Kansas Trauma Registry Subcommittee Meeting
Kansas Medical Society – Topeka, Kansas
Minutes
October 18, 2005

Present: Dr. Paul Harrison, Kendra Tinsley, Eric Cook-Wiens, Rosanne Rutkowski, John Araujo, Janet Jilka, Louis Towster, Sharon Gehring, Brenda Olson, and Carrie Saia

Absent: Dr. Brent Steward, Cathy Heikes, Leroy Dyck, Jonathan Dort and Dr. Dennis Allin

Additional Guests: Ryan Hartman

Rosanne Rutkowski called the meeting to order at 10:07 a.m. with introductions of members present.

State Trauma Program Update

Rosanne reported that KDHE is currently reviewing statutes related to hospital verification. Regional trauma plans were approved by the ACT as submitted with several recommendations including using data from the registry for injury prevention, developing triage protocols and education related to use of the registry data and professional education. John Araujo, KDHE Intern did an extensive review of the regional plans related to the trauma registry and data recommendations. As a result, Eric Cook-Wiens has developed a proposed benchmark report that we are requesting feedback from the committee on. The benchmark report is based on data currently collected. The report would be provided to every hospital that reports data on a regular basis and was developed in a comparative format by which individual facilities could compare their averages with state averages. Rosanne also reminded everyone of the November 4th meeting of the Regional Execs in Salina. Other activities include the award of an EMS/Trauma Grant which will fund development of a trauma awareness campaign as well as a Kansas trauma web site. A meeting with the ACT Public Information and Policy subcommittee meeting has been scheduled for November 10th in Wichita. We are in our last year of the 5 year contract for the trauma registry software and will be developing new bid specs for the next contract. There was also a reminder of the Digital Innovation Inc. presentation October 21 at the Topeka Shawnee County Public Library. Four hospitals have expressed interest in piloting the web-based system: Coffeyville, Hutch, Newton and Olathe.

Trauma Registry Update

Eric Cook-Wiens provided an update on the current status of trauma registry reporting. Eric reported on the second quarter 2005 reporting. Compliance with reporting currently stands at 98 hospitals (78%) reporting data which leaves 27 hospitals in the state not reporting in the current quarter. A new version of the trauma registry software was released this summer. Only 67% of hospitals have installed the new version. The reasons outlined for low compliance in installing the new software were confusion with the “Collector Command Center” which is a new section in the software. There continues to be issues with staffing changes and training of new staff.

In the discussion about going to a web-based collector, Eric reported their have been four hospitals that have expressed interest in participating in a pilot program. Paul Harrison inquired about the ability of hospitals to retrieve their own data. Eric replied they would most certainly. Carrie Saia wanted to know about the timeline for the rollout of the pilot program and Rosanne advised that it should take approximately 6 weeks. She also reported that under a clause in our current contract with Digital Innovation we could update to the web based system if the pilot goes well. There are a lot of details however that would need to be worked at with the KDHE IT department. There was some discussion about the location of the data, with Eric informing the group that in the pilot project, DI would be providing the servers. With the need for the servers and support to run 24/7, Rosanne stated that tech support was one of the issues that needed to be worked out.

Eric also discussed linking records currently submitted to the trauma registry, an issue all states are facing to some degree. Recently there has been discourse about using a trauma bracelet to link referring and receiving facility information. KDOT is very supportive of this approach to data linkage. Until that can be put in place, Eric has come up with a 5-match system, which would use facility ID – referring and receiving, date of birth, date of injury and sex to get a more accurate picture of injuries. Briefly, there were 9,135 records, with 5,424 as non-transfers. Of the 3,711 that were transferred 1,703 were not linkable using Eric’s system but 1,526 could be linked. Some possible reasons for those records not being able to be linked could be typos, missing data or one side not entering data. There is no expectation that all will be a perfect match from the state perspective, stated Eric, but 2005 numbers should be higher with more hospitals reporting. Some of Eric’s suggested solutions to the imperfect transfer linkage would be the aforementioned trauma bracelet, greater submission compliance and completeness, getting pre-hospital data, getting out of state data for those transfers out of state, and to have a personal identifier, such as name or social security number, which would not be an option. John Araujo indicated trauma bracelets would be the ideal solution. Brenda Olsen reported that many pediatric patients do not have a SS number and a great number of patients are not willing to give SS number due to identity theft.

