Minutes approved 18 May 2012

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 15 March 2012

Scheduled: 10:00 am until 1:00 pm
Atlanta Medical Center
Health Pavilion-Letton Auditorium
320 Parkway Drive NE-Atlanta, GA 30312

CALL TO ORDER

Dr. Dennis Ashley, Chair, called the scheduled monthly meeting of the Georgia Trauma Care Network Commission to order at 10:09 a.m.

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Linda Cole, RN Dr. Leon Haley Dr. Robert Cowles Dr. Fred Mullins Kurt Stuenkel Elaine Frantz, RN Bill Moore Ben Hinson, (via tele-conference)	

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Office Coordinator	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
John Cannady, TCC Coordinator	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Fran Lewis	Grady
Randy Pierson	Region 1 EMS
Renee Morgan	OEMS/T
Regina Medeiros	GHSU
R. David Bean	EMS Consultant Services
Greg Pereira	CHOA/GCTE
Kim Littleton	GAEMS
John Cannady	TCC
Jim Sargent	North Fulton Hospital
Gage Ochsner	Memorial Health University
Laura Garlow	WellStar Kennestone Hospital
Debra Kitchens	MCCG
Susan Bennett	JMS Burn Centers, Inc.
Lawanna Mercer Cobb	Region 6

Janet Schalbe	Gwinnett Medical Center
Pete Quinones	Region 3
Jo Roland	Archbold Memorial
Gina Solomon	GMC
Scott Maxwell	M & M Inc.
John Harvey	Region 3 EMS Chair

QUORUM ESTABLISHED

Dr. Dennis Ashley confirmed that Mr. Ben Hinson was on the conference call line. Dr. Ashley confirmed with Mr. Pettyjohn that Dr. Fred Mullins, Dr. Robert Cowles and Dr. Leon Haley were in route and would be attending the Commission meeting. Dr. Ashley established quorum and confirmed with Mr. Alex Sponseller.

CALL TO ORDER AND CHAIRMAN'S REPORT

Dr. Ashley stated that he just returned from a meeting with The National Committee on Trauma American College of Surgeons. They have two meetings a year in which all states are pulled together and they go over various details of trauma care. At that meeting he heard a lot of positive comments about what Georgia is doing at the state level. Dr. Ashley stated that he has been talking with the folks at TQIP and they are making great progress. Georgia is one of the few states to come on as an entire state with TQIP and because of that no state reports have been developed yet. The staff at TQIP is working with them to develop Georgia's state reports, and they will use those reports in other states. TQIP has asked Dr. Ashley to make a presentation at their next meeting, which takes place in either September or October and will be the meeting for Quality Outcomes. They have asked us to present the Georgia story, explaining how we got started with TQIP in our state.

Dr. Ashley stated that the next phase is for the Commission to look at outcomes. It has taken a tremendous amount of work from both Commission and non-Commission members to get to the point that we can actually start to think about monitoring outcomes and the methodology for studying our outcomes as a state as well as our regions. Everything that we do is with taxpayer's dollars. Our number one goal is to save lives, but we need to do that in an efficient manner with economic implications. Dr. Ashley met with Dr. Avery Nathans who is the head of TQIP and has a strong history in trauma. They discussed outcomes, designing methodology, and future goals for the state. The Commission had worked with Dr. Nathans before, so he is familiar with Georgia and has agreed to help us with the methodology. Dr. Ashley stated that he is going to put together a team that will help the Commission study outcomes that will withstand scientific scrutiny. Dr. Ashley invited anyone who has an interest in statistics, data analysis or just has an interest in trauma to contact him.

Dr. Ashley stated that there was a bill introduced into the Senate, Bill 489 that talks about the Commission reporting trauma patient care and outcomes to Health and Human Services on an annual basis. He stated that the opportunity on a yearly basis to go before HHS Senate House to present what the Commission has accomplished is a great thing, however there were some problems with the actual wording of the Bill in the sense that it talked about verifying and documenting precise and clear outcomes with every dollar. This would be almost impossible to do; although we do need to try and document how we spend the money it might limit what we can report on. How can we report on something we think might of helped if we do not have clear documentation? We want to be able to report everything to the Senate and to the House to show that we are making a difference, so we worked to change that language. It is now a little clearer and easier to obtain and produce data *(see page 5 Line 17-20 Senate Bill 489 attached to Admin. Report)*.

ADMINISTRATIVE REPORT AND AGENDA REVIEW

Mr. Jim Pettyjohn states that the Administrative Report was posted to the GTCNC website yesterday morning. There was a significant increase in Super Speeder revenues collected for reinstatement fees for February 2012.

The reinstatement fees for January 2012 were $355,260 and in February 2012 it was $1,103,870. The Super Speeder fines for January 2012 were $951,925 and in February 2012 were $1,407,235. If you look at that over the year we will be coming in at a little over 16 million dollars, which goes well for our projection next year of maintaining our budget of 15.9 million for FY 2013 *(Breakdown Department of Driver Services attached to Admin. Report).*

The Draft Strategic Plan Day One of the 26 & 27 January Workshop is included in the Administrative Report along with the draft meeting minutes from day two. The minutes from day two will need the Commissions approval today.

We will be discussing the FY 2013 draft budget that the staff has worked very hard to develop. We will be working from today's discussion with many of you over the next month or so to come up with a budget that will be approved, hopefully in May 2012.

RTAC REPORTS

RTAC IX

Dr. Gage Ochsner presents the Pilot Project for Georgia System Regionalization Region IX *(PowerPoint attached to the meeting minutes).*

Dr. Gage Ochsner stated that there is a lack of available trauma resources for a large portion of the state of Georgia, yielding the current problem, which is a significant number of the citizens of Georgia do not have rapid access to trauma care. There is lack of an effective system that has appropriate assets where they are needed. Dr. Ochsner stated that in Region IX over 75% of the counties are greater than fifty miles away from a Georgia trauma center. We have a lot of time and distance issues in getting our patients to appropriate care.

Dr. Ochsner stated that Memorial University Medical Center is a Level 1 trauma center and has been for over 25 years. They have a commitment to performance improvement and patient safety. Dr. Ochsner sees the RTAC as being the leader in that aspect of each individual region. Memorial was the first hospital in the state of Georgia to be a member of the National Surgical Quality Improvement Program and now there are three, Emory is the second and there is one in Blueridge. They were also the first in the state to become a member of TQIP, which is the Trauma Quality Improvement Program. Dr. Ochsner stated that his institution believes in transparent patient quality care and includes former patients on their quality improvement committees. Memorial has a website that tells you when the last serious safety event took place and what the errors were. Anybody in his community can get on the webpage and find out what happened, and what they are doing about it.

Mr. Bill Moore asked Dr. Ochsner if he had a way to measure risk adjustment mortality for his region.

Dr. Ochsner replied no, it could be measured at their trauma center, but as everybody knows they do not get every trauma patient. There are multiple reasons why people come to a trauma center or do not, insurance status, time and distance. That is why having an inclusive meeting with all the hospitals and opening up the dialog so that every hospital can participate is so important. Finding out if they want to be a trauma center or not and getting their patient data will help.

Mr. Ben Hinson stated we have to figure out which patients went to which hospital, when they got there and where they could of gone. Even if we do not get scientific data we need to get raw numbers so we can get a better handle on how we can move those patients around. It is encouraging to know that as we move down the road we are all staying right in line with our goals.

Dr. Ashley asked Dr. Ochsner what he thought were some of the most important data points the Commission should focus on and whether it would be discharge data. He asked what kind of data could be obtained from other hospitals that would help to guide the Commission in decisions they make.

Dr. Ochsner stated that it would be hard to get an accurate ISS score from the hospital discharge data particularly from hospitals that are not doing them. Now that the state has identified what defines a trauma patient, if every hospital whether it is a trauma center or not met that definition and collected data on it and got involved to some degree with a registry, then we would have a way to access that data and look at those points, which would be from time of injury to time of definitive care and how many steps that it took. Everybody has to put data into the factor and then we can get a better opportunity to analysis it.

Dr. Ashley stated that as a region, or as a state, the one thing that we should strive for is to decrease the time from injury to definitive care for those severely injured patients. It sounds simple but there are more variables involved when you talk about Patient Care Reports, EMS, trauma centers, non-trauma centers, and transport from the scene to a hospital then to a trauma center. That number is not the easiest number to get and the number one key is to get that data.

Dr. Ochsner stated that it could be totally different issues for each region concerning timely transport to a hospital. For instance traffic in Atlanta from 2 pm-4 pm could factor in how fast the patient arrives at definitive care. Although there are not a lot of trauma patients, 75% of trauma patient's deaths occur out of the rural hospitals, because those patients do not get the care they need in a timely fashion. Rapid transport to appropriate care is of utmost importance. As soon as a diagnosis is made if that rural hospital does not have the staff to treat that patient they should not waste time scanning them. They need to transport that patient to the appropriate hospital so they can get the care they need as soon as possible. This whole time issue is correlated with bad outcomes in trauma deaths.

MOTION GTCNC 2012-03-01:
I move that the Commission approve the plan to go forward for RTAC in Region IX.

MOTION BY: **Ms. Elaine Frantz**
SECOND BY: **Mr. Bill Moore**

DISCUSSION: None

ACTION: Approved The motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org)*

RTAC V

Ms. Debra Kitchens stated that one of the areas that they are focusing on with their hospital subcommittee and the RTAC is to try and get facilities that transfer patients to call the TCC and that is something of a learning curve as they are used to calling the transfers in directly and not going through the TCC. Ms. Kitchens goes over a handout that breaks down the total Trauma Registry entries (Consults and Codes) and the Trauma Communications Center (TCC) calls by location. *(Handout attached to the meeting minutes February 2012 Pilot information).* Ms. Kitchens stated that with the handout is a summary or information fact sheet about what Region V is doing as far as their RTAC Pilot and where they are now. *(Handout attached to the meeting minutes Region 5 EMS Trauma Regionalization Pilot Update).* Ms. Kitchens stated that they have updated all of their participating EMS providers and facilities with training materials that include the latest guidelines for field triage of indications.

