Minutes approved 25 January 2013

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 15 November 2012

Scheduled: 10:00 am until 2:00 pm
Joseph M. Still Burn Center
3675 J. Dewey Gray Circle
2nd floor Ed Law Conference Room
Augusta, Georgia 30909

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley	Kurt Stuenkel excused
Linda Cole, RN	Dr. Leon Haley excused
Dr. Robert Cowles	
Dr. Fred Mullins	
Elaine Frantz, RN	
Bill Moore	

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
Renee Morgan	OEMS/T
Karl Gorrell	Doctors Hospital Augusta
Heyward Wells	Doctors Hospital
Regina Medeiros	GHSU
David Bean	EMS Consulting
Julie Tanner	Doctors
Barbara Fiebiger	Doctors
Scott Maxwell	Doctors
Lawanna Mercer-Cobb	Region 6 EMS
Gina Solomon	Gwinnett Medical Center
Courtney Terwilliger	GAEMS
Chad Black	HCFS
Pat O'Neal	DPH
Keven Harralson	LifeLine EMS
Miller Birdsong	Doctors
Rhonda Poole	Doctors

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Josh Morgan	Baldwine FD
Kathy Sego	ARMC
Brandon Fletcher	SRMHS
Jason Troupe	SRMHS
Beverly Losman	Safe Kids Georgia
Megan Popielarczyk	Safe Kids Georgia
David Moore	Candler County EMS Services
Rena Hopkins	Safe Kids East Central
Doug Welch	HCA Health
Greg Pereira	CHOA
Temple Sellers	GHA
Mike Willingham	Region 1 OEMS
David Foster	Region 1 OEMS
Richard Douglass	Safe Kids Georgia
Kristen Sanderson	Safe Kids Georgia
Rachel Ferencik	GA Health Policy Center
Chris Soderquist	GA Health Policy Center
John Walraven	JMS

CALL TO ORDER AND QUORUM ESTABLISHED

Dr. Dennis Ashley, Chair, called the scheduled monthly meeting of the Georgia Trauma Care Network Commission to order at 10:08 a.m. and extended thanks to the Joseph M. Still Burn Center for allowing the Commission to hold the meeting at their facility.

WELCOME and INTRODUCTION

Mr. Doug Welch, CEO of Doctors Hospital of Augusta extended his welcome to everyone. Mr. Welch stated that the hospital opened in 1973, but in 1978 went through a change when Dr. Joe Still asked for one dedicated bed for a burn unit. That one bed grew over the years to 70 beds in 2010 and as of 2011 they have treated over 3000 inpatient burns and thousands of others as outpatient in the burn and wound clinic. The hospital also is in partnership with JMS Burn Research Foundation, which at any given time has between 8 and 12 research studies going on in and around the facility with physicians doing trials. Another huge part of their partnership is with the Southeastern Firefighters Burn Foundation which helps families in the healing process by offering lodging, transportation and a support system for the families that come to Augusta to spend with their loved ones.

CHAIRMAN'S REPORT

Dr. Ashley stated that the trauma medical directors have been meeting by phone every other month. At one of the meetings Dr. Gage Ochsner noticed that his registrars were collecting a lot of data points, some for the state, some for the national trauma data bank, and some for their own particular institution. He suggested taking a closer look at those data points to see if anything could be standardized. The coordinators got involved, made suggestions and worked with Dr. Ochsner put some data points back in *(Comparison of Georgia Trauma Data Element Requirements attached to the Admin. Report*). Recommendations were made and the coordinators and trauma medical directors requested that they be considered. Dr. Ashley is bringing this forward for a vote, but is fully aware that the Commission has no authority to change the State Registry. We are looking into this at the Subcommittees request. This vote has no further action other than it will be sent Dr. Pat O'Neal and the Office of EMS and Trauma where Ms. Renee Morgan will review it. Suggestions and recommendations will be brought back to the Commission for consideration.

Mr. Bill Moore asked if the Trauma Coordinators supported this action as well as the Directors.

Ms. Elaine Frantz stated that it had been reviewed and is supported.

MOTION GTCNC 2012-11- 01:
I make the motion that the Trauma Registry Data Set be moved forward for OEMS/T to consider.

MOTION BY: **Dr. Dennis Ashley**

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)*

Dr. Ashley clarified with Mr. Jim Pettyjohn that the Commission had quorum and that Mr. Alex Sponseller was present.

DATA SUBCOMITTEE: TRAUMA SYSTEM PERFORMANCE TOOL DISCUSSION

Dr. Ashley explained that the Trauma System Performance Tool looks at the GHA discharge database and ascertains where all the trauma patients are and how they are being treated, not just in the trauma registry, but also statewide. As a Commission we are trying to come up with metrics on how to develop a trauma system and knowing where those patients are, and their injury severity scores will help the Commission access how many trauma centers are needed and where. For the first time we really have a way to do that thanks to GHA who has been sharing their database with Mr. Greg Bishop. Mr. Bishop is working with Digital Enovation's who has the software to break down that database and put injury severity scores with it. He is going to talk about the methodology behind this.

Mr. Greg Bishop stated trauma systems are challenged nationally with obtaining information on non-trauma centers and what they are doing with respect to trauma patients. Trying to get all hospitals set up as level fours has been a part of the strategy to bring them into the trauma system. We now have an alternative for looking at data on the non-trauma centers in relation to the trauma patients they take care of and the key data necessary to determine what is going on with trauma patients in non-trauma centers *(GA Trauma System Performance Tool: Concept, Development and Development Georgia Trauma System Performance Tool attached to the Admin. Report page 18).*

The Georgia Hospital Association has been providing data to the trauma system since 2008. Our first project was when Georgia was with the Healthcare Georgia Association and it was at that point that we accessed the 2006 GA Hospital discharge date-set for all trauma patients in the state and were able to make a list of all those patients in terms of how many trauma patients they treated by ISS category, 0-8, 9-14, 16-24 and 25 and above. We have that data from 2006 that we did in 2008 and in that analysis 33% of patients with an injury severity score above 15 were treated in non-trauma centers and these were trauma center eligible patients. This was determined by their Ecodes (as it is called in the data-set), which relates to how they were injured, as well as diagnosis codes. At that point we were able to run the data through an algorithm to produce an injury severity score for each patient, which gave us a baseline for 2006. There was an issue concerning the tool we used for 2006 because it was based upon a previous ISS scoring methodology ISS from 1995. The scoring was changed in 2005 but the scoring tool we had was not. The trauma registry's have since updated their tools for determining ISS and in working with Digital Innovations we were able to apply that technology to the hospital discharge data-set and obtain a more accurate ISS on patients. We ran the 2011 data-set through the Algorithm and we have the ISS and are getting ready to identify the trauma patients in the data-set, which will enable us to produce an accurate run down of trauma patients in the state in terms of where they were treated by severity and what is the comparison of that 33% in terms of ISS over 15 being treated in trauma centers vs. non-trauma centers. There are two pieces to that, with number one being the ISS scoring technology that has been updated and the other is the approach to identify trauma patients in the state

data-set that actually meet trauma center triage criteria. We think at this point it would be a good idea to look at the 2006 data again in order to create a base line using the new technology and then compare the two which would give us an idea of how the trauma system is doing performance wide relating to access to trauma care for high severity patients.

Dr. Ashley stated that the office of OEMS/T is in charge of designating trauma centers. The Commission is in charge of funding those trauma centers. We both have to answer to the State legislators as to whether we are making an impact and how more trauma centers affect the system. This tool will allow us to measure that.

Mr. Bill Moore wanted to know if the 33% patients that went to non-trauma centers if they completed their treatment there and what percentage may have been transferred to a level of care, and secondly do we have outcomes data on the patients that went to non-trauma centers.

Mr. Bishop replied not at this point, but the possibility of answering those two questions is increasing because the hospital discharge data sets have now added outpatient data. The tools for looking at outcomes based upon diagnosis codes have improved also.

Dr. Ashley stated that a Data Committee had been formed and includes himself, Mr. Ben Hinson as Chair, Ms. Linda Cole, and Ms. Elaine Frantz.

Dr. Ashley asked Mr. Bishop what the timeline was on his data.

Mr. Bishop stated that they have the data and are analyzing and creating a new methodology. They have worked with Ms. Emily Denis and OEMS/T and discussed the process on identifying patients in the larger data set. As soon as the Data Subcommittee is ready to meet we have information we can provide to them. In 3 days they will have the initial analysis completed, but new ideas will come up with another look at different data factors, and we will work with OEMS/T and the Data Subcommittee on that.

Dr. Fred Mullins asked if the 33% of patients with an injury severity score above 15 treated in non-trauma centers occurred in a certain area of Georgia.

Mr. Bishop replied that in looking at 2008 data it was pretty obvious that South Georgia had a significantly higher access issue then North Georgia, but they did not break it down.

Dr. Ashley stated the data that we obtain from the Subcommittee we will give us ideas for future endeavors.

Ms. Elaine Frantz asked whether the logistics of extrapolating data from the GHA database and the software that Mr. Bishop developed had been beta tested.

Mr. Bishop stated that it had been tested, and as far as the logistics, GHA provides in a very HIPAA kosher manner the statewide data set to them and Mr. Bishop gives them parameters for the data that is needed. The basic parameters are a list of ICD-9 codes that indicate some potential for serious injury.

Ms. Elaine Frantz also recommended that someone from the GTCE be involved, because of their continual usage of this data.

Mr. Bishop stated that the more involved the better.

Ms. Frantz asked if Ms. Regina Medeiros who was present at the meeting would make that recommendation.

Mr. Jim Pettyjohn stated that he would work with Mr. Ben Hinson to set up a meeting possibly the first week of December and at that time Ms. Frantz and Dr. Regina Medeiros could inform them of that person's name.

Mr. Bishop went on to answer Ms. Frantz's question concerning beta testing stating that the data was part of the trauma center analysis process in Colorado and just recently in Florida, but the real test will be when they generate the data for Georgia and send it to several trauma centers to compare it with their own data to see how well the ISS scoring from the tool and the individual trauma center registries match.

Mr. Bishop stated that they are able to provide the whole data sets scored and ready to go to OEMS/T and can arrange for OEMS/T to get that information anytime they are ready.

Dr. Ashley reiterated how important the work is that Mr. Bishop is doing, by stating that GHA database does not have ISS scoring, but the trauma registries break it down by coding. There are five grades of a ruptured spleen ranging from non-life threatening to being torn in half. Assigning ISS scores into a database for the non- trauma centers will tell us what grade that ruptured spleen was so we will know whether or not that patient was a trauma patient.

DPH OEMST UPDATE

Dr. Pat O'Neal had made a recommendation at the last Commission meeting that a Trauma Advisory Subcommittee be formed. The purpose of this group would be: (1) responsibility for trauma system advocacy, (2) responsibility for leveraging the reach and work of the GTCNC at the community level as directed by the GTCNC.

Mr. Pettyjohn had relayed concerns to Dr. O'Neal that appointing a Committee could create competition that could potentially compromise the effectiveness of the RTAC's. Dr. O'Neal felt that Mr. Pettyjohn had a valid point and suggested that the Commission not move forward with an Advisory Subcommittee, but give the RTAC's time to reach some maturity so they can provide the Commission with that needed feedback. Dr. O'Neal went on to say that if the Commission was successful in the formation of a Trauma Foundation much of the advocacy that could of been achieved with an Advisory Subcommittee could be achieved through the foundation and suggested that the Commission revisit this conversation in a year.

Ms. Renee Morgan stated that she had no new trauma centers to report since the last Commission meeting.
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Dr. O'Neal stated that the American College of Surgeons is sponsoring four meetings across the country and one of them will be in Atlanta on December 12th from 11:00 -12:30 and held at the home office of the American Cancer Society on Williams Street. This meeting will explore how surgery can continue to be offered in an optimal fashion with all the constraints that the country is facing in terms of financial cutbacks and controls.

APPROVAL OF THE MINUTES OF THE 16 August 2012 MEETING

MOTION GTCNC 2012-11- 02:
I move that the minutes of the 16 August meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Ms. Elaine Frantz**

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*)

Mr. Pettyjohn went over the Department of Driver Services Super Speeder collections *(attached to the Admin. Report page 22 HB 160 Notice and Revenue Tracking)*. Mr. Pettyjohn received updated information yesterday from Ms. Michelle Jordan who is with the Department of Driver Services. The Super Speeder bills for October were $1,432,145. The FY2013 total is $5,791, 30.

FIRST QUARTER FY 2013 EXPENDITURE REPORT

Ms. Judy Geiger presented an overview of the budget *(attached to the Admin. Report Pages 25-30 GTC FY 2013 Budget)* and mentioned that at the January Workshop they would be realigning any possible savings in the budget that could be spent in other needed areas.

Ms. Elaine Frantz wanted to know why the TCC rent and utilities had to be paid at 91% in the first quarter.

Ms. Geiger stated that the lease is with Georgia Public Safety and it is written in the agreement.

Ms. Frantz referred to the Bishop and Associates Budget of $75,000 which stated a contract was executed in October and wanted to know what contract it was referring to, because at the August's GTC meeting their had been the discussion to hold off on any further spending until the subcommittee discussed it.

Mr. Pettyjohn stated that the description of that was in the original budget proposal that was approved by the Commission. Through discussions during meetings it was decided that we would not use Bishop & Associates for the Trauma Foundation work. The current contract with Mr. Bishop is for $38,000 for The Trauma System Performance Tool, and also for providing technical and budget support for the FY2014 GA Trauma Foundation Business Plan. The Readiness cost survey activities were funded in the FY2012 contract.

STIPEND CHANGES

Ms. Geiger went on to explain the changes in the Commission's per Diem process. Ms. Geiger investigated the Georgia Code statutes that pertained to this *(attached to the Admin. Report page 31 Commission Member Reimbursement According to the Georgia Code)*. To sum it up the Commission members should be reimbursed when on official business a daily expense allowance equal to what the general assembly receives, which is $75.00 a day plus round trip mile reimbursement at $.55 a mile. If you rent a vehicle you would be reimbursed for the rental.

Ms. Geiger stated that Ms. Lauren Noethen will be passing out the per diem paperwork for your signature today, and you will need to call or email her with your round trip mileage as well as your odometer readings so she can complete the form and send to her to process.

For all future GTC meetings Ms. Noethen will send you an email with the online form that you can complete for reimbursements and then email to Ms. Noethen for the Directors signature.

Ms. Frantz asked if you could opt out on the per diem.

Ms. Geiger stated that it is not mandatory, but if you want to be reimbursed it must be done according to Georgia Code.

BUDGET SUBCOMMITTEE DISCUSSION

Ms. Linda Cole suggested that a Budget Subcommittee be formed. This committee could review and give inpute on the current years budget and help with the rigor of putting together next years budget. They could work out a lot of the challenges and answer questions that arise before the whole Commission meets.

MOTION GTCNC 2012-11- 03:

I make the motion to form a Budget Subcommittee.

MOTION BY:	**Ms. Linda Cole**
SECOND BY:	**Mr. Ben Hinson**

DISCUSSION: Mr. Ben Hinson asked that Ms. Geiger's budget report be sent to the Budget Subcommittee before the Commission meetings.

Ms. Geiger stated that she would make sure that they received the report.

Motion has been copied below:

ACTION: Approved the motion ***PASSED*** with no objections, nor abstentions. *(Approved*

Ms. Cole proposed that Mr. Bill Moore and Ms. Elaine Frantz be on the Budget Subcommittee.

Dr. Ashley appointed Mr. Bill Moore and Ms. Elaine Frantz to the Budget Subcommittee.

Trauma Communications Center

Mr. John Cannady presented an overview of the current and future activities of the TCC *(PowerPoint TCC Update attached to the meeting minutes)*.

Mr. Cannady stated that the TCC's percentage of calls that meet TSEC criteria are increasing and he thinks that is due education and the information on the field criteria as to what actually meets TSEC criteria.

Ms. Frantz asked what period of time the 616 total calls took place.

Mr. Cannady answered from January 01, through October 31st of 2012.

Ms. Frantz wanted to know what Mr. Cannady's opinion on why Region 5 had 452 calls and Region 6 had only 72.

Mr. Cannady stated that Region 6 did not start at the same time as Region 5. There was about a 2-month delay before Region 6 started calling into the TCC, because they wanted to get their education process going throughout the EMS services first. There is also a large EMS service in Region 6 that is not participating in utilizing the TCC, due to some communications issues relating to the TCC's primary needs for communication. The TCC is currently exploring avenues to get that data from them and working out ways to overcome that communication challenge.

Dr. Regina Medeiros stated that Mr. Cannady's information was accurate. One of Region 6 largest 911-zone provider will not allow their medics to utilize cell phones on their trucks, nor will they provide them, therefore they do not have access to the TCC.

Dr. Mullins asked whether the 592 total patients ID's created via EMS had been broken out to show ground transport verses air transport.

Mr. Cannady stated that it had not; but that they have that ability and he would provide that information to him.

Mr. Pettyjohn asked Mr. Cannady where the Burn Center fit in on the slides that show the TCC Patients by Destination Hospital Designation Level.

Mr. Cannady replied that the Burn Center for those numbers would fit in as the non-designated.

Mr. Pettyjohn asked that Mr. Cannady break that out into something special.

Ms. Frantz wanted to know if the 80 patients that went to a non-designated facility did not meet TSEC criteria.

Mr. Cannady stated approximately 52 of those patients met some sort of TSEC criteria, but did not go to a designated trauma center, 46 of those patients the EMS provider called while on his way to a non-designated hospital or after they had already arrived at one and therefore did not ask for the TCC's recommendation on where to transport that patient. The TCC recommended that six of those patients be transported to a trauma center, but the medic made the decision to take five of those patients to the closest hospital for stabilization. The other one was an interfacility transfer and they ended up keeping that patient so we counted that as a non-designated destination also.

