KENTUCKY TRAUMA DATA BANK
2024 ANNUAL REPORT

AUGUST 2025

Kentucky State Trauma System
Right Patient • Right Care • Right Time

Kentucky Public Health
Prevent. Promote. Protect.

KIPRC
KENTUCKY INJURY PREVENTION AND RESEARCH CENTER

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FOREWORD

The Kentucky Trauma Data Bank (KTDB) was established by state law (KRS 211.490 et seq.; 902 KAR 28:040) to be the statewide repository for trauma data. It is housed administratively in the Kentucky Department for Public Health and managed by the Kentucky Injury Prevention and Research Center (KIPRC), a unit of the University of Kentucky's College of Public Health and a bona fide agent of the Kentucky Department for Public Health. All trauma centers designated by the Commissioner of Public Health in the Kentucky Trauma Care System maintain trauma registries that are compatible with the National Trauma Data Bank standards established in the National Trauma Data Standard Data Dictionary. The same standards apply to trauma centers in the process of applying for designation. The trauma centers upload their trauma data electronically to the KTDB at least quarterly. ESO is the vendor that manages the downloading and compilation of data from participating trauma centers, including unverified facilities that report to the data bank, and supplies the data to the Kentucky Injury Prevention and Research Center.

With support from the National Highway Traffic Safety Administration through the Kentucky Transportation Cabinet, KIPRC analyzes the statewide trauma data bank data and provides a detailed profile of the traumatic injuries treated in the state's trauma facilities.

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Introduction

Kentucky law (Kentucky Revised Statutes [KRS] 311A.010) defines trauma as a single- or multi-system injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability. This report summarizes data reported to the Kentucky Trauma Data Bank (KTDB) as of August 2025 on trauma patients cared for at Kentucky trauma centers, both verified and in applicant status, during calendar year 2024. A list of these facilities appears on page 4.

It is important to note several characteristics of the data reported here:

- Governing state law (KRS 211.490 [6]) protects patient privacy by forbidding the identification of individual trauma patients in Kentucky Trauma Data Bank data. Patients transferred between hospitals have separate records for treatment at each reporting facility that cannot be merged because they lack personal identifiers. Thus, the number of records in the KTDB reflects total episodes of care in reporting facilities and is greater than the number of patients treated. The rest of this report refers to each episode of trauma care as a "case".
- These data represent the most serious injuries—those that meet national inclusion criteria—rather than all traumatic injuries in the state.
- Trauma that results in death at the scene of the injury event is not part of the reported data. Hospital trauma registrars report KTDB data only for patients who reach a hospital.
- If a traumatic injury occurs in Kentucky but the patient is treated in an out-of-state facility, the case is not included in KTDB data. Border areas are thus under-represented in this report.

Definitions (per 902 Kentucky Administrative Regulation [KAR] 28:010):

(18) "Level I trauma center" means a regional trauma center that
  (a) provides total care of every aspect of injury from prevention through rehabilitation and
  (b) meets the requirements established in 902 KAR 28:020.

(19) "Level II trauma center" means a regional trauma center that
  (a) provides screening and initial trauma care of the injured patient regardless of the severity of injury and
  (b) meets the requirements established in 902 KAR 28:020.

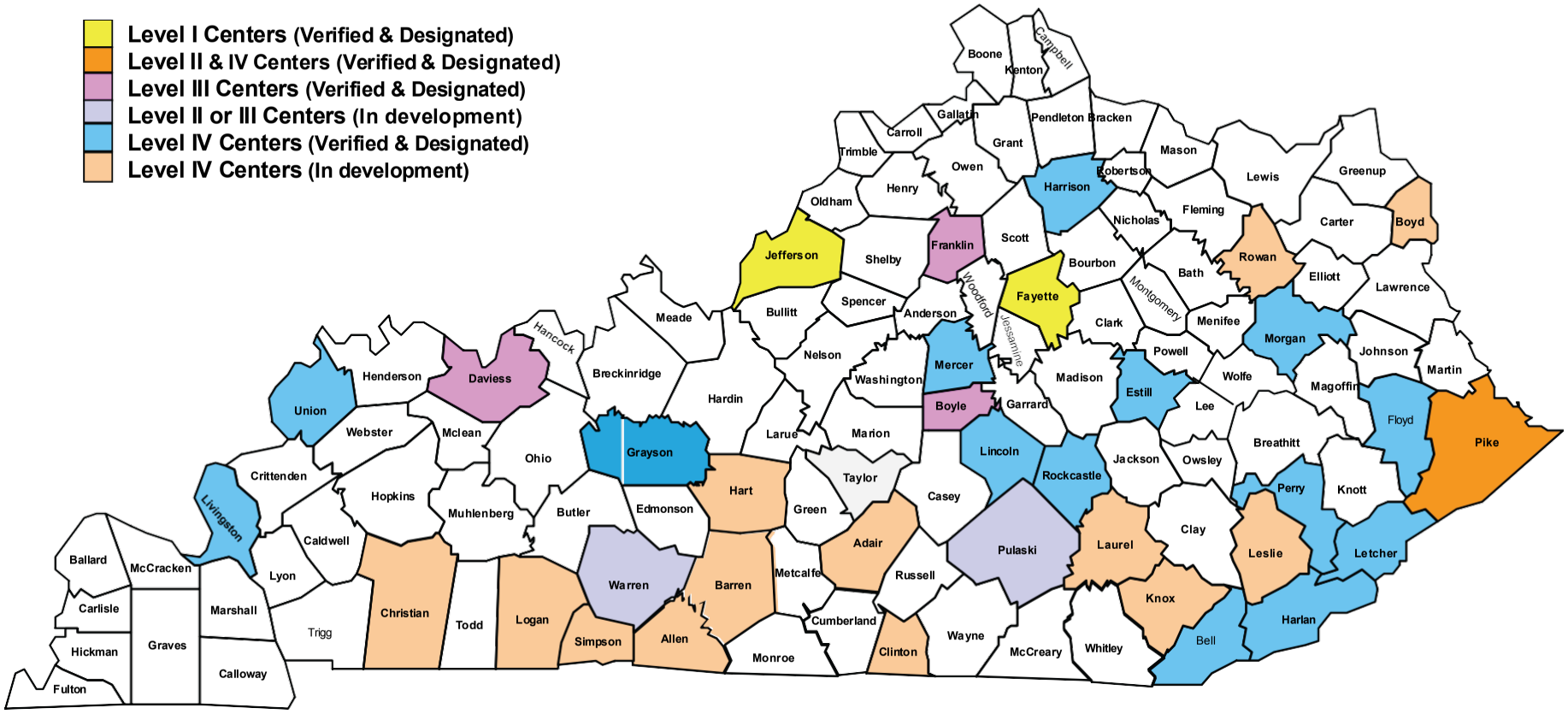
(20) "Level III trauma center" means a regional trauma center that
  (a) provides prompt assessment, resuscitation, emergency operations, and stabilization;
  (b) arranges for transfer to a facility that can provide trauma care at a higher level;
  (c) serves communities that do not have immediate access to a Level I or Level II trauma center; and
  (d) meets the requirements established in 902 KAR 28:020.

