Kansas Trauma Registry Subcommittee Meeting
Via Christi- St. Francis, Wichita Kansas
Minutes
January 18, 2006

Present: Janet Jilka, Sharon Gehring, Brenda Olsen, Dr. Jonathan Dort, Eric Cook-Wiens, Rosanne Rutkowski

Guest: Debbie Helten
Meeting was called to order at 10:30.

State Trauma Program Update:

Rosanne provided an update as to the current state activities. KDHE plans to request changes to the current trauma statutes to cover hospital designation and quality improvement activities. Copies of the proposed changes were provided.

Federal funding for trauma was cut from the HRSA budget. In the past Kansas was awarded a small grant, which was used to fund the EMD project and public information. The greatest loss of the federal program will be support for such things as the Model Trauma Plan and development of a national trauma data set.

The trauma program has plans underway to establish a trauma web site: www.kstrauma.org.

The trauma registry pilot is currently underway with hospitals in Olathe, Newton and Coffeyville serving as test sites. KDHE has authority to sole source the current contract with the current software vendor, Digital Innovation.

Kansas Department of Transportation has undertaken a traffic records project and hopes to develop a warehouse for data from EMS, KDHE, KBI, and KDOT related to traffic crashes etc.

Trauma Registry Issues:

Issue #1
Nature of the Issue:

Request for clarification of the exclusionary criteria for same level falls.

KTRS Recommendation:

A note should be added to the trauma inclusion card to state that same level falls are not included in the registry even if they are transferred to another facility for treatment.

Issue #2
Nature of the Issue:

Some institutions utilize observation units for ED triage. These patients may or may not be admitted to the hospital depending upon the outcome of the observation. Should children with non-severe injuries who are put in an observation or short-stay unit but not admitted to the hospital be included in the registry? Do they meet the status criteria?

KTRS Recommendation:

The intent of the inclusion criteria is to capture those who utilize the services of a trauma system, which would be those with the more severe injuries.

As hospitals vary in how they manage those who stay less than 24 hours in a facility, it is recommended that a survey be sent to the trauma registry users asking if they are currently including those children who are admitted to an observation unit/outpatient unit/extended ED stay are included currently in the registry data submitted.

Issue # 3

Nature of the Issue:

The section of choices given in the ED section of the registry regarding performance of CPR is not appropriate. Current choices are:

*en route
*at the scene
*at the scene & en route or
*no intervention

KTRS recommendation

KTRS recommended they be changed to choices more appropriate to CPR performed in the ED and to include the following:

*no intervention
*CPR performed

Benchmark Report:

Eric provided an update on the status of the trauma benchmarks that he has been concentrating on. Please see attached a copy of the powerpoint presentation.

The recommendations of the committee regarding the benchmark report include the following:

1) Replace the phrase "failed benchmark" with "Outlier"
2) Develop a plan to roll out the benchmark report so that its phased in
3) Provide education to providers regarding the benchmark report
4) In addition to educational efforts, generate documentation explaining the benchmark queries as simply as possible.
5) The language in benchmark #5 needs to be clarified regarding transfers to non-trauma centers. Until hospital verification is established, it is appropriate to include ONLY those facilities currently verified by ACS as Trauma Centers.
6) The hematoma benchmark may not be clinically useful considering the different treatment recommendations for small hospitals compared to trauma centers. KTRS recommends rewriting the benchmark to focus on the transfer process for patients with intra-cranial hemorrhage.
7) It is recommended that heart rate be added to the core data set
8) Zip code needs to be added to the core data set.
9) Reconsider the ordering of the benchmarks placing greater emphasis on "system benchmarks". Reconsider the need to categorize benchmarks as "process" and "clinical". Explain in supporting documentation that the goal of this report will be to evolve into a trauma-system-oriented report in contrast to a clinical benchmarking report.
10) KTRS recommends that "benchmark sharing sessions" be conducted before the next KTRS meeting to initiate the rollout-process, identify potential pitfalls, review and evaluate benchmark queries including specific decisions about ICD9 code ranges, current practices in Kansas and benchmark "evaluability".
11) KTRS recommended the addition of procedure start time to the documentation benchmark.
12) KTRS recommends giving a presentation to ACT on the current version, but beginning phased rollout upon approval of revisions by KTRS at the next meeting.

