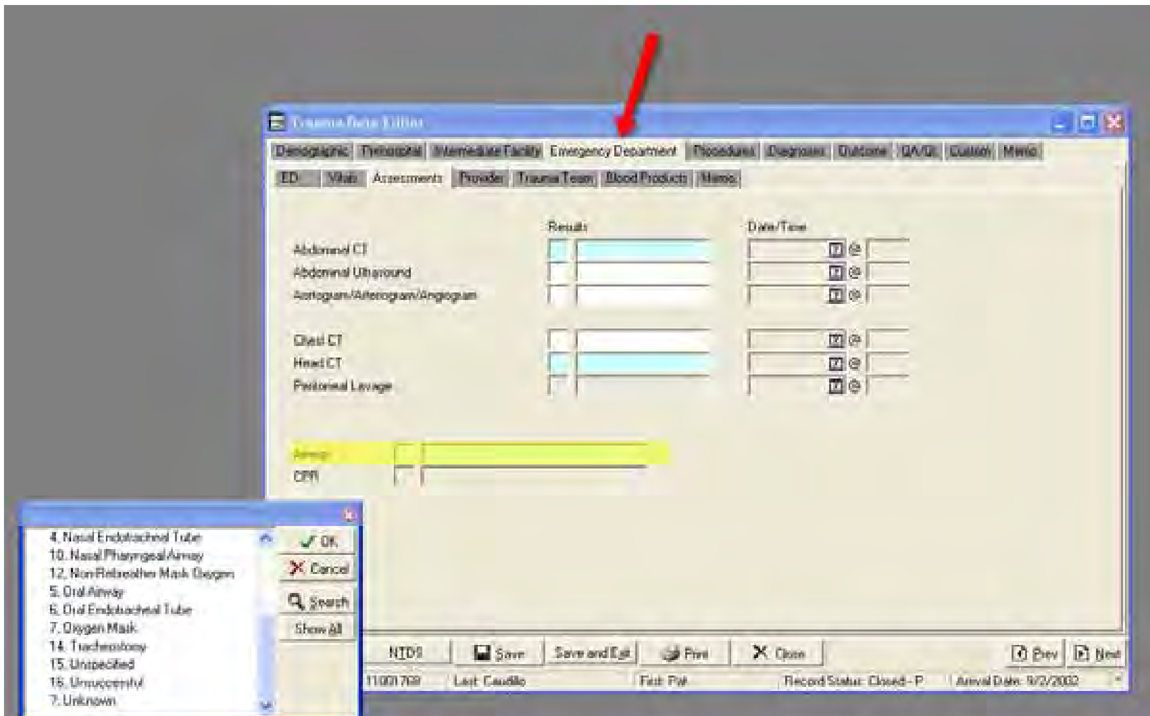
You would code these procedures in two places: 1) the field located under the ED tab, 2) In the procedures list under the procedures tab.

See screen shots below.

1. Code the **Head CT** under the **ED tab** (See screen shot below)

2. Also code the **Head CT** under the **procedures tab** (See screen shot below)

1. What type of **airway** intubation? The codes for different types of airways are found under the **ED tab** – see screen shot below.



2. The **procedure codes** shown in the screen shot below may be used to code an **airway** that was placed in the ED.

What codes would this patient have for the scan and the intubation?
Answer:

Head CT: Under the ED tab, the Head CT would receive a code of either 1, 2, or 3 (see screen shot above). The procedure code for Head CT is 87.03.

Airway: There are many different airways that a patient could receive. For example, a nasophyrangeal airway would receive a code of 10 under the ED tab and a procedure code of 96.01 under the procedures tab. (See screen shots above).