(21) “Level IV trauma center” means a regional trauma center that
(a) provides advanced trauma life support before a patient is transferred to a higher level of care;
(b) is located in a hospital emergency department; and
(c) meets the requirements established in 902 KAR 28:030.

Kentucky's reporting trauma centers, 2024

Trauma Center	Designation/Status
Deaconess Union County Hospital (formerly Methodist Hospital Union County)	Level IV
Ephraim McDowell Fort Logan Hospital	Level IV
Ephraim McDowell James B. Haggin Memorial Hospital	Level IV
Ephraim McDowell Regional Medical Center	Level III
Frankfort Regional Medical Center	Level III
Harlan ARH Hospital	Level IV
Harrison Memorial Hospital	Level IV
Hazard ARH Hospital	Level IV
Highlands ARH Regional Medical Center	Level IV
Livingston Hospital	Level IV in progress
McDowell ARH	Level IV in progress
Mercy Health Marcum and Wallace Memorial Hospital	Level IV
Middlesboro ARH Hospital	Level IV
Morgan County ARH Hospital	Level IV
Norton Children's Hospital	Level 1 Pediatric
Owensboro Medical Center	Level III
Pikeville Medical Center	Level II
Rockcastle Regional Hospital	Level IV
CHI St. Joseph London	Level III in progress
The Medical Center at Bowling Green	Level III in progress
Tug Valley ARH (formerly Williamson ARH)	Level IV
University of Kentucky—Children's	Level I Pediatric in progress
University of Kentucky Medical Center	Level I
University of Louisville Hospital	Level I
Whitesburg ARH Hospital	Level IV

Hospitals in the Kentucky Trauma System (November 25, 2024)



Verified Trauma Centers

Level I, Pediatric — Norton Children's Hospital, Louisville
Level I, Pediatric – Kentucky Children's Hospital, Lexington
Level I — UK Chandler Hospital Lexington
Level I — University of Louisville Hospital, Louisville
Level II — Pikeville Medical Center
Level III — Ephraim McDowell Reg. Med. Center, Danville
Level III — Frankfort Reg. Med. Center
Level III — Owensboro Health Regional Hospital
Level IV — Deaconess Union Co. Hospital, Morganfield
Level IV — Ephraim McDowell Fort Logan Hospital, Stanfor
Level IV — Ephraim McDowell Haggin, Harrodsburg
Level IV — Harlan ARH Hospital
Level IV — Harrison Memorial, Cynthiana
Level IV — Hazard ARH Hospital, Hazard
Level IV — Highlands ARH Reg. Med. Center, Prestonsburg
Level IV — Livingston Hospital, Salem
Level IV — Mercy Marcum & Wallace Hospital, Irvine
Level IV — Middlesboro ARH
Level IV — Morgan Co. ARH, West Liberty
Level-IV — Owensboro Health Twin Lakes Reg. Med. Center, Leitchfield
Level IV — Rockcastle Reg. Hospital, Mt. Vernon
Level IV — Tug Valley ARH Reg Med Cntr, S. Williamson
Level-IV — Whitesburg ARH Hospital

KENTUCKY TRAUMA DATA BANK RECORDS 2024

The Kentucky Trauma Data Bank (KTDB) has grown from five reporting facilities in 2008 to 25 in 2024, although some smaller hospitals have left the trauma system in recent years. A total of 16,001 records were reported in 2024 (Table 1), more than double the 2008 total and a slight increase from 2023.

Table 1. Records by reporting trauma center, 2024

Facility	Number	%
Deaconess Union County Hospital	129	0.81
Ephraim McDowell Fort Logan Hospital	45	0.28
Ephraim McDowell J.B. Haggin Memorial Hospital	33	0.21
Ephraim McDowell Regional Medical Center	505	3.16
Frankfort Regional Medical Center	672	4.20
Harlan ARH	197	1.23
Harrison Memorial Hospital	24	0.15
Hazard ARH	400	2.50
Highlands Regional Medical Center	232	1.45
Livingston Hospital	31	0.19
Marcum Wallace Memorial Hospital	34	0.21
Middlesboro ARH Hospital	111	0.69
Morgan County ARH Hospital	30	0.19
Norton Children's Hospital	305	1.91
Owensboro Medical Center	993	6.21
Pikeville Medical Center	1,092	6.82
Rockcastle Regional Hospital	28	0.17
St. Joseph London	87	0.54
The Medical Center at Bowling Green	367	2.29
Tug Valley ARH	131	0.82
Twin Lakes Regional Medical Center	99	0.62
University of Kentucky Children's Hospital	955	5.97
University of Kentucky Medical Center	5,354	33.46
University of Louisville Hospital	3,995	24.97
Whitesburg ARH	152	0.95
Total	16,001	

SEX

Injuries to males comprised nearly 60% of KTDB records (Table 2). Some Kentucky reporting facilities exclude isolated hip fractures, the most common traumatic injury in older adults and a category in which women are overrepresented because of their greater longevity. Thus, KTDB demographics vary significantly from those of the related report on all Kentucky injuries, in which males and females are roughly equally represented (see Kentucky Inpatient and Emergency Department Traumatic Injury Data Reports at https://kiprc.uky.edu/sites/default/files/2025-05/2023-ky-injury-indicators-report.pdf). Designation of sex was missing from 10 records.

