TQIP Monthly Registry Staff Web Conference

January 28, 2015
Your TQIP Staff

Tammy Morgan
National TQIP Educator

Julia McMurray
Business Operations Manager
Announcements

• Next Call for Data will open February 2
  o Follow the NTDS inclusion/exclusion criteria!
  o Submission deadline March 3

• Data Submission and TQIP reports
  o NTDB data submission
  o Full year of data for inclusion in TQIP reports
  o Pull data for Benchmark reports twice a year
Beginning with January 2016 admissions, we are requiring that all hospitals submit AIS codes in AAAM’s current version, AIS 2005, Update 2008.

More information about licensure can be obtained from the AAAM website: [http://www.aaam.org/ais-licensing.html](http://www.aaam.org/ais-licensing.html)

[www.aaam.org](http://www.aaam.org)
TQIP and AIS

How do you capture AIS?

- Choose the code in your software?
- Refer to AIS for coding rules?
- Choose ICD 9/10 code, and software assigns AIS?
- Submit all injuries in a text field, and software assigns AIS?
- Not at all!
TQIP and AIS

How does AIS affect your TQIP?

Let’s take a look...
Appendix A: Inclusion Criteria

Center level criteria:
- Level I or II ACS verified or state designated trauma centers in NTDB. The trauma level of center is first determined according to ACS verification then by state designation.
- For trauma centers outside US, level will be determined using the information from the corresponding government/health authority.
- Must have 12 months of data between 1/1/2013 and 3/31/2014.
- Must be full TQIP participant, with signed contract and payment, as of July 30th, 2014. Please see Appendix C for a list of centers included in this analysis.

Patient level criteria: (must meet all of the following):
- Age ≥ 16 years.
- At least one valid trauma ICD-9 code in the range of 800–959.9 (excluding late effects (905-909.9), superficial injuries (910-924.9), and foreign bodies (930-939.9).
- Trauma type of blunt or penetrating.
- Injured patients with at least one AIS ≥ 3 in body regions 1 – 8*.
- ED discharge disposition AND hospital discharge disposition cannot both be unknown.
- Exclude patients with ED discharge disposition of home, home with services, transfer to another hospital, other, or left against medical advice.
- Exclude patients with pre-existing advanced directive to withhold life sustaining interventions.
- Exclude patients with the following combinations of ED vital:
  - SBP=0, and pulse=0, and GCS motor=1
  - SBP=NK/NR, and pulse=0, and GCS motor=1
  - SBP=0, and pulse=0, and GCS motor=NK/NR
  - SBP=0, and pulse=NK/NR, and GCS motor=1
  - SBP=NK/NR, and pulse=0, and GCS motor=NK/NR

*AIS crosswalk version 98 was used when available otherwise the ICD9 map was used to calculate the AIS score.
Appendix B: Cohort Criteria

All cohorts are selected from patients meeting the above criteria, and exclude isolated hip fractures in the elderly unless otherwise noted. An isolated hip fracture in the elderly related to a fall is defined as:

- Injury mechanism of fall AND
- Age ≥ 65 AND
- Any of the following AIS codes:
  - 851810.3 Femur, Fracture, Intertrochanteric
  - 851812.3 Femur, Fracture, Neck
  - 851818.3 Femur, Fracture, Subtrochanteric
- AND all other injuries are in AIS body region 'External' (i.e., bruise, abrasion, or laceration)

**Blunt, Multisystem Injury**

- Patients must have blunt mechanism only
- AIS ≥ 3 in at least 2 of the following body regions: head, face, neck, thorax, abdomen, spine, upper, or lower extremity.

**Penetrating injury**

- Patients must have penetrating mechanism only
- Any injury with AIS ≥ 3 in at least one of the following body regions: neck, thorax, or abdomen.