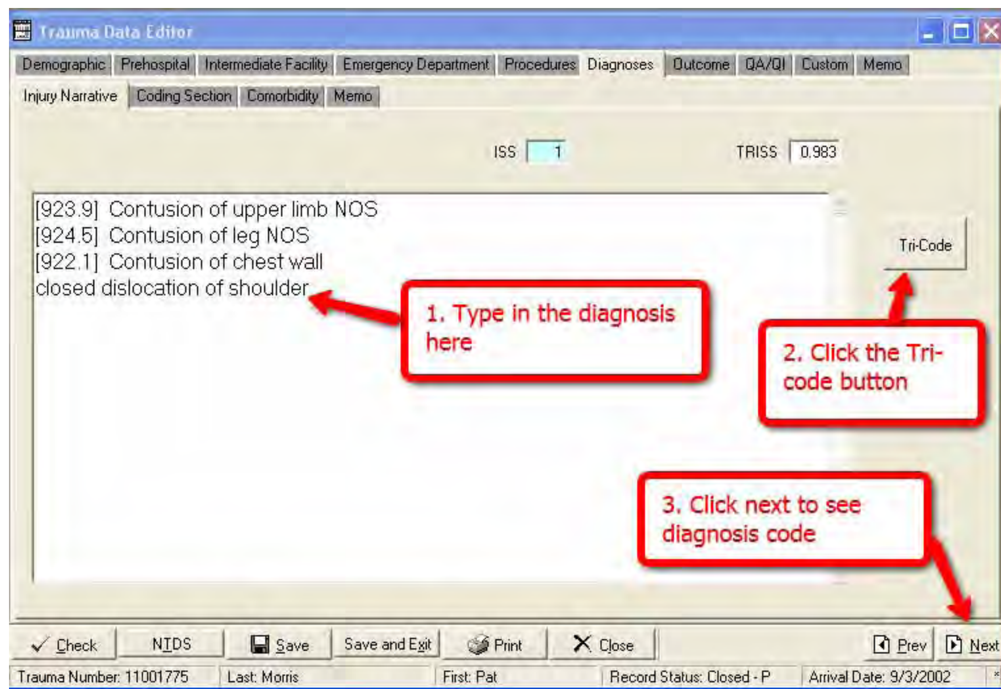
Issue7: Coding dislocation of shoulder and reduction.

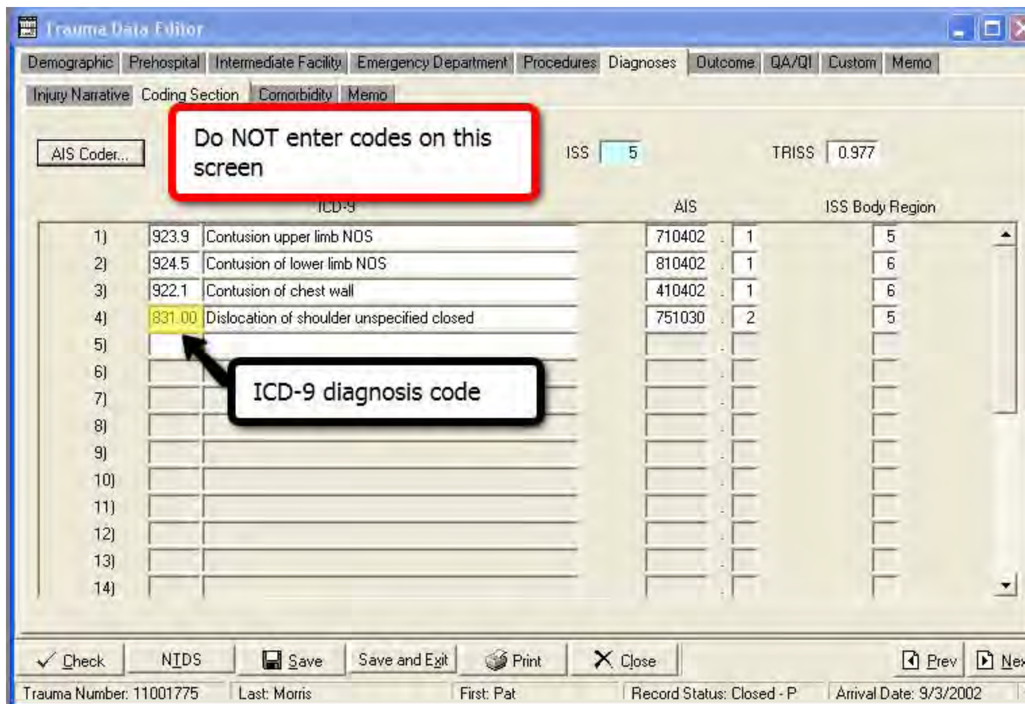
Suppose a patient had a closed dislocation of the shoulder. Where in the registry would you code this injury? What code would you use for this injury?

