GEORGIA TRAUMA COMMISSION

Morgan County Public Safety Complex
May 19, 2022

GEORGIA TRAUMA COMMISSION

Georgia Trauma Commission Meeting
May 19, 2022
09:00 AM to 12:00 Noon
Morgan County Public Safety Complex
Agenda

09:00 am to 09:10 am (10 minutes)

Welcome, call to order & establish quorum	Dr. Dennis Ashley
Approval of March 2, 2022 and April 28, 2022 Meeting Minutes *	
Chairman's Report	

09:10 am to 9:30 am (20 minutes)

Executive Director's Report	Liz Atkins

Committee & Workgroup Reports I 09:30 am to 10:20 am (50 minutes)

Budget Committee Report	Dr. Regina Medeiros
EMS Committee Report	Courtney Terwilliger
Level III/Level IV/Rural Trauma Center Committee	Dr. Greg Patterson Dr. Alicia Register
Georgia Committee for Trauma Excellence	Jesse Gibson

----------BREAK 10:20 am -10:35 am (15 minutes)----------

Committee & Workgroup Reports II 10:35 am to 11:00 am (25 minutes)

Trauma Administrators Committee	Dr. Michelle Wallace
Trauma System Performance Committee	Dr. James Dunne

Trauma System Partner Reports 11:00 am to 11:50 pm (50 minutes)

Georgia Trauma Foundation	Cheryle Ward
Georgia Quality Improvement Program	Dr. S. Rob Todd Gina Solomon
Office of EMS and Trauma	Renee Morgan
GCC (Defer)	
MAG Medical Reserve Corps	Dr. John Harvey

11:50 am

New Business	Dr. Dennis Ashley

11:50 am to 12:00 pm (10 minutes)

Summary of Action Items	Dr. Dennis Ashley
Motion to Adjourn*	

GEORGIA TRAUMA COMMISSION

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DRAFT FOR APPROVAL AT MAY MEETING

GEORGIA TRAUMA COMMISSION

GEORGIA TRAUMA COMMISSION
Wednesday, March 2, 2022
9:00 AM-12:00 PM
Barnsley Resort
Meeting Minutes
Link to meeting material/packet*
*page numbers indicated in minutes refer to meeting packet

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley, Chairman Dr. James Dunne, Vice-Chairman Dr. Regina Medeiros, Secretary /Treasurer Dr. John Bleacher via Zoom Mr. Courtney Terwilliger Dr. Michelle Wallace Mr. James E. Adkins Mr. Victor Drawdy Dr. James J. Smith	

STAFF MEMBERS & OTHERS SIGNING IN	REPRESENTING	ATTENDING
Elizabeth V. Atkins	GTC, Executive Director	In person
Gina Solomon	GTC, GQIP Director	In person
Katie Hamilton	GTC, Finance Operations Officer	In person
Gabriela Saye	GTC, Executive Assistant	In person
Cheryle Ward	Georgia Trauma Foundation	In person
Olalekan Akinyokunbo	Emanuel Medical Center	In person
Naila Avery	Northside Gwinnett Hospital	In person
Rachel Barnhard	OEMST	In person
Riley Benter	AdventHealth Redmond	In person
Kim Brown	Hamilton Medical Center	In person
Ashley Bullington	Crisp Regional Hospital	In person
Nadirah Burgess	Northside Hospital Gwinnett	In person
Ralph Castillo	Morgan Medical Cenrer	In person
Leon Dent	Phoebe Putney Memorial Hospital	Virtually
Brandi Fitzgerald	Phoebe Putney Memorial Hospital	Virtually
Mary Beth Goodwin	John D Archbold	In person
Becca Hallum	Georgia Hospital Association	Virtually
Robyn Hatley	CHOG Augusta University	In person
Sharon Hogue	Atrium Polk Medical Center	In person
Kyndra Holm	Augusta University Health - Children's Hospital of GA	In person

Tracy Johns	Atrium Health Navicent medical center	In person
Michael Johnson	OEMST	In person
David Kiefer	Effingham Health System	In person
Katherine Kohler	AMC	In person
Heather Morgan	Piedmont Athens Regional	In person
Renee Morgan	OEMST	In person
David Newton	OEMST	In person
Terence O'Keeffe	Augusta University	In person
Farrah Parker	JMS Burn Center at Doctors Hospital	In person
Sarah Parker	Grady	In person
Steve Paynter	Hamilton Medical Center	In person
John Pope	Piedmont Cartersville	In person
Marie Probst	OEMST	Virtually
Alicia Register	Crisp Regional	In person
Rana Roberts	Children's Healthcare of Atlanta	Virtually
Kellie Rowker	CHOA	In person
Christopher Ruiz	Doctors Hospital of Augusta	In person
Gabriela Saye	Georgia Trauma Commission	In person
Damien Scott	Emanuel Medical Center	In person
Stephen Shirlock	John D Archbold Memorial Hospital	In person
Michael Shotwell	Piedmont Athens Regional	In person
Corydon Siffring	Doctors Hospital of Augusta	In person
Jessica Story	Warren Averett	In person
Pamela Vanderberg	Wellstar AMC	In person
Matt Vassy	Northeast Georgia Medical Center	In person

Call to order: (00:00:05 on the recording)

Dr. Ashley called the meeting to order at 12:00 PM, with eight of nine members present in the room and one member present via Zoom video conference.

Chairman's Report (00:00:20) ***Presented by Dr. Ashley***

Dr. Ashley welcomed everyone and hoped everyone had enjoyed the recent meetings throughout the last couple of days. It's been very productive, and I'm extremely impressed with all the committee work. We appreciate all your hard work. Dr. Ashley thanked all the staff that made the Winter Meeting a success.

We will start our meeting by approving the November 18, 2021, and January 26, 2022 meeting minutes.

MOTION GTCNC 2022-03-01:
Motion to approve the November 18, 2021, and January 26, 2022 meeting minutes as submitted.

MOTION BY: Courtney Terwilliger
SECOND BY: James Atkins
VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions.

As you may know, the legislative session has started. Liz and I have been busy with presentations. We presented to the Senate Health and Human Services Committee last week, and they were very pleased with our projects and how far we have come. With that being said, I will turn it over to Liz Atkins for the Executive Director's report.

Executive Director Report (00:03:12) ***Presented by Elizabeth Atkins***

We are deep in budget season right now at the capital, so I have some screenshots (packet pages 17-18) from the governor's budget report. The amended FY budget will be voted on shortly, and the FY budget has already started its process. The most exciting report this year is that you see a trauma care trust fund under dedicated state revenues. Now, we have an interest-bearing trust fund. It was a heavy lift to make that happen. You see that 13,594,359 that I have highlighted is dedicated going into our trust fund this year.

Further down the report, you will see the FY 23 dedicated funds, which will be allocated to the FY 23 budget. Next, you will see the amended budget, which they will be voting on this week for FY 22. If you're not familiar with the process, we get a base budget of around 14 million, then an additional 8 million. The biggest change is our total for FY 23 is 21.4 million, no more vetting for our money. We have dedicated funds now because of the language set in the code that states the Super Speeder money should go towards the trauma system. We have had many discussions about what initiatives are occurring and what we need to fund.

Liz Atkins reviewed the Super Speeder Summary (page 19-21). The green line on page 20 indicates our amended budgets, the additional mid-year funds we receive to bring us up the 20 million dollar mark. Now it becomes important to track our progress month over month (page 22). If there are no questions, we will move into a presentation from Jennifer Ward with a TCAA presentation.

Jennifer Ward congratulated everyone on the achievement of having dedicated funds. We are one of the few states that have that. This (23-45) may serve as a refresher for current TCAA members but will provide an overview for those who are not. Ms. Ward gave a detailed presentation on the following topics:

- TCAA Mission, Vision, and Values
- TCAA history
- Current membership overview
- Initiatives

- Services and Benefits
- Upcoming Webinars
- Online Education Navigation
- Helpful TCAA Resources

After the presentation, Liz Atkins asked what the two main focus points are in your advocacy day? Jennifer Ward answered that it is constantly changing, but right now, it's getting mission zero appropriated and improving trauma student care grants from 220 million. Advocacy day will take place March 16-17 virtually. Dr. Ashley asked if Jennifer could elaborate on the 5 million project and how it might affect us. The 5 million project is mission zero, separated into different things, and has money going to military teams and trauma centers. It will help to ensure trauma care readiness by providing federal grants that can be used to integrate military trauma care providers into civilian trauma centers. 5 million doesn't sound like very much money, but it is what you have to start, and then you can add on. The 220 million is the improving system track that I touched on earlier. Dr. Ashley asked if that is something Georgia and EMS centers have access to. We have a trauma coalition that includes all our partners, so they know what is going on. As soon as we are closer to approval, we will send out an application and tell you what you need to do.

Dr. Ashley thanked Ms. Ward for presenting and stated it's great having someone advocating for the system at the national level. Liz Atkins added that level III and IVs are now TCAA members and should have been able to attend the finance consultation Tuesday morning. The manual is developed by TCAA fellows and is very valuable. Please download it when you get a chance.

Jessica Story with Warren Averett was asked to present the level III/IV readiness cost results (46-53). Ms. Story provided a brief background of Warren Averett's history with the Georgia Trauma Commission. We have been working with the Commission since 2008 on various projects. You are probably most familiar with the uncompensated care validation we do every year. Today, I'll be reviewing the readiness cost that we performed on level III and IVs for the calendar year 2019 data. The final results only include costs that are required in the Orange Book. Ms. Story went on to give a detailed explanation of the report.

Dr. Dunne had a question regarding the costs associated with clinical medical costs. Would those positions be eliminated if someone decides not to be a trauma center, or would you need an orthopedic surgeon to still be at the facility? Were those costs associated with on-call in-house costs? Ms. Story answered that on-call was not a requirement, which is not included in the costs. Some centers did have those costs, but that is not reflected in the report. Dr. Ashley clarified that this looks at their call obligation pay. If a center decided not to be a trauma center, the surgeon wouldn't go away, but they wouldn't be mandated to be on call.

Dr. Greg Patterson asked if the Commission would redo all center surveys since newer standards are rolling out. To Dr. Dunne's comment, many trauma centers don't pay for additional resources, I don't get called pay, but our hospital expects us to do it. I would recommend a sub-note to the study to distinguish who pays for it and how much. For the level I and II study, the biggest category is the call pay associated with the medical staff; that isn't the case for us. Dr. Ashley stated that they would be interested in redoing the survey. We have learned how to do the survey now and can understand what's going on.

Committee and Workgroup Reports

Budget Committee Report (00:57:57) ***Presented by Dr. Regina Medeiros***

Dr. Regina Medeiros referenced the AFY Proposed Spend Plan (page 56). Dr. Ashley and Liz have presented our Spend Plan at the capitol, and it has passed the house. As of now, it is still sitting in the Senate for a final vote. We feel very confident in the dollar amount that will be allocated, so we are requesting on behalf of the Budget Committee to approve the AFY 2022 Spend Plan. Please let me know if you have any questions on the allocation line items.

MOTION BY: GTC Budget Subcommittee
MOTION GTCNC 2022-03-02:
I make the motion to approve AFY 2022 Spend Plan as submitted.
MOTION BY: Budget Subcommittee
VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions.

We are working on our grants and contracts workgroup and have some recommendations for minor adjustments. The recommendations will go to the Budget Committee to review.

EMS Committee Report (01:00:39) ***Presented by Courtney Terwilliger***

Courtney referenced the committee report (page 57) and pointed out our two projects. We have added both T-Mobile and Southern Link to our AVLS vendor list. T-Moble has reached out to us and has offered to host a sub-committee meeting at their Innovation Center in Atlanta. We have scheduled a conference call with their healthcare staff to discuss our needs and how current technology might help us. As far as EMS training, in the last FY, our dollars provided 104,000 hours of in-service credit to the EMS Community The EMS Leadership Course has selected this year's class and will begin the training on March 1.

Level III and IV Committee Report (01:04:12) ***Presented by Dr. Greg Patterson***

Dr. Patterson reviewed the committee report (page 59). We have completed our readiness costs surveys presented during the Barnsley Meeting. The ACS consultative process is ongoing. Hopefully, we will continue to work on the ACS Rural initiative to get our system looked at from the rural standpoint

by fall. They are working with the questions we submitted to them and have at least another phone call to establish a process. We have our consultative visits scheduled for level IVs in October. MARCH PAWS is ongoing and may have a working prototype with test classes before our August meeting. We are re-engaging our trauma medical directors to update the access to the specialty care process; This was a low-hanging fruit we tackled early on by publishing all trauma center contact information that Level III and IV centers could reference. We have tabled a couple of projects: IRB for rural centers, hip fracture care, and geriatric care.

Georgia Committee on Trauma Excellence (GCTE) (01:08:39) ***Presented by Tracy Johns***

Our primary focus was aligning our goals under initiatives with our five different subcommittees in the last quarter. The goals we've developed are: decreasing time to definitive care, decreasing the incidence of AKI, and increasing trauma awareness. We're working on getting better data, and we've looked at our registry data to add data fields this year. We are also working on reports to help time to definitive care. For AKI, We've got a predictive calculator that we're looking at doing some prospective data analysis with.

Trauma Administrators Committee (01:10:53) ***Presented by Dr. Michelle Wallace***

We had our Administrators committee yesterday, and it was our first full in-person meeting. There was lots of engagement, and we presented the readiness cost survey. We asked members what they wanted to focus on. We will be planning to meet again in April and looking to establish co-chairs from each level. It was great to see the enthusiasm and the amount of participation involved.

Trauma System Performance Committee (01:13:25) ***Presented by Dr. James Dunne***

Our main focus as a committee is time to definitive care and how long it takes a patient at the scene to get to an appropriate trauma center. The data has been difficult to capture, but the entire committee has done a great job disseminating the available data. Dr. Dunne started to present the April-October Trauma Registry Data Report (69-73). Through this data, we can determine significant delays from patients going to a referring hospital then to definitive care. We've never been able to get the numbers we needed until now, and we can try to figure out solutions. One of the problems we are encountering is obtaining accurate data. Only about 16% of records were complete for analysis.

From a statewide standpoint, we will have to look at the amount of transport available. There are not enough ambulances to transport people from one hospital to another. We have people sitting at these critical access hospitals for hours. Dr. Dunne referenced page 68, which breaks down the amount of time from dispatch to time of definitive care and the amount of record data available within each stage.

Some of the solutions are to increase our data capture, have hospitals build a relationship with their referring hospitals and EMS, and work on process improvement initiatives. We are also working on an armband project, an OEMST initiative to connect records from referring hospitals and EMS.

Vic Drawdy added that ERs have had difficulty finding a facility to accept a patient in the past couple of months, and EMS agencies are traveling long distances for transfers. How much of the time attributed to the scene to the final destination is attributed to trying to locate a facility? Dr. Dunne stated that COVID exposed our weakness in the surge capacity of our tertiary centers. Instead of going to the closet facility, they have to travel further. Tracy Johns stated that it's not only bed shortages but staffing shortages. Hopefully, we will be able to see more information once we obtain better data. Dr. Dunne stated that ISS scores break the data out, and we can see that EMS knows where to go and is transferring people correctly.

System Partner Reports

Georgia Trauma Foundation: (01:39:37) ***Presented by Cheryle Ward***

Our main priorities in the foreseeable future will be focused on board expansion and mission fulfillment. We want to make sure we are doing what we were created to do, raising money to help advance our state's trauma system. Historically, we have been focused on education, which we have done well. Earlier, TCAA mentioned when people hear foundation, they immediately think you don't need money. You give money. As a foundation, for us to give money, we have to make money. As we move forward, you will be hearing more details about what we are doing.

Dr. Ashley added that the foundation was able to add two new board members, which was voted on at that last meeting.

Georgia Quality Improvement Program (GQIP): (01:42:54) ***Presented by Gina Solomon***

We are happy to have Dr. Todd here with us today. He's learning on the fly and has been a great addition. I have a brief update on workgroups. They gave a robust report yesterday and continue to move forward. We did some polling questions during our GQIP meeting, and it appears we are on the right track. We hope we get more calls for volunteers to get some more engagement. The benchmarking platform is still a work in progress. We were waiting on security assessments but have moved passed those and now working on the contract phase. We are continuing to meet with the AG's office special council on peer protection data and use policies. We have started the confidentiality policies and agreement, which is key to moving forward as we start to look at de-identified data. Recently, we engaged some TMDs from centers from around the state to help us move new and old projects forward. For arbormetrics, I included a timeline and hope to kick off in May with the project build phase(77).

Office of EMS and Trauma (OEMST): (01:45:47) ***Presented by Renee Morgan/David Newton***

David Newton updated the Commission that Michael Johnson has been promoted to our Deputy Director for Systems of Care. Kelly Joiner will be the Deputy Director for EMS in our office. We have received the armbands for our project and have been working with Rachel and Cassie, our manager, to

implement the pilot. The original funding for this came from the Governor's Office of Highway Safety, and they came back and said the armbands are only to be used for MVCs. Crashes only account for about 5% of our EMS data, so we would have to find another funding stream for the rest of the armbands. They currently cost 17 cents apiece. We have projected we need about 901,000 armbands, based on the number of 911 calls last year. We will discuss the armbands a bit more and how we can incorporate them into the GCC.

For EMS agencies, we're also working on our timeline for the next version of NEMESIS, which has better integration with things like the trauma registry. Dr. Dunne stated that anytime we change a version, we cannot incorporate the previous data in the new version. Mr. Newton stated this new version only has additional elements with additional choices, so it will still be in the same system.

Rachel Barnhard discussed the GCC website and the requested changes. We are looking to update and edit the current website within the hospital status dashboard. Transfer diversion statuses, emergency department, and service line members' statuses are expected to be included in the hospital dashboard on the new software platform we are working to procure. In the meantime, we are working with our GCC management to see if those statuses and other associated changes can integrate into the current web platform in the format it's already in. It is now at the hands of the developers, and the timeline build out on the integration is dependent on them. We are waiting on how long it will take and some cost estimates. GCC has a huge user base at this point, and education is needed before we make the change live.

Dr. Dunne and Liz Atkins clarified what we are looking for in two categories: 1) trauma transfer diversion-if you're tertiary care, you can't accept transfer patients, 2) EMS Diversion with trauma exception-we can't take anyone right now except for trauma patients.

Ms. Barnhard stated that the separate new platform would encompass EMS and hospitals, which we will tell everyone more about as we move forward. The new platform will take more time, so for the current ask, we are working to integrate that into our current platform, but it's not as simple as adding those options in the drop-down. This did go to our GCC advisory board and the time diversion task force. Both committees have looked at the request. Some things we are working on are limiting the view from the public and making it visible to log-in users.

Dr. Ashley asked if their request was approved. Ms. Hand answered that the necessity of it was understood and agreed upon. I wouldn't say approved is the correct word, but we are working towards implementing it. We're in the mock-up phase and will want to agree on what will look, work best, and make sense to most users making the selection. The biggest feedback we get is working on the definitions of things and ensuring it comes with clarity once we put it there. Once we establish definitions, we can reach out to the Commission to review. As of now, we do not have a timeline.

Dr. Ashley expressed concern about the unknown timeline. We're drowning. How do we get the word across to them that we need this in weeks instead of months? Dr. Wallace added the operating arm of GCC is through Grady. We have challenges and are working on a rebuild. The Trauma Administrators have a lot of interest in this, and we need significant hospital representation.

Ms. Barnhard added that the public and EMS should not see the transfer diversion status for confusion reasons. It is not just trauma. It's all diversions-neuro, neo-natal, etc. We are looking at which ones are causing the most problems right now.

Courtney Terwilliger asked if GCC could tell us who makes the calls and how many calls they get. Ms. Barnhard clarified we are not a dispatch center. If someone calls as trauma, we have no way of knowing if it's truly a trauma. GCC is set up as a communication center. We get ambulance calls to see where they can go, and the entire call is recorded. The ambulance crew has a limited amount of data visible. GCC has more information regarding how many transports have gone to that facility. Liz Atkins stated we need to make sure Level III and IV are informed and can put GCC on our agenda to keep the dialogue open.

Renee Morgan presented some other OEMST updates. We have been able to get reviewers scheduled. We will have a site visit for our first designated trauma center in region four by the end of this month. We have three designations scheduled within the next month. Valdosta and Lagrange are potential areas of interest. Colquitt is aiming for level IV but may be able to go up to III. LaGrange is a IV, but has some backup call schedule issues.

Dr. Dunne asked if there were any designation visits accomplished in 2021. Ms. Morgan stated there weren't any site visits due to a shortage of reviewers and their inability to leave their facility. We were able to do some re-designations and are exploring to set up virtual visits. Dr. Dunne asked Ms. Morgan to send the status of Level III and IV designations and redesignations completed in 2021 to Liz Atkins.

Tracy Johns stated she had sent in two different applications to become a reviewer, but had difficulty with their process and updated forms. She suggested they work on a streamlined process to facilitate the reviewer application process. Ms. Morgan will follow up to see what they can do.

Dr. Ashley asked if there were any new business items for discussion. No items were brought forward for discussion, and Dr. Ashley asked for a motion to adjourn.

MOTION GTCNC 2022-03-03:
I make the motion to adjourn.

MOTION BY: Vic Drawdy
SECOND BY: James Adkins

VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions.

Meeting adjourned at 11:50 AM

Minutes Respectfully Submitted by Gabriela Saye

DRAFT FOR APPROVAL AT MAY MEETING

GEORGIA TRAUMA COMMISSION

Georgia Trauma Commission
Meeting Minutes
Thursday, April 28, 2022
5:00 PM-5:30 PM
Zoom Meeting
Meeting Recording: https://youtu.be/USgLLfE86Nc
Meeting Attachments: trauma.ga.gov

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley, Chairman Dr. James Dunne, Vice-Chairman Dr. Regina Medeiros, Secretary /Treasurer Dr. John Bleacher Mr. Courtney Terwilliger Dr. Michelle Wallace Mr. Jim Adkins Mr. Victor Drawdy Dr. James J. Smith	

STAFF MEMBERS & OTHERS SIGNING IN	REPRESENTING
Gina Solomon	GTC, GQIP Director
Katie Hamilton	GTC, Finance Operations Officer
Gabriela Saye	GTC, Executive Assistant
Becca Hallum	Georgia Hospital Association
Richard Rhodes	Office of EMS and Trauma (OEMST)
Kelly Joiner	Office of EMS and Trauma (OEMST)

Call to Order (00:01:06 on recording)
Dr. James Dunne called the meeting to order at 5:03 PM with eight of nine Commission members present. Dr. Ashley joined the call a few moments later.

FY 2023 Proposed Budget Review and Approval (00:02:59) ***Presented by Dr. Regina Medeiros***
Dr. Medeiros thanked everyone for attending today's called meeting to approve the FY 2023 Budget (ATTACHMENT A). This is a one-page summary of the line items of expenditures for the full 21 million budget. Dr. Medeiros entertained any questions, hearing none, Dr. Medeiros made a motion on behalf of the GTC Budget Committee for approval.

MOTION BY GTC BUDGET COMMITTEE
MOTION GTCNC 2022-04-01:
Motion to approve the FY2023 Proposed Budget

MOTION BY: Budget Committee
SECOND BY: Courtney Terwilliger
VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions.

Without any other topics for discussion, Dr. Ashley asked for a motion to adjourn.

MOTION GTCNC 2022-04-02:
I make the motion to adjourn.

MOTION BY: James Smith
SECOND BY: Michelle Wallace
VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions.

Meeting adjourned at 5:10 PM

Minutes Respectfully Submitted by Gabriela Saye

Executive Director Administrative Report

Elizabeth Atkins

May 19, 2022

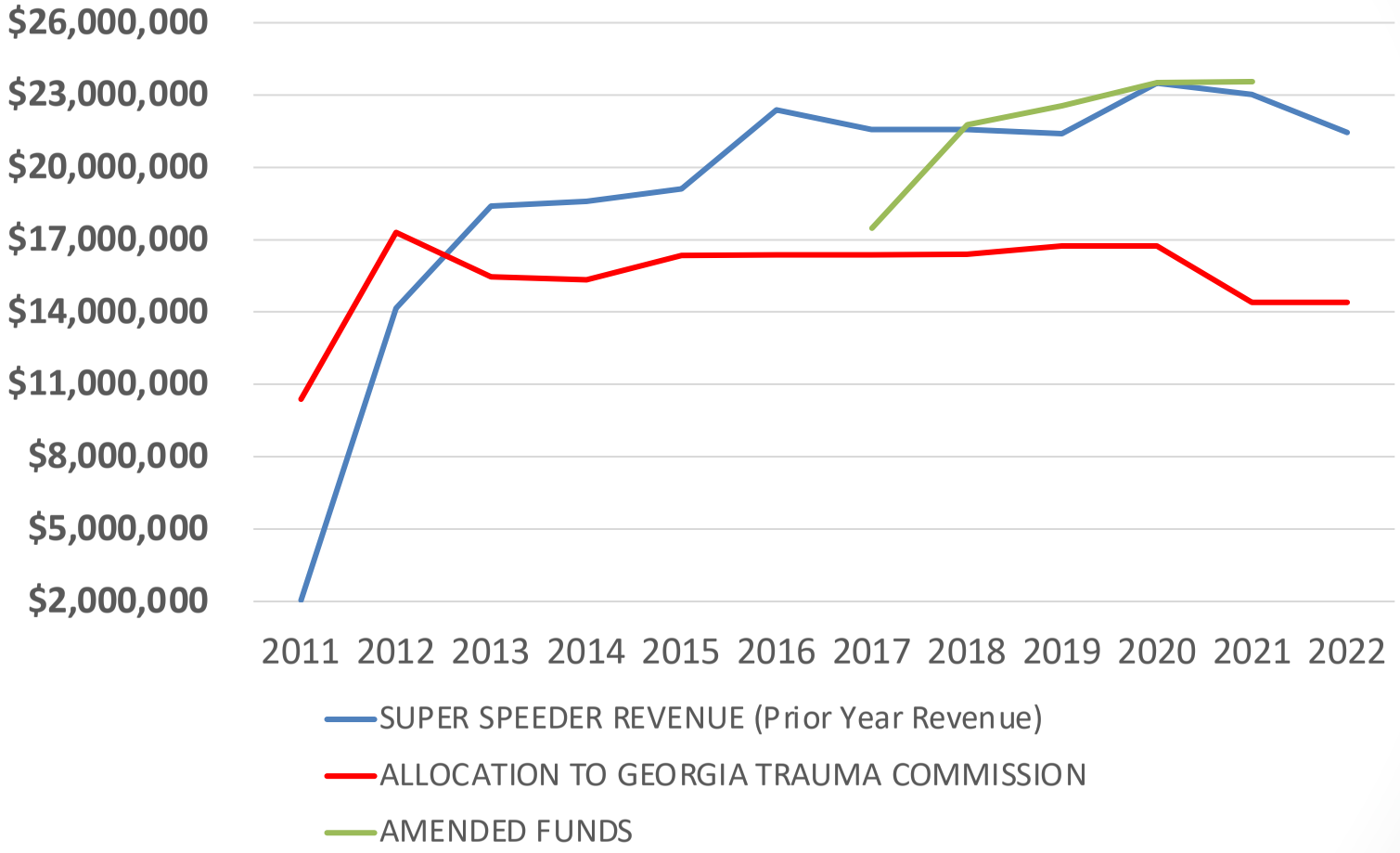
GEORGIA TRAUMA COMMISSION

Congratulations Jesse Gibson!

2022 STN Leadership Award Recipient

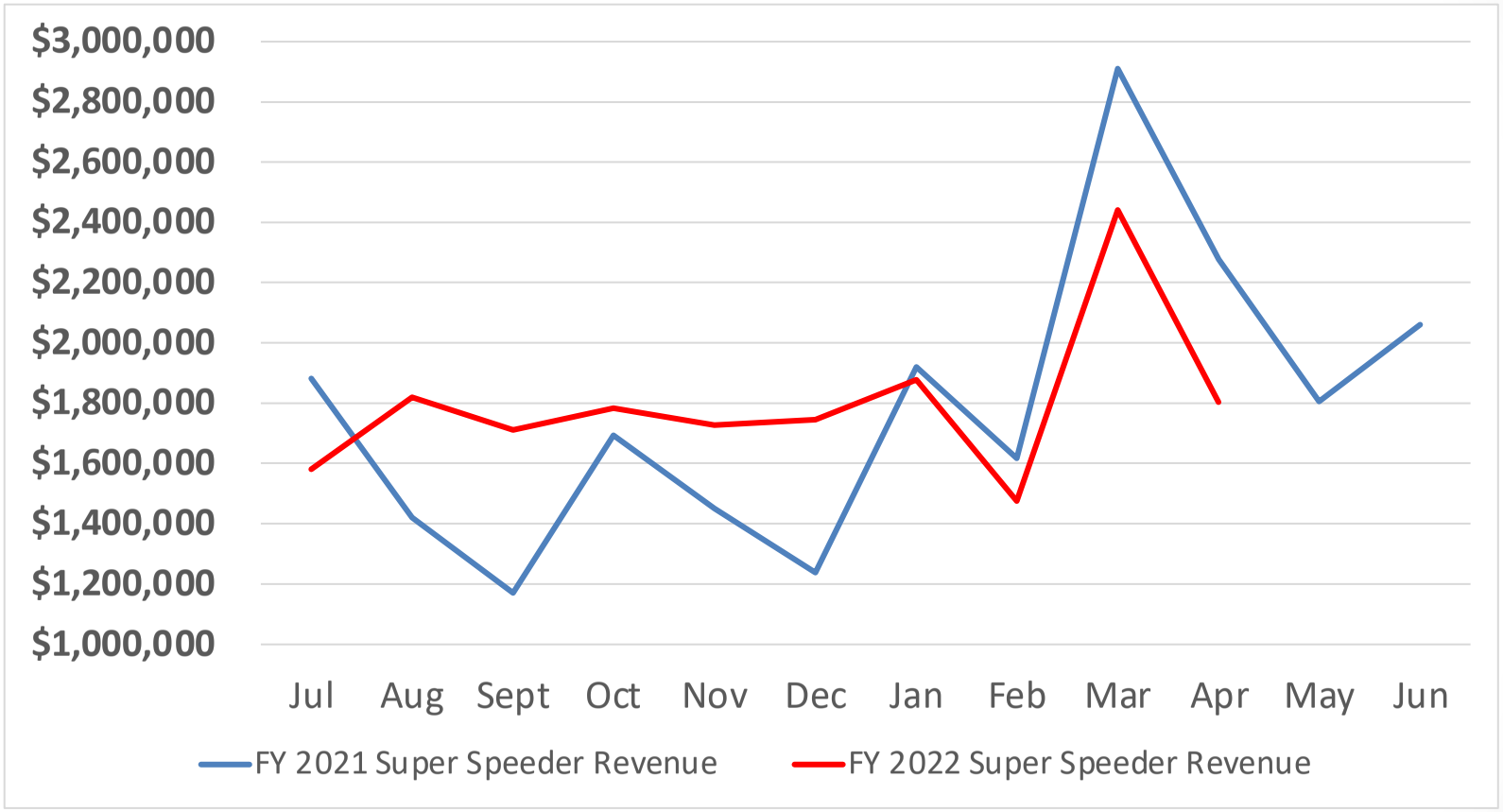
Super Speeder Revenue Summary

Revenue to Budget Comparison: Super Speeder



GEORGIA TRAUMA COMMISSION

Super Speeder Revenues FY 2021 vs. FY 2022



Super Speeder Cumulative Revenue FY 2021 vs. FY 2022

Month	FY 2021 Cumulative Total	FY 2022 Cumulative Total	Cumulative Variance	Percentage +/-
Jul	$ 1,882,436.00	$ 1,580,677.00	$ (301,759.00)	-16%
Aug	$ 3,302,244.00	$ 3,400,448.00	$ 98,204.00	3%
Sept	$ 4,472,201.00	$ 5,111,959.00	$ 639,758.00	14%
Oct	$ 6,165,461.00	$ 6,895,251.00	$ 729,790.00	12%
Nov	$ 7,616,157.00	$ 8,623,089.00	$ 1,006,932.00	13%
Dec	$ 8,853,010.00	$ 10,368,341.00	$ 1,515,331.00	17%
Jan	$ 10,773,002.00	$ 12,245,538.00	$ 1,472,536.00	14%
Feb	$ 12,390,822.00	$ 13,720,763.00	$ 1,329,941.00	11%
Mar	$ 15,301,275.00	$ 16,162,195.00	$ 860,920.00	6%
Apr	$ 17,578,083.00	$ 17,965,676.00	$ 387,593.00	2%
May	$ 19,384,342.00			
Jun	$ 21,444,840.00			

FY 2023 Strategic Planning Process

Subject: FY 2023 Strategic Planning Guidelines
Date: Wednesday, May 4, 2022 at 4:56:56 PM Eastern Daylight Time
From: Westry, Charmayne
Attachments: FY 2023 Strategic Planning Guidelines.pdf, FY 2023 Planning Template.xlsx

Good afternoon Agency Heads and Fiscal Officers:

The Strategic Planning Guidelines for FY 2023 are attached. The purpose of strategic planning is to align agencies' focus with state goals and demonstrate what steps are being taken to meet the agency's statutory requirements, mission, and vision. Plans should be specific, measurable with data, and time bound. Submitted plans will be used by OPB and the Governor's Office as a point of reference when evaluating agency budget requests and agency legislative proposals.

There are three major changes to the guidelines that I would like to highlight:

1. Plans are due July 11, 2022 to allow OPB staff sufficient time to review before budget development in the fall.
2. Agencies are required to submit their strategic plan in the provided template attached. Supplemental materials can be submitted, however the template will be the primary reference point for OPB staff. If your plan is currently in a different format and meets the requirements detailed in the guidelines, the required elements can be copied into the template.
3. Plans are organized by objectives, action plans, and measurable outcomes to better detail the specific actions needed to meet agency responsibilities.

Agencies can seek additional guidance from OPB prior to submission. Please submit your FY 2022-FY 2025 Strategic Plans by July 11, 2022 to Meaghan Carver at Meaghan.Carver@opb.georgia.gov.

FY 2023 Strategic Planning Process
Environmental Scan

[Agency Name] Strategic Plan FY 2022-FY 2025
Agency Mission:
Agency Vision:
Agency Core Values: (optional)
Environmental Scan:

X

Agency Head Signature

FY 2023 Strategic Planning Process
New Template – Due July 11th

[Agency Name] Strategic Plan FY 2022-FY 2025					
Agency Mission:					
Agency Vision:					
Agency Core Values: (optional)					
Objective	**Action Plan**	**Associated Funding**	**Resource/Responsibility**	**Completion Date**	**Outcomes**
2.					
3.					
4.					
5.					

TRAUMA CENTER ASSOCIATION OF AMERICA

2022

VIRTUAL ADVOCACY INSTITUTE & LOBBY DAY

WASHINGTON STRATEGIC CONSULTING

WSW
Winning Strategies Washington

MISSION ZERO

ABOUT MISSION ZERO

- Became law in June 2019 as part of the reauthorization of the Pandemic/All-Hazards Preparedness Act.
- Grants for Level I trauma centers to host military trauma teams.
- Grants for Level I, II, & III trauma centers to host military trauma care providers.
- **Authorizes** ASPR to award a total of $11.5 million per year for 5 years.
- MISSION ZERO cannot be implemented until Congress **appropriates** the funding to ASPR.
- Even more important as a result of the pandemic.

OUR MESSAGE TO CONGRESS

*We urge Congress to **appropriate $11.5 million** in the FY23 Labor, HHS & Education Appropriations bill to fully fund the grant programs.*

Trauma Care Grants

ABOUT TRAUMA CARE GRANTS

- Following a dozen years of inaction, TCAA worked with Sens. Reed (D-RI) & Moran (R-KA) to modernize and reauthorize federal trauma care grant programs.
- In February 2022, Sens. Reed and Moran introduced the Improving Trauma Systems and Emergency Care Act (S. 3566)
- The legislation was also included in the PREVENT Pandemics Act, a discussion draft introduced by Chair Murray (D-WA) and Ranking Member Burr (R-NC).

The legislation would create and authorize funding for three grant programs:

- Pilot Grants for Trauma Centers
- Trauma Care Readiness & Coordination
- Grants to Improve Trauma Care in Rural Areas

OUR MESSAGE TO CONGRESS

Uphold the federal government's commitment that all Americans have access to life-saving trauma care by…

Supporting the Improving Trauma Systems and Emergency Care Act (S. 3566)

- We are grateful that the Senate HELP Committee included S. 3566 in the larger PREVENTS Pandemic Act, which was approved by HELP on March 15th.
  - Because the outlook for the Prevents Act is unclear, we ask Congress to pass S. 3566 before the end of the year.

TRAUMA CARE IN THE UNITED STATES – Talking Points

- Traumatic injury is the leading cause of death for people under age 44 and the fourth leading cause of death of all age groups in the United States – claiming more than 270,000 lives annually (in 2020 and 2021, COVID-19 surpassed traumatic injury as the third leading cause of death).

- However, during the pandemic automobile crashes and deaths began surging in the summer of 2020, surprising traffic experts who had hoped that relatively empty roads would cause accidents to decline. Instead, an increase in aggressive driving more than made up for the decline in driving. And crashes continued to increase when people returned to the roads, later in the pandemic.

- Per capita vehicle deaths rose 17.5 percent from the summer of 2019 to last summer, according to a New York Times analysis of federal data. It is the largest two-year increase since just after World War II.

- Falls are also a leading cause of traumatic injuries, especially among the elderly, creating a significant burden for Medicare. Each year, 2.9 million older people are treated in emergency departments for nonfatal fall injuries, for a total Medicare spend of $28.9 billion.

- Trauma care costs exceed $72 billion annually – more than the cost of treating heart conditions and cancer.

