Approved 17 March 2016

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

GEORGIA TRAUMA COMMISSION MEETING MINUTES

Thursday, 21 January 2016
8:00 AM to 3:00 PM

DAY 1

Macon Marriott City Center
240 Coliseum Drive
Macon, Georgia 31217

Magnolia Banquet Room A & B

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

STAFF MEMBERS & OTHERS SIGNING IN	**REPRESENTING**
Monica Sullivan	Attorney General's Office
Dena Abston	Georgia Trauma Care Network Commission, staff
Lisa McDowd	Georgia Trauma Care Network Commission, staff
Marie Probst	OEMS/T
Renee Morgan	OEMS/T
Keith Wages	OEMS/T
Ernie Doss	OEMS/T
Lori Mabry	Georgia Trauma Foundation
Scott Maxwell	Mathews & Maxwell, Inc.
Jim Sargent	North Fulton Hospital
Gina Solomon	Gwinnett Medical Center
Jo Roland	Archbold
Susan Bennett	JMS Burn Centers
Heyward Wells	JMS Burn Centers
Laura Garlow	Kennestone
Dr. Regina Medeiros	GRU Health
Dr. John Harvey	MAG
Randy Pierson	Region 1
David Foster	Region 1

Paul Beamon	Region 4
Kristal Smith	Region 5
Kim Littleton	GAEMS
Sharon Nieb	Emory University Center for Injury Control

Call to Order: 8:11 AM

Quorum Established: 8:12 AM, 8 of 9 commission members present.

Welcome Remarks Presented by Dr. Dennis Ashley

Dr. Ashley welcomed everyone to the meeting and stated we now go into a closed session to discuss staffing, when we reconvene GTC business will be conducted.

CLOSED SESSION

MOTION GTCNC 2016-01-01:
I make the motion to go into closed session for discussion of staffing.

MOTION BY: DR. ROBERT COWLES
SECOND BY: MR. VIC DRAWDY
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Began regular scheduled portion of the meeting at 9:48 AM.

Chairman's Report Presented by Dr. Dennis Ashley

Dr. Ashley started his report with a presentation please see attached slides. **Attachment 1**

APPROVAL OF MINUTES

MOTION GTCNC 2016-01-02:
I make the motion to approve the minutes of 19 November 2015 Commission meeting as written.

MOTION BY: MR. VIC DRAWDY
SECOND BY: DR. JAMES DUNNE
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Administrative Report Presented by Ms. Dena Abston

Ms. Abston stated the Administrative Report was sent out on Tuesday, January 19, 2016 by email, is in today's packet for the commission members, and posted on the GTC website.

All supporting documents in the Administrative Report will be addressed as we move through the meeting.

The Governor's Budget Report has been released for the Amended FY 2016 and FY 2017, and was sent out in an email January 14, 2016. Please see pages 2-4 of the Administrative Report. There is no impact to the report for the Amended FY 2016. The FY 2017 was increased slightly to $16,385,913 for merit-based pay adjustments and employee recruitment and retention initiatives.

Ms. Abston continued her report stating the CY 2016 Proposed Commission meeting schedule needs to be approved.

APPROVAL OF CY 2016 & 2017 MEETING SCHEDULE

MOTION GTCNC 2016-01-03:
I make the motion to approve the CY 2016 & 2017 meeting schedule for the Georgia Trauma Commission meetings as presented.

MOTION BY: COURTNEY TERWILLIGER
SECOND BY: VIC DRAWDY
VOTING: All members approved the motion.
ACTION: The motion ***PASSED*** with no objection or abstentions.

APPROVAL OF CY 2016 Subcommittees, Committees & Foundation

MOTION GTCNC 2016-01-04:
I make the motion to approve the CY 2016 Georgia Trauma Commission Active Subcommittees, Supported Committees, and Foundation as presented.

MOTION BY: COURTNEY TERWILLIGER
SECOND BY: FRED MULLINS
VOTING: All members approved the motion.
ACTION: The motion ***PASSED*** with no objection or abstentions.

MAG contract update Presented by Dr. John Harvey

Dr. Harvey started by thanking the Commission for the initial funding and continued his report with a power point presentation. Please see **Attachment 2**. Additional information for MAG is listed in the Administrative Report, Pages 12-15.

