**Sec. 19a-177-7. Data collection**

(a) **Trauma registry**

(1) The trauma registry shall include data:

(A) on all admitted trauma patients and all traumatic brain injury patients;

(B) on all trauma patients who died in the field, in the Emergency Department and in the hospital; and,

(C) on all trauma patients and all traumatic brain injury patients who are transferred.

(2) Beginning October 1, 1995, for all nonscheduled transports of trauma patients and all traumatic brain injury patients each emergency medical service provider shall provide, on forms approved by the commissioner, to the receiving hospital prior to departing from the hospital, the following data. The forms shall become a part of the patient's medical record at the receiving hospital, and shall include but not necessarily be limited to:

(A) ambulance service identification number;

(B) ambulance run number;

(C) patient's name;

(D) patient's gender and ethnicity;

(E) patient's date of birth;

(F) injury date and time of onset of injury or medical problem;

(G) town and zip code location of site of EMS response;

(H) time of dispatch of first responder;

(I) time of arrival of first responder at scene of the injury/incident;

(J) time of dispatch of ambulance;

(K) time of arrival of ambulance at scene of the injury/incident;

(L) time of departure from scene of the injury/incident;

(M) time of arrival at hospital;

(N) transport interventions;

(O) Glasgow eye opening at scene of the injury/incident;

(P) Glasgow verbal at scene of the injury/incident;

(Q) Glasgow motor response at scene of the injury/incident;

(R) systolic blood pressure at scene of the injury/incident;

(S) respiratory rate at scene of the injury/incident;

(T) date of transport;

(U) work related injury/medical problem;

(V) extrication time if motor vehicle accident;

(W) place where injury occurred;

(X) type and use of protective equipment; and

(Y) mechanism of injury.

(3) Beginning October 1, 1995, each licensed Connecticut acute care hospital shall provide, on forms approved by the commissioner, to the trauma registry the following data:

(A) for all trauma patients and all traumatic brain injury patients admitted to the hospital, transferred to another hospital, or discharged dead:

(1) data elements defined in subdivision (2) of this subsection;

(2) patient's health insurance identification number;

(3) patient's zip code of residence;

(4) emergency department admission and discharge Glasgow eye opening;
(5) emergency department admission and discharge Glasgow verbal response;
(6) emergency department admission and discharge Glasgow motor response;
(7) emergency department admission and discharge systolic blood pressure;
(8) emergency department admission and discharge respiratory rate;
(9) patient's social security number;
(10) referring hospital identification number;
(11) emergency department record number (if different than inpatient record number);
(12) mode of arrival at the emergency department;
(13) trauma team alerted, yes or no;
(14) times of notification and arrival of neurosurgeon;
(15) times of notification and arrival of trauma surgeon;
(16) emergency department interventions;
(17) date and time of discharge from emergency department;
(18) disposition from emergency department;
(19) receiving facility post discharge;
(20) documentation of hourly Glasgow coma score and vital signs; and
(21) medical examiner's case number.
(B) for all trauma patients and all traumatic brain injury patients admitted as inpatients:
(1) inpatient medical record number;
(2) first head CT scan date and time;
(3) first neurosurgery date and time,
(4) first orthopedic surgery date and time;
(5) first thoracic/abdominal surgery date and time;
(6) unanticipated return to the operating room within forty-eight (48) hours;
(7) discharge expression;
(8) discharge locomotion;
(9) discharge self feeding;
(10) medical examiner's case number;
(11) E-codes;
(12) hospital identification code;
(13) anatomic diagnoses;
(14) diagnoses onset;
(15) ICD codes for traumatic brain injury patients;
(16) charges by cost center;
(17) attending physician;
(18) operating physician;
(19) principle diagnosis as defined by ICD-9-CM codes;
(20) secondary diagnoses as defined by ICD-9-CM codes;
(21) principle procedure as defined by ICD-9-CM codes and date;
(22) secondary procedures as defined ICD-9-CM codes and dates of procedures;
(23) inpatient disposition;
(24) expected principle source of payment;
(25) psychiatric or rehabilitation unit discharge;

(26) race;
(27) discharge time;
(28) discharge date;
(29) total charges;
(30) admission date;
(31) admission time;
(32) days in ICU;
(33) days in CCU; and
(34) payor source.

