Approved March 23, 2017

GEORGIA TRAUMA COMMISSION

GEORGIA TRAUMA COMMISSION
January 19 – 20, 2017
Macon Marriott City Center
Convention Center Room 306
240 Coliseum Drive
Macon, Georgia 31217

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley, Chairman Dr. Fred Mullins, Vice Chair Mr. Victor Drawdy, Secretary/Treasurer Dr. John Bleacher Dr. Robert Cowles Dr. James Dunne Dr. Jeffrey Nicholas Mr. Courtney Terwilliger	Mark Baker

STAFF MEMBERS & OTHERS SIGNING IN	**REPRESENTING**
Dena Abston	Georgia Trauma Care Network Commission, staff
Erin Bolinger	Georgia Trauma Care Network Commission, staff
Katie Hamilton	Georgia Trauma Care Network Commission, staff
Kathy Browning	American College of Surgeons, Georgia Chapter
Rana Bayakly	DPH SOEMS/T
Earnest Doss	DPH SOEMS/T
Dr. William Hardcastle	DPH SOEMS/T
Danlin Luo	DPH SOEMS/T
Renee Morgan	DPH SOEMS/T
Dr. Pat O'Neal	DPH SOEMS/T
Peki Prince	DPH SOEMS/T
Marie Probst	DPH SOEMS/T
Keith Wages	DPH SOEMS/T
Traci Reece	DPH/Child Safety
Lori Mabry	Georgia Trauma Foundation
Sharon Nieb	Injury Prevention Research Center at Emory
Scott Maxwell	Mathews & Maxwell, Inc.
Chad Black	Region II RTAC & Habersham County EMS
Billy Kunkle	Region III RTAC
John Harvey	M.A.G
Susan Moore	M.A.G
Kyndra Holm	Augusta University
Amanda Wright	Augusta University

Regina Medeiros	AUMC
Melinda Williams	Cartersville Medical Center
Greg Perreira	Children's Hospital of Atlanta
Tawnie Campbell	Coliseum Medical Center
Anastasia Hartigan	Doctor's Hospital of Augusta
Kim Moore	Doctor's Hospital of Augusta
Lynn Grant	Fairview Park Hospital
Chelsea Adams	Fairview Park Hospital
Kim Littleton	GAEMS
Shea Ross	GHA
Karen Waters	GHA
Liz Atkins	Grady Memorial Hospital
Kelli Scott	Grady Memorial Hospital
Elizabeth Williams	Grady Memorial Hospital
Susan Bennett	JMS Burn Center
Farrah Parker	JMS Burn Center
Shawna Baggett	John D. Archbold
Daphne Stitely	John. D Archbold
Deb Battle	North Georgia Medical Center
Jesse Gibson	North Georgia Medical Center
Rochelle Armola	Memorial Savannah
Stephanie Gendron	Memorial Savannah
Amanda Ramirez	Memorial Savannah
Jaina Carnes	Redmond Regional
Alex Jones	Taylor Regional
Kathy Sego	Wellstar – Atlanta Medical Center
Jim Sargent	Wellstar Atlanta Medical Center
Brandon Reese	Wellstar Health Systems
Laura Garlow	Wellstar- Kennestone
Lisa Ulbricht	Wellstar- Kennestone

DAY 1: Call to Order: 9:01 AM

Quorum Established: 8 of 9 commission members present.

MOTION GTCNC 2017-01-01
I make the motion to move to close session for staffing review.

MOTION BY: Vic Drawdy
SECOND BY: Dr. James Dunne
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Welcome Presented by Victor Drawdy

Mr. Drawdy welcomed everyone to the meeting and thanked everyone for being there to serve the great State of Georgia.

Chairman's Report Presented by Dr. Dennis Ashley

Dr. Ashley thanked Mr. Drawdy for the introduction and for everyone and their patience with the closed session portion delaying our original start time. Dr. Ashley recently presented to the House Health Appropriations Committee which is chairmen Butch Parrish' committee. The budget was just released on a Monday and we were to report on a Wednesday. A few key points; the super speeder generates about 21 to 23 million per year and we get 16.3 million each year of those funds. Last year, a bill passed that had two provisions that will affect our funding. The first provision is the Pauper's Affidavit, O.C.A 40-5-9. In the 2016 legislature, the reinstatement fee for every time you lose your license increases with each event. The super speeder fees and a combination of these other fees are a part of our budget. The Pauper's affidavit allows those persons with these types of fees to show that if they are below the poverty level the reinstatement fee is reduced by 50%. This will be a projected loss of 3.4 million to the super speeder revenue. The other part of that law OCGA 17.9.4- The Criminal Justice Reform, or CJR, it also projects a loss of $124,000.00. This brings some concern for our revenue source.

SB350, the Fireworks Tax revenue in FY 2016 the taxation on that was $927,000, the FY 2017 through September reported $886,000.00. Amendment 4 and the potential funds will be disbursed as follows; 55% to the Commission, 40% to Georgia Fire Fighters Standards, and 5% to public safety of local governments. The FY2016 projections to the Commission from SB350 are estimated at around $510,000.00 and the FY2017 projections around $487,000.00. Dr. Ashley says we will just have to see how this all plays out. In our closing presentation slide to the House Health Appropriations Committee there seems to be about $1 million difference in projections (would put our budget at 17.4 million) and we asked to have that $1 million be put into our budget. Of these funds we informed legislature that with the Stop The Bleed campaign the individual kit cost from the American College of Surgeons (as marker numbers only) are $69.00 each and the kits include a tourniquet, hemostatic gauze, gloves, and posters showing how to stop the bleed. We requested funding to install one kit in each Public School in Georgia. Dr. Ashley asked if there are any questions on this.

Dr. Dunne asked about the public school numbers. The estimated numbers show 2,292 Public Schools that are Kindergarten through 12th grade and so that is what we asked that the additional funding be used for. Dr. Nicholas asked about private school inclusion and the numbers that show how many students are in public schools versus private school. Ms. Mabry said she could look into these questions. Dr. Ashley says the last week of February at the Southeastern Surgical Congress we have presented three posters; a Pay-per-Performance poster, a pay-per-readiness poster, and an access to care poster. All posters contained our G.R.I.T logo and Dr. Ashley wanted to congratulate all that put work into the posters and the great work that came from this.

Administrative Report Presented by Ms. Dena Abston

Ms. Abston directed the group to where the G.R.I.T. posters were in their binders and reminded the Commission there are minutes to be approved from the November 2016 Commission meeting.

MOTION GTCNC 2017-01-02
I make the motion to move to approve the November 17, 2016 minutes.

