### Kansas Collector Users Group
**Wednesday September 11, 2013**  
**Minutes**

#### Agenda

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<td>Trauma Registry Announcements</td>
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<td>Summary of Enhancements</td>
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<td>Other Issues with the Registry /Group Question</td>
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<td>Future training opportunities for enhancements</td>
<td>Dee Vernberg</td>
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<td>3:00</td>
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</tr>
</tbody>
</table>
Participants:
Nancy Akin, KDHE
Kathy Auten, Miami County Medical Center
Leslie Bedene, Mercy – Ft. Scott
Melanie Bendure, Overland Park Regional Medical
Jenna Bloomfield, Cloud County Health Center
Jan Bryan, F.W. Huston Medical Center
Amy Bucholtz, Stormont Vail Healthcare
Whitney Bures, Community Memorial Healthcare
Kellie Burnell, Kansas Medical Center
Cathy Claussen, Decatur Health Systems
Lynda Cross, Nemaha Valley Community Hospital
K Judy Davis, Western Plains Medical Complex
Janelle Dimond, VCHP
Candi Douthit, Cheyenne County Hospital
Julie Dillingham, KDHE
Taylor Dirks, Scott County Hospital
Betty Ellis, CHO-Onaga
Alvina Fant, KU Hospital
Leliane Filsinger, Mercy Maude Norton Hospital
Rachelle Giroux, Salina Regional Health Center
Pam Harmon, RCHC
Martha Hett, Lindsborg Community Hospital
Laurie Hoffman, Greeley County Health Services
Melissa Hultman, Providence Medical Center
Jessica Johnson, Wesley Medical Center
Kris Kindler, Jewell County Hospital
Annette Kramer, Overland Park Regional Medical Center
Marcia Kruse, Logan County Hospital
Barb Lindsey, Pratt Regional Medical Center
Cassie Look, Rice County Hospital
Natha Manges, Mercy Regional Health Center - Manhattan
Kimberly McGowen, Hutchinson Regional Medical Center
Brenda Messenger, Mercy Hospital
Julie Miller, Mercy Regional Health Center
Megan Murphy, Wesley Medical Center
Carrie Newcomer, Gove County Medical Center
Elizabeth Novak, Newman Regional Health
Heather Nunamaker, St. Francis Health Center
Margaret Oaks, Overland Park Regional Medical
Saundra Phillips, Great Bend Regional Hospital
Welcome and Introductions

Dee opened the meeting at 1:00 PM, introducing herself and the Trauma program staff.

A webinar poll was taken, asking the question “Which type of trauma registry do you use?” (This is important since some announcements are relevant to web users only while other announcements are relevant to local users only).

Most registry users are web users and log onto the web registry on https://registryanywhere.com The log in page looks like the screen shot below:

```
Please enter your user name and password to log in.

User Name [ ]
Password [ ]
V-Realm [ ]
Log In
```
If you have an icon on your computer that you click on then you are a local user.

If you are not sure if you are web user or a local user, please email Nancy Akin at nakin@kdheks.gov or Dee Vernberg at dvernberg@kdheks.gov and they will assist you.

Registry Announcements

- **ICD-10 Issues and Decisions**
  - All hospitals will begin coding their medical records with ICD-10 October 1, 2014.
  - The figure below shows that medical records for 3rd quarter 2014 trauma cases will be coded with ICD-9 codes, but the medical records for 4th quarter 2014 cases will be coded with ICD-10 diagnosis (Injury & Comorbidity).
  - In 2014 and early 2015, registrars will have 2 registries (one to enter cases that use ICD-9 codes and one registry that will accept ICD-10 codes). At some point in 2015, the ICD-9 registry will be retired and the data from this registry will be combined with the data in the ICD-10 registry.
  - Dee recommended that all web users begin using the ICD-10 registry for patient records coded with ICD-10.
  - Some Level I, Level II and Level III trauma centers will begin using the ICD-10 registry January 1, 2014 but they will not be able to depend on HIM codes for diagnoses or comorbidities.
  - There will be more training as we get closer to the October 1, 2014 date.

**Schematic for Adoption of ICD-10 Codes**
• **DI Conference**
  - DI conference October 2-4 at Crown Center in Kansas City, MO
  - Relevant to Local Users only
  - Preconference Oct 2 - $300.00
    - Registry Software Basics and Four-tier data validation
  - Conference Oct 3-4 - $450.00
    - Report Writer and Excel workshops and speakers
  - If local users need assistance with registration costs, please contact Jeanette Shipley.

• **Registry Anywhere Website – Web users only – This is where you enter your trauma cases (see screen shot below).**

![Registry Anywhere Website Screenshot](image)

The registry anywhere site has been working fairly well, but there is an incompatibility between the latest version of JAVA and the latest version of Internet Explorer 9/10. If your hospital IT updates your JAVA, you may not be able to access the web Registry. You will know it is a JAVA Problem if the hourglass continues to spin. You can go down a version of JAVA or use Google Chrome. Work with your hospital IT department or Digital Innovations(DI) at 800-344-3668 ext. 4. Please let us know if you are having problems.
• Kansas Trauma Web Portal

The Data Report is available on the Kansas Trauma Web Portal. Anyone who uses Data Reports should have received an email from Nancy Akin explaining how to log onto the Kansas Web Portal. If you have not received one, please contact her.

