ACS COT Firearm Injury Prevention Study

Informational Webinar Q&A

September 21, 2020

Q: Does this involve getting a police report? We don't typically get this information, as it is pending investigation when we're seeing the patients.

A: No, we are not expecting you to look at police reports. There certainly are elements of the circumstances that are communicated up front, although they might not be validated at the time from the criminal justice system. For instance, there may be social workers or providers present when doing the intake of the patient, during the H&P, who know certain circumstances about what had happened at the scene when the patient was picked up and therefore some of that is included in the patient's medical record.

Q: How will we find risk factors pertaining to the patient's personal history such as incarcerations prior to our care?

A: This is something that is often overlooked in the medical records, and frequently it is documented in the prior problems list and in the social history. There will be occasions where we are caring for patients and do not know whether they have been previously incarcerated, and that is okay. There are going to be some strategies that we will talk about during the data collection process to perhaps capture some of these data elements a little better, however, we do not expect that all of them will be available or in the medical record.

Q: What will be the opportunities for authorship on manuscripts?

A: For the large study that comes out of the aggregate data, the lead at the participating centers will be listed not as an *author*, but rather as a *collaborator.* The National Library of Medicine includes *collaborators* in PubMed and is searchable by your name. If there is interest in developing your own studies out of the data, the de-identified data set will be available to participants. You would treat authorship as you would for your own works. There will also be the opportunity to write manuscripts off your own local data that, heretofore, you didn't even have access to. Since this data isn't typically available to you, this would create additional opportunities for research that is coming directly out of your center.

Q: We are working toward a community violence prevention/gun violence prevention program. How will you distinguish how such changes in individual participating center's practice or program efforts might have an impact on the study results?

A: It might be possible for us, at the end of the day, to compare the incidence of non-fatal firearm violence in cities where there are such hospital-based violence intervention programs to hospitals where there are no such programs. We could take that into consideration with some of the subsequent analysis.

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Q: Is there a feature to convert the 5-digit zip code to 9 digits?

A: In our data currently, the way the definition is set up and our technical standard is implemented, you can already submit 9-digit zip codes to us, as many people already do. So it depends on how one's registry products work and whether or not that is something that is already integrated. In general, if you have the specific address, getting a 9-digit zip code is simple to obtain beyond the regular 5-digit zip code.

Q: Who is the senior leadership who must agree to our participation?

A: Your participation in this study will be reviewed with your trauma medical director who acknowledges that you have the resources and supports the additional data that needs to be collected.

Q: If the patient is in custody at the time of D/C, are they excluded from the study?

A: No. They are not. They would be imported and utilized just like any other patient in the National Trauma Data Standard (NTDS).

Q: What exactly does manual data entry mean? For the 21-30 data elements, are they going to be put into the registry manually or an additional form manually?

A: For the additional 21-30 data elements we're collecting through this study module, we don't have any features in place to pull the data automatically from the EMR or EHR or your registry. For the data elements that we're defining additionally for this project, you will need to enter them into our form directly from whatever other information you have access to.

Q: When participating in grant-funded, multi-center studies in the past, there has been reimbursement to centers for participation. Is that the case for this study?

A: Unfortunately, the budget does not provide sufficient funds to be able to support centers' data collection on a per patient basis. The benefits would be limited to better understanding what your injury prevention opportunities might be with respect to firearm injury, having this data set so you can create your own publications related to your own patient population, and ones otherwise stated. We would like to be able to support this with dedicated funding, but the budget isn't large enough to do that.

By having that information on non-fatal firearm injuries in your region (not only at your center), you will be able to better calculate what the case fatality rates are for firearm injuries. We can get the deaths from the medical examiners, but we have not had this level of non-fatal injury data before for an entire region.

Once you have that data, there is a real opportunity to organize either statewide or within a region of a state and get all the trauma centers to collaborate. The data mentioned is not only important, but there is other data that could be utilized to look at, for instance, how does firearm ownership correspond now with this new data? It presents this rich opportunity to better understand how these injuries and deaths impact your population.

Q: Is there any estimate on the amount of time needed to add the 21-30 additional fields to data abstraction?

A: It's going to be very dependent upon the existing infrastructure at your trauma center. For some centers, these data elements may already be part of your process or are something you know and have easy access to. For other centers, it might require some additional digging. It will be something you will have to review with your team when we provide the dictionary to decide how much effort you're going to need to collect these additional data elements.

Dr. Hink noted her experience: During the pilot study at Harborview when I was trying to answer these questions to inform the practicality of this effort, I was pleasantly surprised. I'm not a registrar, so there was a learning curve. I was not collecting outside data, rather I started from fresh by entering each medical record trying to find this information. I kept track of the following: (1) Where I was finding this information the most; to help inform where we recommend you look; (2) How long it took me to find this information. It varied based on the patient scenario, but it typically took ~20 minutes per patient, after I got a few under my belt and really understood where most of this data was. Part of this is going to be institutionally dependent on who is documenting and where things are documented. I was surprised that once I got the hang of it, that it was not as tedious as I originally thought, which I think informs the practicality of this, and the ability to provide meaningful data without being overly laborious.

Q: When will the study documents (protocol, central IRB's approval certificate/letter, etc.) be available for our facility IRB to review?

A: We are in the final stages of finalizing the contract and related documents. We will be updating two areas on our website: the ACS injury prevention website and the TQP Participation Hub will have study related documents, link to the webinar recording, and link to confirm participation in the study. We will keep you updated on that progress.

Q: For patients in which all known data elements are unknown (e.g. circumstances of injury), are these patients thrown out or is the information left blank?

A: Even if you do not know some data from the study, that is okay. We still want to get as much data as we can. We will manage missing data during our analysis, but we would not want you to exclude a record just because one or two of these data elements are missing at the start.

During the Harborview pilot study mentioned above, which was retrospective, data was collected with the regular care of patients without the intent necessarily of this study. It was still found that 75% of the time, these data elements were available. We want to get everything we can. Just because some of those elements are missing, we don't want those patients to be excluded. We want all patients that have gunshot wounds, regardless.

Q: Will we be able to review the data dictionary for the study prior to the November 16th deadline to participate?

A: We will make the data dictionary available for you to review before you commit to participating. We are 99% done as of 9/21/20 and are just cleaning it up before we post it, hopefully early next week.

Q: Will data be collected for accidental/ vs. certification (i.e. CCW) to cover firearm safety education component?

A: We will not be collecting or assessing CCW data (formal training with firearms) but that could certainly be an investigation that centers can do with their own data for further study.

Q: What is the acceptable "lag time" for data entry? Resource wise, it would be easier for us to "batch" our entries.

A: The platform allows for data entry whenever you are ready to begin, however you are welcome to wait and submit data in batches if that works better for your team. The data submitted as part of this study should not be submitted later than when the NTDS data are otherwise submitted to TQP.