MOTION BY: Victor Drawdy
SECOND BY: Dr. John Bleacher
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Ms. Abston discussed the November 2016 Super Speeder Revenue report (page 8) we have received so far. Collected for FY 2017 is $8.2 million and Ms. Abston sees no difference in projections at this time. The report (page 9) from the Department of Driver Services is their projection for future revenue. Ms. Abston received the Governor's recommendation recently and the amended FY 2017 budget where the Governor has given to us an additional $1 million in the middle of this fiscal year. The Budget Subcommittee will be working between now and March to determine where we will use those funds. Ms. Abston asked if there were any questions for FY 2017. Mr. Terwilliger asked if a letter thanking the governor be sent to him. Ms. Abston says she is willing to do so and many agreed it was a good idea. Ms. Abston reminded the Commission that she sent a thank you letter to the governor after their meeting in November of last year. Ms. Abston will formulate a letter and have members sign it at the next Commission meeting. Dr. Nicholas asked if (page 10) the public health increase is earmarked for safety-net hospitals as the language specifies that. Is this is in our general budget? Mr. Drawdy thought it was to be in our general budget. Ms. Abston says she will get clarification on this.

Ms. Abston says FY 2018 will be the $16.3 million but they reserve the right to reassess these funds as they did with the FY 2017 budget. So there is possibility for additional funding. For FY 2016 Budget vs. Expenditure and Ms. Abston's projections were around $8,500 but as it turns out it will be around $6,600. Mr. Drawdy says anytime this is under $10,000 it is excellent. Dr. Ashley commended Ms. Abston and Mr. Drawdy on a job well done. Ms. Abston then summarized the annual reporting from the trauma centers on how they spend readiness and uncompensated care funds based on trauma level. Ms. Abston asked the Commission to review the proposed Commission meeting schedule and asked the members to review the dates and locations. The August location may change as we are trying to have our meeting coincide with the Trauma Symposium however there are not hotel rooms available where the meeting is being hosted at this time. Mr. Drawdy is looking into locations close to St. Simons' Island to include Jekyll Island. Dr. Mullins asked if there was anything on Sea Island. Ms. Abston asked members to review the list and note that the August location may change.

MOTION GTCNC 2017-01-03
I make the motion to move to approve the 2017 Commission meeting locations and dates as presented.

MOTION BY: Victor Drawdy
SECOND BY: Dr. Robert Mullins
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Ms. Abston asked Commission members to review the new logo for the redesigned website. The members liked the logos and told Ms. Abston to proceed. It is Ms. Abston's intention to have the new website launched by March. The MAG annual report is also included in the report. Ms. Abston reminded everyone to register for the Day of Trauma and the important upcoming dates. Ms. Abston has Region II's trauma plan enclosed for every ones review. Also included is all the Strategic Planning information for tomorrow.

MAG Contract Update Presented by Dr. John Harvey

Dr. Harvey thanked everyone for the opportunity to come back and report on the progress of the MAG Medical Reserve Corp. This is the 2nd grant to MAG and pleased to have the allocation of these funds. There are three things we have done last year. There are 40 fully deployable Medical members we have ready to deploy in the state of an emergency. There are 30 additional Medical Professional Members working toward deployment

level. This was tested this year in 2 or 3 major training exercises they participated in this year. One training exercise was tested with participation at the National Radiological Response and development of patient reception areas and triage areas. Those participated at a reserve base and worked on patient offload from military aircraft into the triage setting and then processing to either regional hospitals or shelter. This was a federal cooperative multi agency response that they were involved with in planning and participation.

Next, Dr. Harvey reported on the surge hospital facility. The Medical Reserve Corp has worked with the Department of Public Health to be able to render this facility capable of receiving patients or for use as shelter. Dr. Harvey says a triage tent can go up in 2 to 3 hours at this time after recent training events. They have done the entire process twice in a 6 to 8 hour period. Dr. Nicholas was a part of that event. Dr. Harvey thinks this was very effective. FEMA preparation and physical exercise classes have to be complete before a Medical Professional is considered deployable. We are now expanding beyond physicians to nurse groups and paramedical groups to expand the states capability. It is a goal to deploy fully trained and capable teams in the event of an emergency. There were over 25 physicians committed to deployment during the hurricane recently. Lessons learned from that experience was that we truly need an integrated team and not just physicians.

Dr. Ashley thanked Dr. Harvey for all the hard work and dedication to the program. Dr O'Neal says on behalf of the Department of Public Health we have tremendous respect and appreciation for Dr. Harvey and his achievements. Dr. O'Neal noted that the Governor's office is extremely pleased with Dr. Harvey and the support of the MRC. This is a good way to show the trauma system piece and how well it works with the preparedness piece. Dr. O'Neal does not know of any other state that has had the success that Georgia has currently with our MAG initiative. Dr. Harvey says if anyone is interested in becoming a part of this to please e-mail your interest to him self or Ms. Susan Moore, his administrative assistant. The MAG web site is also an easy way to get signed up. Mr. Drawdy asked if anyone else in the nation is doing what we are doing. Dr. Harvey said we are the only state currently doing this.

Dr. O'Neal brought up the participation and the question or personal liability of those medical personnel that are interested in working in these disaster situations. Dr. O'Neal indicated that those willing to be a part of MAG's efforts are given sovereign immunity from insurance liability.

Georgia Trauma Foundation, Inc. Report Presented by Lori Mabry

Ms. Mabry updated the Commission on Stop The Bleed and Trauma Awareness Day at the Capitol. Yesterday the statewide work group for the Stop the Bleed campaign met face to face. We have been pulling in small groups to get all the questions answered in regards to funding and the bleed control kits. The small meeting had vendors send their kit samples to the meeting and everyone dug in and evaluated. After that meeting we sent the RFP's out to all vendors. We did make a decision on the kits being installed at the Capital in a couple of weeks. Ms. Mabry showed the Commission the bleed control kits and shared some of the discussion around making the decisions. After discussing distribution and the required maintenance on the kits, the group decided to go with items with no expiration dates and to not vacuum seal the packs all the way to make them softer when needing to use them. Discussion about quick clot and the expiration period that product carries. Ms. Mabry informed the group there was no quick clot. Ms. Mabry went over the kits and how to maintain the shelf life and what part of the kit would require 5-year maintenance. Dr. Ashley asked Ms. Mabry about training the Capital Police about the kits. The kits are being installed prior to our Trauma Awareness Day.

Ms. Browning with Georgia ACS reviewed the Trauma Awareness Day at the Capitol schedule and explained that we will have on site trainers in several locations. There will be a breakfast and lunch where we have invited the legislature to come and learn about our initiative and teach them how to Stop The Bleed. Dr. Dunne asked about attire. Ms. Browning has asked all that have white coats to wear them and for those that

do not to please stick to the red and white attire if possible. There will be a news conference at noon and we have a PR company putting that together. Ms. Browning said there would be resolutions in both the senate and the house. There will be folders at registration that Ms. Abston and her staff are helping put together that have photos of your local and state officials and Stop The Bleed stickers and talking points for if and when you have a chance to run into your local officials. There also will be a videographer. Ms. Browning reminded the Commission that the State of Georgia is leading in this. National ACS has asked Ms. Browning to share our process with others, which shows Georgia as a leader in this initiative.