Mr. Pettyjohn confirmed with Mr. Cannady that of the patients that do meet TSEC criteria, but a decision is made for whatever reason to take them to a non-designated facility that the call agent follows-up and follows through with that receiving facility to see if they are going to accept the patient or need any further support.

Mr. Cannady stated that the TCC's internal policy in those cases is to make a phone call to that hospital every 30 minutes letting them know that they see that they received a trauma system patient and asking them if they can assist with a transfer to a designated trauma center. They keep following up in that manner until that hospital informs them that they are either going to keep that patient or accept help in a hospital transfer.

Dr. Robert Cowles asked who makes the decision to call or not to call?

Mr. Cannady replied the EMS provider the medic on the truck.

Dr. Cowles ascertained that through education these numbers could improve dramatically, and wanted to know if the patient could direct that the medic call the TCC.

Mr. Cannady replied that if the patient had that knowledge of the TCC they would have the right to request that.

Dr. Cowles stated that it would be a great thing if the Trauma Foundation could educate the public about the TCC.

Mr. Cannady went on to discuss the Sage Data Security testing. After a week of testing it was concluded that the Paratis software and the TCC's communications with the hospitals are safe systems. Sage is now conducting a very through review of the TCC's HIPAA policies. Mr. Cannady will be reporting to the TCC Subcommittee on the progress of that.

Mr. Cannady stated that there is a communication component that is part of the Garmin GPS device that works with the Inmotion Technologies system in the AVLS program. We are exploring ways that the TCC and the EMS providers in the field can make use of that communication component. We will be working with the TCC Subcommittee to report on any developments from that.

Ms. Cole stated that Dr. Ashley had asked her at the last GTC meeting to provide an analysis and recommendations on the TCC Subcommittee, so Mr. Cannady and she worked together to come up with those recommendations *(Attached to the Admin. Report page 35)*.

MOTION GTCNC 2012-11- 04:
I make the motion that the Commission start an official TCC Subcommittee.

MOTION BY:	**Ms. Linda Cole**
SECOND BY:	**Dr. Fred Mullins**

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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*)

The TCC Subcommittee members will be Dr. Ashley, Dr. Fred Mullins, Mr. Ben Hinson and Ms. Linda Cole as Chair. The meetings will be held on an as needed basis.

A SYSTEM DYNAMICS APPROACH TO ADDRESSING MOTOR VEHICLE INJURY PREVENTION IN GEORGIA

Ms. Rachel Ferencik is with Georgia State University and the Andrew Young School of Policy Studies the Georgia Health Policy Center. Ms. Rachel Ferencik stated that the first Model they created was on Childhood Obesity and they used that Model with the Georgia legislators as a part of an education program that they created. Their second Model was for the Department of Community Health on low birth weight. Their funder, The Robert W. Woodruff Foundation was pleased with the modeling they had done and was interested in the area of trauma. That is why she contacted Mr. Pettyjohn and the Commission about a collaborative systems model and bringing folks together who are interested in a certain system to discuss the boundaries of what they want to look at and develop a simple model that would bring about more rigorous discussions. They did not want to do that without the approval of the Commission. In March of 2011 they convened a group of people who were a part of that session discussion to familiarize them with the area of system thinking, learn more about the process, define problems and how they wanted to focus the model *(attached to the meeting minutes COLLABORATIVE SYSTEMS INQUIRY Modeling Team)*. It was at this point that the focus of the model changed from one that was specifically on the trauma system to a model that was more focused on the injury's that result from trauma. The change had to do with some political constraints as well as the groups desire to work more upstream. They felt while the trauma system is so important they thought it would be great to reduce the number of injury's in trauma that come into the system. This is how the focus shifted to Motor Vehicle injury. Ms. Ferencik introduced Mr. Chris Jones who is with the CDC and will speak about his involvement with the model and its benefits and Mr. Chris Soderquist who developed and facilitated the Model will demonstrate how it works.

Mr. Chris Jones is the team lead for the evaluation group of the National Center of Injury and Violence Prevention. His group works specifically with their grantees on using the best available science to make decisions about the strategies to implement in their communities and them how to go about evaluating those strategies. This work fit very will with the work that he does and he found it very interesting because the modeling technique uses the best available science to help make informative decisions, looks at the systems involved that need to be considered, where changes could be made, and also involves the community in the decision making process. Mr. Jones worked with the initial group of collaborators that Ms. Ferencik mentioned, and then with a smaller group of folks from several fields of expertise, and also Motor Vehicle Subject Experts to get impute on key components to include in the Model for the state of Georgia.

Mr. Chris Solderquist area of expertise is in systems analysis. He explained that a model allows us to get the best assumptions available at the time and put them together, rigorously test them, and decide if you agree with those assumptions. They have a Model now that is based upon the best assumptions of trauma prevention strategies from the people involved in the process and the experts they worked with. Mr. Solderquist demonstrated how the Model could be useful and the types of questions that it can answer, making clear that he was not giving any recommendations.

Mr. Hinson asked where Mr. Solderquist where he obtained data numbers for the Model.

Mr. Solderquist replied that they were numbers from 2008 and 2009 obtained from the CODES database (Crash Outcomes Data Evaluation) from the Office of Highway Safety and Injury Prevention and the latest information made available to them. The model addresses the question, "if you were to reduce the number of injuries that resulted from side impacts, people speeding, people of a certain age, or change the environment, how would that change the future? Based on assumptions the Model gives us different possible futures, but these are only assumptions, and not predictions.

Mr. Renee Morgan stated that the CODES database does not include the Trauma Registry at this time.

Dr. Ashley's understands that given the data on how many accidents happen at a certain speed and the resulting injuries, if you were to change that speed on the Model box, it would in turn change all the other boxes on the Model.

Mr. Solderquist stated yes that was correct, you run experiments on the Model by changing data and seeing what the impact of that change is.

Mr. Hinson wanted to know if the Commission could use a similar Model pertaining to the response time for EMS in determining from the time of accident to the time of definitive care and how that affects mortality, and morbidity.

Mr. Solderquist replied that the Model does have those capabilities based on statistics, assumptions, and different scenarios, but the Models could be given more detail as needed, and supplied with the data based on actual averages.

Dr. Ashley stated that the Model is a great tool and wanted to know how the Commission could make use of it.

Ms. Ferencik replied if the Commission is interested in using the Model she would need the Commissions help and guidance concerning where it could be used.

Ms. Cole asked Ms. Ferencik if there was a way that the RTAC could use it for a region.

Mr. Solderquist stated that the Model works better at a larger level in terms of data and usefulness, but conceptually it could be done.

Ms. Cole wanted to know if layering more years of data would help make it more meaningful.

Mr. Solderquist replied that it would.

Ms. Cole stated that she's sees the Model as being a useful tool to tell you where the focus should be to make the the most impact.

Ms. Frantz thinks that the Model could be used for data elements and then plug in some of the prevention models and the Commission could take it to the legislators.

Dr. Ashley asked Mr. Ben Hinson with the Data Subcommittee to work with Ms. Ferencik to come up with a plan to be able to use this Model and report back to the Commission at the January Workshop in Rome.

IMPROVING SAFE KIDS GEORGIA PROGRAM OUTCOMES A PERFORMANCE MANAGEMENT APPROACH

Ms. Linda Cole stated that she had the opportunity to work with Mr. Richard Douglass and the Safe Kids board of Georgia and they have been doing phenomenal work for years. Over the last three years they have taken their

work and put it into outcomes and metrics to demonstrate what they have accomplished and the results from that. Ms. Cole stated that this is a group that the Commission can work with to increase their reach at least for the kids in the state of Georgia. Mr. Richard Douglass who is head of the program subcommittee for the board of directors for Safe Kids of Georgia his here today to share with the Commission his results.

Mr. Douglass stated that they are looking at what programs of Safe Kids Georgia have a positive influence, the evidence that supports those programs and what improvements can be made to them *(attached to the meeting minutes PowerPoint Improving Safe Kids Georgia Program Outcomes: A Performance Management Approach)*.

Ms. Cole asked whether Mr. Douglass had any information to share concerning the results from things Safe Kids had done.

Mr. Douglass replied that he did not have those slides with him, but he would provide the Commission with that information at a later date.

Ms. Cole thinks those studies are very important, because what impressed her was the studies around poisoning and child safety seats to show the reduction in injuries that Safe Kids has seen compared to communities that do not have a coalition.

Mr. Douglass replied that he could see that better results are achieved in coalition counties, but they want to make sure it is because of the things that Safe Kids is doing as opposed to some other factors that are involved. We are heading down that path and he would be happy to share that data, but it will take some time to put in place. They do want to work with the Commission to share data.

Ms. Megan Pobielarezyk a fellow with Safe Kids Georgia stated that they were able to pull data from Oasis that is the state data system and show that the Safe Kids county coalitions have lower rates of motor vehicle fatalities and injuries then non-Safe Kids counties. That involved just looking at the data without doing any analysis on it, so they cannot say whether the Safe Kids program caused those reductions. They hope to be able to say that more definitively. They are involved at the state level with many different organizations and sit on the committee for CODES data and provide inpute. The Safe Kids coalitions are looking at the data, and interpreting the data. They are doing that with the EMS, the trauma or medical systems, and with the fire departments in their counties and see it as one of the ways they could help the Commission.

Dr. Ashley can see the connection between what Safe Kids is doing and the RTAC's that are forming with their work in prevention, and thinks they should be a part of every RTAC.

GEORGIA TRAUMA FOUNDATION UPDATE

Dr. Fred Mullins subcommittee gave a report on the progress of evaluating the proposal made at the last Commission meeting to form a Trauma Foundation. Dr. Mullins thanked Ms. Elaine Frantz, Dr. Robert Cowles, Mr. Pettyjohn, Dr. Gary Nelson who is with the Healthcare Georgia Foundation and Mr. John Cannady for participating in their conference calls. They had three calls and the first call revolved around the charge from the state by Senate Bill 60 to create, oversee, and maintain a foundation to raise funds specifically for investment in the system in overall trauma funding. We discussed who would be the board members, the Missions statement. It was concluded that they have to get started because it is going to take about nine months for them to get the 501 C3. After consulting with Mr. Alex Sponseller, a decision was made for a motion to request the appointment of a special assistant attorney general to assist in the formation of a non-profit foundation and reistering the foundation with the IRS. The Commission will start working on that as well as looking for a potential executive director of the foundation to get the groundwork laid, and identify a host of potential partners such as hospitals, corporations, etc. He stated that it is a tough economic year, but they need to get started on the funding and the general outline of the board of directors, how it will be governed and ran, and pinpoint what exactly their mission statement will be.

MOTION GTCNC 2012-11- 05:
I make the motion to the Special Assistant attorney a general engagement letter for the non-profit incorporation work.

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

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)*

Dr. Mullins went on to say that Mr. Nelson told him that they could also apply for a grant to fund The Special Assistant Attorney General to help get the foundation started and get a reduced rate. It usually cost about $10,000 to $15,000 dollars, but with a reduced rate we could probably get it done for about $5,000 to $6,000. We would like to apply for a grant from Healthcare Georgia Foundation.

MOTION GTCNC 2012-11- 06:
I make the motion to apply for a grant from the Healthcare Georgia Foundation to help get the Commission's foundation started.

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

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)*

Mr. Pettyjohn stated that the Special Assistant Attorney General request form has been signed, and submitted to the Attorney Generals office and because he was anticipating a favorable response from the Commission he has already gone online and made a proposal to the Healthcare Georgia Foundation for $15,000 and has graduated that out to $10,000 for legal services, and $5,000 for administrative support. Ms. Geiger will send that out tomorrow and we anticipate the turn around time for that grant to be sometime in February.

Dr. Ashley stated that he appreciated the support of Mr. Gary Nelson and the Healthcare Georgia Foundation.

Dr. Mullins stated that by next week they should have an outline of the Board of Directors, but we have a few legal questions that need to be answered before we move forward.

EMS SUBCOMMITTEE ON TRAUMA UPDATE
Mr. Ben Hinson stated that the EMS Subcommittee met October 31, in Macon and at that meeting it was decided that the EMS Subcommittee would have bi-monthly meetings the first Thursday of every month that the Commission has a scheduled meeting.

Mr. Hinson stated a motion was made and passed to tie trauma grant funding to the Georgia EMS services strategic resource plan.

Ms. Cole wanted to know if the GAPS report would be available at the Commission's January Workshop.

Mr. Courtney Terwilliger stated that Ms. Ann Carpenter who is the lead person at the Georgia Tech Research Institute could provide that information.

Mr. Pettyjohn will make the necessary contacts to get a full report to the Commission.

GTCE UPDATE

Ms. Elaine Frantz stated that the GTCE Subcommittee met in September and discussed the registry and their analysis of Version Five. The final results of that analysis were submitted to another subcommittee of the GTCE. Ms. Frantz spoke with Dr. Regina Medeiros and the majority of people support Version Five.

Ms. Frantz stated that the Readiness Cost Survey was also discussed and everyone is onboard with completing and submitting the survey on November 30th. Mr. Bishop with review and analyze that report and bring it back to the Commission.

Ms. Frantz stated that there has been a lot of support for requests for EMS Uncompensated Care throughout the state. They have received more requests this year then ever. It is very satisfying that the Commission is able to support the efforts of EMS and respond appropriately, and she thinks that asking various companies to submit their trip report has been helpful.

The last GTCE meeting of the year will be held in Madison, GA.

RTAC 9 UPDATE

Ms. Frantz stated that RTAC 9 started one year ago last week and reviewed how they started and where they are today (*Regional Trauma Advisory Council Region IX attached to the meeting minutes)*.

Dr. Ashley asked Ms. Frantz how they developed the Interfacility Transport Checklist.

Ms. Frantz stated that Dr. William Brombert and Dr. Gage Oschner worked together on the checklist, but she is not sure where it originated. RTAC 9 reviewed it and made changes that made it more relevant to their area.

Dr. Ashley asked whether that checklist was supplied to all the other hospitals in her region.

Ms. Frantz stated that it was rolled out the five main hospitals that they work with and as a pilot. If it works fine it will then be rolled out to everybody.

Dr. Ashley asked how they set up the Performance Improvement with the other Medical Directors.

Ms. Frantz stated that Dr. Ochsner and she pulled some charts, reviewed the records on a few particular cases, discussed them, and then she made the phone calls to the respective hospitals, and spoke with the physician's to set a date for Dr. Ochsner to have a face to face meeting to get those doctors input and review. That meeting included the physician, the CMO, ED physician, the CNO and the Clinical Director of the EED. It was a peer review meeting and that information is protected.

RTAC 1

Mr. David Foster the Region 1 EMS program director stated that the Region 1 RTAC has not been officially formed yet. On October 20th of last year Dr. Ashley, Mr. Pettyjohn and Mr. John Cannady came to Region 1 and made a

presentation to his council about the RTAC and the RTAC developments in Region 5 & 6 and what they had accomplished in developing their RTAC's.

January 2012: the council revised their bylaws to include the RTAC as a subcommittee of the council. The council decided to put together a steering committee made up of council members to look at what Region 5 & 6 did and make a recommendation on how to move forward. They identified a person within the region to be Chair of their RTAC and that person is Mr. Billy Hayes who is the CEO of Northside Cherokee Medical Center Cherokee County in Region 1.

March 2012: Mr. Randy Pierson, the Council Chair and himself approached Mr. Hays and he agreed to be Chair of the RTAC and a decision was made to have the steering committee review what Region 5 & 6 did and come back to the council with a recommendation of what their needs should be based on the HERSA BIS Assessment and how they should move forward with that. That group met several times from April through July.

July 2012: The steering committee met with them and it was decided that they should have an RTAC stakeholders meeting. Region 1 borders three states, and they have two counties that border two states, Dade County in the very northwest corner borders Hamilton County, Merrien County Tennessee and Jackson County Alabama. Fanning County in the Northeast side of Region 1 borders Murphy North Carolina that is in Cherokee County North Carolina and Polk County Tennessee. They do at lot of mutual aid across those lines. So it was decided that they needed representation not only from their bordering counties, but also from the border states. They reached out to their state partners and will have a representative from all three of those states as a voting members of their RTAC. The first stakeholder meeting was held and 103 attended that meeting.

October 2012: They held their second stakeholders meeting and 88 participated.

November 29, 2012: There final stakeholders meeting will be held on November 29th and they will name the voting members of their RTAC.

Mr. Pettyjohn stated that Mr. Foster would be presenting to the Commission at the January Workshop in Rome for approval of Region 1's plan.

Mr. Foster stated that Region 1's plan it will be sent to Mr. Pettyjohn and Dr. Ashley for review before it is presented at the Workshop.

RTAC 6

Dr. Regina Medeiros mentioned that RTAC 6 sent out an educational survey to all the hospitals and EMS providers to do a GAP analysis to see what courses they felt should be emphasized. The feedback was very low, but Region 9 gave consistent feedback from both EMS as well has referring hospitals pertaining to PI, and what they are doing well and not so well, so that when they are faced with the same situations again they can react differently and better. Ms. Medeiros thinks that the RTTDC courses have been instrumental in that feedback, not only in the education of rural hospitals, but in establishing relationships between the lead Level 1 trauma centers in the regions and the smaller hospitals. This brings Dr. Medeiros to the conclusion that the RTTD courses are very beneficial and need to be continued and expanded and she hopes that the Commission provides funding to assist with that. *(Region VI Trauma Advisory Committee update 2012 attached to the Admin. Report page 36).*

Dr. Medeiros would like the Commission to consider establishing a statewide Trauma Advisory Committee. This would help link the RTAC's together as they grow and enable statewide perspective.

