

Kansas Trauma Registry Subcommittee Meeting  
Kansas Medical Society, Topeka, Kansas  
Minutes  
July 18, 2006

Attending: Sharon Gehring, Janet Jilka, Allison Pafume (intern), Eric Cook-Wiens, Joe Moreland, Carrie Saia, Rosanne Rutkowski, Kendra Tinsley and Dr. Chris Bandy

### **Call to Order and Brief Program Update**

Rosanne called the meeting to order and provided a brief update. House Bill 2752 was passed with quality improvement being the most relevant part to this committee. The intent is to have hospitals start using their data first, as regulations are not currently being written for quality improvement. Rosanne has spoken with Sandy Perkins of Kansas Hospital Association (KHA) and with Darlene Bainbridge, who is working with the Office of Rural Health. Darlene will be utilizing the registry data in working with critical access hospitals and will also be speaking at the November 3 executive council meeting. Rosanne is currently working on hospital designation regulations. KHA is contacting hospitals about a July 31<sup>st</sup> webinar on ACS consultation visits. It has been proposed that priority be given to those facilities that serve areas not covered by a level I trauma center, facility commitment to the process and numbers reported.

### **Report on rollout of the web based registry**

Eric reported on the rollout of the web-based registry. Eric reported any technical glitches have been worked out and Digital Innovations has been very helpful. There are two trainings scheduled in Hays and one in Garden City, with twenty sites already trained. The web-based version is operational and at least two facilities have entered data. Issues that have been addressed include record deletion and data upload. Sharon Gehring advised her hospital is not using the system because they cannot run their own reports. It was reported that the web-based software is targeted to facilities that do not want to do their own reports and/or have minimal need for data reporting.

### **2004 DATA Set**

Eric also provided the latest figures on the 2004 data set; with 9,157 total records, 1,652 did not meet inclusion criteria. He has begun to analyze some of the data with the help of summer intern Allison Pafume. Allison's intern project will involve characterizing traumatic brain injuries in the 2004 dataset.

Eric has discovered some discrepancy in the number of potential registry-eligible patients in the hospital discharge dataset and the number in the trauma registry. Sharon Gehring inquired whether the difference of figures from the registry data set and the Hospitals Data Discharge set had to do with not factoring acute verses non-acute injuries, as well as the likelihood in her hospital of inpatient rehab patients getting two separate admissions and discharges. Eric agreed and said he will continue to look into this issue to determine if there is a widespread misunderstanding of the registry inclusion criteria.

### **Bracelet Pilot Project**

Rosanne reported that the South Central Kansas Regional Trauma Council (SCKRTC) has discussed the potential for a pilot project using the trauma bracelet. This is a project that KDOT has indicated interest in; however, there are issues that need to be addressed regarding confidentiality. The SCKRTC

representatives have initially proposed three colors, but they are just in the beginning stages of preparation and have yet to finalize their plans.

## Burns

Eric reported on a request to add data elements related to burns to the registry. The burn centers utilized different software to collect data for the national burn registry. The proposed data elements for burns would be part of the comprehensive set. It was reported that the State Fire Marshall also has a burn registry but there was a question of how that information is used. There was some discussion of the likelihood that small hospitals would gather the burn specific measures. There was general agreement that in the future it may be feasible, but we should hold off on making changes to the registry at this time.

## **Benchmark Report**

Eric presented the most recent version of the Benchmark Report based on feedback received from statewide meetings. There was good attendance and excellent discussion. Eric tried to incorporate many suggestions, the first of which was to change the name of the report to simply Data Report. The report will be distributed quarterly with the information from the previous quarter to allow for enough time for full submission.

The front of the report has been adjusted to include demographic information in a local, state and regional format. The color scheme was changed to reflect the new Trauma Program logo. The second page has an additional heading titled “Performance Review Indicators” with an explanation of how the data is broken down. The purpose of the explanation is to make it clear how hospitals should use the report. Eric clarified that the report is sent to hospital primary contacts with the report documentation.