Table 2. Records by sex, 2024

Sex	Number	%
Female	6,781	42.38
Male	9,210	57.56
Missing	10	0.06
Total	16,001	100

RACE/ETHNICITY

Most (88.71%) of the records reported treatment for white patients, reflecting Kentucky's largely white population, while about one in 12 (7.83%) were for black patients (Table 3). Information on patient race was missing in 1% of cases; a similar proportion was missing information on ethnicity.

Table 3. Records by race and ethnicity, 2024

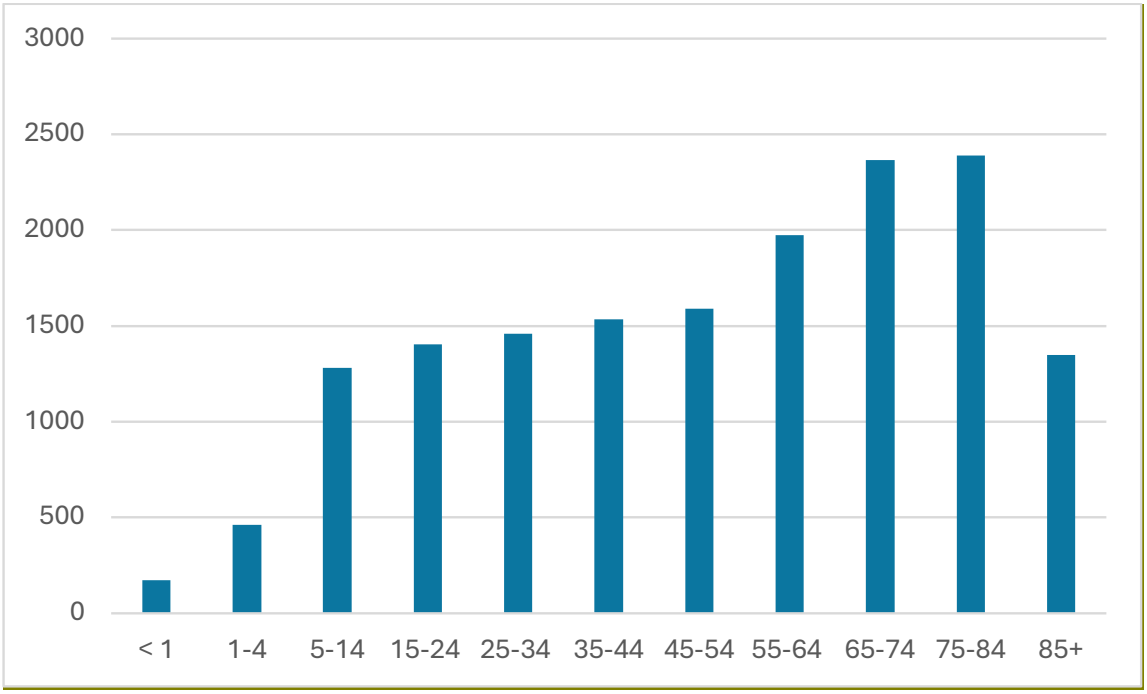
Race	Ethnicity				
	Missing	Hispanic or Latino	Not Hispanic or Latino	Total	%
White	87	185	13,923	14,195	88.71
Black or African American	13	15	1,225	1,253	7.83
Other race	6	173	70	249	1.56
More than one race	0	*	24	27	0.17
Asian	0	*	59	60	0.37
American Indian	*	36	7	44	0.27
Hawaiian/Pacific Islander	0	0	6	6	0.04
Unknown	53	64	50	167	1.04
Total	160	477	15,364	16,001	

*Counts greater than zero but less than five were suppressed in accordance with state data management policy.

AGE

Inclusion criteria influence the distribution of trauma records by age group. The statewide hospitalization data for all types of injury are skewed toward older age groups due to the inclusion of hip fractures, whereas about two-thirds of KTDB records are for adults under 65 years of age (Figure 1).

Figure 1. Records by age group, 2024



PATIENT COUNTY OF RESIDENCE

Table 4 includes the number and proportion of KTDB records for the counties with the highest number of reports. One-fifth (20.04%) of the records were for patients residing in Jefferson or Fayette counties, which is expected as these are the most populous counties in the state. Almost one-tenth (10.77%) of the total KTDB records were for out-of-state patients.