In the future, the following features will also be available on the Kansas Trauma Web Portal:
  a. Driller (Dee has been testing this; it should be available very soon). This is relevant for all trauma registry users.
     o Reporting tool that allows hospitals to view their own data with charts and graphs
  b. Dashboard (Dee will begin to test this soon). This will be relevant to all registry users.
     o Visual display that allows hospitals to view regional and state findings from the registry.
  c. Enhanced Web Registry (will be delayed until ICD-10 and is relevant to web users only).
     o Enhanced Web Registry will replace the current Web Registry (RegistryAnywhere) late 2014
  d. Report Runner for web users (we are working with DI – should be available fairly soon)
     o Will allow web registry users to analyze their data with a set of queries and reports. These reports should help hospitals with their performance improvement.

Dee conducted a webinar poll, asking the question, “Have you been to the Web Portal?”

  33% - Yes
  66% - No
  2% - I don’t know

Many people have not been to the web portal yet. Please contact Nancy Akin nakin@kdheks.gov if you do not have instructions on how to log in.

To access your data report, you must log onto the Kansas Trauma Web Portal at https://ks.centralsiteportal.com/
To log onto the Portal Website:

During your initial login, you will need to change the temporary password to a new password you have chosen (see screen shot below). Remember to change your temporary password to a new one within 30 days or your account is deactivated.

How to change your password on the Kansas Trauma Web Portal
What will be in the Kansas Trauma Web Portal?
- Tools to analyze data
- A space to view Reports (Data Reports)
- Future home of enhanced web registry

To Access Your Data Report: Once you are on the Web Portal, click “View Reports” in the middle of the web portal under “Reporting” (see screen shot above). Then choose “Data Report” and click “Search” on left (See screen shot below).

All data reports will appear. Find the one you want and click on it – the name on the left or the icon on the right – and a PDF of data report will appear for you to save or print.
The screen shot below shows what the data report looks like.

e. **Check and Close Cases**
   - You must close cases to send cases to KDHE.
     - Web Users – when you close a case, it is automatically sent to KDHE
     - Local Users – after you close a case, you must then use Isend to send the record to KDHE
   - If you make a correction in a case, you must re-close the case.
To determine if you have any records that need closing, use the manage function in the registry (see screen shot below).

The screen shot below shows that all of these records are “active” which means that they are not closed.
To close a case, open a trauma record and click the “check” box in the bottom left hand screen of the registry (see screenshot below).

Please contact Nancy Akin nakin@kdheks.gov with any questions about closing cases.
f. NTDB – Data Use Agreement
   o Certain Local Users ONLY – only those who submit to NTDB
   o There is a new Business Associate and Data Use Agreement (BAA/DUA) that your hospital needs to sign and return to ACS.
     ▪ If you participate in NTDB, TQIP, Cancer or Bariatrics
     ▪ Should have received email from NTDB
     ▪ This business associate and Data User Agreement is due September 23, 2013
     ▪ Contact ACS with questions

Business Associate and Data Use Agreement

NAME OF COVERED ENTITY: 

COVERED ENTITY FEIN/TAX ID: 

COVERED ENTITY ADDRESS:

This Business Associate and Data Use Agreement (“Agreement”) is effective as of the date signed by both parties (“Effective Date”) between __________________ ("Covered Entity") and the American College of Surgeons ("ACS") and shall continue until terminated in accordance with Section 10 below.

WHEREAS, Covered Entity desires to participate in one or more quality improvement programs administered by ACS ("ACS Program") which requires Covered Entity to allow ACS to have access to Covered Entity’s Protected Health Information ("PHI"); and

WHEREAS, Covered Entity and ACS may have entered into one or more certain written agreement(s) regarding Covered Entity’s participation in the ACS program(s) ("Underlying Agreement(s)”).

NOW THEREFORE the parties agree as follows:
Trauma Program Update: Rosanne Rutkowski

Level IV workshop was held on July 31st in Salina. There were 65 people in attendance, representing 39 hospitals. Data collection and use of the registry data for performance improvement is an important component of trauma center designation.

On site Survey Process: We will be developing an onsite review process for Level IV Trauma Centers. We hope to have a policy for review by the November ACT meeting. Survey teams will consist of a physician, nurse teams with experience in trauma care. The purpose will be to serve as a resource to hospitals.

Regional Trauma Plan Review Committee: Each of the six trauma regions have trauma plans which are updated at least every two years. Plans once completed are reviewed by a subcommittee of the ACT and recommendations are made to the regions. The committee met in Wichita at the end of June. It was recommended this time, that regions identify select priorities goals. For many of the regions, they are working on improving both timeliness and quality of trauma data. We need to have all the hospitals report their data.

Regional Trauma Performance Improvement:
The policy on regional improvement has been developed. We are waiting on final ACS recommendations. In the meantime, we are working with hospitals to encourage use of their data report. It’s an excellent tool. Please contact Dee or Nancy if there were problems with your report.

At least one region has identified improved reporting and calculation of the Glasgow Comma Score as a topic for regional improvement. There are differences among providers as to when it’s being used, how it’s being calculated and how it’s being reported. The example was given how different health care providers each calculated a different score on the same patient.
Using your Data Report

Dee conducted a webinar poll, asking “Who do you share your data report with?”

- 50% - ED Director
- 41% - Physician
- 24% - Risk Management
- 28% - CEO
- 48% - Other/I don’t know

Dee suggested that registrars might also share their data report with their Trauma Nurse Coordinator or Chief Nursing Officer. It is important to share your data report findings with a clinical supervisor (e.g. ED Manager) or an administrator so that the findings can be used to make decisions to improve care.

Another poll was taken, asking “How do you use your data report?”

