**Core Indicators for Public Health in Ontario – Injury and Substance Misuse Subgroup**

**Minutes**

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| **Date:** | Monday, October 1st, 2012 |
| **Location:** | Teleconference |
| **Attendees:** | Christina Bradley, Badal Dhar, Suzanne Fegan, Natalie Greenidge, Jeremy Herring, Sean Marshall, Jayne Morrish, Lee-Ann Nalezyty, |
| **Regrets:** | Brenda Guarda, Michelle Policarpio Narhari Timilshina |
| **Chair:** | Suzanne Fegan |
| **Recorder:** | Natalie Greenidge |

**Minutes**

|  | **Item** | **Actions** |
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| **1.0** | **Welcome** |  |
| **2.0** | **Review of Agenda** |  |
| **3.0** | **Review of Minutes:**  **June 7th, 2012** |  |
| **4.0** | **New Business** |  |
| 4.1 | External Review | Reviewer feedback was discussed and the following actions proposed: |
| 4.1.1 | Injury-related mortality | Review of indicator pending. |
| 4.1.2 | Injury-related hospitalization | **Action 1: Suzanne** will clarify the analysis checklist bullet point: “If using the Ambulatory All Visits Main Table, the filter "AM Case Type = EMG" must be used to extract only unscheduled ED visits and disposition status = 6 **or** 7[KR6]…”  Two reviewers noted that it may be difficult to determine if overexertion is related to sport & rec activity or something else (e.g. snow shoveling). Overexertion is separate from Sport and Recreation in the ICD-10 coding document at the present. Sport and Recreation and Overexertion will be left as optional categories in the ICD-10 coding document.  **Action 2: Natalie** will add ‘sport and recreation’ injuries to specific indicators, and a footnote (as found in ICD-10 document) explaining why it’s not a main indicator.  **Action 3: Natalie** will add NACRS as Alternative Data Source.  **Action4: Suzanne** will provide Natalie with IntelliHEALTH comment to be added re: appropriate filter to use if selecting NACRS.  It was noted that “Intentional self-harm hospitalization”, but not the other hospitalization indicators, includes an explanation of why NACRS was chosen over DAD.  **Action 5: Natalie** will gather relevant indicator comments, including comment related to OMHRS, and place them under a subheading (e.g., NACRS vs. DAD) in the indicator comments section.  **Action 6: Natalie** will remove “deaths” and replace with “codes” or “hospitalization”/”ED visit” in the sentence “The grouping of unintentional injury deaths excludes codes for "misadventures to patients during surgical and medical care" (Y40-Y84)” and ensure consistency across the ED visits, hospitalization, mortality indicators. |
| 4.1.3 | Injury-related ED visits | **Action 7: Natalie** will amend the analysis checklist bullet point to read ““Add in a filter on ‘ICD10-CA Problem Code (3char) ONLY All Dx' to filter not equal to for 'Y87', 'Y88' and 'Y89', as these codes are not part of unintentional injuries. (Please note there are no decimal places for ICD-10-CA codes in IntelliHEALTH, i.e., Y87.0 is Y870)”  **Action 8: Natalie** will remove CCHS as an alternative data source, as recommended by reviewers.  **Action 9: Natalie** has put in a standardized placeholder in IntelliHEALTH section (in this and all applicable indicators) as advised. |
| 4.1.4 | Fall-related mortality | Reviewers expressed confusion about classification of falls codes (e.g., exclusion of falls from a ladder scaffolding/ladder from falls from one level to another). Suzanne stated that the Ottawa Injury report was used as a guide.  **Action 10: Suzanne** will examine the codes used in the KFL&A and Ottawa injury reports and report to the group on discrepancies in codes.    One reviewer inquired about the difference between ICD-10 codes and leading cause of death. Suzanne stated that the latter considers at everything, not only falls. Lee-Ann stated that in her PHU, place of occurrence is often unspecified.  **Action 11: Suzanne** will draft an indicator comment about quality of place of occurrence data.  