Minutes approved 25 January 2013

Ms. Cole understands that Dr. Medeiros would like representatives from the RTAC's that are already formed to form an RTAC advisory group to share information.

Mr. David Foster thinks that is a great idea, because each of the different regions has different solutions or ideas and collaborating with each other would solve various issues.

Mr. Pettyjohn suggested holding the first meeting in Rome to coincide with the Annual Workshop.

Dr. Ashley asked whether this would be a subcommittee of the Commission.

Dr. Medeiros stated that as new RTAC's come on board their reporting at a Commission meetings could take up lots of time, so at some point in time the Commission might want to make it an official subcommittee.

Ms. Frantz suggested discussing what would work best at the GTCE meeting in December and bringing that recommendation back to the January Workshop.

Dr. Ashley agreed to that plan.

Region 5

Mr. John Cannady reported on Region 5 and stated that Ms. Debra Kitchens asked him to mention that Region 5 had also sent out a survey monkey for educational needs assessment. Mr. Canady does not have any information on the feedback received. (*Region V Pilot Participation Data Update attached to the Admin. Report)*.

GAEMS UPDATE

Mr. Courtney Terwilliger Chair explained what GAEMS and the EMS community is doing relating to the Leadership course that they just completed, also about vehicle grants, First Responder training, and the direction that they perceive EMS is taking and what they are trying to accomplish *(GAEMS PowerPoint attached to the meeting minutes).*

ADDITIONAL BUSINESS: None

NEXT MEETING Thursday & Friday 24 & 25 January in Rome

MEETING ADJOURNED: Dr. Ashley declared the meeting adjourned at 1:59 pm

Minutes crafted by Lauren Noethen

November 15, 2012

TCC Update

TCC Call Activity

Total calls taken	**616**

(The above number represents the total number of trauma patients as called in by either a hospital or EMS provider.)

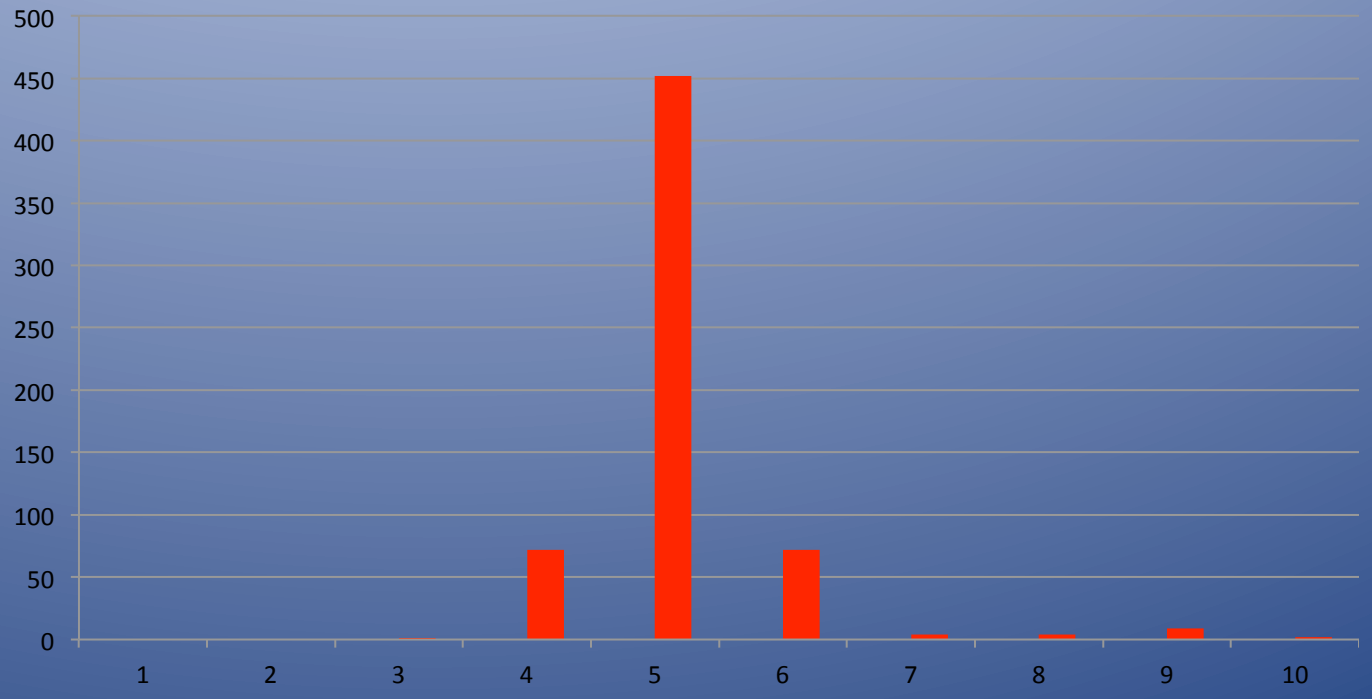
Total patients that came through the TCC that met TSEC Criteria	**568**

Call Origination

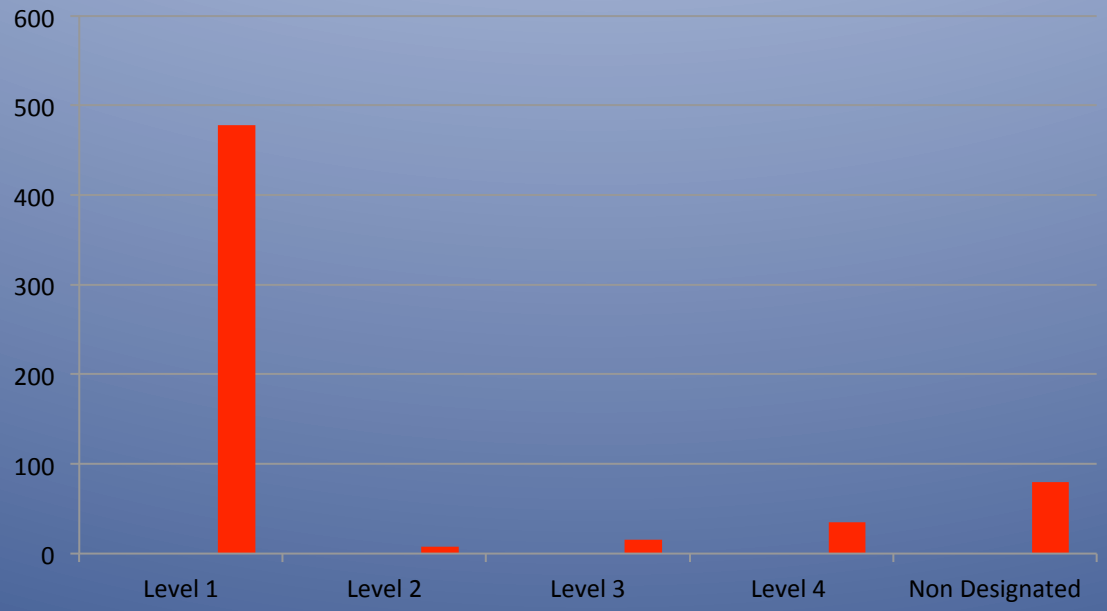
Total patient ID's created via EMS.	592
Total patient ID's created via inter-facility transfers.	24

TCC Calls by Region

Region of Patient Origin	
1	0
2	0
3	1
4	72
5	452
6	72
7	4
8	4
9	9
10	2



TCC Patients by Destination Hospital Designation Level



Level 1	478
Level 2	8
Level 3	15
Level 4	35
Non Designated	80

TCC Performance Indicator to be Reported to the Office of Planning and Budget as Part of the Governor's Strategic Plan

The percentage increase in the number of trauma system patients whose transport to a definitive care hospital was facilitated by the Georgia Trauma Communications Center .

Reported as:

- **Patients meeting TSEC criteria**
- **Recommendation to a Trauma Center given by TCC personnel**
- **Patient transported to the recommended Trauma Center**

Sage Data Security, Inc.

External Vulnerability Assessment and Penetration Test

Sage Data Security, Inc. conducted an approximate week-long external risk and vulnerability assessment on the Paratus software utilized at the TCC.

Result of the assessment revealed that at no time was any protected TCC data compromised or accessed. An action plan was created to address minor security related issues which did not result in unauthorized access. TCC staff work with Saab personnel to address these issues and report progress through the TCC Subcommittee.

HIPAA/HITECH Information Security Policy Assessment and Update

Sage is currently conducting a review of all TCC HIPAA and Information Security Policies to assist in ensuring compliance with all regulations and to identify any needed updates to current TCC policies.

TCC staff will work with Sage during this process and report progress to the TCC Subcommittee.

On the Horizon

Working with the AVLS Working Group, staff have identified a potential opportunity to increase communication options with the TCC and as a result, increase the ability of the TCC to serve as a resource for EMS providers.

The Garmin GPS devices through the In Motion Technology hardware and software package contain a communications component.

Initial discussions have taken place between Saab, TCC staff, In Motion, and GTRI in order to explore the possibility of utilizing this communications component to communicate with EMS providers.

TCC staff will work with the TCC Subcommittee while continuing to explore this possibility.

TCC Subcommittee

Make–up of the TCC Subcommittee: The TCC Subcommittee will initially consist of four Commission members.

Function of the TCC Subcommittee: The basic function of the TCC Subcommittee will be to provide guidance and oversight to TCC management as it relates to the ongoing development of the mission of the TCC. Some examples of mission development may include: the additional function of the TCC as more of a regional and statewide resource by maintaining a database of regional assets and contact information, the possible development and deployment of a TCC smart phone application, and the possibility of allowing EMS agencies access to the RAD. In addition, the Subcommittee will provide counsel and advice in budget related areas such as major system upgrades and personnel changes.

Collaborative Systems Inquiry
Georgia Injury Prevention Model




Rachel Ferencik, MPA
Georgia Health Policy Center

Christopher Jones, Ph.D.
Centers for Disease Control

Chris Soderquist
Pontifex Consulting

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

COLLABORATIVE SYSTEMS INQUIRY
GEORGIA INJURY PREVENTION MODEL

- Background
- Other modeling projects
  - Childhood obesity
  - Low birth weight
- Evolution from trauma system to motor vehicle injury prevention
- Injury prevention modeling process

COLLABORATIVE SYSTEMS INQUIRY
INITIAL TRAINING
MARCH 2011

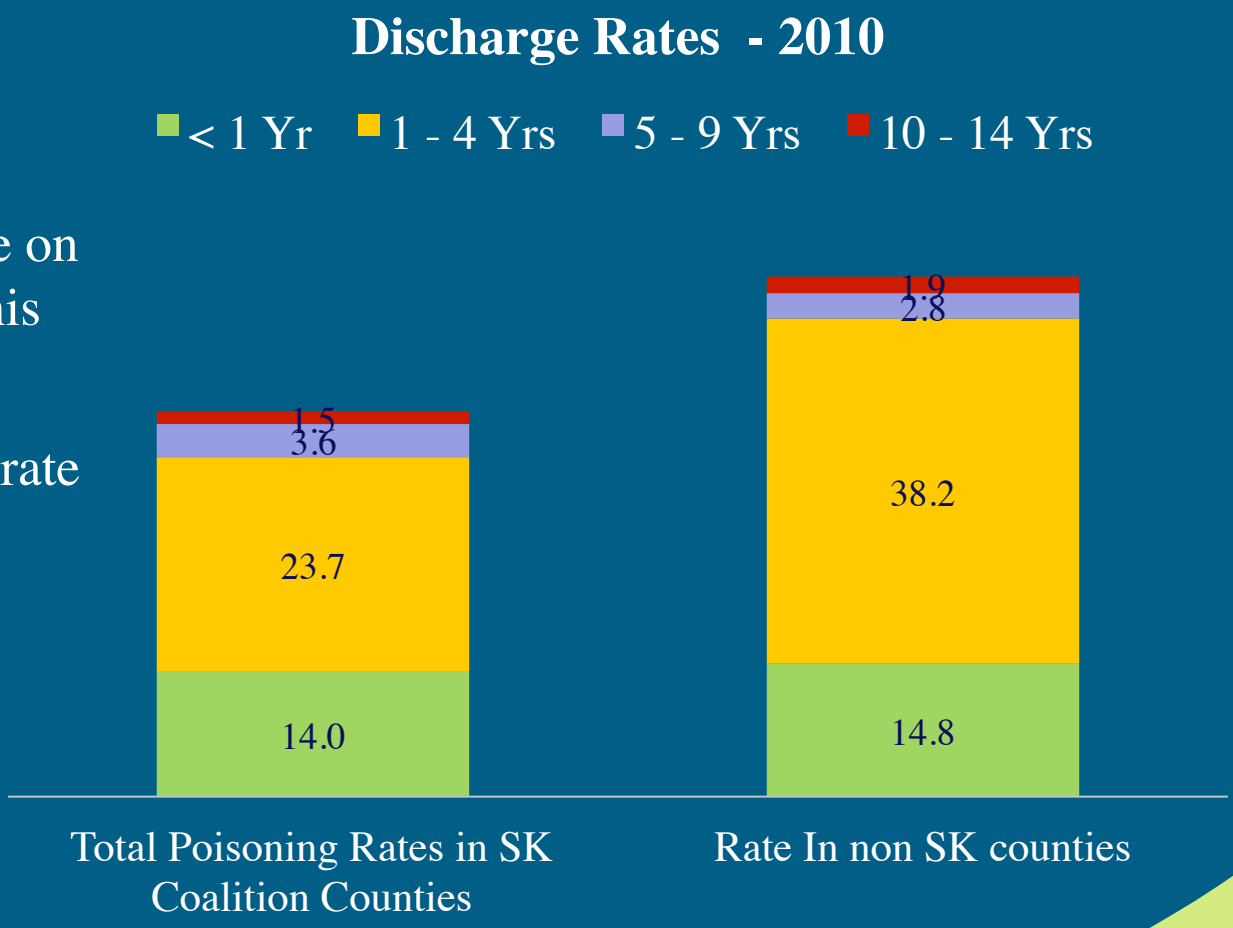
A. Rana Bayakly	GA Dept of Community Health
Randy Clayton	Governor's Office of Highway Safety
Linda Cole	Children's Healthcare of Atlanta
Lisa Dawson	GA Dept of Community Health
Rachel Ferencik	Georgia Health Policy Center
Elaine Frantz	Memorial University Medical Center
David Guthrie	Centers for Disease Control and Prevention
Ben Hinson	Mid Georgia Ambulance
Chris Jones	Centers for Disease Control and Prevention
Sherika Kimbrough	Grady Health Systems
Debra Kitchens	MCCG
Eva Lee	Georgia Institute of Technology
Beverly Losman	Children's Healthcare of Atlanta
Terryi Miller	Children's Healthcare of Atlanta
Jill Mobley	DCH/SOE MST
Rochella Mood	Atlanta Medical Center
Renee Morgan	GA Dept of Community Health
Greg Pereira	Children's Healthcare of Atlanta
Jim Pettyjohn	GA Trauma Care Network Commission
Tanya Simpson	Doctors Hospital
L. Shakiyla Smith	Emory University School of Medicine

COLLABORATIVE SYSTEMS INQUIRY
MODELING TEAM

Chris Soderquist, Pontifex Consulting
Rachel Ferencik, GHPC
Kristi Fuller, GHPC
Chris Jones, CDC
Randy Clayton, GOHS
Elaine Frantz, Memorial UMC
Lisa Dawson, DCH
Denise Yaeger, DCH
Jim Pettyjohn, GTCNC

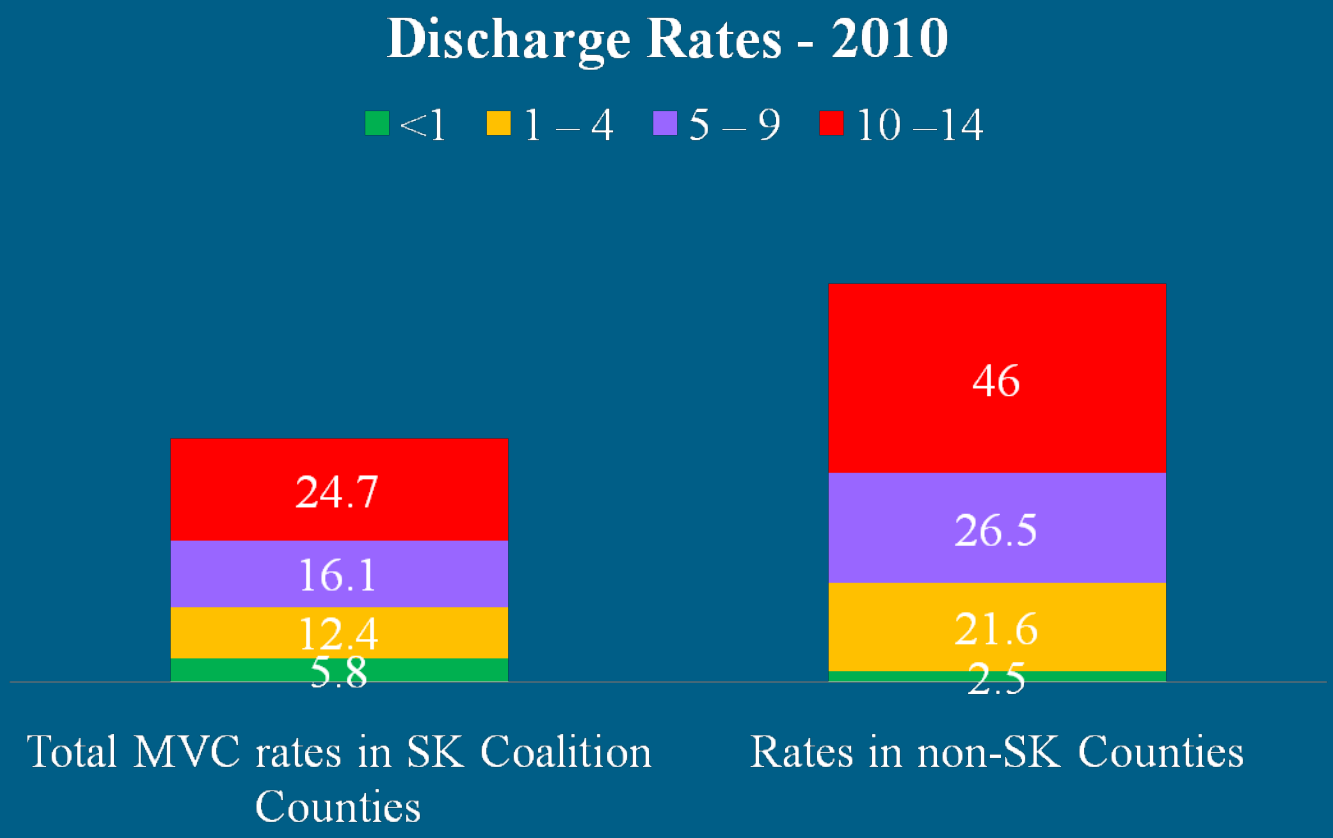
Poisoning rates are lower in Safe Kids coalition counties than in non-SK counties

- Why is this true?
- What data do we have on coalition activity in this area?
- Why is the incidence rate so similar for <1?
- Why higher for 5-9?