- 54% - Distribute it to other people
- 59% - Performance Improvement
- 56% - to check for data errors
- 7% - Other
- 22% - I don’t use my data report

We developed the data report to help hospitals with Performance Improvement. The data report is only one part of a hospital’s performance improvement program, but it has been useful in identifying potential cases to review. If you look at outliers, you may find data entry errors or issues that need to be resolved. Some hospitals use the data report for education. They post the data report in the ED to show improvement and it helps with education in the Trauma Peer and Performance Improvement Meetings.
How to review your data report.
On the Data Report, you are able to see how many trauma cases you have submitted for a specified time period. On the data report below, there were 100 cases submitted by this hospital for the entire year of 2012.

On the front page of the data report, there is information that allows you to compare your hospital with your region and the State on several measures. For example, you can examine age and gender distributions, the % of transfers to other hospitals, and % of transfers into your hospital (see screen shot below).
At the bottom of the front page of the data report, there is information about external cause of injury for your hospital, region and state.

![External Cause Chart]

On pages 2 & 3 of the data report, there are indicators that show outliers that need to be reviewed and the number of cases that had missing data so that the indicator could not be evaluated.

We would like for trauma centers to start looking at indicators and reviewing outliers. We will be starting a project where we look at regional outliers and will need you to determine which outliers are true outliers.

The screen shot below shows that this hospital had 3 outliers and no missing data for the Transfer indicator. This means that 3 patients were transferred more than 6 hours after they arrived at this hospital.

![Transfer Chart]

The trauma numbers for the outliers are located on the last page of the data report. The screen shot to the left shows the trauma numbers for the 3 outliers for the indicator “Transfers” in the screen shot above. Using these trauma numbers, you can go to the Trauma registry to identify the outlier case so you can pull the medical record to review the case. If you are unclear how to use this report, please contact Dee Vernberg dvernberg@kdheks.gov for assistance.

We developed a PI worksheet (attached to end of these minutes) to give you examples of some of the reasons why you might have an outlier. The screen shot below shows the PI worksheet for the indicator “Transfers”. The items under the “Issues to consider “are examples of questions that you might ask if you have an outlier for this indicator (i.e. why did it take more than 6 hours to transfer this patient to another acute care hospital?).
Use the PI Worksheet to review outliers.

Data Report indicators and PI Worksheet

Instructions: Please indicate possible reasons a patient might be an outlier for each data report indicator. These reasons would be issues that a quality director or trauma nurse coordinator would look for to review a case or to decide how to improve trauma care in an institution.

<table>
<thead>
<tr>
<th>Data Report Indicator</th>
<th>Issues to consider if outlier is listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all transferred patients, elapsed time between emergency department arrival and discharge to another acute care hospital does not exceed 6 hours.</td>
<td>1. Weather that does not permit travel, e.g., high winds that would prevent helicopters from flying, low ceiling, snow. 2. Road conditions, e.g., icy. 3. No EMS is available to travel (lack of mutual aid agreements). 4. Referral facility acceptance, bed availability, physician availability. 5. Patient too unstable, e.g., actively coding, uncontrolled bleeding. 6. Decision to transfer based on diagnostic findings — Number of procedures performed or time to perform procedures (e.g., radiology (CT scans bec ETOH involvement, no neurosurgeon available), OR.). O.K. to do plain films to identify pelvis fix or chest x-ray. 7. Delay in recognition that patient needs specialized care in hospital with higher level of care – missed injury. 8. Patient deterioration – change in patient status. 9. Patient or patient’s family did not want transfer but then condition indicated that non-transfer was not an option.</td>
</tr>
</tbody>
</table>

The screen shots below show the other indicators on the data report.

### Critical Transfers

For transfers with Initial Systolic Blood Pressure < 90 or Glasgow Coma Score ≤ 8, elapsed time between emergency department arrival and discharge to another acute care facility does not exceed 1 hour.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator:</td>
<td>1/13</td>
<td>7.69%</td>
</tr>
<tr>
<td>Outlier:</td>
<td>12/13</td>
<td>92.31%</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>87</td>
<td>640</td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>0</td>
<td>35</td>
</tr>
</tbody>
</table>

### Airway

A definitive airway will be established before transfer of a comatose patient (GCS ≤ 8). Definitive airways include: LMA, Combitube, oral endotracheal tube, nasal endotracheal tube, tracheostomy/cricothyroidotomy.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator:</td>
<td>9/10</td>
<td>90.00%</td>
</tr>
<tr>
<td>Outlier:</td>
<td>1/10</td>
<td>10.00%</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>90</td>
<td>647</td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>0</td>
<td>36</td>
</tr>
</tbody>
</table>

### Head Injury

Patients with suspected traumatic brain injury (moderate to severe coma, GCS ≤ 12), who are transferred, are transferred to a level I or level II trauma center for treatment.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator:</td>
<td>8/8</td>
<td>100.00%</td>
</tr>
<tr>
<td>Outlier:</td>
<td>0/8</td>
<td>0.00%</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>92</td>
<td>654</td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>0</td>
<td>33</td>
</tr>
</tbody>
</table>
On the 4\textsuperscript{th} page of the data report, you will find information about documentation (missing data) on a variety of clinical measures for your hospital, your region and the State. If you have missing data, you may want to do education with your ED staff.

### Chest Tube

Patients with pneumothorax (or hemopneumothorax) receive a chest tube before transfer to another acute care facility.