Dr. Ashley has two requests. Please everyone sign up, show up, and wear your lab coat for our Trauma Awareness Day at the Capital. Please also if you have any trauma survivor stories to get that information or family story to Ms. Mabry. Dr. Ashley also noted the importance of the Stop The Bleed initiative and its ultimate goal (a combination of support from American College of Surgeons, National EMS Association, Department of Defense, Homeland Security) is to make this as known as the Heimlich maneuver and C.P.R. for the general population. The legislature can help us get our message out so this is a very important day for the Commission and the State. Mr. Drawdy asked Ms. Mabry what sets the state of Georgia a part from the rest of the Country. Ms. Mabry says at this time we are the only state to ask and train our legislature and use our Trauma Day to train and teach the Stop The Bleed program.

Office of EMS and Trauma Update Presented by Renee Morgan

Ms. Morgan began with saying there are now 30 designated trauma centers now in the state of Georgia. Fairview Park in Dublin, Georgia and Appling in Baxley, Georgia are now designated Level IV Trauma Centers. Ms. Morgan reported on SBERT updates that were just installed this past week and will hopefully link in with what is being done with TQIP. Ms. Morgan says they are in the process of trying to merge the state visits with the ACS visits. Ms. Morgan says if we can complete this and do a good job at it, we will be the first state able to do this. Ms. Morgan says there are several consultative and verification visits scheduled for several of our centers. Ms. Morgan feels the State of Georgia's relationship with ACS has been great and well received and both she and Ms. Probst have learned a lot in the processes. There are several facilities we are working on them coming on to our Trauma Program and we have been talking to Wellstar as we already have some of their hospitals in the trauma system. Ms. Morgan says we have been partnering with HCA for a while to help strategically plan how we can improve trauma care throughout the state. Ms. Morgan reported that working a lot with trauma coordinator group and the Commission as far as Strategic Planning and future. Ms. Abston and Ms. Morgan communicate often about best practices for trauma care. The good thing Ms. Morgan reported on has been the implementation of Performance Based Pay by the Commission as it provides a little bit of teeth when it comes to correction actions on their side and she is very appreciative of that. Dr. Dunne asked Ms. Morgan if anyone she has done a state review when ACS is in for a consultative visit at a center. Ms. Morgan says the state office partners when the ACS arrives and they participate with the team, are included on closed sessions, and receive the feedback. With the implementation of consultation visits that the Commission has requested of our centers, the state office is trying to make this easier by combining the state and ACS visits when it comes to re-designation. There are a lot of line item deficiencies in the ACS report but it is the states intention to set a timeline for corrective action of those items after the ACS visit is complete. In 2002 and 2003 there was a grace period/ transition phase of our first ever designation periods in getting everyone on board and we are in a similar time as then. We want to utilize the ACS visit information and work them in with the verification visits and the re designation visits.

Dr. Dunne asked if we have ever done a formal state review in conjunction with the ACS consultative visit. Ms. Morgan says yes, with Grady and Macon. Dr. Nicholas was a part of the ACS/State visit at Grady. Dr. Ashley thought the process was really smooth for his center in Macon. ACS is interested in how we combine the visits with the state reviews. Dr. Smith one of the reviewers at Macon recently made clear the state obligations were still required regardless of the ACS report. He commended our program since we have ben keep track. Dr.

Nicholas says his center worked on their corrective action plan alongside their ACS visit. The Trauma Coordinators have been very good at sharing the pains and processes of the state and ACS visits in an effort to improve with each new visit and review. Ms. Morgan hopes within the next several months to have a good action plan on paper for Dr. O'Neal to review. Dr. Dunne says his only concern is that the ACS consultative visit can sometimes have a different purpose than a verification visit. Dr. Dunne would want any reviewers to point out any possible issues that may be considered a deficiency so that we have that information to take to our leaders as leverage to improve process. Dr. Dunne wants the difference between a consultative visit and a certification visit to be noted and make sure everyone understands this. Ms. Morgan says ACS is very interested in how we do things, as we are one of the only states trying to implement this at this time. Ms. Morgan encourages the ACS visits. Dr. Nicholas says the criteria deficiencies were what his center focused on.

Hospital Hub Update Presented by Rana Bayakly

Ms. Bayakly gave an update to the Hospital Hub project. The Hospital Hub user guide has been created. There are 19 of our original 26 Trauma Centers that have signed up to use the hub. Now that there are 30 trauma-designated hospitals so Ms. Bayakly will be reaching out to those new ones. The Stroke Registry and Trauma registry centers seems to be using the system more than others. There are some issues with destination codes and accessing PCR's so there is work being done with Image trend to access the PCR's more efficiently. Communication back to Ms. Bayakly is essential when you notice errors, most can be corrected rather quickly and with this being a new tool there are start up corrections to be made.

Mr. Terwilliger says he was at a stroke meeting in August the other day and they were talking about an EVAC tool to work with EMS. Ms. Bayakly says the Stroke Registry group is currently working on the type of communication between the EMS and Trauma Coordinators. The EMS and Stroke coordinators are working together on best practice for this communication piece. Mr. Terwilligers asks on the EMS side how would he get that information currently. Mr. Doss answered Mr. Terwilliger referring him to the GEMSIS system to find the patient information. Mr. Doss is working on a report to run and get out to the EMS community but there are center specific requirements to make sure that all information about all patients is only trauma center and service provider specific.

Dr. Ashley asks what kind of data is being reported back to EMS. Ms. Bayakly says vital status, if they were a stroke patient or not and the EMS technicians would like to know how to improve their process and to provide best care for each patient. Ms. Bayakly is looking in to how to send that information back to the EMS providers. One the PCR is reviewed at the hospital, at the time of discharge if it were (example) confirmed that it was a stroke and they did a neurological exam, it may be noted that something was missed in the initial diagnosis by the EMT. So all the information is housed GEMSIS and then can be generated into a report format to communicate the patient outcome to the EMS provider. Mr. Terwilliger would like all feedback as it only improves our system and the patient income. Dr. Ashley says it sounds great for the Trauma Coordinators to come up with some kind of report to go back the EMS providers. Dr. Ashley does carry concern about time and entering of the information as well. Ms. Bayakly says the coordinators are going to start testing the timeline once the gather as a group what information needs to be delivered back to the paramedic.