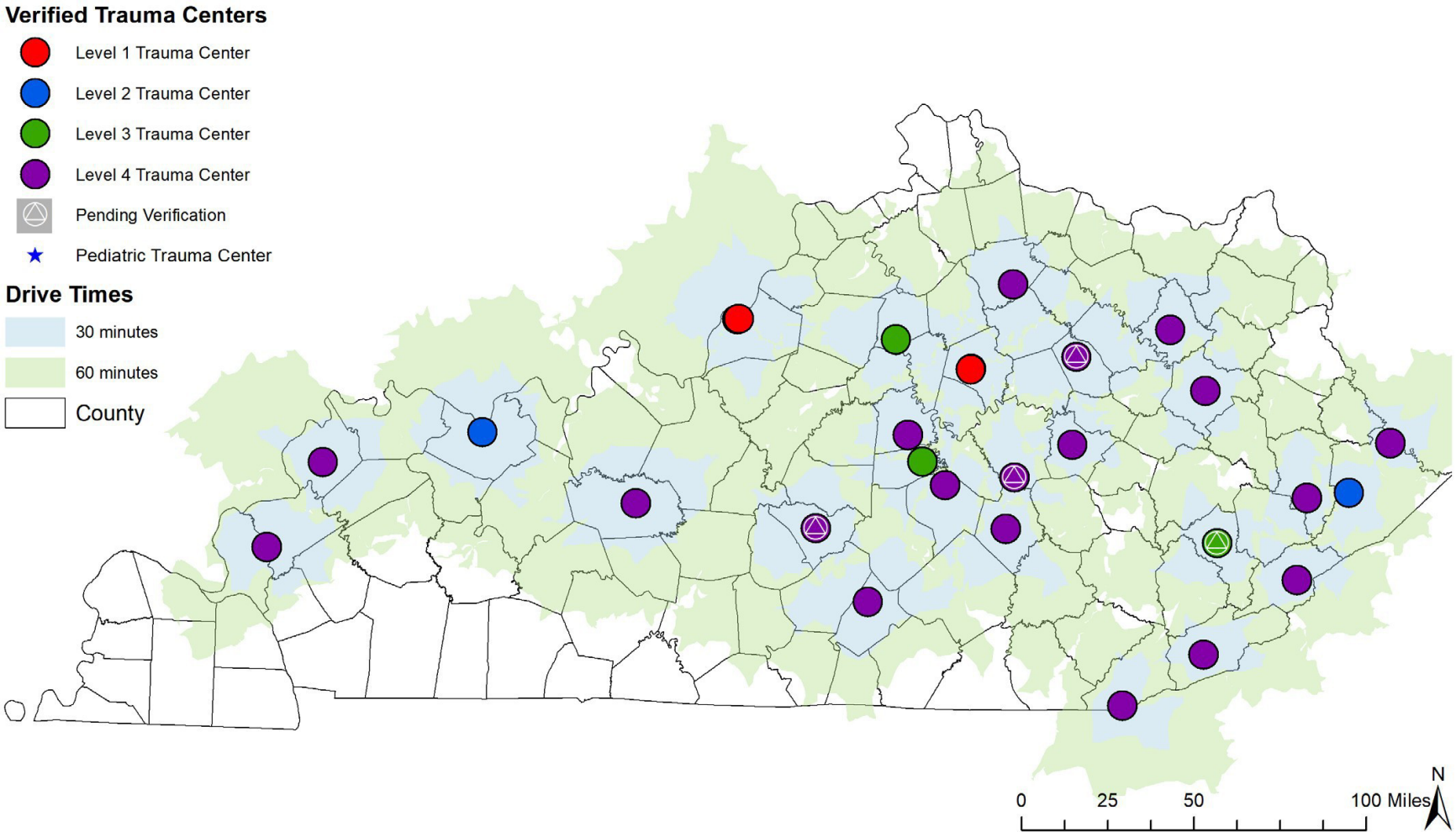
Table 4. Top 10 counties of residence, 2024

Counties	Number	%
Jefferson	2,014	12.59
Fayette	1,192	7.45
Daviess	668	4.17
Franklin	624	3.90
Pike	580	3.62
Madison	407	2.54
Perry	340	2.12
Floyd	320	2.00
Harlan	307	1.92
Boyle	283	1.77
All other Ky. counties combined	7,511	46.94
Out of state	1,723	10.77
Missing	32	0.20
Total	16,001	

A map of travel times to the state's trauma facilities follows.

2024 Trauma Data Bank Facilities for Kentucky with 30- and 60-Minute Drive Time Coverage

KENTUCKY INJURY PREVENTION AND RESEARCH CENTER



WORK-RELATED CASES

Work-related trauma is defined as injury that occurs during paid employment. A total of 479 work-related trauma cases were recorded in the KTDB data set in 2024, a slight increase from cases reported in 2023 (Table 5). Falls were the most common cause of injury.

Table 5. Work-related trauma records by cause of injury, 2024

Cause	Number	%
Fall	187	39.04
Other/Unspecified	98	20.46
Struck by/Against	61	12.73
Machinery	54	11.27
MVT	46	9.60
Cut/Pierce	33	6.89
Total	479	

Table 6 shows the industry associated with the patient's work environment for work-related trauma records. Production industry workers made up the largest single group at nearly one-fourth of all work-related trauma, while construction workers represented another fifth of work-related trauma in the KTDB. However, these numbers are not a complete reflection of the occupational distribution of workplace injuries because over one-fifth of work-related records were missing information regarding occupation.

Table 6. Work-related trauma records by industry, 2024

Occupation	Number
Production Occupations	118
Construction and Extraction Occupations	105
Transportation and Material Moving Occupations	35
Farming, Fishing, and Forestry Occupations	27
Installation, Maintenance, and Repair Occupations	22
Sales and Related Occupations	14
Food Preparation and Serving Occupations	14
Building and Grounds Cleaning and Maintenance Occupations	12
Healthcare Support Occupations	8
Personal Care and Service Occupations	7
Office and Administrative Support Occupations	6
Protective Service Occupations	5
Other	6
Missing	100
Total	479

CAUSE AND INTENT OF INJURY

Codes indicating mechanism and intent were provided for all but 59 of the records in 2024. Unintentional falls (n=7,846) and unintentional motor vehicle traffic collisions (n=3,706) were the leading causes of injuries reported to KTDB (Table 7).

