Minutes approved 27 January 2012

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 17 November 2011

Scheduled: 10:00 am until 1:00 pm
Medical Center of Central Georgia
Peyton Anderson Health Education Center
Weaver Board Room 4th Floor 7
877 Hemlock Street, Macon, GA 31208

Dr. Dennis Ashley, Chair, called the scheduled monthly meeting of the Georgia Trauma Care Network Commission to order at 10:15 a.m.

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

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
Michelle Martin, TCC Operations Assistant	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Alex Sponseller	Assistant Attorney General
Scott Sherrill (via tele-conference)	GTRI
Regina Medeiros	MCG Health
Lawanna Mercer-Cobb	SOEMS/T – Region 6
Marie Probst	OEMS/T
Courtney Terwilliger	GAEMS
Debra Kitchens	MCCG
Danlin Luo	DPH/Chronic Disease
Rana Bayakly	DPH/Chronic Disease
Renee Morgan	OEMS/T
Chris Hobbs	Peach Regional Medical Center
Russ McGee	Region 5 OEMS/T

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT

Dr. Ashley welcomes everyone to Macon. Dr. Leon Haley will be on conference call but has not signed on yet. Dr. Ashley requests that Mr. Jim Pettyjohn monitor the conference call line, and let him know when Dr. Haley joins in.

Dr. Ashley states that he hosts the Trauma Medical Director's conference call every other month, and they have been having very good discussions. Each trauma center is coming online with TQIP, which is the Trauma Quality Improvement Project, and there has been good discussion on how to organize that. Dr. Dente who is Chair of the American College of Surgeons Committee on Trauma will be heading up a meeting with the Medical Directors in conjunction with the Commission, Trauma Coordinators, and Trauma Centers. We will start to work on TQIP data, and how to work on that through the medial directors. Dr. Ashley states that Mr. Pettyjohn, and he were invited to Region 1, which is in the Northwestern part of the state, to explain regionalization, and what we are doing at the Commission level with trauma regionalization in our pilot projects. They were very happy with the Regional Trauma Advisory Committee's and their plans, and during that meeting they Region 1 voted to start the process in forming their RTAC. The Atlanta Region 3 is also starting to entertain the idea of coming into the system as well. We are starting to go to the next level, and Dr. Ashley thinks all that is good, and the Commission will keep pushing in trying to get everything online.

Appreciation of Kelli Vaughn and Rich Bias

Dr. Ashley states that we have two Commission members rotating off today, and we want to recognize them. Dr. Ashley thanks Mr. Rich Bias, and Ms. Kelli Vaughn for all their hard work, and each is presented with a plague in appreciation for their extraordinary record of achievement, and support in the development of the Georgia Trauma System.

Welcome New Georgia Trauma Commission members

Dr. Ashley welcomes Dr. Robert Cowles, and Dr. Fred Mullins and asks them to take their seats with the Commission.

Quorum established

Dr. Ashley asks Mr. Alex Sponseller if quorum has been established. Mr. Sponseller replies, " quorum is established". Dr. Ashley states that he will delay the election of officers until Dr. Haley is on the conference line.

APPROVAL OF THE MINUTES OF THE 15 September 2011 MEETING

The draft minutes of the 15 September 2011 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 2011-11-01:
I move that the minutes of the 15 September meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Mr. Bill Moore**

DISCUSSION: None

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

AGENDA AND ADMINISTRATIVE REPORT REVIEW

Mr. Jim Pettyjohn states that the Administrative Report was posted on the Commission's website yesterday morning, and the Commission members were provided copies of that today.

Mr. Pettyjohn states that the Super Speeder revenues for the period of July 2011 through October 2011 have increased over the amount of Super Speeder revenues from last year, 5.5 million verses 3.7 million respectively. We hope that they will continue in our budget for FY 2013. When the governor releases the amended FY2012 budget in January we hope we will not get a cut of additional funds.

Dr. Ashley states that it looks like we are projected at 16.5 million, and thinks that we are on target for that.

Mr. Pettyjohn states that yes we are on target for that, but remember we are only four months into FY 2012, and he thinks state revenues overall are up 6%.

Ms. Linda Cole wants to know since Super Speeder is tied to the Trauma Commission if they collected more money than we had budgeted would we get those extra dollars?

Mr. Pettyjohn states that we did not get them last year, and we asked the Office of Planning and Budget about that, and we were told that it would take a special action from the governor to do that.

Dr. Ashley states that last year the projected Super Speeder revenues were 10.5 million, and then they actually came in at 14 million, but we did not have the mechanism to obtain those extra dollars. We need to watch that this year, and approach the governor, and legislature, and if there are any extra funds they need to come to the Trauma Commission.

Mr. Pettyjohn states that the governor is going to be releasing his amended FY 2012 budget in January, and he thinks that they are probably working on that now, and this might be the opportunity to get the word to him.

Mr. Pettyjohn states that in the Administrative Report is a spreadsheet showing the outstanding non-hospital contracts. Zoltrice, LLC, formally Broselow Luten Solutions, LLC the safe dose for pediatric dosing, safety software, that is in all the trauma centers, and will be rolled out into Region 5 & 6 hospitals. The safe dose hand held software is being provided free of charge to all the EMS medics in Georgia. We have extended that contract to the end of June FY 2012 in order to allow them to do some live hospital trainings, as well as write their EMS report. Mr. Peter Lazar with Zoltrice and Dr. James Broselow will be at the annual Commission meeting in January to provide an update on our investment of $250,000 over the last two years.

The Turner County EMS, is an ambulance replacement grant, they have their work plan in place, and will be invoicing soon.

Emanuel Medial Center, which is a new trauma center start-up grant, has been extended through the end of this physical year allowing them to schedule their survey visit.

Wellstar Foundation, is a new trauma center start up grant, which went to Kennistone. They have satisfied all their requirements for the new start up grant with designation, and we should be closing that invoice out as well.

Wills Memorial Hospital is a new trauma center start up grant, and they anticipate to have their designation survey by the end of this calendar year, and will close that invoice out as well.

The Zoltrice LLC, which is additional funding, and is an additional contract with the same deliverables, but in a different physical year.

Mr. Pettyjohn states Georgia Association of EMS is GAEMS first responder grant training, and he is working with Courtney Terwilliger, and his group and they should be invoicing for those dollars in the next couple of weeks to provide first responder training throughout the state.

GTRI shows $906,000 outstanding dollars, but it is really about $806,000, and all of that money is accounted for. It is for furniture, software, a generator, and its installation, hardware and other equipment for the TCC. We will probably have a $100,000 left over after we completely operationalize the TCC, and that will go for labor, and software enhancements as we identify those needs.

The Heartland County, Lumpkin County, Wilkinson County, Glascock, and Emanuel County EMS grants are all ambulance replacement grants. Ms. Lauren Noethen is working with them to get their paperwork in, and ensure that we have a quality work plan in place that reflects all the work that they are going to be doing to get those grants.

Bishop & Associates provide technical support to the Commission, and did our financial assessment last year of the hospitals. The Georgia Trauma Commission staff will be taking over the financial assessment of all the trauma centers going forward, and we have a transition in place for that. Bishop & Associates are also working to do a national financial survey of burn centers. Mr. Greg Bishop will be with us at the Commission's January Workshop in Rome, GA to present his Burn Center Assessment Survey for discussion.

Gifford Hillegass & Ingwersen audits the hospitals and EMS audit procedures. The first phase has been accomplished; all the hospitals have been audited. There does continue to be some fall out to the uncompensated care claims. Mr. Pettyjohn states that eight of the hospitals have been asked to go back and scrub their data to make sure that they have identified claims that meet Senate Bill 60 criteria, as well as the clarification of those criteria that were given through your Commission meeting March of last year. They also did a survey of all the trauma centers physician's funding distribution process, and will have that report as well. EMS identified ten services from the FY 2010 and EMS uncompensated care program, and they have asked some pointed questions as to how they identified their claims, what processes they used to submit those claims, and if they were able to receive any funding back from those claims since that submission. GH&I will be presenting their report at the January Commission meeting as well.

Mr. Bill Moore wants to know if Gifford Hillegass & Ingwersen auditing of the EMS is new this year.

Mr. Pettyjohn replies, "yes it is", and it is just fact finding, and hopefully will help us move forward with our EMS Uncompensated Care Program.

The DPH/OEMS/T the Senate Bill 60 provision of up to 3% that is $489,000 of which they have invoiced for the first quarter, and you can see the remaining dollars.

The Moa Department for the Department of Public Health, that is for Ms. Judy Geiger's office space rental, and telephone, and that is about $1,642.22 a year.

The Trauma Associates of Georgia, which TAG is a direct grant award for an AAAM course. Mr. Jim Pettyjohn states that all the trauma centers had representatives their of success, and there is going to be two or three rural trauma team development courses planned for the year as well.

COMMISSION BUSINESS OPERATIONS REPORT

Ms. Judy Geiger goes over the Commission's Business Operations Report starting with page 7 *(Report attached to the Administrative report)*. Ms. Geiger states that she would like to give a general overview of how we got to this point. During the August Commission meeting, she provided information about the Strategic Planning piece, Program Performance Measures, and Zero Based budgeting, and how all three related to Program Based Budgeting in the state of Georgia. All three are tied to program based budgeting, and they help the governor and legislature determine funding levels. For the strategic planning piece we were tasked to develop and enter our 3-5 year strategic plan into the states database, which is called Horizon. Mr. Greg Bishop, from Bishop & Associates for the Commission, developed the strategic plan. This plan contains the Commission's goals and strategies to achieve those goals. The Commissions goals align with the state's broad goals of a healthy Georgia, and that is one of the criteria in all of the states budget programs. Since that time OPB has reviewed and thanked the Commission for

the amount of time spent on the Comprehensive Strategic Plan. As a way to monitor progress towards reaching the goals outlined and the Strategic Plan, the performance measures are developed. We were tasked with developing 3 overarching performance measures for the Trauma Commission, and this assignment was given to us by OPB. It was unique to us because existing state budget programs had their Performance Measures developed for years, but because the Trauma Commission's budget was sitting within a Public Health program until 2011 the Commission did not have to create its own performance measures. This year OPB requested that we do so. To get direction because it was something new to the Commission, Mr. Jim Pettyjohn and I met with Ms. Alice Zimmerman, the Strategic Planning Coordinator for OPB, and Ms. Paula Brown who is the OPB analyst. They gave us some guidance on how to develop our performance measures. Ms. Geiger states that page 7 contains the results of the overarching 3 performance measures that were submitted to Ms. Alice Zimmerman, and Ms. Paula Brown, and these were the 3 measures that were entered into the states system called Budget Tools. Budget Tools is where they enter the proposed cuts, as well as the performance measures. It is a data based system for OPB to develop their report to the governor for all the budget programs within the state of Georgia.