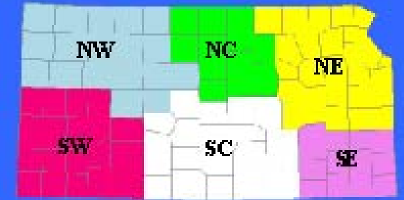
The meeting dates for 2006 are as follows. It was discussed that Tuesdays work for most of the committee members.

April 18—Topeka
July 18-Wichita
October 17- Topeka

The committee would like to thank Kris Hill and Via Christi for providing meeting room accommodations.

Meeting adjourned at 3:00

Trauma Registry Update

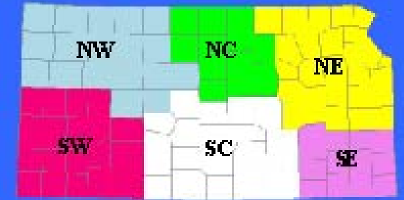


I. Registry Update
   I. Reporting for 3rd Quarter
   II. Web-based Pilot
   III. Record Linkage / Data Cleaning
   IV. Out of State Data

II. Issue Review

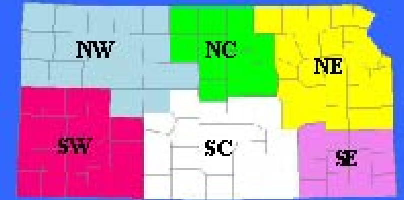
III. Benchmarks

3rd Quarter Submissions



- 100/125 Reporting
- 80% compliance (78% at last KTRS meeting)
- Protocol for call-backs
- Non-submission mailing
- Basic Training January 26

Web-Version Pilot



- Data entry during January, covers records discharged over one complete month from 4th quarter, 2005.
- Solution for “Core” users only
- “Core+” dataset
- Coffeyville, Newton, Olathe

S Trauma Reg

V4 Registry - KANSAS, 1: State of Kansas

Record Edit Navigate Window Help

Trauma Data Editor (ViewOnly)

Demographic | Prehospital | Referring Facility | ED | Procedures | Anatomical Diagnoses | Outcome | QA/QI

Prehospital Data | Transport Provider 1 | Transport Provider 2 | Transport Provider 3

Incident Date and Time / / @ :

Primary Injury Type

Causes of Injury

Primary E-Code

Secondary E-Code

Tertiary E-Code

Specify

Places of Injury

Primary E849.

Secondary E849.

Tertiary E849.

ZIP Code -

City

If Other

County

State

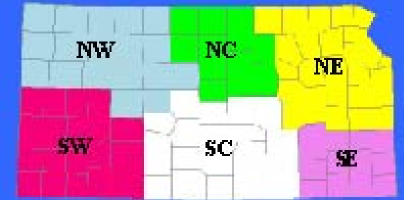
Protective Devices

If Other:

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

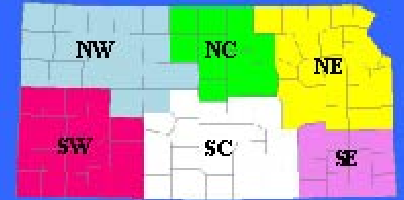
Trauma Number: 20060001 | EDA Date:

Record Linkage & Data Cleaning



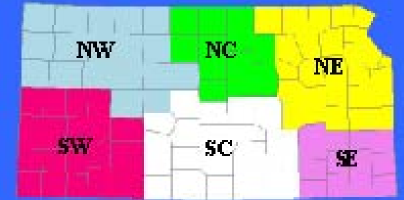
- Revised linking algorithm
  1. Eyeball and Crystallize in Collector
  2. Considerable "false negative" rate, low "false positive" rate
  3. Down the road: linking benchmark?
- Dataset preparation
  1. Policies and Procedures
  2. Issues:
     a. Exporting
     b. Normalization
     c. Cleaning