Ms. Atkins says that if we are relying on the trauma registry that you are allowed 60 days to close out a chart. The methodology would create a delay for the trauma feedback. The trauma registry is not concurrent enough. Most Trauma Centers are struggling with the 60-day requirement at this time. Ms. Atkins says they have been striving to create a system outside of the trauma registry. Most centers as confirmed by the OEMS/T slides shows how must centers are really struggling to keep up with the data entry which makes it more complicated in getting the real time delay information. Ms. Garlow agrees with Ms. Atkins on this. She says it is a real struggle just to keep the information current and adding the additional workload creates burden. As far as that stroke registry, those patients have a shorter length of stay than those on the trauma

registry. She suspects the stroke registry will be more successful due to that. Ms. Solomon is the pilot program for this. Ms. Garlow says they are also working with the RTAC's in their regions to uncover specific information needed to make this efficient and effective and to create value between the EMS and Trauma Center.

Ms. Soloman says they have been seeing records with the input of information to GEMSIS vs. Hospital Hub. You are given 60 days after discharge to close a file. That information depending on how long the patients' stay was can create a time gap for the EMT that was interested in the feedback regarding the patient outcome but due to the timeline the information shared became ineffective. The Stroke population probably is easier to track. Ms. Bayakly says those in the Stroke Registry that use that information the most is working on building relationships with the EMT's. Dr. Nicholas asked about the range of stroke centers. Ms. Bayakly says there are approximately 24,000 stroke patients. Dr. Nicholas requested to know the annual number of patients for a stroke center? Dr. Nicholas wants to compare Trauma and Stroke volume and the timing issues versus the staffing issues at hand. Dr. O'Neal says that at Grady the Trauma and Stroke Center patient intake are very comparable.

Dr. Dunne asked Mr. Terwilliger if an EMS would typically complete the PCR at the hospital after patient drop off. They may begin the trip report but may get another call at that time. Mr. Terwilliger discussed the 60-second form to uncover the patient needs. Mr. Drawdy says the GEMSIS group is working on a short form. MR. Terwilliger says the GEMSIS group should collaborate with his group, as it seems both are working on a similar task. Dr. Dunne says that the EMS PCR completion varies per center and region it appears. MR. Terwilliger says in his RTAC they are trying to get a 60 second rule. When the patient arrives, the EMT can have 60 seconds to share patient information with the receiving doctor. Dr. Nicholas asks if some do an initial abstract of the patient. Ms. Garlow says this depends on the center. Others might not be addressed for weeks or until discharge. Dr. Dunne says a list may be developed but not entered until after discharge. Depending on center volume defines how things are tracked and when they are tracked.

EMS Subcommittee Update Presented by Courtney Terwilliger

Mr. Terwilliger gave an update to the AVLS equipment replacement timeline and is working with Tim Boone from GTRI on getting the new units to all that applied for them. In February the week of the 13-17 will be EMS Technology Week. There are some AVLS training dates that week and Technology Day is scheduled for Thursday February 16. Mr. Terwilliger is having experts come in from Sierra Wireless and there will be different levels of training that week. The fast surveys with the sonogram technology will also be in house on the 16. The TECC and EVOC classes are ongoing. The classes fill up extremely fast. They are well-respected courses and there is a desire to attend. The Regional Grants are in motion and the BCON courses are active.

Strategic Planning Session Presented by Ms. Zimmerman

Ms. Zimmerman thanked everyone for having her and she looks forward to working with everyone after a quick lunch on the FY2018 Strategic Planning for the Trauma Commission.

Adjourned for lunch at 12:52 PM.

Minutes crafted by Erin Bolinger

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Convention Center Room 306
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Jim Sargent	Wellstar Health Systems
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Laura Garlow	Wellstar- Kennestone
Lisa Ulbricht	

DAY 2: Call to Order: 9:01 AM

Quorum Established: 8 of 9 commission members present.

GCTE Report Presented by Laura Garlow

GCTE met yesterday and had a very robust discussion on many levels. All subcommittees were represented and gave comprehensive reports. Injury Prevention has a lot of good work going on. Education is moving forward with getting everything on to the foundations website. There are several upcoming RTDC courses and TNCC courses as well as 3 TCAR courses for the 2nd and 3rd quarter of FY17 are being planned. There was a discussion on Long ID and adding this component to the registry began at the beginning of January. There was an agreement that all hospitals will put the Long Id in and we will continue to work with EMS agencies on

follow up. We also agreed that one of the largest projects we would like to complete this year is a resource guide for developing trauma centers to include all orange book information, trauma registry, registrar support, using the data dictionary, and other helpful resources. This is not just to help the program managers develop their program at their centers; this is also for the registrars. Another component of this resource guide is a list of human resources that are considered experts on certain components. This resource guide would cover whom to contact for PI or Education and refer the new staff to these that really understand and can be a mentor and are considered an expert. We are hoping to have this complete buy the end of the calendar year.

There is work being done to the data dictionary, we are asking centers to have 1 full year of data prior to designation. GCTE discussed the saturation and diversion issues, communication issues, and best practice for how to communicate via region or across the state. Ms. Atkins has worked to get an Administrators group going and the first meeting is next week. We are asking that group to define saturation, diversion, and to help facilitate inter facility transfers. The first meeting of this group is Monday 1/24/17 at 5:00 P.M. MCCG also committed to helping with agendas and minutes and keeping the momentum going for the Administrators' group. Ms. Waters asked about the hospital event log and Ms. Garlow discussed saturation and the use of the log once the Administrator's group has defined the issues at hand. There is intent to have something more immediate than the hospital event log, particularly for Region III in Atlanta where there have been some recent saturation issues that cause a statewide effect. Ms. Solomon discussed patient holding and knowing each centers thresholds more efficiently. Dr. Dunne agrees that it is a problem across the state currently.

Region 1 RTAC Report Presented by: Jaina Carnes

The developed Strike Teams in their area were able to send 2 teams to Hurricane Matthew relief and evacuations. That has been very effective. There have been some other things that our teams have been asked to participate in at different locations and they intend to participate. As far as data goes for our area, we like many other regions have had a hard time getting traction. There has been some problems getting data but we have a cohesive group that works well together with each trauma center having representation. Ms. Carnes reported that they are about to have 1 full year of data and do an assessment at the end of February. Also developed was a facility resource document which ever since TCC has been eliminated it has been difficult to see the service lines. We have created a document that we will look at quarterly to update that will list service lines available.

Region 2 RTAC Report Presented by: Chad Black

The Region 2 RTAC plan was presented to the Commission. The regional council approved the completed RTAC plan. Mr. Black says that they were behind in the initial planning as there was not a trauma center until Northeast Georgia received their designation a couple years ago. The RTAC plan is now complete and will work within our region well and we are requesting Commission approval.

In October, a Trauma Symposium was held at Northeast Georgia Medical Center with over 300 attendees and there was originally space for an expected 100. Mr. Black is looking into possibly hosting a GAEMS event in his area in October 2017. Mr. Black wanted to do a Stop The Bleed for his area for law enforcement and school staff and children. There were 195 trained in the Stop The Bleed initiative. If the area has any funds left over they intend to use it for additional Stop The Bleed training and next years trauma symposium to offset some of the costs. They are looking into creating a Region 2 STRIKE team and are using Region 1 plan to begin that.