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator</td>
<td>1/2</td>
<td>50.00%</td>
<td>2/6</td>
</tr>
<tr>
<td>Outlier</td>
<td>1/2</td>
<td>50.00%</td>
<td>4/6</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>2</td>
<td>6</td>
<td>694</td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>98</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

### On Time

Trauma team leader response is timely (within 30 minutes).

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator</td>
<td>65/75</td>
<td>86.67%</td>
<td>46/100</td>
</tr>
<tr>
<td>Outlier</td>
<td>10/75</td>
<td>13.33%</td>
<td>54/100</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>75</td>
<td>100</td>
<td>4247</td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>10</td>
<td>572</td>
<td>3372</td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>15</td>
<td>30</td>
<td>3526</td>
</tr>
</tbody>
</table>

### EMS Delay at Transfer

EMS arrival is within 1 hour for transfers.

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met Indicator</td>
<td>65/66</td>
<td>98.48%</td>
<td>277/285</td>
</tr>
<tr>
<td>Outlier</td>
<td>1/66</td>
<td>1.52%</td>
<td>8/285</td>
</tr>
<tr>
<td>Qualified for Benchmark (cases):</td>
<td>66</td>
<td>2654</td>
<td></td>
</tr>
<tr>
<td>Did Not Qualify (cases):</td>
<td>34</td>
<td>8485</td>
<td></td>
</tr>
<tr>
<td>Couldn't Evaluate Due to Missing Data:</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

### Documentation

The following clinical measures will be documented in the hospital medical record.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Hospital</th>
<th>Region</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Scale</td>
<td>96/100</td>
<td>96.00%</td>
<td>651/702</td>
</tr>
<tr>
<td>Injury Date &amp; Time</td>
<td>100/100</td>
<td>100.00%</td>
<td>648/702</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>95/100</td>
<td>95.00%</td>
<td>689/702</td>
</tr>
<tr>
<td>Systolic Blood Pressure</td>
<td>97/100</td>
<td>97.00%</td>
<td>690/702</td>
</tr>
<tr>
<td>Temperature</td>
<td>89/100</td>
<td>89.00%</td>
<td>670/702</td>
</tr>
<tr>
<td>ISS (Injury Severity Score)</td>
<td>100/100</td>
<td>100.00%</td>
<td>672/702</td>
</tr>
<tr>
<td>Discharge Date &amp; Time</td>
<td>100/100</td>
<td>100.00%</td>
<td>701/702</td>
</tr>
</tbody>
</table>
On the last page of the data report is a page showing the trauma numbers for indicator outliers. As the registrar, you can find a case with these numbers in the trauma registry so the medical record can be pulled to review the case.

The Regional Trauma Councils will be addressing system issues which are issues that cannot be addressed by any one hospital alone. Your review of outliers will be a very important step to the process of identifying system issues.

Question: If an outlier is due to a data collection error, do I need to go back and change the error?
Answer: Yes. Please correct this error as it will affect regional analyses. If you would like an updated report after you have corrected any errors, please let Dee know and she will run a new data report for you.
July Update and Enhancements Summary

There were several changes to your report writer (local users only) and to the registry (web and local users) in the July update.

Local Users only – In the last update, your report writer was modified so that you can now choose records by discharge date, as well as ED arrival date (see screen shot below).

Changes to the Registry since the last update (web and local users)

Update to Entry Form 14: All web users who start a new record will now see Entry Form Number 14 on the Demographics tab (see screen shot below).

Local users – if you don’t see Entry Form Number 14 on new records, you need to apply the July update. Please let Dee know if you need help (see screen shot below).
??? for Unknown SS #: You can now insert question marks for missing social security numbers. You may also continue to use 999 99 9999 for missing social security number.

Ecode Validation: You can no longer validate a record or close a record if you have an Ecode that doesn’t have a description.

Injury Mechanism is Core Variable. There are many different options. If you choose “Off Road Vehicle”, it will open the “Offroad Vehicle” variable on the ED tab (see screen shot below). The “Off Road Vehicle” variable was located on the prehospital tab before this update.
Off-road vehicle variable was moved to ED tab from pre-hospital tab.

Ventilator Tab – Actual Time. If a patient is on a ventilator and you complete the start/stop time, the “Ventilator Days” variable are calculated using NTDB rules (see screen shot below). We have a new variable “Total Ventilator Time” that is auto-calculated and gives you the actual time a patient was on the ventilator. Many trauma centers wanted this for research. In the screen shot below, you can see that “Ventilator Days” is 1, but “Total Ventilator Time” - the time the patient was actually on the ventilator was 3 hours.
**Discharge-To Options.**

If a patient is discharged to higher level of care, please use the option: Discharge to acute care hospital.

**Discharge Memo:** This is a memo field where you may put in more information about how a patient was discharged (you may leave this space blank). Do not put PI information or confidential information in this field.
EMS Options:
- New
  - 200775 – Haskell County Ambulances Services
  - 200930 – EagleMed
- Retire
  - 484809 – Midwest Lifeteam
  - 002031 – Critical Care Transfer – Ulysses
  - 119995 – EagleMed
  - 201900 – Sublette EMS
  - 201900 – Sublette EMS
  - 201710 – Satanta Ambulance Service

Facility Options:
- New
  - Hutchinson Regional Medical Center
    - 17S020 – Rehabilitation
    - 17T020 – Psychiatric Unit
  - Regent Park Rehab and Health Care 176627
  - Anthony Medical Center Skilled Nursing 17U124
  - Via Christi – St. Teresa – Rehab 173028

