



Trauma System Performance (Data) Committee

Meeting Minutes

April 30, 2026

12:00 PM – 1:00 PM

Zoom Meeting

[Link to Meeting Documents](#)

COMMITTEE MEMBERS PRESENT	COMMITTEE MEMBERS ABSENT
Dr. James Dunne, Chair Courtney Terwilliger, GTC Dr. Elizabeth Benjamin, TMD Danlin Luo, OEMST Marie Probst, OEMST Kelly Joiner, OEMST Gina Solomon, GQIP Kelli Vaughn, GCTE	Dr. Patricia Ayoung-Chee, GQIP April Moss, OEMST

COMMISSION MEMBERS PRESENT	STAFF MEMBERS & OTHERS PRESENT
Dr. James Dunne, GTC Courtney Terwilliger, GTC	Elizabeth Atkins, GTC, Executive Director Gabriela Saye, GTC, Business Operations Manager Gina Solomon, GTC, GQIP Director Crystal Shelnutt, Regional Trauma System Development Manager Katie Vaughan, Finance Operations Officer

CALL TO ORDER

The meeting was called to order at 1:02 PM with nine committee members present.

APPROVAL OF MINUTES

Presented by Dr. James Dunne

Dr. Dunne asked for a motion to approve the previous meeting minutes.

MOTION TRAUMA SYSTEM PERFORMANCE COMMITTEE 2026-04-01:

Motion to approve February 19, 2026, meeting minutes

MOTION BY: Courtney Terwilliger

SECOND BY: Kelly Joiner

VOTING: All members are in favor of the motion.

ACTION: The motion ***PASSED*** with no objections nor abstentions

TRAUMA REGISTRY DATA REPORT: UPDATE ON IMAGE TREND MIGRATION STATUS

Presented by Marie Probst

Marie Probst provided an update on the data migration. She reported that all 2025 data downloads to the ImageTrend system have been completed and that the ESO system update for their office was distributed on April 23, followed by a reminder email to ensure all recipients received and installed the update. Users may now begin downloading 2026 records. In response to a question regarding the 2025 annual report, Marie indicated that it is



typically prepared for distribution by Danlin in August or September.

TIME TO DEFINITIVE CARE | SYSTEM-WIDE STUDY

Presented by Dr. Dunne

The committee discussed the Time to Definitive Care Statewide Initiative. No update was available regarding Institutional Review Board (IRB) approval. Gina Solomon stated she would follow up to obtain updates on both the IRB status and overall project progress. Gina confirmed that the statistician is under contract, has the data, and is moving forward with the analysis. Concern was raised that the analysis was proceeding without IRB approval, but it may be protected as a performance improvement project. Gina agreed to provide Dr. Dunne with the contact information for the GQIP scholar and Dr. Ayoung-Chee to follow up directly with the involved parties.

TRAUMA SYSTEM DASHBOARD

Gabby Saye reviewed Trauma System Dashboard updates (**ATTACHMENT A**). She outlined the updated metrics, including:

1. Original: Median Time: PSAP (911 call) to First Hospital (Primary)
Revised: Median Time: PSAP (911 call) to First Hospital (Direct Transports)
2. Original: Median Time: PSAP (911 call) to Definitive Care (Ultimate Hospital)
Revised: Median Time: PSAP (911 call) to Second Hospital (Transfers)
3. Original: Number of Hospitals Before Definitive Care
Revised: Double Transfers
4. Overtriage and Undertriage at Second Hospital
 - a. Based on NFTI
5. Prehospital Blood Administration
 - a. Heat map of counties with and without prehospital blood capability
 - b. Total number of patients receiving prehospital blood

Overtriage and Undertriage Metric

The committee discussed concerns about overtriage and undertriage at the second hospital, as defined by NFTI criteria. Members noted that these measures are designed to assess trauma team activation rather than transfer appropriateness and could misclassify necessary transfers as overtriage. Data limitations further complicate their use. There was general agreement that this metric may not accurately reflect system performance and should likely be removed or reconsidered.

Alternative metrics were explored, including tracking non-therapeutic transfers, defined as patients transferred and subsequently discharged from the receiving emergency department. This was identified as a potential indicator of system inefficiency and an opportunity for interventions such as telehealth. Ongoing work through GQIP was noted, though members acknowledged challenges in defining and interpreting this metric. While potentially valuable for performance improvement, the group agreed it may be premature to include it on the dashboard without further analysis and context.

The committee reaffirmed that the dashboard's primary purpose is to measure system-level efficiency and avoid duplicating existing quality metrics tracked elsewhere. It was agreed that additional measures could be incorporated over time as needed. Gabby will add non-therapeutic transfers to a list of future metrics for consideration, and the group indicated that over- and under-triage at the second hospital should likely be excluded from the dashboard at this time.