<u>KTRS Issue Review</u>

Issue 1:
Currently there is nowhere to enter clinical data for providers transporting patients from the referring facility.

KTRS Recommendation:
The committee all agreed that it would be reasonable to put as much useful information in as possible. Rosanne indicated changes are made once per year in June. There were no objections to adding new entry points for a third transfer.

Issue 2:
The Kansas State Council of the Emergency Nurses Association suggested that duplication of entering information might be avoided if only the final receiving institute entered the patient into

the database. The receiving facility would send cumulative reports back the referring facility possibly as part of the transfer agreement.

KTRS Recommendation:
After discussion the committee agreed the referring facilities would lose important information by not collecting or reporting data. It was also discussed that with a move to a web based system collection could be easier on smaller facilities. The committee is aware of the request; it has been carefully deliberated, and at this time doesn't feel it would be in their best interest.

Issue 3:
Drug Categories used by prehospital providers and referring hospitals (intermediate facility) are outdated and do not represent the most appropriate drug used in a trauma setting. This results in medications that are not properly categorized or staff assigning medications to an incorrect category.

KTRS Recommendation:
The list of 46 drug categories was developed to be as all-inclusive as possible. There is some struggle with non-nursing staff are putting information in, and it is in understanding the groups rather than the individual drugs. If the individual drugs were entered instead, the list would need to be updated monthly, which is not possible. The recommendation was to send the issue back to the users group to gather more information on examples of what's being entered mistakenly, whether there should be more education for those who enter information, and what specifically needs to be changed.

Benchmarking / QI Report

Eric Cook-Wiens reported on benchmarking and quality improvement and began by advising his expertise is in data analysis and not clinical terminology. The hospital role in benchmarking is to measure, evaluate and improve. While the trauma system role is to enable comparison, support report development and to develop tools for hospital performance improvement. In the benchmarking report, Eric has found the registry can be useful even to small hospitals for measuring comparisons. There can be quarterly or yearly reports, which can be dependant on the size of the institution. The most important factor in being able to create benchmarks is compliance, timeliness and appropriateness. Discussion began on giving hospitals a reason to collect and possible reasons some hospitals are not reporting. Eric advised there are reports that hospitals can run themselves, which he would be happy to help in creating and distributing.

The Pre-Hospital benchmark was seen as helpful, but with needing more clarification as to whether information was from an EMS run sheet or given verbally. It was also seen as important to be able to give hospitals information as to why their data failed, i.e. data unknown or out-of-range. Discourse about the Transport Time benchmark began with a concern about the calculation of transport time and the classification of rural, suburban or urban hospital. The Transfer Flow and Severe Transfers benchmark were seen as appropriate with the committee wishing for ISS to be spelled out on the report. The On Time benchmark, as defined by hospital, was decided as something individual hospitals could use to see if they are meeting their own criteria. Both Chest Tube and Airway benchmarks were appropriate. On the Head Injury

benchmark there was some discussion on what the qualifications of the receiving trauma center would be, but otherwise found appropriate. The Blunt benchmark had discussion on all imaging, chest, pelvic and spine, being necessary and it was recommended the benchmark be changed to track blunt trauma with ISS>15 with chest and pelvic imaging. Dislocation, Hematoma, Splenectomy, Hypovolemic and Temperature benchmarks were all seen as important. With the Late Surgery benchmark it was discussed to add an "other" category and that some hospitals would not have any data. Eric advised the Quality and Completeness benchmark was an aggregate of all data. The Non-injury Related Occurrence benchmark was seen as helpful, with discussion on adhering to HIPPA. Brenda Olson advised all of the information was OK to email except the Non-Injury Related Occurrence benchmark due to the Trauma Number being used as a personal identifier. The report itself was seen as good, with distribution through e-mail currently but possibly acquiring a secure web site. Eric invited committee members to let him know of any new data elements for the core set. The timeline includes bringing the report to ACT to approve, and then continued fine-tuning. Rosanne advised they are starting to look at a label of confidential and privileged to further protect privacy.

Miscellaneous

Meeting dates for next year are currently: January 18, April 19, July 19, and October 18.

KDOT is working on traffic records flow, with EMS and KDHE to be a part of a new data warehouse. Rosanne provided a copy of the handout indicating the recommended data flow among agencies.

The next ACT meeting will be held November 16, in Topeka. The meeting adjourned at 1:38 p.m.