MOTION GTCNC 2017-01-05
I make the motion to approve the RTAC II plan.

MOTION BY: Courtney Terwilliger
SECOND BY: Dr. Robert Mullins
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Dr. O'Neal is very proud of the Region II work. Ms. Abston said this makes the 6th approved RTAC plan for our state.

Region 3 RTAC Report Presented by: Billy Kunkle

Region 3 is having a BIS assessment. Each subcommittee has gone through portions applicable to them. They began this initiative over 2 years ago and will look at it all again at their February RTAC meeting as data sources have greatly improved over this time. Dr. Nicholas is spearheading the overburden problem going on in our region in our centers. There has been diversion at Grady and it is region wide including Children's Hospital. It can become a statewide problem when our region is overburdened. Models and measures are being looked at now, as these issues do not seem to be improving. The group is looking at different data points; patient population, over/under triage, overall area population, and other measures. Region IV sends most trauma patients to our region, as they do not have a designated trauma center. So there are areas to look into and find improvement.

The other things being worked on are the 2016 Regional Systems Improvement grant and they are working on the accounting challenges that came with this. Those funds will cover several courses. Rockdale Hospital in Conyers has offered their facility to host some courses. Dr. Nicholas says the grant funds came from the EMS Subcommittee and these are the three projects our regions received funding for. The region is actively looking at how to spend these funds. Mr. Terwilliger asked if they are able to study the over/under triage. Dr. Nicholas says each center looks at this individually and on a monthly basis. The Cribari GRID can be a flawed tool for under triage. Dr. Nicholas says when in the field the EMS performs an outside assessment of the patient and when the patient arrives at one of our trauma centers there are cat scans and internal injuries are potentially found and an ISS of 16 or greater is given then by definition you have an under triaged patient if you are not at full ISS level activation. Dr. Nicholas says the trauma center coordinators and their staff spend a lot of time sorting out which patients were under triaged. Actively working on deciding if there is a better use for the Cribari Grid or is there a better methodology to determine under triage. Jim Davis presented papers to AAST in September and we are looking into taking what he did and apply it across the state. Dr. Nicholas is attempting to get his work to review. In the field it is hard to predict internal injuries. They are looking into better practice regarding over/under triage.

Dr. Nicholas would like to get a handle on all of this. If we could track how many times a patient is transferred or diverted due to capacity issues and find a way to share this information. Region 3 has a large problem, as there is not enough Level 1 trauma support, as there seems to be no transfer capacity. If we could work to get a handle on the transfer data and could track if a patient skipped over a trauma center to get to another for an open bed that would be a good start. In metro Atlanta it comes down to a need for an additional level 1 or 2-trauma center that will increase the bed pool for the metro area.

Region 4 RTAC Report Presented by: Paul Beamon

Region 4 is being smiled upon. As you know this area is relatively young. Mr. Beamon suspects within the next 2 to 3 years there are some hospitals in his area looking into designation to become perhaps a level 3. There is also a hospital in his area looking to purchase the trauma registry software and will be gin using that. They are working on a Region 4 planner and are getting that set up.

Region 5 RTAC Report Presented by: Todd Dixon

Our Region V RTAC has created a vision. Region V is committed to their trauma plan and RTAC will provide leadership regarding the care of trauma patients in the region and across the state and reduce the number of traumatic deaths and to use our resources to improve outcomes. There are 4 objectives for this region. The first objective is to collaborate with participating agencies to provide oversight and guidance for system evaluation and education. They have realized this objective with Region 5 conducting the immediate care/ school response program training in the area. Currently, 80 schools and 26 counties have now received this school response program training. Preparation is made to roll this out to all the middle schools in our area. ACS Stop the Bleed educational materials are being used. Through the Regional Trauma System Improvement grant they have been able to enlist 69 law enforcement agencies and they are slated to participate in the February initiative. Several RTAC 5 members are signed up for our Trauma Day at the Capital to teach the Stop The Bleed program. The region has adopted spinal motion restriction guidelines and has adopted an inter-facility transfer for trauma patients. The second objective is to work with the OEMST to monitor system resources for trauma care. Third objective is to evaluate patient outcomes at a systems level. The fourth objective is to analyze the systems and results and make recommendations of change; they have been able to do this with guidance and support of OEMS/T. Region 5 is looking forward to 2017 and hoping to continue the school response program and the Stop The Bleed training for all healthcare professionals who can then teach this to other community members. There is a lot of good work going on in Region 5.

Dr. Nicholas asked about their Patient Intake process. He inquired on Region 5's process to select what cases are studied in the P.I (patient intake) review. Ms. Smith has two pathways to report on. They can be reported directly through Todd and he conveys to the PI subcommittee through Kelly or also through our RTAC PI subcommittee chair. She is tasked with blinding the information- like the ambulance service or hospitals are blinded for the discussion. The meetings are primarily by conference call after the case specifics are put together. The trauma managers and the in house personnel review these cases. The information put out to the region is based on their findings. They realized there were issues with pre-notification, which enabled us to go back to our regional councils and ask for help with this. Also from this we have put additional process in place.

Dr. Nicholas asked how outcomes are reported back and if they are through the EMS council. Yes, they are under the EMS council. Dr. Dunne asks if you're talking about the case at 30,000 feet or investigating the issue. So the calls being held are discussing both findings and solution. Ms. Smith says the conference calls present all the pertinent facts and then the methodology is discussed as to how best handle the situation. For the most part, this is an education initiative and all can benefit from this. Dr. Dunne was very complimentary to this process. Dr. Dunne asked if there is a process for loop closure. Ms. Smith says the spinal motion restriction is a continuing item that is monitored as well as decontamination and airway restriction, which are all items they continue to monitor. Dr. Nicholas asked if any other region is conducting case reviews like region 5. Regina says that her area is establishing a guideline similar to region 5. It appears region 5 is able to get around the confidentiality issues with the blinding of the information they have. One of the items Regina's area is looking at is time spent in referring hospitals.

Region 6 RTAC Report Presented by: Regina Medeiros

Diverted her time to others.

Region 7 and 8 RTAC Report Presented by: Dena Abston

Region 7 just completed their first BIS assessment and are working on hiring an RTAC Coordinator

Region 8 has been collecting letters of support.