At present, the analysis checklist includes the following: “To capture falls-related mortality, filter on ‘ICD10 Block All Dx'= W00-W19”. One reviewer noted that the variable named ‘ICD10 Block All Dx’ does not exist in the Death data source and wondered if it is it supposed to be the variable named ‘ICD1-Code (3 char) Primary Cause’.  **Action 12: Suzanne** will re-write the filter.  A reviewer found an analysis checklist bullet point about ICD9 and ICD10 codes to be unclear. The group was unsure about the origin of the bullet point.  **Acton 13: Suzanne** will attempt to clarify with JoAnn Heale.  **Action 14: Natalie** will make the following additions (in bold) to the analysis checklist:   * Use Deaths data source from the Vital Statistics folder in IntelliHEALTH, select # **Dths (ON res)** measure (number of deaths for Ontario residents who died in Ontario). Note: deaths for Ontario residents who died outside the province are not captured in Vital Statistics. * Select appropriate geography from Deceased Information folder (public health unit or LHIN). Include other items, depending on your requirements (ICD-10-CA Chapter, Lead Cause Group, age group, **year**, sex, etc.). |
| 4.1.5 | Fall-related hospitalization | A reviewer noted that the phrase: “A patient may be admitted to one hospital and transferred to another. To avoid double counting” is included in the analysis checklist and indicator comments of this indicator.  **Action 15:** **Suzanne** will check the relevance of this point to this indicator and remove it from one or both locations if indicated.  As with “Injury-related hospitalization” above, a reviewer wondered why **OR** is used instead of **AND** below:  “To select clients admitted as inpatients, use the 'Disposition Status' variables = '6' - (i.e., 'Client admitted as inpatient to critical care unit/operating room in reporting facility direct from amb care visit functional center') OR = '7' ('Client admitted as inpatient to other units in reporting facility direct from amb. care visit functional').”  **Action 16: Suzanne** will clarify this analysis checklist bullet point |
| 4.1.6 | Fall-related ED visits | A reviewer noted that the Ontario Trauma Registry (OTR) is a subset of NARCS. Suzanne stated that OTR is different in that she believes it includes injury severity score (ISS) data.  **Action 17: Lee-Ann,** with assistance from **Suzanne** will investigate the source of OTR data  Until the predefined report is available in IntelliHEALTH, the indicator currently contains the following placeholder:  A pre-defined report titled 'Fall-related Emergency Department Visits' can be found in .... (Pre-defined report is under construction, location in IntelliHEALTH TBD)... folder in IntelliHEALTH.)  A reviewer noted that “The report is located in “SAS Folders/Standard Reports/04 Ambulatory Visits” and is called “Fall-related emergency visits – 65+ - patient PHU”. If they want the report for all ages, they can remove the Age 65+ filter”  **Action 17: Suzanne** will check with Joanne re: pre-defined report name/location.  **Action 18: Natalie** will remove CCHS as an alternative data source as recommended by a reviewer.  **Action 19: Suzanne** will examine grouping of ICD-10 codes for falls.  **Action 20:** **Natalie** will change “The IntelliHEALTH User Guides tab contains an ‘An Ambulatory Visits User Guide'” to “An ambulatory care user guide is available within IntelliHEALTH”  **Action 21: Natalie** will create 2 sentences from the following:  “It is important to note that an individual can have more than one external cause diagnosis for each ED visit, unlike with other ICD-10-CA diagnostic codes, no ‘most responsible diagnosis' exists for external cause diagnosis.” It is important to note that an individual can have more than one external cause diagnosis for each ED visit. Unlike other ICD-10-CA diagnostic codes, no ‘most responsible diagnosis' exists for external cause diagnosis.  **Action 22: Natalie** will make the following additions to the analysis checklist point (bolded):  Please note that this source differs from the Ambulatory All Visits Main Table in that **it** **~~only~~** includes **only** unscheduled ED visits.  One reviewer found an analysis checklist point pertaining to ICD9, ICD-10-CA, and V-Y codes to be confusing. Suzanne stated that there is no relationship between V-Y codes and ICD9 and ICD-10 codes and believes the information came from JoAnn Heale. **Action 23:** **Badal** will investigate this checklist point.  The group decided that a disclaimer about forward conversion of ICD9 to ICD10 should be included in the ICD-10 document.  **Action 24:** **Suzanne** will determine if we have already included such a comment in some of the indicators.  One reviewer was unclear about the meaning of the following “Although crosstab tables and summing across distinct counts are now available (with the new IntelliHEALTH), users should be cautious”. The intention of this analysis checklist point was to inform users that totals and sums for distinct counts are now available in IntelliHEALTH.  **Action 24: Suzanne** will modify the bullet point.  **Action 25: Natalie** will remove the following:  “Hospital information (hospital name, PHU or LHIN) can also be selected in the report” and “Note that inpatient data are reported by fiscal year (April 1 - March 31). Any changes in the source data occur on a fiscal year basis (e.g., ICD-10-CA reporting began on April 1, 2002) and will affect reporting by calendar year”.  And replace it with:  Note that inpatient data are reported by fiscal year but calendar year can be selected. OR  Note inpatient data are collected on a fiscal year but you may choose to report on a calendar year  Data reporting changes are made on a fiscal year basis.”  Changes in data recording occur by fiscal year.  **Action 26: Suzanne** will ask JoAnn for the best way to ensure full year of data (fiscal/calendar) are pulled.  **Action 27: Natalie** will list the basic categories for age groups as follows:  <1; 1-4; 5-9; 10-14;15-19; 20-24; 25-44, 45-64; 65-74, 75-84, 85+  OR  <1; 1-4; 5-9; 10-14;15-19; 20-24; 25-44, 45-64; 65+,  One reviewer recommended, for clarity, dividing indicator comments into three sections: 1. general 2. CCHS & 3. NACRS.  **Action 28: Natalie** will add indicator comment subheadings.  **Action 29: Natalie** will remove “However, emergency department visits may occur in which the primary diagnosis is injury, but no external cause describes the circumstances of the accident that caused the injury” from ‘indicator comments’ section.  **Action 30: Suzanne** will examine a comment pertaining to CCHS and rates made by one reviewer  One reviewer noted that the following is unclear:  To best understand mortality or disease trends in a population, it is important to determine crude rates, age-specific rates and age-standardized rates (SRATES) or ratios (SMRs, SIRs).  This is a standard phrase used in many Core Indicators  **Action 31:** **Suzanne** will take this back to CIWG.  **Action 32: Suzanne** will attempt to clarify concerns of one reviewer over the use of “unintentional” injury in the indicator definition.  **Action 33: Natalie** will examine the specific indicator for SMR in other indicators and make them more specific as was done in this case. |
| 4.1.7 | Neurotrauma-related hospitalization | Review of indicator is pending |
| 4.1.8 | Self-reported Injury | Review of indicator is pending |
| 4.1.9 | Illicit Drug Use | A reviewer noted that the links were broken.  **Action 34: Natalie** checked and links are intact. |
| 4.1.10 | Seat Belt Use | One reviewer shared SAS syntax. The group suggested that if the decision is made to include syntax for this indicator, syntax should probably be provided for other relevant indicators (i.e., within Injury and Substance Misuse prevention and beyond) and for various statistical programs (i.e., SPSS, Stata). The group suggested that perhaps the new APHEO discussion board under development may be a better forum for sharing syntax.  **Action 35: Suzanne** will take issue to CIWG.  One reviewer noted that the CCHS Driving and Safety Module was not administered in Ontario in 2007/2008.  **Action 36: Suzanne** will check. |