Decisions:



- Remove Overtriage/Undertriage from dashboard
- Add non-therapeutic transfers metric for future consideration

Additional Dashboard Context & Limitations

Discussion emphasized the need to present data with context, particularly for double transfers, by including denominators and percentages rather than raw numbers. The group reaffirmed that the dashboard should remain a high-level, visual tool for system efficiency, with detailed performance improvement analyses conducted separately.

Gabby outlined the ongoing development of a data dictionary and noted limitations in summarized registry data, manual data extraction, and constraints on visualization in Smartsheet. The group agreed to continue using the platform for now.

PSAP to First Hospital Metric

The committee clarified that the PSAP-to-first-hospital metric reflects direct transports to trauma centers and may be misleading as labeled. Members agreed the metric is valid but requires clearer terminology, with refinements to be addressed offline.

Decision: Update PSAP to First Hospital to PSAP to Presentation at Designated Trauma Center

Additional Metrics

The committee discussed additional dashboard metrics, including tracking double transfers with appropriate context (total registry patients, total transfers, and percentages). Members also revisited the potential value of tracking patients transferred and discharged from the emergency department, agreeing that this may be a useful measure to monitor. Pre-hospital blood administration metrics were supported, including the total number of patients receiving blood, the total units administered, and quarterly trends, with emphasis on tracking growth in whole-blood use.

The need for contextual data, particularly total pre-hospital transports, was emphasized to better interpret blood administration rates. Members noted that while the number of patients receiving pre-hospital blood is relatively small, it would be valuable to understand how many patients who clinically needed blood actually received it, though this may be better suited for a performance improvement initiative. Additional discussion highlighted variation in practice across regions, with interest in using heat maps to identify geographic gaps in blood administration, particularly in rural areas.

Decision:

- Add a percentage metric to review the number of patients transferred and discharged from the emergency department
- Add necessary context to the dashboard, include denominators or percentages where applicable
 - Total registry patients
 - Total transfers
 - Total pre-hospital transports
- Potential metric: How many patients who clinically need blood actually receive it (PI project)

Prehospital Blood Map

Kelly Joiner reviewed a draft heat map showing where pre-hospital blood is available.

- Red indicates counties where ground EMS administers blood



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- Purple indicates partial coverage
- Helicopter icons represent air services carrying blood.

The map reflects availability but may underrepresent actual usage, since helicopters and mutual aid can deliver blood across county lines.

Feedback emphasized improving the visualization by creating two maps: one showing where blood is available and another showing where it is actually administered, ideally distinguishing between ground and air. There was also interest in analyzing helicopter transport as a potentially more scalable approach, given centralized hubs and broader reach.

Decision: Create two prehospital blood maps: 1) where blood is available, 2) where it is administered, distinguishing between ground and air.

Discussion highlighted regional variation; some urban EMS systems resist pre-hospital blood due to proximity to trauma centers, while others report improved outcomes with its use. Barriers include low utilization rates, training burdens, and product waste costs, limiting the adoption of whole blood in some areas. Emerging evidence on whole blood effectiveness was noted, suggesting the need for careful evaluation before expanding programs.

Additional analysis was proposed to identify patients who would benefit most, for example, those with hypotension or a high shock index in the field, and to map geographic gaps in access. Early findings suggest certain regions may have higher unmet need.

Dr. Dunne advised that the discussion has exceeded the time allotted for the meeting and advised that he will meet with Gabby to review the proposed edits and next steps.

SUMMARY OF MEETING & ADJOURNMENT

- Marie Probst shared updates on the registry data and data migration progress.
- The Time to Definitive Care Statewide is pending IRB approval. Gina Solomon stated she would follow up to obtain updates on both the IRB status and overall project progress. Gina also agreed to provide Dr. Dunne with the contact information for the project's participants.
- Gabriela Saye reviewed Trauma System Dashboard progress (**ATTACHMENT A**). Committee members reviewed the metrics and made the following adjustments:
 - Remove:
 - Overtriage/Undertriage metrics
 - Add:
 - A percentage metric to review the number of patients transferred and discharged from the emergency department
 - Necessary context to the dashboard, including denominators or percentages where applicable:
 - Total registry patients
 - Total transfers
 - Total pre-hospital transports
 - Update:
 - PSAP to "First Hospital" to PSAP to "Presentation at Designated Trauma Center"
 - Future considerations:



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- Non-therapeutic transfers
- How many patients who clinically need blood actually receive it (PI project)
- Kelly Joiner reviewed a draft heat map showing where pre-hospital blood is available (**ATTACHMENT B**). Committee members proposed to create two prehospital blood maps: 1) where blood is available, 2) where it is administered, distinguishing between ground and air.

The meeting adjourned at 1:06 PM.

Minutes Respectfully Submitted by Gabriela Saye