

Trauma Registry Committee Agenda

December 17, 2002

St Al's McCleary

Attendees: Steve Millard, Lynette Sharp, Ginger Floerchinger-Franks, Kay Chicoine, Leslie Tengelsen, Barbara Freeman, John Cramer, Joesph Morris, Chris Marselle, Steve Rich, Bob Seehusen, William Ganz, Boni Carrell, Dia Gainor, Bob Coscia, Richard Schultz, Murry Sturkie, Clay Mann, Senator Darrington, Howard Tanzman

| Agenda Items | Discussion | Actions/Decisions |
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| Welcome & Introductions | Susan Kunz resigned. Need representative for small hospitals. | |
| Review Minutes | | Minutes approved. |
| Follow-up Items <ul style="list-style-type: none"> ▪ Charter ▪ Inclusion Criteria Document ▪ Out of State EMS Transfers ▪ Trauma Registry Web Sites | Dana: Update to charter, Inclusion Criteria, 1997-2001 out of state transports, sample state trauma registry web sites were distributed in packet. Large increase in transports is due to increased compliance level of submitted PCR reports. | |
| Data Architecture | Presentation by Clay Mann of National EMS Data Analysis Resource Center (NEDARC). Main questions: How do you get data in and how do you get data out? Large hospitals (extended data), medium hospitals (minimal data – required state data set), small hospitals (proxy data – mail into central data entry location). Provide data on web via a password, view their data and similar sized hospitals aggregated. CUBE – free plug in to SQL. Allows user to use variables. Patient Cube (1 per patient) and Procedures Cubes. Buy-In by hospitals has been good with the Utah Registry software because of the free plug in. Has built system for other states. Q. What about duplication? Receiving and admitting hospital policies. A. Inclusionary criteria: presents at ED, captured in registry. | |

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| | <p>Linked by looking at similar data to make one record. Small hospitals least vocal about the process. Their process is to copy, mark out name, and mail. Records are then shredded.</p> <p>Trauma based software is proprietary. Has been problematic. Receiving of the data via website works well.</p> <p>Q. With web entry, big hospitals would have to double enter data. A. Export of data to SQL server works well.</p> <p>Utah has 40 variables. EMS run sheets left at the hospital is entered by hospital staff. If the run sheet is not left, the data is missing.</p> | |
| Evaluation Matrix | <p>Difficult to document costs because of diverse sources. Schultz: Can make recommendations back to Legislature about difficulties of collecting data to assess fiscal impact of trauma care. Not necessarily given the mandate to collect all data. Morris: Charges could be proxy for costs and is easily extractable. Seehusen: Politically have to collect cost data initially.</p> <p>Schultz: Linked data and repository. Export in ASCII, can be linked. Hospitals inputs into repository, ITD, Vital Stats, and EMS are separate system. Does the end user get data from the repository? Yes.</p> <p>Ganz: Run reports with information about the incident would be useful to the hospital practitioner. This would be a good tool but is not in the venue of the Trauma registry which will be retrospective.</p> <p>GCS is critical data.</p> <p>Mann: Utah failed to create a field that captured the purpose of the EMS agency.</p> <p>Gainor: Idaho has a response outcome field and each agency has specific capacities.</p> <p>How do we link multiple transfers – trauma band.</p> <p>225: Interfacility transfers that by pass ED. Institutional issue rather than an EMS issue.</p> | <p>Need a matrix of EMS data already collected compared to what the hospitals and ITD collects.</p> <p>Create subcommittee to look at data points and make recommendation for minimum data points. Look at Utah's 40 data elements. Next meeting Feb 14.</p> <p>Subcommittee members: Chris Marselle, Murry Sturkie, Steve Rich, Leslie Tengelsen, Ginger Floerschinger-Franks. Chair: Chris Marselle. EMS Bureau Staff: Dia Gainor, Boni Carrell, John Cramer</p> |

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| | <p>Strike 234, 27, 241, 245, 249-253.</p> <p>Mark 269-273. Strike 293.</p> <p>If 247-250 is not part of the hospital data EMS would include generic field whether there was a trauma team activated.</p> <p>Hospital's evaluation of airway interventions by EMS. #200.</p> <p>Keep it simple and limit data elements. Need to arrive at a discrete list to evaluate software products.</p> | |
| <p>St Alphonsus TRACS demonstration</p> | <p>Chris Marselle and staff (Tammy and Marsha) demonstrated St. Al's TRAC.</p> <p>ISS scores. What about patient information from transfers. Do both hospitals enter data? Would apply depending on length of stay at the first hospital. Dedicated coders to input and document data is valuable. TRACS being utilized in several areas of the state and support resources are available.</p> <p>Do we train small hospitals to do coding. All hospitals have coders for ICD9 for insurance billings and can be converted to ISS codes.</p> <p>Concurrent vs. retrospective data collection. Can make pro-active changes when data is meaningful, accurate, and timely.</p> <p>Align resource utilization with acuity of injury severity. Over or under triaging. Over triage: Level 1 trauma activation with an ISS of 15 or less. Under triage: any non leveled trauma with an ISS of >15.</p> <p>1200 records annually – 300+ data points. 500-750 records per FTE with this many data points.</p> <p>How is a state level registry going to assist the hospitals more than their own current systems? If you don't have data you don't know what you're doing. Objective is to improve care. Years ago 20% of those with trauma injuries died (with the exception head injuries) currently at 2%. Compare hospitals</p> | |

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| | <p>with each other. Majority trauma at regional medical center is already being tracked and can currently benchmark with NTB. Increase accountability.</p> <p>Legislation is to collect data. Darrington: anticipated time when insurance companies take hard look at cost of transports. Envision, after this is implemented, smaller hospitals can evaluate whether they have transferred patients appropriately. Advantage to those smaller facilities in analysis and insurance companies are going to be interested because it is a big budget item.</p> <p>Schultz: Q. Why should the state invest into this? A. Data is incomplete, doesn't talk to other entities – EMS, law enforcement, ITD. A lot of missing data. Not representative. Public policy based on what is occurring in Idaho and use of resources.</p> <p>Mann: Conclusions, level 1 centers are fantastic. No one was overlooking the system. Market share concerns. Found undertriage 2%, over triage 40%. System inherently conservative. Put patients back in their communities at less cost. Integrated cities, cost of trauma went down. Coordinated system and oversight will save the state money.</p> <p>Have been dealt the hand to create the registry and need to move on. Has already been debated.</p> | |
| National Trauma Data Bank Presentation | <p>Presentation by Howard Tanzman – Chief of Information Services American College of Surgeons.</p> <p>Non-proprietary national database ACS. Doesn't provide analysis. 1997 first call for data, 2001 first annual report, 2002 second report, 2003, continuing to accrue cases and is now working on a web presence. Voluntarily submission to increase validity of conclusions. Some states are submitting from their state registries.</p> <p>130 trauma centers in 25 states.</p> | |

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| | <p>www.facs.org</p> <p>Working on web based, user defined, report writing system, increased standardization of trauma data definitions, web based submission, analysis of additional data points including procedures, complications and outcomes, additional internal staff for research.</p> <p>HIPPA – business associate agreement promises to safeguard data. Research data bases may not need the business associate agreement. Waiting for interpretation.</p> <p>Htanzman@facs.org 312-202-5392.</p> | |
| Future Agenda Items | | <p>Minimum data set.</p> <p>Software and data elements compatibility. Look at existing systems. Clay Mann: Will approach manufacturers.</p> <p>Critical Capacity List. EMS refining draft.</p> <p>Nomination for representative for small hospitals.</p> |