Region 9 RTAC Report Presented by: Dr. James Dunne

Region 9 has had a lot of activity. Amanda Ramirez our Injury Prevention coordinator for our level 1 hospital has been working on fall prevention and motor vehicle crash classes. There is a tremendous response in our area to our education classes. We are working on a violence prevention project in Savannah we are experiencing a surge of penetrating trauma. We have a new RTAC coordinator that used to be our Pediatric Safe Kids program director. We are utilizing her skills to reach out to areas, as our region geographically is quite large. We do have 3 level 4 trauma centers but most just stabilize and ship. Like every other region here we are having over/under triage issues. It is very timely to go through our records to figure out the under triage situations. Right now, Dr. Dunne is ashamed to say that we are shipping trauma patients out of state to South Carolina or Jacksonville due to space availability. There are multiple TNCC and TCAR courses going on throughout the region. Ms. Ramirez and Ms. Armola are spearheading most of the education.

We are looking a time to access for our Level 1. Initially he thought he would see patients transferring to our smaller hospitals and then being transferred to our level 1. That is not the case, our nurses are doing an excellent job in determining the patient needs, and this is a benefit to our region and to the state. We are in the middle of an upcoming ACS consultative visit that is occurring mid February. As painful as the getting ready process has been we are very excited about the ACS visit.

Region 10 RTAC Report Presented by: Dena Abston

Ms. Abston attended the last Region 10 meeting, they are working with Regions 1, and 2 to develop their RTAC plan. They are using a student intern to help them with the RTAC plan. They are finalizing their mission and objectives and presenting them to their subcommittee. They hope by Summer 2017 to have their plan complete and ready to present and to be finished by the end of the calendar year 2017.

Strategic Planning Session Presented by: Alice Zimmerman

Combined with yesterday's Strategic Planning See attached Strategic Planning initiatives and completed worksheets provided by Ms. Zimmerman. Attached are all Strategic Planning documents.

Minutes Crafted By: Erin Bolinger

Table Exercise (1-2 strategies per table)				Strategy January 2017 Status Update		
Component	**strategy #**	**Strategy Description (January 2016)**	**Old Strategy Description (January 2015)**	**Status Update - Accomplishments (include sub-strategies and other known activities)**	**Status Update - Barriers (include sub-strategies and other known activities)**	**Status Color (Jan 2017)**
II. Public Information, Education and Prevention	8	**RTAC Injury Prevention Committee:** Form committee or other structure to ensure that injury prevention efforts are coordinated, inclusive and not duplicative, and to establish a mechanism to promote regular communication	**Combines strategies s#8,9,16,17,18,44:** 8. Facilitate partnership with Emory Injury Prevention Center to further integrate injury prevention in RTACs. 9. Provide information about injury prevention evidence-based strategies and validate the system cost savings from injury prevention. 16. Identify potential stakeholders to participate in the Foundation	Regions 3 & 9 involved in injury prevention initiatives; Partnering with Emory on injury prevention; Launched campaigns (e.g., stop the bleed, car fit)	Lack of funding; Participation - need to advertise; Challenge coordinating with multiple partners; Insufficient training space; Logistics for larger regions;	Yellow
II. Public Information, Education and Prevention	19	**Trauma Quality Improvement Program (TQIP) and NISQIP Data Analysis Team** (requires new funding $200K)	Collaborate with NISQIP to request support from BCBS to fund the process to gather and transmit quality data from TQIP and NISQIP.	TQIP and NISQIP champions have been identified; Job descriptions developed and coordinators interviewed.	None	Yellow
II. Public Information, Education and Prevention	21	**Strategic Budgeting for Trauma System:** Address what can be achieved at different funding levels, state contribution levels for uncompensated care and readiness costs; RTAC regarding sustainment funding	**Combines Strategies 21 and 1:** 21) Determine how much trauma system funding is needed to adequately fund the trauma system by reviewing readiness cost data (July), EMS data (not included in readiness survey) and Dr. Pracht's report to identify gaps/areas that need to be funded. 1) Once an approved trauma plan is in place, RTACs can request sustainment administrative funding from the GTC to continue the work of the RTAC.	Current readiness cost survey will include a validation piece, which will add integrity to cost estimates;2011 survey results are being published;	Vendor's cost validation approach is still unclear; Estimates show that uncompensated care is only cents on the dollar. Legislators want to know where cost estimates come from, so validation will be important.	Yellow

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III. Professional Resources	27	**Mobile Integrated Health** (Based on Spaulding County Pilot)	Explore potential opportunities to implement mobile integrated healthcare based on the pilot project in Spaulding to include both rural and urban areas.	Grady achieved cost aversion by reducing transports. Harrelson county using EMS to identify and serve high risk population and reduce ER visits.	Lack of designated funding; Lack of awareness that this is a needed and viable mitigation approach; Curriculum is ever evolving.	Yellow
IV. Pre-Hospital Resources	2	**RTAC Regional Data Reports**	Summarize the Pracht data by region for each RTAC to determine needs.	Pracht data provided state level insight on population living within 50 miles of a trauma center and offers need assessment for number of trauma centers needed statewide; NBATS study completed, offering tool for determining number of TC needed in a region;	NBATS tool needs to be validated (considering use of Pracht data as test data); Still need to analyze Pracht data at regional level.	Yellow
IV. Pre-Hospital Resources	3	**Benchmarks, Indicator and Scoring (BIS) Assessment**	Examine the gaps and needs identified in the BIS Assessments completed by the RTACs to identify shared system needs for funding.	BIS Assessment completed for regions 2,3,and 10. Regions 1, 5, 6, and 9 are complete but may need updating; 4,7,and 8 are not started.	Lack of designated personnel has impeded completion; need to identify statewide gaps and commonalities across regions.	Yellow

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IV. Pre-Hospital Resources	14	**Pediatric Data and Analysis**	Collect data to better understand disposition of pediatric patients including an examination of EMS trip reports or other data to understand how decisions are made for pediatric patients. There may be a potential role for flight deployment.	Successful outreach to hospitals stressing early transfers of severely injured children to pediatric hospitals; Several hospitals entered new transfer agreements; Diversion hours are down dramatically (1/20 of prior diversions).	Lack of available pediatric transport teams; Pediatric patients still being taken to adult hospitals first, instead of direct transport to pediatric hospitals.	Green
IV. Pre-Hospital Resources	25	**Multi-County Coordination Pilot**	Implement a multi- county pilot project to identify efficiencies working together (e.g. policies and procedures, mutual aid agreements).	EMS 20/20 agreement established; Grant-funded study on multi county EMS agreements completed and found that despite barriers multi county agreements are possible; cost efficient and encouraged.	Lack of trust across jurisdictions; the desire for autonomy; coordinating staffing	Green
IV. Pre-Hospital Resources	47	**RTAC Structure, Coordinator and Uniform Guidelines**	N/A - New strategy in 2016	RTAC coordinator hired; Developed uniform guidelines; Several RTAC plans ready for GTC approval.	None	Green