Out-of-state Linkage



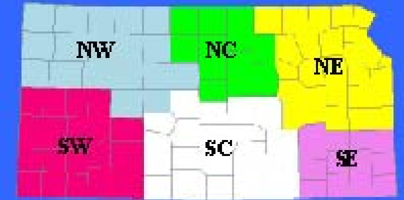
- Contact with OK-DOH
- May not be able to get zip code level place-of-injury data
- Linkage may not be possible
- Aggregate counts from DOH will give some insights

Issue Review



1. Exclusionary Criteria
2. Observation Units
3. CPR in the ED

Benchmark Report

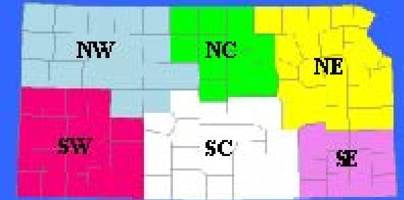


- Help from DI
  1. Help writing queries
  2. Clinical comments – consistency with other trauma systems
  3. Automation
- Benchmarks follow a 3-query form:

Qualify **Fail** **Miss**

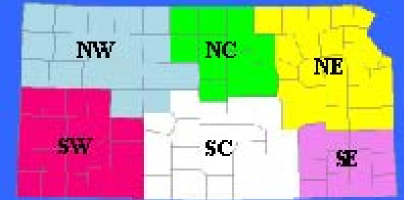
- Queries will be available in Collector 4

Benchmark text



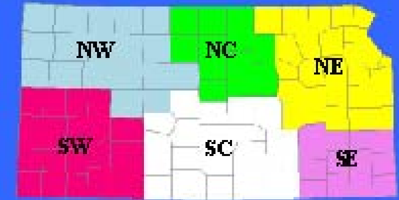
- For all transferred patients, elapsed time between emergency department arrival and discharge to another acute care facility does not exceed 6 hours.
- For transfers with Injury Severity Score ≥ 15, elapsed time between emergency department arrival and discharge to another acute care facility will not exceed 3 hours.
- Patients with pneumothorax (or pneumohemothorax) receive a chest tube before transfer to another acute care facility.
- An airway will be established before transfer of comatose patients (GCS ≤ 8).
- Patients with serious head injury (Abbreviated Injury Score ≥ 3) are transferred to a level I or level II trauma center for treatment. This benchmark applies only to Kansas facilities not currently verified by the American college of Surgeons transferring patients within the state.