Table 7. Records by cause and intent of injury, 2024

	Intent							
Cause	Unintentional		Intentional		Other/ Undetermined		Total	
	N	%	N	%	N	%	N	%
Fall	7,846	53.44	14	1.16	20	18.18	7,880	49.25
MVT	3,706	25.24	*	0.41	6	5.45	3,717	23.23
Struck by/Against	519	3.53	300	24.83	6	5.45	825	5.16
MV Nontraffic	755	5.14	0	0	0	0	755	4.72
Firearm	136	0.93	453	37.5	45	40.91	634	3.96
Cut/Pierce	293	2	245	20.28	*	3.64	542	3.39
Other Specified, Classifiable	241	1.64	11	0.91	*	2.73	255	1.59
Other Land Transport	183	1.25	0	0	0	0	183	1.14
Machinery	171	1.16	0	0	0	0	171	1.07
Fire/Flame	165	1.12	0	0	0	0	165	1.03
Bite/Sting	137	0.93	0	0	0	0	137	0.86
Pedal Cyclist, Other	134	0.91	0	0	0	0	134	0.84
Child/Adult Abuse	0	0	131	10.84	0	0	131	0.82
Hot Object/Substance	95	0.65	*	0.08	*	0.91	97	0.61
Natural/Environmental	89	0.61	0	0	*	0.91	90	0.56
Overexertion	74	0.5	0	0	0	0	74	0.46
Pedestrian, Other	63	0.43	0	0	0	0	63	0.39
Unspecified	32	0.22	15	1.24	12	10.91	59	0.37
Other Specified	0	0	23	1.9	11	10	34	0.21
Other Transport	16	0.11	0	0	0	0	16	0.1
Foreign Body	16	0.11	0	0	0	0	16	0.1
Suffocation	0	0	10	0.83	0	0	10	0.06
Poisoning	10	0.07	0	0	0	0	10	0.06
Drowning/Submersion	*	0.01	0	0	*	0.91	*	0.02
Total	14,683		1,208		110		16,001	

*Counts greater than zero but less than five were suppressed in accordance with state data management policy.

CAUSE AND INTENT OF INJURY BY AGE GROUP

In 2024, patients aged 15–24 accounted for nearly one-sixth (16.68%) of motor vehicle crash-related trauma, followed by those aged 35–44 (14.84%) and 25-34 (14.37%) (Table 8). This finding is similar to those of previous years. Falls among those 55 and older accounted for nearly three-quarters (73.74%) of all unintentional falls treated in trauma centers. Nearly half (48.74%) of the injuries that are attributed to being unintentionally struck by or against an object were experienced by patients 5–24 years of age. An earlier review of the struck by/against injuries in this age group found that more than half were sports-related. More than 60% of assault injuries were to adolescents and young adults aged 15–44. Self-harm is far less common than assault as a cause of trauma hospitalization in Kentucky because it more frequently leads to death than to survivable injury.

Table 8. Records by age and major cause of injury, 2024

	Intention													
	Unintentional										**Intentional**			
	Other Unintent'l		Falls		Motor Vehicle		Other transport		Struck by/Against		Self-Harm		Assault	
Age Group	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<1	12	0.82	73	0.93	5	0.11	0	0	3	0.58	0	0	76	7.55
1-4	82	5.61	247	3.15	50	1.12	14	3.54	26	5.01	0	0	41	4.07
5-14	162	11.09	553	7.06	349	7.83	69	17.42	113	21.77	6	3.02	24	2.38
15-24	141	9.65	161	2.06	744	16.68	47	11.87	76	14.64	35	17.59	183	18.17
25-34	174	11.91	230	2.94	662	14.84	44	11.11	64	12.33	33	16.58	233	23.14
35-44	227	15.54	308	3.93	641	14.37	49	12.37	62	11.95	52	26.13	175	17.38
45-54	209	14.31	485	6.19	602	13.5	54	13.64	54	10.4	25	12.56	144	14.3
55-64	187	12.8	1,000	12.76	574	12.87	59	14.9	47	9.06	18	9.05	79	7.85
65-74	152	10.4	1,628	20.78	445	9.98	42	10.61	40	7.71	15	7.54	37	3.67
75-84	92	6.3	1,949	24.88	282	6.32	12	3.03	27	5.2	13	6.53	10	0.99
85+	23	1.57	1,200	15.32	106	2.38	6	1.52	7	1.35	2	1.01	5	0.5
Total	1,461	100	7,834	100	4,460	100	396	100	519	100	199	100	1,007	100

*Counts greater than zero but less than five were suppressed in accordance with state data management policy.
Motor vehicle injuries include both traffic and non-traffic injuries.

TRAFFIC COLLISION INVOLVEMENT

Among the 2024 motor vehicle traffic collision records, over three-quarters (76.16%) were coded as vehicle occupants and 14.61% as motorcyclists (Table 9). The rate of traumatic injury among motorcycle riders in Kentucky is unknown because of the large number of unregistered vehicles. Pedestrians and pedal cyclists accounted for 9.04% of traffic-related trauma.

Table 9. Traffic collision involvement, 2024

Role in Motor Vehicle Traffic Collision	Number	%
Motor vehicle occupant	2,831	76.16
Motorcyclist	543	14.61
Pedestrian	265	7.13
Pedal cyclist	71	1.91
Unknown	*	0.08
Other	*	0.11
Total	3,717	100

*Counts greater than zero but less than five were suppressed in accordance with state data management policy.

PROTECTIVE DEVICES

There were 3,717 records for vehicle occupants injured in motor vehicle traffic collisions in 2024. The numbers in the table below reflect some entries where multiple protective devices were noted. Protective devices were not used in nearly one-fifth (17.27%) of reported cases. Kentucky continues to fall well below national norms for use of motor vehicle occupant protective devices, and helmets are not mandated for motorcycle users.

Table 10. Use of occupant protective devices in motor vehicle traffic collisions (MVTCs), 2024

Protective device	Use of protective devices by occupants in MVTC	
	Number	%
Shoulder and lap belt	1,558	55.03
Shoulder belt only	21	0.74
Lap belt only	51	1.80
Child restraint	45	1.59
Airbag	1,771	62.56
No protective device used	489	17.27

Data were missing for 98 (3.46%) cases.
Note: In some records, two or more protective devices were listed; therefore, counts do not add up to the total number of MVTC cases.