Dr. Ashley stated that each region needs a very disciplined approach to participation in taking care of the patients in their region. A one-stamp template for the entire state will not work, because what works in one region may not work in another. We need to empower the RTAC's in each region because they actually know what is going on. It is amazing to see how the RTAC's work and the great discussions that goes on at their meetings. The numbers coming from the TCC look small now, but its job is to tie this all together. The TCC is basically the hub to pull all the RTAC's together and houses a lot of data that can be very useful in a disaster or a trauma situation and allow us to know very quickly what our resources are. It is not perfect yet, but we are building information and need to stay focused and keep empowering the regions to come online to develop and show us what they

need. The Commission does not know what every region needs and that is why the RTAC's are so important. It is nice to have data that we can start to tweak, even though it is a very small amount of data, we are off to a good start.

Ms. Kitchens stated that Ms. Kristal Smith her RTAC Coordinator and she are working with Mr. John Cannady weekly to identify calls from EMS regions that are not coming through the TCC so that they can get with those people, educate them about the TCC, ask what they can do to help them, and find out the reasons why they may not be calling. Hopefully by March or April we will continue to see the number of calls steadily increase.

Dr. Cowles wants to know why 40% of all the calls made are from Houston County and whether they been better educated or are just more enthusiastic.

Ms. Kitchens stated that they do seem to be more enthusiastic. Their EMS director has really been pushing them to call the TCC. All of the same regions have received the same training.

Dr. Cowles stated unless they have substantially more trauma then other counties do, or they are calling for things that they do not really need to call for, then that simple call does not really add to the data.

Ms. Kitchens stated that calls have been received at the TCC that did not meet TSEC criteria and that is the data that is being looked at. We are encouraging EMS to call and want to do this as a positive thing right now, so whenever they call in the TCC is taking that call. We are collecting the data and then we will sit down with each individual director and go over their data and the calls that did not meet TSEC criteria. We are gathering the data now so we can sit down as a group and discuss what we need to tweak and who needs to be reeducated.

Mr. Hinson stated that EMS is going to have to be trained on how to use the TCC and it is always easier for them to overuse the TCC to start with and then pare it down. We do not need to look at the data that we are gathering quickly as a substantive thing, we need to look at it as part of the process of obtaining data that eventually we can use.

Dr. Cowles stated that he totally agrees that right now it is better to error on the side of the patient not being ok and then find out that they are.

Mr. Hinson stated that in the trauma world we really have to watch for false negatives, because that is where you can have a problem.

Dr. Cowles stated that he totally agrees he would want more people to call more times so that we can gather up data and then we can properly educate as long as we have the proper metrics that we can educate them with.

Ms. Linda Cole stated that it is her understanding that the TCC is gathering all data, even the data that does not necessarily meet TSEC criteria, so they can get a better understanding of the areas where more education is required.

Mr. Cannady stated that is correct. The data that we are gathering is very useful.

RTAC VI

Dr. Regina Medeiros stated that they had spent a great deal of time training EMS personnel and discussing their needs. Key elements of training included PAMCO reporting and how it is used. EMS personnel expressed understanding of PAMCO and the use of essential elements to trigger a trauma team response most appropriate to meet patient's needs. Dr. Medeiros stated that EMS personnel would call the TCC for all patients that they consider a trauma. The TCC will collect data on all calls in order to develop an injury profile of patients for the region. We desire to be inclusive within Region VI, which may or may not mean that hospitals choose to become designated: some may not, but might still want to participate. We want to match injuries to resources. RTAC IV'S Resource Workgroup is collecting hospital resource information as well as EMS location. They have created a map, which provides a visual depiction of resource availability. They are now collecting injury data and will

overlay that on the map in order to provide a snapshot of where injuries are occurring in the region in relation to resource availability. Once we collect a large number of patient injury data points we will be able to match patients that may be geographically closer to a participating hospital. A patient with an isolated orthopedic injury that now would come to a Level I trauma center might eventually go to another participating hospital that is closer who has the necessary resources and has made the commitment to provide that level of care. Another thing that they are doing differently is crossing the state borders. South Carolina is now participating and will be educated on the TCC and their requirements. We are just working out the details of who is going to report, and they will be coming on board as well.

Dr. Ashley stated that it is his understanding that when Region VI EMS picks up a Trauma patient they call the TCC and all that data is captured.

Dr. Medeiros stated that the EMS providers call the TCC and ask to be patched through to MCG and they have a three-way conversation. The TCC operator is collecting the data and MCG's ECC listens to the patient care report to determine the level of response. Instead of just TSEC patients they are collecting data on all patients.

Dr. Ashley stated that he thinks that is great and the data collected may be very valuable.

Dr. Medeiros stated that their Resource Subcommittee has access to Geo-mapping software and can overlay all the data. They have hospitals and EMS mapped up and then they have a map of the injuries over that so they can look at the area of concentration for injuries. We hope to use this information for injury prevention programs. This will hopefully identify certain concentrated areas for accidents and what would be the best definitive care for those patients injured in a certain area. We still cannot figure out how to capture the time of injury to definitive care, despite the fact that we have 911 involved.

Mr. Bill Moore asked Dr. Medeiros about the 911 involvements and whether they provide the time of the injury.

Dr. Medeiros stated that right now the TCC operators are calling 911 and getting the time of injury. A 911-operator dispatcher representative will be attending their next RTAC meeting. Dr. Medeiros stated that because of HIPAA all information collected in the TCC is de-identified. This poses a challenge at times to go back and figure out which patient ended where.

Mr. John Cannady stated that the closest they have come to an actual time of injury has been the time 911 was actually contacted. We get this time of injury by speaking with EMS after they have completed their run or by re-contacting their dispatch center.

Dr. Medeiros stated that we should call it time of injury as identified, to the time of definitive care, because it may not be the time the injury actually occurred. A patient that is injured and not found right away may affect the outcome.

RTAC I

Mr. Randy Pierson stated that they are not in the RTAC as of yet, but at the October meeting they voted to proceed with the RTAC formation. We formed a subcommittee to change the bylaws and make corrections that might be needed within the organization. At the January meeting the bylaws were presented for the first time, and they were approved in March. By April we hope to have those bylaws back from the Office of EMS/T, approved and be ready to move forward with the RTAC. We have some unique challenges as we have a Level 1 trauma center in Chattanooga TN, Two Level 2's inside Region 1 and one just outside, we border three states and three other EMS regions. We are looking forward to the challenge. We are identifying key players that will need to be involved.

Ms. Elaine Frantz asked which Level 2 Trauma Centers are in Mr. Pierson's region.

Mr. Pierson stated Floyd Medical Center in Rome, Hamilton Medical Center in Whitfield County, which is towards Chattanooga and Kennestone just outside Region 1 in Marietta.

RTAC III

Dr. John Harvey stated the he is Chair of Region 3 Council, a member of the Georgia Society of the American College of Surgeons and also The Medical Association of Georgia and serves on their boards, and they are very supportive in the effort to develop the trauma system in Georgia. His history goes back to the Georgia Trauma Advisory Committee, which he chaired in the mid 1980's. He continues to serve on EMSAC the Emergency Medical Services Advisory Council and the Emergency Medical Services Medical Directors Advisory Council both of which advise the State office on some of the background with the trauma system and with the principals of which they deal with.

Dr. Harvey stated that Region III had the first RTAC. Region III is one of the smallest as far as square miles and yet has the largest population density of any region. Over 50% of the 911 calls from the state come from Region III and the severity nature of those calls are at a higher level than any of the other regions. We have already dealt with many of the issues and challenges that the Georgia Trauma Commission is facing right now. Dr. Harvey thinks Region III has a wealth of background that could be integrated into this program. They have two Level 1 Trauma Centers, three Level 2 Trauma Centers, a Trauma Specialty Pediatrics Center and fourteen 911 services. They have integrated that into a system of hospitals where the trauma centers work together trying affect better patient outcomes. He has seen that develop over the years from a system that fought over geographic areas to be developed as zones where you could capture patients, to a more integrated approach of patient management of transferring the patient either from the site, to the initial hospital, and then to the most effective trauma treatment facility to manage their needs. That is a credit to EMS, the trauma hospitals, and the trauma program managers and their problem solving approach.

Dr. Harvey stated that RTAC III has recently been reassigned to Dr. Jeffrey Salomone who is the Chair of their RTAC and they had discussed looking at the principals of the medical trained system plan and integrating that into a formal format for accessing trauma principals within Region III. Dr. Harvey stated that he is sorry that Dr. Salomone could not be here today to present the plans. In Region III we are dealing with all emergencies and not just trauma. We are trying to put not only our RTAC plans in place, but also our emergency management plans in place to handle all emergencies that EMS and major hospitals have to deal with in this complex region. That has recently advanced to stroke management, and cardiac care study programs. We are integrating the systems that were well founded in trauma management, going back to Dr. Donald Trunkey when he showed the differences in getting the patient to affective care, definitive care at the right time would affect the outcome. We are building on what we have as trauma programs and trauma background and that has largely come from data. It comes from data that goes into the trauma registries. He realizes that there are problems even within his own region in that not all the hospitals feed into the registry data that we have to look at. From the state policy standpoint we have less than 50% of all the traumatic injuries entered into an affective trauma system where we can obtain registry data, which makes it hard to access full outcome of the problems. Our interest is to improve the capture of that data. Dr. Harvey thinks that the trauma registry has very affective management of a lot of the information. It has been his advocacy for a long time that this in a coordinated network will continue to prorogate the affective data that will drive funding for the program. The charge that Dr. Harvey has given to the Trauma Advisory Committee in Region III is how to more effectively integrate the patient into the system to achieve the desired outcomes.

Dr. Ashley stated that he was happy that Dr. Harvey attended the Commission meeting and started the dialog. He is excited about working together, realizes Region III's accomplishments and is ready to provide support anyway he can.

DRAFT STRATEGIC PLAN

Dr. Ashley confirmed that Ms. Carol Peirce is on the conference line and ready to present the Draft Strategic Plan *(Attached to the Administrative Report Draft Strategic Plan)*. Dr. Ashley stated that Ms. Pierce facilitated the Commission's Rome, Georgia Workshop meeting in January of this year where the Commission, the Office of EMS and Trauma, and the stakeholders did some hard core strategic planning Ms. Pierce stated that the report is currently a draft and is not finalized. She needs input and further dialog to make sure that it represents the best thinking in the room. In preparation for the Rome meeting they referred to the American College of Surgeons

report that gave an assessment of what some of the gaps were in the Georgia Trauma System. They got input from GTCE staff along with OEMS/T staff on what were some of the accomplishments to address some of those gaps and what were some of the remaining gaps. From the feedback that was received from staff it was narrowed down to ten of the most important priorities for the Georgia Trauma System to address in order to move forward. Through our discussion we added an eleventh one about coalition building. We then identified what the actions would be to address those remaining gaps.

