Pennsylvania TRAUMA SYSTEMS Foundation

Georgia Trauma Commission
2025 Level IV Consultative Visit Summary

The Pennsylvania Trauma Systems Foundation (PTSF) was contracted by the Georgia Trauma Commission (GTC) for Phase 3 of the pilot project to conduct consultative visits at Georgia Level IV trauma centers. One survey team carried out an abbreviated consultative visit for two hospitals that had been previously reviewed in 2022. The focus was to assess the implementation of previous recommendations. This is a brief summary of the visit.

AGGREGATE THEMES FROM TRAUMA CENTERS

1. Commitment
    a. Strong backing from hospital leadership.
    b. Enthusiastic and dedicated trauma program administrative and hospital staff.
    c. Well-equipped, state-of-the-art facilities.
    d. Commitment to community well-being through injury prevention initiatives.
    e. Demonstrate a strong commitment to trauma nursing education by aiming for all emergency department (ED) registered nurses to complete the Emergency Nurses Association's (ENA) Trauma Nursing Core Course (TNCC).

2. Clinical Care
    a. Persistent concern for undertriage.
    b. Inconsistent adherence to Advanced Trauma Life Support principles.
    c. Hospitals and resuscitation areas are well-equipped.
    d. A need to use electronic medical records for consistent trauma documentation.

3. Performance Improvement
    a. There is a need to seek educational opportunities to improve skills in using the trauma registry and performance improvement (PI) databases, ensuring efficient data utilization to validate the quality of the trauma program.
    b. Inconsistent implementation of a PI Plan, despite Trauma Program Managers attending the Society of Trauma Nurses' (STN) Trauma Outcomes and Performance Improvement Course (TOPIC).

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GEORGIA TRAUMA SYSTEM RECOMMENDATIONS

1. Undertriage
    a. There is a consistent pattern of centers not initiating trauma activations even when patients meet the criteria. ED staff often hesitate to initiate the activation upon the patient's arrival, due to a misconception that it is unnecessary since key staff are already present. Additionally, the institutions could enhance their recognition of trauma care efforts, as current operations meetings only highlight cases that meet state-wide reporting requirements—overlooking the broader scope of care provided by the facilities. Activation methods are also inconsistent, with some facilities using a manual process involving phone calls to each provider.
        i. Promote the inclusion of patients who do not meet state-wide reporting inclusion criteria in the institution's trauma registry. This could assist in analyzing over/undertriage rates and determining the overall trauma workload for optimal resource utilization.
        ii. Collaborate with EMS to educate them on the capabilities and benefits of Level IV trauma centers and identify which patients meet the center's activation criteria.
        iii. Advocate for a consistent efficient trauma activation process, utilizing methods such as group text notifications or overhead paging.

2. Performance Improvement
    a. There is limited knowledge regarding the use of the PI module in the registry and report writing. This variability in software utilization leads to inconsistent and inefficient workflows, PI data, and tracking of results. Just as the electronic health record has revolutionized healthcare implementation, similar measures and outcomes can be applied to enhance PI efforts.
        i. Provide education on the expected use of the PI module.
        ii. Standardize software utilization.
        iii. Offer education and training in report writing, including vendor support.
        iv. Distribute education and training manuals from the vendor.

3. Transfers
    a. Each Level IV trauma center demonstrated exemplary ED dwell times in the reviewed cases. The clinical care was effective, enabling rapid diagnosis and transport for severely injured patients. However, due to the brief nature of this follow-up consultative visit, a larger sample size medical record review is needed to consistently confirm these findings across the entire trauma population. Fortunately, both institutions were supported by hospital-based EMS programs that expedited transportation efforts. A consistent issue was the lack of receiving follow-up letters from higher-level trauma centers, as neither facility succeeded in obtaining them.
        i. Establish a statewide standard process of receiving trauma centers providing follow-up letters to referring trauma centers. The information provided should be from the trauma registry data, including diagnoses and injury severity score, and also PI opportunities for improvement.

ii. Ensure that follow-up letters are provided for all transferred patients, as they are valuable tools for a Level IV trauma center's quality measures that could result in feedback leading to positive improvement at the center. Additionally, it would assist in building relationships between trauma centers.

4. EMS Patient Care Records (PCR)
    a. The centers are unaware of computer interfaces that can automatically import the PCR directly into the electronic health record (EHR). As a result, trauma staff spend an excessive amount of time manually contacting EMS programs, receiving records via fax, and then scanning them into the EHR. When this information is not obtained, there is a lack of timely understanding of the care provided by EMS and subsequent PI efforts to improve EMS care performance.
        i. Offer statewide guidance on how common EMS PCR databases, such as GEMSIS, can integrate with a facility's IT department using Health Level Seven interfaces.
        ii. Educate centers on the capability to automatically import the PCR into a patient's individual health record.