TRANSPORTATION MODE

The mode of transportation to trauma facilities and incidence of interfacility transfers are presented in Table 11. The interfacility transfer variable indicates whether the patient was transferred to the reporting facility from another acute care facility. Helicopter ambulances were used in 897 (15.40%) of interfacility transfers and 1,050 (9.43%) of the non-transfer cases in 2024.

Table 11. Transportation mode, 2024

	Interfacility Transfer					
Transport Mode	**Yes**		**No**		**Total**	
	N	%	No	%	N	%
Ground ambulance	3,794	65.12	6,891	68.34	10,321	67.16
Private/Public vehicle/Walk-in	1,115	19.14	2,202	21.84	3,317	20.85
Helicopter ambulance	897	15.40	1,050	9.43	1,848	11.62
Police	14	0.24	40	0.33	47	0.30
Other	*	0.07	6	0.06	10	0.06
Fixed-wing ambulance	*	0.02	0	0.00	*	0.01
Total	5,826		10,083		15,909	

Data were missing for 92 cases.

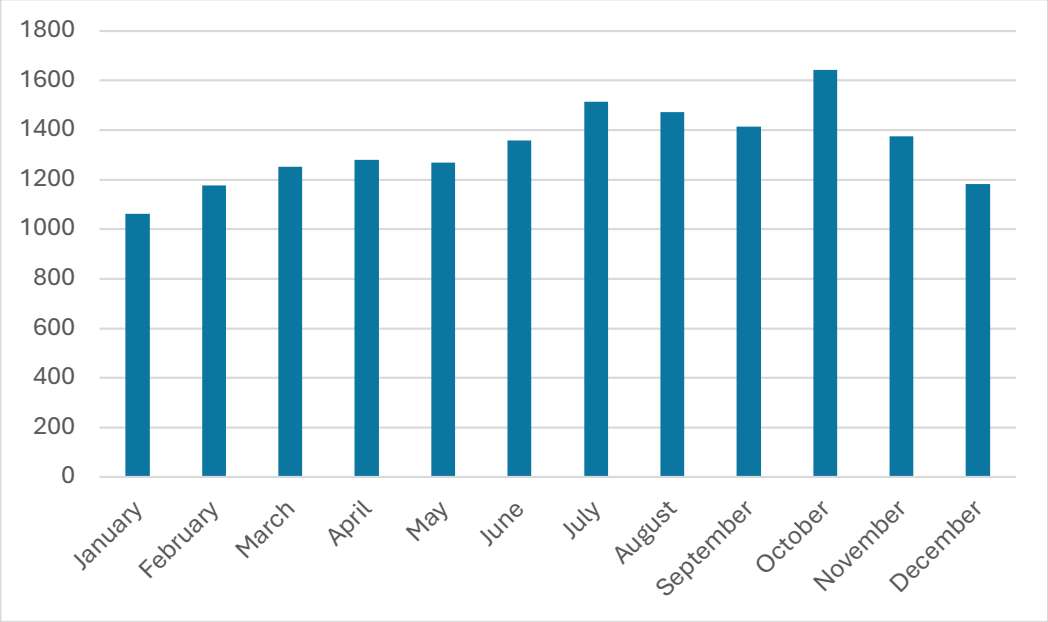
EMS Information

EMS notification, departure, and arrival times are not applicable data elements for patients who arrived at the trauma facility by private vehicle, and they may not be known for patients transferred from another acute care facility. It is reasonable to expect that EMS information will be available for patients who were not interfacility transferees and were transported to the trauma facility by ground ambulance (n=6,891) or air ambulance (n=1,050) (Table 11). Work is ongoing to integrate these data elements with future KTDB reports.

MONTH OF ARRIVAL AT EMERGENCY DEPARTMENT (ED)/HOSPITAL

Trauma volume typically varies by season, with a higher volume during summer months, and this pattern continued with the exception of a peak in October (Figure 2).

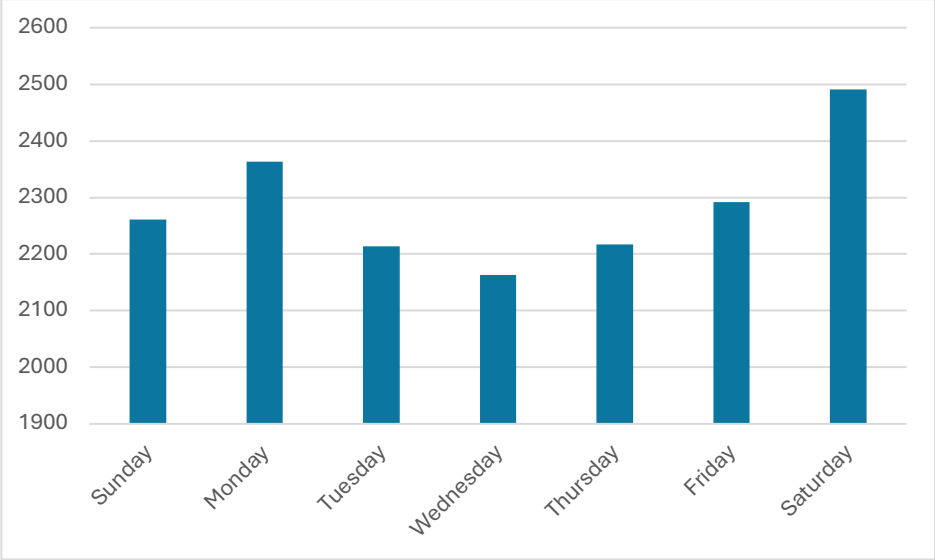
Figure 2. Month of emergency department/hospital arrival, 2024



WEEKDAY OF ARRIVAL TO ED/HOSPITAL

Mondays and Saturdays saw larger volumes of ED trauma cases (Figure 3).