Ms. Geiger states that page 8 is the Performance Measures by budget area, that we were requested to complete by Ms. Paula Brown, because she selected the Georgia Trauma Commission as the budget that she would present for the ZBB initiative. Ms. Geiger states that in the beginning Jim and I thought that the ZBB initiative was to develop the Trauma Commission budget from zero up, which we already do, and in later discussions with Ms. Brown we found out we were to present these performance measures by budget area, and in turn Ms. Brown would present a report for review to the House of Senate Budget Offices. Ms. Geiger states that to her knowledge she thinks that has been completed. The last discussion that Ms. Geiger, and Mr. Pettyjohn had with Ms. Alice Zimmerman indicated that the house and senate budget offices in OPB were all still reviewing the performance measures, and they would come up with their recommendations and let us know something by Thanksgiving. Ms. Geiger states that she spoke with the public health budget director Ms. Dionne Denson to see what her experiences were with performance measures in the past, and she told her that normally you present your performance measures and they are reviewed, then they come back with a recommendation to either eliminate some of them, modify, or request new ones. As soon as Ms. Geiger, and Mr. Pettyjohn find out this information they will pass it onto the Commission.

Dr. Ashley states that this is so new we are basically just into the point of making sure we pick the right performance measures that they want to see.

Ms. Geiger states that is correct.

Mr. Pettyjohn states they shot several performance measures out to them, and these were these 3 were the ones that were chosen.

1. **Effectiveness:** Number of EMS Regions (out of 10 possible) participating in trauma system regionalization activities.

2. **Efficiency:** Average time in minutes, and by Injury Severity Score for a Trauma System patient to reach definitive care from scene of injury

3. **Workload:** Number of First Responders Trained using Commission Funding

Dr. Ashley thinks that the Effectiveness measure is a good one because that is where the Commission is trying to grow. He also thinks the Efficiency measure the average time in minutes to definitive care is what the Commission is all about. Dr. Ashley states that we need to get a number, and then we should start seeing that number come down.

Ms. Linda Cole sees that there are two variables, minutes and ISS score, and wants to know if we are eventually going to pick an ISS score.

Mr. Pettyjohn states that we hope to accomplish that through the Communications Center by assigning a unique identifier number on all patients, and tracking those numbers through to the Trauma Center to find what their ISS score is. The time they arrived on the scene, and the time they arrived at definitive care. This is all built into the TCC software.

Ms. Cole wants to know how that information is going to narrow it down to one number.

Mr. Pettyjohn states that they will have multiple numbers by groups, and it can be queried out.

Dr. Ashley states that it is worded a little bit funny in a sense that the average time in minutes, and by injury severity scores for a trauma system patient. Dr. Ashley maybe it should say something like the average time in minutes for any given severity injury score, because that is what you are doing. You are looking at the different levels of sickness, and them looking at the time frame. This will show us if we are making a difference, and them we can eventually tie that into mortality, and mobility.

Ms. Cole wants to know if there is any way we can get pre-going live with the TCC, and post going live with the TCC information.

Dr. Ashley states that is something state experts could help us do. Dr. Ashley wants to know if there is any way we can get a number working with hospital data banks, population data banks, state data banks or state registry to get an idea how long it takes the patients to eventually get to the trauma centers. How long did it take them from the scene, to the hospital, and then to the trauma center? Not all trauma patients just the ones we are looking at. Did they get from the scene to the trauma center in 57 minutes or 32 minutes? That is the kind of impact we want to show, but we do not have that initial information upfront, and there should be someway to get that data.

Ms. Rana Bayakly states she actually had this discussion yesterday, and wanted to talk more with the EMS group, and then come back to see if we are able to that. Essentially the way she sees it at this point is that we each have these data systems, but they do not talk to each other. There is no common field that allows them to talk to each other. At this time we are looking at the hospital discharge, and the trauma registry.

Mr. Pettyjohn states that the TCC is hoping to increase the time from field to definitive care as well as to the community hospital and then to definitive care.

Ms. Cole states that she understands that, but if you have the pre-TCC data then you have data to show that we decreased the time that the patient reached definitive care.

Mr. Pettyjohn states that he thinks the effectiveness of the TCC will be proven with the information from day one, year one, to day one year three.

Dr. Ashley asks Ms. Debra Kitchens, "what data do we have that enables each trauma center in their local region to know that flow of patients, and those time frames?

Ms. Kitchens states that the problem with having the viewer query 30 patients is that initially she may not have all of the EMS PCR'S, but we could obtain them with a little work. One of our problems has been getting the PCR'S from EMS. Ms. Kitchens states that out of 30 patients right now she can safely say that she has at least 20 PCR'S. So she is going to have from scene time, or transfer time the ISS scores, as are the majority of the trauma centers in the state of Georgia.

Ms. Renee Morgan states that at one time Ms. Kitchens was asking about the initial transfer, and if it was to a rural facility, and not a designated center. What was the time frame from the initial injury to that center, and then to the designated trauma center? Ms. Morgan states that she does not have a linkage to that. Those are the kind of things that we are looking to work on with EMS, and hopefully get that

initial call time where they may have went to another center, and them ended up at a designated trauma center.

Ms. Linda Cole thought that had been figured out. For example, if the original ambulance took the patient to a non-designated center, and that patient turned out to be a trauma patient they could get reimbursement as an uncompensated patient. Ms. Cole states, so we figured it out in one way.

Ms. Morgan states, "yes", but we have just not connected all the pieces.

Dr. Robert Cowles wants to know why patients are going to non-designated trauma centers and then having to be transferred, when we have designated trauma centers?

Ms. Renee Morgan states that we do not have enough designated trauma centers. Currently if you count the Burn Center and the pediatric centers we have 20 facilities that are designated in Georgia. We have a lot of areas where patients go to good quality hospitals, but those hospitals are not participating in the designation process, because it is a volunteer process.

Mr. Cowles states that unfortunately he would also presume they might go to some rural hospitals that are not good quality.

Ms. Morgan states that is correct, and a lot of it depends on the location of where the call starts, and what the needs of the patient are. Sometimes they have to be transported to a local facility just to be stabilized, and then transferred to another facility.

Dr. Ashley states that there are areas of the state especially south Georgia where we do not have the coverage, areas where we do not have the capability to get patients quickly from the scene of the accident, straight to the trauma center. We need to get some hospitals to step up to the plate, come into the system, and do what they need to do to meet the designation process. That is what we are doing with our regional plan. We are trying to get those plans written to make all that happen. You are going to hear Region 5's pilot plan today, which is the Macon area, and the 23 counties.

Dr. Cowles wants to know because we are stipulating times from pick up to delivery are we are proving that has positive performance in regards to outcomes. Is the Commission asking for funding based on something that we do not even know about?

Ms. Morgan states that question is still in the investigation process. We have not been able to achieve the answers to those questions because there has been no funding to move forward with the programs in the past. Up until 2002 we had no concise state registry for the trauma patients to enter into. We had several different programs working at the same time. Even though we had a data set that all the information was going into, actually up until the past 18 months or so we had the data there but we had no concise analysis of the data other than what we could do ourselves. We recently brought on an epidemiologist to assist us with that data profile and set. Georgia is not unlike a lot of other states in the fact that our EMS and our trauma system data do not merge. Ms. Morgan feels like we are a little bit ahead of the game then most, because we have started producing reports to the Commission from our registry, and the individual trauma centers produce reports from their registry. So we can backup some of our information that we are putting out, but there is still a lot of definitions that we just do not have the answers to, because we have not been able to proceed with that investigation to the extent that we need to.

Dr. Cowles states that if he was to go to the Capital and ask for more money, and they say can you prove to me that what you are doing works, I do not have any prove at this moment it time that it works, is that right?

Dr. Fred Mullins states that you can look at national data, and it shows that it does work.

Dr. Cowles states that we just do not know about the pick-up to delivery time.

Dr. Ashley states that we do have the data, and they're a lot of pieces to that data. Number one is that we do have Georgia data, in the sense that Dr. Pat O'Neal as this data in the Department of Transportation. For motor vehicle crashes if you put the trauma center at the epicenter of the circle and as you move out in that concentric circle the death rate goes up. So yes we do have data to show that the further you get from the trauma center, and you can say is that miles or is that time, well they are equal, if it takes you longer to go 20 miles then it does to go ten miles, so we can equate time and distance at the same time. Then you have the Birmingham data, which is getting the patient from the scene bypassing the smaller hospitals that does not have the appropriate surgical staff, and going straight to the trauma center. They did show a 12% decrease in mortality, and it went from 16 days length of stay down to 12 days, for injury severity score greater than 15. So we do have data, and then as far as what you have found in Houston as far a trauma center, the New England Journal of Medicine article of 2006 showed where they looked at a large number of trauma centers, non- trauma centers in about 18 states, and there was a 25% reduction in death, if you went to a trauma center verses non-trauma center. Dr. Ashley states that when Dr. Cowles goes to the legislature he can give him that data, and you can really speak boldly about what we are doing. Dr. Ashley states that he can not say that doing his plan in Region 5 that he has that data show the they made a difference, because that plan has not been put into action yet, and that his why they are doing that plan, because he wants to show that they made a difference.

Ms. Rana Bayakly states that they actually have a couple of initiatives in order to respond to some of these questions. Number one is that we try to link the trauma registry data with the EMS data, and the hospital discharge data. We know there are common fields between these sets, but unfortunately they are not all populated. So it is really hard to link, but we are going to figure out a mechanism to link that information. The second initiative we are doing along with our epidemiologist is looking at the areas where there are no designated trauma centers for 100 miles, and look at those patients, and their outcome through the hospital discharge data. We will compare that data to the patients who going to the trauma registry, and look at their survival, and how well they are doing. It will be reason to encourage the facilities in those areas, which is essentially the southeast area of Georgia to have more designated trauma centers. I think we will be able to answer those questions in the near future.

Dr. Mullins wants to know if we can just add the fields to the trauma registry.

Ms. Bayakly states that the field is there it is just not populated. Which means that there is the trip report, but it is unknown in the majority of the cases. The trip report would link the data from the trauma registry to the EMS system.

Dr. Mullins states that all patients come in with a trip sheet, and wants to know why the registrar in each hospital couldn't get that data and enter it in. You may have to call the trauma center and get it.

Ms. Morgan states that it is a difficult situation, because it places added burden on the trauma coordinator, to call and track that information down. Some hospitals have a good system where it is electronically submitted into the hospital database, but there is still quite a disconnect, in that it is a constant moving target.

Dr. Mullins thinks that most systems are electronic.