Hospital Name Change:
- Mercy Maude Norton Hospital
  - Formerly St. Johns Maude Norton Memorial Hospital
Trauma Registry Enhancements – 2013:

<table>
<thead>
<tr>
<th>Tasks - 2013</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web portal Access</td>
<td>July, 2013</td>
</tr>
<tr>
<td>Report Pick-up</td>
<td>July, 2013 Data Reports</td>
</tr>
<tr>
<td>Data Report</td>
<td>Dashboards – in testing</td>
</tr>
<tr>
<td>Dashboards</td>
<td></td>
</tr>
<tr>
<td>Trauma Driller</td>
<td>In testing – anticipate soon</td>
</tr>
<tr>
<td>Enhanced Web Registry</td>
<td>October, 2014 with ICD-10 enhancements</td>
</tr>
<tr>
<td>Web Report Runner</td>
<td>2013 – in development</td>
</tr>
<tr>
<td>Aggregate trauma Maps</td>
<td>Anticipated later in 2013</td>
</tr>
</tbody>
</table>

Other Issues

1. Local Updates: Several centers have had trouble when they applied the last update. They have lost records or had records that were incomplete. Centers should always make a back-up of their data before applying any update. If there have been problems with applying updates, consider asking DI for help with the next update.
   a. Note: Web users do not have this problem as the update was completed for you.
2. Problems with error messages for NTDB submissions for the drug and alcohol variables. Local users should ignore the warning message and in the 2014 NTDB module, the mapping rules will be fixed for both NTDB and TQIP submissions. Prior to submitting data, centers can run a batch validator and the errors/warnings will no longer be there. DI support will be available to help centers with this.
3. Final Discharge Memo – What type of information should be put here? Dee said that it is a memo that will allow you to describe more fully what happened at discharge. You may describe how the patient was transferred (e.g., land ambulance took patient to airport where fixed wing was waiting). It is not a field that must be filled out.
Trauma Team Activation

Trauma Activation Variable for web users (see screen shot below)

Local Users (See screen shot below):

a. If you collect core data and are a local user, you will need to fill out the “Activation” variable (see screen shot below):

b. If you collect comprehensive data, information from “trauma response” will populate the “activation” variable.

- Why trauma activation?
  - New Core Variable – June 2012
  - Way for Level IV Centers to keep track of trauma team activation
    - PI purposes
  - One measure of how seriously injured a patient might be/hospital resources used
• **Trauma Centers** have formal Trauma Activation Protocols
  - Rules for when trauma team is activated
  - Recorded in medical record

• **How to code Trauma Team Activation**
  - Trauma Centers – Code “YES” if you activate your trauma team according to your trauma team activation protocol.

• **Non-Trauma Centers**
  - Rarely have formal trauma team activation protocols. It can be challenging to figure out how to fill this out.

• **Non-Trauma Centers – Coding Rule**
  - EMS calls in or you hear that EMS is transporting patient.
    - Code Red, Blue, Black – Code Trauma Activation Y (see screen shot below)
    - EMS Code Green, Yellow - Code Trauma Activation N (see screen shot below)
    - If patient is POV, code “N”
    - If patient arrives by EMS and EMS code not documented (Green, yellow, red, etc) code “N”
Dee conducted a webinar poll, asking “Does your ED staff respond differently if EMS calls Code Red, Blue, Black?”

37% - Yes, Code Red
51% - Yes, Code Blue
19% - Yes, Code Black
33% - No, our activation is not based on EMS codes
16% - I don’t know

Many trauma centers don’t use EMS to activate, so the high number of people answering No is understandable. This variable is trying to measure whether something happens differently when EMS calls in a serious patient. Dee will be calling non-trauma centers to get more insight.

Another webinar poll was given, asking “If EMS calls in a Code Red, Blue or Black, is this recorded in your medical record?”

15% - Yes, Code Red
35% - Yes, Code Blue
14% - Yes, Code Black
49% - No, never recorded
19% - I don’t know

Very often EMS codes are not recorded in the medical record. The registrar may have to get this information off the EMS run sheet or patient care record.
Scenarios

Scenario 1:

A patient is severely injured in a motor vehicle crash. EMS arrives at your hospital with CPR in progress. The patient subsequently dies in your ED (ICD-9 diagnosis code 959.8). She is pronounced dead at 12:57. The patient is an organ donor and the body is released to Midwest Transplant Network at 16:40.

a. How would you code discharge time? How would you code discharge to?

Answer:

The way you know to code Time of Death and not Time discharged to Midwest Transplant Network can be found in the trauma registry data dictionary (see screen shot below).

You can include information about Midwest Transplant Network by using the new Final Discharge Memo field (see screen shot below).

b. How would you code the injury diagnosis? What is the ISS for this patient? Why?
Answer:
After entering the ICD-9 code, 959.9, and clicking on the Tri-code button nothing happens (see screen shot below).

This is because 959.9 is a non-specific trauma code. This code is o.k., however, nonspecific codes will not give you an ISS (see blank ISS in screen shot below). Check your medical record to see if there is any additional documentation that will allow you to give this patient a more specific injury diagnosis. Having a non-specific ICD-9 code is one of the legitimate reasons for not having an ISS (Injury Severity Score).
Examples of other non-specific ICD-9 trauma diagnosis codes.

Notice that there is no description after the ICD-9 code after clicking the tri-code button (see screen shot below).
**Scenario 2:**

What is wrong with the coding of these e-codes? Correct each one.

Because Collector will no longer allow you to validate an incorrect e-code, these examples will show you what to do to correct errors that you may encounter.

a) What is the correct e-code? How would you enter this correct e-code into Collector?