**Shock**

- Initial ED/Hospital 0 ≤ SBP ≤ 90
TQIP and AIS

Traumatic Brain Injury
1. Traumatic Brain Injury (TBI)
   o AIS severity ≥ 4 for body region Head AND no other severe (AIS>2) injuries in any other body region OR
   o AIS severity ≥ 3 for body region Head and initial GCS motor score in ED ≤ 4 AND no other severe (AIS>2) injuries in any other body region
   o Excluded from entry into the cohort if the qualifying AIS code (i.e., to get them into the cohort) is any of the following:
     ▪ Scalp injuries:
       ▪ 110606.3
       ▪ 110806.3
       ▪ 110808.3
     ▪ Internal carotid artery injuries
       ▪ 121099.3
       ▪ 121002.5
       ▪ 121004.4
       ▪ 121006.3
     ▪ Vertebral artery injuries
       ▪ 122899.3
       ▪ 122802.5
       ▪ 122804.3
       ▪ 122806.3
     ▪ Bony injuries
       ▪ 15XXX.X where X=any value.
   o Note patients can enter this cohort with these if they have another qualifying injury (i.e., if they have a brain injury AND a code above, they can enter the cohort).

2. Intubated Traumatic Brain Injury (ITBI)
   o Patients must meet above criteria for TBI
   o Patients must have
     ▪ Ventilator days > 0 OR
     ▪ Respiratory Assistance in ED = 'Assisted Respiratory Rate' OR
     ▪ Procedure code of 96.70, 96.71, or 96.72
TQIP and AIS

Let’s talk about documentation?

- Do you get the documentation needed to code accurately?
- If not, what do you do?
- What *should* you do?

*TQIP is a team effort. Take it to your team!*
TQIP and AIS

January 2016

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Highest Standards, Better Outcomes

100 years
Andrea Ogden
TQIP Education Coordinator
Holly Michaels
TQIP Program Manager
Let’s get started!
Alternate Home Residence (pg. 7)

Alter home resid (pg7) says only complete when zip code is NA (pg2). The Undoc citz has a Zip Code. can we do both zc and Und

If a zip code is reported, then the null value “Not Applicable” should be reported for the data field Alternate Home Residence.
When it comes to airbag deployment, if there is no indication of airbags in the vehicle at all, should we be checking N/A or #1?

The data field *Airbag Deployment* should only be completed if the data field *Protective Devices* include “Airbag.” So, in this case you would use the null value “Not Applicable.”
I have a scenario on the physical abuse question: report and investigation were yes for elder abuse, I put n/a in the caregiver box per pg 36 due to being older than a minor but got an error when I ran the check stating n/a was wrong. Any suggestions?

You are correct to use the null value “Not Applicable.” The definition for Caregiver At Discharge states under Additional Information “The null value ‘Not Applicable’ should be used for patients where Report of Physical Abuse is No or where older than the state/local age definition of a minor.”

Continued on next slide...
Caregiver At Discharge cont’d (pg. 36)

For 2014 admissions, there was a level 3 flag when the null value “Not Applicable” was reported for this field. However, level 3 flags do not mean your data are wrong.

This level 3 flag was removed for 2015 admissions.
Initial Field Respiratory Rate (pg. 48)

If a pt arrives intubated & bagged by EMS and there is no pulse or blood pressure, would unassisted RR = 0?

It is most important to report what is documented on the EMS report. If this information is not documented, you would use the null value “Not Known/Not Recorded.”
**Initial Field Systolic Blood Pressure (pg. 46-53 for all vitals)**

What is considered "first recorded vitals at scene of injury" if both ground EMS and flight EMS arrive at scene?

The definition is asking for the first recorded, so use the vitals from whichever EMS agency documented them first.
**Trauma Center Criteria and Vehicular, Pedestrian, Other Risk Injury** *(pg. 55-56)*

Triage collection, must it be from EMS using Nemsis version 3 only (dictionary does not state such) clarify once again please.

If Trauma Center Criteria and Vehicular, Pedestrian, Other Risk Injury are reported on your EMS report, then report to NTDB. Those EMS agencies that are using NEMSIS v3 are required to report this information.