Ms. Morgan states that she thinks that we still have a few rural areas that are not electronic.

Mr. Keith Wages states that we do not accept data in any other form.

Dr. Mullins states that it maybe there is someway to link that information so you can look it up and add it in to the report. The time of the accident, the time of the EMS arrival, and the time of arrival to definitive care.

Dr. Ashley states that information is going to be the key to everything that we do, we need to have that number. Dr. Ashley asks Ms. Debra Kitchens, and Ms. Regina Medeiros if there is anything that can be done at the hospital level internally to help out. We just need this number and you need to tell me how to do this, and we need to take action.

Ms. Regina Medeiros states that she knows everyone comes with a trip sheet as Dr. Mullin stated, and we have spent countless hours calling the EMS services to request copies of trip sheets. We recently requested access to the Gemsis system, to be able to login but it is proprietarily owned by each service just like the registry is owned by each hospital. It would be a matter of getting access to get the specific data elements from the trip sheets. Ms. Morgan does not know if that will come about as it is an individual negotiation from the hospital to each individual EMS provider, and whether they will allow us to do that or not. Sometimes we get the trip sheets but the dispatch times are blank.

Dr. Ashley wants to know if the coordinators could find number **1.** The patients that were transferred. 2. What region did the accident happen in? **3.** What time were they injured? Then all that you would need to know is the time that they were injured to the time that they got to the trauma centers door. If that is 2 hours then that is the only number needed. Then you just add it up and divide and we have our number.

Ms. Medeiros thinks that we can do that, but there are so many variables in looking at injury types, were they entrapped, how long did it take to get them out. Ms. Medeiros thinks that picking a pure number based on ISS scores, and times for transport is not really going to get it. Just because historically if you do a three-month retrospective review of transports from the field, how are you really going to say that it is the same situation, and that you reduced the time to definitive care. Ms. Morgan feels we need longitudinal data to really show a true decrease as opposed to a snap shop of data. We are trying to show whether we can show a definitive change putting our regionalization plan in place and utilizing the TCC.

Dr. Ashley understands that there is some variances scoop and run, entrapped, but if you look over 6 months period it should balance out.

Ms. Morgan states that she would like to propose that the trauma coordinators meet in the next couple of weeks with Ms. Regina Medeiros, and Ms. Debra Kitchens help, along with EMS to do a brainstorm on how to approach this problem. Then at the Commission meeting in January we can bring an outline that will that you know our obstacles have been, what our course of actions will be, and present the Commission with a clearer definition.

Dr. Ashley states that is a good idea lets do that.

Ms. Judy Geiger continues with the performance measures with the Commission Operations Measures Page 8. This measure is the number in days required to have grants and contracts executed. Mr. Pettyjohn and she felt this was very important, because in the past we were supported by DHR, and DCH state agencies in executing contracts. The data you really see from FY 2010 is DHR and the FY 2011 is DCH. If you turn to page 6 this spreadsheet outlines the hospital contracts that the Commission staff has been executing this year, and at the bottom there is a summary of the total number of days, number of contracts, and the average day of execution, which is 14.3, and a marked improvement since bringing the contracts process and execution in house. (*Hospital Contract Execution Tracking for SFY 2012 attached to Admin. Report).* We are also getting the money out to the Trauma centers quicker. The rest of the performance measures are the System Development/Access/Accountability, and the Stakeholder Support also explained on page 8 of the Administrative Report.

Mr. Bill Moore wants to know if all entities contracting with OPB, and funded by OPB are required to establish these measurements.

Ms. Geiger states that yes every budget program within the state of Georgia is required to submit these measures. The House, Senate, and the Office of Planning and Budget Services review the measures, and come back with recommendations.

Ms. Geiger continues with the Expenditure Report on page 9, which is a summary of the budget with the 2% cuts, and the expenditures to date. Expenditures include purchase orders, which have taken the money out of the budget and are waiting for payments, and also actual checks and electronic transfers sent out to vendors.

Mr. Pettyjohn states that we are having a complete hard budget review in January where we will identify funds that can be appropriated to other program areas. We will present that review at the January Annual Commission Workshop, and we may have additional funds for stakeholders.

Ms. Geiger states that on page 10 an adjustment was made. The staff cell phones of which there was $15, 000 budgeted in the TCC budget was moved. That $15,000 was moved to the Operations Budget to so we could pay for all the staffs cell phones.

Mr. Pettyjohn states that these budgets that we proposed for the TCC as well as operations were done when there were just two of us, myself and Ms. Lauren Noethen. As we have grown Ms. Geiger came on board and the staff was hired for the TCC to get that up and running. It may look kind of silly right now that there was so much money put aside for something that should not of had so much money put aside, but again we are going to re-adjust those dollars in January, and come back to you with more realistic numbers.

Ms. Geiger states that we are on target with our budget and we look good right now.

Ms. Geiger continues with the Trauma Communications Center Operations on page 11. Ms. Geiger states that we have executed most of these contracts. Some items we have not started paying for because they are in the existing contract with Georgia Tech Research Institute. The $75,000 we have earmarked for enhancements, and we may end up using contingency funding, and other funding to raise that depending on what the enhancements end up costing. We are partnering with the Department of Administrative Services right now in order to be able to do the enhancement as a Sole Source to SAAB of North America.

Ms. Geiger continues with System Development, Access and Accountability page 12. We have executed all the contracts accept the contract with Georgia Tech Research Institute, and we are working on that now, but first we have to pay out the contact that ends in December 2011, and then we will be starting a new contract with them January 1.

Mr. Pettyjohn states that we still have money left over in the existing contract with GTRI that is going to be extended to June 30th. In January we will talk about what money is left over and we will had identified the deliverables for all of our contractors and vendors to perhaps use that money, and it will be the Commissions decision on how to proceed.

Ms. Geiger continues with EMS Allocation Report on page 13. Ms. Geiger states that we do not show a lot being spent here, as everything is in the works. Mr. Pettyjohn and she will be taking over the EMS Uncompensated Care from Ms. Regina Medeiros. Ms. Lauren Noethen has been working on the FY 2012 EMS Vehicle Equipment Replacement Grants.

Mr. Pettyjohn mentions that the FY2012 EMS Vehicle Equipment Replacement Grant Application was posted to the Georgia Trauma Commissions Website last week, and we will be taking applications for that beginning tomorrow, and will be open for about 45 days. There will be 17 awards, at $70, 052.00 each. The Commission has the opportunity in January to add additional ambulances to the grants, if we have funds left over. That is the opportunity of redirecting the funds after a hard budget review in January.

Ms. Geiger continues with page 13 with the First Responder Training Courses.

Mr. Pettyjohn states that regarding the First Responder Training Courses hopefully we will have an EMS Subcommittee meeting the first week or so in December, and provide the EMS Subcommittee with that plan.

Ms. Geiger states the last page is the contract with the Office of EMS and Trauma Allocation on page 14. They have invoiced, and we have paid 25% of that.

Dr. Ashley confirms that Dr. Leon Haley is on the Conference line.

Election of Officers (Vice Chair and Secretary/Treasurer)

Dr. Ashley states that Dr. Fred Mullins, and Dr. Robert Cowles are now seated at the table. Dr. Ashley states that according to our bylaws it is time to elect new officers. We have two positions, and one is Vice Chair and the other is Secretary of Treasury. Ms. Linda Cole who is the current Secretary of Treasury has been nominated for a second term, and Dr. Leon Haley has been nominated as Vice Chair. Dr. Ashley opens the floor again for any other nominations or discussions.

DISCUSSION : None

MOTION GTCNC 2011-11-02:
I propose that Dr. Leon Haley be nominated for Vice Chair of the Georgia Trauma Commission, and Ms. Linda Cole be nominated for Secretary of Treasury of the Georgia Trauma Commission

MOTION BY: **DR. DENNIS ASHLEY**

DISCUSSION : None

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

TRAUMA COMMUNICATIONS CENTER REPORT

Mr. Jim Pettyjohn states that we have moved forward and great way since the last Commission meeting towards getting the TCC up and running. Mr. Jim Pettyjohn states that he temporarily moved to Forsyth Georgia in October to coordinate the startup of the TCC. He received a call from Ms. Michelle Martin who had been speaking to some folks previously about a job at the TCC. Ms. Martin met with Mr. Pettyjohn and he hired her on the spot. Ms. Martin previously worked with Butts County 911 dispatch. After that Mr. Pettyjohn spoke with Mr. John Cannady who he had previously interviewed for the position of TCC Coordinator when the job was originally posted. Mr. Cannady was currently in a position working for the Department of Revenue, but was still interested in the TCC position. Mr. Pettyjohn then bought Mr. Cannady on board. Since that time it has been a wonderful experience to see the team grow with Mr. Cannady's leadership, and his partnership with Ms. Martin. Mr. Pettyjohn reminds everyone that the TCC Open House is after the Commission meeting today, and hands the meeting over to Mr. John Cannady.

Mr. Cannady states we have made a lot of progress in the month and 1 week since he has been at the TCC. He been traveling around and speaking with people and getting their thoughts on the TCC, and answering questions concerning what the TCC is, and where it is located. Mr. Cannady will answer a few of those questions today with his Power Point Presentation *(Power Point Presentation attached to the meeting minutes)*. Mr. Cannady states that the TCC operates under the theme of getting the right patient, to the right place, at the right time. We are somewhat of a gateway into the trauma system, and the keeper of that update information that can assist the EMS, and rural hospitals that are requesting transport to a designated trauma center. The TCC is centrally located in Forsyth on the campus of the Georgia Public Safety Training Center. We are not a dispatch center; the various 911 centers throughout the state will maintain that 911-dispatch role. When someone calls we do not force a transport decision

on anybody. We are there to provide a service to EMS, and to those hospitals that need transport of a trauma patient. We respect the decisions that get made in the field, and the necessity to keep those decisions in the actual hands of the providers. We do provide recommendations, getting the sickest of the sick to the most appropriate designated trauma center. That is the main focus of what the TCC does.

Mr. Cannady states that the great thing about the software that the TCC is using is that the hospital does not have to download any software to their computer. We are a web-based system, which makes it very easy to use and very user friendly.

Mr. Bill Moore asks Mr. Cannady if this system is just for the EMS or is it available to hospitals that may be looking to transfer patients.

Mr. Cannady states that it is available to the participating hospitals within each region, and all designated trauma centers within the state of Georgia.