- According to the World Health Organization, the leading causes of traumatic death and injury – including traffic accidents, murder, and suicide – are expected to increase substantially by 2030.

- Approximately 46.7 million Americans lack access to Level I trauma centers within the "golden hour" – the 60-minute period following traumatic injury during which there is the highest likelihood that prompt medical treatment will prevent death.

- Care at a trauma center lowers by 25 percent the risk of death for injured patients compared to treatment received at non-trauma centers.

- Trauma centers are uniquely qualified to provide comprehensive, high-level acute care for patients with the most extreme injuries, regardless of the patient's ability to pay.

- The COVID-19 pandemic has created an unprecedented fiscal and staffing shortage crisis for many trauma centers and hospitals.

2022 LEGISLATIVE PRIORITIES and TALKING POINTS

FULLY FUND THE MISSION ZERO ACT

- The MISSION ZERO Act [PL 116-22, Sec. 204] requires the Office of the Assistant Secretary for Preparedness and Response (ASPR) to award grants to civilian trauma centers for the costs of enabling military trauma care providers and trauma teams to provide trauma and related careat civilian trauma centers.

- The legislation was drawn from recommendations made by the National Academies of Science, Engineering and Medicine and enjoys broad support in Congress, among federal agency officials and by trauma care stakeholders across the country.

- TCAA thanks Congress for approving the MISSION ZERO Act as part of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 (Pub. L. 116-22) and for providing $5 million in **FY22 Labor, Health and Human Services and Education Appropriations.**

- TCAA urges Congress to fully fund the program with $11.5 million in the in **FY23 Labor, Health and Human Services and Education Appropriations.**

IMPROVING TRAUMA SYSTEMS AND EMERGENCY CARE ACT (S. 3566)

Sponsors: Sen. Jack Reed (D-RI) & Sen. Jerry Moran (D-KS)

Introduced in the Senate February 2, 2022

- It has been more than 12 years since Congress restructured several federal grant programs to ensure that all Americans, no matter where they reside or travel, have access to high- quality trauma care.

- Unfortunately, Congress has not appropriated the funding for these programs as intended. Over the decade since these programs have gone unfunded, trauma has remained the leading cause of death in Americans younger than age 44, the number and scope of mass casualty events has increased, and the viability and long-term financial health of trauma centers has decreased.

- A recent Avalere study found that more than half of trauma centers report that they are not adequately prepared to respond to a mass casualty event due to a lack of resources – particularly for training and education, clinical staff recruitment and retention, and surge capacity. These underlying pressures have only been exacerbated by the COVID-19 pandemic.

- TCAA urges Congress to uphold the federal government's commitment to ensuring that all Americans have access to life-saving trauma care by supporting the ***Improving Trauma Systems and Emergency Care Act*** (S.3566), legislation that would modernize and authorize funding for existing trauma care and systems grant programs in the Public Health Service Act.

- S. 3566 would modernize and reauthorize grant programs that **fund** pilot grants for trauma centers, supporting trauma care readiness and coordination, and improvements to trauma care in rural areas.
- We are grateful that the Senate HELP Committee included S. 3566 in the larger PREVENTS Pandemic Act, which was approved by the Committee on March 15th.
    - Because the outlook for the Prevents Act is unclear, we ask Congress to pass S. 3566 before the end of the year.

Radienne Slaughter

My name is Radienne Slaughter. I currently reside in Dallas, Georgia. I have an adult son and two grandchildren. I enjoy spending time with my family, reading, yoga, water aerobics, acts of service and arts & crafts. I have worked in a full-time capacity for Greystone Power Corporation for over 30 years. At the time of my traumatic head on car collision on January 27, 2016, I had just turned 51 years old.

I was headed to work when I hit a wet patch of the road on the passenger side of my car. As I steered my car to the left to get back into my lane, the steering wheel locked. I couldn't straighten the wheel! A van was coming over the hill and we collided head on! When I regained consciousness, I heard two men trying to get me out but the car door was jammed. The paramedics and fire department came. I told them my chest and my legs hurt. It was a struggle to breathe! They used the jaws of life to cut me out of the car. I heard them say, we've got to take her to Grady. At that moment, I knew I was in bad shape, because Grady was THE trauma hospital to be taken to in a life-threatening situation!

I had a few cuts and bruises along with the following injuries: both my femurs and both my hips were broken; my ribs were broken; my nose was broken and my liver was lacerated. However, my most life-threatening injury was my aortic dissection. The doctors all told me it was a miracle that I'm alive! I can't describe how incredibly painful the healing process was.... I was in Grady for 22 days. (My sister, Cheryle came to see me every day!) Everyone at Grady, from the Surgeons to the staff that took care of me was AWESOME!

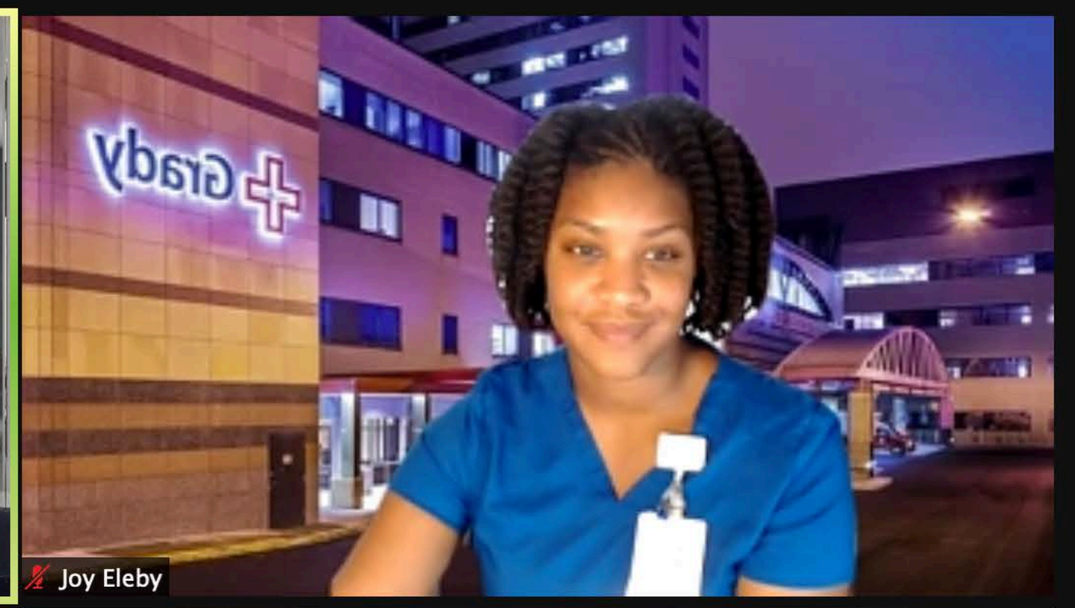
I was then sent to Southern Crescent Traumatic Brain Injury Center in McDonough, Ga. (Thanks to my sister, Cheryle, who researched and visited several facilities before choosing that one for me! She is my SHERO! It was a beautiful, clean and peaceful place!) I was there for three months. They were an Amazing Group of Therapists and Nurses! The physical therapy was intense but thorough! I arrived on a stretcher and walked out using a cane! I was out of work for over 10 months! However, my job was still there for me when I was able to return to work! Thank you, Greystone! Another Blessing!

This experience has made me even more aware and Thankful for this Miracle we call Life! It's taught me the value of Faith, Family and Friends. I will be forever Grateful to God, those who called 911; the Paramedics, the Fire Department, the Grady Surgeons and staff; the SCTBI staff and my Family!
I want to pay it forward and find a way to be active and serve in the Trauma community!

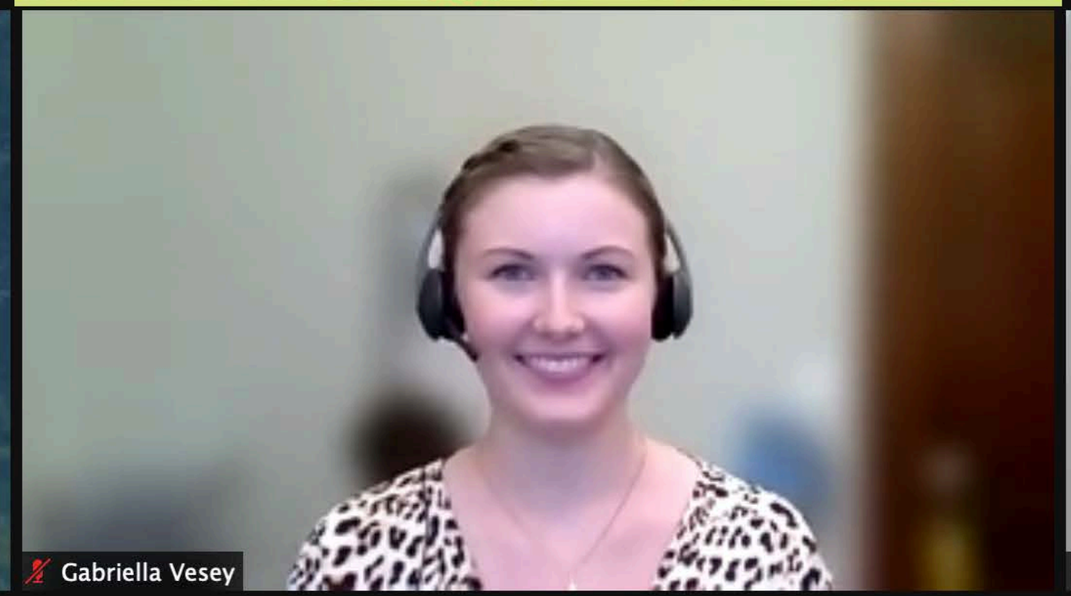
TRAUMA CENTERS
THERE WHEN IT COUNTS


Kevin Croston


Trey Eubanks


Joy Eleby


GEORGIA TRAUMA COMMISSION
Liz Atkins


Gabriella Vesey


Charla Penn


Radienne's Fire


TERESA WINDHAM


Shauna Joas


Regina Medeiros


Cheryle Ward


Adam Haley

VRC VERIFICATION REVIEW CONSULTATION

for excellence in trauma centers

A QUALITY PROGRAM *of the* AMERICAN COLLEGE OF SURGEONS

Resources for Optimal Care of the **Injured Patient**

2022 Standards | **Released March 2022**

ACS AMERICAN COLLEGE OF SURGEONS

ACS NEWS

ACS Committee on Trauma announces release of the revised National Guideline for the Field Triage of Injured Patients

Updated guideline is designed to get the right patient to the right place at the right time

May 2, 2022

Key Takeaways

- Getting injured patients to the right level of trauma center can improve patient outcomes.
- Guideline simplified to better align with the timing of information to EMS.
- Streamlined guideline reflects how assessments occur in the field in order to make more accurate judgments about the level of care an injured patient may need.
- Guideline update incorporated direct feedback from EMS clinicians.

CHICAGO: In the United States, unintentional injury is a leading cause of death, with injury being the most common reason for calling 9-1-1 to activate emergency medical services (EMS).[1, 2] To improve clinical outcomes, a process of field triage is needed to identify seriously injured patients and quickly transport them to the appropriate care facility. The first Field Triage Decision Scheme was developed in 1986 and has been updated periodically over the past three decades. The most recent version, updated in 2021, is published online in the *Journal of Trauma and Acute Care Surgery*.

An interdisciplinary expert panel led by the American College of Surgeons (ACS) undertook the 2021 revision with support from the National Highway Traffic Safety Administration' (NHTSA) Office of EMS, the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau, and EMS for Children Program. It was based on a series of scientific literature reviews conducted by Oregon Health and Science University as well as a broad EMS stakeholder feedback tool, which aimed to capture the perspective from EMS clinicians working in the field.

This update is designed to improve the usability, performance, adherence, and application of the guideline. The guideline is based on the most current science and direct feedback from EMS clinicians to improve prehospital care of injured patients across the country. The new guideline will be most effective when fully implemented into trauma systems and adopted by EMS clinicians.

“The Field Triage Guideline for Injured Patients assists EMS clinicians in identifying the patients at greatest risk of severe injury after a traumatic event and directing high-risk patients to the most appropriate trauma center available to care for them. Getting the right patient to the right place at the right time saves lives,” said Eileen M. Bulger, MD, FACS, Medical Director of ACS Trauma Programs.

The importance of a field triage guideline

“Field triage is the process of identifying seriously injured patients in need of care in specialized trauma centers from among the larger number of patients with minor to moderate injuries who can be cared for in lower-level trauma centers or non-trauma hospitals,” authors note in the recently published article.

An effective field triage guideline has a dual purpose: it seeks to eliminate under-triage, when a seriously injured patient is taken to a hospital lacking the resources needed for appropriate care; and it sets forth a manageable level of over-triage, when a patient with minor to moderate injuries is taken to a trauma center unnecessarily, resulting in overuse of limited resources in the trauma system.

Properly triaging and transporting patients with serious injuries to a trauma center can improve outcomes. Studies show there is 20% lower in-hospital mortality and 25% lower 1-year mortality among patients treated at a Level I trauma center compared with non-trauma hospitals.[3]

“EMS clinicians play a vital role in our communities as they respond to difficult, life-threatening emergencies. For more than 50 years, the U.S. Department of Transportation and NHTSA have supported EMS systems and first responders in their important mission,” said Steven Cliff, PhD, NHTSA’s Deputy Administrator. “The Field Trauma Triage Guidelines are an important resource for EMS clinicians, helping them save lives and provide critical care for traumatic injuries. We appreciate the American College of Surgeons’ leadership on this essential publication.”

Guideline updates

Among the updates included in the 2021 guideline are substantive changes to its format and structure. Previously, the guideline used a step-wise algorithmic format that was determined to be overly complex for use in the field. The new guideline was redesigned to reflect the flow of information to EMS clinicians and actual use of the guideline in the field.

The restructure consolidates triage criteria into two main categories based on risk of serious injury: high risk criteria (red) and moderate risk criteria (yellow). Each category is accompanied by a recommendation indicating the patient transport destination.

The guideline, resources, and implementation tools can be found at www.facs.org/fieldtriageguidelines.

Citation: National Guideline for the Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage, 2021. *Journal of Trauma and Acute Care Surgery*. DOI: 10.1097/TA.0000000000003627

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2. Wang HE, Mann NC, Jacobson KE, Ms MD, Mears G, Smyrski K, et al. National characteristics of emergency medical services responses in the United States. Prehosp Emerg Care. 2013;17(1):8-14.
3. MacKenzie EJ, Rivara FP, Jurkovich GJ, Nathens AB, Frey KP, Egleston BL, et al. A national evaluation of the effect of trauma-center care on mortality. *N Engl J Med*. 2006;354(4):366-78.

About the American College of Surgeons

The American College of Surgeons is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and improve the quality of care for all surgical patients. The College is dedicated to the ethical and competent practice of surgery. Its achievements have significantly influenced the course of scientific surgery in America and have established it as an important advocate for all surgical patients. The College has more than 84,000 members and is the largest organization of surgeons in the world. "FACS" designates that a surgeon is a Fellow of the American College of Surgeons.

About the ACS Committee on Trauma (ACS COT)

Formed in 1922, the ACS COT has put forth a continual effort to develop and implement programs that support injury prevention and ensure optimal patient outcomes across the continuum of care. Today, trauma activities are administered through a 100-member committee overseeing a field force of more than 3,500 Fellows who are working to develop and implement meaningful programs for trauma care in local, regional, national, and international arenas. These programs incorporate advocacy, education, trauma center and trauma system resources, best practice creation, outcome assessment, and continuous quality improvement. The COT strives to eliminate preventable deaths and disabilities across the globe by preventing injury and improving the outcomes of trauma patients before, during, and after hospitalization.

Contact

- Dan Hamilton I 312-202-5328
- Sally Garneski I 312-202-5409
- Email: pressinquiry@facs.org

633 N Saint Clair St, Chicago, IL 60611-3295

National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns

- Penetrating injuries to head, neck, torso, and proximal extremities
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients
- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

Age 0–9 years
- SBP < 70mm Hg + (2 x age years)

Age 10–64 years
- SBP < 90 mmHg or
- HR > SBP

Age ≥ 65 years
- SBP < 110 mmHg or
- HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA

Moderate Risk for Serious Injury

Mechanism of Injury

- High-Risk Auto Crash
  - Partial or complete ejection
  - Significant intrusion (including roof)
    - >12 inches occupant site OR
    - >18 inches any site OR
    - Need for extrication for entrapped patient
  - Death in passenger compartment
  - Child (Age 0–9) unrestrained or in unsecured child safety seat
  - Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Fall from height > 10 feet (all ages)

EMS Judgment

Consider risk factors, including:

- Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
- Anticoagulant use
- Suspicion of child abuse
- Special, high-resource healthcare needs
- Pregnancy > 20 weeks
- Burns in conjunction with trauma
- Children should be triaged preferentially to pediatric capable centers

If concerned, take to a trauma center

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

Safe Surroundings

Preventing injuries from violence
and promoting peace ...
community by community

National Trauma Survivors Day 2022 Toolkit

trauma survivors network provided by ATS

When is NTSD?	May 18,2022
What is NTSD?	A day to celebrate survivors of traumatic injury
How To Get Involved:	We invite trauma centers, survivors and their communities to celebrate the strength and determination of trauma survivors. There are many different ways to participate.

We are very excited to get Trauma Centers worldwide involved in NTSD. It is a wonderful way to celebrate survivors, their family members/friends and the health care trauma teams.

NTSD is a day we come together and honor the strength, courage and hope that those impacted by trauma show every day in the healing process.

In this toolkit, we will provide some ideas of how you can celebrate at your Trauma Center!

Here we have listed some ideas and details on each event. Be creative. Adapt this to your time and budget. Even a small act of kindness or appreciation can bring about great results.

Social Media

Individuals or groups can use Instagram, Twitter or Facebook to tell their story or celebrate a survivor. On May 18th: print out this sign, write your message, take a selfie and upload it to any of the social media sites with **#TraumaSurvivorsDay and #NTSD**. You can also email your picture to the ATS. admin@traumasurvivorsnetwork.org

This is an easy way for survivors, families, and trauma teams to participate on their own, or as a group. Some hospitals have social media accounts and may be very interested in partnering with you for this activity. It is important to include your Communication/PR department in this activity if you are taking pictures on site. They will have the photo release forms necessary for taking and posting pictures. They can advise you on any other privacy concerns.

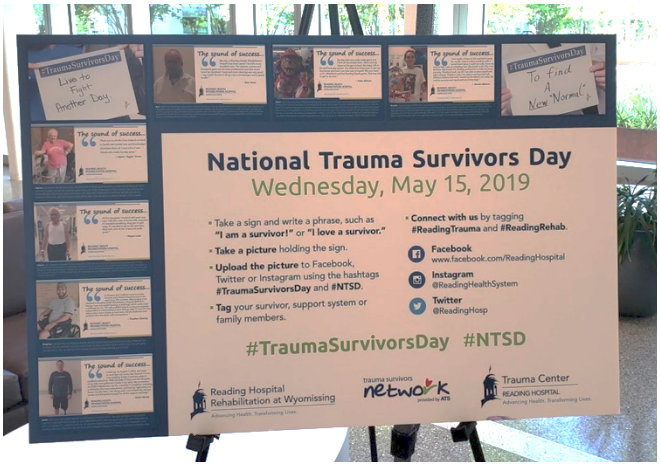
Participate in Race to Rebuild

Race to Rebuild is a virtual 5K/1 Mile Walk/Run/Cycle/Roll event that anyone can take part in anywhere and anytime between May 1st and May 31st. All participants will receive a Race to Rebuild t-shirt and other TSN swag. To learn more, visit https://www.traumasurvivorsnetwork.org/pages/2022-race-to-rebuild-a-virtual-5k-1-mile-walk-run-cycle-roll-event.

Gather a team within your hospital and in your community. Set a date and time for individuals to meet and complete a 5K or 1 mile walk/run/cycle/roll. Map out the distance at a local park or even on your trauma center campus. Encourage participants to wear their Race to Rebuild swag and invite your Communication/PR department in this activity if you are taking pictures on site.

Spread the Word

Setting up a TSN information table is an easy way to spread the word about National Trauma Survivors Day and inform staff and visitors of the TSN program. Work with your hospital administration team to receive approval to set up a "health fair" style table. Set up in an area with high traffic such as near the main entrance or cafeteria. You can have flyers and pamphlets for the TSN laid out for people to pick up. Set up a fun backdrop that people can participate in the social media campaign and take pictures at your booth with the NTSD sign. Add some TSN swag such as pens, candy, hand sanitizers, etc. with the TSN and your hospital's logo. Most importantly, reach out to some survivors and family members and see if they are available to spend time at the table so that visitors can have face to face interaction with people who have first-hand experience with the benefits of the TSN program. This is an easy way to promote the TSN program especially at sites who are newly starting the program.



Survivor Reunion, Reception, Picnic, or Ice Cream Social

Survivor Reunions, Receptions, Picnics, or Socials give your Trauma Center an opportunity to bring your local survivors and trauma teams together for support and celebration. Create a flyer inviting survivors, their family/friends, and trauma teammates to your event. It can be a simple drop-in or can be more formal. It's up to you and your team. Just mail or e-mail your flyer invitations to several discharged trauma patients who are in your local area. Ask your volunteer services if they can help provide volunteers to help prepare the mailing. Take flyers to the Rehabilitation Center or Outpatient Trauma Clinics where trauma patients return for ongoing follow-up appointments. Ask TSN Peer Visitors or even trauma teammates to help volunteer with set up, clean up, etc.

This can be an inexpensive way to celebrate together. Have fun! Bring some balloons. Make it a party. Invite your Trauma Center's pet therapy to come. If you already have an established Survivors Group, everyone can bring a dish to pass and you can invite new survivors to attend. This can be in place of a current support group meeting or in addition to the group meeting. You may want to partner with other organizations such as brain injury, spinal cord injury, or amputee groups and celebrate together.

Whether big or small, this event will need prior planning and we recommend partnering with your PR/Media department. They should have experience marketing these kinds of events at your Trauma Center. A more formal reception could include 1 or 2 survivors who retell their stories. Both survivors and specific care team members could receive recognition awards. It is a wonderful way to celebrate the work of both the healthcare professionals and the hard work the survivors put into their own recovery.

Peer Mentor Recognition Lunch or Dinner

Recognizing the commitment and time of survivors who volunteer as TSN Peer Visitors is important. One way to show your thanks is by inviting TSN Peer Visitors to a special lunch or dinner. This event will have some costs associated. You may want to hold this at the hospital with catering or you may want to reserve a meeting room in a local restaurant. Ask a respected surgeon to come share as a special speaker. Invite trauma nurses and surgeons to attend. Take a special group picture of your TSN Peer Visitor team. Create an award or certificate to honor each Peer Visitor individually. It is a time to recognize the countless hours of volunteering that Peer Visitors gave over the past year. The heart of the TSN is truly the dedicated survivors and family members who share their stories and help connect with others in need.

Survivors Giving Back

Survivors often love the opportunity to "pay it forward" or to say "thanks" to their trauma teams who gave them life- saving care. This is a wonderful and informal way to make that happen. Organize a snack donation drive to create baskets of goodies for the trauma staff members. Identify the number of floors, units, or departments that you are interested in thanking. This would be a great group activity to do during a TSN Survivors Group! Working with your survivors, put the baskets together and create a sign or card that your survivors could all sign for each trauma unit or trauma team. Come help your survivors deliver the baskets and cards/signs to the trauma floors. This can be done on a small budget and with little lead time.

Trying to Grow your Program?

- **Launch Peer Visitation:** Include a peer visitor drive at your event to connect with survivors who are interested in becoming TSN Peer Visitors.
- **Launch a Survivors Group:** Spread the good news of your first support group meeting. Make a flyer to hand out at your event. Invite survivors to join in the new TSN Survivors Group.
- **Build Support for your TSN program:** Use this campaign to create awareness and support within your trauma center for these new TSN program initiatives.

pennsylvania TRAUMA SYSTEMS foundation

Georgia Consultative Visit Education

for Georgia Trauma Program Staff

Amy Krichten, Darlene Gondell and Anna Over

1

Purpose

- The Pennsylvania Trauma Systems Foundation was asked by the Georgia Trauma Commission to complete a Consultative Site Visit on 6 - Level 4 Trauma Centers in Georgia.
- **Consultative Visit Goal**: To assist the trauma program in preparation for a state verification visit and provide education and best practices.
- This PowerPoint provides an overview of how to prepare for the visit and covers logistic and details of the visit.

2

Consultative Visit Overview

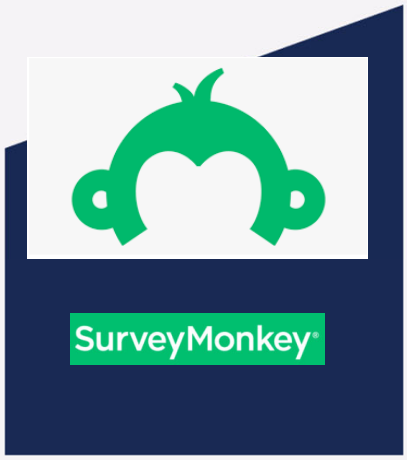
- Scheduled the week of October 10th, 2022
- Completed over the course of 1 day
- Will include the following components:
  - Hospital Overview presentation
  - Performance Improvement presentation
  - Physician, Nursing and Collaborative Services Group meeting
  - Hospital Tour
  - Medical Record Review
  - Leadership Closing Meeting
- Throughout the day, feedback will be provided to the hospital staff on compliance with state and national standards, administrative support, clinical care, as well as performance improvement.

3

Timeline

- April – September
  - Complete application
  - Medical Record selection and preparations
  - Presentation preparations
  - Engage participants (block schedules)
  - Logistic preparations: reserve room, plan for IT/computers, plan for food
  - PTSF collaboration
- September 1:
  - Submit Application
  - Submit Consult Visit Information Form
- Mid-September
  - Participate in PTSF preparation call

4



Consult Visit Application

- **Purpose:** Gather details about the trauma program prior to visit.
- Completed via SurveyMonkey by TPM
- Be candid and answer as much as possible!
  - The survey team can only provide feedback and recommendations on things they are told about!
  - If you do not know the answer to a question, or if it is N/A, you may leave the question empty.
- Consult team will have access to the completed application ~1 month prior to the visit.
- For assistance with completion, or clarification of a question, please contact PTSF staff.
- Reporting period of the Application: CY 2021
- **Application due date: September 1st, 2022**

5

PTSF is conducting a Consultative Visit at your Trauma Center. Complete as much of this application as possible to provide information to your Consult Team prior to their arrival at your Trauma Center. If you Trauma Program does not have a policy/data for a question please let us know that it is not applicable to your center.

If you have any questions, do not hesitate to contact the PTSF Staff:

Amy Krichten - akrichten@ptsf.org
Darlene Gondell - dgondell@ptsf.org
Anna Over - aover@ptsf.org

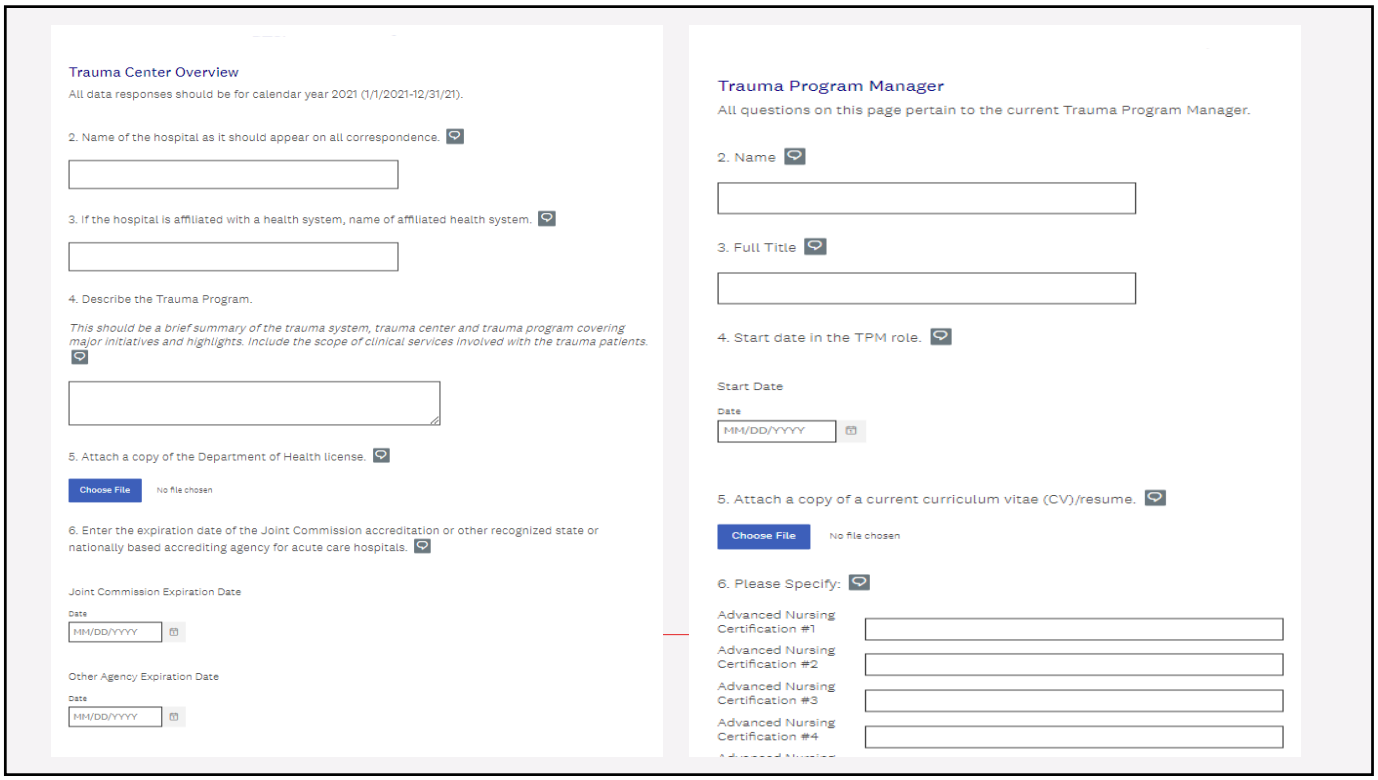
1. The Application has the following sections. You can go through the Application page by page or you can come back to this question and choose the section you want to go directly to.

- ◯ Trauma Center Overview
- ◯ Trauma Program Medical Director
- ◯ Trauma Program Manager
- ◯ Trauma Registry
- ◯ Trauma Performance Improvement
- ◯ Continuing Education
- ◯ Injury Prevention
- ◯ Physicians, Advanced Practitioners & Residents

Application Tips

- The Application can be saved and may be completed in multiple settings.
- You may go through the Application page by page by clicking “Next” at the bottom of each page OR you may start at the home page, select the desired section and hit “next”, which will jump you to that section. When complete, click “previous” to return to home page.
- Saving occurs when you hit “next” or “previous”, not after you complete a question.
- Please attach requested attachments in PDF format!
- Once completed, “submit” the AFS by pressing the “Done” button on the last page and notify PTSF via email that you are finished.

6



Trauma Center Overview

All data responses should be for calendar year 2021 (1/1/2021-12/31/21).

2. Name of the hospital as it should appear on all correspondence.

3. If the hospital is affiliated with a health system, name of affiliated health system.

4. Describe the Trauma Program.

This should be a brief summary of the trauma system, trauma center and trauma program covering major initiatives and highlights. Include the scope of clinical services involved with the trauma patients.

5. Attach a copy of the Department of Health license.

Choose File | No file chosen

6. Enter the expiration date of the Joint Commission accreditation or other recognized state or nationally based accrediting agency for acute care hospitals.

Joint Commission Expiration Date

Date

MM/DD/YYYY

Other Agency Expiration Date

Date

MM/DD/YYYY

Trauma Program Manager

All questions on this page pertain to the current Trauma Program Manager.

2. Name

3. Full Title

4. Start date in the TPM role.

Start Date

Date

MM/DD/YYYY

5. Attach a copy of a current curriculum vitae (CV)/resume.

Choose File | No file chosen

6. Please Specify:

Advanced Nursing Certification #1

Advanced Nursing Certification #2

Advanced Nursing Certification #3

Advanced Nursing Certification #4

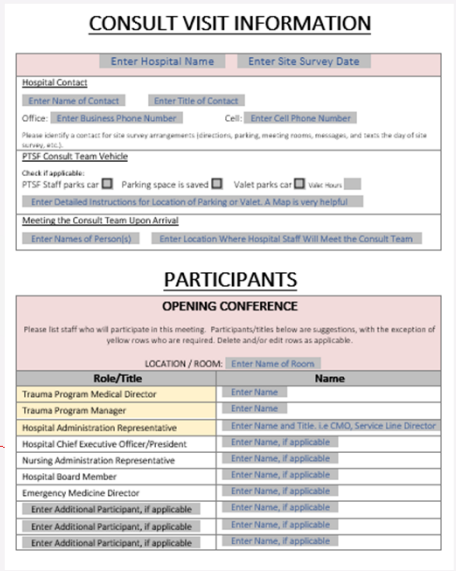
7

Consultative Visit Information Form

Submit to PTSF via email on or before September 1st, 2022.

Includes:

- Hospital Address/directions
- Parking location and details
- Names and roles of participants for each presentation
- Contact information for the hospital in case of emergency



CONSULT VISIT INFORMATION

Enter Hospital Name | Enter Site Survey Date

Hospital Contact

Enter Name of Contact | Enter Title of Contact

Office: Enter Business Phone Number | Cell: Enter Cell Phone Number

Please identify a contact for site survey arrangements (directions, parking, meeting rooms, messages, and texts the day of site survey, etc.).

PTSF Consult Team Vehicle

Check if applicable:

PTSF Staff parks car | Parking space is saved | Valet parks car | Valet Hours

Enter Detailed Instructions for Location of Parking or Valet. A Map is very helpful

Meeting the Consult Team Upon Arrival

Enter Names of Person(s) | Enter Location Where Hospital Staff Will Meet the Consult Team

PARTICIPANTS

OPENING CONFERENCE

Please list staff who will participate in this meeting. Participants/titles below are suggestions, with the exception of yellow rows who are required. Delete and/or edit rows as applicable.

LOCATION / ROOM: Enter Name of Room

Role/Title	Name
Trauma Program Medical Director	Enter Name
Trauma Program Manager	Enter Name
Hospital Administration Representative	Enter Name and Title, i.e CMO, Service Line Director
Hospital Chief Executive Officer/President	Enter Name, if applicable
Nursing Administration Representative	Enter Name, if applicable
Hospital Board Member	Enter Name, if applicable
Emergency Medicine Director	Enter Name, if applicable
Enter Additional Participant, if applicable	Enter Name, if applicable
Enter Additional Participant, if applicable	Enter Name, if applicable
Enter Additional Participant, if applicable	Enter Name, if applicable

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Georgia Consultative Visit Education

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Prep Call with PTSF

- Completed ~1 month prior to the visit to discuss last minute logistics including (Mid-September):
  - Parking
  - Directions
  - Team Members
  - Schedule of the Day
  - Last Minute Questions

9

Survey Team Members

1 RN Surveyor
(PTSF Staff Member)

1 EM Physician Surveyor

1 PTSF Staff Member
(Logistics Support)

10

TIME	ACTIVITY
0800 – 0815	Survey Team Arrival & Brief Introductions
0815 – 0845	Trauma Program Overview • Hospital Overview: details on health system/hospital • Trauma Program Overview: history and scope of services • Demographics: patient population and statistics
0845 – 0925	Performance Improvement Overview • PI Structure and Process • PI Project Demonstrating Process
0925 – 0930	Break
0930 – 1030	Physician, Nursing & Collaborative Services Group Meeting • Administrator(s) • Physician Liaisons • Nursing Leaders • Collaborative Services
1030 – 1115	Hospital Tour • Helipad • Emergency Department • Radiology • Operating Room *if applicable • In-patient Unit (ICU / Surgical Floor) *if applicable
1115 – 1145	Private Survey Team Lunch
1145 – 1600	Medical Record Review • Provide one computer with access to Electronic Health Record • Provide Power source for PTSF laptop • Provide Face Sheet and PI documentation for every medical record • TPMD with Physician Surveyor • TPM with Nurse Surveyor
1600 – 1645	Private Survey Team Discussion
1645 – 1730	Leadership Closing Meeting

Schedule of the Day

- Here is a traditional visit schedule
  - The day begins at 0800, and ends around 1730
- The schedule may be modified based on information received in the Application, or information identified during the visit, to allow additional time to focus on certain areas of the program.

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Arrival Logistics

- Reserve parking for PTSF staff and Survey Team
- Meet & greet sets the tone: Please have someone at the hospital entrance to meet the team in the morning.
- Identify a go-to resource person
  - —It is expected that the TPM/TPMD will be present with the Team for the entire day.
  - —A resource person should be identified to run errands, retrieve requested documents, and do other requested tasks so the TPM/TPMD can remain present.

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A Note about Room Reservations…

- If you have not done so already, please reserve a large room with computers and A/V technology for the visit date.
- The hospital may choose to complete the morning presentations in one room, then move the team to another room with computers for Medical Review OR you may keep the team in the same room all day.

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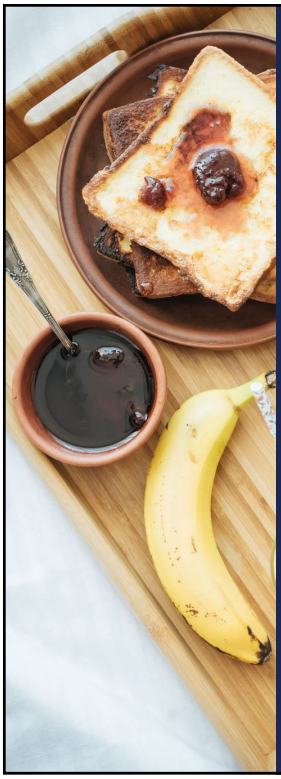

A Note about Food…..