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V. Definitive Care Facilities	4	**Develop New TC Resource Document**	Develop a Resource Document for new Trauma Centers with details for a hospital who is seeking trauma center designation.	Mentoring resources under development; mentoring process planned to overcome challenges associated with varying skill levels of hospital staff.	Lack of data repository and lack of access; varying skill levels among staff; Fear of job creep associated with TC designation;	Yellow
V. Definitive Care Facilities	5	**Streamline Re-designation Process**	Combines strategies 5,6,7: 5. Develop a process to synchronize the state redesignation process with GTC readiness cost reimbursement (change from uncompensated costs) to promote alignment on level of service provided and reimbursement. 6. Determine a redesignation process budget. 7. Reexamine development of a summary report with information about designation and redesignation (e.g. dates, schedule) to be provided to the GTC.	Synchronized process to align service levels and reimbursement across hospitals; Performance budgeting implemented;	Lack of designated funding for redesignation process makes it difficult to plan budget; Budget has not increased with increase in trauma centers requiring redesignations; Redesignations are secondary among funding priorities.	Red
VI. Evaluation	32	**"Time to Care" Metric**	Identify baseline measure for the response time from dispatch to destination for trauma patients (measure #5).	Successfully measuring time from dispatch to initial to initial hospital; Manual and local data successes measuring time from non-TC hospital to TC or pediatric TC;	Difficulty collecting and measuring statewide data on time for hospital transfers;	Yellow
VI. Evaluation	33	**Set Targets for Evaluation Metrics**	Identify targets for each of the five evaluation measures.	Reported annual data to OPB each year for four years;	Have not discussed or recommended targets (OPB does not currently require agencies to submit targets.)	Yellow

Instructions:
1. Review the fundamental component summary and associated goals.
2. Consider Thursday's strategy status updates
3. For each strategy discuss (5 minutes per strategy):
   - the impact of implementation and the harm or risk of not implementing in 2017;
   - whether it could be started immediately (i.e., not dependent on completion of another strategy or other dependency which will delay implementation);
4. As a group discuss which strategy would have the greatest impact on the Georgia Trauma System and the public (i.e., your WIG). (Note: If another strategy, not listed here, would have a greater impact on the GTS, you may recommend adding it to the strategy prioritization list.) (5-10 minutes)
5. Report your team's recommendation back to large group.

				Small Team Exercise (4 Teams)		
Component	**strategy #**	**(Combines #s)**	**Strategy Description (January 2016)**	**Importance (Positive Impact of Implementation / Risk of Not Implementing)**	**Feasible (Immediately Actionable) (Yes/No)**	**Team Priority Recommendation (Choose One) (i.e., Most Impact on GTS and Public)**
II. Public Information, Education and Prevention	21	1,21	**Strategic Budgeting for Trauma System:** Address what can be achieved at different funding levels, state contribution levels for uncompensated care and readiness costs; RTAC regarding sustainment funding	Discussed by Group 1	Discussed by Group 1	Discussed by Group 1
II. Public Information, Education and Prevention	19	19	**Trauma Quality Improvement Program (TQIP) and NISQIP Data Analysis Team** (requires new funding $200K)	Discussed by Group 1	Discussed by Group 1	Group 1 selected TQIP and NISQIP as the top priority for Public Education and Prevention. They reasoned that to get the resources they need, they first need the data. Good data and data analysis will allow us to show what works and justify requests for funding.

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II. Public Information, Education and Prevention	8	8, 9, 16, 17, 18, 44	**RTAC Injury Prevention Committee:** Form committee or other structure to ensure that injury prevention efforts are coordinated, inclusive and not duplicative, and to establish a mechanism to promote regular communication with RTACs. (Members may include Foundation, TAG, RTACs, ECIC, GCTE, Safekids, GOHS, others)	Discussed by Group 1	Discussed by Group 1	Discussed by Group 1
III. Professional Resources	27	27	**Mobile Integrated Health** (Based on Spaulding County Pilot)	Discussed by Group 3	Discussed by Group 3	Discussed by Group 3

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IV. Pre-Hospital Resources	47	47	**RTAC Structure, Coordinator and Uniform Guidelines**	Discussed by Group 2	Discussed by Group 2	Discussed by Group 2
IV. Pre-Hospital Resources	14	14	**Pediatric Data and Analysis**	Discussed by Group 2	Discussed by Group 2	Discussed by Group 2
IV. Pre-Hospital Resources	25	25	**Multi-County Coordination Pilot**	Discussed by Group 2	Discussed by Group 2	Discussed by Group 2
IV. Pre-Hospital Resources	2	2	**RTAC Regional Data Reports**	Discussed by Group 2	Discussed by Group 2	Discussed by Group 2

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1. Review the fundamental component summary and associated goals.
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5. Report your team's recommendation back to large group.

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Component	**strategy #**	**(Combines #s)**	**Strategy Description (January 2016)**	**Importance (Positive Impact of Implementation / Risk of Not Implementing)**	**Feasible (Immediately Actionable) (Yes/No)**	**Team Priority Recommendation (Choose One) (i.e., Most Impact on GTS and Public)**
IV. Pre-Hospital Resources	3	3	**Benchmarks, Indicator and Scoring (BIS) Assessment**	Discussed by Group 2	Discussed by Group 2	Group 2 selected the BIS Assessment as the top Pre-Hospital Resources priority, reasoning that the BIS assessment is key to showing how the system is improving regionally.
V. Definitive Care Facilities	5	5,6,7	**Streamline Redesignation Process**	Discussed by Group 3	Discussed by Group 3	Group 3 selected the resdeignation process as rhe top priority for Definitive Care Facilities. The team further recommended that the strategy be to establish a redesignation process that accounts for the growing number of trauma centers and that has a planned (not reactionary budget).
V. Definitive Care Facilities	4	4	**Develop New TC Resource Document**	Discussed by Group 3	Discussed by Group 3	Discussed by Group 3

Instructions:
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   - the impact of implementation and the harm or risk of not implementing in 2017;
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5. Report your team's recommendation back to large group.