Safe Kids Georgia

MVC rates are lower in Safe Kids coalition counties than in non-SK counties



Safe Kids Georgia

Improving Safe Kids Georgia Program Outcomes: A Performance Management Approach

November 15, 2012

Richard Douglass

B.O.D. Safe Kids Georgia

Program Committee Chairman

Safe Kids Georgia

Agenda

- Overview of Safe Kids Georgia charter and organization
- Summary of program results in 2011
- Systematically evaluating program effectiveness
  - Identify target groups and unmet needs
  - Ensure timely and accurate collection of program activity data
  - Establish a regular cadence, or rhythm, of reporting progress
  - Periodically assess program impact and identify areas for improvement

Safe Kids Georgia

SKG OVERVIEW

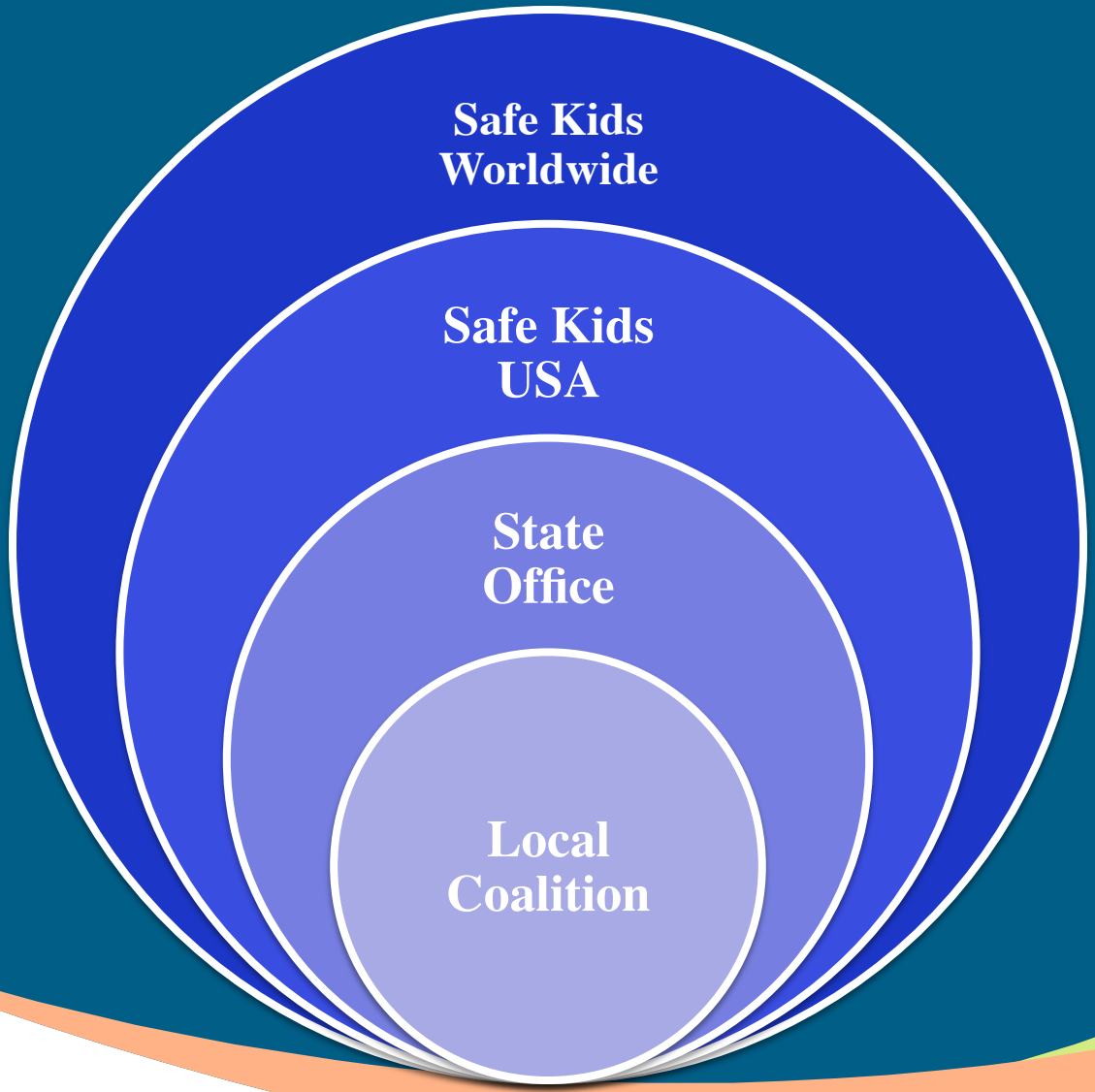
Safe Kids Georgia

Safe Kids

- 19 countries, worldwide
- 50 states, nationwide
- 26 counties, statewide

Safe Kids
Georgia

Organizational Structure



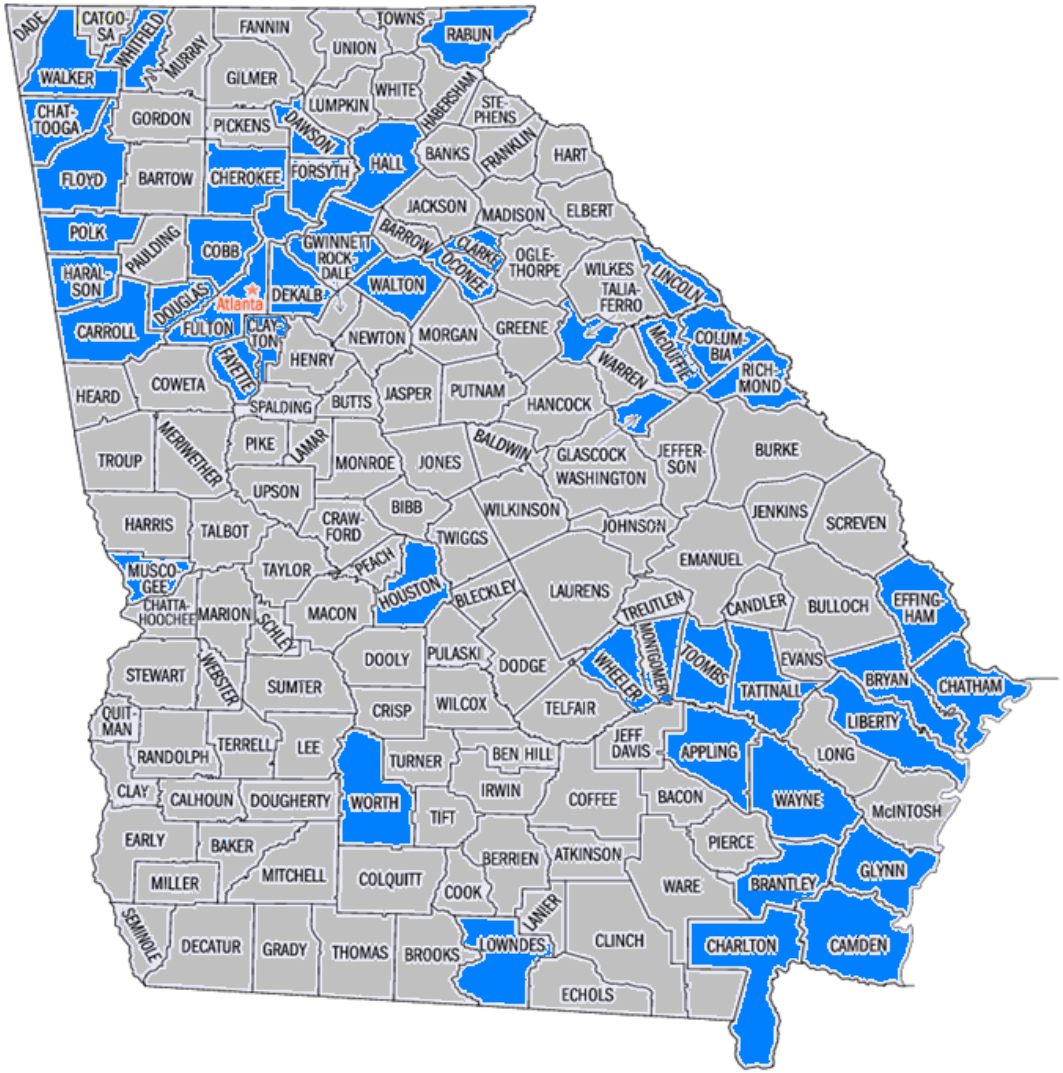
Safe Kids Georgia

What is Safe Kids Georgia?

- Started in 1991, Safe Kids Georgia is a 501(c)3 non-profit organization dedicated to leading a statewide network in order to prevent unintentional injury, the #1 cause of death of children fourteen and under.
- We bring together private and public, state and local organizations and individual volunteers to keep our kids safe in cars, on wheels, in water, and at home.
- We are celebrating our 22nd year under the auspices of Children's Healthcare of Atlanta.

Safe Kids Georgia

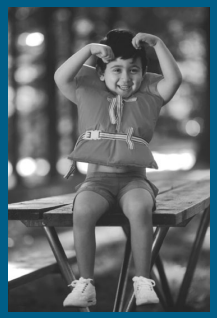
Our Coalitions

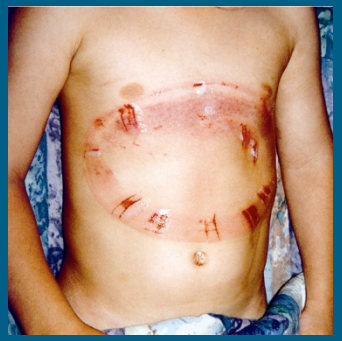


Safe Kids Georgia

Most Common Injuries

- Falls
- Motor Vehicle Crashes
- Poisoning
- Drowning
- Pedestrian
- Burns
- Choking/Suffocation
- Dog Bites





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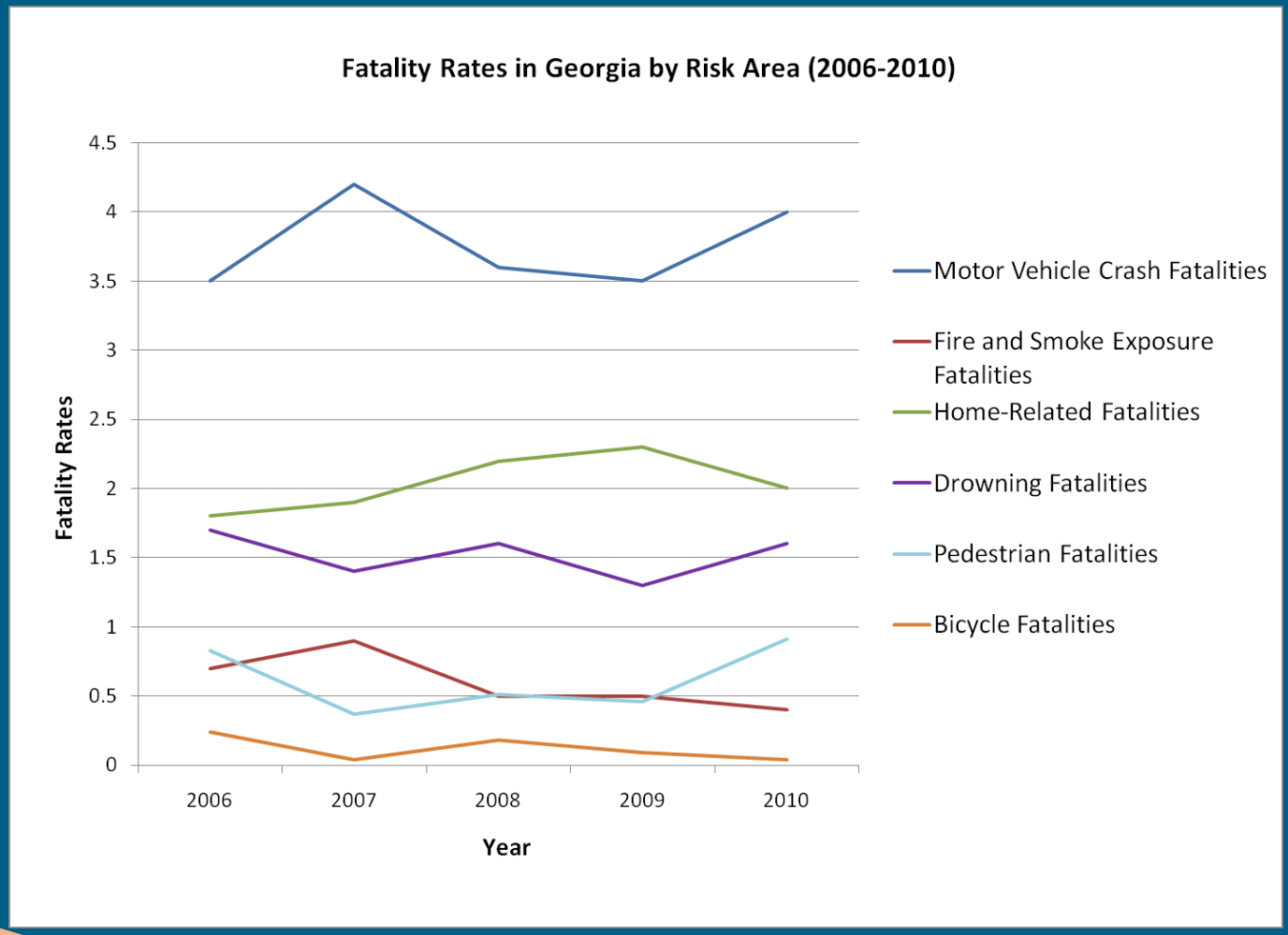
Georgia Fatality Rates



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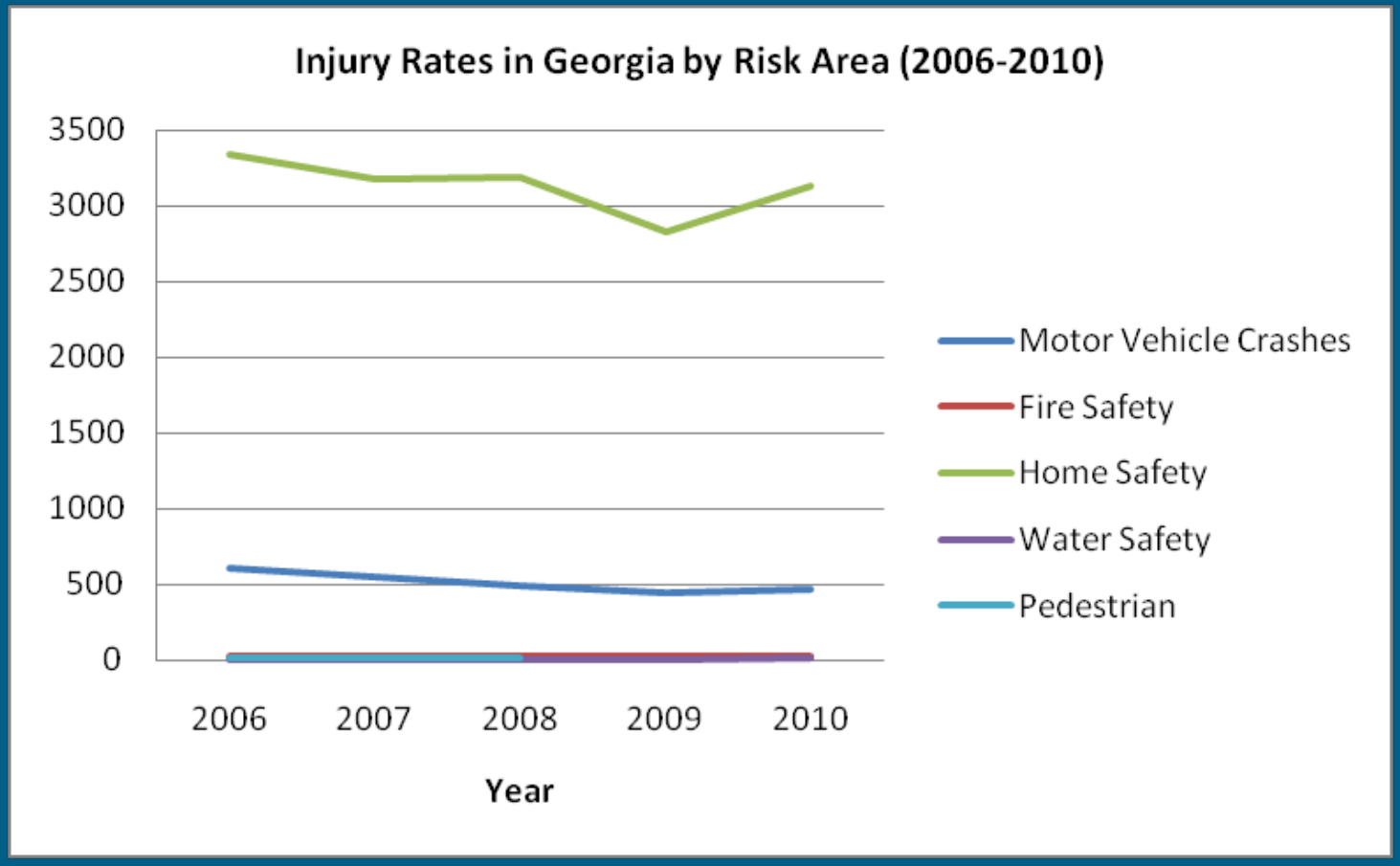
Georgia Injury Rates