Remember, this will most likely be in a pick list or drop down on the EMS report. Let’s take a look!
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<tr>
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<tr>
<td>Right: Normal</td>
<td>RA: Normal</td>
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<tr>
<td>Reacts: Reactive</td>
<td>LL: Normal</td>
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<td></td>
<td>RL: Normal</td>
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<td>Effort: Normal</td>
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<td></td>
<td>Outcome: Improved</td>
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<table>
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<tr>
<th>Involved: MVI</th>
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<tbody>
<tr>
<td>2</td>
<td>Reason for Encounter: Injury/Trauma</td>
</tr>
<tr>
<td>Airbag: No Airbag Deployed</td>
<td>Trauma Center Criteria:</td>
</tr>
<tr>
<td>Location of Pt: Front Seat-Left</td>
<td>- Chest Wall instability or deformity (e.g., flail chest)</td>
</tr>
<tr>
<td>in vehicle: Side (or motorcycle driver)</td>
<td>- Glasgow Coma Score &lt;14</td>
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<tr>
<td>Vehicle Impact: 12</td>
<td>Intentional: No</td>
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<tr>
<td>Extrication: Yes</td>
<td>Fall Height: 0 ft.</td>
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<tr>
<td>Required: Yes</td>
<td>Fall Surface: Not Recorded</td>
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<tr>
<td>Was CAN Used: No</td>
<td>Injury Cause: Motor Vehicle Loss of Control, Driver Injured</td>
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<table>
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<th>Initial Physical Findings</th>
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<tr>
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</tr>
<tr>
<td>Spine: Not Done</td>
</tr>
<tr>
<td>Chest: Normal BS Findings: Crepitus noted on L chest wall</td>
</tr>
</tbody>
</table>

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Trauma Center Criteria and Vehicular, Pedestrian, Other Risk Injury (pg. 55-56)

Trauma Center Criteria and Vehicle, Ped, Other: Which null value if pt was NOT transported from the scene to a trauma center? (i.e., Pt transported from scene to non-trauma center and eventually transferred to trauma center. Scene EMS sheet does not indicate reason to transport to trauma center since they didn't take pt to one. Should fields be recorded as (N/A)?

As indicated in the Additional Information section of both Trauma Center Criteria and Vehicular, Pedestrian, Other Risk Injury data fields, the null value “Not Known/Not Recorded” should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
**Initial ED/Hospital Respiratory Rate (pg. 64)**

If Trauma Flow states on Vent and doesn't write in resp. rate. How do you prefer we answer this?

For the data field *Initial ED/Hospital Respiratory Rate*, if a respiratory rate is not documented in the patient record, use the null value “Not Known/Not Recorded.”
Pre-Hospital Information (pg. 37-57)

Is there value in transfer run sheet data? All questions seem to refer to scene to orig hosp- as a level 1 we get a lot of trans

Let’s take a look....
EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition
The date the unit transporting to your hospital arrived on the scene/transferring facility.

Field Values
- Relevant value for data element

Additional Information
- Collected as YYYY-MM-DD.
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).

All EMS Date & Time data fields:
- EMS Dispatch Date
- EMS Dispatch Time
- EMS Unit Arrival Date At Scene OR Transferring Facility
- EMS Unit Arrival Time At Scene OR Transferring Facility
- EMS Unit Departure Date From Scene OR Transferring Facility
- EMS Unit Departure Time From Scene OR Transferring Facility
All Initial Field Vital Signs:
- *Initial Field Systolic Blood Pressure*
- *Initial Field Pulse Rate*
- *Initial Field Respiratory Rate*
- *Initial Field Oxygen Saturation*
- *Initial Field GCS – Eye*
- *Initial Field GCS – Verbal*
- *Initial Field GCS – Motor*
- *Initial Field GCS - Total*
Initial ED/Hospital Supplemental Oxygen (pg. 67)

ED/Hosp Suppl O2, says to only complete if value provided for O2 Sat. Leave blank or put N/A? Both are Level 4 errors.

For the data field Initial ED/Hospital Supplemental Oxygen, there is a level 2 flag that states “Field cannot be blank when Initial ED/Hospital Oxygen Saturation is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded.”

Therefore, if you are not reporting an O2 sat. level, you will not get a flag for using the null value “Not Applicable.”
ED Discharge Date & Time (pg. 79-80)

What is ED discharge time when patient dies in ED? Is it recorded/called time of death or when patient's body physically remove.