Ms. Pierce stated that the document that everyone has in front of them summarizes the conversation and includes the actions that were identified. From the discussion Mr. Pettyjohn and she worked together and added objectives, time frames, and metrics.

Dr. Ashley stated that he thinks Ms. Pierce did a great job of summing up a robust discussion. It has been put into a form that can actually be followed, where there are assessments, goals, objectives, and timelines. The Commissions next challenge would be to get people involved and identify expertise to keep this plan moving forward. Over the next six months we will need to keep Ms. Pierce involved to keep a scorecard of where we are and how we are doing.

Mr. Pettyjohn asked Ms. Pierce what process she is suggesting in order to make this a final document that the Commission could approve in May.

Ms. Pierce stated that she would like everyone to take the time to look it over and send her an email with any questions. To make this plan living and breathing it has to feel doable and realistic. Ms. Pierce invites folks to push back if it does not look like the timeline is right.

Dr. Ashley asked if it would be reasonable between now and May for Ms. Peirce to contact Commission members, folks from OEMS/T and other stakeholders in order to identify areas of interest and expertise, and put peoples names to those areas.

Dr. Leon Haley stated that he agreed with Dr. Ashley, but he also thinks that it may require a separate call in May with the key stakeholders so they can really walk through the plan. He also suggests another call based on what resources are going to be needed to get those tasks done. Then come back to the Commission and be prepared to vote in May.

Mr. Pettyjohn asked if this would be a Commission meeting call.

Dr. Haley stated that it would be a call among the stakeholders because we have identified some other folks that are not part of the Commission and need to make sure they are included if we are going to attach an assignment to them.

Ms. Pierce stated that it sounds like a combination of a scheduled meetings in April with Commission members and key stakeholders as appropriate to move this forward. She would like to talk with the leadership of OEMS/T and their reaction to the plan and what they think is doable.

Dr. Ashley asked if anyone present today representing OEMS/T would like to make a comment as to whether they thought the Commission was going down the right path and providing a reasonable timeline to get people to discuss the plan and assign tasks.

Mr. Keith Wages stated that he would be glad to work within any timeframe that the Commission deems reasonable.

Mr. Pettyjohn stated that Ms. Pierce and he would work together and get the call schedules out.

Mr. Pettyjohn stated that the Strategic Plan has a budget impact column and wanted to know if there should be another column added that does not necessarily address dollars but maybe a project management idea of what needs to precede each activity and what that activity is associated with.

Dr. Haley stated that there are projects that are going to require some technology because we want lots of supportive data. We need to identify those needs, whether they are human needs for someone to manage the technology, or software for pulling in all the information. This involves more than just what the dollar amount will be for that, but how are we going to actually put it in a plan.

Mr. Pettyjohn suggests that Ms. Pierce go back and look at who the key players were in the discussion, identify specific resources that those key players could bring to future discussions, create a new column and put those resources there.

JANUARY WORKSHOP UPDATE AND MINUTES APPROVAL

The draft minutes of the 26 & 27 January meeting were distributed to the Commission prior to the meeting via electronic means and are also available to meeting attendees in printed form.

MOTION GTCNC 2012-03-02:
I move that the minutes of the 26 & 27 meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Dr. Dennis Ashley**
SECOND BY: **Ms. Linda Cole**

DISCUSSION: None

Motion has been copied below:

ACTION: Approved the motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org*)

GEORGIA COMMITTEE ON TRAUMA EXCELLENCE REPORT

Ms. Elaine Frantz stated that key leaders on this Subcommittee Dr. Regina Medeiros, Mr. Greg Pereira and herself met and looked at what was being accomplished, where they were, and where they needed to be. They decided they needed to align themselves more closely with the Trauma Commission's bylaws and outcomes, in terms of quality and injury prevention. They met and developed a plan and Mr. Greg Pereira who is the president of this Subcommittee is here to explain that plan to you.

Mr. Greg Pereira stated that GTCE has been in existence for 15-20 years and over that time as the environment of trauma care throughout the state of Georgia changed, GTCE has changed too. They have modified their bylaws and way of performing and his PowerPoint will go over some of those changes *(Attached to the meeting minutes GCTE PowerPoint)*. Mr. Pereira stated that it is still a work in progress and they already have a couple of modifications that they are going to make. When Mr. Pereira first started the Coordinator group eight years ago there were maybe 15 people that attended each meeting, but because of the expansion of trauma in Georgia, the additional trauma centers, and addition of stakeholders into the group, they now have approximately forty members that attend the meetings. They have outgrown having a group discussion type of environment and are going to formalize it more and form subcommittees.

Ms. Frantz stated that this committee as a subcommittee would report to the Commission. They will not make any decisions only recommendations to the Commission.

Dr. Ochsner stated that it is important to start talking about registry data and what is going to be collected, and the Medical Directors should be included in that conversation. He also thinks that the geriatric trauma patient should be added to the Specialty Care Subcommittee so they can be prepare in advance for a large amount of aging patients headed their way.

Dr. Medeiros stated that there would be lots of opportunities on various subcommittees where they will have to have physician representation, community stakeholder's representation, and include trauma patient's representation on special projects to be truly successful. They need to benchmark against each other collaboratively. At future COT meetings they plan on inviting identified centers to present their best practices, so that everyone in the state benefits from incorporating some of their concepts and ideas like we are doing with our RTAC's.

Mr. Pereira stated that it is not just enough to say where the individual data points came from; we need to define what the real options are. We have all added our own custom fields and custom data items into each drop down, which means we are not all using the same information and comparing that information like to like.

Ms. Renee Morgan stated that when the data sets were set up for the state the Trauma Coordinators were extremely involved. The data points were also reviewed by the trauma committee that we had at the time, which included Dr. Harvey, and Dr. Ashley. Ms. Morgan stated that she is totally in favor of revisiting data points, looking at where they are now and revising, especially now that they have an epidemiologist on board who strongly supports the need to clarify some of the entered points and make sure everybody is consistent.

Dr. Ashley stated that the Registry Subcommittee is so overarching that it should get impute from the Medical Director Subcommittee, the subcommittee here and the state office of OEMS/T and give a final recommendation to the Commission. Dr. Ashley wanted to know if Ms. Frantz thinks that is doable.

Ms. Frantz stated that she agrees and thinks it doable.

EMS SUBCOMMITTEE OF TRAUMA REPORT

Mr. Ben Hinson stated that their last meeting in Atlanta on February 7th was a great meeting with good conversation. They received an update from Mr. John Cannady on the Trauma Communications Center and also worked on the Uncompensated Care Program and set a flat rate of $400.00. Mr. Hinson stated that nobody gets paid that amount it is more of a relative value placeholder and will make the process easier to understand. Each service applying for the uncompensated care will have to have a point person so whenever there is an audit one person can come in from the service and answer all the questions. Mr. Hinson wants to know if these decisions need action from the Commission.

Mr. Pettyjohn stated that on day two of the January Workshop Mr. Hinson empowered the Subcommittee to make determination on how the FY 2012 EMS funds would be disbursed and he sees this as part of that. You incorporated each recommendation in the EMS Uncompensated Care Program of which you have already opened. It has been posted to the Internet, and folks are already making applications, so the Commission moves forward with it.

Mr. Hinson stated that the next motion regarded how the EMS wanted to spend some of the funds that had been allocated for training courses and never used because there were not enough applicants. They are going to be doing some support for an EMS Leadership Programs through Georgia Southern for rural EMS Directors. At one point it was suggested that every student attending the class would get a laptop computer to take the course and they would be able to keep it at the conclusion of the class. The reason for that was that a lot of the class coursework is done online and trying to incorporate a wide variety of computers and operating systems would be technically difficult. It was decided GAEMS will set perimeters on what people need to supply to take the course and then if someone can not make that happen from a technological standpoint they will be supplied with a computer for the duration of the course. At the end of the course those computers will be returned for other people to use for the next course.

FY 2012 EMS VEHICLE EQUIPMENT GRANTS

Mr. Pettyjohn stated that FY 2012 was the Vehicle Equipment Replacement Grants Awards forth year and was opened for applications November 18 2011 and closed December 31 2011. Our office received 53 applications, which were reviewed thoroughly by Ms. Lauren Noethen. She called individual applicants for any missing or inconsistent information. Mr. Pettyjohn and Ms. Noethen then met with Mr. Keith Wages of the Evaluation and Validation Committee and they went through the top 17 scoring applications. They all agreed the applications were scored appropriately and all the information was correct. *(Attached to the meeting minutes Top 17 Qualifying Applications by Score)*. In order to make sure everyone was comfortable with the process Mr. Pettyjohn had an email exchange with Mr. Bill Moore, Kurt Stuenkel and Dr. Leon Haley of the Trauma Center and Physician Funding Subcommittee to go over the application process, ask questions, and make recommendations. Mr. Pettyjohn stated that the Commission would need to approve the top 17 awards today. The notices of awards would be sent to them next week and the final excel spreadsheet that showed all 53 scores would be posted to the GTCNC website.

Mr. Bill Moore wanted to know the total amount of awards given out since the program was started, including the FY 2012 awards.

Mr. Pettyjohn stated that there had been 96 as of 2011 and 17 as of 2012.

Dr. Haley asked if we knew where we replaced the vehicles and if we had it mapped out.

Mr. Pettyjohn stated that he did not have that available today, but he can certainly make it available.

Dr. Haley stated that as we move forward and we think about our strategy and our impact he thinks that it is important which services in the state have made an impact with new vehicles and what does that translate into.

Mr. Pettyjohn stated that would be a very good report for our first report to the subcommittees.

MOTION GTCNC 2012-03-03
I make the motion that the FY 2012 EMS Vehicle Equipment Replacement Grant Awards top 17 qualifying applications be approved.

MOTION BY:	**Mr. Ben Hinson**
SECOND BY:	**Dr. Fred Mullins**

DISCUSSION: Dr. Ashley stated that he thinks Dr. Haley made a good point about looking at the EMS Vehicle Equipment Replacement Grant program and the impact that it has made.