Figure 3: Day of emergency department/hospital arrival, 2024



TIME TO ED/HOSPITAL ARRIVAL

Because patients with traumatic injuries need timely access to definitive care, the length of time between the injury incident and hospital arrival is an important indicator of trauma system quality. The distribution of KTDB records by time from injury to hospital arrival and interfacility transfer status is presented in Table 12. Interfacility transfers are patients who are transferred to the reporting facility from another acute care facility. Due to the lack of personal identifiers in trauma registry data collection, we cannot track specific patients from one facility to another. Further complicating this analysis, the incident time is unknown or missing in over half (55.67%) of cases. This data gap reflects the lack of integration between emergency medical services data and hospital-based data and is the subject of ongoing data linkage initiatives. The absence of time-of-injury indicators hinders efforts to assess the critical metric of timely transportation to definitive care for trauma patients as well as outcome data that may reflect delays in access to definitive care.

Table 12. Time to emergency department/hospital arrival, 2024

	Interfacility Transfer	
Time to Hospital	Yes	No
<1 hour	*	1,595
1-2 hours	34	1,326
2-5 hours	793	526
5-12 hours	1,222	206
12-24 hours	220	183
24+ hours	474	510
Same day (exact incident time unknown)	2,261	5,431
Next day or later (exact incident time unknown)	831	322
Total	5,839	10,100

Information on interfacility transfer is missing for 62 records.

ALCOHOL USE INDICATORS

Of the 4,837 (30.23%) trauma cases tested for blood alcohol in 2024, nearly three-quarters (74.51%) had concentrations of zero, while about one in seven (15.86%) had concentrations over the legal limit of .08%.

Table 13. Alcohol use indicators, 2024

Blood Alcohol Concentration	Count	%
0	3,604	74.51
0.01-0.07	245	5.07
0.08-0.20	457	9.45
0.21-0.30	240	4.96
0.31-0.40	62	1.28
0.41 and above	8	0.17
Missing	221	4.57
Total	4,837	
Not tested	10,899	68.11
Missing	265	1.66

DRUG USE INDICATORS

Illegal use of illicit or prescription drugs was confirmed in 2,854 (17.8%) of 2024 records (Table 14a). However, it is important to note that 70% of cases either were not tested for drug use or did not document whether testing was performed, so the extent of this relationship is unknown. A new table in this report (Table 14b) sets out the types of drugs found on testing. Marijuana and opioids were each found in about one-quarter of those tested.

Table 14a. Drug use indicators, 2024

Drug Use Indicators	Number	%
No (confirmed by test)	1,939	12.10
Yes (confirmed by test)	2,854	17.80
Not documented	10,197	63.70
Missing	1,011	0.06
Total	16,001	

Table 14b. Drug type, 2024

Drug Type	Count	%
Amphetamines	685	15.10
Barbituates	54	1.20
Benzodiazepines	487	10.70
Cocaine	207	4.50
Ecstasy (MDMA)	35	0.80
Marijuana	1,117	24.50
Methamphetamines	181	4.00
Methadone	93	2.00
Opioids	1,115	24.50
Other	210	4.60
Oxycodone	338	7.40
Phencyclidine (PCP)	13	0.30
Tricyclic Antidepressants (TRI)	16	0.40
Total	4,551	

INJURY SEVERITY SCORES

The Injury Severity Score (ISS) is an anatomical rating system that provides numerical values for patients with multiple and varying injuries. The National Trauma Data Bank characterizes ISS scores of 1–9 as mild, 10–15 as moderate, 16–24 as severe, and over 24 as very severe.

Using this metric, more than two-thirds (67.75%) of 2024 trauma registry injuries were mild, 16.19% were moderate, 9.04% were severe, and 6.01% were very severe (Table 15). ISS was missing for one percent of the records.

Table 15. Records by Injury Severity Score, 2024

Injury Severity Score Range	Category	Number	%
1-9	Mild	10,841	67.75
10-15	Moderate	2,591	16.19
16-24	Severe	1,447	9.04
25-75	Very Severe	962	6.01
Missing	Missing	160	0.66
Total		16,001	100.00

Table 16. Discharge type by facility, 2024

	Discharged				
	ED Discharge		Inpatient Discharge		Total
Facility	N	%	N	%	
CHI St. Joseph London	28	0.78	59	0.48	87
Deaconess Union County Hospital	85	2.36	44	0.35	129
Ephraim McDowell Fort Logan Hospital	45	1.25	0	0.00	45
Ephraim McDowell J.B. Haggin Memorial Hospital	33	0.92	0	0.00	33
Ephraim McDowell Regional Medical Center	242	6.72	263	2.12	505
Frankfort Regional Medical Center	285	7.91	387	3.12	672
Harlan ARH	108	3.00	89	0.72	197
Harrison Memorial Hospital	23	0.64	*	0.01	24
Hazard ARH	123	3.42	277	2.23	400
Highlands Regional Medical Center	202	5.61	30	0.24	232
Livingston Hospital	9	0.25	22	0.18	31
Mercy Health Marcum & Wallace Memorial Hospital	34	0.94	0	0.00	34
Middlesboro ARH Hospital	86	2.39	25	0.20	111
Morgan County ARH Hospital	30	0.83	0	0.00	30
Norton Children's Hospital	147	4.08	158	1.27	305
Owensboro Medical Center	102	2.83	891	7.19	993
Pikeville Medical Center	125	3.47	967	7.80	1,092
Rockcastle Regional Hospital	27	0.75	1	0.01	28
The Medical Center at Bowling Green	*	0.08	364	2.94	367
Tug Valley ARH	131	3.64	0	0.00	131
Twin Lakes Regional Medical Center	73	2.03	26	0.21	99
University of Kentucky Children's Hospital	396	11.00	559	4.51	955
University of Kentucky Medical Center	1,043	28.96	4,311	34.77	5,354
University of Louisville Hospital	90	2.50	3,905	31.49	3,995
Whitesburg ARH	131	3.64	21	0.17	152
Total	3,573		12,400		15,914

*Counts greater than zero but less than five were suppressed in accordance with state data management policy.
87 cases were missing discharge information. McDowell ARH reported no trauma cases for 2024.