- Light breakfast
- A warm lunch is preferred
  - May be in the MRR room
- Light afternoon snacks
- Beverages (coffee, soda & water)
- We will notify you of any dietary restrictions

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Survey Day Folders

- Create 1 folder per Consult Team Member (3 total)
- Can be in a paper or plastic folder/file, or a binder.
- Should include:
  - Copy of Presentations (2 slides/page, can be black and white)
  - Schedule of the day with names/titles of participants
  - Trauma Activation Policy

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Opening Presentation: Trauma Program Overview

- Typically attended by hospital and trauma program leadership/administration
- PTSF Staff will open with greeting and Team introductions
- Hospital Leader to welcome team (Admin, Board Member, etc.)
- At a minimum include:
  - Hospital overview, including scope of clinical services
  - Trauma program overview
  - Trauma program demographics
  - EMS catchment area details
  - A state map with your location
  - Findings from most recent trauma survey

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Performance Improvement Presentation

- Who Attends?
  - Trauma Program Leadership
  - Key Participants in the trauma program's PI program
- Present the Trauma Program's PI Process
  - Include 4 levels of review and meeting descriptions
- Highlight successful PI initiatives
  - Data is key (Graphs/Charts)!
- Discuss any challenges the trauma program has, and what is being done to address them.

PTSF staff are available for assistance with presentation preparation and content recommendations!

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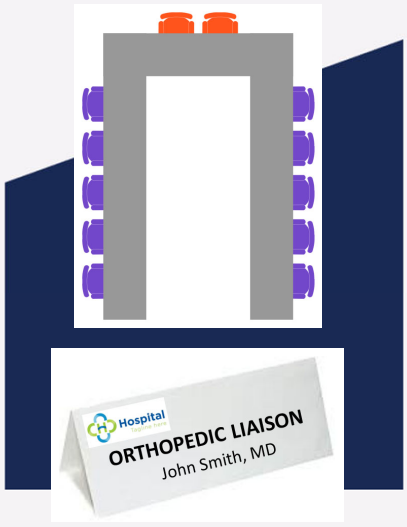

Physician, Nursing and Collaborative Services Group Meeting

- Names and titles of participants should be provided to the PTSF via the Consult Visit Information Form.
  - Should include TPM/TPMD, liaisons from subspecialties, floor/unit managers, EMS representative at a minimum.
- Discussion will be led by the Physician Team Member, and typically follows a patient through course of care/departments.
- The team will attempt to hear from everyone
- Be proud of what you do / Take credit for your successes
  - Be prepared to expand on exciting ventures!
- *Practice makes perfect!*

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Hospital Tour

- Short timeline, keep moving
- Route includes:
  - Helipad
  - Emergency Department
  - Radiology / CT
  - Operating Room (if applicable)
  - Inpatient Units: ICU and/or Floor
- Surveyors may engage staff in questions
- Hallway conversations

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Medical Record Review

- Two workstations
  - One for PTSF EM Surveyor and TPMD
  - One for PTSF RN Surveyor and TPM
- Hospital provides for each station:
  - One computer
    - Accessing the electronic health record
    - Two mice to control the screen
    - Recommend large screens
  - Power source for PTSF computer
    - Used to access medical record review forms
- One table/desk area for PTSF staff facilitator
  - Power source for PTSF computer

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Medical Record Selection

- Selected by the trauma program using a criteria provided by PTSF
- Try to select recent records, *from January 1st of 2022 to present (CY 2022)*.
- 15 medical records total, each from a different category
- If you do not have a record falling into one of the 15 categories, select a patient of your choosing to replace (complex patient, difficult PI, critical injuries, etc.).
- *Complete "Medical Record Review Cover Sheet" and "PI Review Template" for each record prior to the visit.*

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15 Medical Record Categories

Highest level of alert (trauma activation) and admitted	Highest level of alert (trauma activation) and transferred out	Non-alert but admitted	Non-alert but transferred out	Operating room
Transfer after admission	Pediatric (</= 14 years old)	Orthopedic Injury	Head Injury	Abdominal / Blunt Trauma Injury
Penetrating Injury	Admission to ICU	Admission to Floor	Death	ISS > 25

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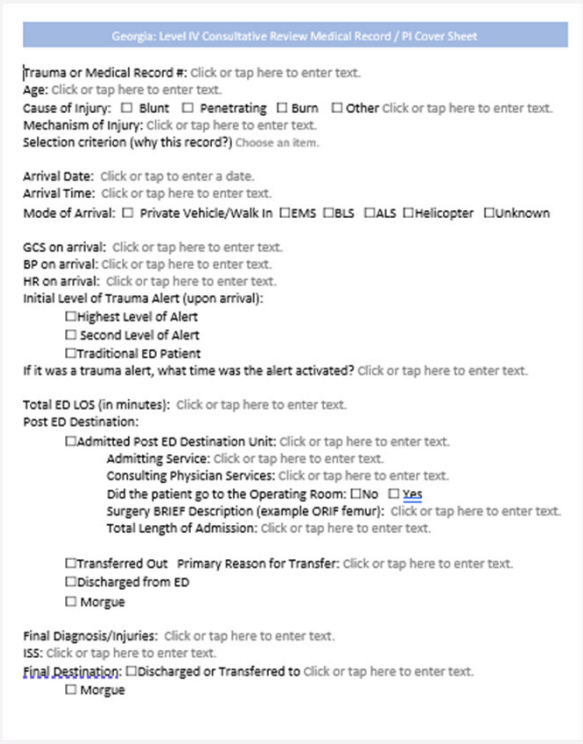
Medical Record Cover Sheet



Georgia: Level IV Consultative Review Medical Record / PI Cover Sheet

Trauma or Medical Record #: Click or tap here to enter text.
Age: Click or tap here to enter text.
Cause of Injury: ☐ Blunt ☐ Penetrating ☐ Burn ☐ Other Click or tap here to enter text.
Mechanism of Injury: Click or tap here to enter text.
Selection criterion (why this record?) Choose an item.

Arrival Date: Click or tap to enter a date.
Arrival Time: Click or tap here to enter text.
Mode of Arrival: ☐ Private Vehicle/Walk In ☐EMS ☐BLS ☐ALS ☐Helicopter ☐Unknown

GCS on arrival: Click or tap here to enter text.
BP on arrival: Click or tap here to enter text.
HR on arrival: Click or tap here to enter text.
Initial Level of Trauma Alert (upon arrival):
☐Highest Level of Alert
☐ Second Level of Alert
☐Traditional ED Patient
If it was a trauma alert, what time was the alert activated? Click or tap here to enter text.

Total ED LOS (in minutes): Click or tap here to enter text.
Post ED Destination:
☐Admitted Post ED Destination Unit: Click or tap here to enter text.
Admitting Service: Click or tap here to enter text.
Consulting Physician Services: Click or tap here to enter text.
Did the patient go to the Operating Room: ☐No ☐ Yes
Surgery BRIEF Description (example ORIF femur): Click or tap here to enter text.
Total Length of Admission: Click or tap here to enter text.

☐Transferred Out Primary Reason for Transfer: Click or tap here to enter text.
☐Discharged from ED
☐ Morgue

Final Diagnosis/Injuries: Click or tap here to enter text.
ISS: Click or tap here to enter text.
Final Destination: ☐Discharged or Transferred to Click or tap here to enter text.
☐ Morgue

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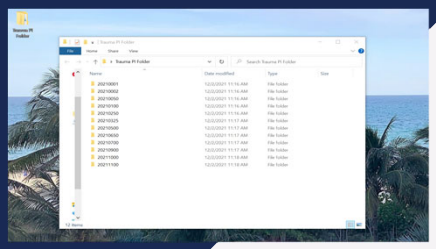

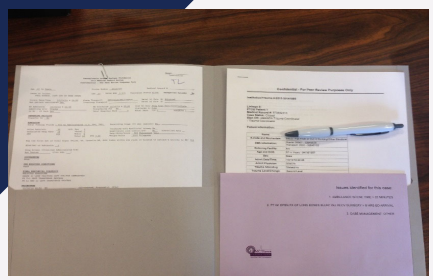

Presenting PI during MRR

- Provide all PI documentation for each case in electronic or paper folders for the Consult Team. This must include:
  - Medical Record Cover Sheet
  - List of events/issues identified by Trauma Program
  - Details of each event/issue taken through the Trauma PI process
  - Optional utilization of PI template
- This might also include:
  - Evidence of each level of review
  - Evidence of PI Communication
  - Evidence of Corrective Actions
    - Education
    - Policy Updates
  - Meeting Minutes
  - Follow-up communication for transfer-outs
  - Evidence of loop closure or ongoing monitoring; DATA!

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PI Documentation

Required for Each Record

Georgia: Level IV Consultative Review Medical Record / PI Cover Sheet

Performance Improvement: For every identified performance improvement event/issue please list:

1. Name of Event/Issue
2. Corrective Action(s) taken
3. Loop-closure/Resolution of Event (include data that supports the corrective action(s) mitigated recurrence of the event)
4. Determination/Classification

Event: Click or tap here to enter text.
Actions: Click or tap here to enter text.
Loop Closure: Click or tap here to enter text.
Determination: Click or tap here to enter text.
Comments: Click or tap here to enter text.

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Medical Record Review by Surveyor

- Surveyor reviews each record and responds to questions in the Site Survey Software
- The software is broken down into “Phases of Care”
- Surveyor rates each phase of care
  - —Acceptable
  - —Acceptable with Reservations*
  - —Unacceptable*
- * = Requires a surveyor comment

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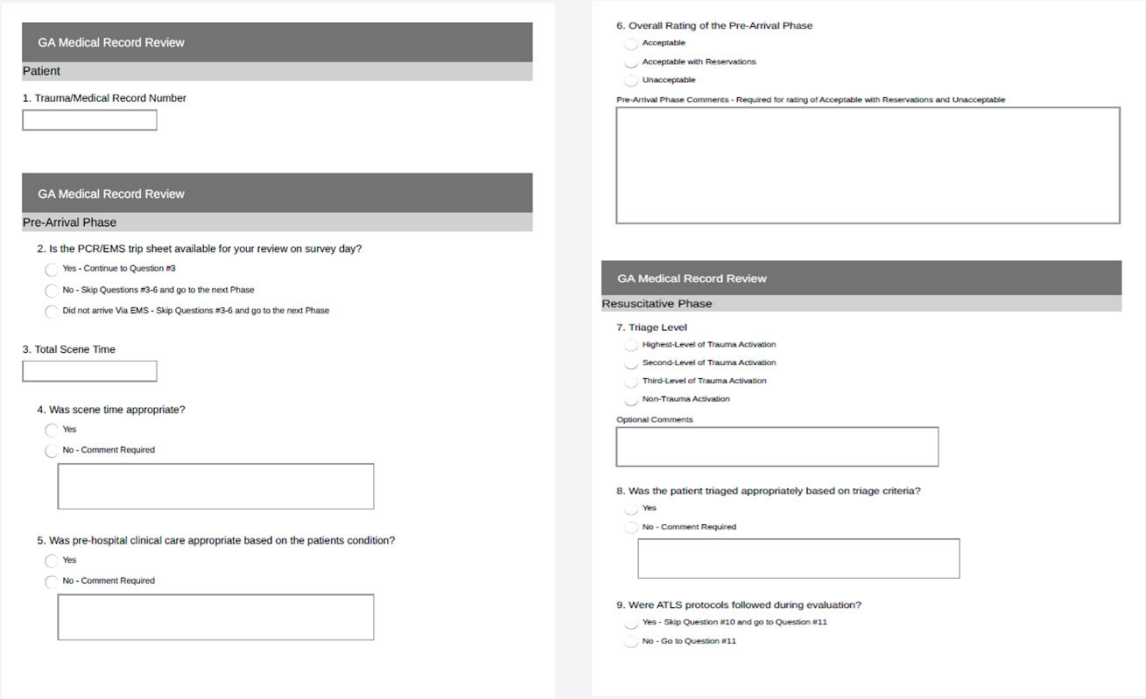

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Resources to have available during visit

In the Room (may be electronic):

- Trauma Practice Management Guidelines
- Trauma Policies
- PI Dashboard
- Performance Improvement Meeting Minutes
- PI Binders / Education Materials

Available/Handy:

- On-call schedules
- Query abilities / Printer
- IT Support
- Contact Phone Numbers

Optional: Posters/Screen Savers displaying Trauma Program Projects and Initiatives, Research, Injury Prevention Efforts, etc. May be scattered around the room for the team to browse at their leisure!

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Leadership/Closing Meeting

- Provides a summary of the day and feedback on the program to hospital leadership.
- 10 or fewer participants ideal:
  - TPMD, TPM, Representative from Hospital Administration, Representative from Nursing Administration, CEO/President, ED Director
- Start time may vary
- PTSF opens with remarks!
- Open Dialogue
- Surveyors are instructed to be candid and offer their impressions of your program.

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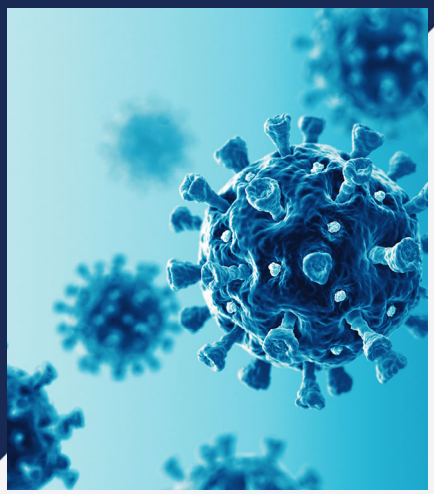

Covid Risk Mitigation

- Will be based on local, state, and national guidance at the time of survey.
- Masking and social distancing will be in accordance with hospital policy.
- ***Final determination/plan to be discussed and determined on 1 month prep call!***

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Post Visit: Consultative Visit Report

- Completed no later than 60-days post visit
- Will include:
  - Overall impression of the Administrative and Trauma Program Commitment
  - Overall impression of the Trauma Clinical Care
  - Overall impression of the Trauma Performance Improvement Program
  - List of Strengths of the Trauma Program
  - List of Opportunities for Improvement
  - Summary of Medical Record Review
- The Georgia Trauma Commission (GTC)/Dept. of Health (DOH) will NOT receive a copy of this report from the PTSF
- The GTC WILL receive a blinded, aggregate report showing details of the statewide review
- TPM will receive a survey monkey related to process

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What to expect next?

- Access and Complete the Application via SurveyMonkey
- Follow up email including:
  - Surveyor Biographies
  - Consult Day Schedule
  - Medical Record and PI Review Templates
  - Medical Record Selection Grid
  - Consult Visit Information Form
- As we get closer to the date, we will determine extent of COVID risk mitigation
- **One month prior:** 30-minute call with PTSF to confirm logistics

- Please do not hesitate to contact us with any questions or for preparation assistance!

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Contact Us

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Manager of Trauma Center Development
aover@ptsf.org
W) 717.857.7391

Pennsylvania Trauma Systems Foundation
Physical Office Address:
3907 Hartzdale Drive, Suite 702
Camp Hill, PA 17011
Phone: 717-697-5512
www.ptsf.org

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GTCNC Malicious Email

GTCNC Malicious Email SBAR

Situation:

Thursday April 14th at approximately 11:53 AM, emails, were sent from the accounts of Liz and Katie through an unauthorized access of the GTCNC email account. Liz was notified by a contact outside of the agency who suspected the email was not authentic, by 12:05 PM. Email passwords were able to be changed within 30 minutes by all GTCNC staff.

Background:

The GTCNC has historically operated on a ".org" email domain supported by a contracted entity. This was a known vulnerability and an RG (requirements gathering) was submitted by the Executive Director & Katrina Johnson, DPH Sr. IT Manager through Capgemini to transition to a ".ga.gov" server on October 13, 2021.

Assessment:

The GTCNC email server was able to be accessed and malicious emails were distributed widely internally and externally. The unauthorized user was able to create a global admin account. MFA was not enabled on desktops, was installed on mobile devices but not connected to the email accounts.

Recommendations:

1. Determine status of ".ga.gov" email Domain for GTCNC
2. Establish global admin for DPH IT security for added layer of protection until email domain transition
3. Cybersecurity training for all GTCNC staff – access through DPH emails
4. Cybersecurity tip sheet for internal/external use
5. Enable MFA for Box account

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	Budget Committee – May 2022
Project/Activity[1]	**Comments**
1. FY 23 Budget	There was a called commission meeting held on April 28 to review and approved the FY 23 GTCNC operating budget. Of note this is the first year of the full budget – close monitoring of expense to budget will be done to ensure we are on track and to make any adjustment needed proactively.
Status: Approved 4/28/2022	**Support GTC Strategic Priorities? (Y/N): Yes**
2. FY 24 Budget Proposal	The budget subcommittee will be taking up review of the FY 24 budget. The final budget proposal and review of the strategic plan will be due to DPH September 1, 2022
Status: Pending	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Grants and Contracts Workgroup	The G&C workgroup has completed their review and has submitted their recommendations to the budget committee for discussion and implementation in the FY 23 contracts and grants.
Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Yes**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Committee Members:	Commission - Dennis Ashley; Courtney Terwilliger; James Dunne Commission Staff – Liz Atkins; Gabby Saye; Katie Hamilton
Chair/Commission Liaison:	Regina Medeiros
Date of Next Committee Meeting:	June 8, 2022

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103.

GEORGIA TRAUMA COMMISSION

Elizabeth V. Atkins, MSN, RN, TCRN
Executive Director
Liz@gtcnc.org
Office: 706-841-2800
Cell: 762-887-0096

The Georgia Trauma Care Network Commission distributes funds appropriated for trauma system improvement and works to stabilize and strengthen the state's trauma care system.

Georgia Trauma Care Network Commission FY 2023 Proposed Budget			
Budget Areas	**Description**	**O.C.G.A. Reference**	**$ 21,444,840.00**
Commission Operations	Staff salaries, benefits, office rental, business IT, telecommunications, virtual meeting platforms, meeting equipment, and travel; standardize grant and contracting processes; implement buisness intelligence processes and tools	O.C.G.A. § 31.11.102.11,16	$ 1,074,627
System Development, Access & Accountability	Regional trauma system development & outcome metrics	O.C.G.A. § 31.11.102.12-15	$ 530,396
MAG Medical Reserve Corps	Medical reserve corps administrative, recruitment and education support	O.C.G.A. § 31.11.102.13	$ 170,000
Georgia Quality Improvement Program (GQIP)	National benchmarking to elevate the quality of trauma care in Georgia. Includes over 850 participating centers nationally.	O.C.G.A. § 31.11.102.14	$ 164,630
Injury Prevention	Coordinate, establish, maintain and administer programs designed to educate the citizens of Georgia on trauma prevention	O.C.G.A. § 31.11.102.13	$ 50,000
Georgia Trauma Foundation	Create, oversee, and maintain a foundation to raise funds specifically for investment in the overall trauma system.	O.C.G.A. § 31.11.102.8	$ 182,000
DPH Office of EMS & Trauma (Maximum 3%)	Monitor state-wide trauma care, recruitment of trauma care service providers into the network as needed and continue to operate and improve the system	O.C.G.A. § 31.11.102.9	$ 432,183
Subtotal of Budget Areas			**$ 2,603,837**
Available for Stakeholders Distribution			**$ 18,841,003**
EMS Stakeholders	Supports emergency medical services trauma readiness costs. Provide Ambulance Automatic Vehicle Location Systems (AVLS) maintenance and Pre-hospital provider education.	O.C.G.A. § 31.11.102.7	$ 3,768,201
Trauma Center UCC Audits	Annual third party validation of uncompensated care claims	O.C.G.A. § 31.11.102.5	$ 50,000
Trauma Centers & Physicians Stakeholders	Support trauma center readiness and uncompensated care	O.C.G.A. § 31.11.102.3-5	$ 15,022,803
Subtotal of Stakeholder Distribution			**$ 18,841,003**
Totals			**$ 21,444,840**

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	EMS Committee
Project/Activity[1]	**Comments**
1. Budget	We have a called EMS subcommittee meeting on May 24th to review our spending plan.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Y**
2. Automatic Vehicle Location System	We had our last subcommittee meeting at the T-Mobille Innovation center. There were several presenters who gave us information on potential systems that might enhance the AVLS system. We also put out a policy of an "open enrollment" time frame for changing vendors for the InMotion devices. This will allow us to better plan our budget process.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Y**
3. Learning Management System	As part of the MARCH-PAWS initiative we are investigating the Moodle platform for training purposes.
Status: In Development	**Support GTC Strategic Priorities? (Y/N): Y**
4. EMS Training	The classes have been scheduled and are on-going. We continue to get positive feedback from these classes. During the May 24th discussion we will discuss the merits of the different courses we are currently supporting.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Y**
5. Online EMS training	We have had discussions with an individual who helps design this type of system.
Status: Under Consideration	**Support GTC Strategic Priorities? (Y/N): Y**
6. Fiscal Accountability	We continue to monitor expenditures to ensure the contractors meet our deliverables.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Y**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Committee Members:	Courtney Terwilliger, Vic Drawdy, Regina Medeiros, Marty Robinson, Jeffrey Adams, Pete Quinones, Sam Polk, Lee Oliver, Blake Thompson, Duane Montgomery, David Edwards, Huey Atkins
Chair/Commission Liaison:	Courtney Terwilliger
Date of Next Committee Meeting:	

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103.

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	Level III/Level IV Rural Trauma Center Commiteee
Project/Activity[1]	**Comments**
1. Cost of care - defining readiness costs for LIII/LIV (including trauma center start up costs to drive grant process)	Oral abstract accepted for presentation at the AAST
Status: COMPLETE	**Support GTC Strategic Priorities? (Y/N):**
2. LIII/IV Trauma Center Consult Process Level III - ACS Level IV – PTSF	Level III consult visits progressing Level IV PTSF visits October 10– 14, 2022; PTSF provided an orientation call – included in Commission meeting packet
Status:	**Support GTC Strategic Priorities? (Y/N):**
3. Grants (capital equipment & rural education)	Georgia MARCH PAWS initiative – ongoing development
Status:	**Support GTC Strategic Priorities? (Y/N):**
4. Access to specialty care e.g., re-implantation, ECMO	Meeting May 13
Status:	**Support GTC Strategic Priorities? (Y/N):**
5. IRB for Rural centers	TABLED
Status:	**Support GTC Strategic Priorities? (Y/N):**
6. Web-based Registry & contracted abstraction services	Quotes in progress
Status:	**Support GTC Strategic Priorities? (Y/N):**
7. PI project specific to LIII/LIV: (1) Hip fx care (2) Geriatric care	TABLED until Arbormetrix launch

Questions, Issues, and Recommendations Requiring Commission Discussion:	Quotes for ESO web-based registry
Motions for Consideration at the Commission Meeting:	None

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103.

GEORGIA TRAUMA COMMISSION

Committee Members:	LIII/IV Trauma Center TPM, TMD, and Administrators
Chair/Commission Liaison:	Chair: Dr. Patterson
Date of Next Committee Meeting:	TBD

Quote Date:	02/08/2022
Customer Name:	Georgia Trauma Care Network Commission
Quote #:	Q-60415
Quote Expiration date:	05/09/2022
ESO Account Manager:	Debi Bowman debi.bowman@eso.com

CUSTOMER CONTACT

Customer Name	Georgia Trauma Care Network Commission Gina Solomon
Email	gina@gtcnc.org
Phone	(762)887-1849

BILLING CONTACT

Payor Name	Georgia Trauma Care Network Commission
Email	
Phone	

Address	410 Chickamauga Ave Suite 332 Rossville GA, 30741
Billing Frequency	Annual
Initial Term	12 months

DI

Product		Hospital Name	Total	Fee Type
Hosting Services	1 Facilities	Archbold Medical Center	$17,595.00	Recurring
Hosting Services	1 Facilities	Crisp Regional Hospital	$8,595.00	Recurring
Hosting Services	1 Facilities	Effingham Hospital	$11,995.00	Recurring
Hosting Services	1 Facilities	Emanuel Medical Center (GA)	$11,995.00	Recurring
Hosting Services	1 Facilities	Fairview Park Hospital	$11,995.00	Recurring
Hosting Services	1 Facilities	Hamilton Medical Center	$17,595.00	Recurring
Hosting Services	1 Facilities	Winn Army Community Hospital	$11,995.00	Recurring
Hosting Services	1 Facilities	Morgan Memorial Hospital	$8,595.00	Recurring
Hosting Services	1 Facilities	Piedmont Walton	$8,595.00	Recurring
Hosting Services	1 Facilities	Polk Medical Center	$8,595.00	Recurring
Hosting Services	1 Facilities	Redmond Regional Medical Center	$17,595.00	Recurring
Hosting Services	1 Facilities	Piedmont Cartersville Medical Center	$11,995.00	Recurring
Hosting Services	1 Facilities	Memorial Health Meadows Hospital	$8,595.00	Recurring

Total Recurring Fees	$	155,735.00
Total One-Time Fees	$	0.00
TOTAL FEES	$	155,735.00

Quote Date:	02/08/2022
Customer Name:	Georgia Trauma Care Network Commission
Quote #:	Q-60415
Quote Expiration date:	05/09/2022
ESO Account Manager:	Debi Bowman

DI

Product	Description
Hosting Services	Provide Hosting Environment for clients for the use of the various trauma products.
Hosting Services	Provide Hosting Environment for clients for the use of the various trauma products.
Hosting Services	Provide Hosting Environment for clients for the use of the various trauma products.
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Hosting Services	Provide Hosting Environment for clients for the use of the various trauma products.

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	Georgia Committee for Trauma Excellence	
Project/Activity[1]	**Comments**	
1. Pediatric Subcommittee	1. Pediatric Readiness Presentation: There will be a presentation on pediatric readiness during the summer Day of Trauma meeting. The session will specifically target adult trauma centers to help prepare for the requirements of the Gray Book. 2. Pediatric Readiness Package: The subcommittee is putting together a pediatric readiness package to be distributed at the summer meeting. 3. Gun Violence: Collaboration with the Augusta team on a violence intervention program, specifically targeting pediatric gun violence. There is potential for a presentation on this during a future meeting. 4. SIPA: Working with Education Subcommittee and the Registry Subcommittee to move the project forward.	
Status: In progress		**Support GTC Strategic Priorities? (Y/N): Y**
2. Registry Subcommittee	1. Time to Definitive Care: Continue working on report to distribute to centers to run and identify themes in the reports 2. 2023 Registry Requests: Requests for changes to the V5 software presented for approval of the sub-committee 3. 2022 ACS Standards Presentation: Discussion around data inclusion criteria acceptance of state/local inclusion criteria and 0.5 FTE per 200 – 300 registry patients • Educational requirements • Survey monkey distributed to all centers related to above standards for feedback of education needs/ requests	
Status: In progress		**Support GTC Strategic Priorities? (Y/N): Y**

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3. Education Subcommittee	1. Transfer to Definitive Care: A workgroup has been created within the Education Subcommittee to focus on this initiative. At this point, a literature review has been done and objectives for the education material created. An outline has been shared with the group. Discussion regarding if it is valuable to determine which injuries require a rapid (2-hour window of transfer) versus those injuries that do not. 2. Acute Kidney Injury: Objectives and literature review are underway as the first steps in creating education material. 3. Utilizing State Funding for Education: The state had education funding left over from the previous FY. They have asked the education subcommittee to help fund educational offerings. The Education Subcommittee had approx. $11,000 to help fund educational offerings around the state. • Funding an ATCN course at Grady on June 11 for $4000. 24 applicants for course at Grady. 16 participant spots. Will accept all of the non-trauma applicants or from hospitals who only have 1 applicant. Will try to accept 2 applicants from the other trauma programs who applied. Erin and Jessica will work together to prioritize the names for the other spots. • Funding TNCC Provider Course at Phoebe Putney $5000 – invoice has been sent to the state. • TNCC Instructor Course at Piedmont Henry $1,000 – invoice pending being sent to state. • Purchased the new STN Trauma E-Library for the state-wide trauma designated or ACS verified trauma center use. Jessica is working on the Agreement letter for hospitals. Will share the E-Library to the Education Committee Teams folder for dissemination.
Status: In progress	**Support GTC Strategic Priorities? (Y/N): Y**
4. Injury Prevention and Outreach Subcommittee	1. Increase Trauma Awareness: Each of the IP and Outreach Subcommittee Task Forces (Special Events, Falls, Traffic Injury, and Intentional Injury) and will produce at least **ONE** webinar during calendar year 2022. 2. Georgia STOP THE BLEED Training Blitz: The Special Events Task Force assisted with the STOP THE BLEED® - Bleeding Control U event for colleges and universities. There were more than 200 participants. The Georgia STOP THE BLEED® Blitz is underway with a full day of STOP THE BLEED® Webinars planned for May 19, 2022. **Trauma centers and trauma system partners are encouraged to provide a STOP THE BLEED® training offering during May (National STOP THE BLEED® Month).** Training can be directed to staff members and the community. With the popularity of on-demand and webinar offerings, In-person Skills Only courses are needed. **Over 2,000 participants in Georgia Trauma System STOP THE BLEED® Webinars to date.** 3. Prevent Trauma-The Road Ahead: The Traffic Injury Prevention Task Force hosted, Prevent Trauma, The Road Ahead, a peer-led teen driving webinar on Thursday,

GEORGIA TRAUMA COMMISSION

	March 24, 2022, at 7:00pm. The panel discussion featured two moderators from Northeast Georgia Medical Center, a Georgia Trauma Survivor, Teens for Balwin County High School's Teens in the Driver's Seat (TDS) Team, and deputies from Monroe County Sheriff's Office. There were over 70 attendees from fifteen Georgia counties. (49% Teens, 40% Parents, 11% Teachers or Community Partners). 4. Prevent Trauma- Child Abuse Prevention: The Violence and Self-harm Prevention Task Force hosted Prevent Trauma: Child Abuse Prevalence, Prevention, and Response on Wednesday, April 27th, at 12:00pm. Our Georgia Trauma System Partners from Memorial Health University, Atrium Health Navicent, August University, and Children's Healthcare of Atlanta participated in the panel discussion. There were over 25 attendees, from ten Georgia counties. 5. Bingocize and Falls Free Fridays: We completed multi-site Bingocize cohort on March 31, 2022. Facilitators included the Middle Georgia Regional Commission (MGRC), Atrium Health Navicent, Fairview Park, Northside Gwinnett, Kennestone, and Grady. There were over 125 participants from ten counties. Northeast Georgia and Memorial Health University also facilitated cohorts this past quarter. We partnered with the MGRC to provide a Bingocize webinar to the Georgia Department of Human Services, Division of Aging Services on April 12, 2022. The next multi-site Bingocize cohort, coordinated by Northside Gwinnett is set for June.
Status: In progress	**Support GTC Strategic Priorities? (Y/N): Y**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Committee Members:	GCTE Board: GCTE Board: Chair, Jesse Gibson, Vice-Chair, Tracy Johns, Past Chair, Karen Hill and GTC member, Dr. Regina Medeiros GCTE Subcommittee Chairs: Registry, Kelli Vaughn, PI, John Pope, Pediatrics, Kellie Rowker, Education, Jessica Mantooth, Injury Prevention, Kristal Smith
Chair/Commission Liaison:	Jesse Gibson
Date of Next Committee Meeting:	TBD

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	Trauma Admininstrators Committee
Project/Activity[1]	**Comments**
1. Develop Charter and Purpose for the group	Clearly define the goals, objectives and expected outcomes as they align to the needs of the GTC with a focus on quality, access and finance
Status: In Process	**Support GTC Strategic Priorities? (Y/N):Y**
2. Meeting cadence	
Status: Complete	**Support GTC Strategic Priorities? (Y/N):Y**
3. Co- chair development	
Status: Complete	**Support GTC Strategic Priorities? (Y/N):Y**
4. Workgroup meeting kickoff	Finance, Diversion, Education
Status: In Process	**Support GTC Strategic Priorities? (Y/N):Y**
5. GCC status for trauma	Screen shots sent- need to be finalized
Status: In Process	**Support GTC Strategic Priorities? (Y/N):Y**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None currently
Motions for Consideration at the Commission Meeting:	None currently
Committee Members:	Senior Leaders- each trauma center
Chair/Commission Liaison:	Michelle Wallace
Date of Next Committee Meeting:	July TBD Virtual, Co-chairs in person in St. Simons- strategic planning session

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103.

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	Trauma System Performance
Project/Activity[1]	**Comments**
1. ED LOS for high yield patients	Migration to ImageTrend central site still in progress. Issue discovered with centers sending data which required rework. Testing with pilot centers in progress. No new data for analysis until migration complete.
Status:	**Support GTC Strategic Priorities? (Y/N): Y**
2. FY 2022 Data pull	No new data for analysis until new central site migration complete.
Status:	**Support GTC Strategic Priorities? (Y/N): Y**
3. Transfers to Definitive Care	Registry subcommittee working to build reports to review transfers in and out. Plan is for centers to build PI process around improving data capture.
Status:	**Support GTC Strategic Priorities? (Y/N): Y**
4. Region 10 armband pilot project	Pilot in Region 10 still in development phase. No date for pilot start.
Status:	**Support GTC Strategic Priorities? (Y/N): Y**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Committee Members:	Marie Probst, Renee Morgan, Tracy Johns, Kelli Vaughn, Courtney Terwilliger, Danlin Luo, David Newton, Gina Solomon
Chair/Commission Liaison:	Dr. James Dunne
Date of Next Committee Meeting:	July TBD

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GEORGIA TRAUMA COMMISSION

Trauma System Partner Report to the Georgia Trauma Care Network Commission

Name of Partner:	Georgia Trauma Foundation
Project/Activity[1]	**Comments**
1. Mission Fulfillment	To increase its effectiveness in providing philanthropic support to the state's trauma system, GTF is partnering with Alexander Haas – one of the leading fundraising consulting firms in the nation. During its initial engagement, the Haas team will work with GTF and its Board of Directors to better position the organization for fundraising success.
Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Y**
2. Continuing Education Data Base Project	GTF is spearheading a project for the State Office of Rural Health. The project is grant-funded. Upon completion, the data base will serve as a one-stop shop to identify course faculty for state and nationally approved continuing education programs, including TNCC, ATCN, and ATLS.
Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Y**
3.	
Status:	**Support GTC Strategic Priorities? (Y/N):**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Commission Liaison:	John Bleacher
Date of Next Foundation Meeting:	July 6, 2022

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GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	GQIP
Project/Activity[1]	**Comments**
1. AKI, TBI & Opioid Workgroups 2. VAP Guideline Review	**AKI**: Plan for more recent data pull for comparison to 2017 data. Poster on AKI Physician Practice Survey accepted at Quality & Safety Conference. **TBI:** Completing larger data pull from centers for analysis**. Opioids:** Continuing to work on Multimodal guidelines**. VAP Guideline Review:** Workgroup developed to review and update as needed**.**
Status: In Progress	**Support GTC Strategic Priorities? (Y/N): Y**
3. Benchmarking Platform & Data Central Site	The new contract process requires contracts involving software to be reviewed by the Georgia Technology Authority (GTA). Their review requested numerous changes. Changes completed & back to commercial contract team to finalize and resend to GTA for approval. Once GTA approves can send to benchmarking platform vendor. Awaiting project timeline and SOW for central site project.
Status: In progress	**Support GTC Strategic Priorities? (Y/N): Y**
4. Peer Protection & Data Use Policies	Meetings continue with the special counsel and AG office. Recent focus on clarifying status in regards to HIPAA-covered entity. Moving forward GTC is clarified as a non-covered entity in regards to HIPAA.
Status: In Progress	**Support GTC Strategic Priorities? (Y/N): Y**
5. GQIP Trauma Advisory Committee	Committee meeting monthly. Input for Summer Meeting Agenda (attached).
Status: In Progress	**Support GTC Strategic Priorities? (Y/N): Y**

Questions, Issues, and Recommendations Requiring Commission Discussion:	None
Motions for Consideration at the Commission Meeting:	None
Committee Members:	Dr. R. Todd, Dr. J. Sharma, G. Solomon, Trauma Center Progam Staff

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GEORGIA TRAUMA COMMISSION

Chair/Commission Liaison:	Dr. Todd & G. Solomon
Date of Next Committee Meeting:	March 17 @ 4 PM; August 12 Summer Meeting

GEORGIA QUALITY IMPROVEMENT PROGRAM

GQIP Trauma Collaborative Summer Meeting
Agenda
August 12, 2022

Time	Topic	Speaker	Length
0830	Welcome	Dr. Todd & Gina Solomon	10 min
0840	Review of Spring 2022 Collaborative TQIP Report	Dr. Todd	10 min
0850	GQIP Research Resident Update	Dr. Codner Dr. Mlaver	10 min
0900	Level III/IV Focus: TBD		30 min
0930	**Break**		15 min
0945	Improving Practice Presentations: VTE Prophylaxis & Hip Fracture Optimization	Tracy Johns Pam Vanderberg	30 min
1015	Workgroup Updates: AKI, Opioid & TBI	Dr. Ayoung-Chee Dr. Kohler Dr. Benjamin	60 min
1115	VAP Guideline Review	Dr. Avery	15 min
1130	NSQIP Update	Dr. Sharma	15 min
1145	**Lunch**		60 min
1245	Keynote Address: Building the Optimal Trauma Quality Collaborative	Dr. Lillian Kao	60 min
1345	Pediatric Focus: Pediatric Readiness	Dr. Natalie Lane	30 min
1415	ArborMetrix Update & Metric Discussion	Dr. Todd	30 min
1445	**Break**		15 min
1500	M. Gage Ochsner Resident Paper Competition		120 min

This Program was made possible in part by State of Georgia funding provided through the Georgia Trauma Care Network Commission.