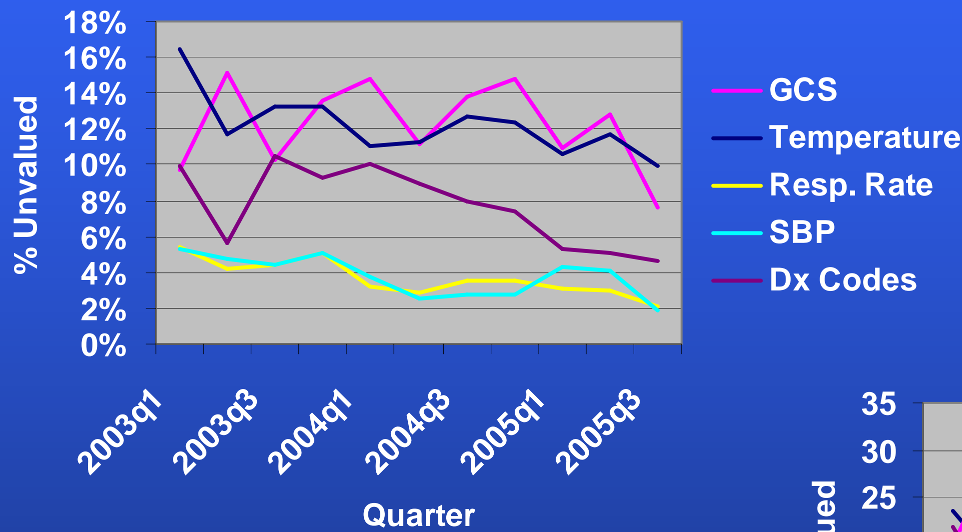
Benchmark Text

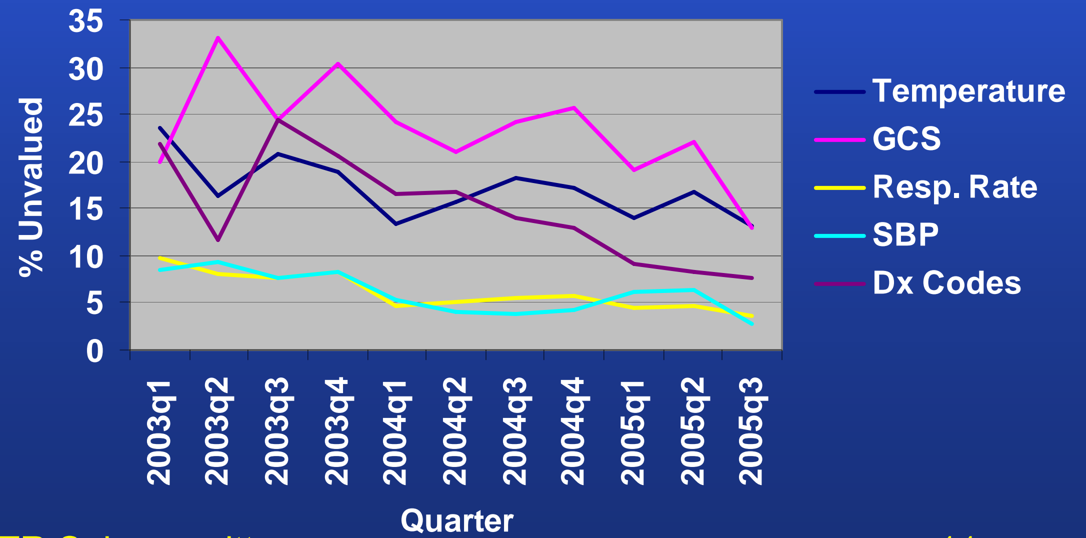


- Trauma surgeon response is timely.
- Patients with open fractures receive operative intervention within 8 hours of ED arrival. Excludes patients who died or were discharged within 8 hours of ED arrival.
- Patients with dislocation receive reduction within 6 hours of ED arrival. Excludes patients who died or were discharged within 6 hours of ED arrival.
- Patients with intra-cranial hemorrhage will undergo craniotomy within 4 hours of ED arrival. Excludes patients who were transferred or died within 4 hours. Excludes patients undergoing other operations on skull, brain and meninges including ICP monitoring (P1.18).
- Patients with non-severe splenic laceration, AIS ≤ 3, do not undergo splenectomy.
- Patients with penetrating injury and SBP ≤ 90 mmHg will receive operative intervention within 30 minutes of Emergency Department Arrival.
- All patients will receive operative intervention of some kind within 24 hours of ED arrival. Excludes patients who were transferred or died within 24 hours.
- The following clinical measures will be documented in the ED.
- The following data elements will be documented in the ED: Temperature, Glasgow Coma Score, Respiratory Rate, Systolic Blood Pressure, Diagnosis (any ICD9 codes).

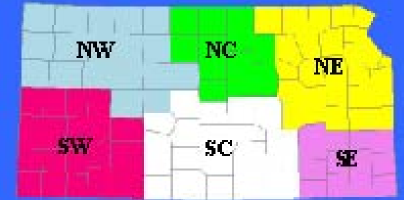
Documentation







Plans



- Take to ACT, pending approval
- Discuss with volunteer hospitals/regions
- Continue to evaluate/tweak queries
- Finish automation
- Develop distribution system
- Training
- Include in annual data report for 2004