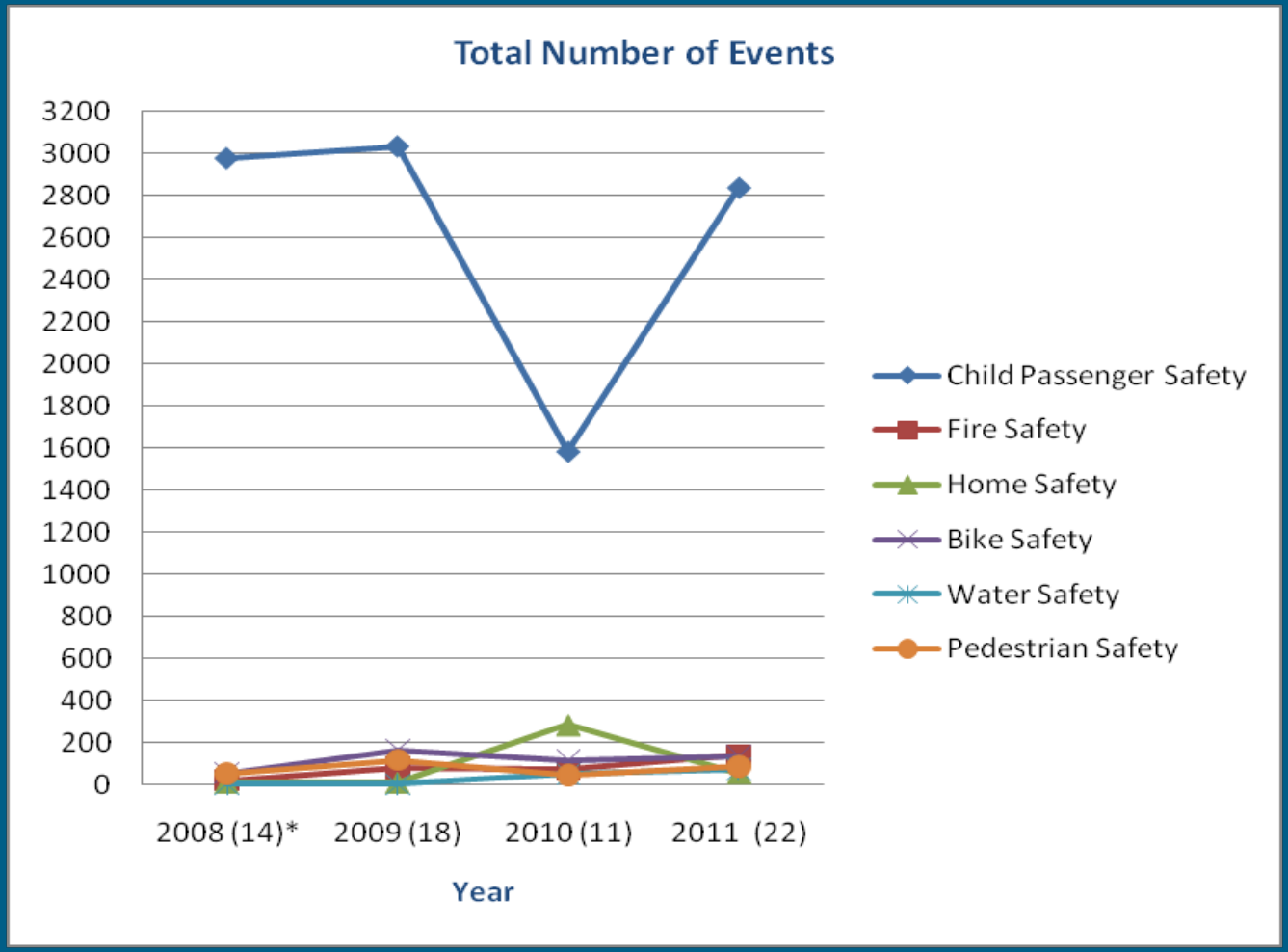


Safe Kids Georgia

2011 PROGRAM ACTIVITIES

Safe Kids Georgia

Summary of Program Activity



Safe Kids Georgia

Child Passenger Safety

- Seat Distribution with Education
- Legislation
- Check Points
- 2011Fast Facts:
  - 4385 Seats Distributed
  - 236 Classes
  - Passage of Booster Seat Legislation
  - 1812 inspection events
  - 620 Click it or ticket events

Safe Kids Georgia

Wheeled Sport Safety

- Helmet Distribution and Education
- Bike Rodeos
- 2011 Fast Facts:
  - 107 Events
  - 3512 Helmets Distributed

Safe Kids Georgia

Pedestrian Safety

- International Walk to School Day
- Environmental Taskforces
- 2011 Fast Facts:
  - 71 Events
  - 15,533 Reflectors
  - 2 Environmental Taskforces

Safe Kids Georgia

Home Safety

- Home Safety Education
  - Falls
  - Poisonings
  - Furniture Hazards
  - Choking
  - Dog Bite
- 2011 Fast Facts:
  - 39 Events
  - 373 CO Detectors Distributed

Safe Kids Georgia

Water Safety

- Water Safety Education
- Life Jacket Loaner Stations
- 2011 Fast Facts:
  - 68 Events
  - 2057 Life Jackets Distributed

Safe Kids
Georgia

Fire Safety

- School Based Education
- Public Safety Days
- 2011 Fast Facts:
  - 111 Events
  - 692 Smoke Alarms Distributed

Safe Kids Georgia

Sports Safety

- Sports Safety Clinics
  - Athletes and Parents
  - Coaches and Athletic Trainers

- 100 Kits Distributed

Safe Kids Georgia

PERFORMANCE MANAGEMENT AND PROCESS IMPROVEMENT

Safe Kids Georgia

Objectives and Initial Priorities for Performance Management

OBJECTIVE

Establish a set of metrics and an overall performance management model that allow us to track program activity (reach) and effectiveness

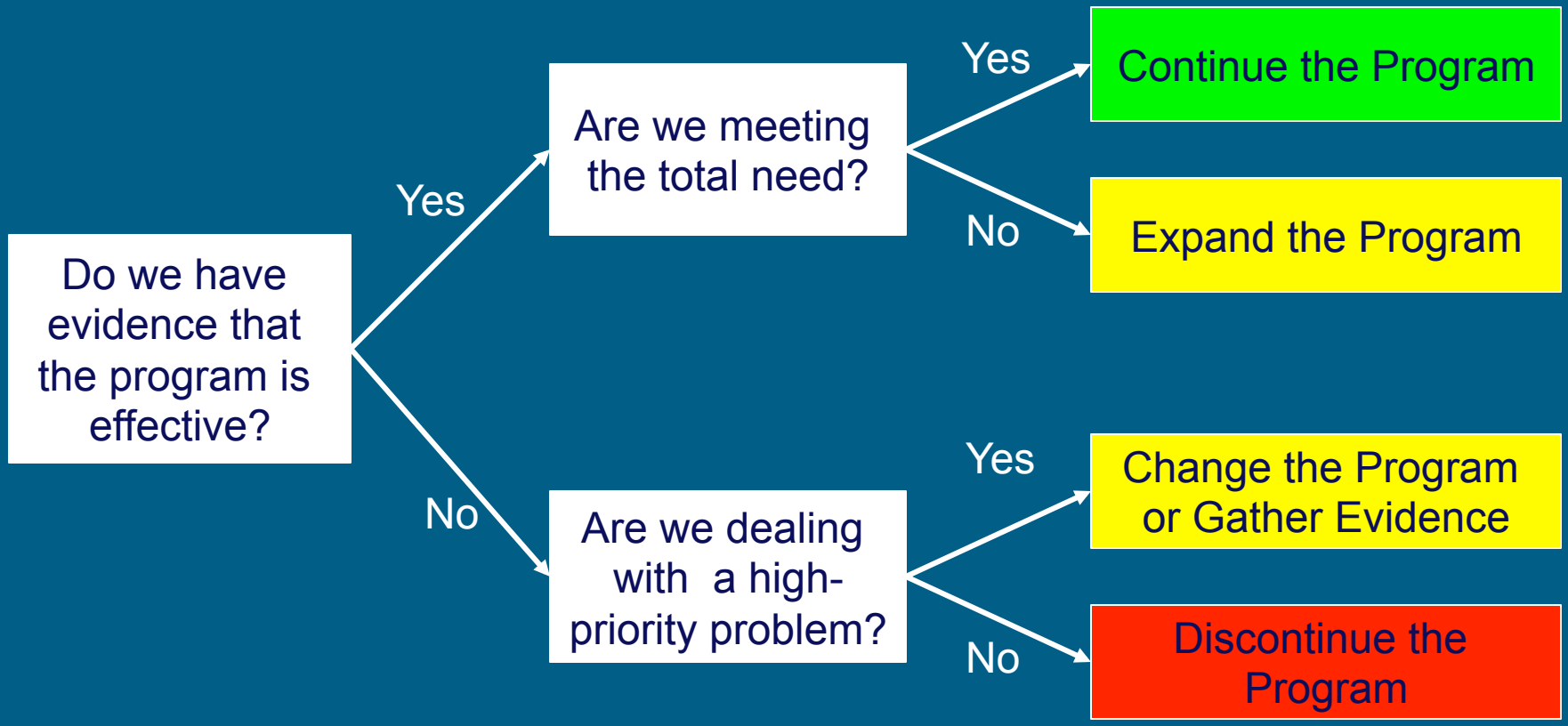
CHALLENGES

Changing behavior (preventative) vs. trauma services (restorative).

There are many factors that influence safety and the incidence of injury: laws, law enforcement, community development, demographics

Safe Kids Georgia

4 basic decisions we need to make about programs



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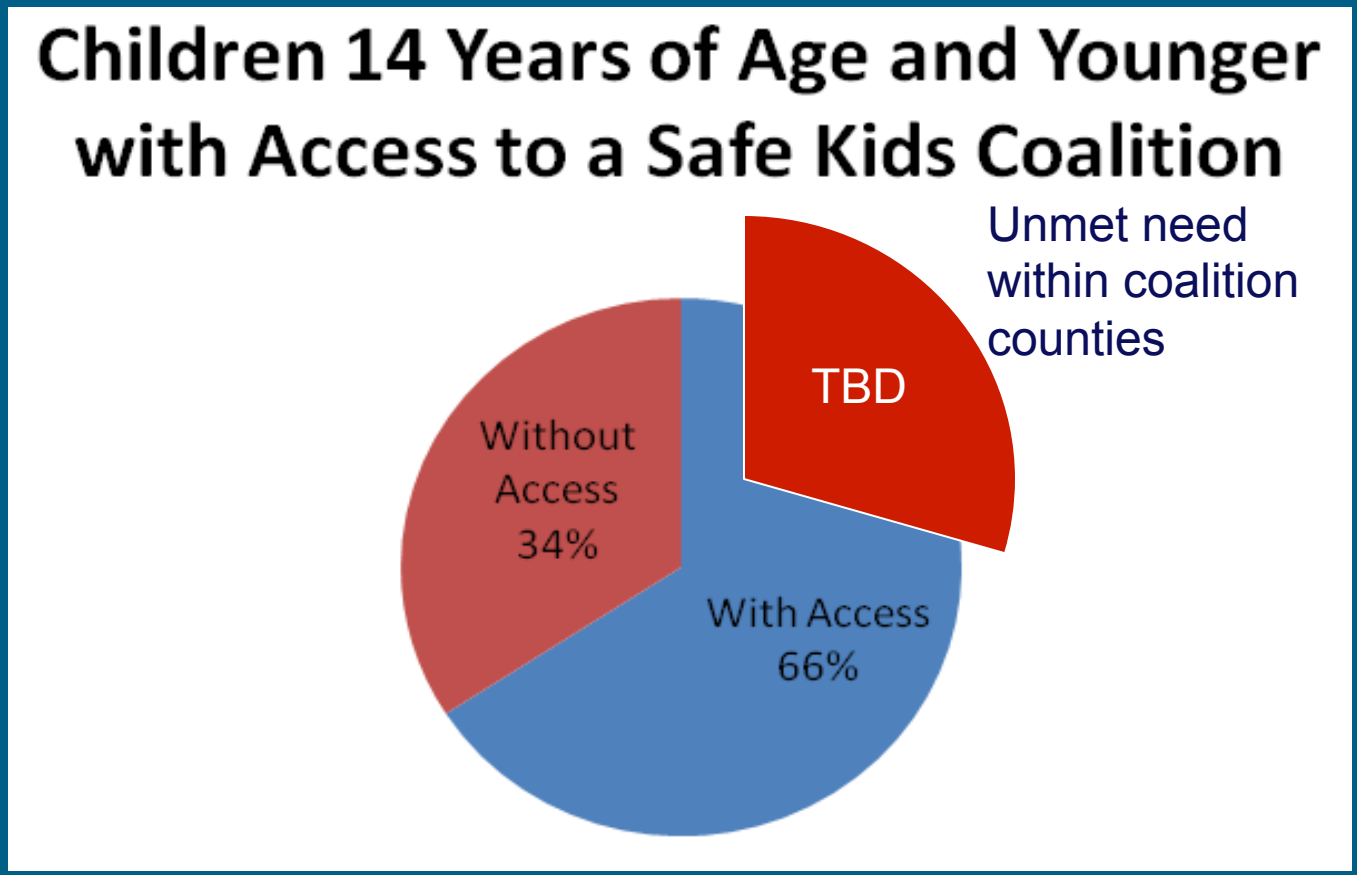
Target Groups

- There are certain demographic factors that make children at higher risk for Injuries:
  - Gender: Male
  - Low- Income
  - Less Education or Lack of Knowledge
  - Location (Urban Vs. Rural)
  - Ethnicity
  - Cultural Norms Around Safety
- Usage factors
  - Ability to Obtain Safety Equipment
  - Proper Use of Safety Equipment

Safe Kids Georgia

Unmet Need – within the coalitions and within the state as a whole



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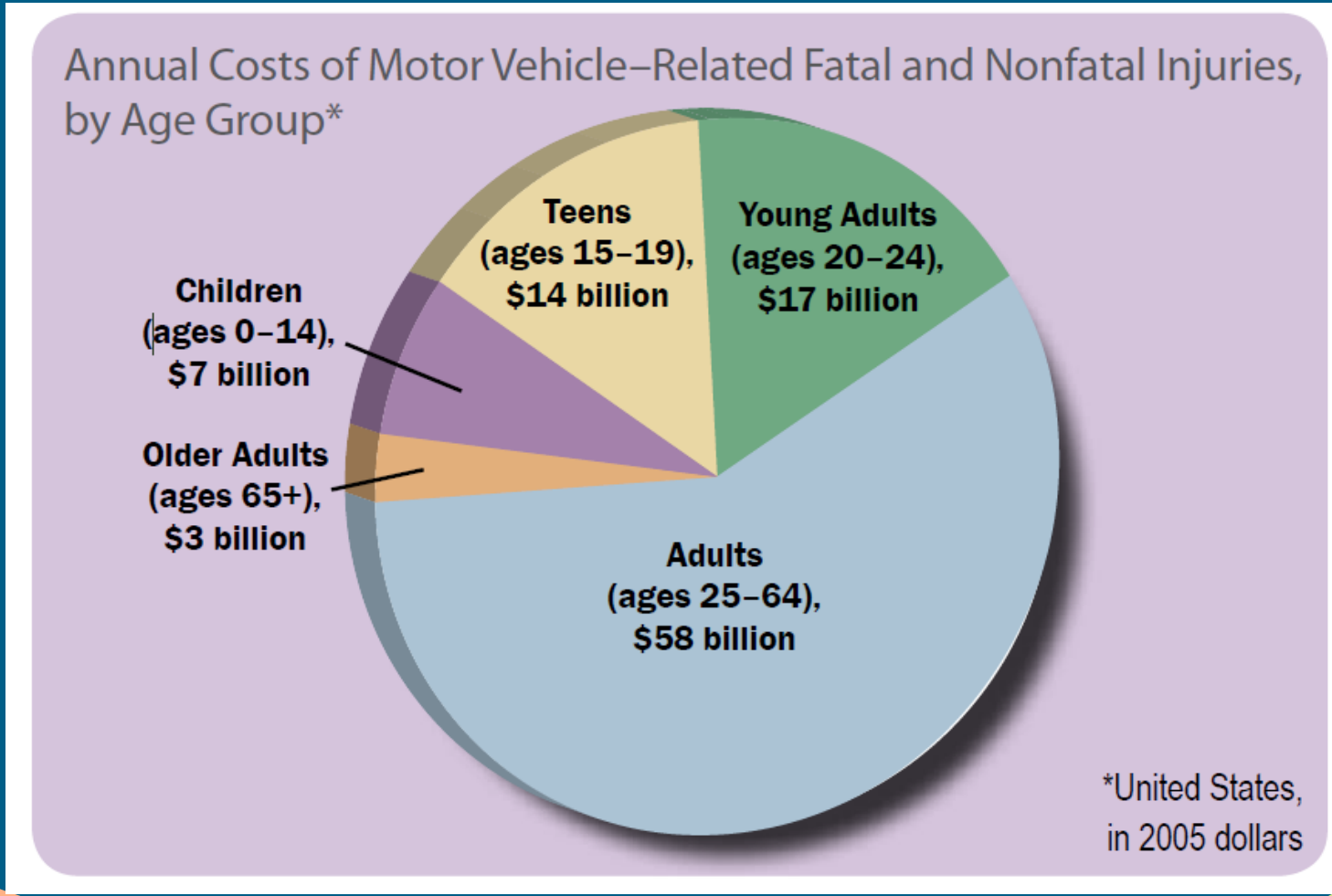
Costs of Injury