**Answer:**

Enter a point 0 (.0) after the code (see screen shot below). Notice the description after the ecode when it is corrected.
b. What is the correct e-code? How would you enter this correct e-code into Collector?

**Answer:**
Enter a point 0 (.0) after the code (see screen shot below). Notice the description after the ecode when it is corrected.
c. What is the correct e-code? How do you enter this correct e-code into Collector?

**Answer:**
Enter a point 0 (.0) after the code (see screen shot below). Notice the description after the e-code when it is corrected.
d. What is the correct e-code? How would you enter this correct e-code into Collector?

**Answer:**
Enter a point 0 (.0) after the code (see screen shot below). Notice the description after the e-code when it is corrected.
e. What is the correct e-code? How would you enter this correct e-code into Collector?

Answer:
Put a decimal point after the 5 (see screen shot below). Notice the description after the e-code when it is corrected.
**Scenario 3:**

What is wrong with the coding in the record below?

![Trauma Collector](image)

**Answer:** There are very few instances where you should use “other” for “discharge to” on the outcome tab. For example, observation is considered acute care. “Discharge to” is where the patient is released or treated after receiving acute care; therefore, observation is not an appropriate reason to code “discharge to” as other.

“Discharge to” typically describes where the patient is released or treated after receiving acute care in your hospital (e.g. home, rehabilitation, swing bed, discharge to other acute care hospital).

If a patient dies, then you code where the patient died, that is, either the patient died in the ED or the patient died in the hospital.
**Scenario 4:**

On 03/13/2013 a 25 year old female was an unrestrained passenger in a motor vehicle. At 0930, the patient lost control of the motor vehicle, it rolled over, and the patient was ejected. EMS arrived at the scene at 0945 and at 0950 EMS rated the patient’s consciousness level as a GCS Total 3. At 0955, EMS inserted an oral endotracheal tube. En-route to the hospital, no CPR was initiated. The patient arrives at your ED at 1011 and your ED physician is waiting for the patient. On arrival her ED Total GCS is recorded as a 3. In the ED, the patient’s airway is maintained with an oral endotracheal tube (same one that was inserted by EMS).

- How would you code incident date and time, specify, and restraint?

![Trauma Data Editor Image]
**Answer:** In the scenario, the patient rolled the car at 9:30. In the “Specify” section, you write the whole story. Since this is a motor vehicle crash, you will complete the fields for restraint and airbag, but you will put n/a for equipment since most people do not wear helmets when they drive a vehicle.
Local Registry – Restraints are located on the Prehospital/Location-Devices tab.

<table>
<thead>
<tr>
<th>Trauma Collector</th>
<th>Prehospital</th>
<th>Location/Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Injury Location

- Address
- ZIP
- Street1
- Street2
- City
- State
- County
- If Other

Police Report Number

- On Lap
- Position in Vehicle
- If Other

Protective Devices

<table>
<thead>
<tr>
<th>Restraint</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airbag</td>
<td>Unk</td>
</tr>
<tr>
<td>Equipment</td>
<td>n/a</td>
</tr>
<tr>
<td>If Other</td>
<td></td>
</tr>
</tbody>
</table>
b. How would you code prehospital Airway, CPR, and Prehospital GCS, and GCS qualifier?

**Answer:** The GCS qualifier is “no qualifier” because EMS inserted the oral endotracheal tube after the first GCS was measured.
If you use the EMS linkage module (link to KEMSIS) to code the prehospital information, you must manually enter the airway information. Look in the narrative to see if an airway was used. To code GCS qualifier, you must determine if there was a GCS qualifier (this is usually not recorded in patient care records).

c. How would you code ED arrived from, ED admission date/time, ED airway, ED GCS, ED GCS qualifier?

Answers:
Coding ED admission date/time and ED “arrived from”
Local Registry – The local registry shows the ED arrival time on the ED tab. Like the web version of Collector, “arrived from” is on the ED tab (see screen shot below).

Coding ED GCS, GCS qualifier and Airway:

If the total GCS is 3, do you put in 1 for eye, 1 for verbal and 1 for motor? Many users said yes to this. For the GCS qualifier, you would code that the patient is intubated because EMS intubated the patient before the patient arrived at the hospital. Therefore, the GCS was measured after the patient was intubated.

Web Registry – Coding GCS, qualifier and airway
Local Registry – coding ED GCS, qualifier and airway

ED Airway
Local Registry
Why do you code the ED airway as “oral endotracheal tube” when it was inserted by EMS?

Answer: Look in the data dictionary (see screen shot below). As you can see, the ED airway field asks for the most invasive airway used in the ED. It does not ask what type of airway was inserted in the ED.

Data Dictionary

| Window Location: Emergency Department - Assessment |
| Data Field Name: E1_AIR |
| State Required: Yes |
| Type of Field: Integer |
| Length: 2 |

**DEFINITIONS**

Airway - A device or procedure used to prevent or correct obstructed respiratory passage

**INSTRUCTIONS**

Enter the most invasive airway adjunct to assist the patient used in your ED. Enter the appropriate option.