Dr. Bandy commented that there might need to be further clarification in the explanation on data outliers as these indicators in no way imply less than the standard of care. Simply that these outliers should be reviewed by medical and nursing staff who care for these patients in the process of performance improvement. All were in agreement about further education of staff about the reason and documentation of indicators. Eric discussed specific changes in each of the indicators. It was recommended KDHE produce an annual report in addition to the quarterly report. An annual report would be more important for smaller hospitals to see yearly data. Joe Moreland suggested that even if a hospital does not have any records to submit for a give quarter, they might still appreciate getting a copy of the report. It was agreed that the report should be emailed quarterly to all hospitals regardless of record volume.

## **Issue Reviews**

### **Issue One**

There is a national initiative to adopt a standard data dictionary. The Kansas data dictionary is currently very close to the National Trauma Registry (NTR) data dictionary, but is missing several crucial fields. In order to adhere to the NTR registry the following elements should be moved to the core state-required dataset from the comprehensive dataset:

1. Patient residence zip code
2. Patient residence city
3. Patient residence county
4. Patient residence state

**KTRS Recommendation:**

All were in favor to add these elements to the core state required dataset. Entering zip code will automatically populate city, county and state.

**Issue Two**

In order to adhere to the NTR registry the data element 'Occupation' should be added to the core state-required dataset.

**KTRS Recommendation:**

All were in favor not to include 'Occupation'. The concerns were that many facilities do not ask for occupation and the categories in the NTR were confusing and not as expansive as necessary.

**Issue Three**

In order to adhere to the NTR registry the pick list for protective devices should be changed to the following:

1. None
2. Lap Belt
3. Personal Floatation Device
4. Protective Non-Clothing Gear (e.g., shin guard)
5. Eye Protection
6. Child Restraint (booster seat, child car seat)
7. Helmet (e.g., bicycle, skiing, motorcycle)
8. Airbag
9. Protective Clothing (e.g., padded leather pants)
10. Shoulder Belt
11. Other

**KRTS Recommendation:**

All were in favor of adding this element to the core state-required dataset. The field values should be adopted as suggested, with one exception to add the parenthetical phrase after number eight, Airbag (either deployed or not deployed).

**Issue Four**

In order to adhere to the NTR registry the data element 'Airbag Deployment' should be added to the data dictionary. The question will only be asked if an airbag was indicated for one of the protective devices.

Field values:

1. No Airbag Deployed
2. Airbag Deployed Front
3. Airbag Deployed Side
4. Airbag Deployed Other (knee, airbelt, curtain, etc...)

### **KTRS Recommendation:**

All were in favor of adding these elements to the core state required dataset with the following changes: field 1. Airbag equipped vehicle, not deployed; and adding 5. Airbag Deployed Unspecified.

### **Issue Five**

In order to adhere to the NTR registry the data element 'Child Specific Restraint' should be added to the dataset. This question will only be asked if the patient is a child (age  $\leq 14$ ) and one of the protective devices indicated "Child Restraint".

Field values:

1. Child car seat
2. Infant car seat
3. Child booster seat

### **KTRS Recommendation:**

All were in favor of adding these data elements, with the modifications of the order: 1. Infant car seat, 2. Child car seat, 3. Child booster seat, and the addition of 4. Child seat, unspecified type.

### **Issue Six**

In order to adhere to the NTR registry the data element 'GCS Assessment Qualifiers' should be added to the dataset. This question will be asked in the ED section after the GCS question and will be asked of all patients.

Field values:

4. No qualifier
5. Patient Chemically Sedated
6. Obstruction to the patient's eye
7. Patient Intubated
9. Not documented

### **KTRS Recommendation:**

All were in favor of adding these data elements, with the modification of line 2 – Chemically altered mental status and the addition of another field 'Patient intubated and chemically altered mental status'.

### **Issue Seven**

In order to adhere to the NTR registry the element "co-morbid condition" should be added to the core state-required dataset. No changes should be made to the current ICD9-based pick list. However, only fields in the following minimal list included in the NTR will be available to web-based users.

