APPROVED
04.30.26

GEORGIA TRAUMA COMMISSION

Trauma System Performance (Data) Committee
Meeting Minutes
February 19, 2026
5:30 PM – 6:30 PM
Zoom Meeting
Link to Meeting Documents

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

COMMISSION MEMBERS PRESENT	STAFF MEMBERS & OTHERS PRESENT
Dr. James Dunne, GTC Courtney Terwilliger, GTC	Elizabeth Atkins, GTC, Executive Director Gabriela Saye, GTC, Business Operations Manager Gina Solomon, GTC, GQIP Director Nicolle Sorto-Reyna, GTC, Intern

CALL TO ORDER

The meeting was called to order at 5:15 PM with nine committee members present.

APPROVAL OF MINUTES

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

MOTION TRAUMA SYSTEM PERFORMANCE COMMITTEE 2026-02-01:
Motion to approve October 28, 2025, meeting minutes

MOTION BY: Patricia Ayoung-Chee
SECOND BY: Kelli Vaughn
VOTING: All members are in favor of the motion.
ACTION: The motion ***PASSED*** with no objections nor abstentions

TRAUMA REGISTRY DATA REPORT: UPDATE ON IMAGE TREND MIGRATION STATUS

Presented by Marie Probst
Marie Probst provided an update on the registry data. She reported that the final 2025 download is beginning to come in, despite ongoing technical issues causing system timeouts. Marie is working with the remaining centers to resolve system and schema errors from the December download. A preliminary data quality check shows that the ImageTrend patient registry validity score is 88% for January through September 2025, with a total of 37,000 records received for that period. The HCA centers are considering the Rosie system, but they have received the

annual schemas and agency/hospital lists from ImageTrend and ESO. Currently, the central database accepts data only from ESO; integrating with other platforms would require creating a new schema and incurring additional costs.

TIME TO DEFINITIVE CARE | SYSTEM-WIDE STUDY

Presented by Dr. Dunne

Dr. Dunne provided a brief update, noting Dr. Anderson is reviewing data provided by Gina and has asked detailed statistical questions to guide further analysis. The committee decided to rely only on registry data moving forward, eliminating the previously manual extraction from EMS agencies. The initiative aims to track time to definitive care and overall system efficiency, with quarterly updates planned once the IRB process is clarified. Alternative IRB oversight options were discussed, including the potential use of Emory or Memorial Health.

TRAUMA SYSTEM DASHBOARD

Gabriela Saye provided an overview of the Trauma System Dashboard scope and development (**ATTACHMENT A**). She highlighted proposed key focus areas, including pre-hospital decision-making, inter-facility transfers, time to definitive care, and system capacity and flow constraints. The dashboard could address critical system-level questions, such as whether injured patients reach the appropriate facility, how long it takes to receive definitive care, how efficiently transfers are conducted, and whether system performance is improving over time.

Dashboard examples from Maryland, Virginia, Arizona, and Montana were reviewed to understand what other states share publicly and to inform potential design approaches. Visualization tools under consideration include Smartsheet, which offers a simple, accessible preliminary format, and Tableau, which supports more advanced, interactive visualizations.

Three versions of the Trauma System Dashboard were presented. Version 1 is text-heavy and would benefit from enhanced visual elements. Version 2 is a more visually engaging, PowerPoint-style iteration. Version 3 is Smartsheet-based, allowing for automatic updates and public view-only access. The committee emphasized careful consideration of publicly displayed data to ensure that peer-protected information is not disclosed.

The committee emphasized the importance of avoiding duplication of existing TQIP measures and of protecting sensitive or peer-reviewed data, with potential metric review by a peer-protection attorney to ensure compliance.

The intended primary audience for the dashboard was discussed, and the committee confirmed that it is designed primarily for trauma system stakeholders rather than the general public, while remaining aware that the public may view the dashboard.

Dashboard Metrics Discussion

Committee members started the discussion by emphasizing the importance of distinguishing between rural and urban settings, including defining criteria such as population density.

Proposed Core Metrics

1) Median Time: PSAP (911 call) to First Hospital (Primary)
2) Median Time: PSAP (911 call) to Definitive Care (Ultimate Hospital)

It was noted that only about 25-30% of records include complete data from the first hospital, which limits some analyses, but the team agreed to move forward with what is available. It was also decided to exclude patients transferred outside the state.

3) Number of Hospitals Before Definitive Care (bar graph with cluster over time)

This metric tracks patients who were transferred to more than one hospital before receiving definitive care. The committee agreed that this better represents secondary transfer rates than reporting transfer percentages alone.