(4) Beginning October 1,1995, for all trauma patients and all traumatic brain injury patients who are immediate transfers from an acute care facility to a rehabilitation service, each provider of rehabilitation services shall provide, on forms approved by the commissioner, to the trauma registry the following data:

(A) admission date;
(B) referring facility;
(C) patient's date of birth;
(D) patient's gender;
(E) patient's zip code;
(F) total charges;
(G) functional independence measures on admission and discharge,
(ii) eating,
(ii) grooming,
(iii) bathing,
(iv) dressing,
(v) toileting,
(vi) bladder management,
(vii) mobility,
(viii) locomotion,
(ix) communication,
(x) social cognition, and
(xi) total function independence measure;
(H) patient's health insurance claim number and social security number;
(I) discharge date;
(J) disposition from rehabilitation;
(K) discharge expression;
(L) discharge locomotion;
(M) discharge self feeding; and
(N) hospital identification code.

(5) Beginning October 1, 1995, for all deaths that occur as a result of injury outside a hospital, the trauma registry shall obtain from the state medical examiner the data specified in this subsection:

(A) date of injury/incident;
(B) time of injury/incident;
(C) location of injury/incident;

(D) type of injury/incident;
(E) victim's date of birth;
(F) victim's gender;
(G) name of pre-hospital provider service, if applicable;
(H) results of the autopsy, if performed;
(I) cause of death;
(J) death date;
(K) place of death;
(L) victim's race;
(M) victim's residence address;
(N) victim's residence zip code; and
(O) victim's social security number.

(6) All data required by subdivisions (2), (3), (4), and (5) of this subsection shall be submitted by the following schedule:
(A) first quarter due June 30;
(B) second quarter due September 30;
(C) third quarter due December 30; and
(D) fourth quarter due March 30.

(7) The trauma registry shall maintain, process, and analyze such data as are needed to provide to the commissioner the following summary data reports within ninety (90) days after the data are due for each quarter:
(A) EMS provider response time by region;
(B) EMS provider response time for Connecticut;
(C) mechanism of injury by region;
(D) type of injury by region;
(E) type of injury, severity and categorization level of triage hospital (Level I, II, III, and IV as designated by the OEMS);
(F) safety device use frequency by type of device;
(G) type, severity, and mechanism of injury by town of injury occurrence;
(H) number of deaths taken directly to the morgue; and
(I) other special studies at an aggregate level at the request of the commissioner that shall facilitate the department's ability to follow a patient through the statewide trauma system.

(b) If the patient is further transported from one acute care hospital to another acute care hospital, a copy of the completed patient care form shall be provided by the sending hospital to the emergency medical service transport personnel and provided to the receiving hospital.

(c) The information contained in the trauma registry shall be made available only to those who have been approved for use of the information by the commissioner pursuant to section 19a-6e of the Connecticut General Statutes and in accordance with sections 19a-25-1 through 19a-25-4, inclusive, of the Regulations of Connecticut State Agencies.

(d) Summary data will be available for public inspection and distribution. However, data containing patient specific information and provider and facility identification shall not be available and shall be kept confidential pursuant to sections 19a-25, 19a-6e and 1-210 of the Connecticut General Statutes.

(e) Each emergency medical service provider shall supply an annual report to the commissioner on all transports. Annual reports for the year ending June 30 shall be due by September 30 each year. Reports shall include:

(1) number of transports per emergency medical service provider;

(2) number of prior arranged transports;

(3) number of transports not arranged prior to the call that results in dispatch;

(4) number of paramedic intercepts; and

(5) number of helicopter assists.

(f) Ownership of data. All raw data collected and maintained by the department or pursuant to a contract with the commissioner shall remain the property of the department. All raw data collected and maintained by a contractor independent of a contract with the commissioner shall remain the property of the contractor.

(Adopted effective March 22, 1995; Amended September 6, 2005)