

TRAC Minutes
October 18, 2002

TOPIC	DISCUSSION	DECISIONS/OUTCOMES
Welcome & Introductions	Steve Millard, Chair welcomed members. Boni Carrell, Kay Chicoine, Randall Cordle, John Cramer, Ginger Franks, Barbara Freeman, Dia Gainor, Ron Hodges, Susan Kunz, Chris Marselle. Joe Morris, Dana Myers, Steve Rich, Dick Schultz, Lynette Sharp, Murry Sturkie, Leslie Tengelsen,	
Review committee charge and charter. Tab 3.	<p>Boni Carrell reviewed the charter. Dick Schultz responded to the question about whether this would be an ongoing committee stating that the primary goal is to have a draft trauma registry. The current charge is design and development. The next step would depend upon funding resources for implementation. That would be the time to evaluate whether this committee is the right committee to assist with implementation. There will be a need for an oversight committee to monitor and evaluate data at a state level.</p> <p>Users would also need to meet – technical updates, etc.</p> <p>The timeline gives a sense of activities.</p>	<p>Set all next meeting dates rather than minimums outlined in charter. A decision was made to avoid EMSAC meetings dates.</p> <p>December 17, 2002 (hosted by Chris Marselle at St Al's.)</p> <p>February 14, 2003 April 10, 2003 June 12, 2003 July 31, 2003 October 2, 2003 December 11, 2003</p> <p>Review in 6 months for 2004 meeting dates.</p> <p>Send out meeting schedule hard copy. Meeting materials by email. Members should acknowledge receipt of email.</p> <p>Line 112 – strike word “acting.” Meetings will be conducted in an informal manner.</p> <p>A Motion to approve the charter was seconded and carried.</p>
History of trauma registry activities	Dia Gainor: reviewed the history of the trauma registry.	
Data Linkage and the trauma registry	Boni Carrell presented Power Point information about Data Linkage. Questions about HIPPA followed. Issues to consider are patient authorization, how the data is used and reported. Dana Meyers mentioned that the purpose of the matrix is to avoid	The number of out of state transfers available in the PCR data will be presented at the next meeting.

	<p>duplication of data and effort. Capturing watercraft caused trauma, out of state destination for accidents in Idaho was discussed. Dia Gainor stated that run reports capture number of out of state destination transfers. Legislation gives authority to obtain data from other states. But do we have the capacity to accomplish it?</p>	
<p>Define questions we want to answer/ask of the trauma registry and linked data</p>	<p>Can't pick software off the shelf until we have criteria and know what questions we need answered.</p> <p>Research from Vermont about Hospital Trauma Care in a Rural State without a Formal Trauma Center was cited and discussed.</p> <p>Will want to be able to compare and benchmark data with other states, so don't want to be too unique.</p> <p>Existing software may be customizable.</p> <p>Funding may restrict options.</p> <p>Comparison Matrix variable by variable is privileged and is not available.</p> <p>Don't want to collect data for the sake of collecting. Need to determine what minimum data set would be the threshold. Will need consistent definitions.</p> <p>Modular approach might be cost effective. Initially Idaho's PCR was shortest like report in the nation. Adding later modules has been very successful.</p> <p>After one year of data collection, what would you want to see answers to in a report?</p> <p>High level approach. Need agreement as to what the registry should yield.</p> <p>Need level above registry objectives. Define what data set would meet objectives.</p>	<p>I. Develop a process to evaluate existing software systems (TRACS, collector, TXCDC, Clay Mann). Develop a matrix to evaluate. Action Step: EMS Bureau</p> <p>II. Develop criteria to evaluate systems.</p> <ul style="list-style-type: none"> ▪ Cost ▪ User friendly ▪ Idaho specific variables – ability to customize ▪ National benchmarking ▪ Cost to change to another package ▪ Web compatibility ▪ Remote data entry (laptop) ▪ Central repository ▪ Data manipulation ability (server level) ▪ Population based ▪ Regulatory Restrictions ▪ How will data be collected ▪ Support <p>Action Step: Ongoing working list. EMS Bureau will compile list of web sites for members to look at other states' trauma registry web site as a reference or model. Invitation for any member to investigate St. Al's system.</p> <p>III. How will the registry interface with other systems? - discharge database, PACS (pediatric database), etc. DHW Information Technology System Division [ITSD] involvement, etc.</p> <p>Action Step: IHA and DHW discuss how they will interact</p>

	<p>Utilize data already collected.</p> <p>Definition of trauma. Hospital transfers may inflate numbers. Diagnosis code – ICD no. Inclusion bias. Only sicker patients are included in the criteria and their outcome is worse. Will want to include every possible trauma patient to improve their outcomes. Some patients will be included because they are transferred, but because they are a trauma patient. If we don't address this issue, it will harm the small hospitals. Will give faulty data that will make places that receive transfers look better. Severity score would be irrelevant unless they are transferred or admitted.</p> <p>Are you stating that the in patient requirement will exclude cases who are successfully managed at the community hospital that have enough injury to be included in the trauma range, won't see that hospital's role in treating patient in trauma data? If we accept in-patient criteria, will we miss the community hospitals – won't see the successfully treated patient.</p> <p>Practical point of view, can't capture all patients.</p> <p>Data element – how did you get into the database/study. Need to segregate transfer patients.</p> <p>Are we going to use TRACs? Will hospitals be willing to change software. Need to focus on the outcome! Won't be able to compare software without knowing desired outcome.</p> <p>Get access to data points of existing software and evaluate and then select. Comparison matrix. Presentation by vendors of available software. Minimum data set. Information readily available. Recreating what Clay Mann cannot release to us. Clay will be available at the December</p>	<p>with each other.</p> <p>IV. How would we use the data. (Research, publication, internal quality issues.)</p> <p>Action Step: Ongoing list. Keep in mind in making future decisions.</p> <p>V. Relationship to Legislative Objectives.</p> <p>VI. Who will have access to develop reports. How will data be compiled. Develop public policy.</p>
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	<p>meeting.</p> <p>Legislation states that there will not be a cost incurred by the hospital.</p> <p>Concern expressed that we will not be doing injury surveillance or capturing data about incidence and prevalence as outlined in the Legislation. Dick Schultz stated that the mandate is the surveillance of trauma – not injury. There will be uncaptured injury – (doctor’s office, clinics, etc).</p> <p>Inclusion criteria is not included in Legislation. And the definition of trauma includes injury.</p> <p>Discussion took place about the intent of the legislation and meeting the objectives. Steve Millard and Dick Schultz agreed that we do not have to do population based injury surveillance nor document the incidence and prevalence of trauma.</p> <p>Could get what we need from a discharge database. Discharge in and out patient. No – need to gather data about every injury. What percentage of hospitals are not electronic? IHA is investigating discharge database. Start with inpatient data. As an option, as we investigate trauma registry, could we compare with the discharge database? Could be discussed.</p> <p>Use of Data</p> <ul style="list-style-type: none"> • Relationship to Legislative Objectives • Ability to monitor the result of change • Research capabilities • Publication • Internal Use (evaluation systems, health system performance) <p>Compare ourselves on a national level</p>	
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	Concern: Independent introduction of parallel databases.	
Establish subcommittee objectives for data elements and collection capacity		IHA will query hospitals as to their collection capacity.
Action items and assignments		TRAC demonstration at St Al's - Chris Marselle Collection capacity – Steve Millard Software matrix – EMS Bureau
Funding Resources	Boni Carrell reviewed current funding resources.	