Georgia Office of EMS and Trauma Report to Trauma Commission – May 19, 2022

	Trauma Program
Significant Events (Previous or Upcoming):	• Published Georgia Trauma Registry – 2019 Annual Report • Developing Armband Pilot Project (Crash Records, EMS Records, and Hospital Records) • NHTSA EMS Assessment for Georgia will be before the end of the federal fiscal year (9/31)
Successes for the Entity/Program/Region:	• TRAIN Georgia Education platform is active and available with free education available. Organizations can become course providers and place content on TRAIN. Education is free with CE awarded. • A new Level IV facility in Region 4 has had their site visit and final report is pending. • Site visit in processed of being scheduled for a potential new Level IV facility in Region 4. • One potential Level IV in Region 8 has completed PRQ and is being scheduled for site visit. • OEMST participated in 3 ACS visits, 2 – Level II and 1 – Level III. Waiting on final report. • Continue preparation of web-based trauma registry that will be of no cost to users. Two facilities that were selected as pilots are doing well.
Challenges for the Entity/Program/Region:	• Scheduling Georgia site redesignation visits while the GTC is scheduling rural health assessment site visits is challenging for hospitals. • ED Physicians, Trauma Surgeons and Trauma Coordinators are needed for site reviewers. Need to be from a designated/verified Trauma Center. If interested contact Renee Morgan renee.morgan@dph.ga.gov • Still continue to see high turnover with trauma staffing at Trauma Centers.
Name of Person Submitting Report:	Renee Morgan, David Newton, Kelly Joiner

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

Update of designations as of April 25, 2022

Of the 8 Level III's

3 are current

1 Re-designated awaiting final report.

1 Waiting on final report from ACS consult.

3 Are awaiting ACS Consults in 2022

Of the 7 Level IV's

3 are current

2 are in process of setting dates and teams for re-designation

2 are preparing PRQ's.

4 NEW facilities (Level IV) have submitted PRQs and are awaiting tabletops pre-visit, setting dates and team or has had visit and awaiting final report.

Over all 2 Visits were done in 2021

2020 and 2021 visits were severely impacted by COVID. Many III's and IV's had to totally divert resources to critical care from trauma services. There has also been issues with the II's and III's on ACS visits. Many centers have been rescheduled multiple times. We are just now beginning to schedule visits and recruit team to survey.

Renee Morgan
Trauma Program Director
DPH

Georgia Trauma Registry
2019 Annual Report

Office of EMS and Trauma

Vision

A Healthy and Safe Georgia – exceptional patient outcomes through comprehensive, statewide, integrated, data–driven, equitable, and people–centered Emergency Medical Services and time–sensitive systems of care.

Mission

The mission of the Georgia Office of EMS and Trauma is to reduce death and disability by providing regulation, guidance, and leadership to enable the assessment, planning, development, and promotion of statewide Emergency Medical Services and time–sensitive systems of care.

Contents

Introduction

The Georgia Trauma Annual Report 2019 is a demographic epidemiological analysis of the Georgia Trauma Registry data for the year 2019 based on data downloaded on August 1, 2021. The Designated Trauma Centers (DTC) in Georgia participate in the National Trauma Data Bank (NTDB). In 2019, Georgia had 31 DTC; 6 facilities were designated at Level I, 11 were Level II, 7 were Level III, and 7 were designated at Level IV. Included in facility totals are one Level I pediatric facility and two Level II pediatric facilities. A total of 34,419 trauma cases were reported in 2019 from 31 DTC in Georgia. Facility information such as trauma levels is provided to allow readers to have an overall picture of the Georgia Designated Trauma Centers (Appendix 1). Trauma registry criteria are provided in the Appendix 2. This report provides analysis of time to definitive care, patient's demographic information, injury characteristics, payment sources, intents, mortality, and outcomes.

The mission of the Georgia trauma system is to save lives and provide the best possible outcomes through improved trauma care and injury prevention. The Georgia Trauma Registry is dedicated to collect trauma data and provide useful information to benefit the public health of Georgia's citizens.

The purpose of this report is to inform the medical community, the public, and the decision makers about issues that characterize the most recent state of care for trauma patients. Implications of this report are wide in areas including epidemiology, injury prevention, research, education, acute care, resource allocation, and policy decision.
The Georgia Department of Public Health, Office of EMS and Trauma would like to thank all the trauma centers that contributed data. Many thanks go to the Georgia trauma coordinators, trauma registrars and staff for their great efforts in collecting data and improving data quality.

Contact Information:

Georgia Department of Public Health, Office of EMS and Trauma
David Newton, Director of the Division of Health Protection and the Office of EMS and Trauma, david.newton@dph.ga.gov
Renee Morgan, Trauma Program Director, renee.morgan@dph.ga.gov
Danlin Luo, Ph.D., Trauma Epidemiologist, danlin.luo@dph.ga.gov
Marie Probst, State Trauma Registrar, marie.probst@dph.ga.gov

Summary

Hospitals

- 31 designated trauma hospitals submitted data in 2019.
  - 5 Level I adult centers and 1 Level 1 pediatric center.
  - 9 Level II adult centers and 2 Level 2 pediatric centers.
  - 7 Level III adult centers.
  - 7 Level IV adult centers.

Age

- The frequency of injuries initially peak in ages 18 to 30, primarily from MVT-related incidents, and peak again between the ages of 56 and 61, when falls begin to increase.
- Fall-related injuries spike in children aged 0-9 and adults over the age of 60.
- Males account for 66.6% of all incidents up to age 70; after age 70, most patients are female.

Mechanism of Injury

The mechanism of injury was based on NTDB published reference 'External Cause of Injury Matrix and Trauma Type Map (https://www.facs.org/quality-programs/trauma/tqp/center-programs/ntdb).

- Falls account for 44.3% of cases in the registry data. The frequency of Fall related injuries increases in children under age 9 and adults over the age of 60.
- Motor vehicle traffic related (MVT) injuries account for 30.2% of cases in the registry data. The frequency of MVT injuries peak between age 18 to 29.
- Firearm injuries account for 6.7% of cases in the registry data and peak between age 18 to 30.
- Suffocation, firearm, and drowning/submersion injuries have the highest case fatality rates, with suffocation at 57.1%, firearm at 16.5%, and drowning/submersion at 11.1%.

Injury Severity Score

The Injury Severity Score (ISS) is a system for numerically stratifying injury severity. The ISS system has a range of 1-75, and injury severity increases with a higher score. This

report groups ISS 1-8 as minor; 9-15 as moderate; 16-24 as severe; and greater than 24 as very severe.

- Almost half (45.1%) of the trauma registry patients suffered minor injuries and about one-third (37.3%) have moderate injuries.
- Case fatality rates increase with injury severity, with the most severe group experiencing a case fatality rate of almost 29.8%.
- Median Length of Stay (LOS) increases for each consecutive severity grouping.
- Median Ventilator Days increase for each consecutive severity grouping.
- Median Intensive Care Unit (ICU) Days increase for each consecutive severity grouping.

Mortality

- The overall mortality rate is 4.0%.
- Case fatality rates are highest in the patient age group 20-24.
- The male case fatality rate (4.9%) is much higher than female case fatality rate (2.6%).
- The largest number of deaths is caused by motor vehicle traffic injuries, followed by firearm injuries and fall-related injuries.
- Firearm, suffocation, and drowning/submersion have the highest case fatality rates.
- Firearm injuries have the highest case fatality rate at 16.5% among the selected mechanisms (top six) shown in the report.

Payment

- Medicare is the largest payment source at 27.0%.
- Private/Commercial insurance is the second largest category at 21.8%.
- Self-Pay is the third largest category at 18.7%.
- Medicaid is the fourth largest category at 11.6%.

Facility Information

All facilities seeking designation status are expected to meet specific criteria as set forth by the Department of Public Health, Office of EMS and Trauma (OEMST). The department utilizes the document, "Resources for Optimal Care of the Injured Patient", published by the American College of Surgeons. All designated hospital must submit trauma registry data to the OEMST and maintain a performance improvement process with thorough documentation.

Level I Trauma Facility – is the highest level of trauma center designation and offers the greatest level of comprehensive trauma care, from prevention through rehabilitation.
Level I facilities have the major responsibility for leading in trauma education, research, and planning. Facilities that meet Level I criteria will be academic facilities.

Level II Trauma Facility – can provide the same level of clinical care as a Level I, but usually does not have the focus on research, education, and systems planning. Some patients with very complex injuries, such as replantation, may require transfer to a Level I center.

Level III Trauma Facility – provides trauma assessment, resuscitation, emergency surgery, stabilization and if needed, transfer of patients requiring more definitive care to Level I or II centers. Well trained emergency department physicians and general surgeons
are required.

Level IV Trauma Facility – provides advanced trauma life support and stabilization of patients received in their facility. Well trained mid-level providers may assist to expedite the transfer of patients requiring more definitive care to Level I or II centers. Level IV centers may be a clinic or hospital in a remote or rural area and may or may not have a physician available 24 hours a day.

Table 1

Facilities by Level		
Level	Number	Percent
I	6	19.4
II	11	35.5
III	7	22.6
IV	7	22.6
Total	31	100.0
More than half of the designated trauma facilities are either a Level I or Level II trauma center.		

Figure 1

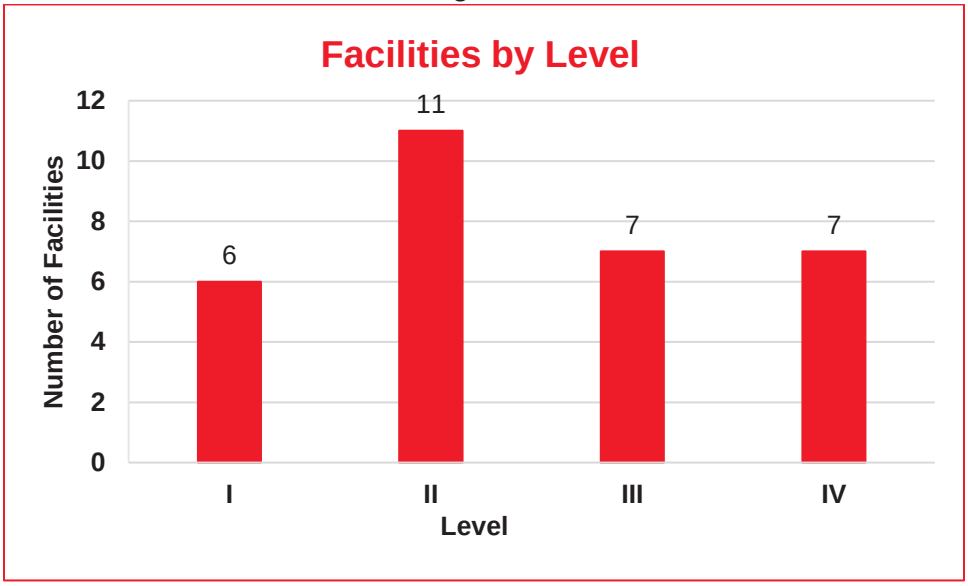


Table 2

Incidents by Facility Level		
Level	**Number**	**Percent**
I	17,608	51.2
II	13,649	39.7
III	2,697	7.8
IV	465	1.4
Total	34,419	100.0
About 90% trauma patients were treated in Level I or Level II trauma facilities.		

Figure 2A

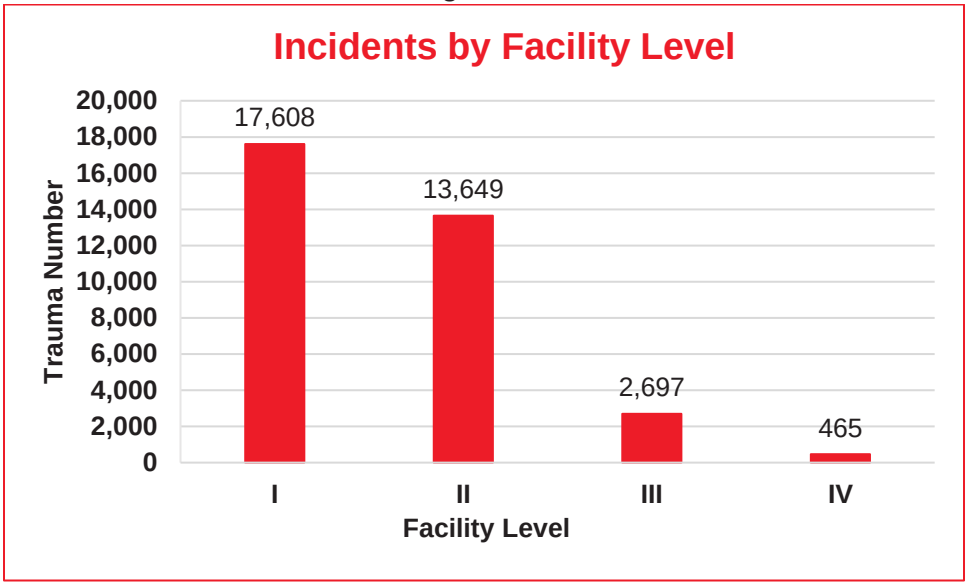
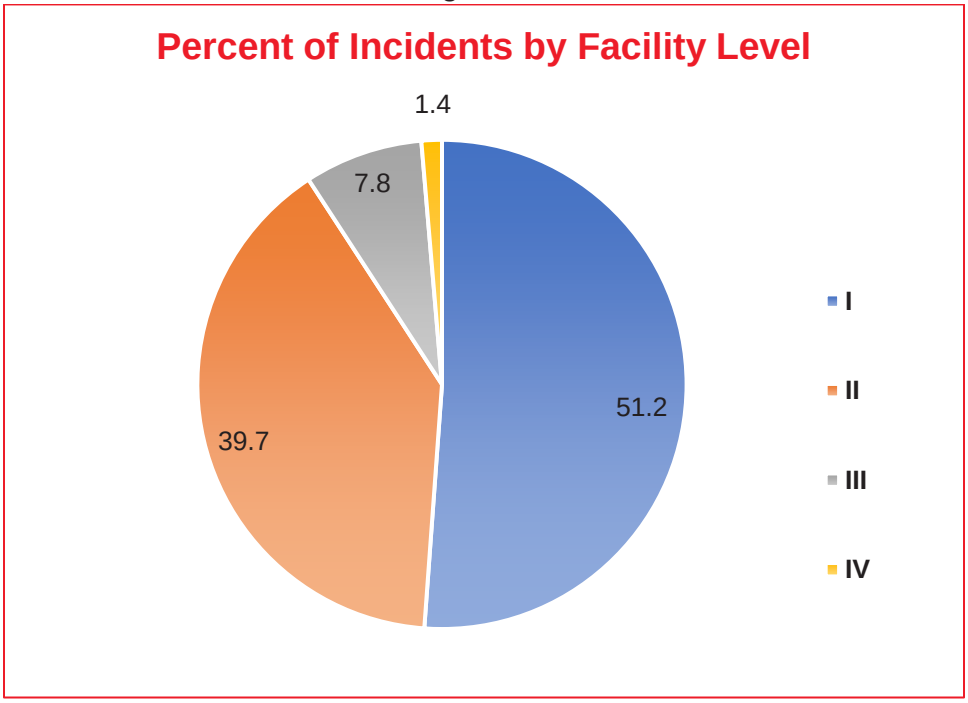


Figure 2B



Prehospital Information

The goal of the Emergency Medical Services (EMS) system is to prevent further injury, initiate resuscitation, and provide safe and timely transport of the injured patient. Patients should be transported directly to the center most appropriately equipped and staffed to handle the patient's injuries. The tables and graphs in this section display data indicating where patients came from before arriving at a designated trauma center.

Table 3

Incidents by EMS Region		
EMS Region	**Frequency**	**Percent**
R1	2,546	7.4
R2	1,838	5.3
R3	15,901	46.2
R5	3,697	10.7
R6	3,209	9.3
R7	971	2.8
R8	757	2.2
R9	3,535	10.3
R10	1,965	5.7
Total	34,419	100.0

The frequency of trauma patients in Table 3 represents the number of patients treated in designated trauma centers located in different EMS regions. In 2019, there were no designated trauma centers in EMS Region 4. Facilities in EMS Region 3 treated the most trauma patients (46.2%).

Figure 3A

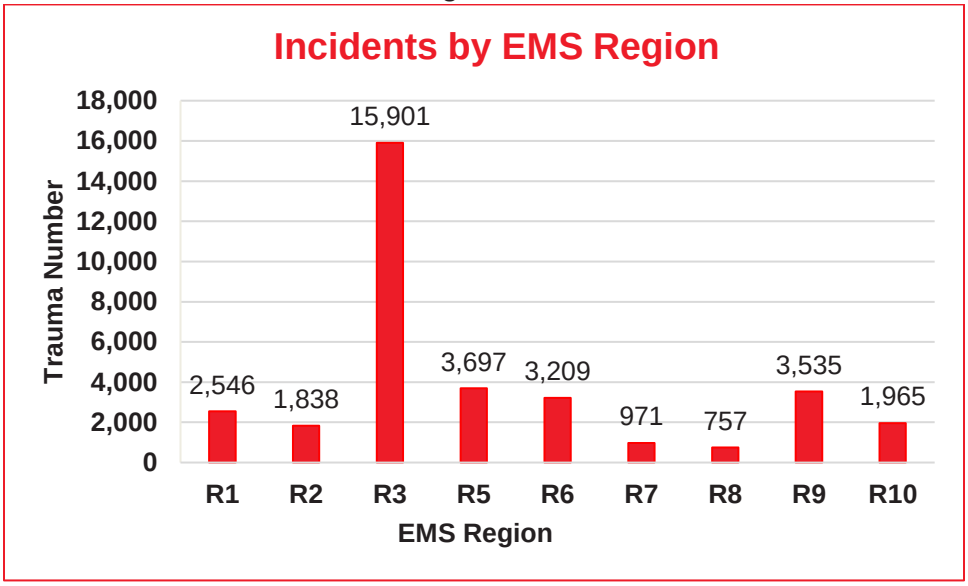


Figure 3B

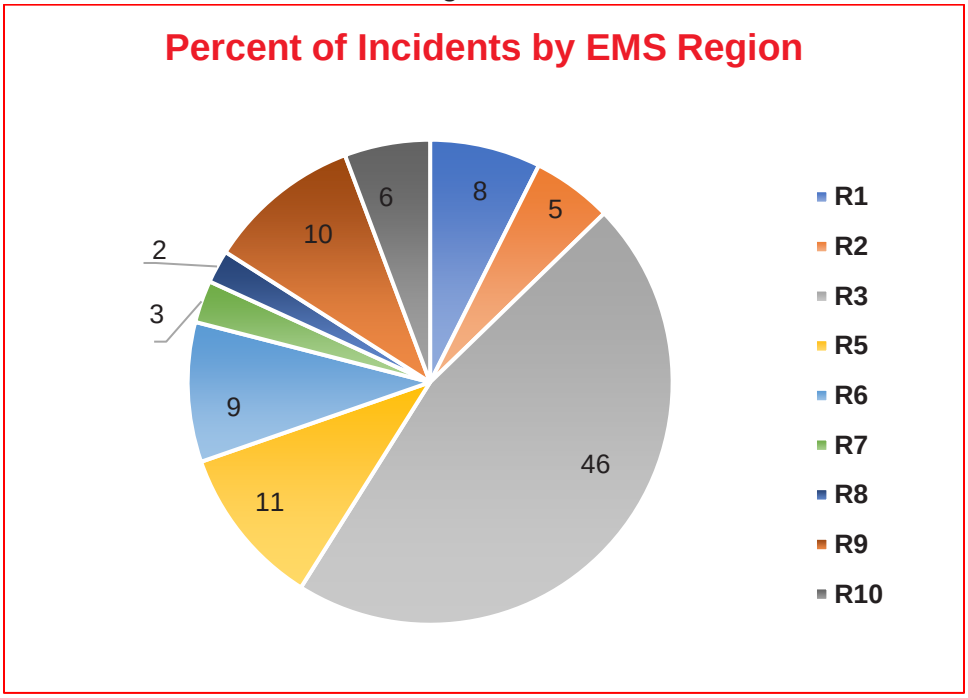
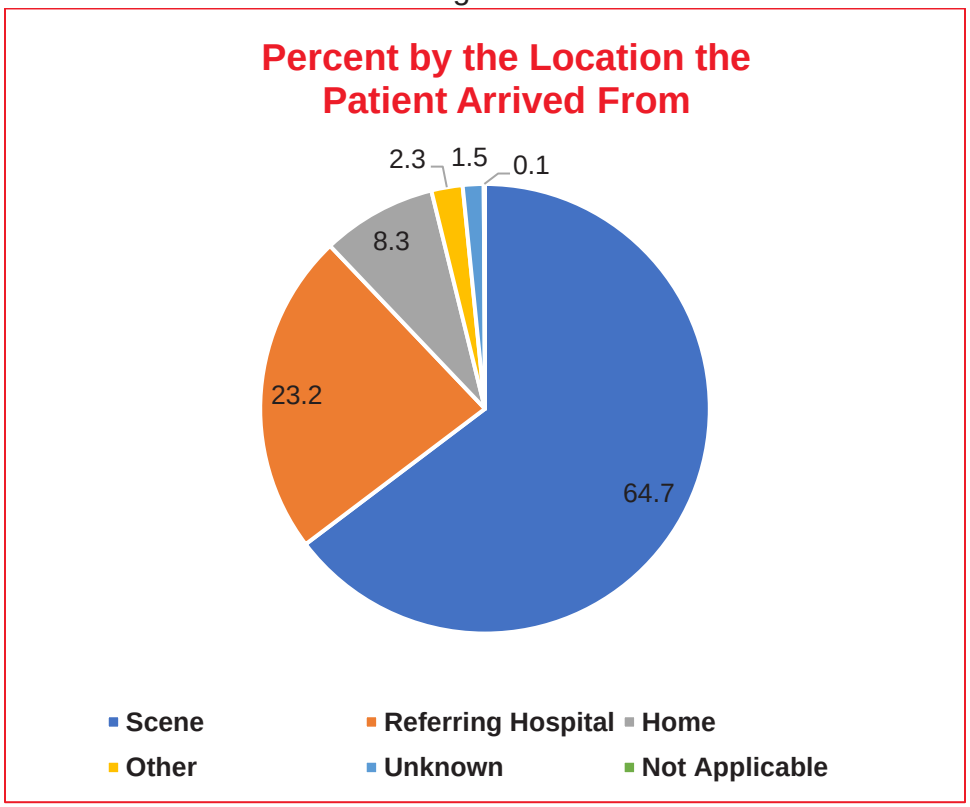


Table 4

Frequency of Patients by the Location the Patient Arrived From				
Frequency	**ISS<=15**	**ISS>15**	**Total**	**Percent**
Scene	17,865	4,363	22,228	64.7
Referring Hospital	6,670	1,296	7,966	23.2
Home	2,625	214	2,839	8.3
Other	719	55	774	2.3
Not Applicable	29	3	32	0.1
Unknown	434	80	514	1.5
Total	28,342	6,011	34,353	100.0
Frequency missing = 66.				

Figure 4



Time to Definitive Care Analysis

In the trauma registry data, 22,228 cases (64.7%) reported the patient arrived from the 'Scene' of the injury, which are the original data sources for **Scene Group** (S Group). Additionally, 7,966 cases (23.2%) reported the patient arrived from a 'Referring Hospital', which are the original data sources for **Referring Group** (R Group).

For Patients from the 'Scene' of the Injury: S Group

There are 22,228 cases reported to have arrived from the '**Scene**' of the injury. Among these 22,228 cases, 19,763 cases were linked with a Prehospital Provider data. Among these 19,763 cases, 18,481 cases have the Emergency Medical Service (EMS) provider's role as '**Transport from Scene to Facility**'. These 18,481 cases are the data sources of the **S Group**.

Time from EMS Dispatch Time to EMS Scene Arrival Time (Tables 5A1, 5A2, 5A3)

Among these 18,481 cases, 15,969 cases (86.4%) have valid values in the four fields: EMS Dispatch Date, EMS Dispatch Time, EMS Scene Arrival Date, and EMS Scene Arrival Time. Among these 18,481 cases, **13.6% of the cases have missing data in at least one of the four fields.** The data in the 15,969 cases is used to calculate the median time from EMS Dispatch to EMS Scene Arrival.

Table 5A1

S Group, All ISS, Median Time from EMS Dispatch Time to EMS Scene Arrival Time

Hospital Level	Frequency	Median Total Time
1	7,814	0:09:00
2	6,846	0:08:00
3	1,177	0:08:00
4	132	0:09:00
Total	15,969	0:09:00

Time Format is HH:MM:SS (the following tables have the same Time Format). The hospitals are the destination Hospitals. The median total time from EMS Dispatch Time to EMS Scene Arrival Time is 9 minutes.

Table 5A2

S Group, ISS <=15, Median Time from EMS Dispatch Time to EMS Scene Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	5,893	0:09:00
2	5,568	0:08:00
3	1,075	0:08:00
4	106	0:09:30
Total	12,642	0:09:00

Table 5A3

S Group, ISS >15, Median Time from EMS Dispatch Time to EMS Scene Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,921	0:09:00
2	1,278	0:08:00
3	102	0:08:00
4	26	0:08:00
Total	3,327	0:08:00
For more severely injured patients (ISS >15), the median total time from EMS Dispatch Time to the EMS Scene Arrival Time is 1 minute shorter than that of minor and moderate injured patients (ISS <=15).		

Time from EMS Scene Arrival Time to EMS Scene Departure Time (Tables 5B1, 5B2, 5B3)

Among these 18,481 cases, 15,914 cases (86.1%) have valid values in the four fields: EMS Scene Arrival Date, EMS Scene Arrival Time, EMS Scene Departure Date, and EMS Scene Departure Time. Among these 18,481 cases, **13.9% of the cases have missing data in at least one of the four fields.** The data from these 15,914 cases is used to calculate the median time from EMS Scene Arrival Time to EMS Scene Departure Time.

Table 5B1

S Group, ISS All, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	7,783	0:18:00
2	6,825	0:16:00
3	1,174	0:18:00
4	132	0:17:00
Total	15,914	0:17:00
The median total time from EMS Scene Arrival Time to EMS Scene Departure Time is 17 minutes.		

Table 5B2

S Group, ISS <=15, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	5,871	0:19:00
2	5,551	0:17:00
3	1,072	0:18:00
4	106	0:18:00
Total	12,600	0:18:00

Table 5B3

S Group, ISS >15, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,912	0:16:00
2	1,274	0:15:00
3	102	0:18:00
4	26	0:15:00
Total	3,314	0:16:00
For more severely injured patients (ISS >15), median total time from EMS Scene Arrival Time to EMS Scene Departure Time is 2 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

Time from EMS Scene Departure Time to Hospital Emergency Department (ED) Arrival Time (Tables 5C1, 5C2, 5C3)

Among these 18,481 cases, 15,927 cases (86.2%) have valid values in the four fields: EMS Scene Departure Date, EMS Scene Departure Time, ED Arrival Date, and ED Arrival Time. Among these 18,481 cases, **13.8% of the cases have missing data in at least one of the four fields.** The data from these 15,927 cases is used to calculate the median time from EMS Scene Departure Time to the Hospital ED Arrival Time.

Table 5C1

S Group, ISS All, Median Time from EMS Scene Departure Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	7,792	0:24:00
2	6,830	0:24:00
3	1,173	0:21:00
4	132	0:16:00
Total	15,927	0:24:00
The median total time from EMS Scene Departure Time to Hospital ED Arrival Time is 24 minutes.		

Table 5C2

S Group, ISS <=15, Median Time from EMS Scene Departure Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	5,878	0:24:00
2	5,555	0:25:00
3	1,071	0:22:00
4	106	0:16:00
Total	12,610	0:24:00

Table 5C3

S Group, ISS >15, Median Time from EMS Scene Departure Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,914	0:22:00
2	1,275	0:20:00
3	102	0:14:00
4	26	0:10:00
Total	3,317	0:21:00
For more severely injured patients (ISS >15), median total time from EMS Scene Departure Time to Hospital ED Arrival Time is 3 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

Time from EMS Dispatch Time to Hospital ED Arrival Time (Tables 5D1, 5D2, 5D3)

Among these 18,481 cases, 15,997cases (86.6%) have valid values in the four fields: EMS Dispatch Date, EMS Dispatch Time, ED Arrival Date, and ED Arrival Time. Among these 18,481 cases, **13.4% of the cases have missing data in at least one of the four fields.** The data from these 15,997 cases is used to calculate the median time from EMS Dispatch Time to Hospital ED Arrival Time.

Table 5D1

S Group, ISS All, Median Time from EMS Dispatch Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	7,832	0:54:00
2	6,856	0:51:00
3	1,177	0:51:00
4	132	0:45:30
Total	15,997	0:52:00
The median total time from EMS Dispatch Time to Hospital ED Arrival Time is 52 minutes.		

Table 5D2

S Group, ISS <=15, Median Time from EMS Dispatch Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	5,906	0:55:00
2	5,576	0:52:00
3	1,075	0:52:00
4	106	0:48:00
Total	12,663	0:53:00

Table 5D3

S Group, ISS >15, Median Time from EMS Dispatch Time to Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,926	0:50:00
2	1,280	0:44:30
3	102	0:44:00
4	26	0:40:00
Total	3,334	0:47:00
For more severely injured patients (ISS >15), median total time from EMS Dispatch Time to Hospital ED Arrival Time is 6 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

For Patients from Referral Hospital: R Group

There are 7,966 cases reported to have arrived from a 'Referring Hospital'. Among these 7,966 cases, 7,920 cases were linked with Referring Hospital data. Among these 7,920 cases, 4,465 cases were linked with Prehospital Provider data. Among these 4,465 cases, 3,107 cases have the EMS provider's role as 'Transport from Scene to Facility'. These 3,107 cases are used for analysis for R Group time analysis.

Time from EMS Dispatch to EMS Scene Arrival Time (Tables 6A1, 6A2, 6A3)

Among these 3,107 cases, 580 cases (18.7%) have valid values in the four fields: EMS Dispatch Date, EMS Dispatch Time, EMS Scene Arrival Date, and EMS Scene Arrival Time. Among these 3,107 cases, **81.3% of the cases have missing data in at least one of the four fields.** The data with these 580 cases is used to calculate the median time from EMS Dispatch Time to EMS Scene Arrival Time.

Table 6A1

R Group, ISS All, Median Time from EMS Dispatch Time to EMS Scene Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	358	0:09:00
2	217	0:09:00
3	5	0:13:00
Total	580	0:09:00
The median total time from EMS Dispatch Time to Scene Arrival Time is 9 minutes, which is the same as that in the S Group.		

Table 6A2

R Group, ISS <=15, Median Time from EMS Dispatch Time to EMS Scene Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	264	0:09:00
2	174	0:09:00
3	4	0:11:00
Total	442	0:09:00

Table 6A3

R Group, ISS >15, Median Time from EMS Dispatch Time to EMS Scene Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	94	0:09:00
2	43	0:08:00
3	1	0:16:00
Total	138	0:09:00
Both the more severely injured patients (ISS >15) and minor and moderate injured patients (ISS <=15) have the same median total time from EMS Dispatch Time to EMS Scene Arrival Time.		

Time from EMS Scene Arrival Time to EMS Scene Departure Time (Tables 6B1, 6B2, 6B3)

Among these 3,107 cases, 573 cases (18.4%) have valid values in the four fields: EMS Scene Arrival Date, EMS Scene Arrival Time, EMS Scene Departure Date, and EMS Scene Departure Time. Among these 3,107 cases, **81.6% of the cases have missing data in at least one of the four fields.** The data with these 573 cases is used to calculate the median time from EMS Scene Arrival Time to EMS Scene Departure Time.

Table 6B1

R Group, ISS All, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	352	0:18:00
2	216	0:16:00
3	5	0:20:00
Total	573	0:17:00
The median total time from EMS Scene Arrival Time to EMS Scene Departure Time is 17 minutes, which is the same as that of S Group.		

Table 6B2

R Group, ISS <=15, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	261	0:19:00
2	173	0:16:00
3	4	0:20:30
Total	438	0:18:00

Table 6B3

R Group, ISS >15, Median Time from EMS Scene Arrival Time to EMS Scene Departure Time		
Hospital Level	**Frequency**	**Median Total Time**
1	91	0:16:00
2	43	0:16:00
3	1	0:14:00
Total	135	0:16:00
For more severely injured patients (ISS >15), median total time from EMS Scene Arrival Time to EMS Scene Departure Time is 2 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

Time from EMS Scene Departure Time to Referral Hospital Arrival Time (Tables 6C1, 6C2, 6C3)

Among these 3,107 cases, 526 cases (16.9%) have valid values in the four fields: EMS Scene Departure Date, and EMS Scene Departure Time, Referral Hospital Arrival Date, and Referral Hospital Arrival Time.

Among these 3,107 cases, **83.1% of the cases have missing data in at least one of the four fields.** The data from the 526 cases is used to calculate the median time from EMS Scene Departure Time to Referral Hospital Arrival Time.

Table 6C1

R Group, ISS All, Median Time from EMS Scene Departure Time to Referral Hospital Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	316	0:18:00
2	205	0:19:00
3	5	0:16:00
Total	526	0:18:00
The median total time from EMS Scene Departure Time to Referral Hospital Arrival Time is 18 minutes.		

Table 6C2

R Group, ISS <=15, Median Time from EMS Scene Departure Time to Referral Hospital Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	234	0:18:00
2	163	0:19:00
3	4	0:14:00
Total	401	0:18:00

Table 6C3

R Group, ISS >15, Median Time from EMS Scene Departure Time to Referral Hospital Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	82	0:17:00
2	42	0:18:30
3	1	0:23:00
Total	125	0:18:00

Time from Referral Hospital Arrival Time to the Final Destination Hospital ED Arrival Time (Tables 6D1, 6D2, 6D3)

Among these 3,107 cases, 2,396 cases (77.1%) have valid values in the four fields: Referral Hospital Arrival Date, Referral Hospital Arrival Time, final destination Hospital ED arrival Date, and final destination Hospital ED arrival Time. Among these 3,107 cases, **22.9% of the cases have missing data in at least one of the four fields.** The data from the 2,396 cases is used to calculate the median time from Referral Hospital Arrival Time to the final destination Hospital ED Arrival Time.

Table 6D1

R Group, ISS All, Median Time from Referral Hospital Arrival Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,755	4:38:00
2	634	4:49:00
3	7	11:30:00
Total	2,396	4:41:00
The median total time from Referral Hospital Arrival to Destination Hospital ED Arrival is 4 hours and 41 minutes.		

Table 6D2

R Group, ISS <=15, Median Time from Referral Hospital Arrival Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	1,331	4:49:00
2	524	4:59:00
3	5	11:30:00
Total	1,860	4:53:00

Table 6D3

R Group, ISS >15, Median Time from Referral Hospital Arrival Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	424	3:59:30
2	110	3:57:00
3	2	21:53:00
Total	536	3:59:30
For more severely injured patients (ISS >15), median total time from the Referral Hospital Arrival Time to the final destination Hospital ED Arrival Time is about 53 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

Time from EMS Dispatch Time to the Final Destination Hospital ED Arrival Time (Tables 6E1, 6E2, 6E3)

Among these 3,107 cases, 583 cases (18.8%) have valid values in the four fields: EMS Dispatch Date, EMS Dispatch Time, final destination Hospital ED arrival Date, and final destination Hospital ED arrival Time. Among these 3,107 cases, **81.2% of the cases have missing data in at least one of the four fields.** The data from the 583 cases is used to calculate the mean and median time from EMS Dispatch Time to the final destination Hospital ED Arrival Time.

Table 6E1

R Group, ISS All, Median Time from EMS Dispatch Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	361	5:07:00
2	219	5:40:00
3	3	12:53:00
Total	583	5:23:00

Table 6E2

R Group, ISS <=15, Median Time from EMS Dispatch Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	265	5:35:00
2	177	5:45:00
3	2	11:06:30
Total	444	5:40:30

Table 6E3

R Group, ISS >15, Median Time from EMS Dispatch Time to the Final Destination Hospital ED Arrival Time		
Hospital Level	**Frequency**	**Median Total Time**
1	96	4:17:00
2	42	4:40:30
3	1	36:31:00
Total	139	4:24:00
For more severely injured patients (ISS >15), median total time from EMS Dispatch Time to the final destination Hospital ED Arrival Time is about 76 minutes shorter than that of minor and moderate injured patients (ISS <=15).		

Demographic Information

Demographics are used to identify age groups and genders that may be at high risk for certain injuries. With this type of information, injury prevention programs can focus on the causes of injuries, a target audience, and specific regions of the state.

Table 7

Incidents by Age				
Age Group	**Number**	**Percent**	**Deaths**	**Case Fatality Rate**
<1	470	1.4	12	2.6
1-4	976	2.8	11	1.1
5-9	1,416	4.1	9	0.6
10-14	1,290	3.7	18	1.4
15-19	1,938	5.6	75	3.9
20-24	2,209	6.4	123	5.6
25-34	4,373	12.7	202	4.6
35-44	3,404	9.9	140	4.1
45-54	3,485	10.1	154	4.4
55-64	4,070	11.8	178	4.4
65-74	4,041	11.7	158	3.9
75-84	3,830	11.1	156	4.1
>=85	2,916	8.5	133	4.6
NK/NR	1	0.0	1	100.0
Total	34,419	100.0	1,370	4.0
Case Fatality Rate in age group 20-24 is the highest (5.6%).				