Region 5 RTAC: School Resource Program Presented by Ms. Kristal Smith

Ms. Smith thanked everyone for the opportunity to update the Commission on the School Resource Program. Please see **Attachment 3.**

Telemedicine Pilot Project Presented by Mr. Paul Beamon

Mr. Beamon thanked the Commission, and gave a short update on Region 4. Progress is going forward in Region 4. We have a committee together, and plan to have a meeting with Ms. Renee Morgan. We are excited about where we are going in our Region.

Mr. Beamon continued his report with the Telemedicine Pilot Project. With the Telemedicine Project it is possible to give an on screen, in route, visual of the patient being transported. With the Telemedicine funding using the AVL system and changing to a multi antenna system, we were able to piecemeal together a system that works. This was to make the system cost effective, reproducible, and affordable to all services. The computer used and docking station is the most costly part of our system. When this has a strong signal, like connecting to an ER, you are able to drive down the road at 60mph with no delay. While in route to the hospital the physician is able to start assessing the patient and assist the medic in the patient care.

Questions and comments ensued:

Dr. Ashley asked, what is the goal? Mr. Beamon stated to give the patient better care, start early assessment while in route to the hospital. Dr. Ashley asked if any data has been collected to see how this is moving forward. Mr. Beamon stated we would be able to start collecting data soon.

Mr. Drawdy stated the advantage I see in Wayne County, we are in the middle of that gap, where there isn't a trauma center. While traveling to Memorial Hospital, 70 miles away and we are able to connect to the hospital in route. The physician could guide the medic in the patient's care or even to the right hospital.

Region 1 RTAC: DART Pilot Project Presented by Mr. Randy Pierson
Mr. David Foster

Mr. Pierson started his report with an update for Region 1 RTAC, DART Pilot Project classes, and training. Mr. Foster continued the report for the DART Pilot Project. See handout as **Attachment 4.**

Questions and comments ensued:

Mr. Terwilliger ask if they had a list for what the residual funding would be spent on. Mr. Foster stated they would set up a meeting with Ms. Dena Abston to discuss residual funding.

Mr. Terwilliger asked what was the cost of each bag. Mr. Foster stated we purchase 78 sets with 100 radios; cost was around $980.00 per bag as opposed to the $1,500.00 that was projected to cost.

Mr. Terwilliger asked how many bags does each truck have. Mr. Foster stated each truck has 3 bags and 4 radios.

Dr. Ashley stated this is phenomenal work, have we looked at this in other regions of the state, and maybe on a smaller scale with something like a mutual aid agreement. Possibly in daily life with assisting other services who may need that additional help at times on a daily basis. Mr. Foster stated we can go back and look at this, maybe tweak something to fit this in a daily need with an expanded mutual aid agreement, but at this time we do not have something like that in place.

Mr. Foster thanked the Commission and stated without your support this would not have been possible.

Office of EMS and Trauma update Presented by Mr. Keith Wages
Mr. Ernie Doss
Ms. Renee Morgan

Mr. Wages started by stating based on the Trauma System, Ms. Kelly Nadeau, Healthcare Preparedness Director at GA Dept. of Public Health along with Peki Prince and Ernie Doss, with teamwork, and working together with hospitals, and EMS agencies, put together the Infectious Disease Transportation Network in preparing for the response to the Ebola situation. This was Public Health's finest hour, and when we make one component of our system stronger we make the whole system stronger. Mr. Wages asked if Ms. Nadeau had anything to add. Ms. Nadeau gave a brief description of the Infectious Disease Network. Georgia has a tiered hospital system. Tier 3 facility is to identify, isolate, and inform, Tier 2 Assessment facilities, and Tier 1 treatment hospitals. We are holding one-day education sessions in each of the healthcare coalitions between now and June about the Ebola disease, other infectious diseases, about our Georgia plan and our regional plan. I invite you to come to one of these sessions, and if you need any additional information regarding dates and time please let us know and we will get you that information.

Mr. Doss started his report with an update on the business operation platform SED. We use this platform to approve all of our licensing, training, investigations, and education courses. We have spent most of the last 6 to 7 months to redesign our program to work how we want it to. We hope once this project is completed it will help our office work more efficiently as well as help with tracking our training. The next thing I would like to updated the group on is our training platform with the Georgia Public Safety Training Center, it is up and running. We have 2 classes on it and we are using it to register our IDDN training. We have contracted with the foundation to do some training and we are in phase 1 of that training. They are helping us to develop a pediatric burn class that we want to put on the classroom. In closing, I would like to update you on moving through to our new GEMSIS platform we are working on our policies, and our data set. Our version 3.4 site is up, and we will be able to accept the new version data in January of next year. The data set as we get it will be HL7 compatible, so we have hopes, the services, and hospital that can and want to will be able to submit their reports through the hospital electronic data system.