Minimal list Field values

- |                                           |                                       |
|-------------------------------------------|---------------------------------------|
| 1. No co-morbid condition present         | 7. Current smoker                     |
| 2. Alcoholism                             | 8. Currently requiring or on dialysis |
| 3. Ascites within 30 days                 | 9. CVA/residual neurological deficit  |
| 4. Bleeding Disorder                      | 10. Diabetes mellitus                 |
| 5. Chemotherapy for cancer within 30 days | 11. Disseminated cancer               |
| 6. Congestive heart failure               | 12. Do Not Resuscitate (DNR) status   |

13. Esophageal varices
14. Functional health status
15. History of angina within past 1 month
16. History of myocardial infarction within past 6 months
17. History of severe COPD

18. History of revascularization / amputation for PVD
19. Hypertension requiring medication
20. Impaired sensorium
21. Obesity
22. Steroid use

### **KTRS Recommendation:**

All were in favor to not include the element ‘co-morbid condition,’ instead to move the current comorbid conditions field in the comprehensive dataset (which takes ICD9 code values) to the core state required data.

### **Issue Eight**

In order to adhere to the NTR registry the QA/QI element “non-injury-related occurrences” should be removed from the core dataset but preserved in the comprehensive dataset. Instead, a field called “hospital complications” should be added to both the core and comprehensive datasets.

Field Values:

- |                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| 1. No medical complication occurred           | 14. Deep Vein Thrombosis (DVT)/thrombophlebitis |
| 2. Abdominal compartment syndrome             | 15. Extremity compartment syndrome              |
| 3. Abdominal fascia                           | 16. Graft/prosthesis/flap failure               |
| 4. Acute renal failure                        | 17. Intracranial pressure                       |
| 5. Acute respiratory distress syndrome (ARDS) | 18. Myocardial infarction                       |
| 6. Base deficit                               | 19. Organ/space surgical site infection         |
| 7. Bleeding                                   | 20. Pneumonia                                   |
| 8. Cardiac arrest with CPR                    | 21. Pulmonary embolism                          |
| 9. Coagulopathy                               | 22. Stroke/CVA                                  |
| 10. Coma                                      | 23. Superficial surgical site infection         |
| 11. Decubitus ulcer                           | 24. Systemic sepsis                             |
| 12. Deep surgical site infection              | 25. Unplanned intubation                        |
| 13. Drug or alcohol withdrawal syndrome       | 26. Wound disruption                            |

### **KTRS Recommendation:**

All were in favor of adding these elements to the core state required dataset, with the modifications of removing numbers 3, 6, 13 and 17, grouping certain ones together (e.g 12, 19, 23 and 26) and changing the heading to hospital occurrences.

### **Issue Nine**

In order to adhere to the NTR registry the pick list for ‘ED Discharge Disposition’ should be changed to the following:

1. Floor bed (general admission, non specialty unit bed)
2. Observation unit (unit that provides < 24 hour stays)
3. Telemetry/step-down unit (less acuity than ICU)
4. Home with services

5. Died
6. Other (jail, institutional care, mental health, etc...)
7. Operating Room
8. Intensive Care Unit
9. Home without services
10. Left against medical advice
11. Transferred to another hospital

**KTRS Recommendation:**

All were in favor of querying larger trauma centers to see if this element is currently being used as it currently reads. If it is currently being used the recommendation would be to leave it as is, otherwise to move to the smaller list.

**Issue Ten**

Acute transfers are identified by the “discharge to” field indicating “Other Acute Care Hospital”. There is no way, in the core dataset, to indicate discharges to other acute care facilities for non-medical purposes (for example, insurance transfers).

**KTRS Recommendation:**

All were in favor of adding an additional field value of “Non-medical transfer,” in order to properly identify transfers of this nature.

**Other**

Rosanne advised the subcommittee that the next scheduled meeting is in October and that she would like to move the meeting to twice a year rather than quarterly. She inquired if meeting in Topeka would be acceptable to everyone and all were in favor of that option, depending on weather conditions. Arrangements would be made for conference calling capability.

Adjourned – 1:14pm.