Dr. Robert Cowles wants to know why we are supplying ambulances to counties when we pay local taxes that buy local ambulances. He wants to know why we should pay state taxes to buy ambulances to give back to the local people when they already have ambulances. Dr. Cowles stated that money is tight now and asked whether that money could be better spent elsewhere.

Mr. Ben Hinson stated that Dr. Cowles asked very valid question and the EMS Subcommittee has struggled with that question in the past. They certainly do not want to give money to a county to replace an ambulance and remove them from the responsibility of providing good ambulances, however the feeling of the EMS community and the EMS Subcommittee was that there are some places where ambulances are in bad condition and providing quality vehicles for them to use is something the Commission should do. Mr. Hinson stated that he is certainly open to a robust conversation as to whether they should continue the EMS Vehicle Equipment Replacement Grants Award Program.

Mr. Bill Moore asked Mr. Pettyjohn if the mileage on those vehicles that the Commission is replacing is still part of the criteria.

Mr. Pettyjohn stated that yes it still is.

Mr. Moore stated that it might be interesting to see if we are starting to replace ambulances that have less mileage then in the past.

Mr. Pettyjohn stated that he thinks that is a very good question and should be addressed.

ACTION: Approved

The motion ***PASSED*** by majority vote with one person Dr. Robert Cowles voting against, and no abstentions. *(Approved minutes will be posted to www.gtcnc.org*

Mr. Pettyjohn stated that he received a call and a letter about two weeks ago from the Brooks County manager. Brooks County is with an organization called Regional EMS, which provides their 911 services and was successful in year 2009 and 2010 in receiving a Vehicle from the program. One of the requirements to receive the vehicle was that they keep that vehicle in service, and insured for five years. The other requirement was that any disposition of the vehicle would have to be approved by the Commission and specifically any transfer of ownership to another 911 provider. There has been a request to transfer the title from Brooks DVA Regional EMS to Brooks County DVA South Georgia Ambulance. Upon receiving this letter Mr. Pettyjohn contacted Mr. Hinson and he suggested that the Commission consult with Mr. Alex Sponseller.

LAW REPORT

Mr. Sponseller stated that he talked to Mr. Pettyjohn about this issue and it does say in the original grant to the service that there is a possibility that the Commission would approve a transfer to another provider. This transfer could be a problem if this provider is involved with a bankruptcy he would not be able to transfer the vehicle. In bankruptcy you cannot just transfer assets around. He suggests the Commission authorize Mr. Pettyjohn to approve the transfer of this ambulance to another provider once he obtains all the details.

Mr. Pettyjohn stated this would allow him to make a decision before the May Commission meeting. He would keep Dr. Ashley informed as to what the issues are and if the Commission needed to vote on it he would wait and seek Mr. Sponsellers counsel again.

Mr. Sponseller stated that the Commission needed to know if the person involved filed for bankruptcy and if the new company that that is being proposed to transfer is owned by the same person who might be trying to move assets around.

Mr. Kurt Stuenkel thinks that it is very important to gather all the facts as Mr. Sponseller suggested, but he is concerned that someone might criticize Mr. Pettyjohn's decision.

Dr. Ashley stated that he would prefer Mr. Sponseller further research this issue and bring it back to the Commission in May.

TRAUMA COMMUNICATIONS CENTER UPDATE

Mr. John Cannady stated that his presentation would go over a Summary of the TCC's accomplishments and their plans for the future. The TCC was made available to take calls on January 01, 2012, but did not take the first call until January 21, due to some regional training and the way the training was rolled out to the EMS services. *(The Georgia Trauma Communications Center PowerPoint attached to the meeting minutes)*.

Ms. Linda Cole asked whether Paratus Software Systems are in all the trauma centers now.

Mr. Cannady stated that yes they are and that was the minimum requirement before they actually went online.

Ms. Linda Cole asked whether they are tracking the amount of time on diversion from those hospitals.

Mr. Cannady stated that that they have the ability to track resource availability statuses.

Ms. Cole stated that in looking at impact she thinks that diversion would be an important thing to track in order to evaluate if the TCC has decreased diversion hours through the support they are providing to physicians and hospitals.

Mr. Pettyjohn stated that the TCC would become more accurate on getting diversion data when all trauma centers at risk for receiving a call from the TCC become more current with the data they supply to the Resource Availability Display. The TCC is not reporting hospitals on diversion, but the hospitals ability to receive the trauma patients at any given time. Mr. Pettyjohn stated that the formation of a TCC Advisory Board would be very beneficial in bringing this all together so we can move forward.

Ms. Cole stated Ms. Kelli Vaughn had come up with a trauma definition of diversion through a project she had a couple of years ago.

Mr. Pettyjohn stated that they are using that definition, which is anything that prevents a hospital from receiving a trauma patient. We continue to receive that data in our office and we can use that data to provide a report.

Ms. Elaine Frantz stated that she would like to see some of the data that Mr. Cannady is collecting put on grafts. We could then look at the data in a year and see the improvements. This information would be something else that could be taken to the state in terms of pre-hospital outcomes.

Ms. Jo Roland stated that some hospitals facilities have already developed strategic relationships with other hospitals and regional referral centers. Ms. Roland wanted to know if they call us and we receive their patient how Mr. Cannady will address that situation and whether it will it be coming out as recommendations from the RTAC's in that region when there are multiple areas where a patient could go.

Mr. Cannady stated that those kinds of discussions would be well suited to be handled within the RTAC's as the internal protocols are discussed and could certainly be accommodated by the TCC once they have been set forth through the RTAC's.

Dr. Ashley stated that is why the RTAC are so important. The TCC is not to change your relationships or the flow of patients and make the trauma centers do something differently than they had done in the past. They are available to give you real-time data so that the you can make informed choices as to which hospital is better equipped at that particular time to receive that patient.

Dr. Harvey asked whether destination recommendations that the TCC had given so far altered the destination that was intended by the EMS crew at that time.

Mr. Cannady stated that in some cases it did, but he does not have the breakdown with him right now. He thinks of the 25 recommendations about half the medics ultimately made the discretion to go to a different location.

Dr. Harvey asked whether the TCC's is using the recent CDC trauma triage data.

Mr. Cannady stated that they updated internally with the CDC new guidelines.

Dr. Harvey asked whether the RTAC's could offer the CDC guidelines if they choose as to whether they would consider that in the destination recommendations.

Mr. Cannady stated that the RTAC's are the TCC's driving force and they have the ability to accommodate their transport destination guidelines.

Trauma Centers and Physicians Funding Subcommittee Report

Mr. Bishop stated that the funding for trauma centers and now the Doctors Burn Center is broken into Readiness and Uncompensated Care components. The Burn Center will not be eligible for Uncompensated Care until they are designated and until the survey process rotates around to survey the year the they were designated in. Doctors Burn Center was designated by the state in 2011. The next survey for the budget process will be 2010, so the next year would be the one that they would be included in and that would make them eligible for the next years funding as far as Uncompensated Care is concerned.

On the issue of Readiness we looked at the average Readiness cost for the states burn centers in comparison to Level 2 trauma centers as the closest model. The Readiness costs for burn centers equate to 81% of those of Level 2 trauma centers. In the budget payment formula Level 2's are pegged at 60% of Level 1's. That would put the burn centers at 50% to the Level 2's 60%. This is how the Doctors Burn Center is being incorporated into the Trauma Commission Trauma System. This analysis indicated that the trauma center funding levels are not consistent with actual costs (i.e., Level 2 trauma centers receive 60% of Level 1 readiness funds but only incur 31% of Level 1 readiness costs). This issue can be addressed subsequent to an updated survey of trauma and burn center readiness costs this year.

The recommendation was to conduct readiness cost analysis for trauma centers for CY 2010 and transition funding level over three years to reflect trauma and burn center investment in readiness.

Mr. Kurt Stuenkel stated that he recalls conversation previously where Mr. Bishops concluded that trauma centers show a loss on operations and burn centers show a profit. Mr. Stuenkel wanted to know why the Commission is moving towards funding a burn center. He thought that one of the reasons for our funding was to support money-losing operations in trauma centers.

Dr. Haley stated that it was decided that we would take away the probability component of one center verses another particularly when you start thinking about one standard level of compensation for Uncompensated Care for another. There are some exposures for the burn center as well as the trauma center around Readiness. In fact one of the proposals was to go to an all Readiness model and take away the Uncompensated Care piece completely from all the centers. We felt as a Subcommittee that we were not at that point yet, but we may evolve to that stage depending upon health reform and additional funding. So we decided to include the burn centers in the Readiness formula.

Dr. Ashley stated that since this is an update these are the kinds of issues and questions that need to filter back to Dr. Haley's Subcommittee. To finalize this the Subcommittee will bring back a recommendation in May to the Commission.

Mr. Bill Moore suggested that this issue be the first one on the May Commission meeting agenda to allow sufficient time.

Old business: None

New business

Ms. Cole stated that each topic should be assigned an allotted time, in order to address everything at the next Commission meeting

Dr. Cowles would like ample time for discussions and questions.

It was decided that the next meeting would start at 09:00 am and run until 02:00 pm with a break and a working lunch.

NEXT MEETING Friday 18 May 2012 in Savannah. Location to be announced.