Mr. Cannady states that all the full-time staff for the TCC has been identified. Ms. Michelle Martin is the Operations Specialist. Ms. Martin has been coordinating information from various hospitals within the regions. There are eight full-time agents, and two part-time agents. The minimum staffing will be two agents on shifts 24 hours a day. That is the beginning minimum staffing, with the ability to evaluate that as we progress. The agents have been rotating into the TCC conducting training, and assisting with the system testing. There has been scenario-based training, enabling them to learn what they are going to be hearing from the EMS units at the scene and they have been in-putting that into the system. Some areas for software upgrades have been identified, and that would not of happened without the agents running through the scenarios, and running through the system.

Mr. Cannady states that there is a target date for our first call towards the end of November/ first part of December, and we are on track to hit that date. At a bare minimum what we need for that to happen is for all the designated trauma centers to have their CPU's in place, and have received their training on the TCC system. As soon as that happens we will release the TCC contact information, and as that progresses and moves forward we will continue coordination with the RTAC's to get the CPU's into each participating hospital. We will also through the RTAC's begin the training process for EMS.

Mr. Kurt Stuenkel wants to know if the connection to EMS in the field is via radio, or cell phone?

Mr. Cannady states that they have a state toll free number; free mobile-to-mobile, as well as SouthernLinc capabilities, and a limited range VHF hear system.

PROPOSED TRAUMA SYSTEM ENTRY CRITERIA CHANGES

Dr. Ashley states that when they stated the regionalization process, we decided to come up with the TSEC criteria, which are the triage criteria for how to enter patients into the system. This was from the CDC, and the American College of surgeons criteria that is well-established state and nationally, and recognizes what a severe trauma patient is, and whether they should go to a trauma center. It is broken down into four categories, 1. Physiologic 2. Anatomically 3. Mechanism of injury 4. Co-morbid factors. We made some minor provisions, and you will see those listed in red on page 15 *(Primary Triage Decision Scheme Georgia Trauma System, Attached to the Admin. Report)*. If you would like to see exactly how it reads before the provisions see page 16*(Report Field Triage Decision Scheme: The National Trauma Triage Protocol attached to Admin. Report)*. As we formed our RTAC's in two regions, and had multiple discussions with stakeholders, hospitals, physicians, and EMS we found that a lot of ambulance services are already using the basic CDC criteria, and Region 6 has developed their plan with the CDC criteria. Dr. Ashley states that because of these minor provisions that have been made it causes some confusion when going out to educate the hospitals. We have to state that we almost use CDC criteria. It would be easier to educate the masses if we just went strictly with the CDC criteria, because that is what is accepted nationally.

MOTION GTCNC 2011-11-03:
I PROPOSE THAT THE COMMISSION ACCEPT THE CDC CRITERIA AS IT WAS WRITTEN.

MOTION BY: **DR. DENNIS ASHLEY**

SECOND BY: **MR. BILL MOORE**

Mr. Pettyjohn states that he would like have that motion amended to state that the Commission will utilize the CDC trauma triage criteria as CDC has it at any given time as our TSEC criteria. That way the Commission would not have to come back and vote to approve any changes in the future.

MOTION GTCNC 2011-11-04:
I PROPOSE TO AMMEND THE MOTION TO READ THAT THE COMMISSION ACCEPTS THE CDC CRITERIA, AND THEIR STANDARD REVISIONS.

MOTION: **DR. DENNIS ASHLEY**

SECOND: **DR. ROBERT MULLINS**

DISCUSSION: None

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

RTAC V REGIONAL TRAUMA PLAN PRESENTATION

Dr. Ashley states that this is a big day for our region, Region 5, as Ms. Kristal Claxton Smith presents our regional plan, hopefully for your approval.

Ms. Kristal Smith states that in building their plan Region 5 traversed much of the same route that Region 6 did. Ms. Claxton states that Region 6 laid out a good foundation for us, and we were able to move forward with their help, and build our plan, which is largely patterned after Region 6. In January an RTAC steering committee was created which included the Council Chair, EMS Program Director from our region, and the Trauma Program Manager. We developed a pilot plan, and the Region 5 EMS council decided to move forward with the plan, and creating our RTAC. *(Region 5 Trauma Regionalization Pilot PowerPoint attached to the meeting minutes)*. We hit the road and traveled throughout our region, and visited pretty much all the hospitals in the region, and EMS Directors. We shared the concept of the Trauma Regionalization Committee, and the TCC. We told them that we would be getting back with them in a couple of months, and we want you to come to the table and participate in developing our Regional Trauma Plan. In August we had our first Trauma Regionalization stakeholders meeting. To start off our meeting the steering committee provided the attendees with an overview of the Trauma Commissions history, and the components of the RTAC Pilot. In that meeting we divided into two working groups, a pre-hospital, and hospital-working group. Our focus of that meeting was to ask these individuals, "What are your barriers to getting your patients to the right place at the right time, quickly, and efficiently"? We identified several barriers, and discussed training needs, and geographic considerations within our region. We used that information to help evolve our Regional Trauma Plan. We asked them to reconvened in September, and in September the Steering Committee took the information that both the working groups had worked on, summarized that information, and we asked them to move foreword and begin drafting our plan. They reconvened for a final meeting in October, and we presented our final draft plan, *(Attached to the meeting minutes EMS Region 5 Regional Trauma Plan)*. The stakeholders decided to move forward with that plan and present it to our Regional Council in October. In that October meeting our RTAC was actually appointed. (Attached to the meeting minutes Region 5 Regional Trauma Advisory Council Members list). Ms. Smith states that we also began working to get our letters of support from our various hospitals, and also rather than ask each EMS provider to come up with a letter of support, we drafted one letter of support which all of our EMS providers, and service directors signed at our Regional Council meetings. Ms. Smith states that here we are now in November, and we are asking that you

review, and adopt our Regional Trauma Plan. In addition we have already begun working with various stakeholders with the Trauma Communications Center to establish some sort of education timeline, to address both pre-hospital, and hospital educational means. We are working together to build a common resource that will be utilized throughout our region to roll out this training. We have developed some standardized training material, and are rolling that out in the coming weeks. That training will also be an ongoing resource for EMS, and hospital providers in our region, so they will be able to update, and orientate staff when needed. Ms. Smith states that every hospital within their region agreed to participate in this program, and the plan development project. In addition we went outside of our boundaries and incorporated into our plan Upson Regional, Crisp Regional, Meadows Memorial, and Emanuel Medical Center. We also have some outlying 911 EMS services that have agreed to take part in this pilot.

Ms. Linda Cole asks if the hospital and EMS providers who are sort of crossing lines to participate in Region 5 pilot will they also be participating in their own regions plan?

Ms. Smith states that they all have voiced plans to participate in their own regions RTAC.

MOTION GTCNC 2011-11-05:
I MAKE THE MOTION AS A REPRESENTIVE FROM REGION V THAT THE COMMISSION ADOPT AND APPROVE REGION V REGIONAL TRAUMA PLAN.

MOTION BY: **DR. DENNIS ASHLEY**

SECOND BY: **MS. LINDA COLE**

DISCUSSION: NONE

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

RTAC VI UPDATE

Ms. Regina Medeiros states that Region 6 has had their two official meetings, and the next meeting is scheduled for December 1, 2011. Ms. Medeiros state that they decided that it was way too much work for 14 members to accomplish or operationalize by themselves so we elected to establish work groups, which are listed on the update page *(Region VI Trauma Advisory Committee Trauma Commission Update attached to Admin. Report page 17)*. As they get started the work groups will meet in between the full committee meetings. Almost all of them have had their meetings, and they will present the objectives of their group, and their timeline that will have measurable goals associated with it to make sure that we keep moving forward.

DPH, OEMS, AND OFFICE OF TRAUMA

Ms. Rana Bayakly states that at the last Commission meeting she presented the pediatric analysis on the disposition for a patient who had a severity score more than 24, and Dr. Ashley was concerned that a patient with an ISS score of more than 24 would be transferred to the floor. The trauma registry staff reviewed the 23 pediatric trauma patients with ISS >24, and had ED disposition to the hospital floor. Based on the review the majority of these cases came from trauma centers that are certified as pediatric trauma, these cases were evenly distributed across all years (2004-2009), and 20 of the 23 cases were discharged home after being on the hospital floor, 2 went to rehab and 1 was transferred to another trauma center. Ms. Bayakly states that she is willing to share with the pediatric centers the patients that have been transported to the floor, with a severity score more than 24, to see if that is an issue or a regular practice.

Ms. Cole states that it would be an interesting case study, because it makes you wonder what was going on with the 23 patients that went to the floor.

Dr. Ashley states that it is such a low number of patients it makes you wonder if it was just a coding error.

Ms. Cole states that is one of the reasons she would like more information, is to find that out.

Ms. Bayakly states that another question that arose from her presentation to the Commission was, "Is travel time on the transfer of a patient increasing the length of the patients stay at the hospital"? This question is one more reason that Ms. Bayakly feels the need to link with the EMS data set, and they are pursuing that. We are working with Dr.Linda Capewell who has access to the 2009 hospital discharge data to obtain information concerning only the trauma patient as defined by the trauma registry. Once we do that then we want to look at the areas on the map that is on the Commission website concerning access of patients with distance from the facility. We will be looking at the area where it is colored white and blue, which are the areas more than 100 miles distance to a designated trauma center, whether in state or out of state. We will be looking at the patient characteristics, as to where are they going. Are they going to a non-designated facility, and then we will look at their outcome, to see if those patients were treated appropriately. We will look at how many more patients we could add to the trauma registry if we had those centers designated.

Dr. Ashley wants to know if you can do that with discharge data.

Ms. Bayakly states yes, but only once we come to the same definition as the trauma registry.

Ms. Bayakly states that she would like to discuss this in detail at the January Commission meeting. We are really pushing to get that analysis by then. At the September Commission meeting we also discussed presenting the data basis that are available at the Department of Public Health, to the Emory Injury Center, and we actually had a researcher that is interested in looking at pediatric cases, and the distance from injury zip code to a facility that they were transported too. Ms. Bayakly states that she and her associates will be doing the study with that researcher. We will be doing two things in that study, one is we looked at that injury zip variable, and it is 50% unknown, so we have 50% of the zip code injury data available, and 50% of it we do not. So the second part of the study involves re-abstracting that field. Ms. Bayakly also wants the Commission to know they created a central newsletter called the RegiStream, it will go to the registry coordinator in each trauma center to give them a quick analysis, and feedback on the submitted data.

Ms. Marie Probst states that Kennestone had their site visit. They have some things that they continue to work on, and we will be returning in six months for a partial visit to be making sure that they are still on target. Everything is going well and moving in that direction.

Dr. Ashley states that Kennistone will become another Level II trauma center in the system.