| 4.1.12. | Car Seat & Booster Seat Safety | One reviewer suggested that response options for variables should be included in the ‘Survey Questions’ table  **Action 37: Natalie** will add response options.  One reviewer suggested, for clarity, including names of variables to be used in the ‘method of calculation’ section.  **Action 38: Suzanne** will add variable names to equations.  **Action 39: Natalie** will check the age range for Booster Seat use (4 – 11 (currently in indicator) vs. 4 – 7 (correct range suggested by reviewer) and amend accordingly.  **Action 40: Suzanne/Natalie:** will add URLs for non-journal ‘other references’ that have been provided. |
| 4.1.13 | Cellphone Use While Driving | **Action 41: Natalie** will check the cellphone use terminology (i.e., every time I use a cell phone while driving”, vs. “Every time I drive”).  **Action 42: Natalie** will remove “In general the simple computation of the C.I. for a proportion assuming SEp = sqrt(pq/n) and CI95% = p +/- 1.96\*SEp is sufficient.” from the RRFSS ‘analysis checklist’ section  **Action 43: Natalie and Suzanne** will address the additional reviewer comments re: method of calculation. |
| 4.1.14 | Suicide Mortality | One reviewer suggested using more recent references, including references pertaining to why suspected self-harm-related deaths in children under 10 years of age cannot be classified suicide. (References are included in the report “Suicide in Waterloo Region <http://chd.region.waterloo.on.ca/en/researchResourcesPublications/resources/Suicide_Status.pdf>). The group recognized that there is some self-harm related injury coding for kids under 10 for ED visits and hospitalization, but numbers are low.  **Action 44: Natalie** will send references from the Waterloo report to Jayne.  **Action 45: Jayne** will attempt to secure these references, as well as approach a colleague for other potentially useful references. |
| 4.1.15 | Suicidal Thoughts & Attempts | One reviewer noted the potential for age-specific bias in self-reported suicidal thoughts and attempts. The group noted that bias is inherent to all self-reported behavior and perhaps a general comment in the data source for CCHS to that effect is required.  **Action 46: ALL** will look for reference(s) to support the ‘age-specific bias in self-reported suicidal thoughts and attempts’ statement.  **Action 47:** **Suzanne** will take the issue of potentially altering the CCHS data source resource to the CIWG.  **Action 48: Natalie** will amend “Corresponding indicators from other sources” section by adding OSDUHS to the CAMH reference. Natalie will remove “(1)” citation.  **Action 49: Natalie** will check the CCHS analysis checklist to ensure it includes all relevant information included in the “Guide to editing and creating Core Indicator pages” document.  **Action 50: Natalie** will clarify the “Basic Categories” – age groups – section:  From: 15-19, 20-24, (15-24), 25-44, 45-64, 65-74, 75+  To: 15-19, 20-24, 25-44, 45-64, 65-74, 75+  OR  15-24, 25-44, 45-64, 65-74, 75+  A reviewer suggested providing full journal names in references instead of abbreviations. Natalie stated she has been using the Vancouver citation method, which uses abbreviations.  **Action 51: Suzanne** will clarify with the CIWG. |
| 4.1.16 | Intentional Self-Harm-Related Hospitalization | **Action 52: Natalie and Suzanne** will go over reviewer comments |
| 4.1.17 | NARCS | **Action 53: Natalie** will incorporate JoAnn Heale’s suggestions into the resources. |
| 4.1.18 | Vital Statistics Mortality | Review of resource is pending. |
| 4.1.19 | ICD-10-Ca coding document | One reviewer wondered why transport codes were excluded from the ICD-10 coding document.  **Action 54: Suzanne** will attempt to clarify with JoAnn Heale |
| 4.1.20 | OSDUHS Data Source | Natalie and Suzanne will go over reviewers’ comments |
| **5.0** | **Next Meeting** | TBA – approximately 2 weeks. |