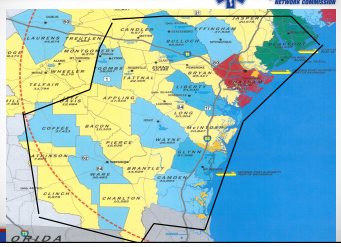
Adjourn: 1:24 pm

Minutes crafted by Lauren Noethen

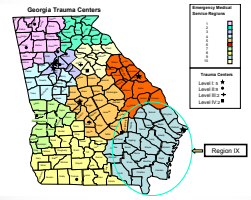
Georgia Trauma Care
NETWORK COMMISSION

Pilot Project
for Georgia Trauma System Regionalization
Region IX

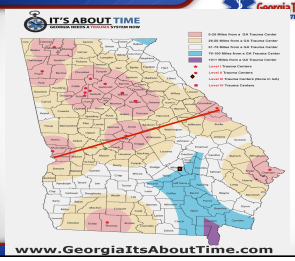
Georgia Region IX; SC counties



Georgia Trauma Centers



OUR REALITY



Trauma System Development

❑ **Georgia SB 60: Established GTCNC 2007**

- ➢ Administer and prioritize state funds to EMS and Trauma Centers
- ➢ Establish, maintain and administer a trauma center network
- ➢ Establish and administer education programs for the prevention of trauma
- ➢ Evaluation of data to improve delivery of trauma care services

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BREMSS

❑ **Birmingham Regional Emergency Medical Services System**

- •Voluntary system initiated in 1996
  - •From 1996-2005:
    - →Over 23,000 patients treated for major trauma
    - →12% decrease in the death rate from trauma
    - →Decrease average length of stay from 16 days to 9 days
    - →No change for the rest of the state

Regional Trauma System Planning

❑ GTCNC 2009: Framework for Regional Trauma System
- ❑ Components:

I. Pre-Hospital Component
   A. State OEMS&T Rules and Regulations
   B. EMS Regional Councils

II. Hospital Component
   A. Continuum of hospital participation

III. Communications Component
   A. Georgia Trauma Communications Center

Regional Trauma System Planning

❑ GTCNC 2009: Framework for Regional Trauma System
- ❑ Components:

IV. Data Driven Performance Improvement Component
   A. Standardized pre-hospital dataset (EMS run data)
   B. Trauma Registry minimum data set
   C. Trauma Communications Center Database

V. Regional Trauma Advisory Council

RTAC Region IX

➢ The Regional Trauma Advisory Council will:

A. Encourage multi-community participation in providing trauma care, ensuring the most efficient, consistent, and expeditious care for each individual who experiences an acute injury.
B. Enhance assessment, triage and communication between pre-hospital providers and hospitals to facilitate treatment and transportation of patients to the most appropriate trauma facility.
C. Attain funding resources for medical and public trauma education and awareness
D. Develop and maintain integrated quality processes in patient care, research, education and prevention

Regional Trauma System Planning: RTAC

➢ The Regional Trauma Advisory Council cont' d:

E. Assess current trauma care capacity and capabilities within Region

F. Be comprised of regional trauma system stakeholders

G. Develop and implement a Regional Trauma System Plan

H. Oversee continued function of Plan and conduct regional performance improvement

Regional Trauma System Planning: RTAC

A Regional Trauma System Plan developed using the Framework

- Provide a comprehensive regional trauma care system
  - Ensure care for patients from the moment of injury through rehabilitation
  - Utilize existing resources and work to fill any identified gaps
- Develop and implement a regional program for injury prevention

Region IX RTAC Planning

- **Hospital Assessments**

July 2010	Satilla Regional Hospital		
August 2010	Effingham County Hospital	Meadows Regional Hospital	E. Ga. Regional
September 2010	Coffee Regional Hospital	Coastal Carolina Medical Center	
October 2010	E. Ga. Regional	Wayne Memorial Hospital	Liberty Regional Medical Center
December 2010	Evans Memorial Hospital	Candler County Hospital	
January 2011	Appling Health Care Hospital	Winn Army Hospital	
June 2011	Jeff Davis County Hospital	Bacon County Health System	SE Ga. Regional Medical Center
August 2011	Lower Oconee Hospital		

Region IX RTAC Planning

Sample Hospital Meeting Agenda

Satilla Regional Medical Center
July 12, 2010
Discussion Points

Trauma Services: Georgia EMS Region IX

- **Overall Assessment of Memorial response**
  - **EMS: Ground vs Air**
  - **Dispatch to Memorial Trauma MD**
  - **Communication between ED nurses**
- **Services**
  - **Orthopedic Trauma Surgeons**
  - **Acute and Surgical Critical Care**
  - **Education: Grand Rounds; ATLS; RTTDC**
- **Georgia Trauma Care Network Commission (GTCNC)**
  - **Accomplishments**
  - **Georgia Trauma Network**
  - **State Legislation pending**
- **Regional Trauma Advisory Council (RTAC)**
- **Designation of Trauma Centers – Office of EMS and Trauma**
- **Trauma Communications Center**
  - **Expected date of implementation**

RTAC Region IX

- **MISSION STATEMENT**
  The primary mission of the Regional Trauma Advisory Council for Region IX is to address trauma system development, assist member organizations in attaining trauma designation or re-designation and provide oversight to ensure quality of care and patient safety.

- **VISION**
  We will be the model regional trauma, disaster and emergency healthcare system in the United States which will result in the lowest risk-adjusted mortality for emergency healthcare.

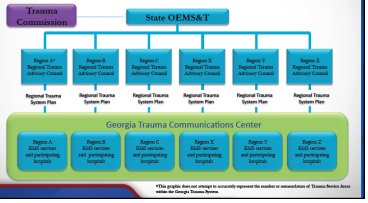
A Strong Regional Trauma Plan

◆ Essential Ingredients:

✓ Network of hospitals with the commitment and the resources to care for Trauma System patients
✓ Organized plan to route critical patients to the right hospital that is ready to care for them
✓ Constant monitoring of the system to correct problems, improve the system, and validate the quality of care provided

Trauma System Regionalization

Trauma system regionalization as a possible construct for Georgia Trauma System development



Region IX RTAC Planning

- **Timeline**
  - **March 2011 GTCNC Commission Meeting**
    - **Approved Region IX as RTAC Pilot**
  - **June and August 2011**
    - **Final visits to Region IX hospitals**
  - **October 28**
    - **First RTTDC**

Region IX RTAC

- **Implementation**
  - **Conducted 1st RTTDC: October 28, 2011**
    - **Meadows Regional Medical Center, Vidalia, GA**
    - **25 students: MDs, RNs, Paramedics**
    - **Excellent Feedback**
- **Regional EMS Council**
  - **Attended quarterly meetings, 2010 and 2011**
  - **Physician and trauma nurse involved**
  - **Dr. Ochsner: Medical Director Omniflight**
  - **Dr. Davis: Medical Director Southside EMS**

Region IX RTAC

❖**Initial RTAC Meeting November 3, 2011**

- **Memorial University Medical Center**
- **67 Attendees from Region IX**
- **Physicians, Nurses, EMS personnel, Administrators, Public Health Department staff, OEMST and GTCNC management**
- **Presentation included detailed review and analysis of HRSA document***

System Stakeholders

All stakeholders have a role to play in the regional trauma system, including

- Trauma Centers
- Non-designated participating hospitals
- EMS Providers
- Physicians
- Hospital Leadership
- Local Government
- Public Health
- Emergency Management

Trauma System Regionalization

U.S. Department of Health and Human Services

➢Model Trauma System Planning and Evaluation

➢Trauma System Self-Assessment Supplemental Tool

▪Benchmarks - Goals, Expectations, Outcomes

▪Indicators – Actions; Measurable components

▪Scoring – Current Status; Progress over time

▪Progress Scoring:

Not Known 0 → Full 5

Region IX RTAC

➢Trauma System Planning and Assessment

HRSA Document, Region IX Aggregate Results:

100. **Assessment:** **Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community**

Median Assessment Score = 2.0

200. **Policy Development:** **Promoting the use of scientific knowledge in decision making that includes building constituencies; identifying needs and setting priorities; legislative authority and funding to develop plans and policies to address needs; and ensuring the public's health and safety.**

Median Policy Development Score = 1.75

Region IX RTAC

➢Trauma System Planning and Assessment

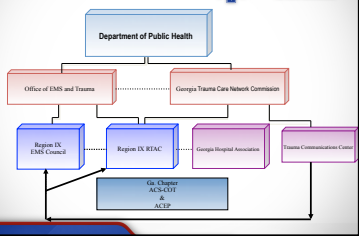
HRSA Document, Region IX Aggregate Results:

300. **Assurance:** **Assurance to constituents that services necessary to achieve agreed-on goals are provided encouraging actions of others (public or private) requiring action through regulation, or providing services directly.**

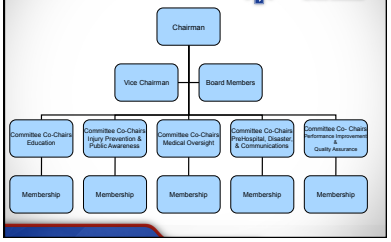
Median Assurance Score = 1.0

➢ **Overall Median HRSA Score = 1.75**

Georgia DPH: RTAC Region IX Relationship



Organizational Structure Region IX RTAC

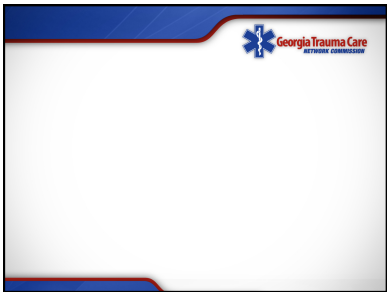


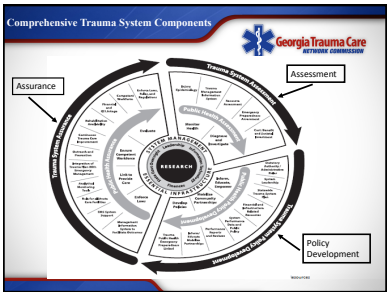
RTAC Sub-Committees

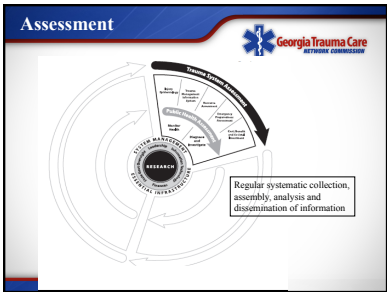
- **Education**
  - ❖ Mission: To facilitate and increase the number of trauma related education opportunities available in the RTAC Region IX area for healthcare providers related to the practice of trauma care
- **Injury Prevention and Public Awareness**
  - ❖ Mission: To reduce the incidences, severity and cost of intentional and/or unintentional injuries through the implementation of effective prevention strategies to include education, improved technology and public policy
- **Medical Oversight**
  - ❖ Mission: To develop a network of physicians who are committed to the improvement of trauma care in the regiona, addressing issue related to Pre-Hospital and Hospital trauma care

RTAC Sub-Committees

- **PreHospital, Disaster and Communications**
  - ❖ Mission: To assist in the development of the Regional Trauma Advisory Council plans concerning bypass, diversion and disaster preparedness in conjunction with the Medical Oversight Committee and the RTAC board members and to identify concerns in the current communication network.
- **Quality Assurance-Performance Improvement**
  - ❖ Mission: To monitor the performance of the regional trauma system as it relates to the quality of patient care through data analysis, and, to formulate plans to provide the citizens of Region IX with the highest quality trauma care possible.