BRAIN & SPINAL INJURY TRUST FUND COMMISSION

Dr. Ashley introduces Ms. Kelley Mautz from the Brain & Spinal Injury Trust Fund Commission. Dr. Ashley states that our organizations have a lot of common interests, we both want to take care of the trauma patient, and we are both interested in prevention. In order to get to know one another better Dr. Ashley has asked Ms. Mautz to brief the Commission on what their Commissions goals and functions are, and see if there are any efforts the Trauma Commission can collaborate on in the future.

Ms. Kelley Mautz states that the TBI Commission was established through a constitutional amendment back in 1998 by the overwhelming majority of 73% who wanted to create a trust fund to address traumatic brain & spinal injuries. They are paid for through surcharges on DUI fines, 10% to be exact. There is no state revenue that go's into it. Our leadership is solely governor appointed. Ms. Mautz states that half of their folks are from the community of either the injured person, or someone caring for that person, the other part of the Commission is made up from specialists in the field, services organizations and advocacy organizations.

This Commission addresses traumatic brain & spinal injury, not all brain & spinal injury, but just that sustained through trauma. Ms. Mautz states that we do that in order to give those folks affected meaning, and independence in their life *(Traumatic Brain & Spinal Injury Power point attached to the meeting minutes)*.

Ms. Mautz states that there may be ways that the Georgia Trauma Commission, and the TBI Commission can help each other. Our populations that we serve, and our goals that we would like to see for each of those persons affected are similar. Hopefully we could maybe discuss ways to alien our efforts. Ms. Mautz states that they have their infrastructure that provides a lot of different communities that the Commission could get involved in. The Georgia Concussion Coalition in the legislature this next session will require some letters of support, and we would love to have one from the Georgia Trauma Commission, supporting that legislation.

Mr. Bill Moore wants to know if the annual funding produces funding from DUI?

Ms. Mautz states that she thinks when it was started it produced upwards of 8 million, and each year it has come down, dropping dramatically, and we are not sure why that is. We do not know if it is because of pleas that occur, things that are happening within the court system. We are working with our partners in law enforcement to try and understand that process. Ms. Mautz would like to say it is because DUI offences are down, and we will look into that.

LAW REPORT

Mr. Alex Sponseller states that he has no report at this time.

Mr. Sponseller wants to know if there are any bills circulating that were pre-filed for the next legislative session, and if we know of any bills or proposals affecting the Commissions budget.

Dr. Ashley states that he is not familiar with any, and asks the Commission if they are familiar with anything that should be on the Commission's radar screen.

Mr. Jim Pettyjohn states that there was a resolution already last year that is sitting there waiting which is about carving out $10.00 from the existing car tag.

Mr. Sponseller states that he thinks that is still there, and they could take that up again, but a vote would have to be made to do that.

Dr. Ashley states that is the only one he is aware of and he thinks it is still in the senate.

Old business: None

New business: None

NEXT MEETING: Jan 26 & 27 Rome, Georgia

Mr. Pettyjohn states that the January meeting will be to full days, Thursday, and Friday, and we are requesting the Commission to arrive the night before the meeting.

Mr. Pettyjohn also mentions that the TCC is having their open house immediately following todays Commission meeting.

Meeting Adjourned: 1:20

Minutes crafted by Lauren Noethen

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

When every second counts, we are your one call connection to the Georgia Trauma System… providing you with up to the minute information for your transport decisions.

Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION

Who We Are

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Who We Are

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

- The TCC is centrally located in Georgia on the campus of GPSTC in Forsyth, GA.
- We will be staffed 24/7/365.
- We are an integral source of information and a link between providers and Trauma Centers.
- We are dedicated to helping you get the right patients to the right hospital at the right time.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

- We are NOT a dispatch center. We DO NOT dispatch ambulances.
- We DO NOT force a transport decision on units in the field or non-designated hospitals transferring patients.
- We DO provide recommendations for the most appropriate Trauma Center based on your patient status, location, and up to the minute Trauma Center information.
- We DO help you get the right patients to the right hospital at the right time.

Georgia Trauma Commission
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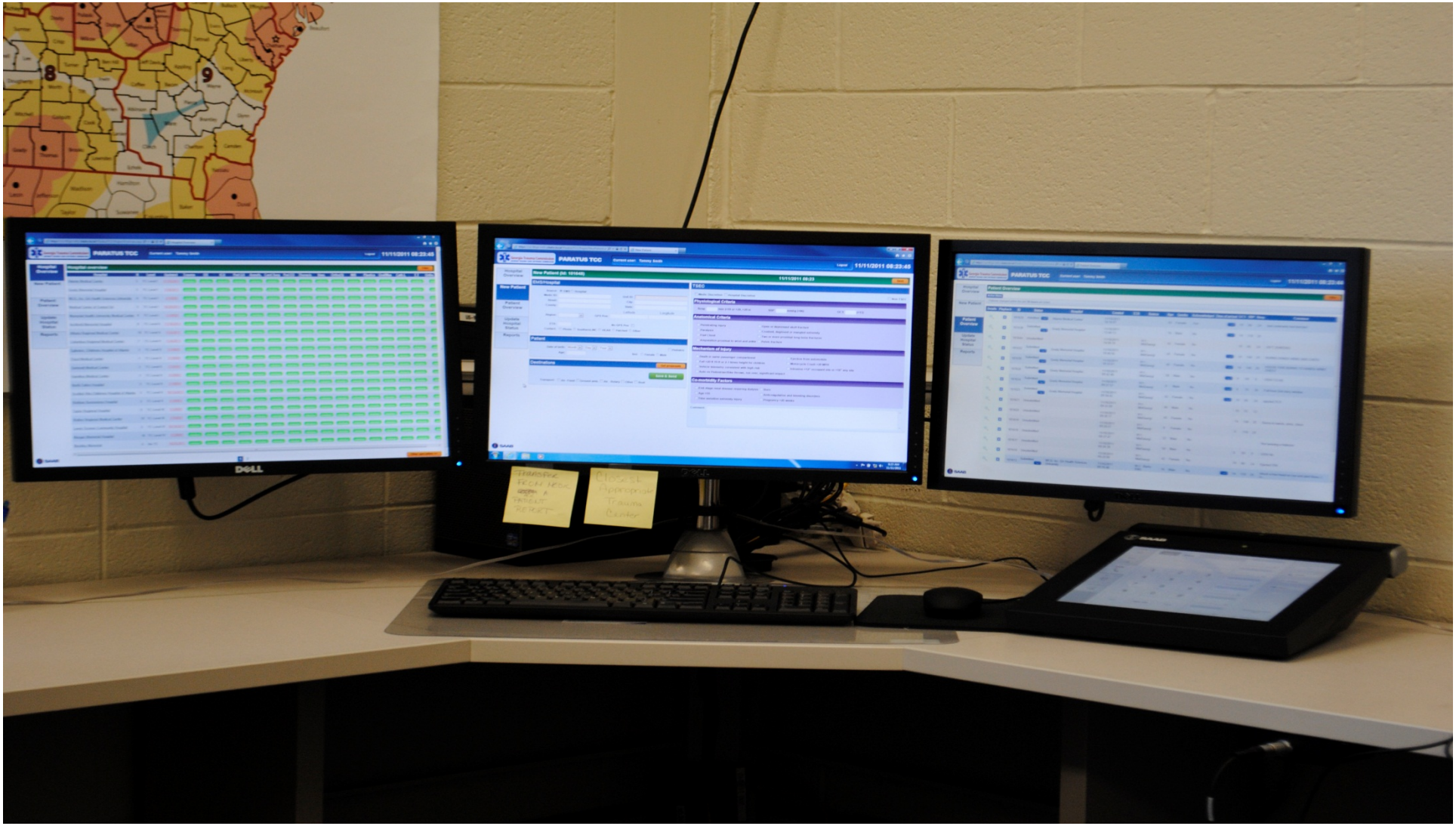
Our Facility

Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION

Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION



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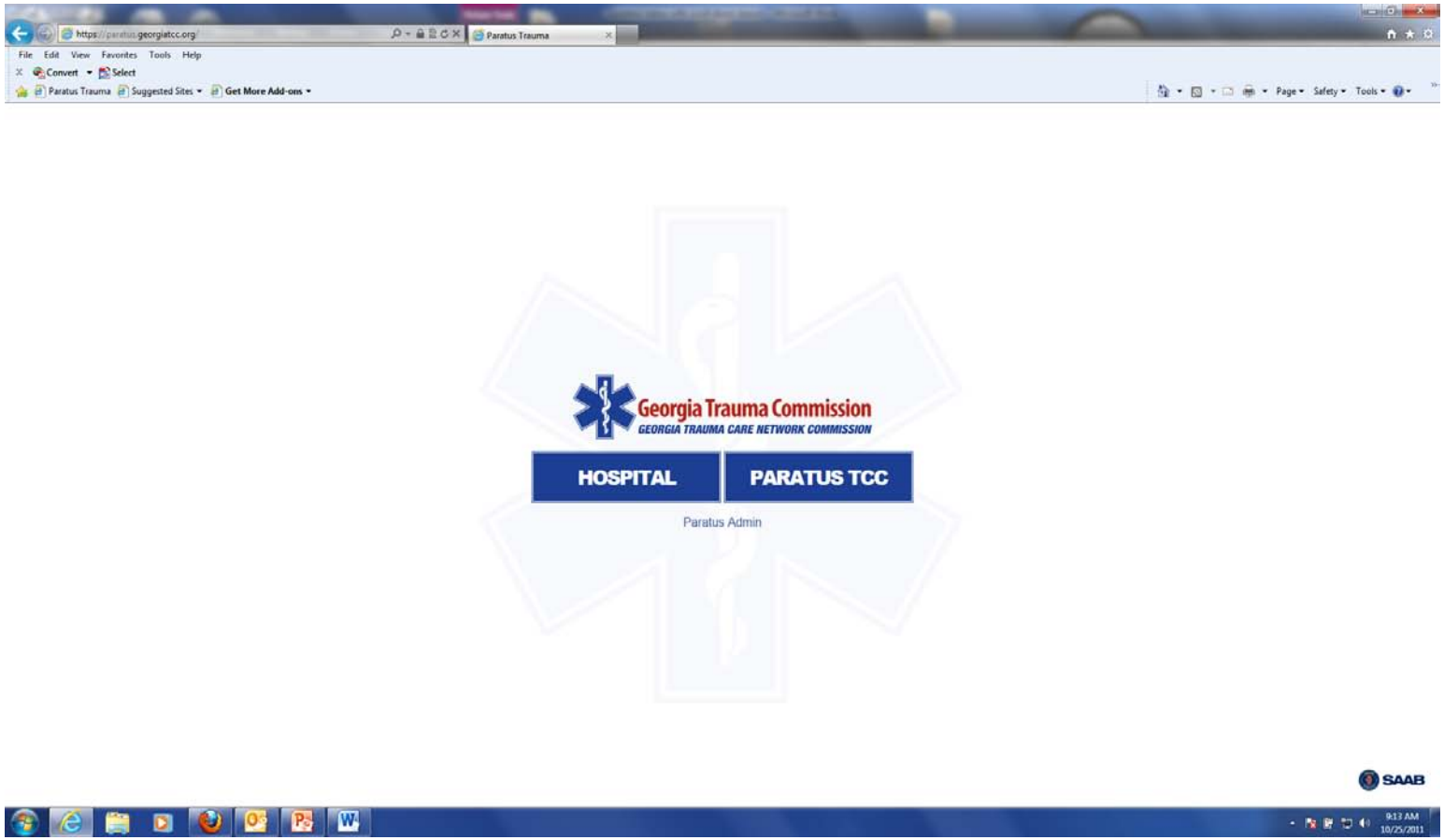
Our Software