Ms. Morgan started her report with an update on the designated trauma centers. See pages 26 – 28 of the administrative report. Ms. Morgan stated within the next 6 months we would probably have two new trauma centers joining us. Fairview Park a level 3 and Appling a level 4. We are talking to Spalding Regional, which is located in region 4. Our assessment has not been completed on Spalding yet, but they should be a level 3. We are also in the process of finalizing Fort Stewart, which will be our first military base. We have been working on updates to the trauma plan. A new thing we are working on that has not been completed is the induction of the rehab centers. We are working with Shepard's Spinal Center to develop the criteria. We will have level 1 and level 2 rehab centers. Ms. Morgan concluded her report by introducing Dr. William Hardcastle who has been recruited by Dr. O'Neal to be the new Deputy Medical Director for OEMS/T. Dr. Hardcastle stated he is glad to be back in the world of Trauma.

Questions and comments ensued:

Dr. Dunne asked I have had several comments from several registrars and program managers through out the state, when at various meetings, regarding additional data requirements that the state has. What are these additional data fields and what are they being used for? Ms. Morgan stated the additional data fields are use to compile reports, use for verification and consultative visits. We have added these to get the centers use to writing reports, so when the college comes in for their verification visit, the centers will know how to run those reports.

Dr. Dunne asked what is the state using the additional data for that the centers are sending. Ms. Morgan stated some goes to injury prevention.

Dr. Medeiros stated NTDB is a very small, minimal data set. There are other data elements contained in the registry that are required for both state designation as well as ACS verification, that are not contained in the NTDB data set. I agree we are over burdened with the number of data elements that we currently collect and that we are collecting a tremendous amount of data elements that appears to not be used for anything. I do not disagree that we might need to take another look at what we are doing, but the reports that Marie and Renee are working on would not be contained in the NTDB data set. The reports that give the Commission a quick snapshot of the metrics of trauma centers readiness.

Dr. Dunne stated I want to be sure that the requirements we are placing on the centers are appropriate, useful and if we are requiring them to collect data, they get reports back on the data collected.

Ms. Morgan stated we are open to suggestions and review on how to improve the system.

Dr. Ashley stated the strategic planning session would take place tomorrow there will be goals and review, some of these questions and issues may be addressed.

Georgia Trauma Foundation, Inc. Presented by Ms. Lori Mabry

Ms. Mabry started her report by introducing Dr. Gregory Starr who is with Phoebe Putney and new to the GTF board. Please see pages 18 – 25 of the administrative report for information covered in her report. Ms. Mabry continued her report by stating one of our strongest most successful partnerships so far is our acquisition of TAG. We have already strengthened the education platform with the GA Tech group Computing for Good. They have developed an online course registration system for all courses that we acquired from TAG. With the GA Tech partnership we can continue to take projects to them every semester. This is a huge benefit and great program. Another relationship we have built with the American Trauma Society is with their Trauma Survivors Network. They have an online component for the Trauma Survivors Network for the family members and this gives them a wealth of knowledge and resource information. We are working with them to develop an app to offer to our centers here in Georgia. If we can help them develop this app, maybe we can get this great resource for free. At this time the cost is a fee around $1,500 for an annual membership to have access to the network. We will continue to negotiate with this program and hope to be leaders alongside them.

Questions and comments ensued:

Dr. Ashley asked this infrastructure takes care of the education part and one of the missions of the Georgia Trauma Foundation, could this infrastructure also be used for a grants process, grants and research papers, grading and other things like this? Ms. Mabry and Dr. Mullins both stated yes it could be used for this as well.

Georgia Committee for Trauma Excellence Presented by Ms. Laura Garlow

Ms. Garlow stated it is an honor and privilege to stand before you today as the new Chair of the GCTE.
We would like to take this time to acknowledge Ms. Gina Solomon for her 2 years of service and present her with a plaque for her dedicated services to the state of Georgia, thank you. Ms. Liz Atkins is the new Vice Chair and we will both serve a two-year term.