Assessment

❑**Benchmark 101**

➢Thorough description of injury epidemiology in system jurisdiction using population-based and clinical data bases:

- Thorough description of epidemiology of injury mortality _____
- Description of injuries: distribution by geographic area _____
- Comparison of injury mortality with local , regional, statewide and national data _____
- Collaboration : EMS, public health, trauma system leaders to complete risk assessments _____
- Integration of injury into other public health risk assessments _____
- EMS, Public Health and Trauma systems complete regional study of injury determinants _____
- Identification of at-risk populations _____

Assessment

❑**Benchmark 102**

➢There is an established trauma MIS for ongoing injury surveillance and system performance assessment.

- Injury surveillance is coordinated within the region _____
- Trauma data are electronically *linked* from a variety of sources _____
- Processes exist to evaluate quality, timeliness, completeness and confidentiality of data _____
- An established method for collecting all trauma financial data from all health care facilities exists _____

Assessment

❑**Benchmark 103**

➢A resource assessment for the trauma system has been completed and is regularly updated.

- The trauma system has completed a comprehensive system status inventory: Identification of distribution and availability of current capabilities and resources _____
- Completion of gap analysis _____
- Initial assessment and periodic reassessments of overall system effectiveness in addition to an external independent analysis _____

Assessment

❑**Benchmark 104**

➢Assessment of the trauma system's emergency preparedness has been completed: Coordinated with the public health, EMS system and emergency management agency.

- Resource assessment of trauma system's capability to expand capacity: Responsiveness to mass casualty incidents (MCIs) _____
- Completion of gap analysis for trauma emergency preparedness, ability to respond to mass casualty incidents _____

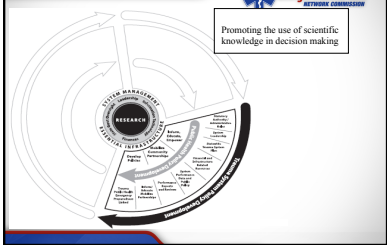
Assessment

❑**Benchmark 105**

➢Assessment and monitoring of the trauma system value to its constituents in terms of cost-benefit analysis and societal investment.

- Benefits of trauma system in terms of YPLL, quality-adjusted life years (QALY) and disability-adjusted life years (DALY) described _____
- Cases documenting the societal benefit are reported to community _____
- Needs of public officials and media concerning trauma system information conducted _____
- Needs of general public concerning trauma system information determined _____
- Assessment of needs of general medical community, i.e. physicians, nurses, prehospital providers and others has been completed _____

Policy Development



Policy Development

❑**Benchmark 201**

➢Comprehensive State statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight and future development.

- The legislative authority plans, develop, implements, manages, and evaluates the trauma system and component parts including identification of lead agency and trauma facility designation _____
- Legislative authority states: All trauma system components, EMS, injury control, incident management and planning documents collaborate _____
- Administrative rules/regulations direct development of operational policies and procedures _____
- Lead agency has adopted clearly defined trauma system stadards to include facility standards, triage and transfer guidelines, data collection: Ensures and enforces compliance_____

Policy Development

❑**Benchmark 202**

➢Trauma system leaders use a process to establish, maintain and constantly evaluate and improve a comprehensive trauma system in cooperation with medical, professional, governmental and citizen organizations.

- The lead agency promotes collaboration with all system components to implement and maintain a comprehensive trauma system _____
- Lead agency develops and implements trauma-specific multidisciplinary, multi-agency advisory committee to provide overall guidance to trauma system planning strategies _____
- Clearly defined structure in place for trauma system decision-making process _____
- Trauma system leaders adopt and use goals and time-specific, quantifiable and measurable objectives for trauma system _____

Policy Development

❑**Benchmark 203**

➢The written trauma system plan is developed in collaboration with community partners and stakeholders. The state lead agency plan, based on national guidelines integrates trauma system with EMS, public health, emergency preparedness and incident management.

- A trauma-specific multidisciplinary, multi-agency advisory committee has adopted a trauma system plan _____
- The trauma system plan exists and based on analysis of trauma demographics and resource assessments.
- The trauma system plan describes the system design – components necessary for integrated and inclusive trauma system
- Injury prevention and control plans developed and coordinated with other agencies: data driven with targeted programs with measurable objectives_____
- The system plan has established clearly defined methods of integrating with emergency preparedness plans _____
- Trauma system plan has clearly defined methods of integrating EMS, emergency and public health preparedness plans _____

Policy Development

❑**Benchmark 204**

➢Sufficient resources, including financial and infrastructure related, support system planning, implementation and maintenance.

- The trauma system plan clearly identifies the human resources and equipment necessary to develop, implement and manage all aspects of the trauma program _____
- Financial resources including designated funding exist to support the planning, implementation and continual management of the trauma system. Legislative appropriate funding exists _____
- Operational budgets of all trauma system components are aligned with the plan and priorities, ie infrastructure and communication system support _____

Policy Development

❑**Benchmark 205**

➢Collected data are used to evaluate system performance *and* to develop public policy.

- Collected data from various sources used to plan and review:
  - Strategic Plans
  - Budgets
  - Appropriateness of trauma system policies and procedures
- The trauma MIS (central repository) assesses:
  - System performance, compliance, allocation of resources, system needs
  - Intervention strategies for injury prevention programs
  - Education for trauma system participants

Policy Development

❑**Benchmark 206**

➢Trauma system leaders regularly review system performance reports.

- Trauma data reports generated at least annually, disseminated to trauma system leaders and stakeholders
  - Evaluate and improve system performance
  - Determine needs for system modifications

Policy Development

❑**Benchmark 207**

➢The lead agency ensures communications, collaboration and cooperation between State, regional and local systems

- Fosters collaboration for system enhancement and injury control_____
- Inform and educate constituencies and policy makers throughout region; collaborations aimed at injury prevention
- Mobilize community partners in identifying injury problems throughout region; build coalitions to design systems aimed at injury prevention _____
- Trauma system plan exists to provide public information: _____
  - Heighten awareness of trauma as disease
  - Need for trauma care system
  - Injury Prevention

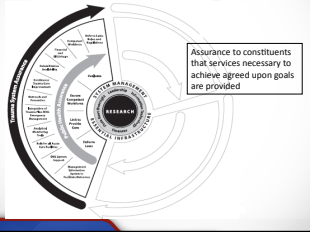
Policy Development

❑**Benchmark 208**

➢The trauma, public health and emergency preparedness systems are closely linked

- Established linkages and data sharing
  - Focused public health surveillance and evaluation for acute and chronic traumatic injury and injury prevention ____

Assurance



Assurance

❑**Benchmark 301**

➢ The trauma management information system, MIS, used to facilitate ongoing assessment and assurance of system performance and outcomes.

- Each component of trauma system: pre-hospital, trauma and non-trauma designated hospitals, and rehabilitation, collects, evaluates and disseminates data to assess system performance and quality improvement initiatives _____
- Prehospital care providers collect data, submit to hospitals and lead agencies and evaluate within own agency; monitor trends_____
- Linkages in place between trauma registry, Emergency Departments, prehospital providers, rehabilitation and other databases_____
- A trauma system registry exists _____

Assurance

❑ **Benchmark 302**

➢ The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage and transportation

➢ Strong integration of trauma system, EMS system and public health agency

- Defined trauma system medical oversight integrating the specialty needs of trauma system and EMS system _____
- Clearly defined, cooperative and ongoing relationship between trauma physician leaders and EMS system _____
- Legal authority clearly defined for EMS system medical director _____
- Trauma system Medical Director:
  - Active involvement with development, implementation and ongoing evaluation of EMS system dispatch protocols; congruency with trauma system_____
- Medical oversight of EMS system: trauma triage, communications, treatment and transport, coordinated with PI processes of trauma system
- Mandatory system-wide prehospital triage criteria exist to ensure:
  - Trauma patients' transported to appropriate facility _____
  - Criteria are regularly evaluated and updated ____

Assurance

❑**Benchmark 302 cont'd.**

- Universal access numbers for citizens to access EMS/trauma system and a central communication system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications _____
- Sufficient and well-coordinated transportation resources ensure EMS system maximize functioning for prompt and expeditious transport to the correct hospital by the correct transportation mode _____
- Procedures in place for interfacility communications; contingencies for radio or telephone system failures_____
- Established procedures for EMS and trauma system communications for all-hazards or major EMS incidents _____

Assurance

❑**Benchmark 302 cont'd.**

- Universal access numbers for citizens to access EMS/trauma system and a central communication system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications _____
- Sufficient and well-coordinated transportation resources ensure EMS system maximize functioning for prompt and expeditious transport to the correct hospital by the correct transportation mode _____
- Procedures in place for interfacility communications; contingencies for radio or telephone system failures_____
- Established procedures for EMS and trauma system communications for all-hazards or major EMS incidents _____

Assurance

❑**Benchmark 303**

➢ Acute care facilities are integrated into a resource-efficient inclusive network.

- Roles and responsibilities of all acute care facilities treating trauma patients are defined _____
- Ensure that the number, levels and distribution of trauma centers to meet system demand exist_____
- Trauma lead authority ensures that trauma facility patient outcomes and quality of care are monitored; deficiencies recognized; improvements implemented _____
- Appropriate level of definitive care paramount _____
  - Regular monitoring ensures that injured patients are expeditiously transferred to the appropriate, system-defined trauma facility_____
  - Needs of various cultures and respective needs are accommodated __

Assurance

❑**Benchmark 304**

➢ The state and lead trauma system agency use analytical tools to monitor system performance including prevention and services

- Annual reports of injury prevention and trauma care distributed ____
- Trauma system MIS database provides concurrent access ____

Assurance

❑**Benchmark 305**

➢ The state and lead trauma system agency ensure that the regional trauma system plan is integrated with the comprehensive mass casualty plan for natural and man-made incidents to include an all-hazards approach.

- Operational trauma, all-hazards and EMS response plans are established and provide for collaboration across each entity _____
- All-hazards events routinely tested for response capabilities and surge capacities_____
- Additional equipment from state available for large scale traumatic events _____

Assurance

❑**Benchmark 307**

➢ To maintain state, regional or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes.