Georgia Trauma Commission

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Hospital	R	Level	Updated	Trauma	ER	ICU	Ped GS	Anesth.	Card Surg	Ped ED	Thoracic	Vasc	Ortho(S)	NIR	Plastics	Oral/Max	Cath L	T T	Ortho Trauma
Atlanta Medical Center	3	TC Level I	10/27/2011																
Grady Memorial Hospital	3	TC Level I	10/27/2011																
MCG. Inc Augusta	6	TC Level I	1/1/0001																
Medical Center of Central GA	5	TC Level I	10/28/2011																
Memorial Health University Medical Center	9	TC Level I	1/1/0001																
Archbold Memorial Hospital	8	TC Level II	10/27/2011																
Athens Regional Medical Center	10	TC Level II	10/13/2011																
Columbus Regional Medical Center	7	TC Level II	10/20/2011																
Egleston: Childrens Hospital of Atlanta	3	TC Level II	1/1/0001																
Floyd Medical Center	1	TC Level II	1/1/0001																
Gwinnett Medical Center	2	TC Level II	1/1/0001																
Hamilton Medical Center	1	TC Level II	1/1/0001																
North Fulton Hospital	3	TC Level II	1/1/0001																
Scottish Rite:Childrens Hospital of Atlanta	3	TC Level II	10/13/2011																
Taylor Regional Hospital	5	TC Level III	1/1/0001																
Walton Regional Medical Center	10	TC Level III	1/1/0001																
Lower Oconee Community Hospital	5	TC Level IV	10/19/2011																
Morgan Memorial Hospital	10	TC Level IV	1/1/0001																


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https://paratus.georgiatcc.org/ParatusTCC/Pages/NewPatient.aspx
New Patient
File Edit View Favorites Tools Help
Convert Select
DOAS Fleet Support Servic... Paratus Trauma Suggested Sites Get More Add-ons
Page Safety Tools
Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION
PARATUS TCC
Current user: John Cannady
Logout
10/31/2011 15:56:05
Hospital Overview
New Patient
Patient Overview
Update Hospital Status
Reports
New Patient (Id: 101078)
10/31/2011 15:56
Save
EMS/Hospital
Source: EMS Hospital
Medic ID:
Unit ID:
Street:
City:
County:
State:
Latitude
Longitude
Region:
GPS Pos:
ETA:
No GPS Pos
Contact: Phone SouthernLINC HEAR Patched Other
Patient
Date of birth: Month Day Year
Pediatric
Age:
Sex: Female Male
Destinations
Get proposals
Transport: Air- Fixed Ground amb. Air - Rotary Other Boat
Save & Send
TSEC
Medic Discretion
Hospital Discretion
Non-TSEC
Physiological Criteria
Resp /min (<10 or >29, >20 in
SBP mmhg (<90)
GCS (<13)
Anatomical Criteria
Penetrating injury
Open or depressed skull fracture
Paralysis
Crushed, degloved or mangled extremity
Flail Chest
Two or more proximal long bone fractures
Amputation proximal to wrist and ankle
Pelvic fracture
Mechanism of Injury
Death in same passenger compartment
Ejection from automobile
Fall >20 ft 10 ft or 2-3 times height for children
Motorcycle Crash >20 MPH
Vehicle telemetry consistent with high risk
Intrusion >12" occupant site or >18" any site
Auto vs Pedestrian/Bike thrown, run over, significant impact
Co-morbidity Factors
End-stage renal disease requiring dialysis
Burn
Age >55
Anticoagulation and bleeding disorders
Time sensitive extremity injury
Pregnancy >20 weeks
Comment:
SAAB
3:56 PM
10/31/2011

Georgia Trauma Commission

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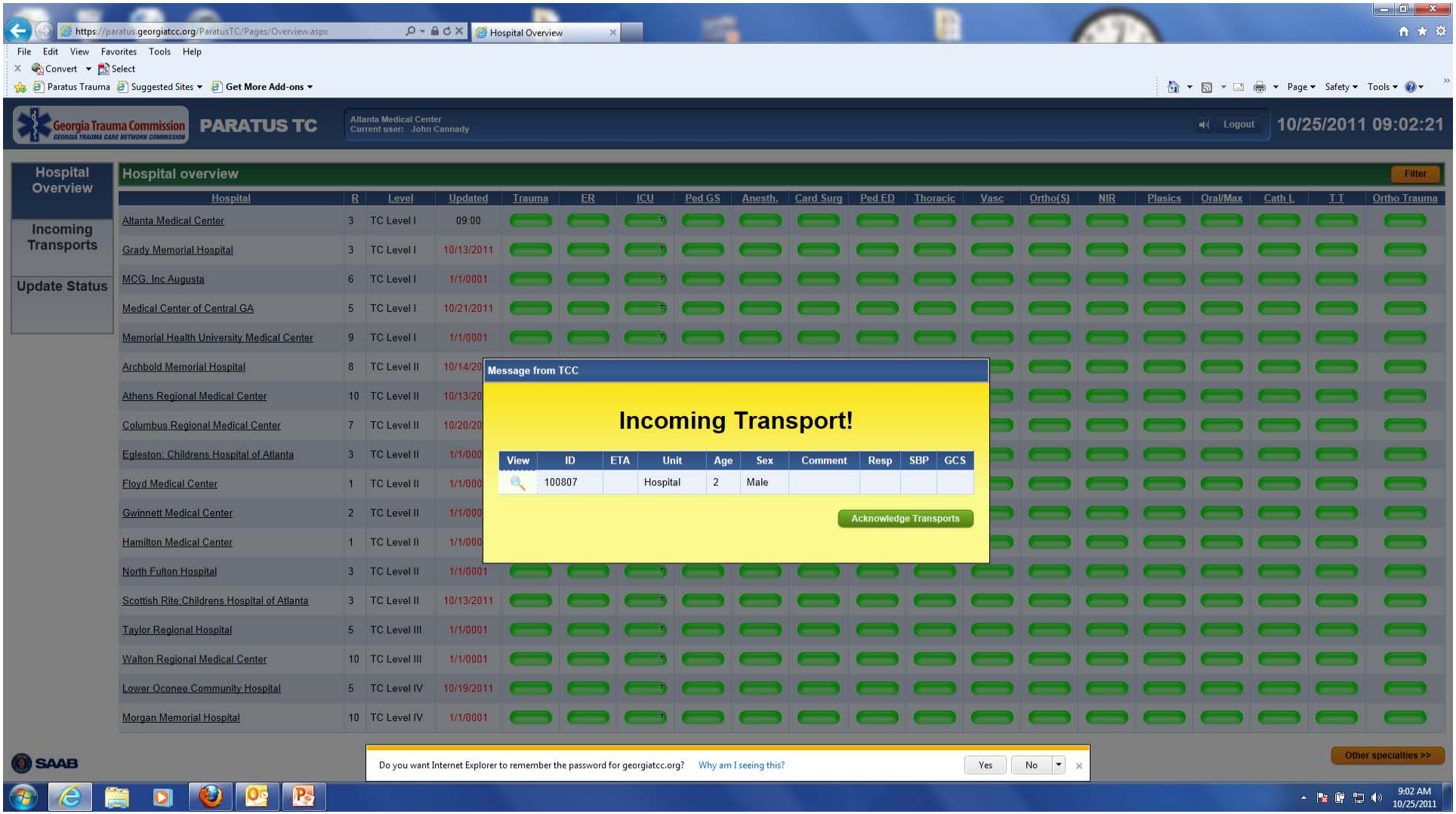