**VALID OPTIONS**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No Intervention</td>
</tr>
<tr>
<td>01</td>
<td>Assisted by Bag and Mask</td>
</tr>
<tr>
<td>02</td>
<td>Cricothyrotomy</td>
</tr>
<tr>
<td>03</td>
<td>Esophageal Obtrurator Airway</td>
</tr>
<tr>
<td>04</td>
<td>Nasal Endotracheal Tube</td>
</tr>
<tr>
<td>05</td>
<td>Oral Airway</td>
</tr>
<tr>
<td>06</td>
<td>Oral Endotracheal Tube</td>
</tr>
<tr>
<td>07</td>
<td>Oxygen Mask</td>
</tr>
<tr>
<td>08</td>
<td>LMA</td>
</tr>
<tr>
<td>09</td>
<td>Combi Tube</td>
</tr>
<tr>
<td>10</td>
<td>Nasal Pharyngeal Airway</td>
</tr>
<tr>
<td>11</td>
<td>Blow By</td>
</tr>
<tr>
<td>12</td>
<td>Non-Rebreather Mask Oxygen</td>
</tr>
<tr>
<td>13</td>
<td>Nasal Cannula Oxygen</td>
</tr>
<tr>
<td>14</td>
<td>Tracheostomy</td>
</tr>
<tr>
<td>15</td>
<td>Unspecified</td>
</tr>
<tr>
<td>16</td>
<td>Unsuccessful</td>
</tr>
<tr>
<td>17</td>
<td>Failed</td>
</tr>
<tr>
<td>18</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Scenario 5:

You are reviewing the EMS patient care record and find this note:

```
Medications Indicated on PCS Form
Oxygen [non-rebreather mask]
```

a. How would you code prehospital Airway?

Answer:

```
Airway
Non-Rebreather Mask Oxygen
```

GCS Qualifier

No Qualifier
**Scenario 6:**

A 45 year old was involved in a multiple vehicle motor vehicle crash on September 1, 2013 at 19:50. The patient’s car rolled several times. An EMS agency was called and made patient contact at 20:09. When the patient was assessed, it was noted that she had a GCS of 7 (Eye- 2, Verbal, 1, Motor 4). EMS then established a BVM airway. The patient received IV fluids at the scene but no medications were administered. The patient arrived at your ED at 20:46 and her first GSC was documented as Total 8 (Eye- 1, Verbal – 2, and Motor- 5). After assessing her vital signs, the ED staff inserted an oral endotracheal tube. The patient’s blood alcohol level was tested and was 300.

a. How would you code prehospital airway, prehospital GCS and GCS qualifier?
Answer: Note: BVM is coded as Assisted by Bag and Mask. GCS qualifier is “no qualifier” because there was no endotracheal tube inserted prior to measuring the GCS. Also, do not code “chemically altered mental status” if a patient has a high blood alcohol level. Use “chemically altered mental status” only if the patient was given sedatives or is neuromuscular blockade was induced with medications (usually before intubation).
The patient arrived at your ED at 20:46 and her first GSC was documented as Total 8 (Eye—1, Verbal – 2, and Motor – 5). After assessing her vital signs, the ED staff inserted an oral endotracheal tube. The patient’s blood alcohol level was tested and was 300.

a. How would you code ED GCS, ED GCS qualifier and ED airway?

Web Registry

Local:
Answer: Local Collector: Code ED airway as Oral Endotracheal tube

Answer: GCS qualifier should be “no qualifier” – see screen shot below. ED airway on the web version (see screen shot below) is on the same screen as the ED GCS.
Scenario 7:

A 45-year old patient is in a motor vehicle crash and is brought to your ED by Private Vehicle (POV). The patient’s vital signs are normal and she has a GCS of 15. The ED physician was in the ED when the patient arrived and examined the patient 10 minutes after her arrival. On examination, this patient has abdominal injuries and is discharged to higher level of care by Ground EMS. Your hospital does not have a formal activation policy. How would you code activation?

Answer:

Not a trauma center and patient arrived by POV, so code activation as N.
Scenario 8:

A 16 year old is crossing the street and is hit by a car. At the scene, EMS finds the patient unconscious (GCS Total=3). No CPR is initiated as vital signs at the scene are normal. EMS calls your hospital to let you know that they are bringing in a patient (assume EMS called in a code Red). On arrival to your ED, the patient’s total GCS is 7 [eye=1 (none), verbal=2 (incomprehensible sounds), and motor=4 (withdraws to pain)]. The patient’s abdominal CT is positive but head CT and Chest CT is negative. You transfer this patient to higher level of care by helicopter 1 hour 7 minutes after ED arrival. You do not have a formal activation policy at your hospital. How would you code trauma activation?

Answer:

[Image of Trauma Data Editor]

**Activation is Y because EMS called in Code Red**
Scenario 9:
A 25 year old was riding a motorcycle and was hit by a car. EMS was called. At the scene, vital signs were unknown, the patient was unconscious (Total GCS =3). CPR is done at the scene and en-route to the hospital. EMS calls your ED with a Code Blue. In the ED, the patient has no signs of life (no spontaneous respirations, no unassisted blood pressure, no pupillary response and no organized EKG activity). CPR is continued in the ED and the patient is pronounced dead 9 minutes after ED arrival. Your hospital has no formal activation policy. How would you code trauma activation?

Answer:

Activation is Y because EMS called in Code Blue
**Scenario 10:**

You are coding a trauma record and notice that the procedure code in your medical record is a CPT procedure code (Collector uses ICD-9 procedure codes). You are trying to code open reduction of a humerus fracture with internal fixation. What is the ICD-9 procedure code? Hint: Use the Search Feature and type in humerus or open reduction.
79.31, Open reduction of fracture with internal fixation, humerus
Scenario 11:
Suppose you had a patient who attempted suicide by hanging. How would you code this external cause of injury in the Injury Mechanism field?