Figure 7A

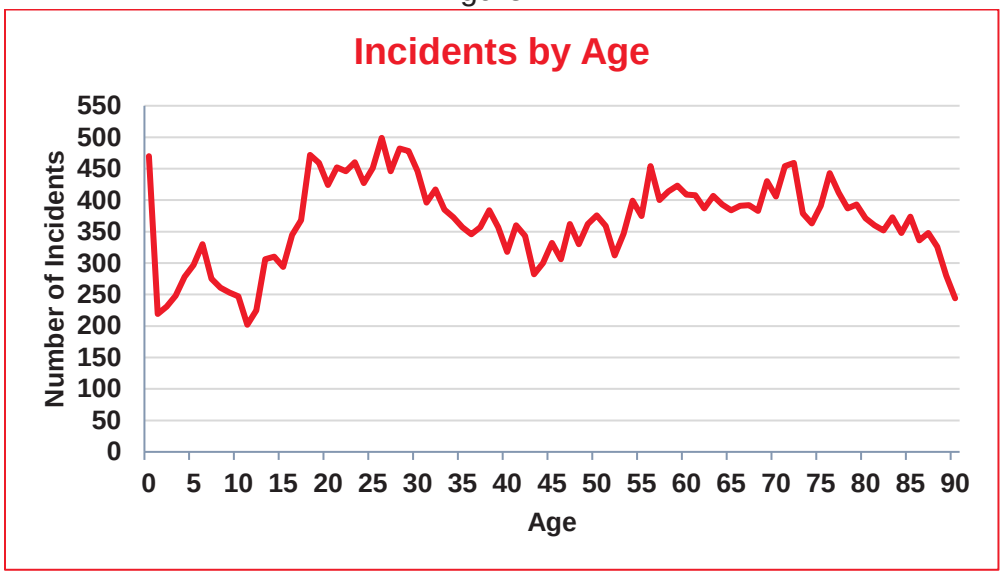


Figure 7B

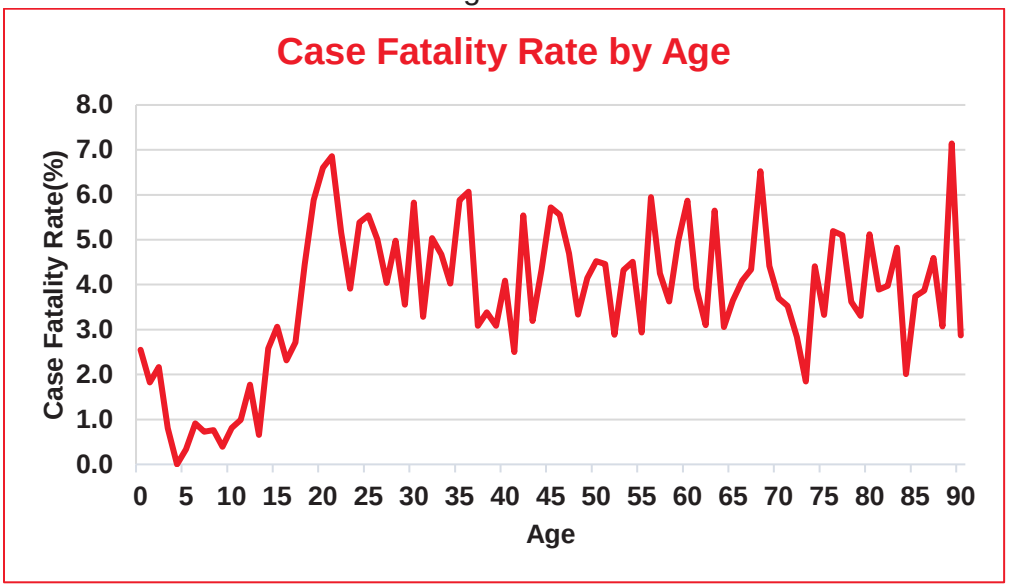


Table 8

Incidents and Case Fatality Rate by Age and Gender						
Age	**Number (Female)**	**Number (Male)**	**Deaths (Female)**	**Deaths (Male)**	**Case Fatality Rate (Female)**	**Case Fatality Rate (Male)**
<1	208	262	5	7	2.4	2.7
1-4	417	559	4	7	1.0	1.3
5-9	607	809	4	5	0.7	0.6
10-14	414	876	8	10	1.9	1.1
15-19	521	1,417	13	62	2.5	4.4
20-24	564	1,645	23	100	4.1	6.1
25-34	1,176	3,197	30	172	2.6	5.4
35-44	965	2,439	26	114	2.7	4.7
45-54	1,108	2,377	41	113	3.7	4.8
55-64	1,575	2,495	39	139	2.5	5.6
65-74	2,023	2,018	55	103	2.7	5.1
75-84	2,355	1,475	54	102	2.3	6.9
>=85	2,103	813	69	64	3.3	7.9
NK/NR	0	1	0	1	0.0	100.0
Total	14,036	20,383	371	999	2.6	4.9

The Incidents number of males (20,383) is much higher than that of female (14,036). Male Case Fatality Rate (4.9%) is higher than female Case Fatality Rate (2.6%). In the female population, the Case Fatality Rate in age group 20-24 is the highest (4.1%). In the male population, the Case Fatality Rate in age group equal or above 85 is the highest (7.9%).

Figure 8A

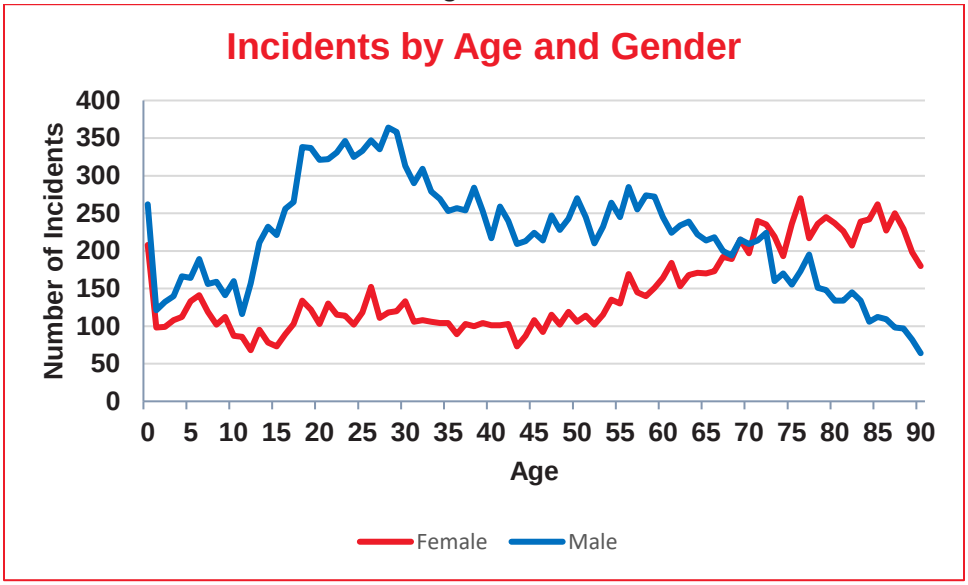


Figure 8B

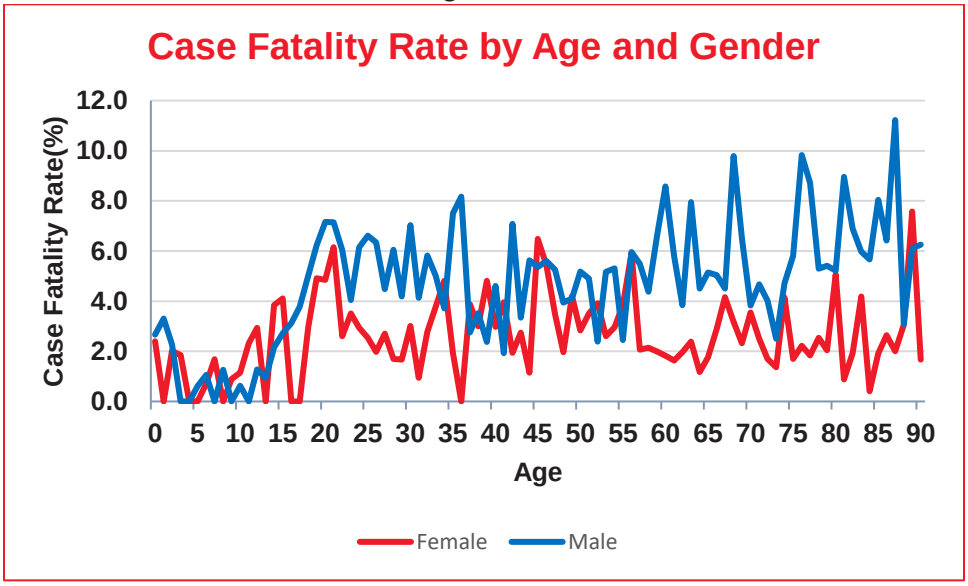


Table 9

Incidents by Alcohol Use		
Alcohol Use Indicator	**Number**	**Percent**
No (Not Tested)	21,530	62.6
No (Confirmed by Test)	9,421	27.4
Yes (Confirmed by Test [Beyond Legal Limit])	2,496	7.3
Yes (Confirmed by Test [Trace Levels])	903	2.6
Not Applicable	57	0.2
Unknown	11	0.0
Total	34,418	100.0
Frequency missing = 1. The incidents number of Alcohol level beyond legal limit (confirmed by test) is 2,496 (7.3%).		

Figure 9

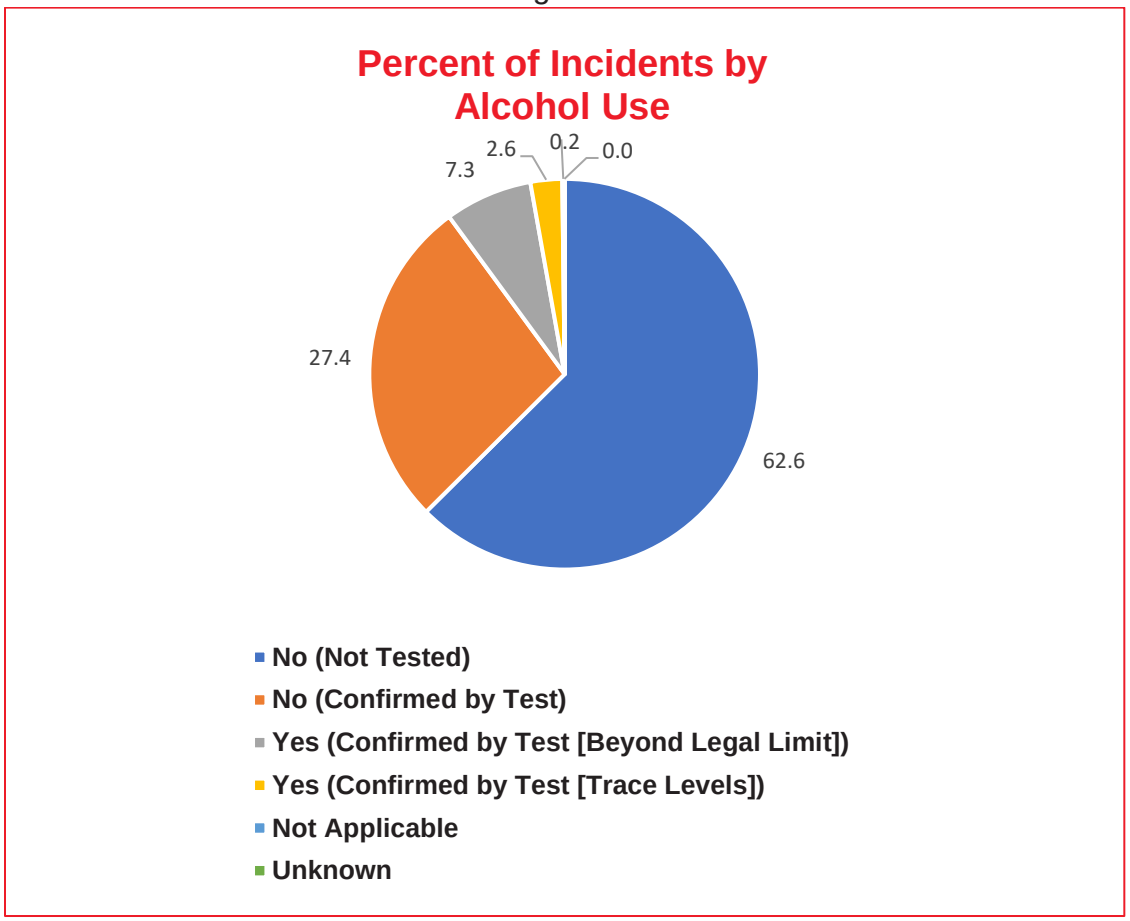


Table 10

Incidents by Drug Use		
Drug Code	**Frequency**	**Percent**
No (Not Tested)	26,626	77.4
No (Confirmed by Test)	3,275	9.5
Yes (Confirmed by Test [Illegal Use Drug])	2,382	6.9
Not Applicable	1,610	4.7
Yes (Confirmed by Test [Prescription Drug])	509	1.5
Unknown	16	0.0
Total	34,418	100.0
Frequency missing = 1. The incidents number of illegal drug use (confirmed by test) is 2,382 (6.9%).		

Figure 10

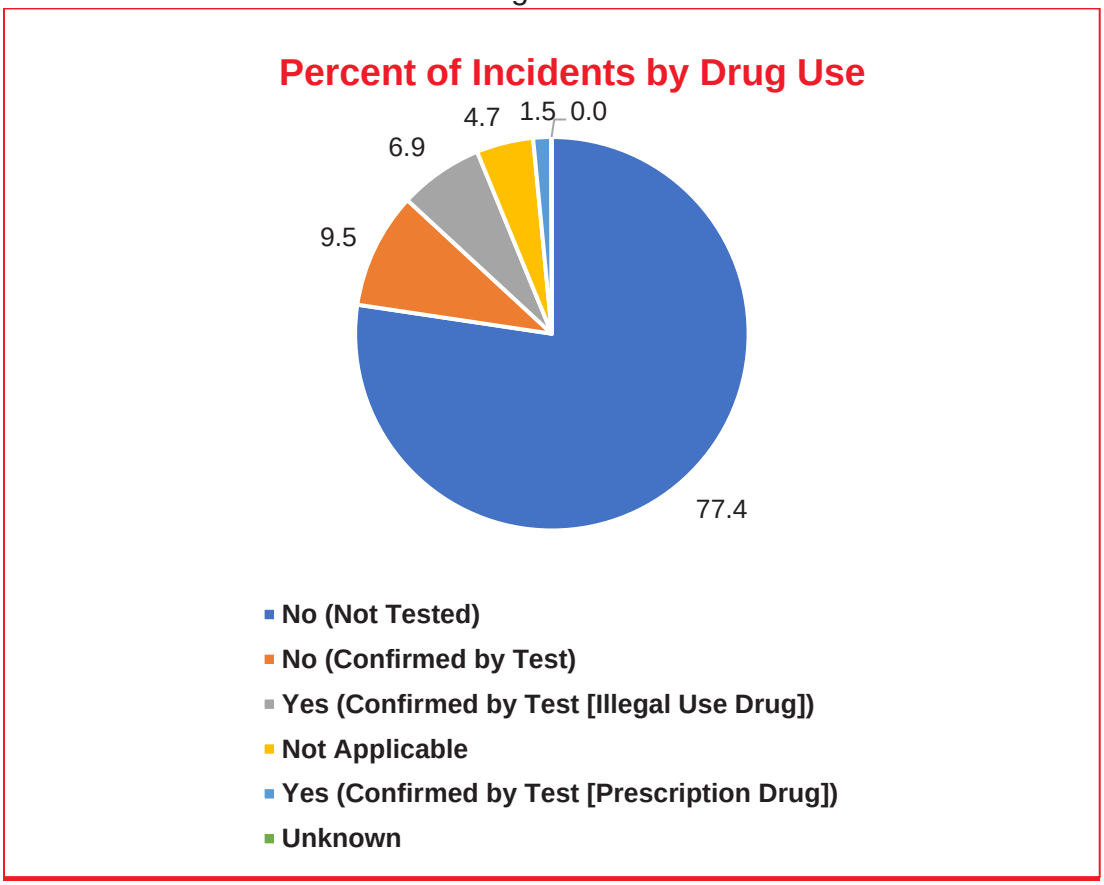
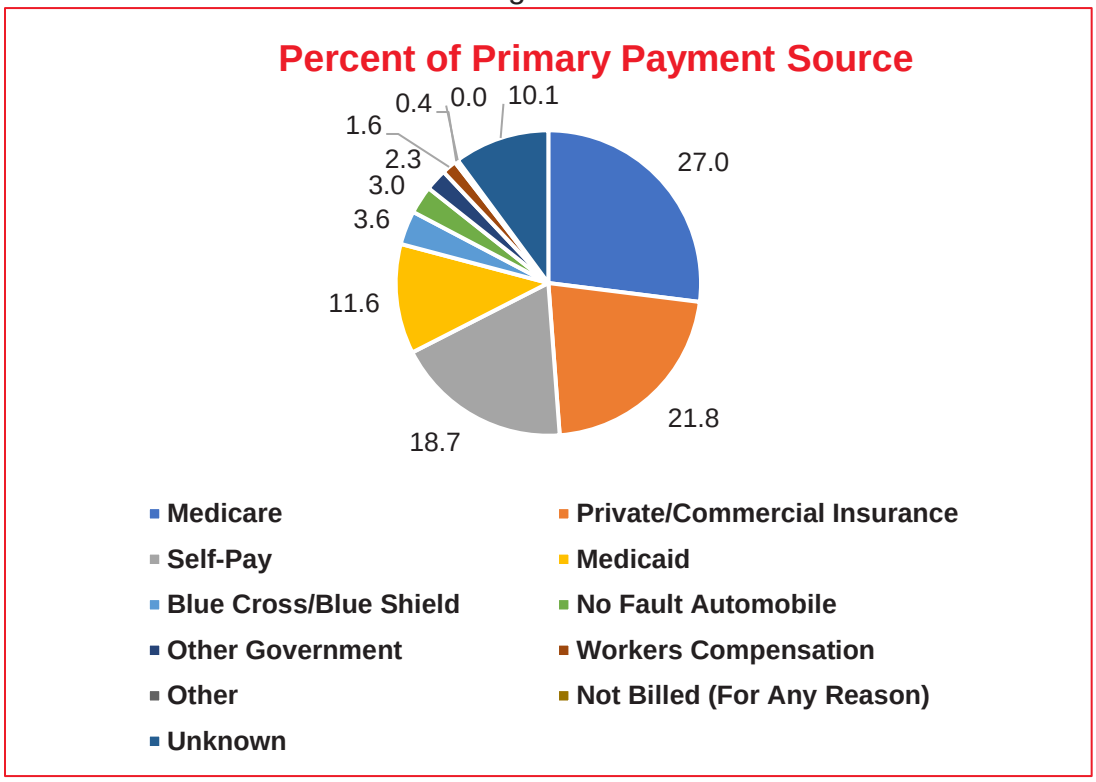


Table 11

Primary Payment Source		
Primary Payor	**Frequency**	**Percent**
Medicare	9,287	27.0
Private/Commercial Insurance	7,514	21.8
Self-Pay	6,428	18.7
Medicaid	4,004	11.6
Blue Cross/Blue Shield	1,234	3.6
No Fault Automobile	1,014	3.0
Other Government	794	2.3
Workers Compensation	535	1.6
Other	123	0.4
Not Billed (For Any Reason)	4	0.0
Unknown	3,481	10.1
Total	34,418	100.0
Frequency missing = 1. The most frequent primary payor is Medicare (27%).		

Figure 11



Injury Characteristics

Mechanism of injury or causes of injury are identified and tracked in the trauma registry. Some age groups may be identified as at risk for certain injuries such as motor vehicle crashes or falls. This information is also used to target injury prevention programs. In some cases, road improvements, pedestrian walkways and driving laws have been improved to reduce injury.

Table 12

Incidents by Mechanism of Injury

Mechanism	Number	Percent	Deaths	Case Fatality Rate
Fall	15,147	44.3	366	2.4
Motor vehicle traffic	10,333	30.2	519	5.0
Firearm	2,294	6.7	379	16.5
Struck by, against	1,992	5.8	22	1.1
Cut/pierce	1,398	4.1	18	1.3
Transport, other	873	2.6	15	1.7
Other specified and classifiable	459	1.3	7	1.5
Pedal cyclist, other	395	1.2	6	1.5
Natural/environmental, Bites and Stings	260	0.8	1	0.4
Machinery	248	0.7	2	0.8
Pedestrian, other	214	0.6	10	4.7
Natural/environmental, Other	132	0.4	1	0.8
Overexertion	122	0.4	0	0.0
Other specified, not elsewhere classifiable	80	0.2	5	6.3
Fire/flame	79	0.2	2	2.5
Unspecified	71	0.2	2	2.8
Hot object/substance	56	0.2	0	0.0
Drowning/submersion	9	0.0	1	11.1
Suffocation	7	0.0	4	57.1
Poisoning	1	0.0	0	0.0
Total	34,170	100.0	1,360	4.0

Frequency missing = 249. The largest number of incidents is caused by fall injuries, followed by motor vehicle traffic injuries and firearm injuries. Among these top three injuries, firearm injury has the highest case fatality rate (16.5%).

Figure 12A

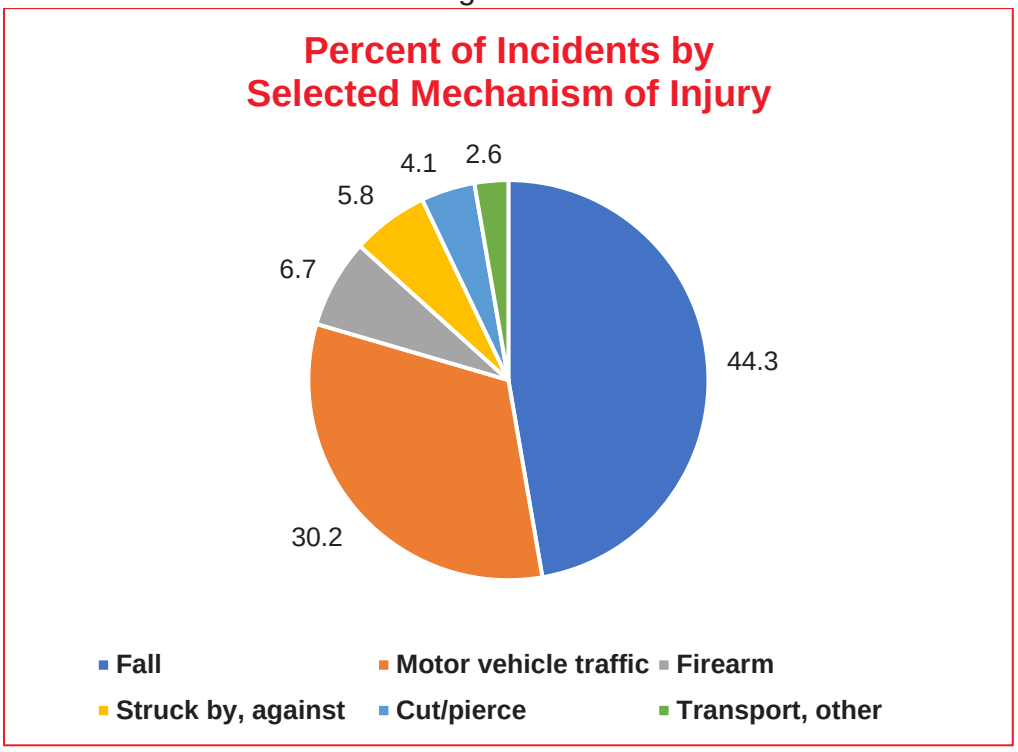


Figure 12B

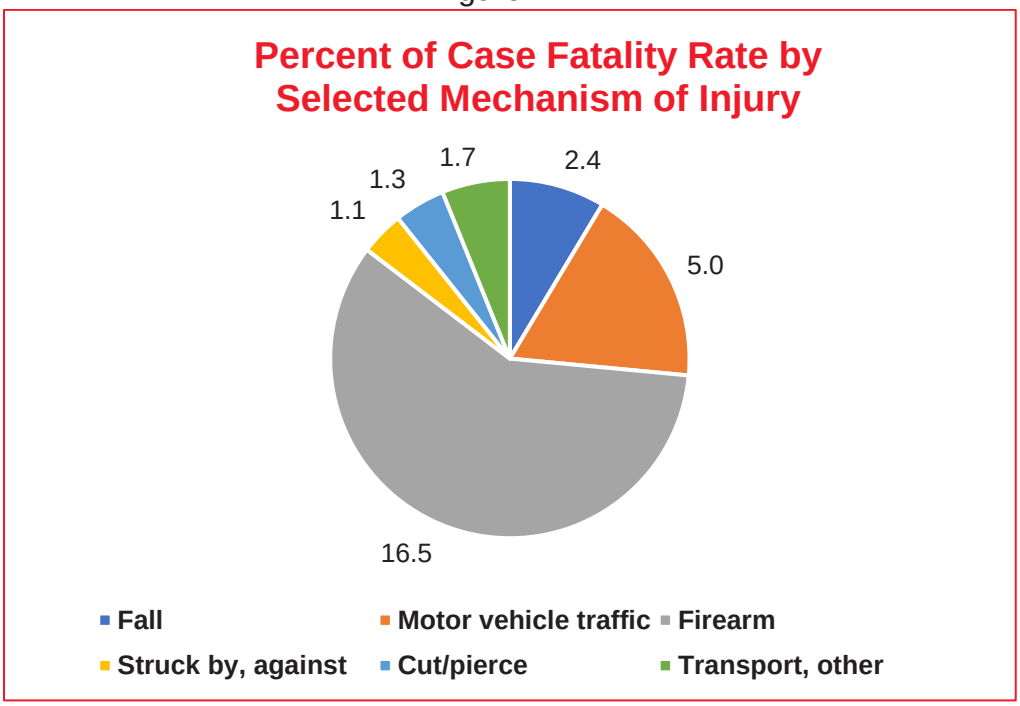


Table 13

Incidents by Selected Mechanism of Injury and Age						
Age	**Fall**	**Motor vehicle traffic**	**Firearm**	**Struck by, against**	**Cut/pierce**	**Transport, other**
<1	246	34	2	17	1	2
1-4	523	135	19	49	19	31
5-9	764	275	22	90	24	61
10-14	424	287	64	153	31	143
15-19	270	833	324	197	84	101
20-24	211	1,057	441	146	160	71
25-34	536	1,994	709	312	401	135
35-44	689	1,436	331	312	279	97
45-54	1,029	1,398	211	288	190	95
55-64	1,895	1,351	106	223	127	71
65-74	2,710	892	40	119	69	47
75-84	3,188	466	16	56	11	15
>=85	2,662	175	8	30	2	4
NK/NR	0	0	1	0	0	0
Total	15,147	10,333	2,294	1,992	1,398	873
For people age less than 15 years and older than 54 years, the number of fall injuries is higher than motor vehicle traffic injuries. For people age between 15 to 54 years, the number of motor vehicle traffic injuries is higher than fall injuries.						

Figure 13

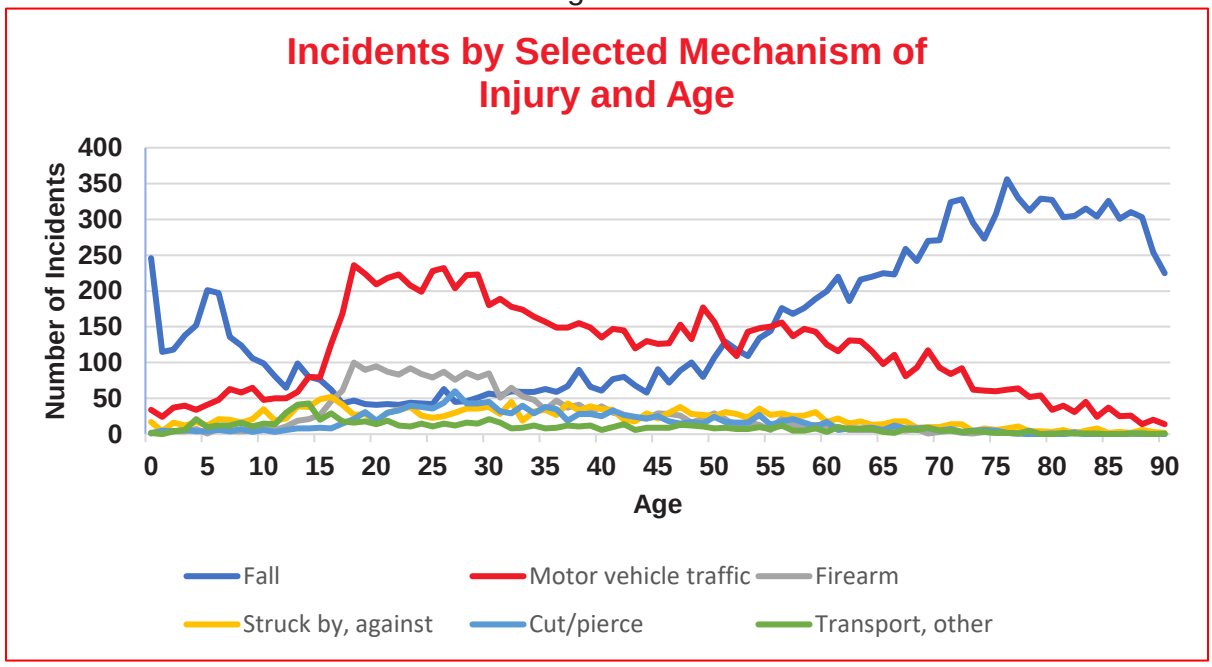


Table 14

Case Fatality Rate by Selected Mechanism of Injury and Age

Age	Fall	Motor vehicle traffic	Firearm	Struck by, against	Cut/pierce	Transport, other
<1	0.4	14.7	0.0	0.0	0.0	0.0
1-4	0.4	0.7	10.5	0.0	0.0	0.0
5-9	0.0	2.5	9.1	0.0	0.0	0.0
10-14	0.0	3.1	7.8	0.0	0.0	0.7
15-19	0.4	2.5	14.5	0.5	1.2	2.0
20-24	0.9	4.4	14.1	0.7	1.9	4.2
25-34	1.3	3.9	14.1	1.6	1.0	0.7
35-44	1.5	4.0	17.8	0.3	1.1	2.1
45-54	1.7	5.5	22.7	0.7	1.6	2.1
55-64	2.0	7.4	24.5	1.8	3.1	2.8
65-74	2.8	7.1	30.0	4.2	0.0	0.0
75-84	3.5	7.3	50.0	3.6	0.0	6.7
>=85	3.8	11.4	87.5	3.3	0.0	25.0
NK/NR	0.0	0.0	100.0	0.0	0.0	0.0
Total	2.4	5.0	16.5	1.1	1.3	1.7

Among the six selected mechanisms, the highest case fatality rate is in firearm injuries.

Figure 14

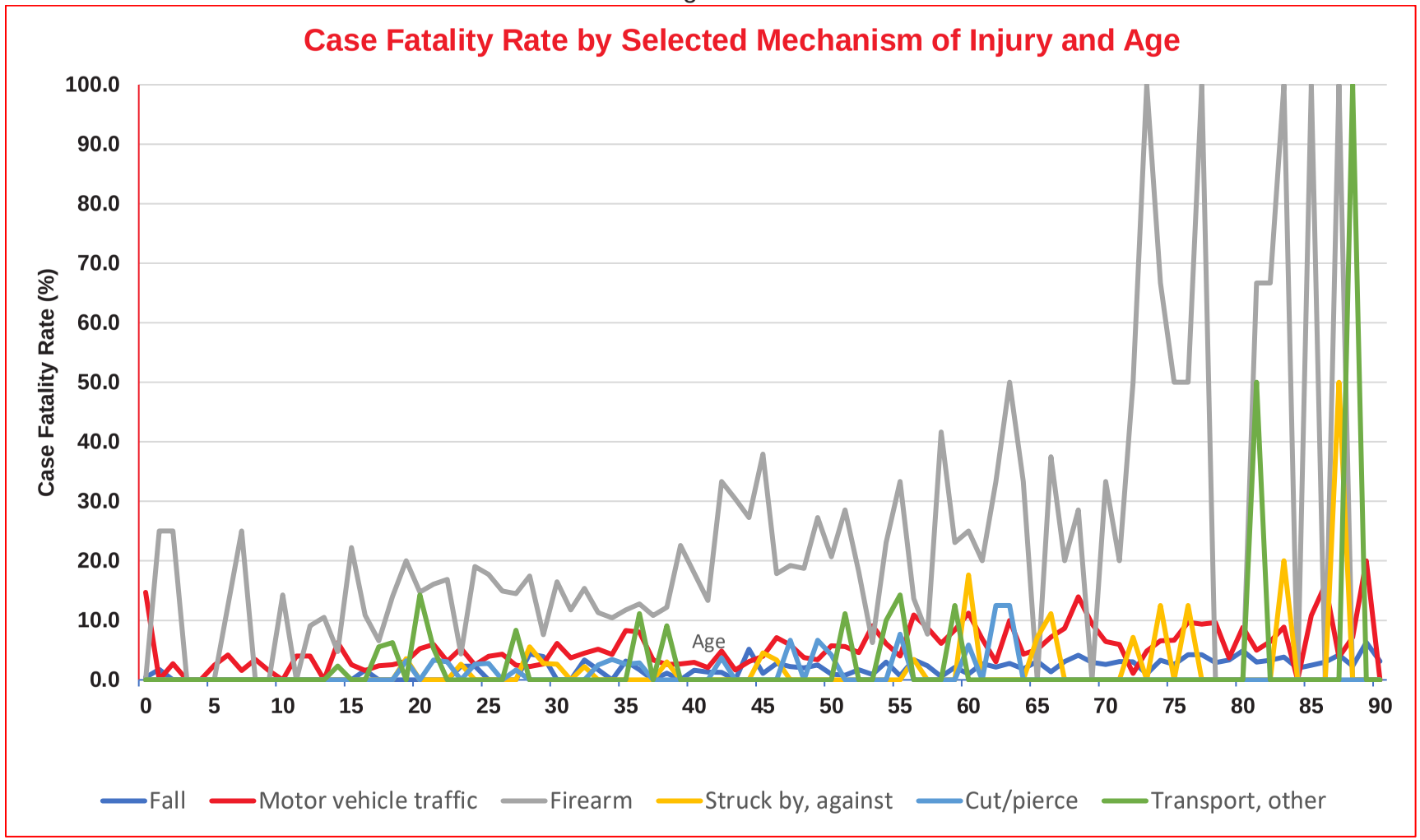

Case Fatality Rate by Selected Mechanism of Injury and Age
Case Fatality Rate (%)
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
0
5
10
15
20
25
30
35
40
45
50
55
60
65
70
75
80
85
90
Age
Fall
Motor vehicle traffic
Firearm
Struck by, against
Cut/pierce
Transport, other

Table 15

Incidents and Case Fatality Rate by Mechanism of Injury and Gender

Mechanism	Percent (Female)	Percent (Male)	Case Fatality Rate (Female)	Case Fatality Rate (Male)
Fall	57.9	35.0	1.8	3.1
Motor vehicle traffic	28.7	31.3	3.7	5.9
Firearm	2.3	9.8	15.1	16.8
Struck by, against	3.0	7.8	0.7	1.2
Cut/pierce	1.7	5.8	2.6	1.0
Transport, other	2.2	2.8	1.0	2.1
Other specified and classifiable	0.5	1.9	2.7	1.3
Pedal cyclist, other	0.6	1.6	1.3	1.6
Natural/environmental, Bites and stings	1.0	0.6	0.7	0.0
Machinery	0.2	1.1	0.0	0.9
Pedestrian, other	0.6	0.6	2.4	6.2
Natural/environmental, Other	0.5	0.3	0.0	1.5
Overexertion	0.3	0.4	0.0	0.0
Other specified, not elsewhere classifiable	0.2	0.2	6.7	6.0
Fire/flame	0.2	0.3	3.8	1.9
Unspecified	0.1	0.3	6.7	1.8
Hot object/substance	0.2	0.2	0.0	0.0
Drowning/submersion	0.0	0.0	0.0	16.7
Suffocation	0.0	0.0	50.0	60.0
Poisoning	0.0	0.0	0.0	0.0
Total	100.0	100.0	2.6	4.9

The percent of fall injuries in female (57.9%) is much higher than that in male (35.0%). The percent of firearm injuries in male (9.8%) is much higher than that in female (2.3%). Case fatality rate in male (4.9%) is much higher than that in female (2.6%).