Georgia Trauma Commission

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Details	ID	Status	Created	ETA	Source	Age	Gender	Acknowledged	Time of arrival	GCS	SBP	Resp	Comment
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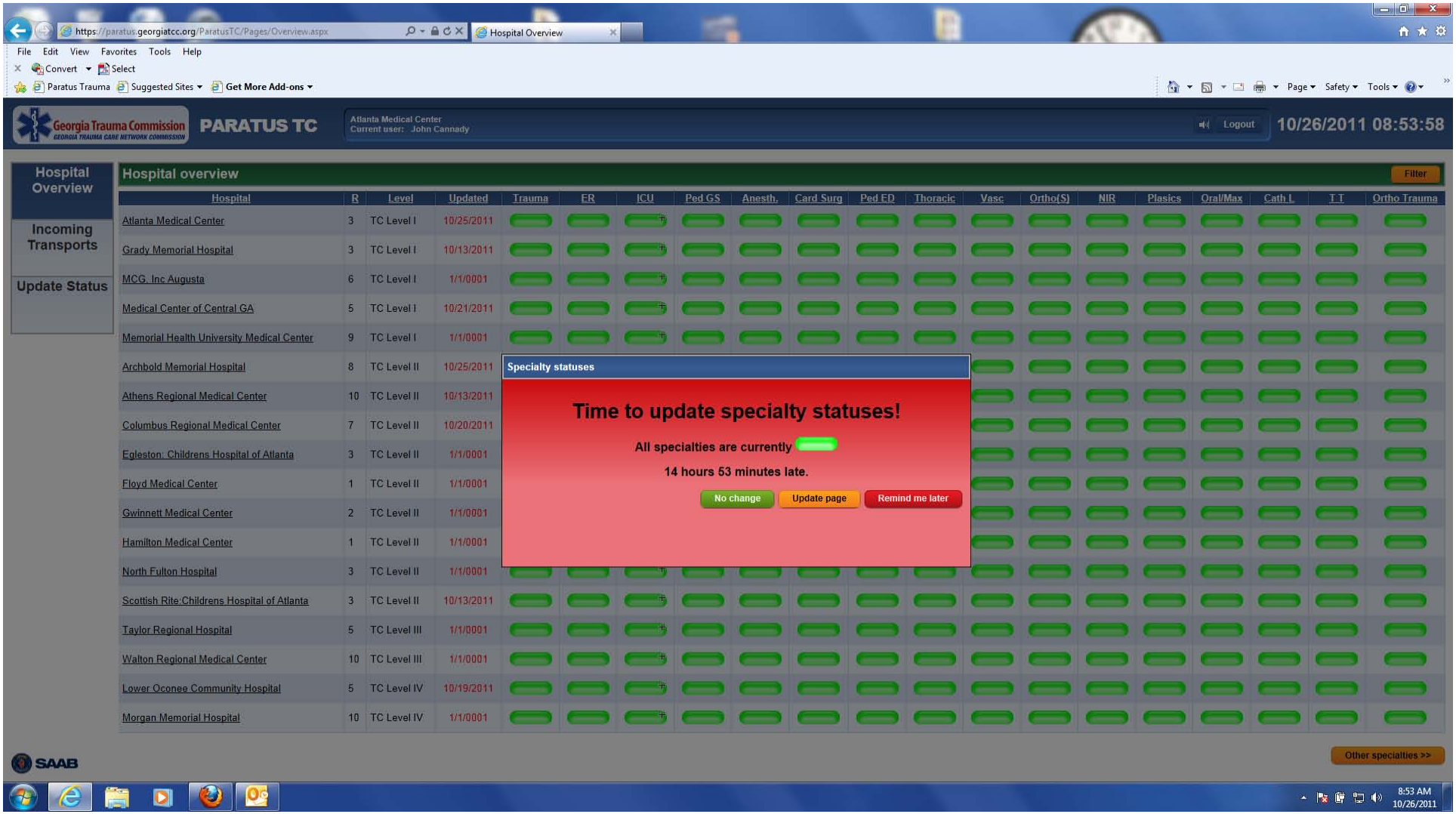
	101176	Submitted	11/1/2011 13:53:49		911	42	Female	Yes		10	86	24	15 ft thrown
	101156	Submitted	11/1/2011 11:36:07		911 - MidGeorgi	8	Male	Yes		8	7	36	
	101155	Submitted	11/1/2011 11:33:52		11 M 01 - MCCG	42	Female	Yes		10	86	24	
	101154	Submitted	11/1/2011 11:28:11		53-M1 - Emanuel	16	Male	Yes		14	84	22	no seat belt
	101153	Submitted	11/1/2011 11:26:15		810 - MidGeorgi	86	Male	Yes		10	70	12	
	101140	Submitted	11/1/2011 10:58:08		41	54	Male	Yes		8	60	8	
	101122	Submitted	11/1/2011 10:29:14		911 - MidGeorgi	42	Female	Yes		10	86	24	
	101118	Submitted	11/1/2011 10:24:51		53-M1 - Emanuel	16	Male	Yes		14	84	22	T-bone , right side chest , right hand

Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION



Georgia Trauma Commission

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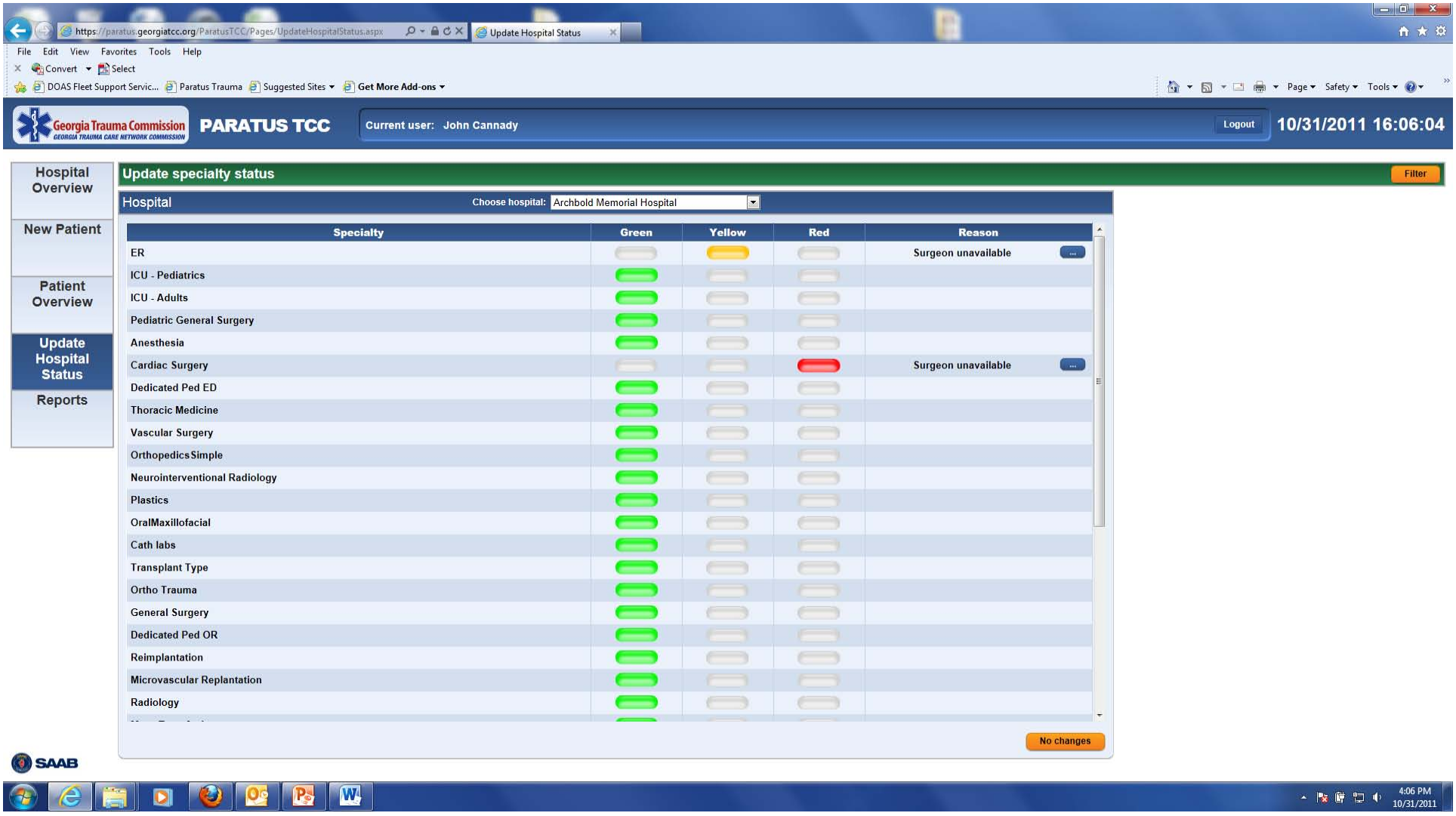

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Staffing

- All full time staff have been identified.
- Coordinator – John Cannady
- Operations Specialist – Michelle Martin
- 8 Full Time Agents/2 Part Time Agents
- 2 Agents 24/7 (12 hours shifts)
- Agents are currently conducting training and assisting with system testing.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Hospital Participation

- 80% of all designated trauma centers either have dedicated CPU/monitors on site or have them already ordered.
- 88% of non-designated hospitals within regions 5 and 6 have expressed a commitment to participate.
- 54% of participating non-designated hospitals within regions 5 and 6 either have dedicated CPU/monitors on site or have them already ordered.
- Efforts are continuing to ensure placement of dedicated CPU/monitors in Trauma Centers and participating hospitals.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Required Before Taking Our First Call:

- At a minimum all designated trauma centers must have dedicated CPU's in place and obtained familiarity with their RAD.
- Release of TCC contact information.
- Coordination with RTACs to conduct EMS education programs within regions 5 and 6.
- Preferably all participating hospitals in regions 5 and 6 will have dedicated CPU's in place and obtained familiarity with their RAD.
- Outreach to 911 dispatch centers with TCC contact information.

Georgia Trauma Commission
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How We Benefit EMS

- The TCC will provide real-time Trauma Center status and service line availability information to EMS providers.
- The TCC will provide transport destination recommendations to EMS providers in the field based on incident location, patient trauma triage information as provided by EMS providers, and Trauma Center availability.
- The TCC will provide a direct communications link between EMS providers and receiving Trauma Centers.
- The TCC will assist in identifying patients who meet TSEC criteria.
- The TCC will be a resource for EMS with all patient care decisions left to EMS providers in the field.

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

How We Benefit Hospitals

- The TCC will provide real-time Trauma Center status and service line availability information to Trauma Centers and non-designated participating hospitals.
- The TCC will provide a direct communications link between EMS providers and receiving Trauma Centers.
- The TCC will provide patient trauma triage information as provided by EMS providers to Trauma Centers through the RAD.
- The TCC will maintain a database and provide reporting capabilities to assist Trauma Centers and RTACs with measuring system performance and CQI.
- The TCC will provide a communications link between participating non-designated hospitals and Trauma Centers.
- The TCC will provide a unique patient ID number which will follow the patient through discharge and rehabilitation.

Georgia Trauma Commission
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How We Benefit Trauma Patients

- The TCC will assist EMS with identifying trauma patients who meet TSEC criteria.
- The TCC will assist EMS with decreasing the time from initial injury to definitive care in the most appropriate designated Trauma Center.
- The TCC will assist local hospitals transferring trauma patients to designated Trauma Centers where they can receive definitive care.
- The TCC will play a crucial role in helping EMS and local hospitals get **the Right Patient to the Right Hospital at the Right Time.**

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Questions?