All of our subcommittee's chairs with the exception of two have accepted another two-year appointment in their positions. Ms. Lisa Ulbricht with Kennestone will chair Injury Prevention. We would like to thank Ms. Emma Harrington for 2 years of service as chair for subcommittee Injury Prevention group. Over the last year Injury Prevention has been involved in Matter of Balance one of the largest injury prevention programs they have sponsored. They have conducted 28 classes with 150 to 200 participants and have trained over 30 master trainers for that program.

Registry Subcommittee work continues with the state registry. We are working on transitions from ICD 9 to ICD 10. We are working on the GA data dictionary so we have consistent definitions for data elements that the state of Georgia specifically wants us to collect.

The Education committee is working with the Trauma Foundation, thank you Ms. Mabry for your support, and the website. TAG's administrative functions will be transitioning; the goal is by the end of March so that they do not have to register again with the state as a 501(c)(3). The education committee will still maintain the responsibilities of presenting and developing courses. They are working with the Foundation to use the

website as a document repository for resource and development and existing trauma centers, documents such as job descriptions, protocol, policies and other kinds of resources that we might be able to use this for. There are multiple courses scheduled between now and the end of the year. We are working on developing a statewide list of instructors as well as gaining more course directors. We will be submitting budget request for FY 2017 for courses we would like to conduct next year.

The PI group is working to maximize the outcomes module in the trauma registry by working with the track issue function. They are trying to figure out the features and make this really functional. Then we will offer some educational opportunities so we all can benefit from the use, and utilize the trauma registry to its maximum capacity, as well as working on process improvement. We have two level three hospitals in the pilot program for the TQIP group, it is exciting to have some of our own level three's working on that. The PI group is also working with Ms. Gina Solomon and the TQIP group on the geriatric triage project.

Emergency Preparedness has a new chair it is Ms. Sabrina Westbrook with Clearview Regional. They will work to develop goals for the year and make recommendations to the GCTE.

The GA TQIP Collaborative presented for the 4th consecutive year at the TQIP annual meeting. Ms. Liz Atkins, Ms. Gina Solomon, and Ms. Tracy Johns represented the GA trauma centers and we are very proud of that.

EMS Subcommittee on Trauma Presented by Mr. Courtney Terwilliger

Mr. Terwilliger started his report addressing the AVLS program. Please see power point presentation slides 1 – 10, **Attachment 5**.

Mr. Terwilliger continued his report with the EMS subcommittee Budget FY 2016. Please see power point presentation slides 11 – 14, **Attachment 5**. Please see Administrative Report pages 29 – 38.

APPROVAL OF FY 2016 EMS Subcommittee Budget Presented

MOTION GTCNC 2016-01-05:
I make the motion that the Trauma Commission approves the FY 2016 budget for the EMS subcommittee as presented.

MOTION BY: EMS SUBCOMMITTEE
SECOND BY: NOT NEEDED (recommendation came from EMS Subcommittee)
VOTING: All members are in favor of motion.
ACTION: The motion PASSED with no objections, nor abstentions.

Georgia Association of Emergency Medical Services Presented by Ms. Kim Littleton

Ms. Littleton started her report with the deliverables for the FY 2014 and FY 2015 contracts. The FY 2014 contract sits fully in the GAEMS. The FY 2015 contract is a flow through contract with the Emergency Preparedness Foundation, so there is a lengthy process with this contract in working with the Foundation to pull together the deliverables for those two contracts. We did have two line items within the FY 2014 and FY 2015 that were running simultaneously, the Trauma Equipment Grant, and the EMR/EMT Grants. The FY 2014 Trauma Equipment Grant money has been completely expended, now we are working on the FY 2015. To give you a background on the 183, zoned 911 services that applied for the trauma equipment grants, it equates into 1,181 units or ambulances that we are putting trauma equipment on or $2,700 per ambulance of trauma equipment.

EMR and EMT courses, we had 17 courses in FY 2014 that were awarded, 4 courses are now fully completed. Child safety seat tech course are moving forward to conduct those training courses across the state. Kim Martin who is the facilitator is steering that program. In FY 2015 funding the same trauma training line item, we have 17 courses that are to be provided, 3 of those courses are complete the other 14 will be delivered in this grant cycle. In the leadership course we have graduated 27 students, Mr. Vic Drawdy being one of those students. This is the first year of four years conducting this course that we have ended the class with the same number of students we started with. The GEMSIS meetings are continuing to progress. We have conducted 4 of the EMS 2020 meetings across the state and are developing the information from the data that we are receiving back from those meetings. We will have one additional meeting that will be conducted in Riverdale on 24th of February if anyone is interested. This meeting will be wrapping up what the whole process has been about. One additional item that may have been recorded in a prior GTC meeting, CAT Tourniquets provided to 283 DNR rangers along with training. We are still working on a press release for this.