- The trauma system regularly evaluates all licensed acute care facilities providing trauma care _____
- Trauma system implements and reviews standardized report of patient care outcomes benchmarked against national norms _____

Assurance

❑**Benchmark 308**

➢ Lead agency ensure adequate rehab facilities integrated into trauma system

- Trauma system plan included requirements for rehab services including interfacility transfers of trauma patients to rehab centers_____
- Rehab centers provide data on trauma patients to central trauma registry_____
- Rehab centers participate in PI processes _____

Assurance

❑**Benchmark 309**

➢ Financial aspects of the trauma system integrated into overall performance improvement system to ensure ongoing cost-effectiveness and "fine-tuning."

- Cost data collected and provided to trauma system registry for each major component of system _____
- Cost, charge, collections and reimbursement data submitted in the aggregate to include all system entities _____
- Financial data included and distributed in annual system report _____
- Analyses of financial data correlated with other data to produce applicable measures: YPLL, ICU LOS, QALY

Assurance

❑**Benchmark 310**

➢ Competent workforce is assured

- Guidelines for prehospital personnel for initial and ongoing trauma training readily available _____
- Prehospital personnel possess current trauma training certificates and other applicable certifications as required by licensure authority and performance improvement driven _____
- Established standards for trauma training for applicable nursing personnel in place, ensuring that training available _____
- Ensure that nursing personnel have current trauma training certificate(s) _____
- Appropriate levels of trauma training for physicians established ___
- Ensure that physicians providing trauma care to patients have current trauma training certificate(s) _____
- Conduct at least 1 mulitdisciplinary trauma conference annually, encouraging system and team approaches to trauma care _____

Assurance

❑**Benchmark 310, cont'd.**

➢ Competent workforce is assured

- Conduct at least 1 mulitdisciplinary trauma conference annually, encouraging system and team approaches to trauma care _____
- Structured mechanisms in place to disseminate new protocols and treatment approaches, thus informing all system personnel _____
- Mechanisms within the system performance improvement process identify and correct systemic personnel deficiencies _____
- Mechanisms exist within agency and institutional PI processes to identify and correct deficiencies of individual proactitioners within trauma system _____
- Authority for Trauma Medical Director with job description, requisite education, training and certification exists_____

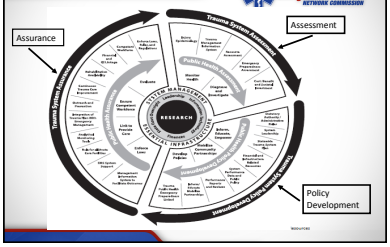
Assurance

❑**Benchmark 311**

➢ The lead agency/state acts to protect the public welfare: enforces laws, regulations, rules as related to the trauma system.

- Prehospital regulatory agency ensures prehospital care provided by licensed agencies and incompliance with protocols specific to prehospital trauma delivery _____
- State enforces laws, etc. concerning designation of trauma centers _____
- Laws, rules and regulations routinely reviewed and revised to strengthen and improve the trauma system _____
- Incentives provided to individual agencies and institutions to seek state or national accreditation, designation in areas that will contribute to overall improvement across the trauma system_____

Regional Trauma System



GTCNC

SB 60

- Passed in 2007
- Established a nine member, Georgia Trauma Care Network Commission (GTCNC)

Trauma System Regionalization

Trauma Communications Center

■ The Georgia Trauma Communications Center will:

- Coordinate the transport needs of EMS providers with the capacity of all Trauma Centers
- Assign a unique System I.D. to patients meeting Trauma System Entry Criteria
- Maintain Trauma Center Communications Database
- Recommend patient destination based upon Resource Availability Display (RAD) status and regional protocols
- EMS provider makes the final transport decision

February 2012 Pilot Information

Total Trauma Registry Entries (Consults and Codes): 121

Inter-facility Transfers

Trauma transfers from participating faclities:	31
Trauma Consults:	30
Trauma Codes:	1
Transfers likely meeting TSEC/CDC Criteria:	17
TCC Facilitated Transfers:	2

Prehospital Patients

Incoming patients from prehospital TCC callers:	39
Trauma Consults:	11
Trauma Codes:	12
Total Trauma Codes from Participating Counties:	22

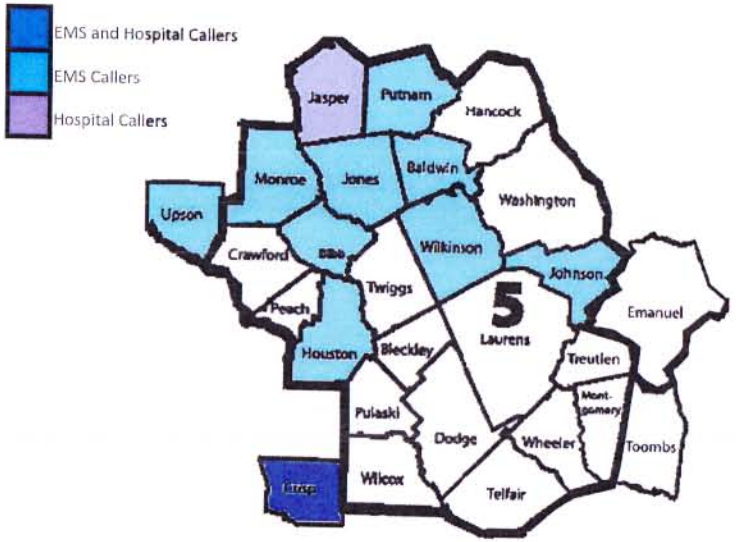
Trauma Centers

Medical Center of Central Georgia:	41
Grady:	1

Non-Designated Participating Facilities

Fairview Park Hospital:	3
Upson Regional Medical Center:	1

Trauma Communications Center (TCC) Calls by Location:



Mechanism of Injury for Pilot Entries (MCCG)

Top 4:	MVC	25
	Falls	7
	ATV	3
	Motocycle	3

Region 5 EMS Trauma Regionalization Pilot Update

Right Patient ◊ Right Place ◊ Right Time

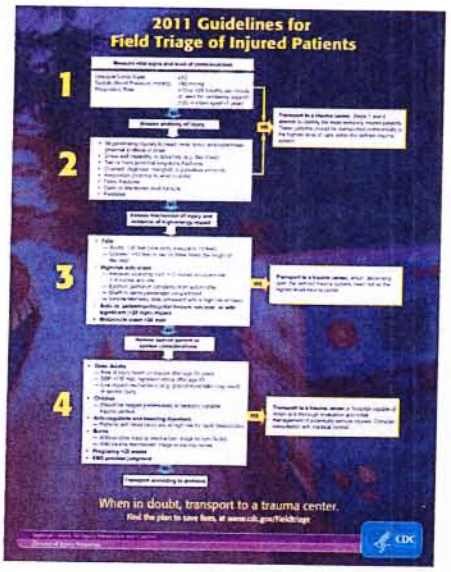
In January 2009, the Georgia Trauma Care Network Commission released "Our Emerging Vision – A New Public Service for Georgia" which identifies steps to move the Georgia Trauma System forward over a five year period. It was proposed that the Georgia Trauma system be comprised of integrated regional systems and plans with a centralized statewide Trauma Communications Center (TCC). Each region will represent a trauma service area which will accommodate patient catchment areas.

The Region 5 Trauma Plan

Composed by stakeholders that represent trauma center and non-trauma center hospitals, physicians, and EMS providers throughout Central Georgia, the Region 5 Trauma Plan organizes existing resources to provide a comprehensive trauma care system for patients from the moment of injury through rehabilitation.

Region 5 Pilot Participants

Central Georgia's Region 5 is comprised of 23 counties and spans 8257 square miles. There are 16 acute care hospitals and 20 EMS agencies (911 Providers) which serve the 685,372 residents in Region 5. Every hospital and 911 EMS provider in Region 5 has agreed to participate. Additionally, the Region 5 Trauma Plan included hospitals and EMS providers located in Crisp, Emanuel, Toombs, and Upson counties were also included in Regional Trauma Planning. While Meadows Regional Medical Center and Emanuel Medical Center are participants in sister RTACS, Crisp Regional and Upson Regional Medical Centers are active participants in the Region 5 RTAC.



Trauma Plan Implementation

Once the Region 5 Trauma Plan was approved by the Regional EMS advisory Council and the Georgia Trauma Network Commission, the 29 member Regional Trauma Advisory Committee (RTAC) immediately directed its efforts toward Trauma Plan Implementation. Utilizing a common set of Trauma Regionalization Training Resources and four strategically located Train-the-trainer sessions, EMS and hospital providers participating in the pilot were educated on the importance of accurate trauma patient triage and the CDC Field Triage Decision Scheme. Additionally, providers were trained to operationalize the Regional Prehospital Destination Guidelines, the Inter-facility Transfer Guidelines, and use of the TCC. By mid-January 46 individuals representing 17 counties had participated in Train-the-Trainer sessions and 12 Region participating hospitals were actively communicating with the TCC and updating their Resource Availability Display (RAD). At present, trauma regionalization training for EMS providers has been completed in all but four counties and only one Region 5 non-designated participating facility needs to undergo Paratus training.

The Georgia Trauma Communications Center

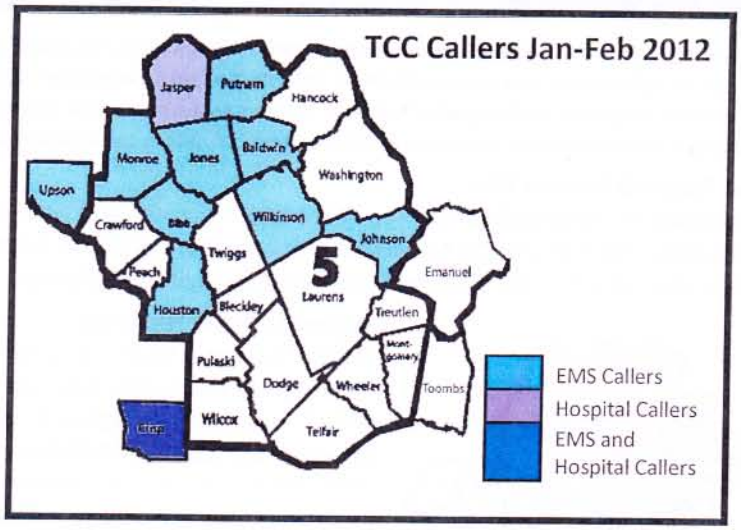
The TCC is a centralized communications center located on the campus of GPSTC in Forsyth, GA. It is a resource for EMS personnel in the field to assist with transport recommendations for the most seriously injured trauma patients. The TCC maintains up to the minute trauma center status and service line information, utilizes AVLS (Automatic Vehicle Location System) information to determine distance in road miles to designated trauma centers, provides a direct connection between EMS units in the field and receiving hospitals, and electronically forwards patient information received from EMS units in the field directly to the receiving hospital. The TCC is also a resource for hospitals needing to transfer trauma patients requiring care at a designated trauma center. With training ongoing within the region, a "phased-in" approach for utilization of the TCC was implemented. Once trained, participating facilities having patient's meeting Trauma System Entry Criteria, were encouraged to begin calling the TCC for assistance with transferring patients to the most appropriate level Trauma Center on January 1st. EMS agencies, upon completing their training, began utilizing the TCC for assistance with transporting patients meeting CDC/TSEC criteria on January 15th.