Figure 15A

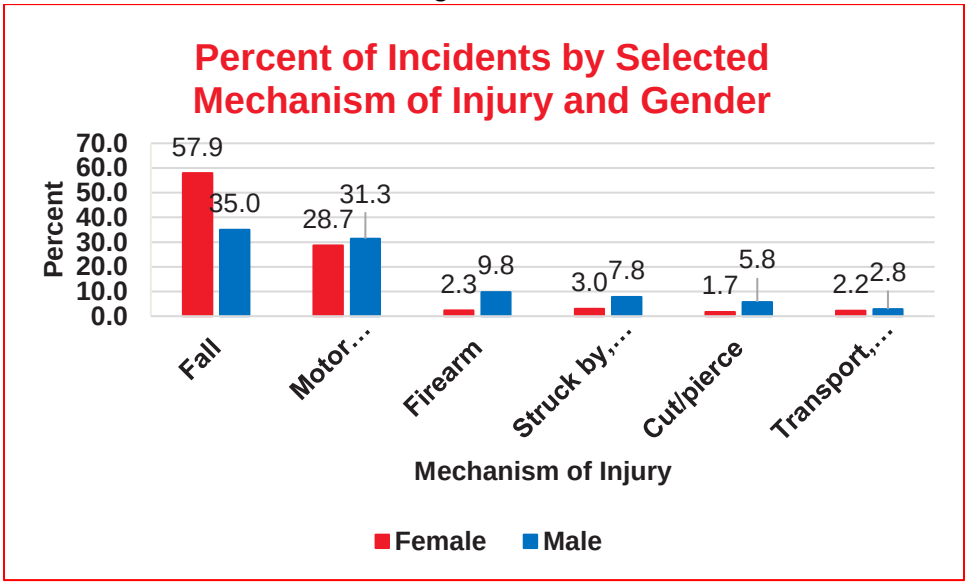


Figure 15B

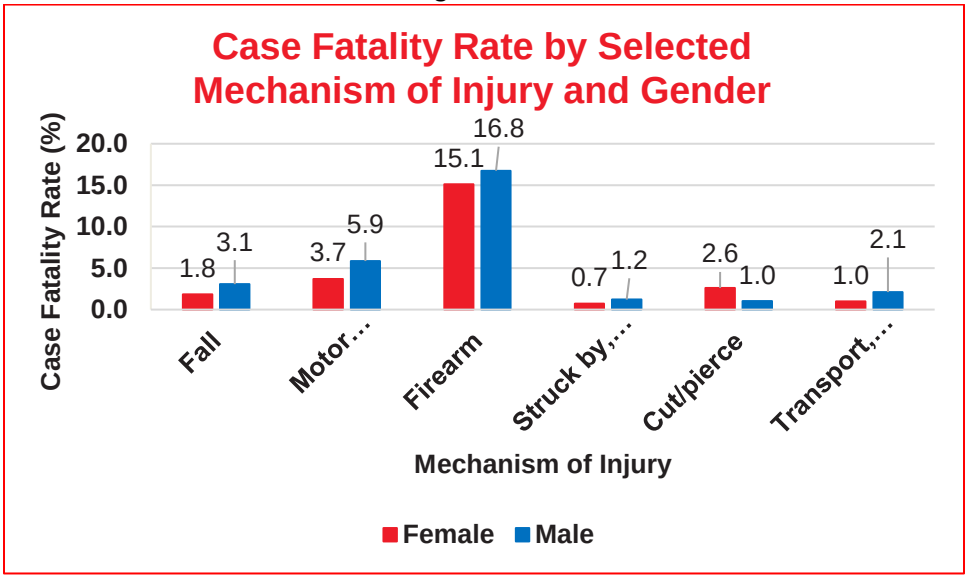


Table 16

Incidents and Case Fatality Rate by Injury Severity Score (ISS)				
ISS	**Number**	**Percent**	**Deaths**	**Case Fatality Rate**
1-8	15,523	45.1	160	1.0
9-15	12,833	37.3	246	1.9
16-24	3,505	10.2	206	5.9
>24	2,518	7.3	751	29.8
NK/NR	40	0.1	7	17.5
Total	34,419	100.0	1,370	4.0
Minor injuries (45.1%) and moderate injuries (37.3%) account for 82.4 percent of all the injuries. Very severe injuries have the highest case fatality rate (29.8%).				

Figure 16A

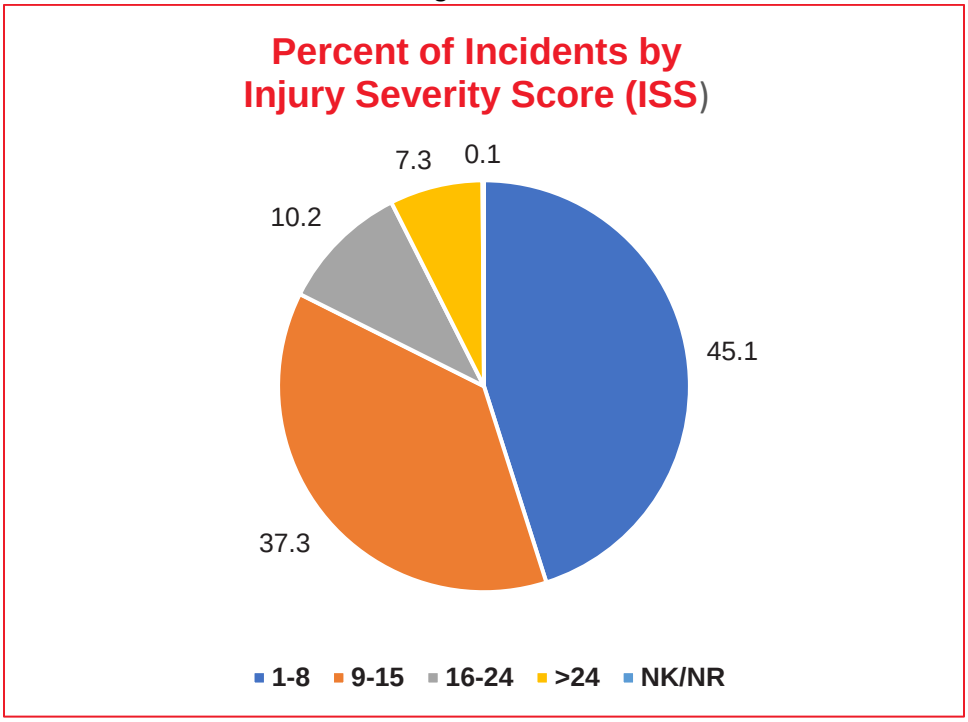


Figure 16B

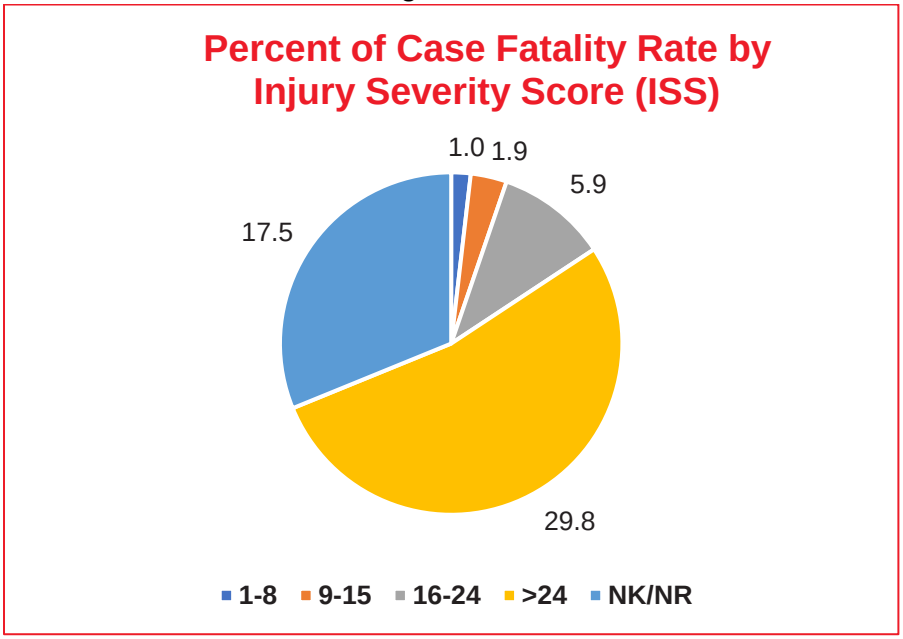


Table 17

Incidents by Injury Severity Score (ISS) and Age

Age	ISS 1-8	ISS 9-15	ISS 16-24	ISS >24	ISS NK/NR	Total
<1	228	166	41	35	0	470
1-4	672	229	47	25	3	976
5-9	1,156	169	55	36	0	1,416
10-14	897	275	65	49	4	1,290
15-19	977	589	203	166	3	1,938
20-24	969	703	275	262	0	2,209
25-34	2,057	1,345	521	443	7	4,373
35-44	1,621	1,088	390	301	4	3,404
45-54	1,551	1,199	442	292	1	3,485
55-64	1,715	1,590	477	284	4	4,070
65-74	1,487	1,877	413	259	5	4,041
75-84	1,302	1,946	356	222	4	3,830
>=85	891	1,657	219	144	5	2,916
NK/NR	0	0	1	0	0	1
Total	15,523	12,833	3,505	2,518	40	34,419

The largest number (443) of very severe injuries (ISS >24) is in age group 25-34.

Figure 17

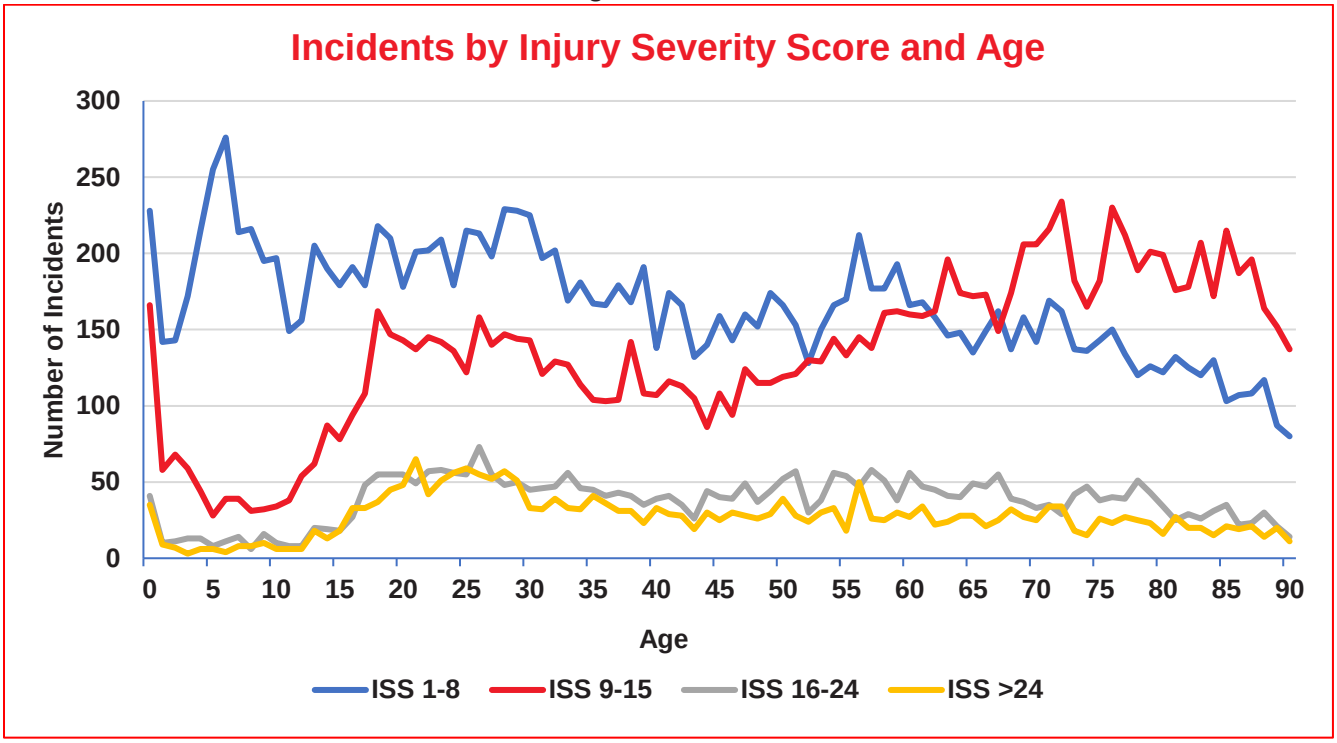


Table 18

Case Fatality Rate by Injury Severity Score (ISS) and Age						
Age Group	ISS 1-8	ISS 9-15	ISS 16-24	ISS >24	NK/NR	Total
<1	0.9	0.6	4.9	20.0	0.0	2.6
1-4	0.0	0.4	6.4	20.0	66.7	1.1
5-9	0.0	0.6	7.3	11.1	0.0	0.6
10-14	0.2	0.4	1.5	26.5	25.0	1.4
15-19	0.5	1.5	6.4	28.9	0.0	3.9
20-24	1.1	0.9	6.2	34.0	0.0	5.6
25-34	1.1	1.5	5.2	29.6	14.3	4.6
35-44	0.8	0.9	3.3	34.6	0.0	4.1
45-54	1.2	1.8	6.3	29.5	100.0	4.4
55-64	2.0	1.8	5.7	30.6	25.0	4.4
65-74	1.5	2.3	4.6	28.2	20.0	3.9
75-84	1.2	2.6	8.1	27.5	0.0	4.1
>=85	1.5	3.3	10.0	29.9	0.0	4.6
NK/NR	0.0	0.0	100.0	0.0	0.0	100.0
Total	1.0	1.9	5.9	29.8	17.5	4.0
The largest total case fatality rate (5.6%) is in age group 20-24.						

Figure 18

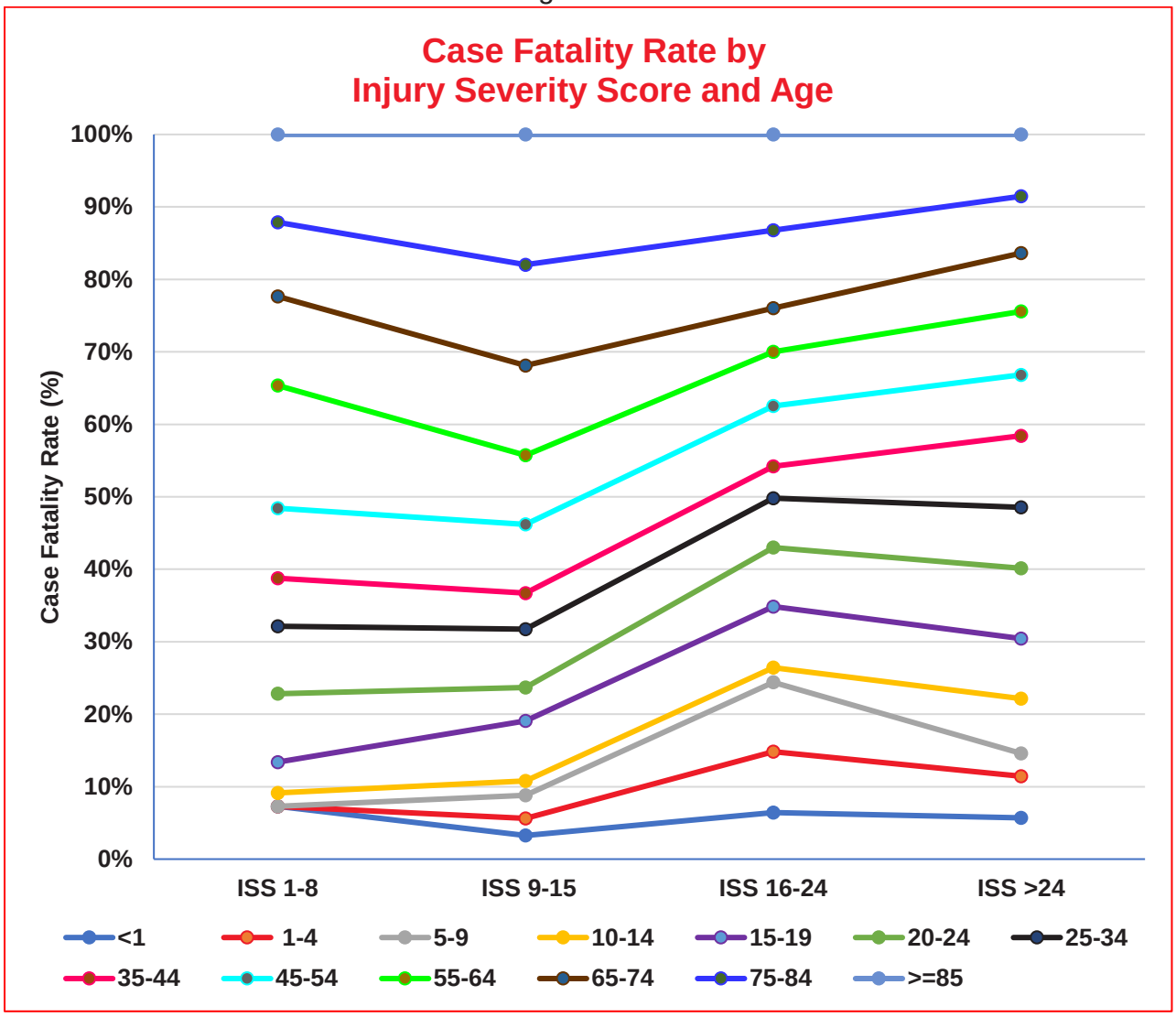

Case Fatality Rate by
Injury Severity Score and Age
Case Fatality Rate (%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ISS 1-8
ISS 9-15
ISS 16-24
ISS >24
<1
1-4
5-9
10-14
15-19
20-24
25-34
35-44
45-54
55-64
65-74
75-84
>=85

Table 19

Incidents and Case Fatality Rate by Work-Related Injury				
Work-Related Injury	**Number**	**Percent**	**Deaths**	**Case Fatality Rate**
False	32,944	95.7	1,346	4.1
True	1,395	4.1	21	1.5
Unknown	80	0.2	3	3.8
Total	34,419	100.0	1,370	4.0
There are 1,395 incidents reported as true work-related injuries, which account for 4.1 percent of all injuries.				

Figure 19A

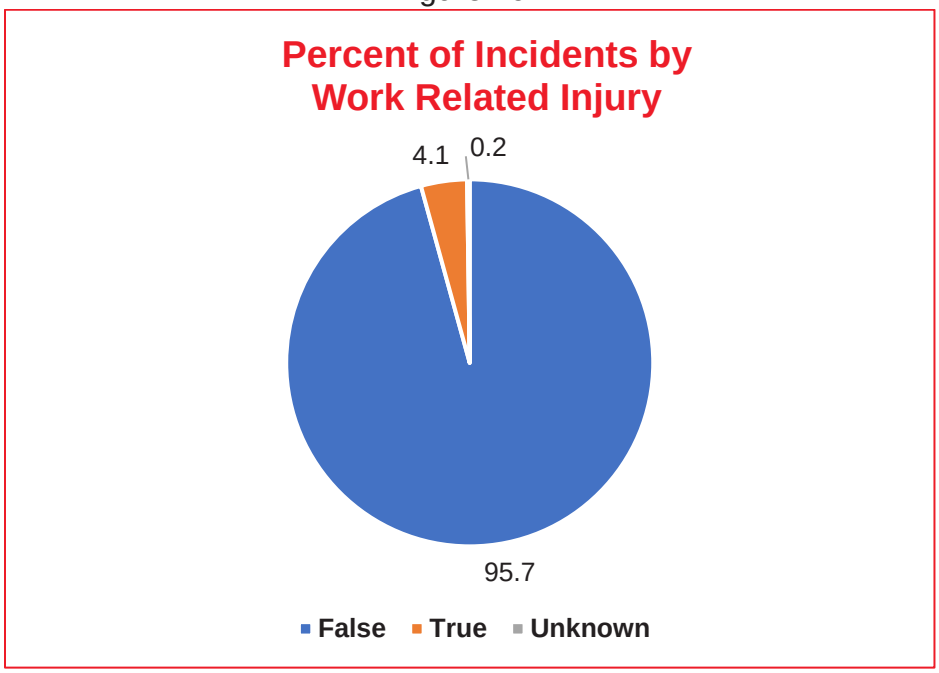


Figure 19B

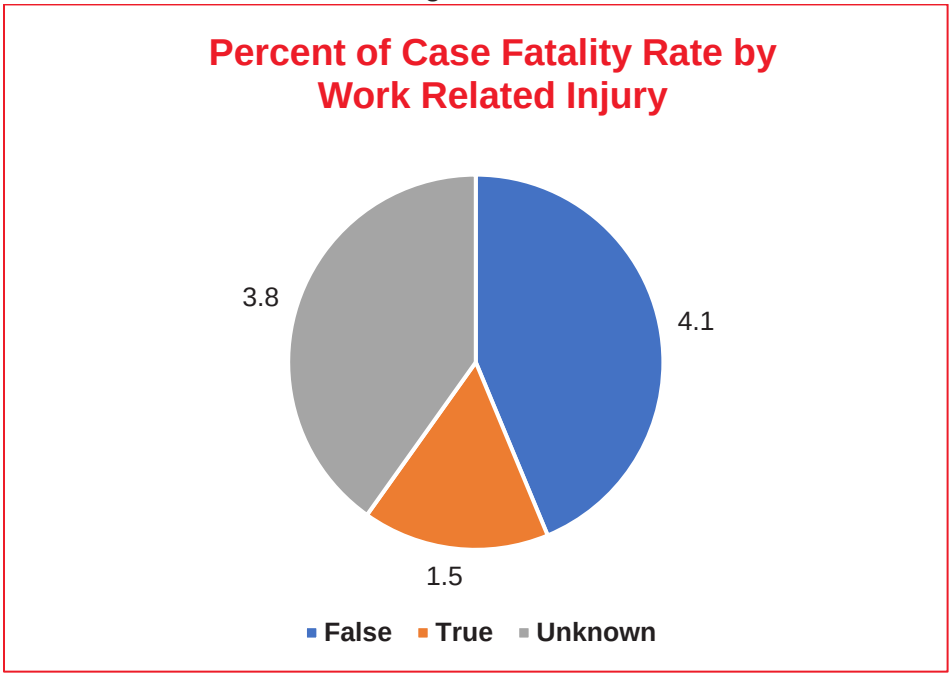


Table 20

Incidents and Case Fatality Rate by Intent

Intent	Number	Percent	Deaths	Case Fatality Rate
Unintentional	30,145	87.6	952	3.2
Assault	3,405	9.9	242	7.1
Self-inflicted	447	1.3	124	27.7
Undetermined	330	1.0	39	11.8
Other	66	0.2	11	16.7
Total	34,393	100.0	1,368	4.0

Frequency missing = 26. Most of the injuries are unintentional injuries (87.6%). Assault injuries account for 9.9% of all the injuries. The case fatality rate of self-inflicted is the highest (27.7%).

Figure 20A

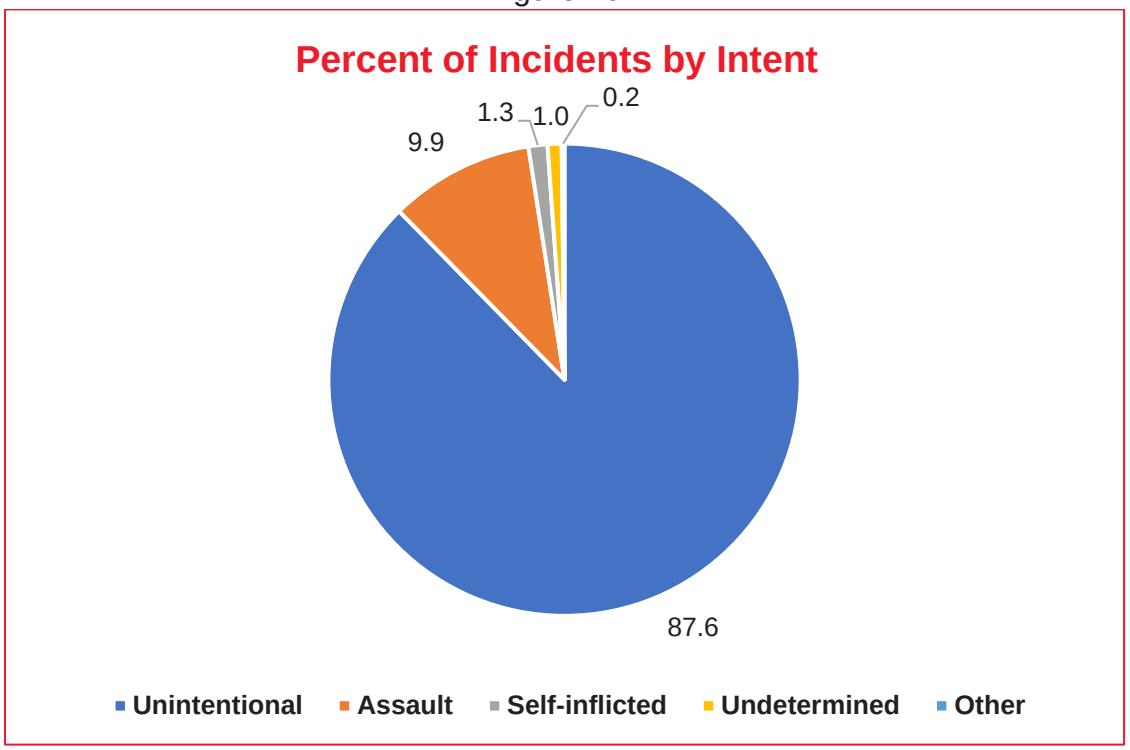


Figure 20B

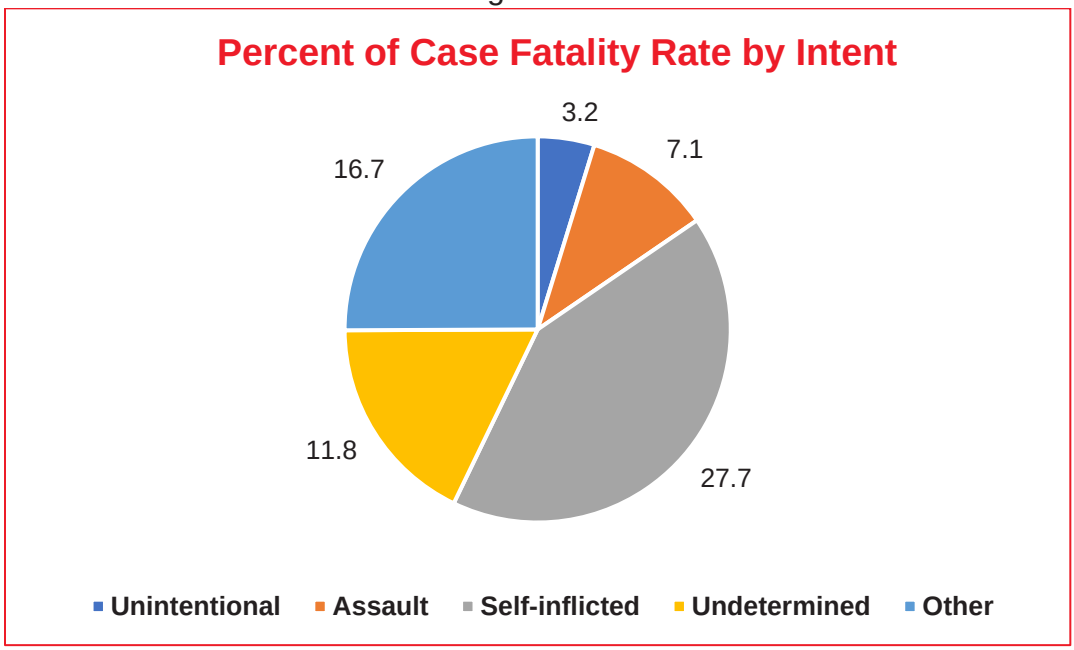


Table 21

Incidents and Case Fatality Rate by Top 40 Injury Places

ICD10 Injury Place	Total	Percent	Dead	Fatality
Unspecified place or not applicable	4,556	13.2	121	2.7
Unspecified street and highway	4,388	12.7	217	4.9
Local residential or business street	3,530	10.3	178	5.0
Unspecified place in single-family (private) house	2,001	5.8	88	4.4
Unspecified place in unspecified non-institutional (private) residence	1,842	5.4	74	4.0
State road	1,425	4.1	91	6.4
Other place in single-family (private) house	1,164	3.4	53	4.6
Interstate highway	958	2.8	57	5.9
Garden or yard in single-family (private) house	946	2.7	39	4.1
Other place in unspecified non-institutional (private) residence	705	2.0	20	2.8
Garden or yard of unspecified non-institutional (private) residence	613	1.8	16	2.6
Bedroom of single-family (private) house	611	1.8	31	5.1
Unspecified place in nursing home	550	1.6	24	4.4
Bathroom of single-family (private) house	515	1.5	18	3.5
Other recreation area	480	1.4	2	0.4
Parking lot	479	1.4	32	6.7
Kitchen of single-family (private) house	425	1.2	10	2.4
Bedroom of unspecified non-institutional (private) residence	420	1.2	17	4.0
Private driveway to single-family (private) house	366	1.1	14	3.8

Unspecified place in apartment	338	1.0	21	6.2
Bathroom of unspecified private residence single-family or house	333	1.0	5	1.5
Unspecified place in prison	332	1.0	3	0.9
Other specified places	330	1.0	8	2.4
Other trade areas	329	1.0	13	4.0
Bedroom in nursing home	328	1.0	14	4.3
Parkway	321	0.9	24	7.5
Sidewalk	303	0.9	8	2.6
Other paved roadways	254	0.7	4	1.6
Restaurant or cafe	252	0.7	13	5.2
Other specified industrial and construction area	249	0.7	6	2.4
Kitchen of unspecified non-institutional (private) residence	233	0.7	1	0.4
Building [any] under construction	208	0.6	1	0.5
Other specified sports and athletic area	191	0.6	0	0.0
Supermarket, store or market	190	0.6	5	2.6
Other place in apartment	186	0.5	14	7.5
Unknown	181	0.5	5	2.8
Other wilderness area	171	0.5	3	1.8
Private garage of single-family (private) house	159	0.5	8	5.0
Shop (commercial)	156	0.5	10	6.4
Unspecified place in other specified residential institution	152	0.4	4	2.6

Table 22

Incidents by AIS Severity and Discharge Status				
AIS Severity	**Total**	**Percent**	**Deaths**	**Case Fatality Rate %**
Maximum	72	0.2	61	84.7
Critical	1,641	4.8	575	35.0
Severe	2,392	7.0	226	9.4
Serious	13,036	37.9	324	2.5
Moderate	13,512	39.3	97	0.7
Minor	3,726	10.8	80	2.1
Total	34,379	100.0	1,363	4.0
Patients with the maximum AIS severity have the highest case fatality rate (84.7%).				

Figure 22A

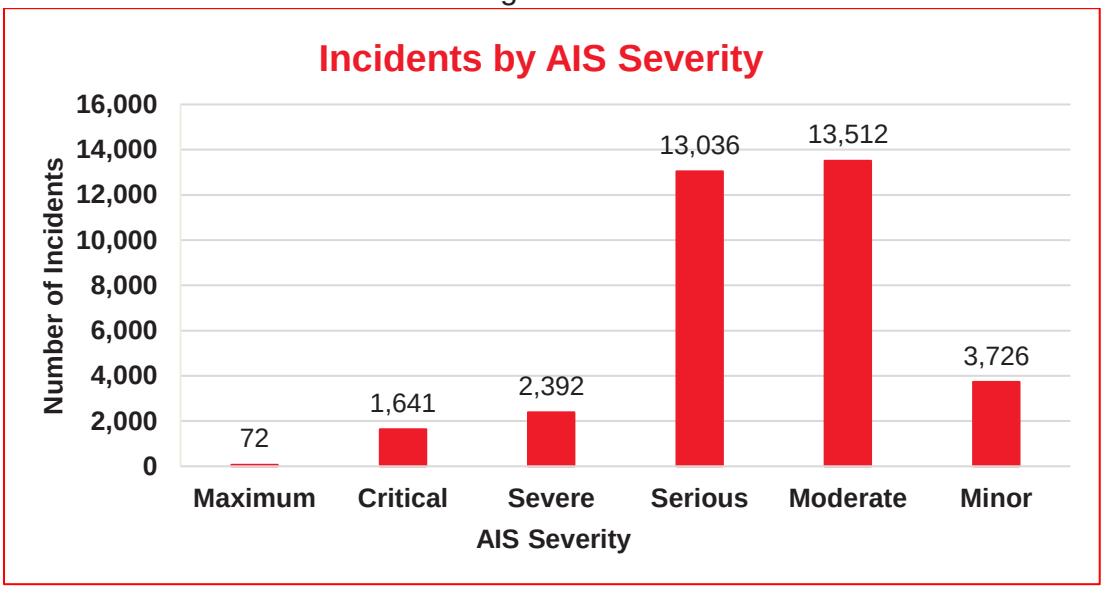


Figure 22B

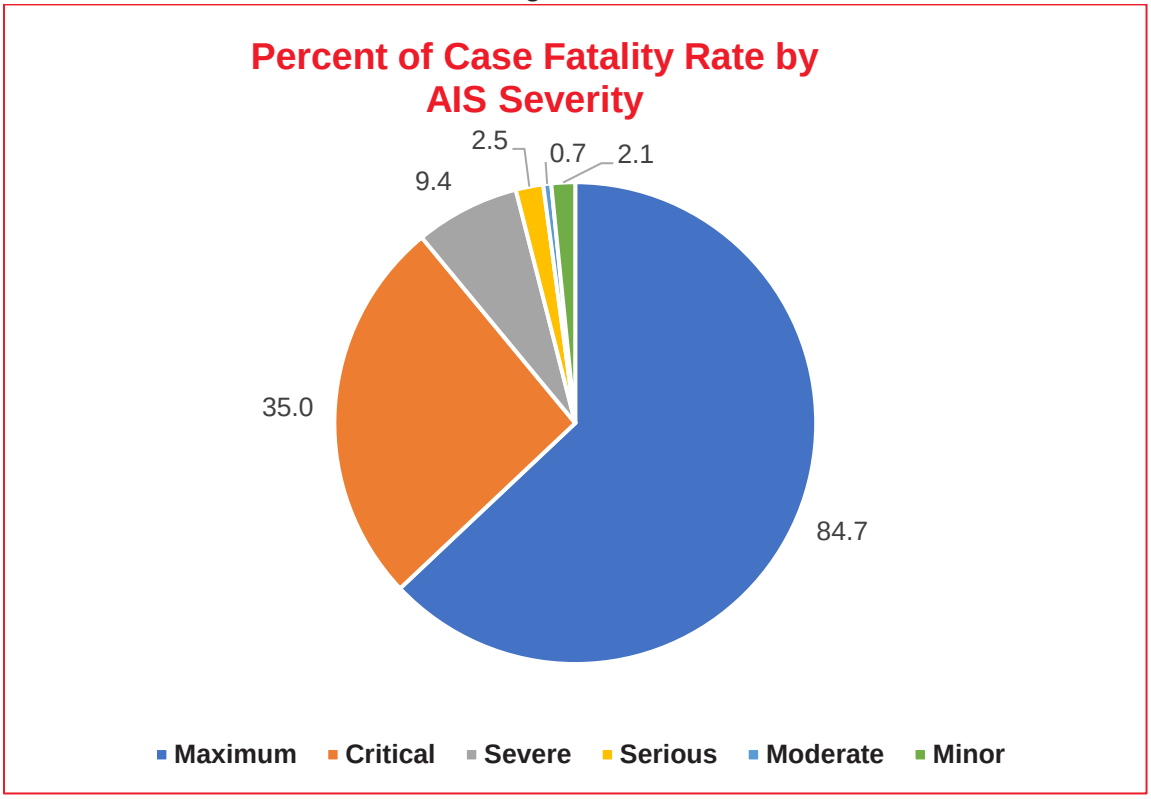


Table 23

Incidents by ISS Body Region and Discharge Status

ISS Body Region	Number	Percent	Deaths	Case Fatality Rate %
Extremities or Pelvic Girdle	14,114	41.1	193	1.4
Head or Neck	8,362	24.3	663	7.9
Chest	5,197	15.1	305	5.9
External	2,765	8.0	104	3.8
Abdominal or Pelvic Contents	2,480	7.2	90	3.6
Face	1,461	4.2	8	0.5
Total	34,379	100.0	1,363	4.0

If a patient has multiple injured body regions, only one region with the highest AIS severity is counted. Patients with the highest AIS severity in head or neck region have the highest case fatality rate (7.9%).