EMERGENCY DEPARTMENT DISCHARGES

More than three-quarters (77.22%) of ED records indicated discharge from the ED to a bed or operating room in the same hospital, while 10.73% were transferred to another hospital (Table 17). Deaths are recorded for 152 (0.96%) of ED patients.

Table 17. Emergency department discharge disposition, 2024

ED Discharge Disposition	Count	%
Floor bed (general admission, non-specialty unit bed)	6,278	39.63
Left against medical advice	25	0.16
Transferred to another hospital	1,700	10.73
Observation unit (unit that provides <24 hour stays)	72	0.45
Telemetry/step-down unit (less acuity than ICU)	1,202	7.59
Home with services	9	0.06
Died	152	0.96
Other (jail, institutional care, mental health, etc,)	*	0.02
Operating room	2,503	15.80
Intensive care unit (ICU)	2,177	13.74
Home without services	1,720	10.86
Total	15,841	

160 cases were missing information on emergency department discharge disposition.

INPATIENT HOSPITAL DISCHARGES

More than half (58.69%) of 2024 trauma registry records on patients discharged from inpatient care indicated that the patient was well enough to go home without formal home health services, but about one-third (32.87%) required some kind of post-acute care (Table 18). In-hospital deaths were recorded for 452 (3.65%) patients.

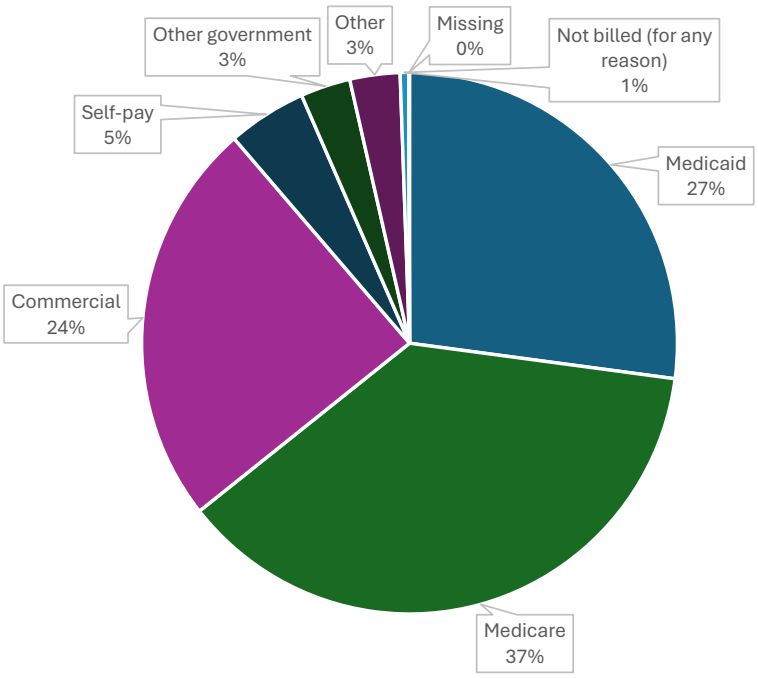
Table 18. Inpatient hospital discharge destination, 2024

Discharge Destination	Count	%
Home with self-care	7,277	58.69
Home health	608	4.90
Inpatient rehab	1,597	12.88
Skilled nursing facility/ICF	1,706	13.76
Died	452	3.65
Law enforcement	89	0.72
Another acute care hospital	78	0.63
Psychiatric hospital	102	0.82
Hospice	55	0.44
Other	8	0.06
Left against medical advice	168	1.35
Total	12,400	

FINANCIAL INFORMATION

Among the encounters listing expected payer in 2024, Medicare (37.25%) was the leader, followed by Medicaid (27.10%) and commercial insurance (24.29%) (Figure 5). The proportion of "self-pay" (i.e., uninsured) patients in 2024, 4.76%, continues to reflect the impact of Medicaid expansion. The "self-pay" category was in the 40% range before 2014, when Medicaid coverage became available to new categories and income levels of Kentuckians. This decline is important because "self-pay" patients are rarely able to pay for their trauma care, and the federal funding that has historically provided some offset to uncompensated care has declined substantially. The expected source of payment was missing for 90 (0.56%) records.

Figure 5. Primary source of payment, 2024



CONCLUSION

As the proportion of Kentucky hospitals reporting to the Kentucky Trauma Data Bank grows, the data bank will become more representative of major trauma in the state as a whole. In a voluntary system like Kentucky's, growth is inevitably slow. The state Trauma Advisory Committee leadership continues to work closely with candidate facilities as they progress toward state or national verification and designation.

Funding from the National Highway Traffic Safety Administration, made available through a grant from the Kentucky Office of Highway Safety, supports software or portal activation costs for a facility's first year in the KTDB as well as the compilation of this report and other initiatives. We look forward to increasing the value of KTDB data for systemwide and facility-specific quality improvement initiatives through collaboration with investigators at the state's research universities and the Transportation Cabinet.

The progress made by Kentucky's trauma system is particularly noteworthy because during the time covered by this report the system had no state funding. The system itself would not have existed without the professionalism and dedication of clinical and support staff. The sustainability of statewide trauma care on this tenuous basis is a constant concern that has been brought before state policymakers repeatedly. The value added by the state's trauma system—saving lives and avoiding catastrophic trauma-related disability—must be recognized and given proportionate support if the state trauma system is to continue its record of growth and effectiveness.

Acknowledgments

In addition to the invaluable support from Trauma Advisory Committee leadership and our grant funders, KTDB facilities' trauma registrars have worked diligently to assure continuous quality improvement for KTDB data as well as trauma care across the state.