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Prevention Savings

- Child Safety Seat Distribution, Ages 0-4
  - $52/seat provided total savings $2,200
    - Every $1 spent on a CR saves between $42-45
    - SK's distributed over 4,500 CRs in 2011
- Booster Seat, Ages 4-7

  $35/seat saves $2,500 per seat

Safe Kids Georgia

Basic Program Metrics Evaluation Cycle

	COLLECT	MANAGE	ASSESS	IMPROVE
WHEN	• Monthly	• Quarterly	• Annually	• On Going

WHAT	• Coalition Activity Tracking	• Program Status Report	• State of Programs Assessment
			  • Accomplishments
			  • Evaluation
			  • Proposals
				• Program Improvement Initiatives

WHY	• Timely, accurate, complete data	• Actions & resources required to close gaps in expected activity	• Recommended changes to programs, marketing, funding • New or changed priorities	• Continuous improvement

Safe Kids Georgia

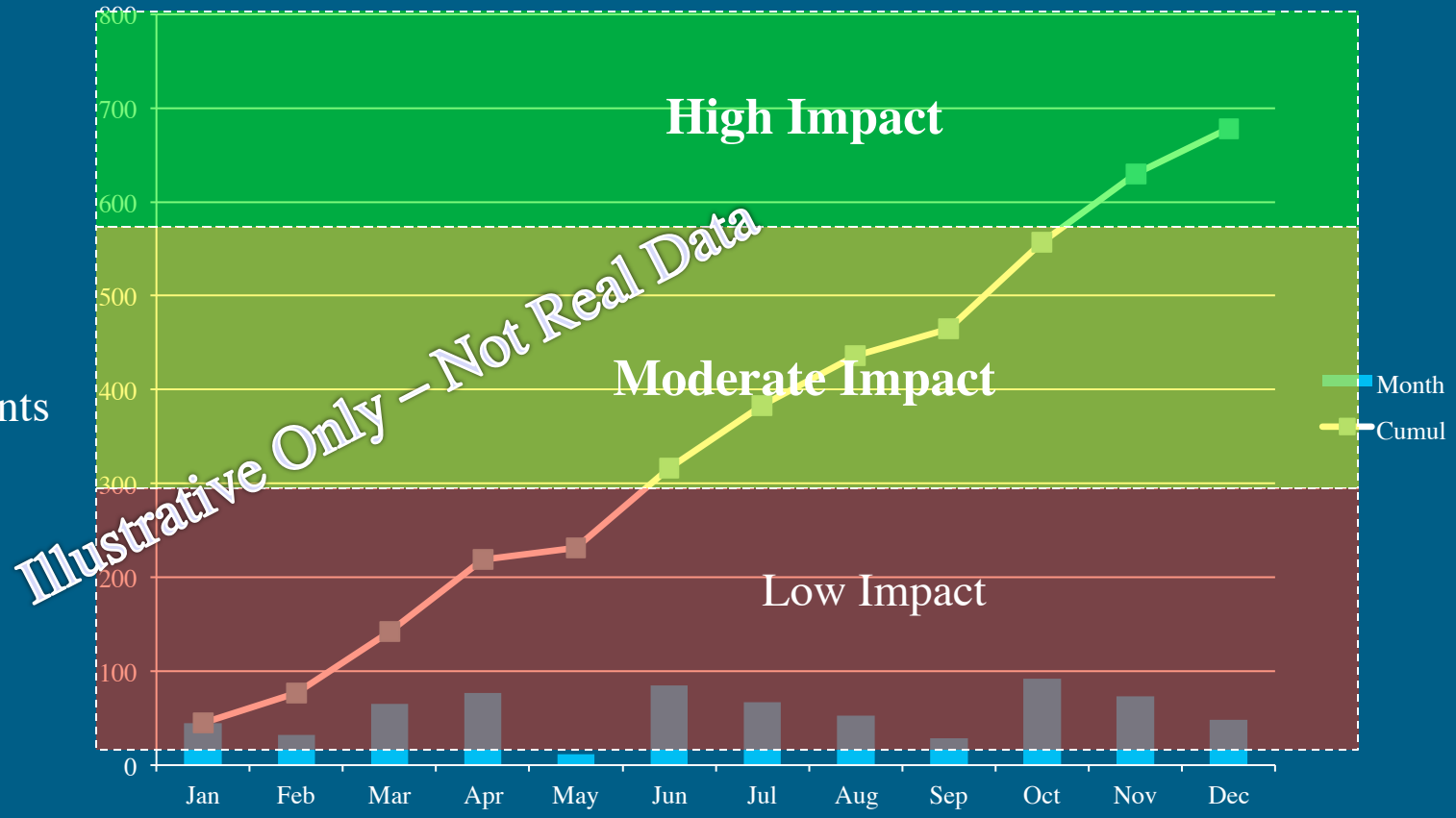
Data Collection Principles

- Collect data as close to time of event or program activity as possible
  - Improve accuracy and reliability of the reported data
  - Provide more timely feedback for program adjustments
- Make data collection as easy and fast as possible
  - Reduce the # of non-reporting coalitions
  - Recognize the diversity of coalition members' roles (part-time vs. full-time, e.g.)

Safe Kids Georgia

MANAGE – Program Activity reporting

participants



By program type, by coalition county

Safe Kids Georgia

ASSESS – State of the Programs Annual Assessment

Injury and Death Statistics

- For all 6 of the focus areas
- Compare to prior 2-3 years

Program Statistics

- Activity levels by program, by coalition
- Coalition building activities and interaction with other agencies
- Program funding & grants
- Staff resources devoted per program

Program Evaluation & Recommendations

- Summary of how SKG "moved the needle"
- Narrative success stories and lessons learned
- Coalition activity and assessment of effectiveness (paid v. volunteer)
- Changes to programs and coalition building
- Additional resources needed (staff and $)
- Input to Marketing and Development

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Our initial priorities and rationale

Priority: Child Passenger Safety

Rationale:

- Largest program
- Has the most evidence supporting risk mitigation approaches

Questions to answer:

- Do we need to do more, and how much more? (unserved population)
- Can we show reasonable impact between SK vs. non-SK?

Priority: Poisoning

Rationale:

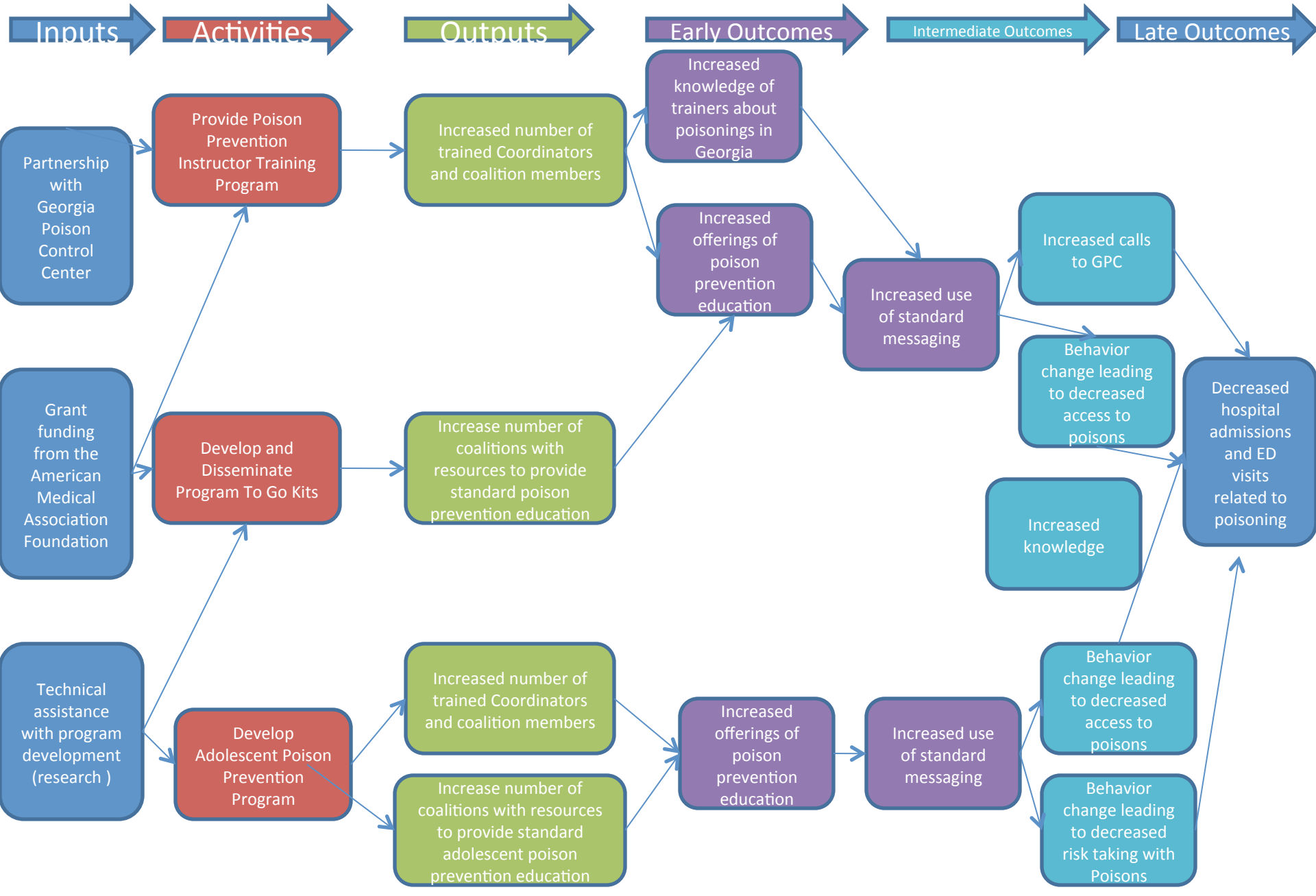
- Recently trended upwards in incidence
- Least evaluated area, least implemented program

Question to answer:

- What needs to be done? What works?

Safe Kids Georgia

Poison Prevention Logic Model



Logic Model - Inputs

Partnership with Georgia Poison Control Center

Grant funding from the American Medical Association Foundation

Technical assistance with program development (research)

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Logic Model - Activities

Provide Poison Prevention Instructor Training Program

Develop and Disseminate Program To Go Kits

Develop Adolescent Poison Prevention Program

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Logic Model - Outputs

Increased number of trained Coordinators and coalition members

Increase number of coalitions with resources to provide standard poison prevention education

Increase number of coalitions with resources to provide standard adolescent poison prevention education

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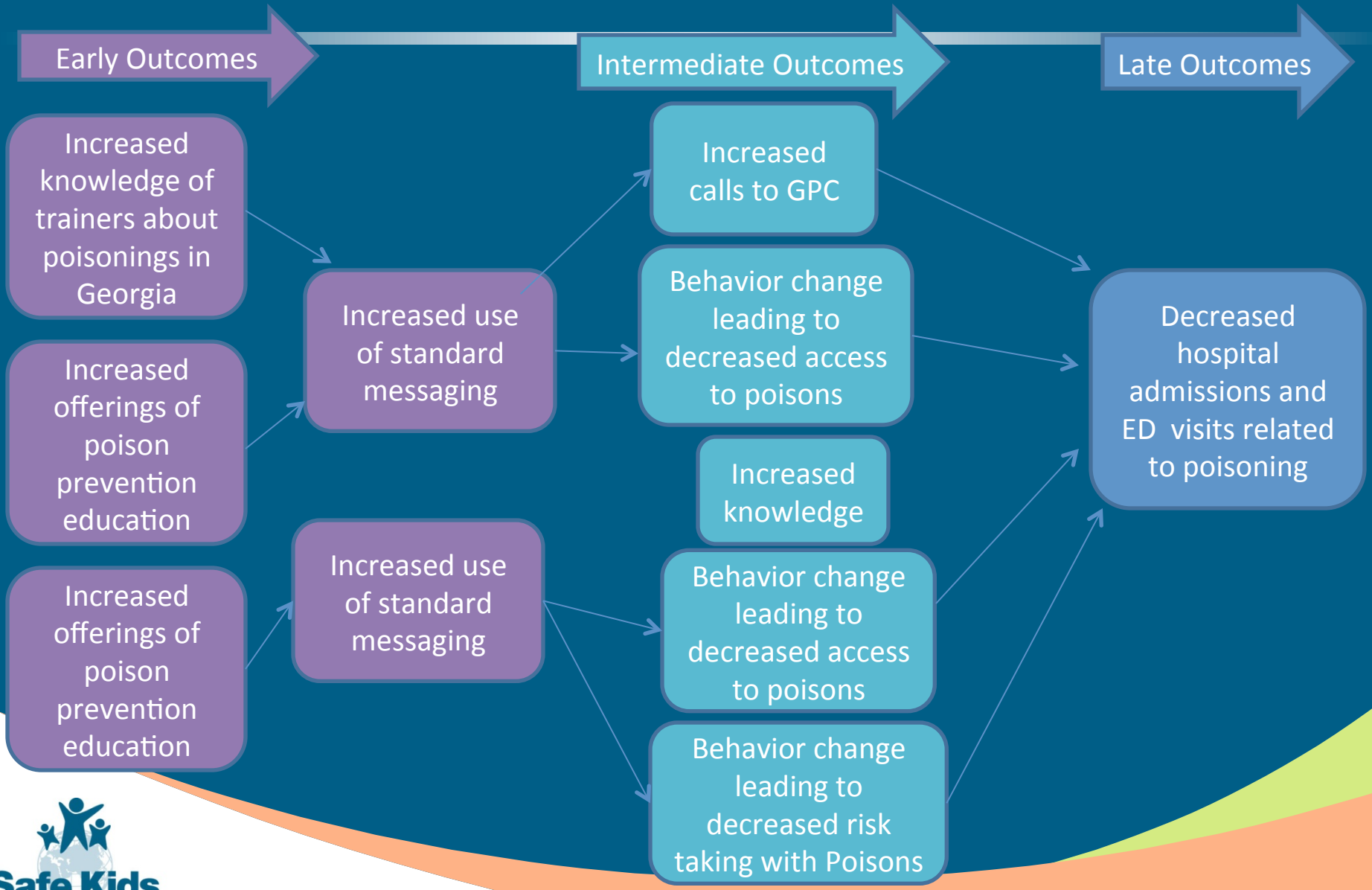
Logic Model - Outcomes



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How Can We Work Together?