Figure 23A

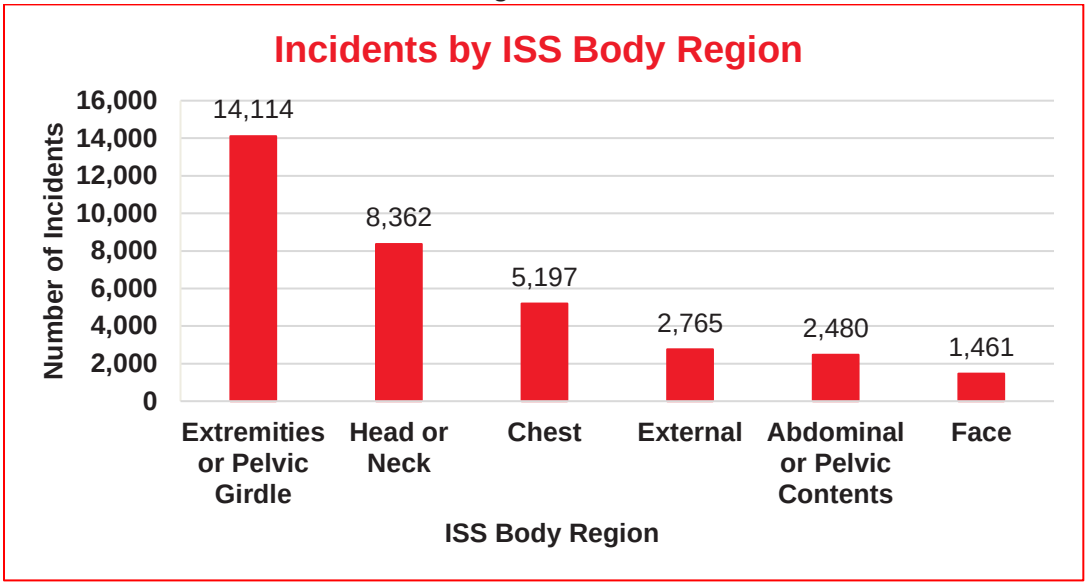


Figure 23B

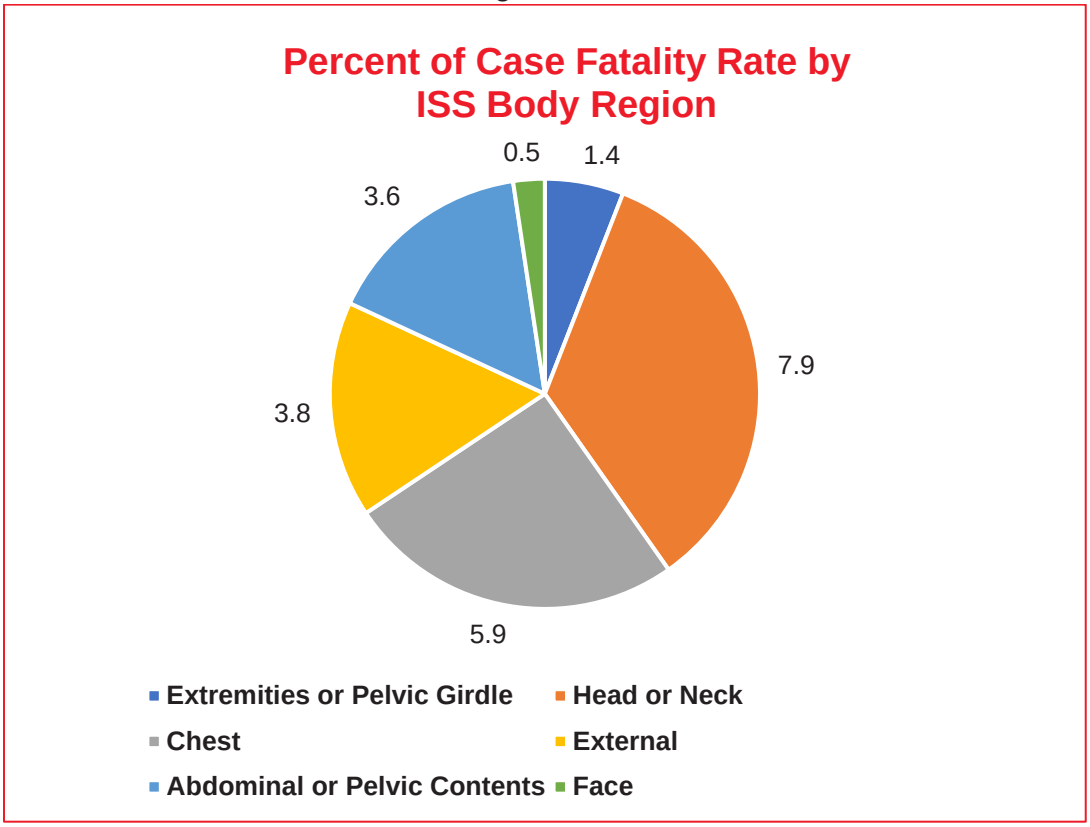
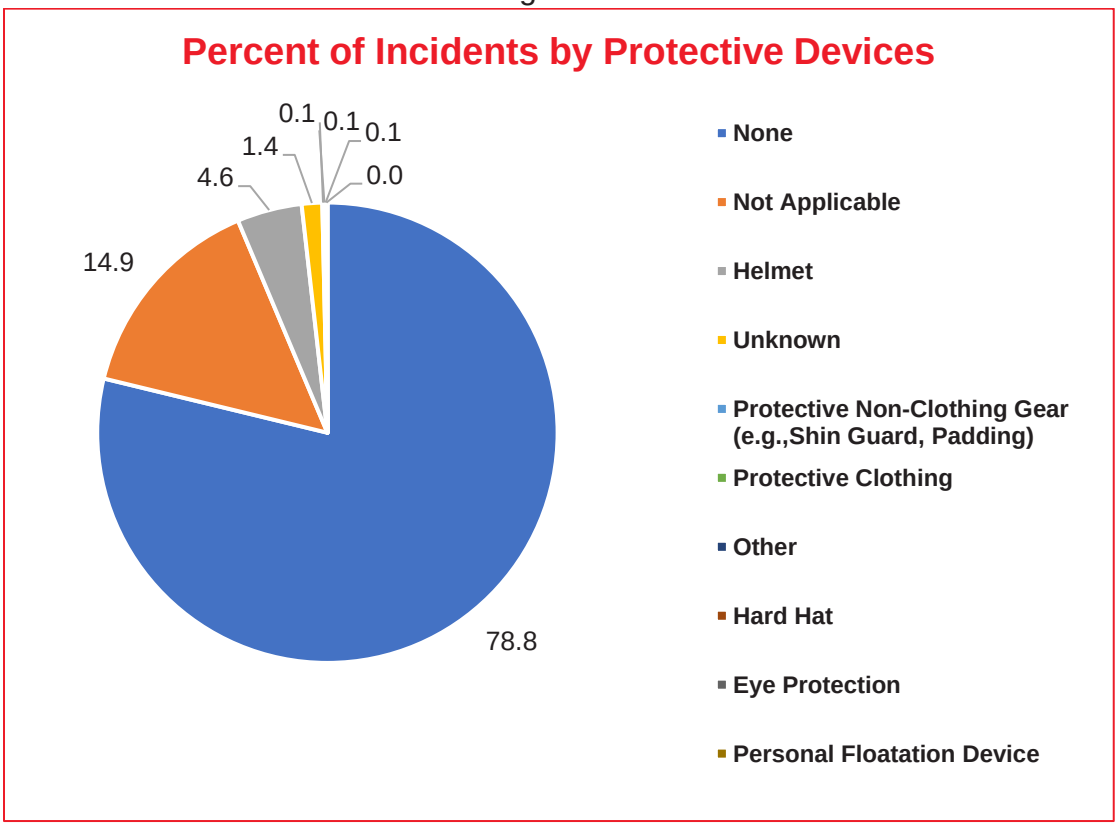


Table 24

Incidents by Protective Devices		
Protective Device	**Frequency**	**Percent**
None	27,118	78.8
Not Applicable	5,115	14.9
Helmet	1,569	4.6
Unknown	495	1.4
Protective Non-Clothing Gear (e.g., Shin Guard, Padding)	35	0.1
Protective Clothing	30	0.1
Other	29	0.1
Hard Hat	13	0.0
Eye Protection	11	0.0
Personal Floatation Device	4	0.0
Total	34,419	100.0

Figure 24



Outcomes Information

Outcome measurements describe the results of intervention and management of injuries. Positive patient outcomes result from an effective and efficient system of care.

Table 25

Median Length of Stay (LOS) in Days by Mechanism of Injury

Mechanism	Number	Median
Fall	14,156	4
Motor vehicle traffic	9,626	3
Firearm	1,965	3
Struck by, against	1,707	2
Cut/pierce	1,250	2
Transport, other	793	2
Other specified and classifiable	414	2
Pedal cyclist, other	319	2
Machinery	236	1
Natural/environmental, Bites and stings	201	2
Pedestrian, other	197	3
Natural/environmental, Other	116	2
Overexertion	109	2
Other specified, not elsewhere classifiable	72	3
Unspecified	66	2
Fire/flame	56	1
Hot object/substance	32	1
Drowning/submersion	9	2
Suffocation	7	1

Patients with fall injuries have the highest median length of stay (4 days).

Figure 25

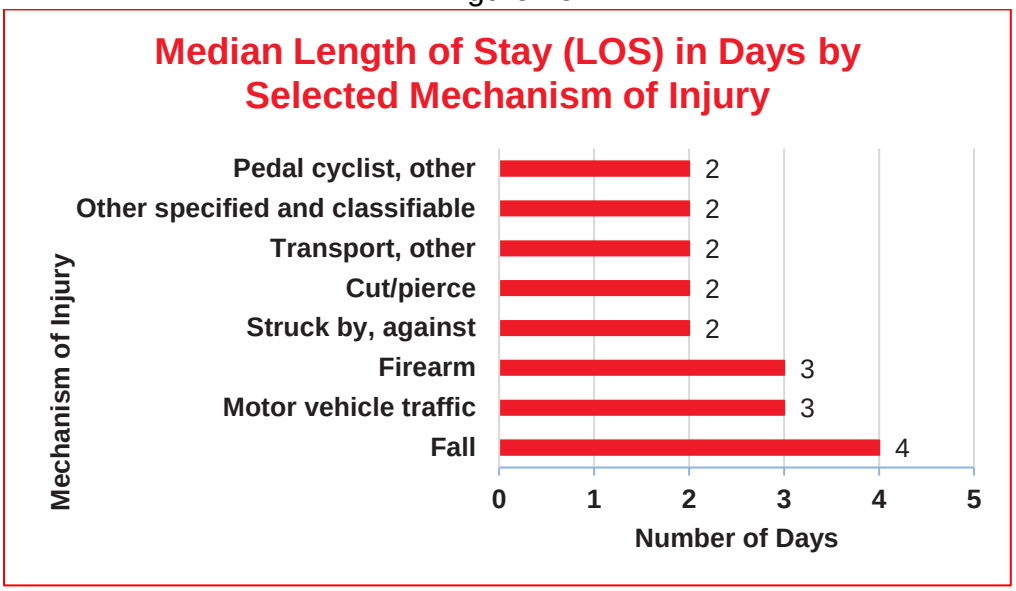


Table 26

Median Length of Stay (LOS) in Days by Injury Severity Score		
ISS	**Number**	**Median**
1-8	13,502	2
9-15	12,384	4
16-24	3,383	6
>24	2,266	9
NK/NR	29	1
Median length of stay increases with injury severity scores.		

Figure 26

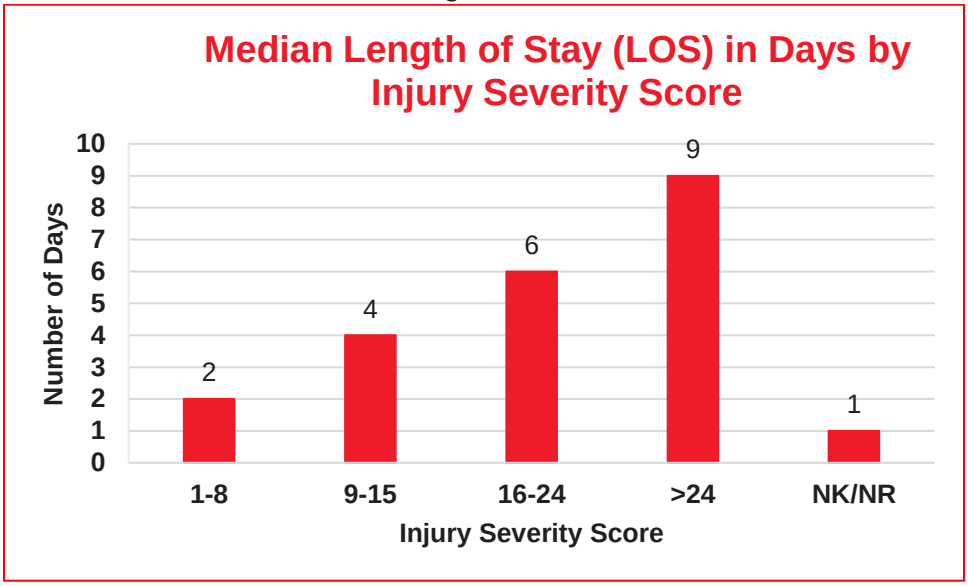


Table 27

Median Ventilator Days by Mechanism of Injury

Mechanism	Number	Median
Motor vehicle traffic	1,431	4
Fall	771	4
Firearm	498	2
Struck by, against	117	3
Cut/pierce	96	2
Transport, other	49	3
Other specified and classifiable	30	3
Fire/flame	25	1
Pedestrian, other	20	4
Other specified, not elsewhere classifiable	14	3
Unspecified	12	3
Machinery	9	3
Natural/environmental, Other	8	4
Pedal cyclist, other	8	3
Natural/environmental, Bites and stings	5	2
Suffocation	3	8
Drowning/submersion	1	4
Overexertion	1	6

Inpatients with ventilator days >0. Patients with suffocation injuries have the highest median ventilator days (8 days).

Figure 27

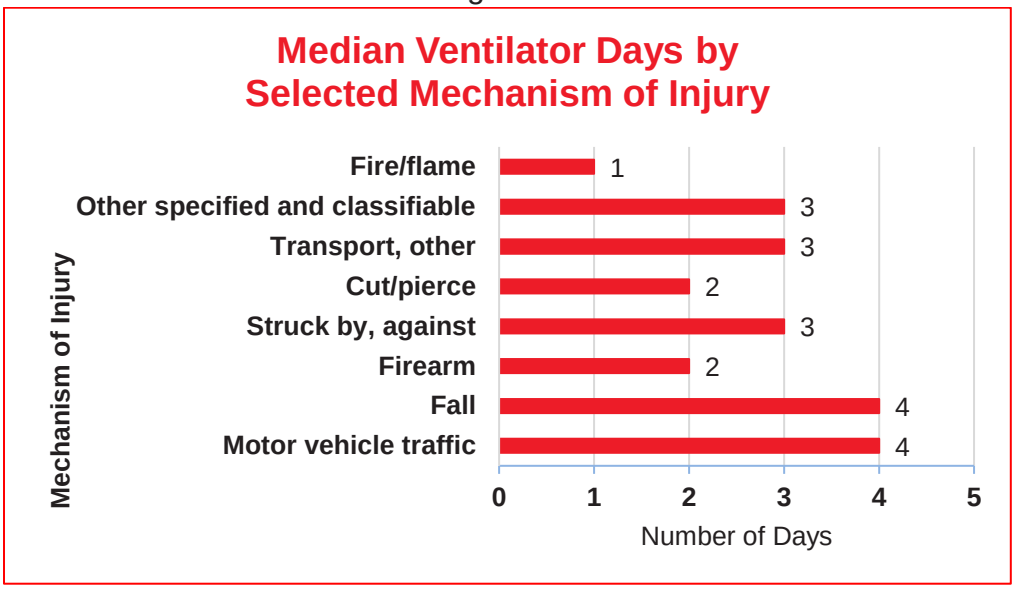


Table 28

Median Ventilator Days by Injury Severity Score (ISS)		
ISS	**Number**	**Median**
1-8	332	2
9-15	648	3
16-24	793	4
>24	1,358	5
NK/NR	3	2
Median ventilator days increase as injury severity scores (ISS) increase.		

Figure 28

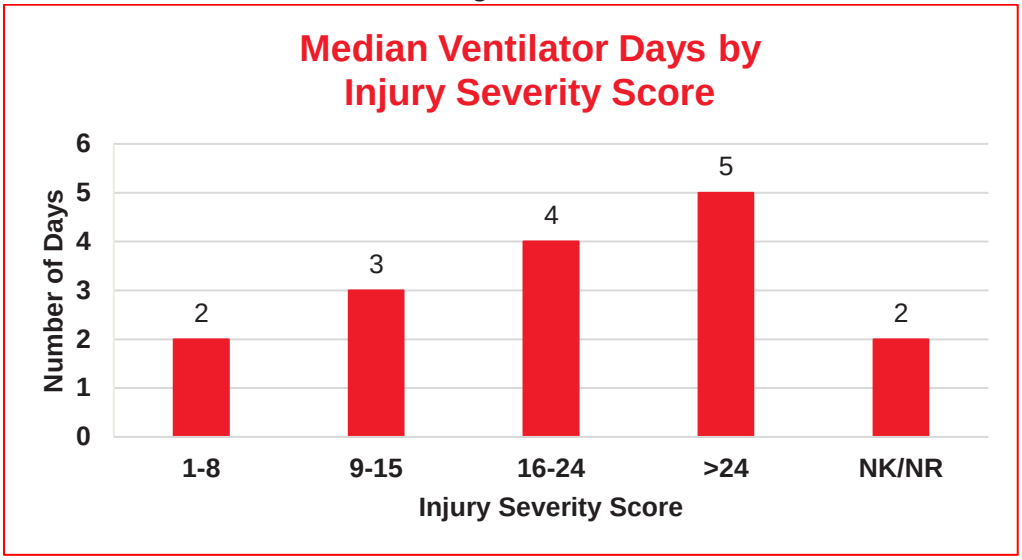


Table 29

Median ICU Days by Mechanism of Injury

Mechanism	Number	Median
Fall	3,224	3
Motor vehicle traffic	3,212	4
Firearm	778	3
Struck by, against	381	3
Cut/pierce	226	3
Transport, other	181	3
Other specified and classifiable	67	4
Pedestrian, other	56	4
Pedal cyclist, other	52	2
Natural/environmental, Other	36	2
Machinery	31	3
Unspecified	22	3
Other specified, not elsewhere classifiable	21	3
Natural/environmental, Bites and stings	15	3
Fire/flame	12	5
Drowning/submersion	5	2
Overexertion	3	2
Suffocation	3	11

Inpatients with ICU days > 0. Patients with fire/flame injuries have the highest median ICU days (5 days).

Figure 29

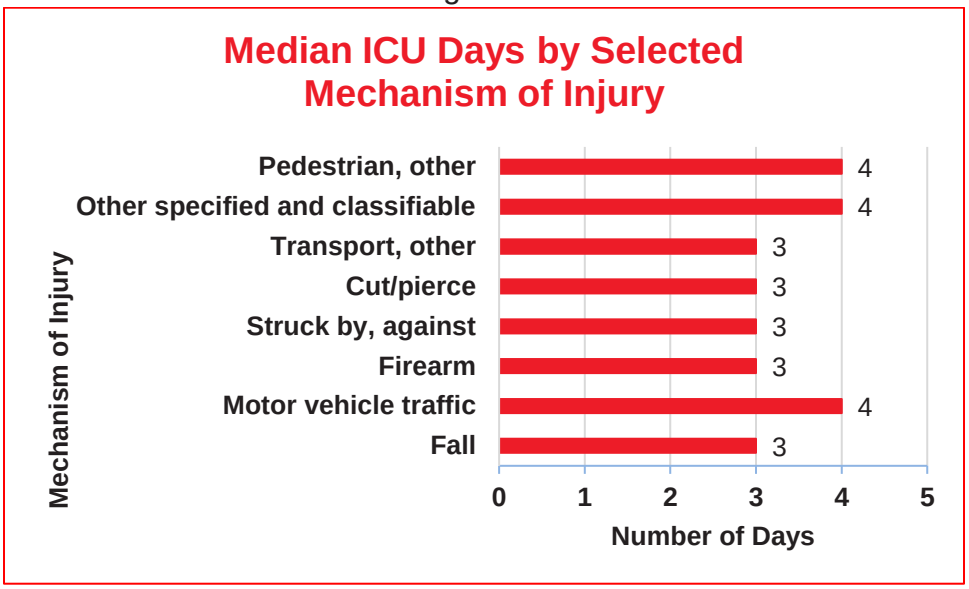


Table 30

Median ICU Days by Injury Severity Score (ISS)		
ISS	**Number**	**Median**
1-8	1,395	2
9-15	2,840	3
16-24	2,203	4
>24	1,948	6
NK/NR	6	4
Median ICU Days increase with injury severity scores.		

Figure 30

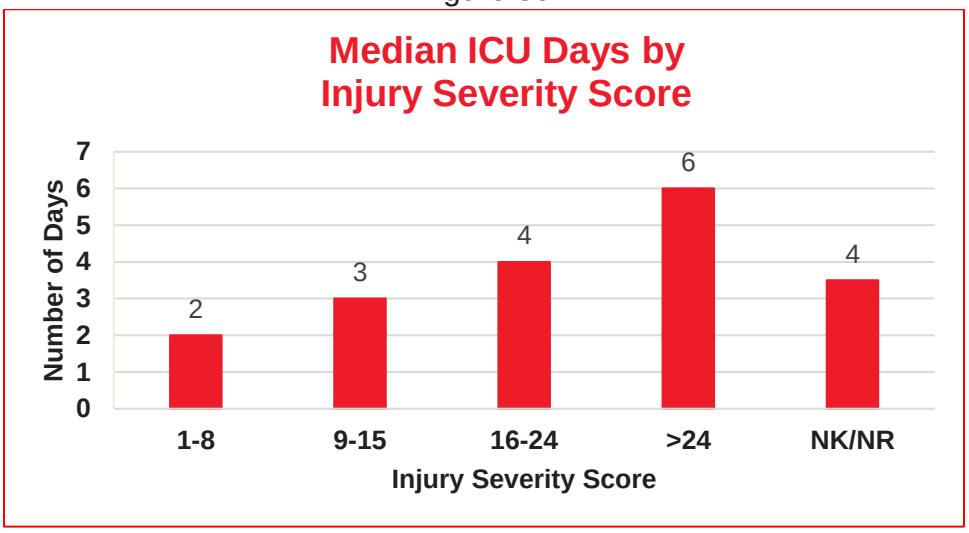


Table 31

Incidents by ED Discharge Disposition		
ED Disposition	**Number**	**Percent**
Floor Bed (General Admission, Non-Specialty Unit Bed)	15,639	45.4
Intensive Care Unit (ICU)	6,018	17.5
Operating Room	5,007	14.5
Home without Services	2,301	6.7
Transferred to Another Hospital	1,763	5.1
Telemetry/Step-Down Unit (Less Acuity than ICU)	1,191	3.5
Observation Unit (Unit that Provides LT 24 Hour Stays)	1,101	3.2
Not Applicable	612	1.8
Died/Expired	539	1.6
Left Against Medical Advice	88	0.3
Burn Center	82	0.2
Other (Jail, Institutional Care, Mental Health, etc.)	67	0.2
Home with Services	8	0.0
Total	34,416	100.0
Frequency missing = 3. Less than half of the ED Dispositions were to a floor Bed (45.4%). Of the 34,416 trauma registry cases, the Emergency Department (ED) disposition mortality rate was 1.6%, representing 539 lives lost.		

Figure 31

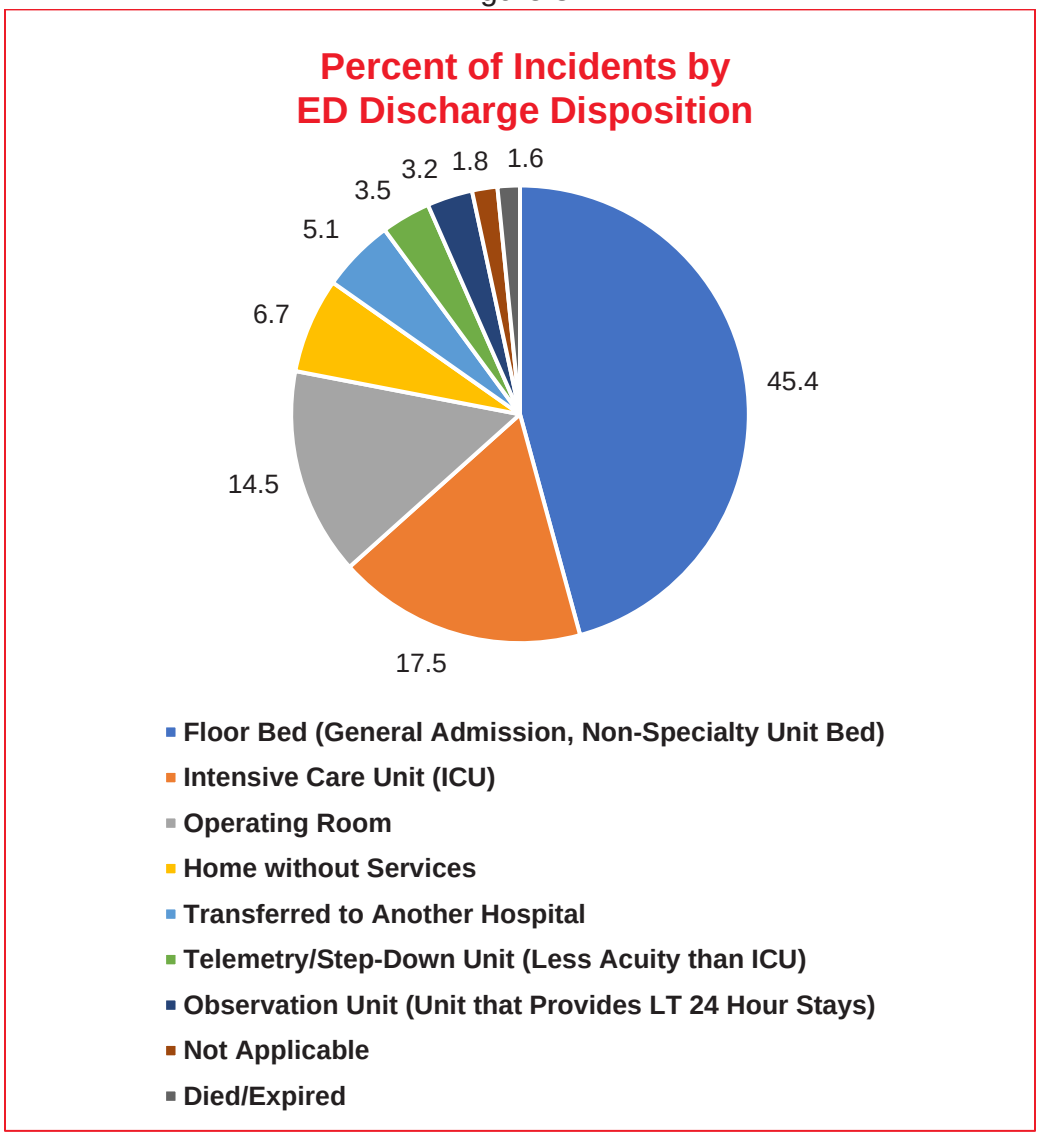

Percent of Incidents by
ED Discharge Disposition
45.4
17.5
14.5
6.7
5.1
3.5
3.2
1.8
1.6
Floor Bed (General Admission, Non-Specialty Unit Bed)
Intensive Care Unit (ICU)
Operating Room
Home without Services
Transferred to Another Hospital
Telemetry/Step-Down Unit (Less Acuity than ICU)
Observation Unit (Unit that Provides LT 24 Hour Stays)
Not Applicable
Died/Expired

Table 32

Incidents by Signs of Life		
Signs of Life	**Number**	**Percent**
Arrived with Signs of Life	33,961	98.7
Arrived with No Signs of Life	456	1.3
Not Applicable	1	0.0
Total	34,418	100.0
Frequency missing = 1. Most (98.7%) patients arrived with signs of life.		

Figure 32

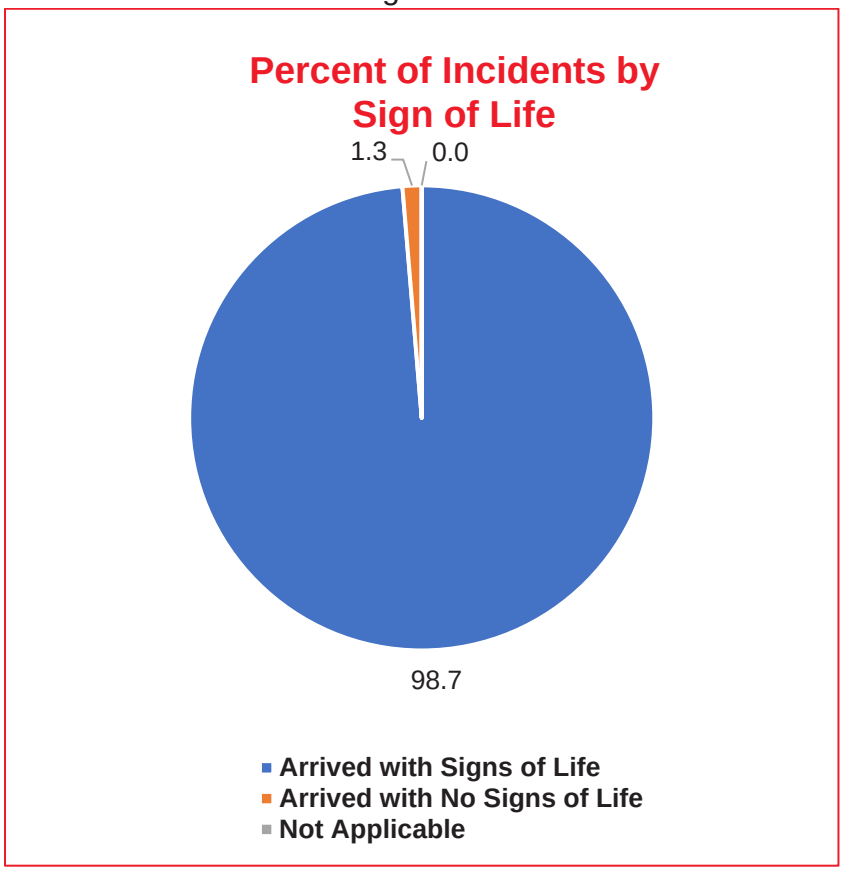
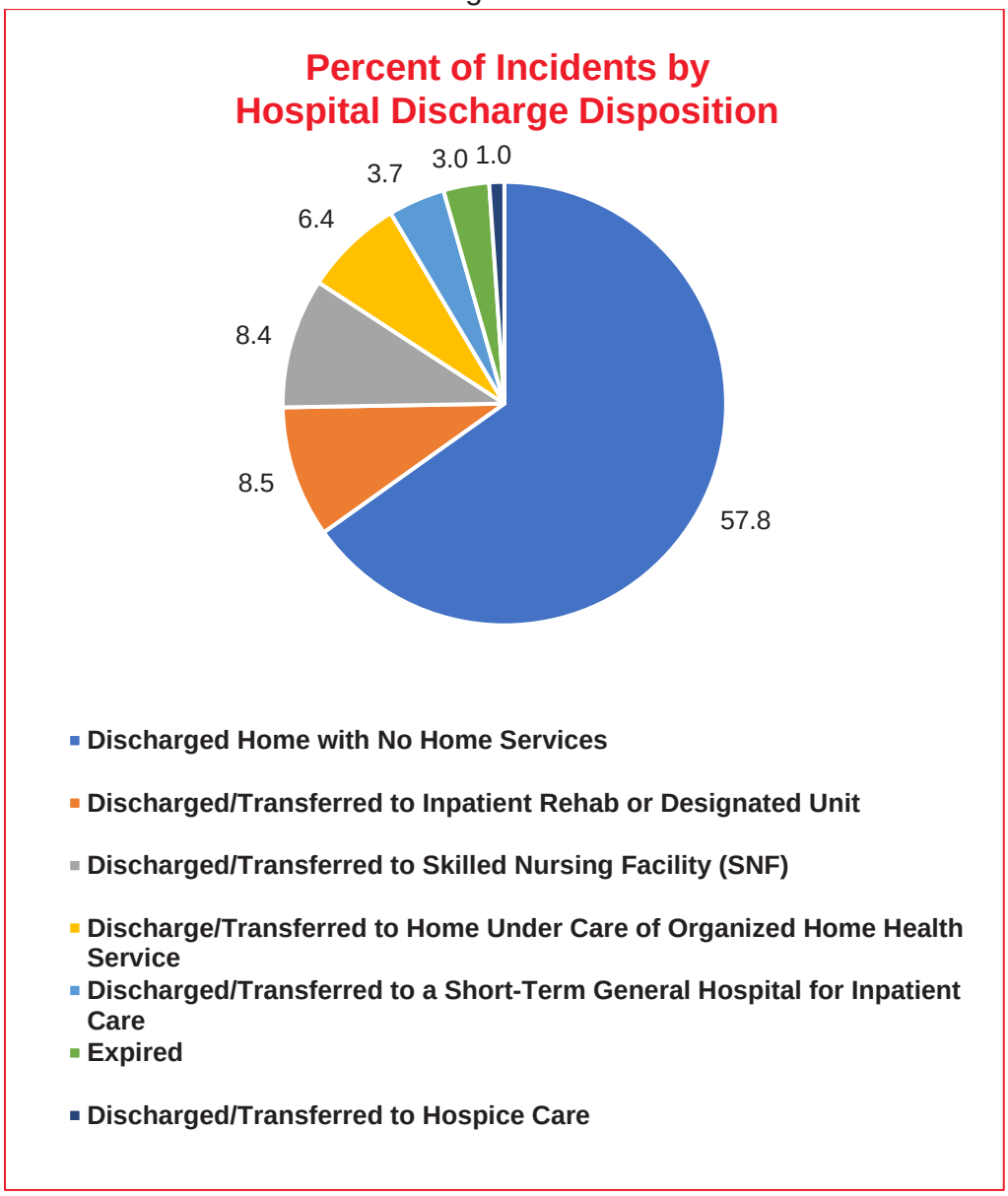


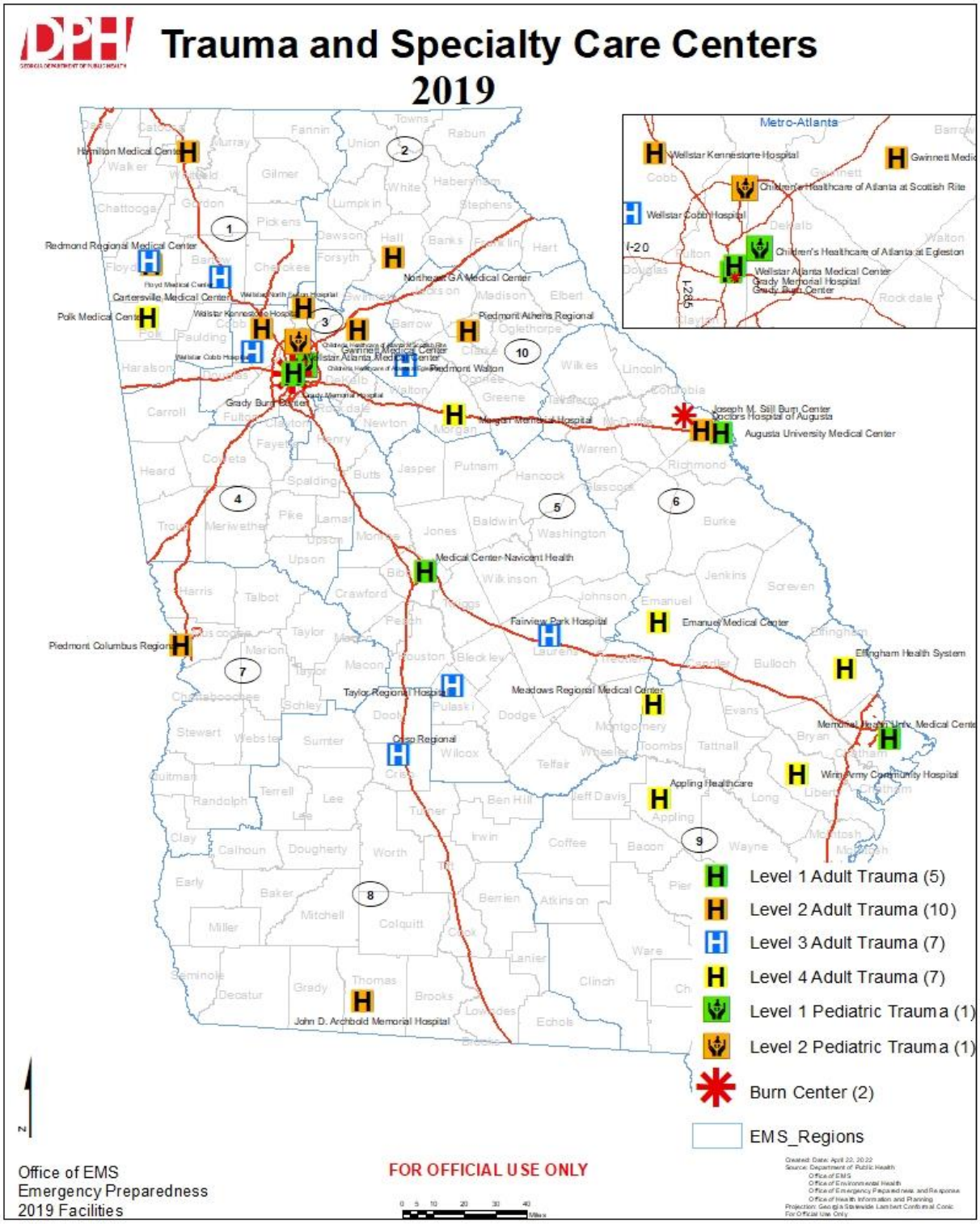
Table 33

Incidents by Hospital Discharge Disposition		
Discharge Disposition	**Number**	**Percent**
Discharged Home with No Home Services	19,908	57.8
Discharged/Transferred to Inpatient Rehab or Designated Unit	2,931	8.5
Discharged/Transferred to Skilled Nursing Facility (SNF)	2,895	8.4
Discharge/Transferred to Home Under Care of Organized Home Health Service	2,211	6.4
Discharged/Transferred to a Short-Term General Hospital for Inpatient Care	1,264	3.7
Expired	1,018	3.0
Discharged/Transferred to Hospice Care	335	1.0
Left Against Medical Advice or Discontinued Care	335	1.0
Discharged/Transferred to Court/Law Enforcement	324	0.9
Discharged/Transferred to Long Term Care Hospital (LTCH)	179	0.5
Discharged/Transferred to Another Type of Institution not Defined Elsewhere	147	0.4
Discharged/Transferred to a Psychiatric Hospital or Distinct Part Unit of a Hosp	138	0.4
Discharged/Transferred to an Intermediate Care Facility (ICF)	110	0.3
Burn Center	63	0.2
Discharged/Transferred to Another Type of Rehab or LTCF	4	0.0
Not Applicable	2,557	7.4
Total	34,419	100.0
Of the 34,416 trauma registry cases, the Hospital Discharge Disposition mortality rate was 3.0%, representing 1,018 lives lost.		