Answer:

Code dislocations under the diagnoses tab. (See screen shot below)

If you don't have specific information about this closed dislocation, the ICD-9 diagnosis code would be 831.00 (Closed dislocation of shoulder – unspecified). Note all 831.0 codes are closed dislocations of the shoulder – the fifth digit gives more information. For example, 831.01 is a closed anterior dislocation of the humerus.



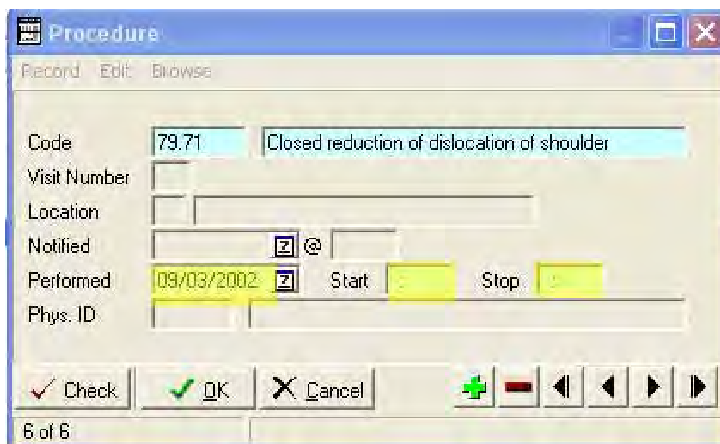


Suppose this patient received a reduction at your hospital. Where would you code this procedure?

Answer:
Under the procedure tab. (See screen shot below).

What code would you use to indicate this procedure?
Answer:
79.71 (See screen shot below).

What other core information should you always enter for procedure codes?
Answer:
Date performed and Start/stop times. (See screen shot below for example).



Topics for Future Meeting: **Dee Vernberg**
Dee asked the group for volunteers to present case presentations at the next users' group meeting. If anyone is interested in presenting, they should contact Dee. We are first interested in cases applicable to all facilities (e.g., transfers and patients whose hospital stay is relatively short). Also, please feel free to bring in questions regarding how to code challenging cases.

Collecting financial information - Collections:

Dee asked the attendees how far in the future are they tracking patients for the financial data element called "collections." The state recommends tracking the patients for six months after discharge. Dee asked the group how they track patients and collect information on collections. Some registrars run a report each month using report writer to identify patients who were discharged 6 months ago. Some registrars are granted access to patient accounts while some are given the authority to view some of the hospital's financial reports. None of the attendees expressed having trouble either getting the financial information or permission to view the information.

EMS information – scene to hospital

Dee mentioned that one of the priorities of the trauma program as defined by one of the BIS (Benchmark, Assessment, and Scoring) assessment items, is to addresses how long it takes a patient to get to the hospital after being injured if they are transported by EMS. This question is difficult to measure but minimally requires that registrars collect information on all the EMS agencies that provide care and transport the patient. This item sparked discussion about the three transport provider fields in collector and how to appropriately complete those fields. Some facilities only capture the provider that brings the patient to the hospital. This method potentially ignores the first responder team that may transport a patient to the next EMS provider. Other facilities attempt to collect data from all the providers that treated and transported the patient from the scene to initial hospital. Dee stated that looking at this from a systems perspective, if we only get information for the last provider we will not be able to answer all the quality improvement system questions regarding how well coordinated transportation resources are for ensuring that EMS providers arrive at the scene promptly or how promptly patients are transported to a hospital from the scene.

The group also discussed the correct order to record multiple transport providers and whether or not the National Trauma Data Bank requires the collection of information on all EMS providers. Dee will follow-up on these questions.