- Provide a continuum for putting data into action
- Work together to respond to immediate injury needs of the community.
- Share Resources
- HRSA RTAC Assessments
  - Provide data and collaboration at the local level around injuries

Safe Kids Georgia

REGIONAL TRAUMA ADVISORY COUNCIL

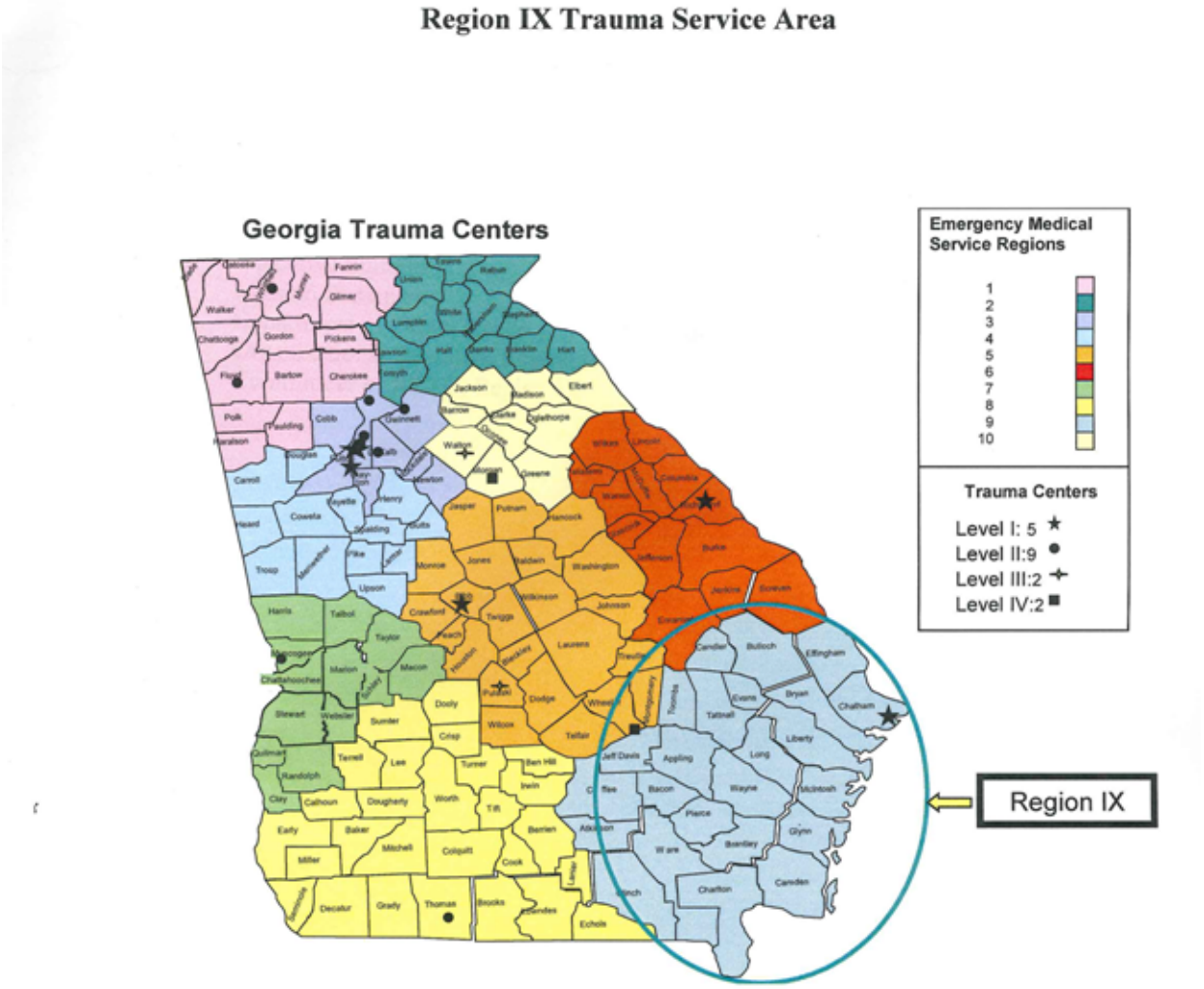
Region IX

Elaine Frantz, RN, BSN, MA

Memorial University Medical Center

Director, Trauma Services

Region IX Service Area



Progress Report

- Inaugural RTAC Aggregate Meeting held on October 28, 2011
- Sub-committees formed and Chairs chosen
- Sub committees have met
  - HRSA document reviewed
  - Needs assessment completed
- Annual RTAC Aggregate Meeting scheduled for February 1, 2013 at Memorial University Medical Center

Trauma System Planning and Evaluation Region IX

100. ASSESSMENT	Regular systematic collection, assembly, analysis, and dissemination of information on the health of the community			
Benchmark 101	*There is a thorough description of the epidemiology of injury in the system jurisdiction using both population-based data and clinical databases*			
	Scores			
Monitor Health	EIF	MGO	RTAC	
101.1	3	3	3	
101.2	2	2	2	
101.3	2	2	2	
101.4	2	1	1	
101.5	3	2	2	
MEDIAN	2	2	2	
Diagnose and Investigate				
101.6	2	1	1	
101.7	1	1	2	
MEDIAN	1.5	1	1	
				Overall
MEDIAN Benchmark 101	1.8	1.5	1.5	**1.5**
Benchmark 102	*There is an established trauma management information system (MIS) for ongoing injury surveillance and system performance assessment*			
Monitor Health	SCORE			
102.1	2	2	2	
102.2	2	2	2	
102.3	3	1	1	
102.4	4	4	3	
102.5	2	2	2	
MEDIAN Benchmark 102	2	2	2	**2**

Trauma System Planning and Evaluation Region IX

Benchmark 103	*A resource assessment for the trauma system has been completed and is regularly updated.*			
Monitor Health	SCORE			
103.1	2	2	2	
MEDIAN	2	2	2	
System Management				
103.2	3	2	2	
103.3	1	1	1	
103.4	2	2	1	
MEDIAN	2	2	1	
MEDIAN Benchmark 103	2	2	1.5	**2**
Benchmark 104	*An assessment of the trauma system's emergency preparedness has been completed including coordination with the public health, EMS system and the emergency management agency.*			
System Management	SCORE			
104.1	4	2	2	
104.2	3	2	2	
104.3	4	3	3	
MEDIAN Benchmark 104	4	2	2	**2**

Trauma System Planning and Evaluation Region IX

Benchmark 105	*The system assesses and monitor its value to its constituents in terms of cost-benefit analysis and societal investment*						
System Management	SCORE						
105.1	1	1	1				
105.2	2	1	1				
105.3	4	2	2				
105.4	2	1	2				
105.5	2	2	2				
105.6	1	1	2				
105.7	1	1	1				
MEDIAN Benchmark 105	2	1	2				
MEDIAN ASSESSMENT SCORE	**2.0**	**2**	**2**	**2.0**			

Trauma System Planning and Evaluation Region IX

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.							
Benchmark 201	*Comprehensive State statutory authority and administrative rules support trauma system leaders and maintain trauma system infrastructure, planning, oversight, and future development.*							
Develop Policies	SCORE							
201.1	5	5	5					
201.2	5	4	3					
201.3	3	4	3					
201.4	2	4	4					
MEDIAN Benchmark 201	4	4	3.5	**4**				

Trauma System Planning and Evaluation Region IX

Benchmark 202	*Trauma system leaders (lead agency, trauma center personnel, and other stakeholders) use a process to establish, maintain, and constantly evaluate and improve a comprehensive trauma system in cooperation with medical, professional, governmental and citizen organizations*			
Mobilize Community Partnership	SCORE			
202.1	1	4	3	
202.2	2	4	3	
MEDIAN	1.5	4	3	
Inform, Educate, Empower				
202.3	3	3	2	
202.4	1	4	1	
MEDIAN	2	3.5	1.5	
MEDIAN Benchmark 202	1.75	3.75	2.25	**2.25**
Benchmark 203	*The state lead agency has a comprehensive written trauma system plan based on national guidelines The plan integrates the trauma system with EMS, public health, emergency preparedness, and incident management. The written trauma system plan is developed in collaboration with community partners and stakeholders.*			
Inform, Educate, Empower	SCORE			
203.1	2	5	4	
203.2	3	4	3	
203.3	2	2	2	
203.4	1	2	1	
203.5	2	1	1	
MEDIAN	2	2	2	
Mobilize Community Partnerships				
203.6	3	2	3	
203.7	2	2	2	
MEDIAN	2.5	2	2.5	
MEDIAN Benchmark 203	2.25	2	2.25	**2.25**

Trauma System Planning and Evaluation Region IX

Benchmark 204	*Sufficient resources, including those both financial and infrastructure related, support system planning, implementation and maintenance.*								
Develop Policies & Sys. Management	SCORE								
204.1	2	2	2						
204.2	3	2	1						
204.3	4	1	1						
204.4	2	2	2						
204.5	1	1	2						
MEDIAN Benchmark 204	2	2	2	**2**					
Benchmark 205	*Collected data are used to evaluate system performance and to develop public policy.*								
Develop Policies & Sys. Management	SCORE								
205.1	2	2	1						
205.2	1	0	1						
205.3	2	2	1						
	2	2	1						
Inform, Educate, Empower									
205.4	2	1	1						
205.5	1	1	1						
	1.5	1	1						
MEDIAN Benchmark 205	1.75	1.5	1	**2**					
Benchmark 206	*Trauma system leaders, including a trauma=specific statewide multidisciplinary, multi-agency advisory committee, regularly review system performance reports.*								
Inform, Educate, Empower	SCORE								
206.1	3	1	1						
206.2	1	3	1						
MEDIAN Benchmark 206	2	2	1	**2**					

Trauma System Planning and Evaluation Region IX

Benchmark 207	*The lead agency inform and educates State, regional and local constituencies and policy*								
	makers to foster collaboration and cooperation for system enhancement and injury control.								
Mobilize Community Partnerships	SCORE								
207.1	2	2	2						
207.2	3	1	1						
207.3	2	1	2						
207.4	1	1	1						
MEDIAN Benchmark 207	2	1	1.5	**1.5**					
Benchmark 208	*The trauma, public health, and emergency preparedness systems are closely linked.*								
Mobilize Community Partnerships	SCORE								
208.1	2	1	1						
208.2	2	2	2						
MEDIAN Benchmark 208	2	1.5	1.5						
MEDIAN POLICY DEVELOPMENT SCORE	**2.0**	**2**	**1.75**	**2**					

Trauma System Planning and Evaluation Region IX

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.							
Benchmark 301	*The trauma management information system (MIS) is used to facilitate ongoing*							
	assessment and assurance of system performance and outcomes and provides							
	a basis for continuously improving the trauma system including a cost-benefit analysis.							
Evaluation	SCORE							
301.1	1	1	1					
301.2	2	2	3					
301.3	2	1	1					
301.4	1.5	1	1					
MEDIAN Benchmark 301	1.75	1	1	**1**				

Trauma System Planning and Evaluation Region IX

Benchmark 302	*The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated.*							
Link to Provide Care	SCORE							
302.1	2	0	2					
302.2	2	2	2					
302.3	2.5	3	2					
Median	2	2	2					
Ensure Competent Workforce	SCORE							
302.4	4.5	1	3					
Median	4.5	1	3					
Evaluation								
305.5	1.5	1	2					
Median	1.5	1	3					
Link to Provide Care								
302.6	3.5	3	2					
302.7	2	2	1					
302.8	3.5	1	2					
302.9	4	3	1					
302.1	4	3	2					
Median	3.5	3	2					
MEDIAN Benchmark 302	2.75	1.5	2.5	**2.5**				

Trauma System Planning and Evaluation Region IX

Benchmark 303	*Acute care facilities are integrated into a resource-efficient, inclusive network that meet required standards and that provide optimal care for all injured patients.*			
Link to Provide Care	SCORE			
303.1	4	3	2	
303.2	3	3	2	
Median	3.5	3	2	
Evaluation	SCORE			
303.3	4.5	3	4	
	4.5	3	4	
Link to Provide Care	SCORE			
303.4	2	1	2	
303.5	2	1	1	
Median	2	1	2	
MEDIAN Benchmark 303	3.5	3	2	**3**
Benchmark 304	*The jurisdictional lead agency, in cooperation with other agencies and organizations uses analytical tools to monitor the performance of population-based prevention and trauma care services.*			
Evaluation	SCORE			
304.1	2	1	3	
304.2	2	1	2	
Median	2	1	2.5	
MEDIAN Benchmark 304	2	1	2.5	**2**

Trauma System Planning and Evaluation Region IX

Benchmark 305	*The lead agency ensures that its trauma system plan is integrated with, and complementary to the comprehensive mass casualty plan for both natural and man-made incidents, including an all-hazards approach to planning and operations.*			
	SCORE			
Link to Provide Care	4	0	1	
Evaluation	3	3	2	
Link to Provide Care	4	1	3	
MEDIAN Benchmark 305	4	1	2	**2**
Benchmark 306	*The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area.*			
Link to Provide Care	SCORE			
306.1	2	1	1	
306.2	2	2	1	
Evaluation				
306.3	3	2	1	
MEDIAN Benchmark 306	2	2	1	**2**
Benchmark 307	*To maintain its state, regional or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes.*			
Evaluation	SCORE			
307.1	2	2	1	
307.2	5	1	1	
MEDIAN Benchmark 307	3.5	1.5	1	**1.5**

Trauma System Planning and Evaluation Region IX

Benchmark 308	*The lead agency ensures that adequate rehabilitation facilities have been integrated into the trauma system and that these resources are made available to all populations requiring them.*			
	SCORE			
Link to Provide Care	5	1	1	
Evaluation	4	1	1	
MEDIAN Benchmark 308	4.5	1	1	**1**
Benchmark 309	*The financial aspects of the trauma system is integrated into the overall performance improvement system to ensure ongoing "fine-tuning" for cost-effectiveness.*			
Evaluation	SCORE			
309.1	3	1	2	
309.2	2	2	1	
309.3	1	1	1	
309.4	1	1	1	
MEDIAN Benchmark 309	1.5	1	1	**1**
Benchmark 310	*The lead trauma authority ensures a competent workforce.*			
Ensure Competent Workforce	SCORE			
310.1	5	5	5	
310.2	5	5	5	
310.3	2	1	1	
310.4	2	2	1	
310.5	1	1	1	
310.6	1	1	1	
310.7	3	1	1	
310.8	1	1	1	
310.9	1.5	1	1	
310.10	1	1	1	
310.11	2	1	1	
310.12	1	1	1	
310.13	5	1	1	
MEDIAN Benchmark 310	2	1	1	**1**

Trauma System Planning and Evaluation Region IX

Benchmark 311	*The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system.*			
Enforce Laws	SCORE			
311.1	3	3	1	
311.2	2	3	4	
311.3	3	3	2	
311.4	4	1	5	
311.5	3	3	4	
311.6	2	2	3	
MEDIAN Benchmark 311	3	3	3.5	**3**
MEDIAN ASSURANCE SCORE	**2.8**	**1**	**1**	**2**
SUMMARY				
MEDIAN ASSESSMENT SCORE	**2.0**	**2**	**2**	
MEDIAN POLICY DEVELOPMENT SCORE	**2.0**	**2**	**1.75**	
MEDIAN ASSURANCE SCORE	**2.8**	**1**	**1**	
OVERALL MEDIAN SCORE	**2.0**	**2**	**1.75**	

Education Sub Committee

- Chair – Diana Sowell, RN, Meadows Regional Hospital
- Meetings held on
  - February 13, April 10, and August 29
- Education and resource assessment completed
- Survey Monkey
  - 6 question assessment
  - Sent to 45 participants – 9 responses
    - 20% response rate

RTAC Education Needs Assessment

RTAC Educational Needs Assessment

Exit this survey

1. Please select all applicable items to best describe your hospital or organization.

- [ ] Single facility hospital
- [ ] Multi-hospital organization
- [ ] EMS
- [ ] Other (please specify)

Other (please specify)

2. Please indicate the number of employee's in your hospital or organization

- ◯ 1-25
- ◯ 26-50
- ◯ 51-100
- ◯ 101-200
- ◯ Greater than 200

3. Please indicate if you have any current instructors within your facility.

- [ ] ACLS
- [ ] PALS
- [ ] TNCC
- [ ] NRP
- [ ] BTLS
- [ ] ENPC
- [ ] EPC

Other (please specify)

4. Please select courses that your facility's employees might like to attend and/or have organized in your area. Use the comment field to list ideas for other courses that may benefit your facility and employees.

- [ ] RTTDC – Rural Trauma Development Course

- [ ] BTLS – Basic Trauma Life Support
- [ ] PHTLS – Pre-hospital Trauma Life Support
- [ ] TNCC – Trauma Nursing Core Class
- [ ] ENPC – Emergency Nursing Pediatric Course
- [ ] CATN – Course in Advanced Trauma Nursing
- [ ] PEPP – Pediatric Education for Pre-hospital Professionals
- [ ] NRP
- [ ] ACLS
- [ ] PALS

Other (please specify)

5. How difficult is it to get the resources you need for continuing education at your facility?

- ◯ Difficult
- ◯ Moderately difficult
- ◯ Very difficult
- ◯ Not difficult at all

Other (please specify)

6. What would you consider to be an obstacle for the provision of educational opportunities to your facility?

- [ ] Course pricing
- [ ] Staffing concerns
- [ ] Availability of courses in the region
- [ ] Notification of courses being offered

Done

Educational Needs Assessment

- Committee's 2nd strategy
  - Letter from Elaine Frantz, Director of Trauma
  - 62 "entities" received a phone call to determine educational contacts
    - Hospitals and EMS
    - Letter sent in July 2012
      - 14 responses – 22.5% response rate
- Education and resource assessment completed
  - Educators for each curricula identified
  - Educator Resource guide sent to hospitals and EMS agencies in Region IX

Educational Needs Assessment

- Recommendations
  - Place education calendar on GTCNC website
  - Development of regional trauma conference
- Challenges
  - Cost of education

Injury Prevention

- Chair – Bonnie Brantley – Meadows Regional Hosptial
- Meetings : February 6, May 18, July 19 and September 27
- Injury Prevention resources identified
  - Existing Programs
    - Example - Safe Kids Rural Road, Car Fit , Teen Maze
  - Entities that can facilitate programs
    - Example - Police, local and state, Schools, Churches, Health Departments
  - Assessment of programs held by county completed
    - Top programs - CDC Safe smoke alarm program, Drive Alive and Rural Roads
    - Seat Belt Survey was held in Montgomery, Toombs and Vidalia Counties
    - Drug Take Back event was held a MUMC
  - Dr. Ochsner sent letter endorsing Drive Alive to all Region IX school district superintendents in September
    - There has been an increased interest in this program

Medical Oversight

- Co-chairs – M. Gage Ochsner, MD and Michael Hamm, MD
- Meeting: June 26, 2012
- Several hospitals have signed a letter of commitment
- Recommendations
  - All hospitals in Region IX can participate in GA trauma registry
    - Develop region wide data collection
    - 50 data points for all hospitals to be determined
    - Participating hospitals to be identified
    - Mechanism for Process Improvement
  - Feed back to referring facilities
    - Letters are being sent to referring physicians - 200+ letters sent to date
    - Develop regional case review process
    - Development of a physician extended programs focused on trauma patient process
  - Work with OMES&T to identify number of Level 3 facilities to meet needs of the region

PreHospital, Disaster, and Communication

- Chair – Frank Davis, MD
- Meetings: February 8, May 9 and November 14
- Review of HRSA Benchmarks has all indicators at a level of 5
- Discussed mission and benefit of Trauma Communication Center
  - Uses statewide protocols and regional protocols
- Action Items
  - Analyze trauma related data
  - Review communication systems
  - Educate pre-hospital providers about the Region IX plan
    - Development of a subcommittee to develop algorithms, address barriers
    - Examine existing effective programs
    - Review preventable deaths
    - Determine volume of trauma patients in Region IX