Figure 33


Percent of Incidents by Hospital Discharge Disposition
57.8
8.5
8.4
6.4
3.7
3.0
1.0
Discharged Home with No Home Services
Discharged/Transferred to Inpatient Rehab or Designated Unit
Discharged/Transferred to Skilled Nursing Facility (SNF)
Discharge/Transferred to Home Under Care of Organized Home Health Service
Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
Expired
Discharged/Transferred to Hospice Care

Appendix 1


Trauma and Specialty Care Centers
2019
Metro-Atlanta
Wellstar Kennestone Hospital
Gwinnett Medic
Children's Healthcare of Atlanta at Scottish Rite
Wellstar Cobb Hospital
I-20
Children's Healthcare of Atlanta at Egleston
Wellstar Atlanta Medical Center
Grady Memorial Hospital
Grady Burn Center
I-285
Hamilton Medical Center
Redmond Regional Medical Center
Floyd Medical Center
Cartersville Medical Center
Polk Medical Center
Wellstar Kennestone Hospital
Northeast GA Medical Center
Piedmont Athens Regional
Piedmont Walton
Grady Burn Center
Joseph M. Still Burn Center
Doctors Hospital of Augusta
Augusta University Medical Center
Medical Center Navicent Health
Fairview Park Hospital
Emanuel Medical Center
Piedmont Columbus Region
Effingham Health System
Taylor Regional Hospital
Meadows Regional Medical Center
Memorial Health Univ. Medical Cente
Ocmulgee Regional
Appling Healthcare
Winn Army Community Hospital
John D. Archbold Memorial Hospital
Level 1 Adult Trauma (5)
Level 2 Adult Trauma (10)
Level 3 Adult Trauma (7)
Level 4 Adult Trauma (7)
Level 1 Pediatric Trauma (1)
Level 2 Pediatric Trauma (1)
Burn Center (2)
EMS_Regions
Office of EMS
Emergency Preparedness
2019 Facilities
FOR OFFICIAL USE ONLY

Appendix 2

Trauma Registry Inclusion Criteria

Any patient with ICD-10_CM diagnosis code below:

- S00-S99 with 7th character modifiers of A, B, or C. (see exclusions)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T79.A1 – T79.A9 with 7th character modifier of A (Traumatic Compartment Syndrome – initial diagnosis)
- Retired ICD-9-CM: any patient with ICD-9-CM diagnosis code between 800.00 – 959.9.

Excluding patients with:

- *Diagnosis codes of ICD-10-CM superficial injuries:*
  - *S00, S10, S20, S30, S40, S50, S60, S70, S80, S90*
- *Late effect codes with the 7th character modifier of D through S.*
- *Patients with isolated burn injuries*
- *Patients with injuries older than 30 days from first ED arrival date*
- *Retired: diagnosis codes of ICD-9-CM 905 –909.9 (late effects of injury)*
- *Retired: diagnosis codes of ICD-9-CM 910-924.9 (blisters, contusions, abrasions, and insect bites)*
- *Retired: diagnosis codes of ICD-9-CM 930-939.9 (foreign bodies*

AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO A QUALIFING DIAGNOSIS CODE LISTED ABOVE

- Admitted to the hospital after discharge from the ED, regardless of length of stay.
- Transferred to or from another facility by ground EMS or Air transport.
- Died, regardless of length of stay.
- DOA: defined as a patient that died from a traumatic injury before hospital arrival.
- Unplanned readmissions, associated with the trauma, within 72 hours of discharge from the first visit.

Additional criteria:

- The Georgia data collection standard for blood utilization includes data for any blood products administered within the first 4 hours from the patient arrival time.

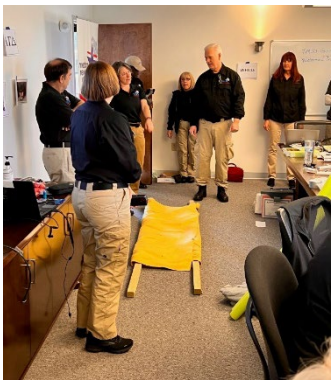
Revised: Blood collection revised 07/10/2019, 12/18/2017 eff. 01/01/2018, 03/01/2016, 05/20/2015, 04/23/2014, 02/14/2013, 12/31/2012 eff. 01/01/2013
Created: 06/26/2002

GEORGIA TRAUMA COMMISSION

Committee and Trauma System Partner Report to the Georgia Trauma Network Care Commission

Name of Committee or Workgroup:	MAG Medical Reserve Corps
Project/Activity[1]	**Comments**
1. MAGMRC Leadership Team Meeting	07/2021 - The MAGMRC Leadership team met in July 2021 to review the then recent mass casualty training event in Warner Robins and to discuss possible future training events.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
2. Meeting with MAG Executive Director	08/2021 – Dr. Harvey and Fred Jones met with Jeremy Bonfini, the new MAG Executive Director to discuss the MAGMRC, its history, its plans, its operational aspects and how as a program it benefits the State of Georgia and MAG.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
3. GTCNC Meeting	08/2021 - Dr. Harvey presented an update on MAGMRC to the GTCNC.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
4. MAG House of Delegates	10/2021 - MAGMRC manned an informational and recruiting display table at MAG's annual House of Delegates. Dr. Harvey presented a report to the more than 200 physicians attending the meeting.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
5. MAGMRC Leadership Team Meeting	01/2022 - The MAGMRC Leadership Team met to finalize plans for upcoming training events and to plan for additional future training in 2022. Upcoming: • Make-shift Medical (February 12) • Active Shooter - Warner Robins (March 26) • Drone Team (May 21) Planning: • Communications Training • Landing Zone Ops Training • K9 Team Veterinary Medicine Training • Shelter Team Training-GDPH/MAGMRC Personal Preparedness – Paul Purcell: training will be video taped and made available as a part of new member orientation; will also be made available to other MRC units for their member training
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
6. Make-shift Medical Training	02/2022 - MAGMRC member and security and anti-terrorism expert Paul Purcell conducted a two-hour training on how everyday household items could be utilized for treating patients if MAGMRC medical personnel found themselves in a household

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103.

	environment without needed equipment or supplies. Eleven MAGMRC medical provider members participated in the training.  
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
7. Active Shooter	03/2022 - MAGMRC participated with the Warner Robins Police Department and Warner Robins Fire Department in their interagency active shooter training conducted at the Central Georgia Technical College on March 26. MAGMRC provided both trainees and trainers.   
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
8. Statewide MRC Meetings	MAGMRC personnel have participated in multiple statewide MRC conference calls with the GDPH over the last year.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**
9. Bi-weekly Covid-19 Operational Information Updates	MAGMRC personnel have participated in multiple bi-weekly Covid-19 update sessions over the last year.
Status: Complete	**Support GTC Strategic Priorities? (Y/N): Y**

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	1	RTAC Chair	John Pope	RTAC Coordinator	Vacant

Date Submitted	04/15/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	Small classes with local law enforcement continue, Two train the trainer classes.
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	We have a DART class that was put on hold due to COVID, it will be rescheduled.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	None completed this quarter
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	None completed this quarter
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	BIS Assessment is complete and scheduled to be voted on at the next meeting.
RTAC Barriers	Due to staff shortages and COVID. The last two meeting have been cancelled.
Date of last BIS Assessment	3/2017
Date of last Trauma Plan	2015
Date of last region meeting	Last RTAC meeting was 7/22/2021 / EMS Council 1/27/2022
Date of next region meeting	4/28/2022

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103. O.C.G.A and Strategic Plan can be found https://trauma.georgia.gov/about-us

Regional Summary

Region 1 has had the last two RTAC meeting cancelled due to staffing shortages and key personal being either reassigned or taxed with other duties due to Covid. The BIS assessment was completed prior to the scheduled meeting and will be voted on at te next scheduled meeting. There are plans for completing the Trauma plan after the system survey and a new templete has been sent out. The school stop the bleed program is done and all but Cherokee County School Buses are complete with them currently sitting at about 51%. There has been limited buy-in from the transportation administration. Scott Lewis has left as the Region 1 RTAC Coordinator due to taking a position in the Office of EMS as the Regional Training Coordinator for Region 1. He will continue to help with the Region RTAC Coordinator duties as possible on his own time, till the position can be filled. An email was sent out to the region looking for interested parties to fill the position. Resume or CV were requested to be mailed to the Regional director who will forward them to the RTAC leadership for discussion. As the production of this document a couple of candidates have shown interest. It will be announced again at the RTAC meeting.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	2	RTAC Chair	Jesse Gibson	RTAC Coordinator	Jackie Payne

Date Submitted	04/18/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	**School Bus Drivers** There are 4 counties that have not completed STB Training. • Towns – STB training scheduled on May 22, 2022. • Hart- Letter sent to superintendent on 2/16 with follow up email on 3/17. No response. • Franklin- Letter sent to superintendent on 2/16 with follow up email on 3/17. No response.
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	**TNCC** TNCC grant funded course completed on Jan 13-14. 15 participants from multiple counties. **Central EMS Mobile Simulation** Completed education for Central EMS (Obstetric delivery, neonatal resuscitation and trauma) with the mobile simulation lab. 53 participants. **PHTLS** PHTLS grant funded course completed on March 10-11th . 14 participants for multiple counites. **Lumpkin Mobile Simulation** Scheduled to complete mobile simulation education for Lumpkin EMS on May 16-18 **Annual Trauma Symposium** The 7th annual Northeast Georgia Trauma Symposium will take place on Friday, October 28th , 2022 at Lanier Technical College Ramsey Conference Center. The event will be a

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	hybrid event offering attendees the opportunity to attend in-person or virtually. Registration opens May 1st! **RTTDC** RTTDC scheduled at Habersham Medical Center on June 16th. **Stephens Mobile Simulation** Scheduled to complete mobile simulation education for Stephens EMS on August 29-30th
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	**Pre-hospital Blood Pilot Project:** The project group recently submitted final information to the Drugs and Devices subcommittee of GEMSMDAC. They then proposed approval at the April GEMSMDAC meeting. GEMSMDAC approved the post licensure skill for paramedics to initiative blood products in the field. The next steps involve the state Office of EMS & Trauma developing the licensing process. For region 2, the pilot work will continue at this time. The group is currently undergoing a change in temperature monitoring device. To this point, 74 field initiations have occurred. **Pre-hospital Ultrasound Project** RTAC 2 purchased 13 Butterfly IQ handheld ultrasound devices. The program is being implemented to assist with decision making regarding needle decompression and also to assist with location of insertion, if indicated. 6 agencies have completed the application process. Education will consist of education modules via the LMS and hands on training. 2 (Jackson and Franklin) of the 6 agencies have completed their training.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	**Bingocize** Completed a 10 week evidenced based fall prevention program for Hall County Senior Center. There was a total of 15 participants. **Empower College and Career Center** Completed STB and hands only CPR for Jefferson High School on March 21st. 65 participants. **The Road Ahead** Partnered with Region 5 for virtual teen safety on March 24th . 70 participants.

Status: On-going	Support GTC Strategic Priorities? (Y/N): Yes

RTAC Successes	**Pre-hospital Ultrasound Project** 2 (Jackson and Franklin) of the 6 agencies have completed their training.
RTAC Barriers	We continue to have challenges with completion of STB training for Hart and Towns. As mentioned above, a formal letter and follow up email have been sent with no response.
Date of last BIS Assessment	Unknown, requires update
Date of last Trauma Plan	Unknown, requires update
Date of last region meeting	RTAC region meetings should occur quarterly at minimum. **Deliverable**: submit meeting minutes from your most recent RTAC meeting along with quarterly report.
Date of next region meeting	Friday, April 22nd, 11:30 am to 1:30 pm Northeast Georgia Medical Center Walters Auditorium, Zoom virtual option

Regional Summary

Region 2 has completed STB education for all schools and 80 % of school bus drivers. The superintendent of the remaining counties has not been responsive to the formal letter and follow up email that was sent in Feb/March. Region 2 will continue their efforts with the remaining counties. Regional STB continues in the community.

Region 2 has completed several grant funded education events this past quarter: TNCC, Mobile Simulation Education for Central EMS, and PHTLS. Future education to include Mobile Simulation Educator for Lumpkin EMS, RTTDC on June 16th at Habersham Medical Center, Mobile Simulation Education for Stephens County August 29th -30th and the Northeast Trauma Symposium on October 28th.

The project group recently submitted final information to the Drugs and Devices subcommittee of GEMSMDAC. They then proposed approval at the April GEMSMDAC meeting. GEMSMDAC approved the post licensure skill for paramedics to initiative blood products in the field. The next steps involve the state Office of EMS & Trauma developing the licensing process. For region 2, the pilot work will continue at this time. The group is currently undergoing a change in temperature monitoring device. To this point, 74 field initiations have occurred.

The Ultrasound Project is being implemented to assist with decision making regarding needle decompression and also to assist with location of insertion, if indicated. 6 agencies have completed the application process. Education will consist of education modules via the LMS and hands on training. 2 (Jackson and Franklin) of the 6 agencies have completed their training.

Region 2 completed Bingocize, a 10 week fall prevention program, for the Hall County senior center and STB and hands only CPR for Empower Career College. Region 2 also partnered with Region 5 for the Road Ahead a virtual teen safety driver event.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	3	RTAC Chair	Dr. Elizabeth R. Benjamin PhD	RTAC Coordinator	Mark Peters

Date Submitted	04/20/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments	
1. Stop the Bleed	I've had numerous inquiries, from non-public schools, for STB classes but the only scheduled class is for the Medical Reserve Corp at Gwinnett County Health Department. Picked up STB training equipment from GPSTC, delivered to regions 2, 3, 5, 10. Inventoried STB kits at Metro Atlanta Ambulance's warehouse. Delivered 200 STB kits to Gwinnett County Schools for new schools and buses.	
Status: On-going		**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	CHOA – Grand Rounds - Shock Index Pediatric Age Adjusted - March 18, 2022 Grady – Trauma Grand Rounds – Reflections of an Academic Trauma Surgeon, Researcher, and Educator – March 1, 2022 Region 3 RTAC - 30 for 30 EMS patient handoff – January-March 2022 Region 3 RTAC – Daniel Wu MD – Cardiff Model – during February RTAC meeting Clayton County Emergency Services - EMS Symposium - February 23-25, 2022	
Status: On-going		**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	None listed.	
Status: On-going		**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	None listed.	
Status: On-going		**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	First educational presentation during an RTAC quarterly meeting. We have a plan to setup a website for our RTAC.
RTAC Barriers	I will try to reestablish Stop the Bleed discussions with Clayton County Schools and DeKalb County Schools.

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103. O.C.G.A and Strategic Plan can be found https://trauma.georgia.gov/about-us

Date of last BIS Assessment	01/2016
Date of last Trauma Plan	08/2016
Date of last region meeting	February 24, 2022
Date of next region meeting	May 26, 2022

Regional Summary

Region 3 RTAC has been picking up momentum. We have a plan to have our own website where we can post education, educational opportunities and events in our region. We have initiatives in-progress for EMS patient handoff education (30 for 30), building a database to collect treatment modalities for adolescents in our region and a blood drive challenge that will include the entire region. A trauma conference for the region is in its infancy but we are working on creating case conferences for presentation as well.
Stop the Bleed –

- Region 3
  - Schools: Overall 75% complete 582 of the 768. Clayton Public Schools 11 of 63 or 17% are complete, Dekalb 18 of 132 or 14% are complete. No activity since Covid. There are eight state charter schools that have not started training.

  - Buses: 9 of the 12 or 75% of the systems are complete with kits delivered. Atlanta Public Schools and Dekalb County started training their bus drivers but have had no activity since Covid. Clayton County has not started training their bus drivers.

  - Training kits: 27 of the 28 or 96% of the systems have been delivered with Clayton County being the only one left.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	4	RTAC Chair	Sam Polk	RTAC Coordinator	Stephanie Jordan

Date Submitted	04/15/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	Coweta County High Schools (3 – East Coweta, Newnan, Northgate) have trained all students in Stop the Bleed. Univeristy of West Georgia is implementing STB Training for their staff, and looking for funding for kits.
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	PHTLS – • Hero Training (hybrid) – 05/19 • FGTC – 06/07-06/10 and 06/23-06/29 TECC – • Coweta County Fire Rescue – 05/14-05/15
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	Data gathering from 911 zone providers, air ambulance providers, hospitals: • Determine Time to Definitive Care – ○ ***PRELIMINARY RESULT*** – Ensure the patient is taken to the 'Right Facility the First Time.' ○ ***RESULT –*** Level 1 and Level 2 Designated Trauma Center overcrowding, due to lack of Level 3 and Level4 Designated Trauma Centers in Region 4. – Piedmont Henry and Wellstar West Georgia are in their reporting and preparation phases to become L3, L4. • Determine need for Additional Regional Resources – ○ ***PRELIMINARY RESULT –*** Continuing Education for Field Providers in trauma-related classes. ○ ***PRELIMINARY RESULT –*** Coordinate surrounding resources for equipment/training not available in an area (mutual aid).
	Support GTC Strategic Priorities? (Y/N): Yes
4. Injury Prevention Activities	• On-going - Stop the Bleed to community stakeholders • On-going – Community Car Seat events • On-going – Firearm and Hunter Safety • On-going - Boy Scout and Girl Scout training (badges)

[1] Wherever possible the topic/task should be related to GTCNC Strategic Plan or activities of the GTCNC as defined by O.C.G.A. § 31-11-100, § 31-11-101, § 31-11-102 and § 31-11-103. O.C.G.A and Strategic Plan can be found https://trauma.georgia.gov/about-us

Status: On-going	Support GTC Strategic Priorities? (Y/N): Yes

RTAC Successes	All Coweta County High School students have been trained in Stop the Bleed, and locations of kits in their respective schools.
RTAC Barriers	Access to Biospatial Data. The RTAC Coordinator and RTAC Committee needs this login/access.
Date of last BIS Assessment	April 2022, awaiting final approval from Region 4 EMS Council. (Next meeting is 17JUL2022)
Date of last Trauma Plan	April 2022, awaiting final approval from Region 4 EMS Council. (Next meeting is 17JUL2022)
Date of last region meeting	Cancelled, due to scheduling conflicts with Committee.
Date of next region meeting	August 2022, date TBA. A new RTAC Chair will be appointed at the 17JUL2022 Region 4 Council meeting.

Regional Summary

Coweta County School Systems agreed to 'trial' one semester of students with Northgate. The found it an easy add-in to the regular Health curriculum, with CPR. The CCSS Middle Schools are adding it in to their curriculum, for 2022-2023. This was a trial, to determine ease of implementation to the current curriculum and accepantce from students. The success of this program will be implemented in the following School Systems, in the 2022-2023 School Year: Spalding County, Lamar County, Upson County, City of Carrollton, Carroll County, Fayette County. Additional Region 4 counties are in progress.

Region 4 is deverse (Urban/Suburban/Rural), and has various needs, depending on location. Through Continuing Education, awareness of the need for improvement is slow (but steady). Many 911 Zone Providers and Hospitals have (or are) revising their Best Practices, to better serve their stakeholders. Community education is vital, in the more rural areas, when available resources are limited.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	5	RTAC Chair	Todd Dixon	RTAC Project Coordinator	Kristal Smith

Date Submitted	04/22/22
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	**1/3/22** - Virtual Course/3 Sessions/310 Attendees/ School District Personnel **1/3/22** - Virtual Instructor Orientation/2 Sessions/20 Attendees/School Nurses, SROs, Health Science Instructors, etc. **1/4/22** - Virtual Course/3 Sessions/181 Attendees/School District Personnel **1/4/22** - Virtual Instructor Orientation/4 Attendees/School Nurses, SROs, etc. **1/5/22** - Virtual Course/3 Sessions/136 Attendees/ School District Personnel **1/5/22** - Virtual Instructor Orientation/3 Sessions/18 Attendees/School Nurses, SROs, Health Science Instructors, etc. **1/6/22** - Virtual Course/3 Sessions/165 Attendees/ School District Personnel **1/6/22** - Virtual Instructor Orientation/3 Sessions/12 Attendees/School Nurses, SROs, Health Science Instructors, etc. **1/29/22** - In-Person Skills Course/CGTC Macon/10 Attendees/EMS, Fire, LE **1/29/22** - Instructor Orientation/CGTC Macon/10 Attendees/EMS, Fire, LE **2/4/22** - Traditional Course/CGTC Macon/8 Attendees/Public Safety Instructors **2/4/22** - Instructor Orientation/CGTC Macon/3 Attendees/Public Safety Instructors **2/25/22** - Traditional Course/GA Academy for the Blind/30 Attendees/Students and Faculty **2/26/22** - In-Person Skills Course/CGTC Macon/8 Attendees/EMS, Fire, LE **2/26/22** - Instructor Orientation/CGTC Macon/5 Attendees/EMS, Fire, LE **3/11/22** - Traditional Course /HOSA,Atlanta/2 Sessions/164 Attendees/Students and Faculty **3/11/22** - Instructor Orientation/ HOSA,Atlanta /70 Attendees/ Students & Faculty **3/25/22** - In-Person Skills Course/CGTC Warner Robins/2 sessions/30 Attendees/EMS, Fire, LE, etc **3/25/22** - Instructor Orientation/CGTC Warner Robins/2 sessions/30 Attendees/EMS, Fire, LE, etc Summary: 12 Virtual Stop the Bleed Courses/792 Attendees 13 Instructor Orientation Sessions/142 Attendees 3 In-Person Skills Course*/48 Attendees *R5Trauma Instructors performed ~a dozen 1-on-1 Skills Courses/Checks

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Status: On-going	Support GTC Strategic Priorities?[1] (Y/N): Yes
2. Education	**1/24/22-1/27/22** - R5 Peds Trauma Symposium (20+ Webinars)/114 Attendees/ 900+ Contact hours awarded/School Nurses, EMS Personnel, Hospital Personnel **1/28/22-1/29/22** – Tactical Emergency Casualty Care/CGTC, Macon/9 Attendees **1/29/22** – Tactical Emergency Casualty Care LEO/CGTC, Macon/3 Attendees **2/25/22** – Trauma Skills Lab/CGTC, Macon **2/25/22-2/26/22** – Tactical Emergency Casualty Care/CGTC, Macon/7 Attendees **3/24/22-3/25/22** – Tactical Emergency Casualty Care/CGTC, Macon/18 Attendees **2/25/22** – Tactical Emergency Casualty Care LEO, CGTC, Macon/15 Attendees **On-going** – R5 RTAC continues to partner with The Q Word Podcast to deliver trauma education targeting Emergency Department Nurses and EMS Personnel. 8 Podcasts have been published to date with nearly 15,000 downloads. The latest episodes on Supraglottic Airways and Resuscitative Sequence Intubation were commissioned by the RTAC PI Subcommittee and have more than 3,500 downloads.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	PI focus for 2022-23 – **Management of blunt trauma arrest and time to definitive care.** Case reviews are ongoing. Several members of the RTAC PI Subcommittee participated in virtual panel discussions during the Pediatric Trauma Symposium. All sessions were recorded for future viewing. Print resources (badge buddies, posters, etc) curated by members of the RTAC PI Subcommittee were mailed to symposium attendees. Presentations designed to facilitate “loop closure” on RTAC PI Cases: **1/24/22** - Principles of Pediatric Patient Assessment/64 Attendees **1/25/22** - Kids in Cars: How Anatomy & Child Restraints Impact Injuries/ 38 Attendees **1/25/22** - Children and Shock: Where Recognition and Early Intervention are Key/ 42 Attendees **1/25/22** - Trauma After-Hours: Challenges with Pediatric Trauma/23 Attendees **1/26/22** - Trauma After-Hours: Non-Accidental Trauma/22 Attendees **1/27/22** - Time Well Spent Simple Tools to Improve Communication, Understanding, and Outcomes/47 Attendees **1/27/22** - Pediatric MCI Triage/40 Attendees **1/27/22** - Need for Speed – Teen Drivers and the Trauma Response/36 Attendees
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	**1/13/22 - 3/31/22** - Bingocize Multiregional Cohort (7 Central Georgia Sites) **3/18/22** - Combined RTAC IP Subcommittee/R5 EMS for Children Meeting Injury Prevention Webinars: **1/24/22 -** Firearm Injuries in Children and Georgia Stay Safe/59 Attendees **1/25/22 -** Kids in Cars: How Anatomy & Child Restraints Impact Injuries/ 38 Attendees **1/26/22 -** Child Abuse Prevalence, Prevention, and Response/49 Attendees

4. Injury Prevention Activities (continued)	**1/26/22 -** ATV Injuries Prevalence, Prevention, and Response/41 Attendees **1/26/22 -** Trauma After-Hours: Non-Accidental Trauma/22 Attendees **1/27/22 -** Suicide Prevention/44 Attendees **1/26/22 -** Trauma After-Hours: Human Trafficking/16 Attendees **3/25/22** - Prevent Trauma: The Road Ahead (Teen Driver Event)/75 Attendees
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	The Pediatric Trauma Symposium was the highlight of the quarter. The presentions were excellent, the audience was engaged, and the feedback was wonderful.
RTAC Barriers	We are very fortunate to be able to count on many regional partners to contribute to the various RTAC projects. Nonetheless, time constraints and staffing demands continues to be a significant barriers in regard to RTAC roject execution.
Date of last BIS Assessment	Adopted Jan 2012; a new BIS assessment is in progress
Date of last Trauma Plan	Adopted October 2016; a Trauma Plan update is in progress
Date of last region meeting	**1/7/22**
Date of next region meeting	**4/27/22**

Regional Summary

Region 5 continues to benefit from the engagement of a broad spectrum of stakeholders. Our RTAC meetings and subcommittee meetings are well attended. Many of our RTAC members and subcommittee members are engaged in multiple RTAC initiaives. We are fortunate to have many informed, capable members that are able to assume leadership roles when needed. Region 5 maintains two virtual "classrooms", a regional resource library, and two regional equipment caches. Thus, we have equipment resources, expertise, and instructional depth to deliver multiple programs simultaneously.

One hundred percent of our public schools have completed their initial Stop the Bleed in-service training. We communicate regularly with our school system partners and work to provide refresher training as needed. Many school districts have the infrastructure, resources, and expertise to sustain in-house Stop the Bleed programming, and a number of our region's school nurses assist with the provision of community training. In addition, our school system partners often attend our other trauma education initiatives.

Ninety-five percent of the region's school buses are equipped with Bleeding Control Kits. We have two school districts, Peach and Pulaski, that have yet to have their school bus drivers complete Stop the Bleed training. Multiple RTAC members and stakeholders have reached out to these districts, and they have had training events scheduled numerous times. Unfortunately, both systems have been plagued by turnover, illness, weather-related emergencies, staffing shortages, etc. We continue to reach out to them on a regular basis regarding available dates and training opportunities. Peach County has committed to training in July 2023. We have equipped 1,316 school buses with kits. We have the 70 kits needed to equip the remaining buses.

Region 5 has a number of events planned for Trauma Awareness Month, EMS Week, Stop the Bleed Day, etc. Our Summer Stop the Bleed efforts will focus on recreational venues.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	6	RTAC Chair	Nicky Drake	RTAC Coordinator	Farrah Parker

Date Submitted	04/20/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	Signal Enlisted Development College 01/05/2022 Students & Teachers
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	Farm Medic & Machinery Extrication Course 02/19-02/20 Emanuel County Trauma Skills Lab 02/11/2022 Columbia County
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	Still coordinating with local grocery stores to complete STB training.
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	Columbia County School buses has not been able to be completed due to the pandemic and timing of school schedule and meetings. Was able to confirm that STB training can be completed during the summer meeting in July. This will complete the school bus training for our region.
RTAC Barriers	Barriers for region 6 has been to keep members engaged outside of quarterly meetings. I continue to have support from some members but to sucessfuly accomplish task and goals we need everyone to be involbed. The Chair has made plans to update the member list of those that want to participate and include more people.
Date of last BIS Assessment	2011
Date of last Trauma Plan	2011
Date of last region meeting	02/03/2022 Meeting Minutes Attached
Date of next region meeting	05/05/2022

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Regional Summary

Region 6 continues to develop ways to engage the region in ongoing education activities and PI projects. Nicky Drake has suggested that we begin to hold a meeting between the quarterly meetings to keep the momentuem. We have improved the meeting attendance and parties seem to be more envolved and can continue.

The BIS assesement has to be completed, and I have secured space at Doctors Hospital with other options like a local Baptist church in Richmond county or Emauel county. We will have people sign up during the next meeting rather than wait on email response, that has not been successful in the past.

The school project has been completed and I have had a few calls asking for additional kits with staffing changes and additions. The school bus project for the region will be 100% completed after the completion of Columbia county in July. I have spoken with 2 of the 3 trauma facilities and they will help coordinate the training since it will be a large group.

I have also reached out the Sheriff Richard Roundtree and the Marshall Ramone Lamkin in Richmond county to coordinate training. I am hoping that is a huge success and will widen the number of law enforcement that has compelted STB training.

Please include the following in your summary:

- School Project percent completed and barriers to completion.
- School Bus Project percent completed and barriers to completion.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	7	RTAC Chair	Duane Montgomery	RTAC Coordinator	Brian Dorriety

Date Submitted	04/19/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	Taught STB to 20 Employees at Piedmont Columbus Regional Hospital,(new nurses) Pick up 5 STB Tariner Kits for Region 7 and 1 for Piedmont Truama Center
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	We had our 3rd annual Trauma Skills Lab January 28, 2022. We had around 100 students attend the lab. We are having a Tactical Emergency Casualty Course May 6-7 at Columbus Fire and EMS
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	Kelly Grasser is working on Trauma Transport Data Collection to track Region 7 scene to trauma center times
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	We had car seats classes online March 17, and will have another one April 21 and May 19. Safe Kids of Columbus March 5, 2022 we had a boating safety course May 14, 2022 we are having a Life Jacket Giveaway May 26, 2022 next boating safety course
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	Successful Trauma Skills Lab Falls are down in region 7 since distributing our Fall Prevention Pamphlets through-out the region.
RTAC Barriers	No barriers noted
Date of last BIS Assessment	March 2020
Date of last Trauma Plan	April 6, 2022

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Date of last region meeting	January 27, 2022
Date of next region meeting	April 19, 2022

Regional Summary

Region 7 has made progress with Stop the Bleed in the hospitals, using our new STB trainer kits. The plan to continue training throughout the region. To include government buildings, civic centers , and schools as they schedule training sessions.

The region is working on rolling out Stop the Bleed training to law enforcement and fire department's due to the increased stress on EMS. Our LEO have been requesting the raining and would love to receive a kit per patrol car.

Region 7 is 100% complete with STB in the Schools and Buses. We will continue to add additional training sessions for new hires and new schools as they request. We have approximately 16 private schools in Region 7 that are interested in the STB training. Awaiting for approval from the GTC to conduct this training and provide them with the STB Kits.

Region 7 continues to schedule different types of training thoughout the region foe EMS agencies and hospitals. We continue offering courses for our region as agencies request. This is an opportunity where a regional training grant may be utilized in the future.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	8	RTAC Chair	David Edwards	RTAC Coordinator	Stephanie Gendron

Date Submitted	05/3/22
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	Public Classes offered by Pheobe Putney including rural fire departments Doughtery County Buses- 150 kits distributed STB training aids distributed
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	GEMSA Sponsored Farm Medic Class TECC Auto Extrication Upcoming: Farm Medic, and Auto Extrication
Status: On-going	**Support GTC Strategic Priorities? (Y/N): N**
3. Performance Improvement Projects	None
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	Occupant Protection; working with GOHS on night roadchecks ATV Program through Memorial Health being offered to outside hospitals
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	We have been able to get the STB Kits out to the school bus transportation systems that are starting to train again. The new training devices have made it to most of the centers through GSP and the additional devices have been distributed.
RTAC Barriers	Distance with RTAC coordinator. Difficulty in transportating large amounts of kits from Atlanta to SW
Date of last BIS Assessment	1/2018
Date of last Trauma Plan	1/2018
Date of last region meeting	1/2022

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Date of next region meeting	TBD- New coordinator

Regional Summary

Region 8 is finally starting to resume training STB at a pace that was seen before the pandemic. We have partnered with GEMA/HS to get the kits to Southwest Georgia, although it is not a one-day process. Having kits in the area will alleviate some of the issues with supplying kits in a timely manner.

This quarter is the last of Stephanie Gendron and all of the equipment for the region has been transferred to DPH, GEMA and trauma facilities. The position will hopefully be filled before the next school year, which will help with the completion of STB and other projects.

Please include the following in your summary:

- School Project percent completed 90%- Barriers- Supplies/teachers
- School Bus Project percent completed and barriers to completion- 50%- Supplies, Teachers, COVID

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	9	RTAC Chair	Dr. Alexis Gage	RTAC Coordinator	Stephanie Gendron

Date Submitted	5/3/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	STB is being offered as requested. STB Kit was successfully used at a Savannah Chatham School in February by a school resource officer. (Will get more info on this) Bacon County Sheriffs Office Vidalia Police Department Tattnall County Police Deparment Bryan County Sheriffs Office
Status: On-going	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	Farm Medic Class, Hazmat/Decon Class, Active Shooter Prevention
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	Attirition Study- In progress Walking College- Begins 5/1/2022
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	ATV Education through Memorial- Ongoing Bike Helmet Giveaways- Ongoing Storm Spotter Training- Complete 4/22 CPST- Car Seat checks- Ongoing
Status: On-going	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	The RTAC has really been able to target Law Enforcement agencies over the past quarter. STB kit was used successfully at a Middle School in Savannah Chatham Schools.
RTAC Barriers	Everyone is still very burned out from COVID, it is difficult to get buy in from our trauma systems with high levels of turnover.
Date of last BIS Assessment	January 2019

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Date of last Trauma Plan	January 2019
Date of last region meeting	April 28th, 2022- RTAC coordinator was unable to attend
Date of next region meeting	July 28th, 2022- Location TBA

Regional Summary

Region 9 has been doing well with classes and STB training. The committee is finally at a place where they are self sufficient in releasing training and completing paperwork and followup without involving the RTAC coordinator every time a class is offered. The region has been creative with funding; receiving great support from North American Rescue and the regional healthcare coalitions. The attrition study on EMS workers is at a standstill due to EMS classes being offered and those on the task being held up with those cohorts. The region did start working as a member of the AARP Georgia Walking College which will start in May and run through September.

Please include the following in your summary:

- School Project percent completed and barriers to completion. 100%-none
- School Bus Project percent completed and barriers to completion. 100%- none; We anticipate 2-3 new schools opening before 2022-2023 school year.

GEORGIA TRAUMA COMMISSION

Regional Advisory Trauma Committee Quarterly Report

EMS Region	10	RTAC Chair	Dr. Kurt Horst	RTAC Coordinator	Crystal Shelnutt

Date Submitted	04/18/2022
Quarter	3

Current Quarter Project/Activity[1]	Comments
1. Stop the Bleed	1/18- Elbert Memorial STB: ED staff received the STB course; two students were guided through the instructor process and left with one training case (5 training STB kits & 5 pool noodle trainers) to conduct training for the remainder of the ED staff 3/30- STB at Oglethorpe County High School Ghost Out, OCHS junior & senior students were trained in tourniquet application and wound packing. STB was one of many stations, including hands-only CPR, an intoxicated driving simulator, and a simulated wreck with extrication and helicopter evacuation. Multiple STB projects are in the late planning/ early implementation stage. Athens-Clarke Co plans to deploy 100 kits to parks and government buildings with in-person and virtual training. Oconee County will deploy 100 kits and require all county employees to receive training in STB. Madison and Oglethorpe Counties plan to deploy 50 kits each to their county buildings, parks, and road department vehicles. Training will be conducted by the EMS services for county employees. RTAC will coordinate with each for assistance in training and us of the wound trainers.
Status: Ongoing	**Support GTC Strategic Priorities?[1] (Y/N): Yes**
2. Education	RTAC is working with Elbert County EMS to develop a Heavy Vehicle Extrication Course. RTAC has voted to support and fund the project once developed. During the most recent RTAC meeting, a sub-committee was established to assist in course development. Dr. Horst, Heather Morgan, and Crystal Shelnutt met on 3/29 at PAR to discuss establishing an ongoing monthly or bi-monthly trauma course for the region. The classes will be virtual and hosted on the OEMS TRAIN site. We will work with local trauma surgeons, ER physicians, and medics for case studies of recent trauma calls. Following the case study, Dr. Horst and Crystal will provide a brief lecture on relevant A&P, current research and best practice, and improving prehospital care of trauma patients.

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Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Yes**
3. Performance Improvement Projects	Blood Products Pilot Project- On March 14th we received the shipment of the final piece of equipment necessary for the project. The coolers, interchangeable inserts, and thermostats are awaiting final testing at the Piedmont Athens Regional blood bank. Elbert County EMS has completed all PLS requirements and is awaiting delivery of plasma.
Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Yes**
4. Injury Prevention Activities	Participation in the Oglethorpe County Ghost Out
Status: Ongoing	**Support GTC Strategic Priorities? (Y/N): Yes**

RTAC Successes	After a long hiatus, in person, STB training is finally receiving renewed interest. Following the last RTAC meeting, where the availability of kits and free training we discussed, many services reached out with interest in developing programs for their community. Four counties are actively scheduling and planning STB projects. Given competing priorities and EMS staffing concerns, this level of interest is a success!
RTAC Barriers	As we continue to expand the role of RTAC in the region, the only barrier we continue to face is active participation from the area. We have a few highly responsive counties but others that we struggle for active engagement.
Date of last BIS Assessment	October 31, 2016
Date of last Trauma Plan	December 18, 2018
Date of last region meeting	March 15, 2022
Date of next region meeting	June 21, 2022

Regional Summary

Region 10 received the new STB wound simulators and immediately put them to good use! We've had great interest from current instructors wanting to incorporate them into their programs. We are developing an online tool to reserve them. The browbbear calendar website is widely used in the region and might provide easy access for requests to schedule STB training equipment. We plan to give a link with scheduling directions when the Region RTAC website is available.

Dr. Horst is excited to begin developing regular training sessions and has received support from the trauma group at PAR. He will be contacting other colleagues with specific backgrounds to gauge interest in providing additional content. Ryan Hollingsworth will assist in accessing the TRAIN site and requirements for use. We are exploring the idea of regional case studies as a framework for each topic and have reached out to training supervisors for cases or other ideas.

All schools in Region 10 have completed STB training and received kits. The Jefferson City School district is the only remaining site for STB training for bus drivers. Jackson County EMS is going to try and assist in facilitating training.