North Carolina Office of Emergency Medical Services
Trauma Registry Task Force Meeting

Wake Forest University Baptist Med Cntr
Winston-Salem, NC

17 January 2000

Attending:

Cape Fear Valley Medical Center
Leo Davidson
Rae Lynn Eckstein
Carolina Medical Center
Jennifer Sarafin
Nora Smith
Linda Spallone
Michael Thomason
Kevan Weaver
Catawba Memorial
Amy Mattes
Central Data Collecting Agency
Sharon Schiro
Cleveland Regional Medical Center
Michael Barringer
Betsy Szumski
Lynda Morrow
Duke University Medical Center
Penny Cooper
Don Hartwell
Claudia McCormick
Becky Schulte-Anderson
Steve Vaslef
Forsyth Medical Center
Lisa Brady
Iredell Memorial Hospital
Lake Norman Regional Medical Center
Cathie Jackson
Joyce McLean
Maria Parham Hospital
Tommy Jackson
William Powell
Mission St. Joseph’s
Leanne Adams
Michael Buechler
Kelli Moore
Moses H. Cone Memorial Hospital
Annette O’Dell
Cheryl Workman
New Hanover Regional Medical Center
Thomas Clancy
Alice Matthews
Northeast Medical Center
Paula Fox
Richard Ozment
Sherry York
Office of Emergency Medical Services
Sharon Rhyne
Presbyterian
Stacy Mazzei
Patricia Wilburn
Rowan Regional Medical Center
University Health Systems of Eastern Carolina
Melinda Bartlett
Kathy Dutton
Michael Rotondo
Bonnie Snyder
Mel Swanson
Linda Walter
University of North Carolina, Chapel Hill
Christopher Baker
Karen Schwabrow
Arvilla Stiffler
Michele Ziglar
Wake Medical Center
Debra Petrarca
Pascal O. Udekwu
Wake Forest University Baptist Medical Center
Gail Klutz
Wayne Meredith
Shannon Tilley
Dianne Wheaton
Watauga Medical Center
LaRaye Rudicile
Connie Simoneau
The meeting was called to order by the Chair, Wayne Meredith.

Wayne Meredith discussed the changes at NTRACS. A consultant hired by NTRACS recommended moving NTRACS off of FoxPro to HTML. Several issues relating to the move to HTML were discussed: confidentiality, location of data storage, time frame, long-term support of NTRACS software by the ACS. Wayne Meredith announced that Karen Van Maldegiam had left her position at NTRACS. Version 3.0 will still come out, and an update of the ICD-9 codes and printer drivers should be out by the end of February (if Version 3.0 can not be distributed by this date).

Central Data Collection Agency:
Sharon Schiro announced that the new version of the data dictionary and hospital list had been distributed to all sites by email. The list of drugs that constitute “chemical sedation” for GCS will be distributed at the Registrar’s meeting later today.

Sharon Schiro requested a change in the patient definition: to include patients transferred from other hospitals. The purpose of adding these patients is to collect information on patients who are transferred due to complications from a trauma, but for whom the injuries in the ICD9 range 800-959.9 were resolved prior to transfer. This change also would allow the capture of patients who are admitted for surgery, but stay less than 24 hours, following transfer from another hospital. The goal is to find a mechanism to follow late transfers. The resulting discussion included considering obtaining this information through the RAC database. Arvilla Stiffler stated that these patients are difficult to identify, since they may not come in as status post trauma. The request was rescinded.

Wayne Meredith described a project that he is interested in pursuing. For a cost (which Wayne Meredith is willing to underwrite), the folks who manage the State Discharge Database agreed to the following project: we will send them our data - with identifiers. They will encrypt our identifiers in the same way that they encrypt theirs. They will then return our dataset and a copy of their dataset, so that we can link the two datasets together. This will allow us to track patients through all hospital in NC, and to identify patients who are in the registry more than once (ie, those patients who have been transferred between hospitals participating in the registry). This combined dataset will allow us to look at ICISS and to evaluate whether AIS coding is worthwhile. Concerns regarding IRB were discussed. Sharon Rhyne stated that she, Drexdal Pratt, and Greg Mears had met with the Hospital Association to describe the databases that OEMS is working with. The Hospital Association is interested in working with the NCTR to mesh databases. OEMS is working on legislation to secure additional confidentiality for their databases.

Wayne Meredith’s project would involve creating a shadow registry with identifiers. Sharon Schiro suggested sending only the trauma registry record number, hospital number, and patient identifiers - no trauma data. Osi Udekwu stated that he was willing to take this through his IRB, given a proposal. Wayne Meredith stated that he was willing to work on a proposal, if he felt that all sites were willing to participate in this project. He asked if anyone present had a problem with this project. There was no response.

