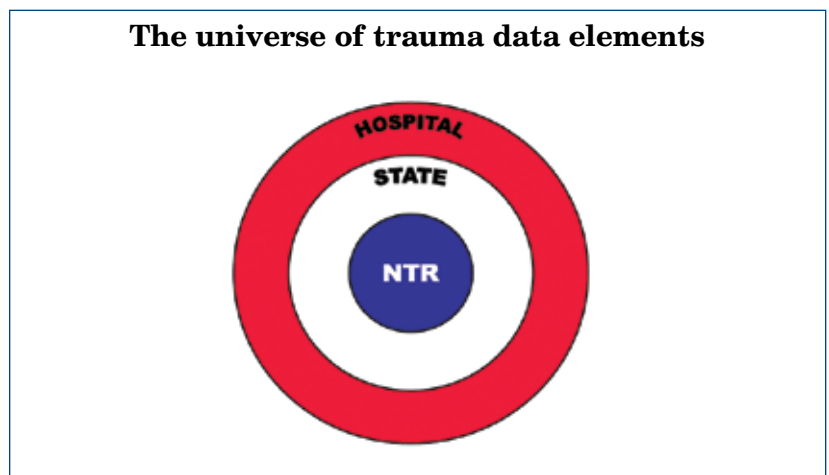

NTDB® data points

Deposit the bull's-eye

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

Each month we have written articles based on the accumulation of records in the National Trauma Data Bank®. We would like to stress the word “bank.” The NTDB acts like a bank and houses data deposited by trauma centers and states. These data are available to be loaned out to researchers for scientific study. In addition, the individual depositing trauma centers are able to get a statement from the bank—the NTDB—benchmarking their data.

For almost two and one-half years, several interest groups, along with the Committee on Trauma with funding from the U.S. Health Resources and Services Administration, have collaborated on the National Trauma Registry Standardization Project. These stakeholders set out to devise a uniform set of trauma registry variables along with specific definitions. Before this monumental undertaking, there had been no standardized data set used in the various registries around the country. Many trauma registries started out as home-grown projects, and over the years, several vendors have offered commercial products. However, these programs too suffered from a lack of uniform inclusion criteria, different sets of variables, definitions, and software field specifica-



tions. Likened this challenge to mixing currency from several different countries in one bank vault. In order to aggregate these data, conversion programs and data cleaning are required to make use of only a portion of the data elements found in those various registry products.

This project has yielded a standardized set of trauma registry inclusion criteria along with standardized data elements and definitions. There is consensus among the software developers that provide trauma registries to approximately 90 percent of the market to include these exact data elements and definitions in their software products. In

doing so, future data that will be deposited in “the bank” will be uniform in consistency and definition.

The National Trauma Registry (NTR) is a core set of data elements for aggregation at a national level. Looking at the universe of trauma center data elements, it is similar to a bull's-eye. It is this central blue core that will be deposited by trauma centers and states into the NTDB (see figure on this page). As we move outward from the center, the next ring represents a larger set of data elements that contain additional information useful for aggregation at a state or regional level. The outermost ring houses the largest

number of data elements. These expanded data elements, which are typically found in a trauma center registry, allow for performance improvement activities and local assessment of trauma care delivery at the institutional level.

To learn more about the National Trauma Registry Standardization Project, there are Web casts and a downloadable final version of the data dictionary. These are available along with the full *2005 National Trauma Data Bank Report, Ver-*

sion 5.0 on the ACS Web site at <http://www.ntdb.org>.

If you are interested in submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

A look at the Joint Commission

Periodic performance reviews

Surgeons play an important role in a new requirement from the Joint Commission: the periodic performance review, or PPR.

Under the PPR, health care organizations self-evaluate their standards compliance once a year and implement improvements based on their findings. The Joint Commission designed the PPR to help organizations maintain continuous standards compliance, so there are no penalties when an organization identifies areas for improvement and addresses them.

The Joint Commission encourages surgeons to participate in their organization's PPR. Many organizations use the tracer methodology to conduct their evaluation, providing a good opportunity for surgeons to get involved. This includes helping to assess compliance with standards addressing informed consent; in-

forming patients of unexpected outcomes; monitoring patients during and after operative procedures, sedation, and anesthesia; implementation of infection control strategies; collection of data to monitor performance; documenting operative procedures and the use of moderate or deep sedation or anesthesia in the medical record; the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™; procurement and donation of organs and other tissues; and clinical practice guidelines. Surgeons may and should assist in the development of plans of action and measures of success for noncompliant standards.

After their organization completes its PPR and submits a plan of action (if necessary) to the Joint Commission, it has the option of participating in a conference call with Joint Commission standards

experts to reach final agreement on corrective actions and discuss standards issues. The Joint Commission encourages as many staff at the organization as possible to be listeners on the conference call, and this includes surgeons. It really is a great learning experience.

The next time surveyors come on-site, they will evaluate if improvements were sustained and effective.

The PPR requirement also applies to the Joint Commission's Ambulatory Care and Office-Based Surgery Accreditation programs.

Each month, this column will focus on activities of the Joint Commission that are relevant to surgeons. For more information on the Joint Commission, and to sign up for Joint Commission e-mail newsletters and announcements, visit www.jcaho.org.