Answer: At this time, you must use the option “other mechanism”. We will discuss this issue in the policy group and we may add another option for this type of situation.
FUTURE WEBINARS

- User’s Group: December 11, 2013
- Driller Training: Watch for email from Nancy Akin

MEETING ADJOURNED
**Data Report indicators and PI Worksheet**

Instructions: Please indicate possible reasons a patient might be an outlier for each data report indicator. These reasons would be issues that a quality director or trauma nurse coordinator would look for to review a case or to decide how to improve trauma care in an institution.

<table>
<thead>
<tr>
<th>Data Report Indicator</th>
<th>Issues to consider if outlier is listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all transferred patients, elapsed time between emergency department arrival and</td>
<td>1. Weather that does not permit travel, e.g., high winds that would prevent helicopters from flying, low</td>
</tr>
<tr>
<td>discharge to another acute care hospital does not exceed 6 hours.</td>
<td>ceiling, snow.</td>
</tr>
<tr>
<td></td>
<td>2. Road conditions, e.g., icy.</td>
</tr>
<tr>
<td></td>
<td>3. No EMS is available to travel (lack of mutual aid agreements)</td>
</tr>
<tr>
<td></td>
<td>4. Referral facility acceptance, bed availability, physician availability, .</td>
</tr>
<tr>
<td></td>
<td>5. Patient too unstable, e.g., actively coding, uncontrolled bleeding.</td>
</tr>
<tr>
<td></td>
<td>6. Decision to transfer based on diagnostic findings -- Number of procedures performed or time to</td>
</tr>
<tr>
<td></td>
<td>perform procedures (e.g., radiology (CT scans b/c ETOH involvement, no neurosurgeon available, OR),</td>
</tr>
<tr>
<td></td>
<td>O.k. to do plain films to identify pelvis fx or chest x-ray.</td>
</tr>
<tr>
<td></td>
<td>7. Delay in recognition that patient needs specialized care in hospital with higher level of care –</td>
</tr>
<tr>
<td></td>
<td>missed injury.</td>
</tr>
<tr>
<td></td>
<td>8. Patient deterioration. – change in patient status.</td>
</tr>
<tr>
<td></td>
<td>9. Patient or patient’s family did not want transfer but then condition indicated that non-transfer was</td>
</tr>
<tr>
<td></td>
<td>not an option.</td>
</tr>
<tr>
<td>For transfers with initial SBP &lt;90 or GCS &lt;8, elapsed time between ED and discharge</td>
<td>Same as above, plus</td>
</tr>
<tr>
<td>to another acute care hospital does not exceed 1 hour.</td>
<td>• Delay in specialist consultation.</td>
</tr>
<tr>
<td></td>
<td>• SBP or GCS increase in subsequent ED measurements</td>
</tr>
<tr>
<td>Data Report Indicator</td>
<td>Issues to consider if outlier is listed</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A <strong>definitive airway</strong> will be established before transfer of a comatose patient (GCS ≤ 8). Definitive airways include: LMA, combitube, oral endotracheal tube, nasal endotracheal tube, tracheostomy/cricothyroidotomy.</td>
<td>1. Never justifiable or acceptable always a variance.</td>
</tr>
</tbody>
</table>
| Patients with suspected **traumatic brain injury** (moderate to severe coma, initial GCS ≤ 12) are transferred to a level I or level II trauma center for treatment. | 1. Patient may have initial GCS ≤ 12, but after a short period of time, the patient’s level of consciousness increased and there were no significant signs of brain injury on diagnostic tests.  
2. Decision to treat patient at facility.  
3. Patient did not want to be transferred. |
| Patients with pneumothorax or hemopneumothorax receive a **chest tube** before transfer to another acute care facility. | 1. No provider with available skill set (referring facility)  
2. Very small pneumothorax that does not require a chest tube. |
| **Trauma team leader response is timely.** (Team leader in ED) | 1. Multiple incident or mass casualty event. Triaged but not treated immediately.  
2. Paging system malfunction  
3. Other reasons not responding to page or call.  
| Patients with hip, knee, shoulder, elbow or ankle **dislocation** receive reduction within 6 hours of ED arrival. Excludes patients who died or who were discharged within 6 hours of ED arrival | 1. Other more severe injuries are being treated first.  
2. No provider with available skill set  
3. Failed attempt to reduce.  
4. Delay in transfer |
<p>| Patients with a low-grade splenic | 1) Physician preference depending on patient status, comorbidities, etc. |</p>
<table>
<thead>
<tr>
<th>Data Report Indicator</th>
<th>Issues to consider if outlier is listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>laceration, AIS ≤ 3 undergo splenectomy.</td>
<td>2) Other associated injuries that would indicate need for splenectomy (such as, severe associated head or thoracic injury)</td>
</tr>
<tr>
<td></td>
<td>3) Shock</td>
</tr>
<tr>
<td>Patients with penetrating abdominal injury and SBP &lt;90 mmHg undergo laparotomy within 60 minutes of ED arrival.</td>
<td>1) No provider with available skill set</td>
</tr>
<tr>
<td></td>
<td>2) Unable to mobilize OR</td>
</tr>
<tr>
<td></td>
<td>3) Availability of OR.</td>
</tr>
<tr>
<td></td>
<td>4) Laparotomy not indicated because abdominal injury not severe.</td>
</tr>
<tr>
<td></td>
<td>5) Blood pressure increases after initial ED systolic blood pressure.</td>
</tr>
<tr>
<td></td>
<td>6) Delay in transfer</td>
</tr>
</tbody>
</table>