4) Overtriage and Undertriage second hospital (pie graph)
   a. Based on NFTI (Need for Trauma Intervention)

The committee emphasized that the key concern is whether critically injured patients (ISS > 15) ultimately receive care at the appropriate trauma center. Previous methodologies used Cribari; NFTI-based life-saving interventions were proposed as a more clinically meaningful approach.

Dr. Dunne proposed incorporating NFTI measures such as:

- Intubation
- Blood transfusion

Transfer Metrics Discussion

The timing of the transfer decision was discussed but deemed difficult to analyze due to variability in documentation. Registry order times may not accurately reflect the time to clinical decision. Additional challenges include ambulance availability and variability between:

- Time of transfer decision
- EMS notification
- Transport confirmation
- Transport arrival

The committee agreed that detailed drill-down transfer interval analyses may be considered in future iterations.

April Moss noted that cardiac and stroke systems analyze transfer intervals in three components:

- Recognition of the need for transfer to EMS notification
- EMS notification to hospital arrival
- arrival to door out

Survival by ISS (metric replaced by Prehospital Blood Administration)

Survival rates by ISS were discussed. While crude mortality was considered less actionable, risk-adjusted survival may help determine whether system performance is improving over time.

The committee emphasized the need for a statewide performance improvement (PI) plan to ensure consistent monitoring of outcome measures.

Pre-Hospital Blood Administration (Replacing Survival Metric)
Pre-hospital blood administration was identified as a high-priority metric and will replace mortality/survival as a primary dashboard measure. Dr. Ayoung-Chee recommended discussing the prehospital metrics with subject-matter experts to inform the selection of the measure.

Liz recommended beginning with foundational questions:

- Who currently has pre-hospital blood capability?
- Who does not?
- Who should have it?

Kelly Joiner reported ongoing development of a map identifying counties and agencies with pre-hospital blood capability. Gina shared that the initial analysis identified approximately 400 patients who received pre-hospital blood between January and September.

5) Proposed prehospital blood administration metric components to include:
   - Heat map of counties with and without pre-hospital blood capability (linked to OEMST map-under-development)
   - Total number of patients receiving pre-hospital blood (by month or year)

Additional Considerations
April Moss suggested incorporating publicly available motor vehicle crash (MVC) data to support statewide collaboration, particularly given grant funding partnerships with the Office of EMS and Trauma. While potentially valuable for context, the committee agreed this may not align with current dashboard objectives but could be considered in future versions.

CLOSING REMARKS
The meeting concluded with a discussion of the next steps. The team will populate dashboard metrics in Smartsheet, integrating transfer, pre-hospital blood, and time-to-care data with Gina's support. The dashboard's visualization format will be finalized, including bar graphs and heat maps. Feedback on the initial version will be solicited from stakeholders. April Moss will inquire at the National Trauma Managers Council about other state dashboards and software solutions. Kelly Joiner will continue developing the heat map of prehospital blood capabilities. The committee emphasized that the dashboard is expected to evolve iteratively, reflecting ongoing improvements and system monitoring.

The meeting was adjourned after a discussion acknowledging that system development is an ongoing journey, with iterative updates anticipated.

SUMMARY OF MEETING & ADJOURNMENT

- Marie Probst shared updates on the registry data, including the 2025 download updates and preliminary data quality checks. The committee also discussed the potential impact if centers transition to alternative registry platforms.
- Dr. Dunne provided an update on the statewide Time to Definitive Care study, noting that Dr. Raeda Anderson has begun reviewing the data.
- Gabriela Saye presented an overview of the Trauma System Dashboard scope and development (**ATTACHMENT A**).

- The committee agreed to launch the dashboard with the following initial metrics:
    1. Median Time: PSAP (911 call) to First Hospital (Primary)
    2. Median Time: PSAP (911 call) to Definitive Care (Ultimate Hospital)
    3. Number of Hospitals Before Definitive Care
    4. Overtriage and Undertriage at Second Hospital
        a. Based on NFTI
    5. Prehospital Blood Administration
        a. Heat map of counties with and without prehospital blood capability (linked to OEMST map – under development)
        b. Total number of patients receiving prehospital blood (reported monthly or annually)
- Gabriela, Nicolle, and Gina will collaborate to develop the first dashboard iteration based on the committee's discussion.
- April Moss will consult with the National Trauma Managers Council regarding other state dashboards and available software solutions.
- Kelly Joiner will continue developing the prehospital blood capability heat map.
- The committee emphasized that the dashboard will evolve iteratively, incorporating ongoing refinements and supporting continuous system performance monitoring.

The meeting adjourned at 6:40 PM.

Minutes Respectfully Submitted by Gabriela Saye