TCC Open House Immediately Following Today's Meeting

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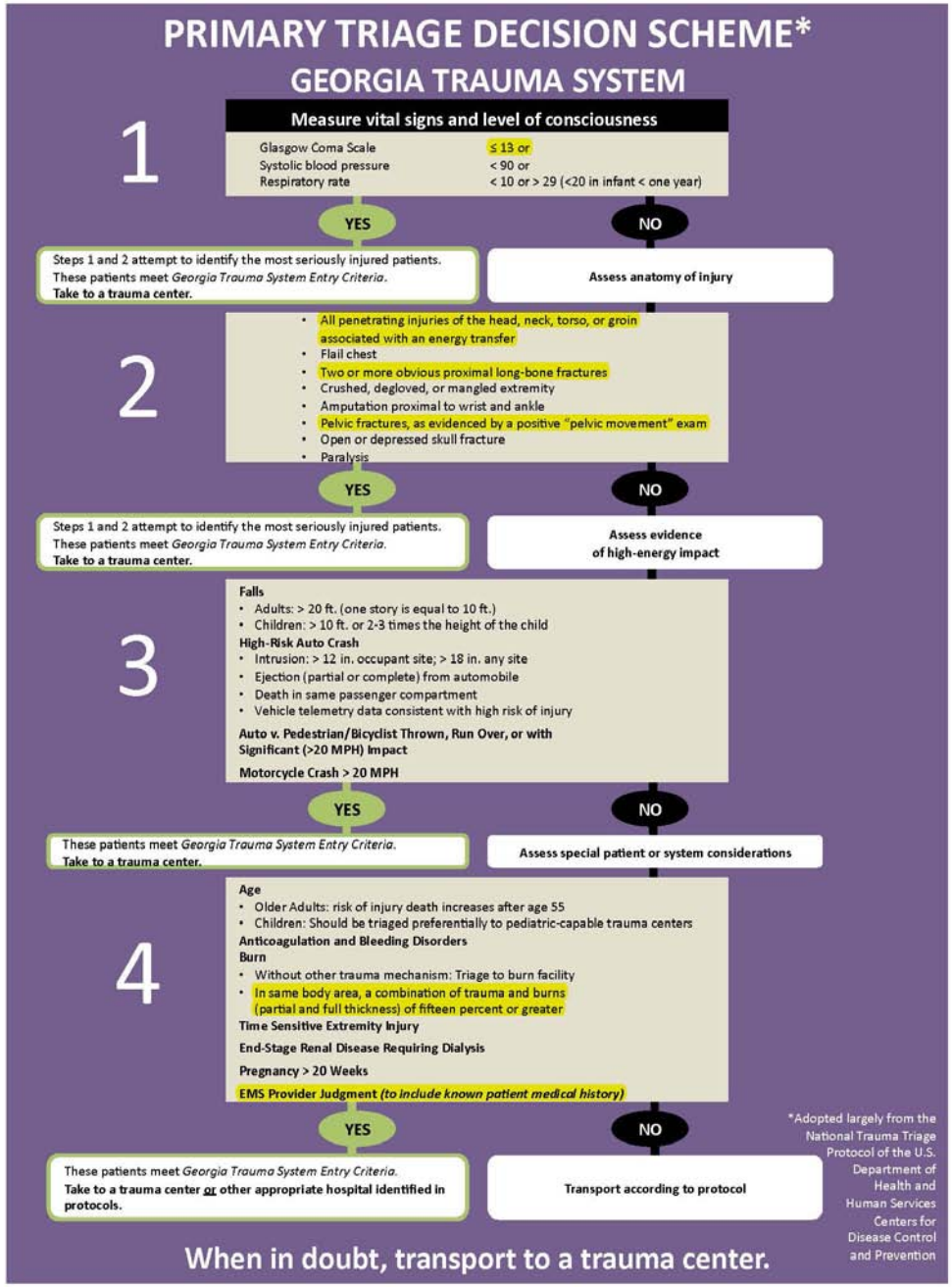
THE GEORGIA TRAUMA COMMUNICATIONS CENTER

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

PRIMARY TRIAGE DECISION SCHEME*

GEORGIA TRAUMA SYSTEM



*Adopted largely from the National Trauma Triage Protocol of the U.S. Department of Health and Human Services Centers for Disease Control and Prevention

When in doubt, transport to a trauma center.

Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION

Region 5 Trauma Regionalization Pilot

Presentation to the GTCNC
November 17, 2011

PILOT TIMELINE

Georgia Trauma Commissio
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January:

- RTAC steering committee created – Council Chair, EMS Program Director, Trauma Commission Chair, Trauma Program Manager
- Pilot proposal presented to the Region 5 EMS Council for consideration and vote
- Council agreed to participate in pilot and endorsed pilot action plan.

PILOT TIMELINE

Georgia Trauma Commissio
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March:

- Letters sent from RTAC steering committee to trauma stakeholders explaining the pilot and informing them a follow up visit would take place to discuss further.

April – July:

- Meetings conducted with various stakeholders throughout Region 5 to discuss the proposed RTAC plan, invite them to the stakeholders meeting, and answer any questions.
- Plans and preparations were made for the first of three stakeholder meetings.

PILOT TIMELINE

Georgia Trauma Commissio
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August:

- First Trauma Regionalization Stakeholders meeting held on August 15th
- Steering committee will provide attendees with a brief history of the Georgia Trauma Care Network Commission and an introduction to the RTAC pilot.
- Prehospital and Hospital working groups established and instructed on tasks to accomplish before next meeting
- Working groups identified barriers and considerations for Trauma Plan Implementation

PILOT TIMELINE

Georgia Trauma Commissio
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September:

- Trauma Plan Development Meeting held on September 7th
- Steering committee summarized findings of the working group assignments from the initial meeting
- Draft plan presented for the stakeholder group to discuss and make recommendations
- Working groups worked to review and developed their respective components of the plan:

Pre-Hospital Destination Guidelines

and

Hospital Guidelines for the Inter-facility Transfer of Trauma System Patients

PILOT TIMELINE

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October:

- Final Plan Development Meeting held on October 5th
- Final draft plan presented for the stakeholder group to discuss and finalize
- Plan presented to the Regional EMS Council for consideration and vote
- EMS Council approved Regional Trauma Plan
- RTAC members appointed by EMS Council Chair
- Letters of support obtained from participants

PILOT TIMELINE

Georgia Trauma Commissio
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November:

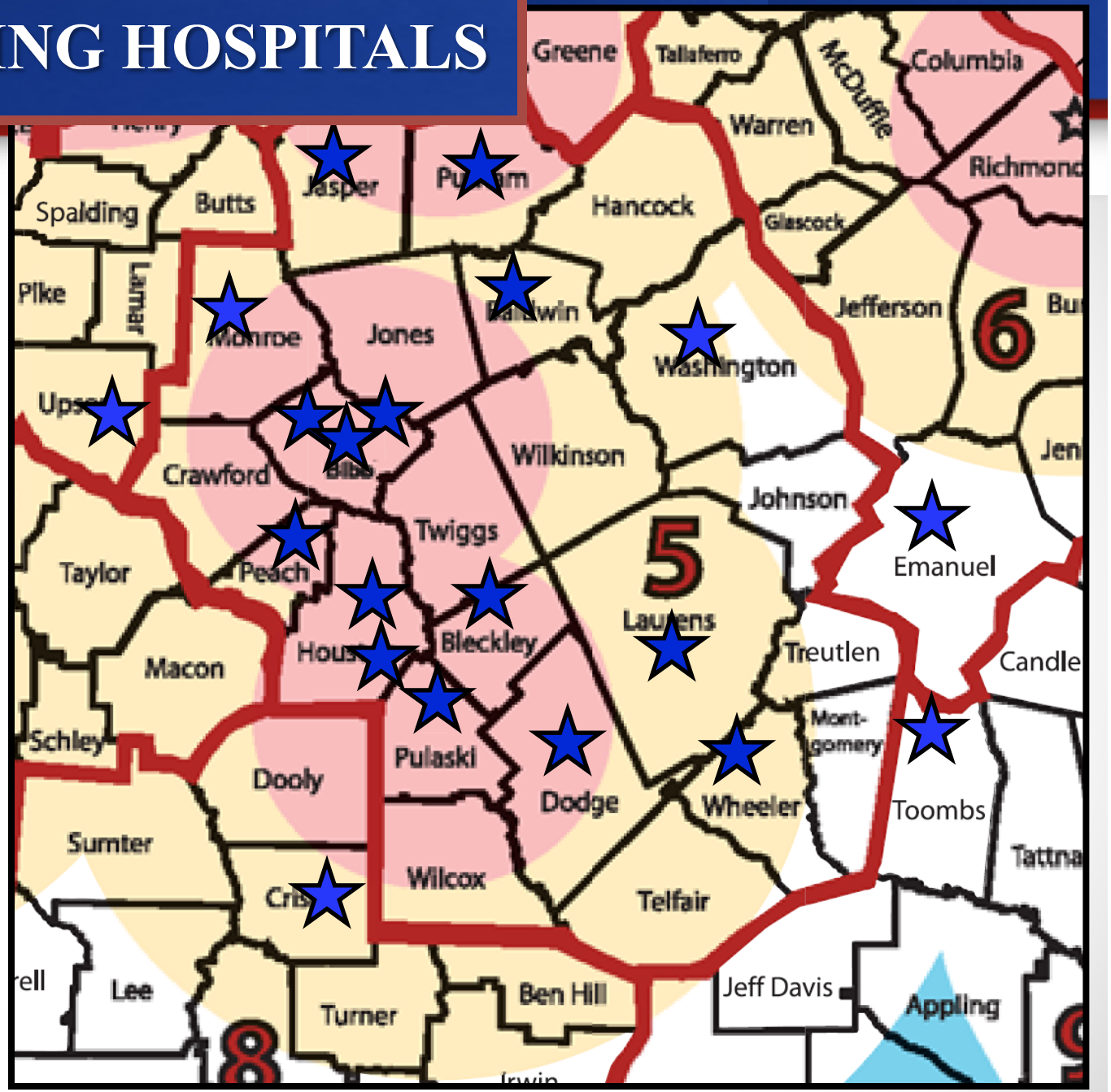
- Request GTCNC approval of plan
- Work in conjunction with the Trauma Communications Center to establish an education timeline to address pre-hospital and hospital components related to plan implementation
- Develop standardized training material for distribution to pilot participants and initial education programs

PARTICIPATING HOSPITALS

Region 5 Hospitals:

Baldwin
Oconee Regional Medical Center
Bibb County
Coliseum Medical Center
Coliseum Northside
Medical Center of Central Georgia
Bleckley County
Bleckley Memorial Hospital
Dodge County
Dodge County Hospital
Houston County
Houston Medical Center
Perry Hospital
Laurens County
Fairview Park Hospital
Jasper County
Jasper Memorial Hospital
Monroe County
Monroe County Hospital
Peach County
Peach Regional Medical Center
Pulaski County
Taylor Regional Medical Center
Putnam County
Putnam General Hospital
Washington County
Washington Co. Regional Medical Center
Wheeler County
Lower Oconee Community Hospital

Other Hospital Stakeholders
Crisp Regional Medical Center
Emanuel Medical Center
Meadows Regional Medical Center
Upson Regional Medical Center



EMS PARTICPANTS

Georgia Trauma Commissio
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Dodge County EMS
Hancock County EMS
Heartland EMS
Houston Healthcare EMS
Jasper County EMS
Johnson County EMS
Laurens County EMS
Medical Center of Central Georgia EMS
Mid GA Ambulance Service
Monroe County Emergency Services
Peach County EMS
Putnam County EMS

Taylor Regional EMS
Telfair County EMS
Treutlen County EMS
Washington County EMS
Wheeler County EMS
Wilkinson County EMS
Wilcox County EMS
Crisp Regional Hospital EMS
Emanuel County EMS
Toombs-Montgomery County EMS
Upson Regional Medical Center EMS