				Small Team Exercise (4 Teams)		
Component	**strategy #**	**(Combines #s)**	**Strategy Description (January 2016)**	**Importance (Positive Impact of Implementation / Risk of Not Implementing)**	**Feasible (Immediately Actionable) (Yes/No)**	**Team Priority Recommendation (Choose One) (i.e., Most Impact on GTS and Public)**
VI. Evaluation	36	28, 36, 37, 38	**Improve Patient Data through TS Registry Interface and GEMSIS 3.4 Update (aka, Hospital Hub Project)**	Discussed by Group 4	Discussed by Group 4	Discussed by Group 4
VI. Evaluation	32	32	**"Time to Care" Metric**	Discussed by Group 4	Discussed by Group 4	Group 4 selected the time-to-care metric as the top priority for evaluation. This metric is essential for decision making related to getting patients to definitive care within the golden hour. Specifically, the data will help us identify where or why access may be a problem as well as analyze hospital diversion. While we have been able to measure the time to the initial hospital, measuring the transfer time to the final trauma center remains elusive. A pilot project of a single trauma center is recommended to study the PCR data.
VI. Evaluation	33	33	**Set Targets for Evaluation Metrics**	Discussed by Group 4	Discussed by Group 4	Discussed by Group 4
VI. Evaluation	35	35	**Align Regional Requirements to Metrics**	Discussed by Group 4	Discussed by Group 4	Discussed by Group 4

Component	strategy #	Strategy #s	Strategy Description (January 2016)	Status Color (2017)	Votes	Ultimately, what Would Successful Completion Look Like?	What Should be Completed by Next Qrtrly Update?	What Should be Completed by CY 2017 End?	Who Will Lead? (Cmte or Name)	Who are the Other Team Participants?
VI. Evaluation	32	32	**"Time to Care" Metric**	Yellow	25 votes (#1 WIG)	Success would include having all necessary data points from the PCRs entered and analyzed, which means that key parties know how to properly complete and interpret the PCR data. A second component of this metric will include studying diversion practices and their impact on time to care.	A pilot study will be completed to test and recommend which data elements from the PCRs should be used to calculate time from 911 call to definitive care at TC. Data elements of pilot study will be identified, cross referenced to PCR and analyzed. Hospital Administrators committee will recommend a definition for measuring diversion (e.g., # of transport denials) so that we may begin collecting and analyzing data across regions.	Provided that the pilot goes well, the goal would be to complete a statewide analysis of "time to care" data by CY end. A standard definition for measuring data would be in place and data would be collected and analyzed to improve policies and decision making.	Ernie will lead the time to care pilot and ensure that OEMS&T completes necessary data analyses. Liz will work with Hospital Administrators and report back recommendations for defining and measuring hospital diversion.	OEMS&T, Vick
II. Public Information, Education and Prevention	19	19	**Trauma Quality Improvement Program (TQIP) and NISQIP Data Analysis Team** (requires new funding $200K)	Yellow	21 votes (#2 WIG)	Success is broader than just TQIP and NISQIP. Success would be to identify meaningful data sets, having access to those data in real time, and using the data for decision making to improve patient outcomes.	By June, GTC will have hired the analyst and coordinator FTEs for the data analysis team.	Analyst will have analyzed data and identified potential injury prevention or related projects for next year based on data, and shared data a GTC meeting during the next Day of Trauma session. By December, GTC will have selected the top project to work on for next year.	Dr. Ashley will report back on personnel matters and either he or a designee will be responsible for reporting on the TQIP/NISQIP data analysis efforts.	Emory team, OEMS&T, GTC, IMD, TPM, and TQIP/NISQIP personnel - Analyst, Champion, coordinator will all be key to ensuring the availability of quality data for the TQIP/NISQIP team.
V. Definitive Care Facilities	5	5,6,7	**Establish Redesignation Process**	Red	18 votes (#3 WIG)	All Trauma Centers will have timely redesignations, which would mean being visited by appropriate oversight body every 3 years without lapse.	Prepare a timeline showing status of all designated trauma centers, including level of designation, date of last visit, date of next scheduled visit if known and other details as deemed appropriate for assessing risk.	Develop a hybrid plan between state and American College of Surgeons to ensure that growing number of trauma centers are timely reviewed and maintain designated trauma center status. Once plan and review schedule has been completed, a budget proposal should be prepared documenting the need, mitigation plan, proposed budget level and anticipated return on investment.	Rene will prepare initial status report and guide the development of the new redeignation plan.	Dr. O'Neal, Rene, Laura, Dena, GTC will all assist as needed during plan development. Depending on how GTC wants to fund redesignations, Dr. O'Neal or Dena should probably develop the budget proposal and justification.

Component	strategy #	Strategy #s	Strategy Description (January 2016)	Status Color (2017)	Votes	Ultimately, what Would Successful Completion Look Like?	What Should be Completed by Next Qrtrly Update?	What Should be Completed by CY 2017 End?	Who Will Lead? (Cmte or Name)	Who are the Other Team Participants?
IV. Pre-Hospital Resources	3	3	**Benchmarks, Indicator and Scoring (BIS) Assessment**	Yellow	10 votes (not tracked as a WIG)	This will be a regional activity and regions should report on their BIS assessment as part of their regular RTAC updates. However, it will not be a statewide Wildly Important Goal tracked by GTC in 2017.	Region 3 should document and share successes of their model (who they involved, how its was handled).			RTAC Coordinator, Trauma System Planner, Vick, Billy
II. Public Information, Education and Prevention	8	8, 9, 16, 17, 18, 44	**RTAC Injury Prevention Committee:** Form committee or other structure to ensure that injury prevention efforts are coordinated, inclusive and not duplicative, and to establish a mechanism to promote regular communication with RTACs. (Members may include Foundation, TAG, RTACs, ECIC, GCTE, Safekids, GOHS, others)	Yellow	3 votes (not tracked as a WIG)	This important activity will continue, but will not be tracked as one of the GTC's Wildly Important Goals during CY 2017.				
IV. Pre-Hospital Resources	25	25	**Multi-County Coordination Pilot**	Green	3 votes (not tracked as a WIG)					
II. Public Information, Education and Prevention	21	1,21	**Strategic Budgeting for Trauma System:** Address what can be achieved at different funding levels, state contribution levels for uncompensated care and readiness costs; RTAC regarding sustainment funding	Yellow	2 votes (not tracked as a WIG)	Recommended that this be undertaken as part of the TQIP/NISQIP analysis.				
III. Professional Resources	27	27	**Mobile Integrated Health** (Based on Spaulding County Pilot)	Yellow						
IV. Pre-Hospital Resources	2	2	**RTAC Regional Data Reports**	Yellow						
IV. Pre-Hospital Resources	14	14	**Pediatric Data and Analysis**	Green						
IV. Pre-Hospital Resources	47	47	**RTAC Structure, Coordinator and Uniform Guidelines**	Green						
V. Definitive Care Facilities	4	4	**Develop New TC Resource Document**	Yellow						
VI. Evaluation	33	33	**Set Targets for Evaluation Metrics**	Yellow						
VI. Evaluation	35	35	**Align Regional Requirements to Metrics**	Red						

Component	strategy #	Strategy #s	Strategy Description (January 2016)	Status Color (2017)	Votes	Ultimately, what Would Successful Completion Look Like?	What Should be Completed by Next Qrtrly Update?	What Should be Completed by CY 2017 End?	Who Will Lead? (Cmte or Name)	Who are the Other Team Participants?
VI. Evaluation	36	28, 36, 37, 38	Improve Patient Data through TS Registry Interface and GEMSIS 3.4 Update (aka, Hospital Hub Project)	Green/Yellow						