Time of death.
**Total ICU Length Of Stay** *(pg. 100)*

ICU length of stay - not all doing it the same, and does not give accurate data on true ICU LOS

It is important that you capture data for your center’s needs. However, when sending data to NTDB, it is also important to follow the definition for each data field. So, you may need to map your data to comply with the definition if you are capturing the data differently in your trauma registry.

The definition for *Total ICU Length Of Stay* states “The cumulative amount of time spend in the ICU. Each partial or full day should be measured as one calendar day.”
Hospital Discharge Disposition (pg. 106)

Why do you want a patient who comes to the hospital from a NH and is discharged back to NH to be discharged as "home"?

Because this is where the patient resides.
If a pt was d/c'd to in-house rehab and readmitted to the hospital, then d/c'd back to in-house rehab is their dispo "home"?

Yes!
**Highest GCS Total** *(pg. 114)*

Re: "AIS head region" for highest GCS total. Is it head only or head and c-spine?

Collection Criterion: *Collect on patients with at least one injury in AIS head region*

Answer: Just head!
Cerebral Monitor (pg. 117)

If a cerebral monitor was unsuccessfully attempted, it should not be included in the Process Measure - correct?

Correct!
If patient arrives already on Coumadin for another disorder such as a-fib, can we count that as VTE prophylaxis?

No!
Transfusion Blood (4 Hours) (pg. 123)

Do we count blood that is being transfused prior to or at patient arrival, in the RBC count transfused in the first four hours?

The definitions for all TQIP process measure blood product fields asks for the quantity transfused at your hospital.
If you put a "0" in the transfusion of blood 4 hrs can you put "NA" in the measurement and conversion field?

The collection criterion for the measurement and conversion data fields (Transfusion Blood, Plasma, Platelets, Cryoprecipitate) is “Collect on all patients with transfused packed red blood cells within first 4 hours after ED/hospital arrival.”

And, the definitions state under Additional Information “The null value ‘Not Applicable’ is used for patients that do not meet the collection criterion.”
Transfusion Plasma, Platelets, Cryoprecipitate
Measurement & Conversion (pg. 129-130, 133-134, 137-138)

How do we answer ‘CONVERSION/MEASUREMENT’ field on FFP/Cryo/PLTS if they only received RBC?

For the Measurement data fields, you can pass the validator by submitting a field value, or the null value “Not Applicable.”

For the Conversion data fields, you can pass the validator by submitting a value, or the null value “Not Applicable.”
Could you please review withdrawal of care and give a few scenarios? Ex. small SDH changing to comfort care

Let’s take a look at the data fields associated with withdrawal of care!
WITHDRAWAL OF CARE

Collection Criterion: Collect on all patients

Definition
Care was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision must be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Field Values
1. Yes
2. No

Additional Information

- DNR not a requirement.
- A note to limit escalation of care qualifies as a withdrawal of care. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).
- Excludes the discontinuation of CPR and typically involves prior planning.
- DNR order is not the same as withdrawal of care.
- The field value ‘No’ should be used for patients whose time of death, according to your hospital’s definition, was prior to the removal of any interventions or escalation of care.

Associated Edit Checks

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<tr>
<td>12403</td>
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WITHDRAWAL OF CARE TIME

Collection Criterion: Collect on all patients

Definition
The time care was withdrawn.

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM military time.
- The null value "Not Applicable" is used for patients where Withdrawal of Care is 'No'.
- Record the time the first of any existing life-sustaining intervention(s) is withdrawn (e.g. extubation). If no intervention(s) is in place, record the time the decision not to proceed with a life-saving intervention(s) occurs (e.g. intubation).

Associated Edit Checks

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**Trauma Registry Vendors**

Can vendors create reporting capabilities for TQIP data? i.e. I can run a report on my TQIP data to review blood/VTE prophylaxis

This is a question for your vendor.
Let’s talk about following the NTDS data definitions!

*Please, follow the definitions. That is all!*
Thanks for your participation!