Quality Assurance- Performance Improvement

- Chair – William Bromberg, MD
- Meetings : May 24 and scheduled for November 28
- Review of HRSA benchmarks indicates many opportunities for Quality Assurance and Performance Improvement across the continuum
  - EMS – ground and aeromedical and hospitals – acute and rehabilitation
- Develop QA/PI criteria – in progress
  - Recommended development of an anonymous reporting mechanism to identify QA/PI issues
  - Development QA/PI point person contact list completed
    - QA/PI issues referred to appropriate point person for investigation
    - Follow up with point person for issue resolution
- Development of MUMC Trauma Patient Transfer Guidelines
  - Distribute to five pilot hospitals
  - Survey included to assess MUMC transfer process

Summary

- Progress has been made on all committees
- Next Steps
  - Integration of committees
    - Medical Oversight and QA/PI to formalize PI plans for region
    - Assessment of regional injury patterns
      - Development of Injury Prevention strategies to reduce these injuries
    - Pre hospital and QA/PI to develop an EMS Regional PI program for care provided to trauma patients
    - Education to collaborate with the implementation of sub committee initiatives

The Georgia Association of Emergency Medical Services

GAEMS

"Dedicated to Quality Pre-Hospital Care"

Topics

- Leadership
- Vehicle Grants
- First Responder Training
- EMS Direction

Leadership

- Initial Partnership Between GAEMS, State Office of Rural Health and Georgia Southern University
  - Year One – Develop Curriculum
  - Focus Groups
  - Research on Other State Efforts
  - Consensus Meetings

Leadership

- Training Provided Over One Year Time Frame
- One Week Per Quarter
- Each Week Between 42-49 Hours of Instruction
- Thirty Hours of On-line Training Done Between Sessions
- Individual Assignments Presented by the Students to the Group

Leadership

- Week One – Leadership Skills
- Week Two – Budget and Financials
- Week Three – Operations, Scheduling, Risk Management, Preventative Maintenance
- Week Four – Emergency Preparedness, Media Relations, Dealing with Personnel Conflicts Future Issues in EMS, Personal Growth, Regionalization

Leadership

- Initial Course – Pilot
- Twenty Students From Rural Georgia
  - Funded by Office of Rural Health
- Five Students From Urban/Suburban Georgia
  - Marginal Cost Funded by Trauma Commission
- Two Program Managers
  - Marginal Cost Funded by Trauma Commission

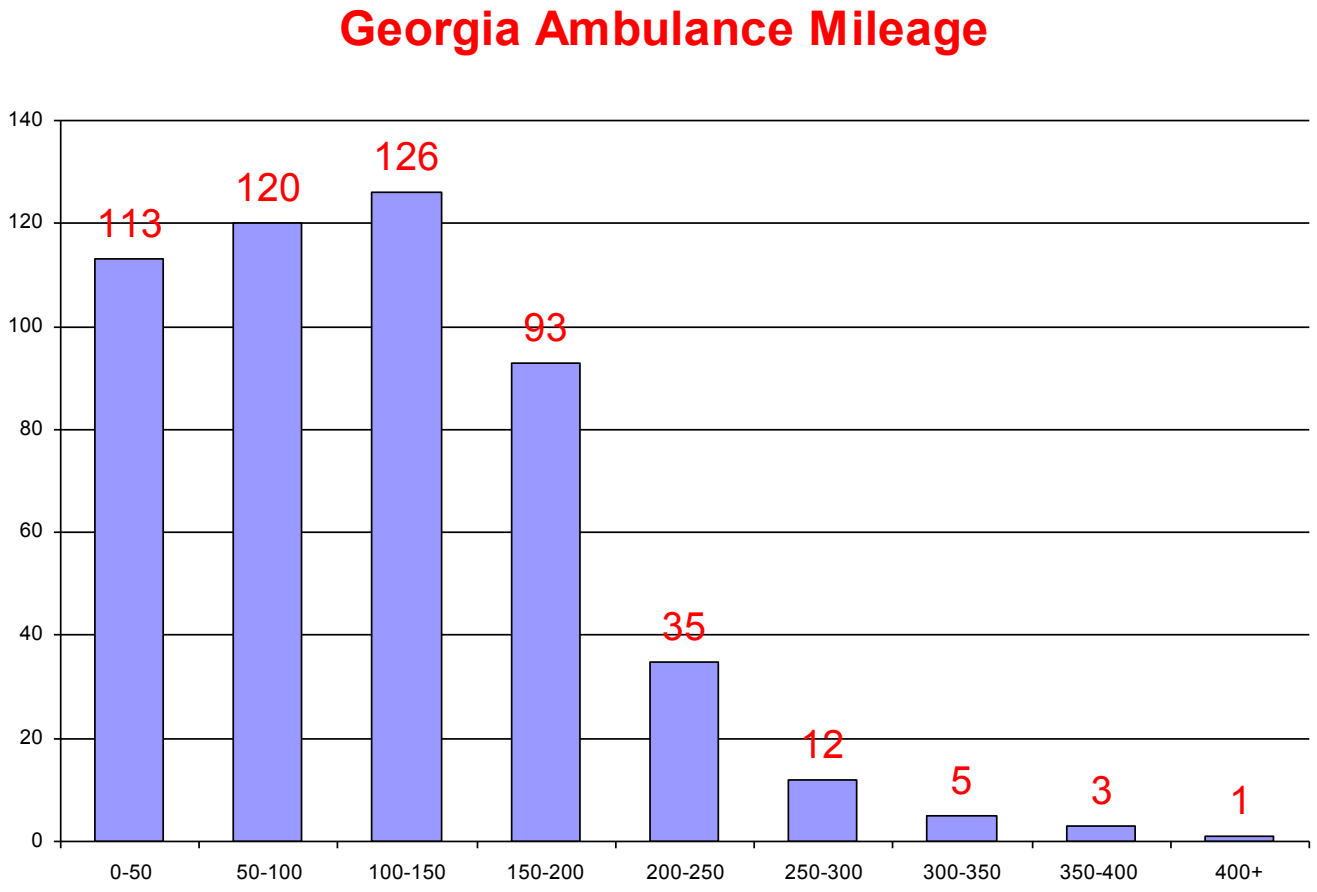
Leadership

- Very Successful
  - Plans to Refine the Curriculum and Continue
    - Funding via Georgia Trauma Commission

Vehicle Grants

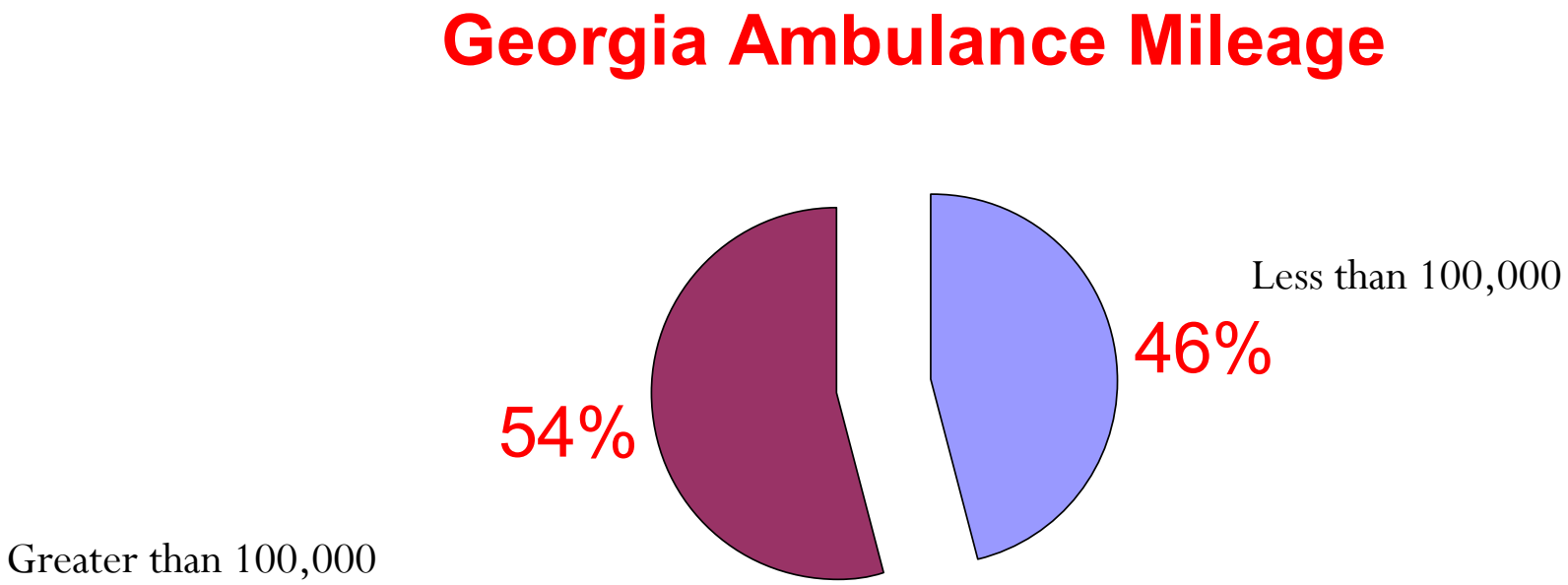
- Competitive Grant – Designed to Favor Rural Services Who Must Travel Greater Distances to Trauma Centers
- Designed to Favor Low Density Area Which Have Higher % of Total Cost in "Readiness Cost"
- Initial Concern from Governor Purdue

Vehicle Grant



0-50 100-150 200-250 300-350 Over 400

Vehicle Grant



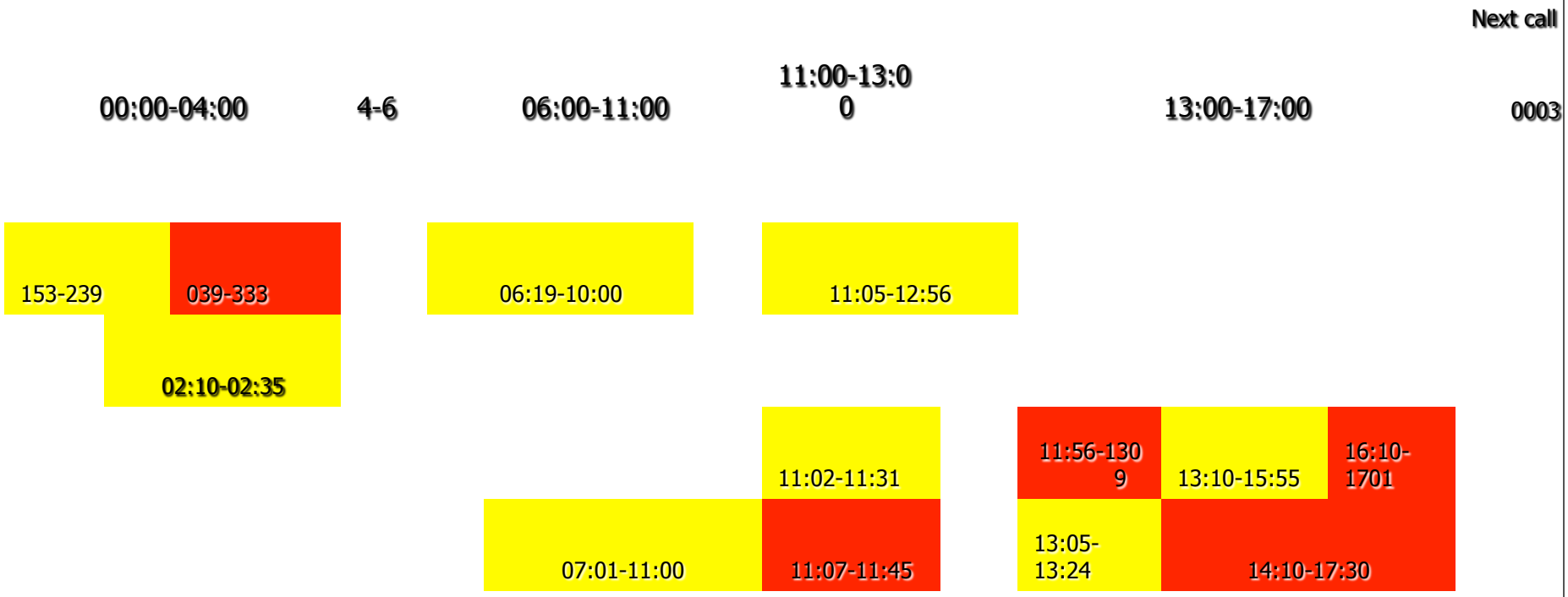
Vehicle Grants

- Continues to be Supported by the EMS Sub-Committee
- Attempts to Balance Funding with Uncompensated Care Funding
- Often the Only Way Rural Services Can Afford New Vehicles

First Responder Training

- Over 1100 Training in Over 65 Counties in Georgia
- Equipment Provided
- Very Well Supported

July 3,2012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13:00-17:00
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06:19-10:00
11:05-12:56
11:02-11:31
07:01-11:00
11:07-11:45
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9
13:10-15:55
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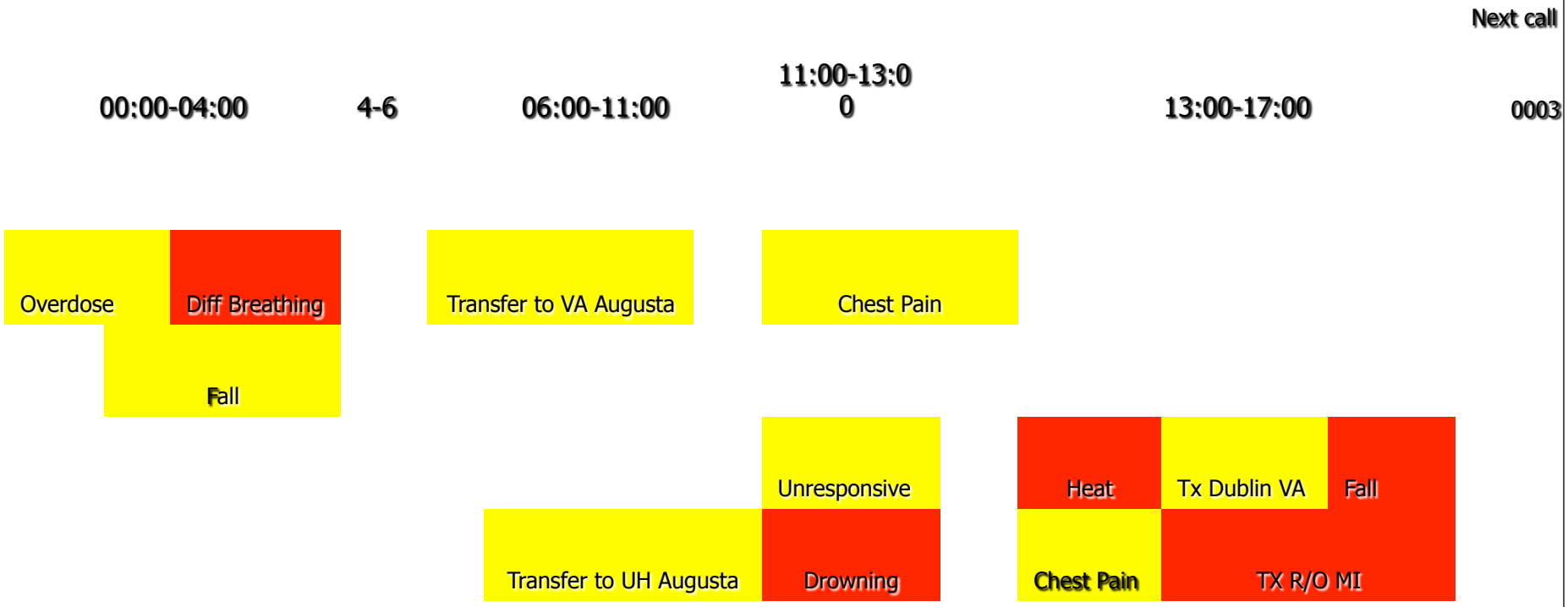
1701
13:05-
13:24
14:10-17:30

July 3,2012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13:00-17:00
Next call
0003
Overdose
Diff Breathing
Fall
Transfer to VA Augusta
Chest Pain
Unresponsive
Transfer to UH Augusta
Drowning
Heat
Tx Dublin VA
Fall
Chest Pain
TX R/O MI


56
Summertown
1
Canoochee
Garfield
Dellwood
Swainsboro
80
Adrian
Norristown
221
Twin City
297
Nunez
Stillmore
16
Oak Park

EMS Direction

- Strategic Gaps Project Between GAEMS/GEMA/GTRI
  - Currently Beginning Year Five
  - Four Years of Solid Data
  - Initiative to Pick Up AVLS Project
  - Four Years of State Wide Table Top Disaster Drills
  - Multi-County Multi-Region Disaster Drill
    - 13 Different Ambulance Services
    - Four Regions Represented
  - Initiative to Implement State Wide Triage Tag

EMS Direction

- Working with OEP on Patient Triage and Tracking Systems
  - Should Work Very Well with AVLS System

EMS Direction

- Automatic Vehicle Location System
  - Initial Project of the Trauma Commission
  - Project Picked up by GEMA Based on Findings From Strategic Gaps Project Allows For Location of Vehicle During Disaster Response
  - Gives Vehicle an Ability to Communicate
    - Phase V Total 802 units 96 Agencies 102 Counties
  - Give Vehicle Internet Capability = Opportunity

EMS Direction

- Training
- Partnerships with
  - OEP
  - Trauma Commission
  - Georgia Southern University
  - Georgia Public Safety Training Center
  - Georgia State Defense Force

EMS Direction

- Improved Data Collection and PI Initiatives
  - 800 Laptops Distributed – GAEMS-OEP-SOEMS/T
  - Multi-County Training Initiatives (Funded by SORH)
  - Rural EMS Protocol Development and PI Tools (Funded by SORH)

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