Linda Spallone presented a report from the FIM Score committee. Michael Bosse, Teresa McDowell, and Linda Spallone participated in a conference call. See the Committee report for further information. They felt that information that was important in assessing outcome included where the patient went from the hospital, and the type of rehab hospital they went to (if they went to rehab). They proposed adding the discharge GCS and possibly the SF36 to the database. They further recommended that we not collect FIM. Osi Udekwu expressed his concerns regarding the discharge GCS, citing his recent paper on GCS and FIM. There are multiple mechanisms for obtaining any one GCS, so it is not a valid tool for assessing discharge functional outcome. The SF36 is the best tool for assessing outcome, but it is expensive (both in postage/phone calls and time). Chip Baker moved that we not collect the discharge GCS, FIM, nor the SF36. The motion was seconded and passed.

NCOEMS Update:
Sharon Rhyne stated that of the 22 hospitals using NTRACS, 8 had paid their fees. She expected that the remaining payments were in process and would be received shortly. The State paid approximately $5000 of the NTRACS fees to keep the hospital’s fees at approximately $1200.

Sharon Rhyne discussed sites for future Task Force meetings. The April meeting will be in Raleigh, but the July and October meetings cannot be held either at WakeMed or NC Baptist. If any site can host either the July or October meeting, please contact Sharon Rhyne.
Research
Chip Baker began the Research portion of the meeting by introducing the new chair of the Research Committee, Michael Rotondo. He thanked Steve Vaslef, the prior Chair, for his work. Michael Rotondo stated that NC is known nationally for its trauma research. NC had great representation at EAST. He also stated that he had met with Sharon Rhyne and Sharon Schiro to learn the infrastructure of the NCTR research process. He would like to add the following tools to the process:

1. Changes in the committee structure: he would like these committees to be inclusive, not exclusive, and to have all members commit to review and support projects. Membership on the committees would rotate and terms would be established, including a term for the Chair. He proposed that the committees meet by conference call over the next month to discuss these issues.

2. A project chart to track progress of all projects.

3. Project selection with efforts on focus and balance.

Chip Baker stated that we tend to be focused on deadlines for conferences, but fears that we may lose good ideas this way. It is ok to do a project and submit directly to a publication.

The following research projects were discussed:

1. Equestrian (Sharon Schiro for Dorothy Hammett): Sharon Schiro presented this proposed project, because the researcher (a non-Task Force member) was not able to travel to the meeting due to physical disability. A discussion of the data request resulted in a request to modify the request to exclude the form to be completed by the Registrars and to change the date range to 1994-1999.

2. Interhospital Transfer versus Scene Transfers (Michele Ziglar): There were few significant differences between the scene and referring hospital groups. The few differences were the reverse of the expected. However, the data did support the expectation that the mean time to definitive care was significantly longer for patients arriving from referring hospitals versus from the scene. An abstract for AAST will be submitted to the Task Force in the near future.

3. Rural Trauma (Arvilla Stiffler, Dale Oller): Arvilla Stiffler stated that a Scientific Data Request would be submitted to the Task Force in the near future.

4. Complications (Steve Vaslef): This project will be discussed in the MD’s meeting this afternoon.

5. Cervical Spine (Osi Udekwu): Osi Udekwu gave a special thanks to Linda Spallone, as her site has many more entries into this project than any other site, due to their patient volume. The paper will include the Task Force members as authors, with a special thanks to the Registrars. Data collection was to start on 1 Nov 2000 and continue for 6 months. One data point was clarified: “Unstable” means that an operation was required for halo or fixation.

6. Occupational Injury (Arvilla Stiffler): The paper is almost complete. It may be sent to AAST, following approval by the Task Force.

7. Compartment Syndrome (Chip Baker): Chip Baker reported that there was not much to report.

Chip Baker encouraged the involvement of the TNCs and Registrars in research, and stated that he wants them to get a chance to present at conferences. Wayne Meredith stated that the Cervical Spine project represents the concept of focusing on a project that is time-limited, then deleting the datapoints from the collection process.

The next meeting of the North Carolina Trauma Registry Task Force will be Wednesday 18 April 2001 at WakeMED’s MEI Building in Raleigh. The remaining meeting dates for 2001 are: 18 July and 17 October.

The meeting was adjourned.

Respectfully submitted,

Sharon Kromhout-Schiro