Region 5 EMS Trauma Regionalization Pilot Update

Right Patient ◊ Right Place ◊ Right Time

Looking Forward

Multidisciplinary RTAC subcommittees were created to assist the RTAC in assuring continued function of the various Plan components. These subcommittees are chaired by members of the RTAC however subcommittee membership was open to any trauma stakeholder interested in participating.



Hospital Subcommittee

One of the initial tasks of the Hospital Subcommittee is to incorporate communication with the TCC in the emergency planning for participating hospitals. In regards to inter-facility transfers, this committee is working to incorporate the usage of the TCC for trauma patient transfers and to improve the procedural components of that process.

Prehospital Subcommittee

In order to improve the speed and accuracy of prehospital triage and communication with the TCC, one of the goals of the prehospital subcommittee is to develop and distribute laminated posters to the EMS providers which include the CDC triage criteria, the TCC contact information, and a scripted TCC patient report format. They also plan to promote EMS provider usage of the TCC by increasing the rigor and frequency of their training efforts in regards to TCC usage. Finally, in conjunction with the PI committee, they are considering suggestions for the implementation of an incentive program to encourage medics to leave PCRs so that their data might be included in the trauma registry.

Performance Improvement (PI)

The PI subcommittee is tasked with the development of a matrix for evaluating the success of the pilot. They will utilize TCC, Trauma Registry and PCR Data to determine the efficacy of the plan implementation and TCC utilization practices. Additionally, the PI subcommittee is working with the Prehospital subcommittee to develop strategies for improving the rate and timeliness of PCR data acquisition.

TCC Calls by Location – January & February 2012

County	Participant	# Calls*
Baldwin	MCCG EMS	1
Bibb	MCCG EMS	9
	Mid Georgia Ambulance	5
Crisp	Crisp Regional EMS	1
	Crisp Regional Hospital	2
Houston	Houston Healthcare EMS	19
Jasper	Jasper Memorial Hospital	1
Johnson	Johnson County EMS	3
Jones	MCCG EMS	1
Monroe	Monroe County EMS	7
Putnam	Putnam EMS	2
Upson	Upson Regional EMS	2
Wilkinson	Heartland/Wilkinson Co. EMS	3
	Total Calls	56

Injury Prevention

The injury prevention subcommittee is responsible for evaluating existing injury prevention resources and utilizing injury data derived from the TCC, Trauma Registry, EMS PCR's and other sources to identify and address areas of the greatest need. Committee members have identified the types of injuries most prevalent in the region for various age groups. Also, they intend to utilize resource information collected to develop a directory of injury prevention organizations and initiatives within the region for distribution to the RTAC and area emergency departments, EMS agencies and other interested parties.

Learn more about the Trauma Regionalization Pilot and the TCC?

More information about the Trauma Regionalization Pilot and the TCC can be found on the Georgia Trauma Care Network Commission's website at www.georgiatraumacommission.org. Also, if you need any additional information or have concerns, please contact Kristal Smith, RTAC Coordinator, at Smith.Kristal@mccg.org.

Georgia Committee for Trauma Excellence

Registry Sub-committee

Member	Facility
Jo Roland- chair	Archbold
Rochella Mood	Atlanta Medical Center
Karen Johnson	CHOA
Colleen Horne	Gwinnett
Jo Roland	Archbold
Gretchen Goodman	Memorial
Carlisa Payne	Taylor Regional
Melissa Brown	GHSU
Marsha Baker	Memorial
Marie Probst, ad hoc consultant	State registrar

- Standardize registry data to comply with TQIP, state and NTBD requirements

Performance Improvement

Member	Facility
Liz Atkins- chair	Egleston
Fran Lewis	Grady
Kim Brown	Hamilton
Mary Lou Dennis	Northeast Georgia
Lynn Grant	Taylor Regional

- Develop performance improvement initiatives based on information obtained from registry data
- Benchmark best PI practice throughout the state to enhance trauma centers

Injury Prevention

Member	Facility
Emily Wright- chair	Grady
Terri Miller	CHOA, Safe Kids
Kathy Sego	Athens Regional
Kathy Slonaker	Shepherd
Jim Sargent	North Fulton
Karen Lowther	Lower Oconee
Imogene Willis	The Medical Center, Columbus
Dr Rita Noonan	CDC

- Includes representatives from trauma centers, rehab center, Safe Kids GA., and CDC epidemiologist

Education

Member	Facility
Debra Kitchens, chair	MCCG
Brandi Holton	Phoebe Putney
Portia Godboldo	Wellstar-Kennestone
Deb Battle	Northeast Georgia
Gail Thornton	Emanual Medical Center
Inez Jordan	MCCG

- Secure funding from variety of sources to provide trauma related education throughout the state
- RTTDC, TNCC, ENPC

6/19/12

Specialty Care

Member	Facility
Tracie Walton	Scottish Rite
Tanya Simpson	Stills Burn Center
Kathy Slonaker	Shepherd
Rebecca Cogburn	MCCG

- Focus on specialty care (pediatrics, burns, rehab)
- Pediatric goal- partner with ENA to establish ENPC throughout the state, 3 offerings in 2013

6/19/12

Resource Development

Member	Facility
Lauren Kubik, chair	The Medical Center, Columbus
Bambi Bruce	Walton Regional
Pam Jones	Scottish Rite
Laura Garlow	Wellstar-Kennestone

- Standardize resources for on-boarding new trauma centers

6/19/12

Special Projects

Member	Facility
Gina Solomon	Gwinnett
Monique Boone	Egleston
Chad Taylor	Floyd
Kim Kotterman	Life Link
Kelly Nadeau, ad hoc consultant	State Office of Emergency Preparedness

- Any special projects requested by commission
- Includes partnerships with Office of Preparedness, Life Link
- GCTE representative to attend EMAG

6/19/12

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Date: 15 March 2011

Re: FY 2012 EMS Vehicle Equipment Replacement Grant Awards
Top 17 Qualifying Applications by Score

1. Terrell County EMS (Region 8)
2. Wheeler County Ambulance Service (Region 5)
3. Vitacare/Sumter County EMS (Region 8)
4. Screven County EMS (Region 6)
5. Wayne County Ambulance Service (Region 9)
6. Crisp County Board of Commissioners (Region 8)
7. Jenkins County EMS (Region 6)
8. Murray County EMS (Region 1)
9. White County EMS (Region 2)
10. Ambucare EMS/Haralson County (Region 1)
11. Pierce County EMS (Region 9)
12. Irwin County EMS (Region 8)
13. Marion County EMS (Region 7)
14. Dooly County EMS (Region 8)
15. Franklin County EMS (Region 2)
16. Hospital Authority of Washington County (Region 5)
17. Toombs County EMS d/b/a Toombs/Montgomery EMS (Region 9)

The list of scores for all applications will be posted to Commission's website by close of business Friday, 17 March 2012.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

- **Right PATIENT**
- **Right PLACE**
- **Right TIME**

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Status Update

- Began taking calls on Jan. 21, 2012.
- We have begun the process of data collection and analysis by sharing data and collaborating with trauma centers in Regions 5 and 6.
- Working to identify specific data points needed for system improvement with the goal of improving patient outcomes.
- QA and review of **all** calls into the TCC to identify internal strengths, weaknesses and areas for improvement.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Call Summary

- 106 Total Calls
- 101 Calls From EMS
- 5 Calls From Hospitals for Transfers
- 34 Calls From Scene
- 33 Calls En-route
- 39 Calls From Hospital.
- Gave Destination Recommendations for 24 Patients.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Call Summary

- Received our first call from Region 5 on January 21, 2012.
- We have received 96 total calls from Region 5 participants as of 3/13.
- We have received calls from 10 agencies participating in Region 5 as of 3/13.
- Received our first call from Region 6 on March 3, 2012.
- We have received 10 total calls from Region 6 as of 3/13.
- We have received calls from 4 agencies in Region 6 as of 3/13.

  *Region 6 TCC training has not yet been completed by all agencies within the region.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Data Collection

- In addition to all patient related information collected at the time of TCC access we are also collecting data from both EMS and Trauma Centers. This data includes: Incident Time (911 Access Time), Arrival at Hospital Time, EMS Agency Incident Number, EMS Agency PCR Number, Registry Number (when applicable).
- Data gathered is intended to help in the PI process and assist with the future matching of patient information between various databases such as Registry and State OEMS databases.
- **The goal of the TCC is to aid EMS and hospitals in improving trauma patient outcomes by assisting in decreasing the time from initial injury to arrival at definitive care**.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Regional Collaboration

- **Continuing to share and gather data with the participating RTACs.**
- Currently working with both RTACs 5 and 6 to identify strengths and weaknesses of the TCC and our processes.
- **Working to identify key data for PI processes within each Region.**
- Collaboration with RTACs 5 and 6 will be ongoing and assist in shaping the future of the TCC and Regional planning.
- TCC has worked with representatives from Region 9 in the shaping of the RTAC 9 Plan.
- TCC has worked with representatives from Region 1 as they move forward with planning and preparation for RTAC creation.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

On-Going Planning

- Adjusting Staffing levels to more adequately reflect current and future call volume.
- **Continued emphasis on data gathering and collaboration with participating RTACs with a goal toward positively impacting patient outcomes and reporting on Commission's performance measures.**
- In negotiations with SAAB to provide for continual uninterrupted operations of the TCC and our software.
- Anticipating increased call volumes as utilization of the TCC by RTACs 5 and 6 increases and other Regions begin participating.
- Developing a TCC Advisory Board consisting of representatives from participating RTACs representatives, the Trauma Commission and Staff.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

THE GEORGIA TRAUMA COMMUNICATIONS CENTER

Questions?