Law Department report Presented by Ms. Monica Sullivan

Ms. Sullivan stated there were questions regarding airfare and travel. The state office and accounting guidelines states that if you are combining personal with business travel the amount you are reimbursed for cannot exceed what the state would pay you if you were not combining personal travel with business travel. I am assuming the airfare would exceed whatever cost each of you would normally get, so that cost would not be reimbursed. Also hotels fall under daily expense, so the daily amount you are paid would cover that. Dr. Ashley asked, there are sometimes when it would be difficult to make it to a meeting if you are driving, if necessary to make it to that meeting can you fly? Ms. Sullivan stated she could look into that. Ms. Abston stated the reimbursement is $105 per day. Mr. Drawdy stated you also get mileage. Ms. Sullivan stated that is correct.

Meeting Adjourned: 4:16 PM

Minutes crafted by: Lisa McDowd

Attachment 1

Georgia Trauma System Annual Report

House Health and Human Services Committee
Representative Sharon Cooper, Madam Chair
February 23, 2016

Dennis W. Ashley, M.D., FACS
Milford B. Hatcher Professor
Chair of Surgery
Mercer University School of Medicine
Director Trauma Services and Critical Care
Medical Center Navicent Health
Chair, Georgia Trauma Commission

Georgia Trauma Commission

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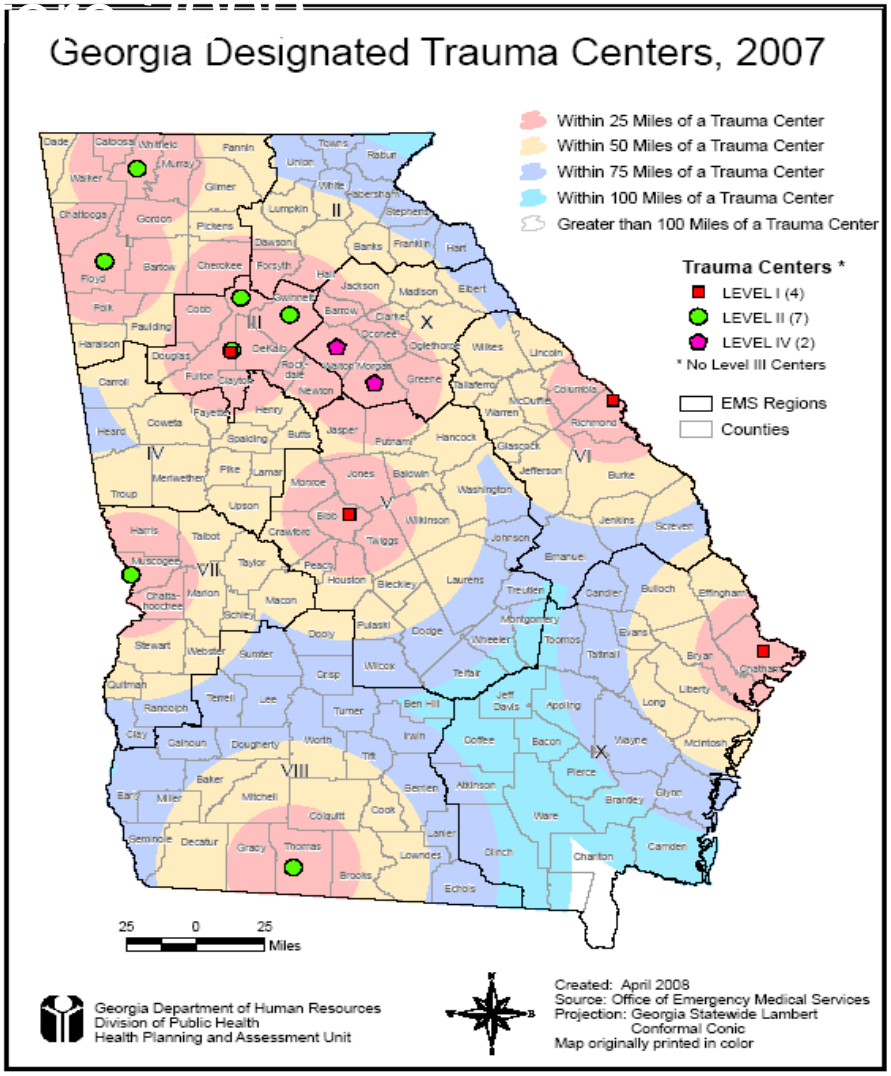
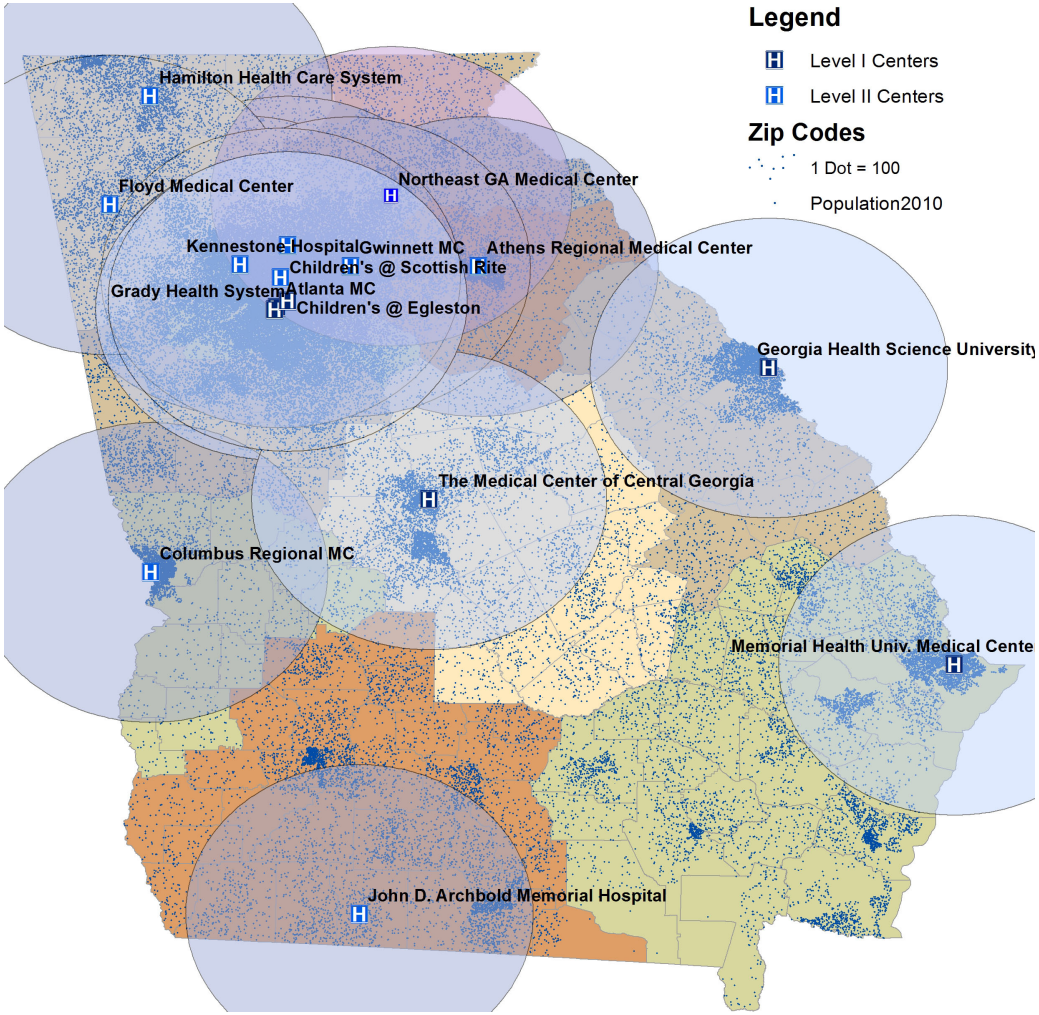

Georgia Designated Trauma Centers, 2007
Within 25 Miles of a Trauma Center
Within 50 Miles of a Trauma Center
Within 75 Miles of a Trauma Center
Within 100 Miles of a Trauma Center
Greater than 100 Miles of a Trauma Center
Trauma Centers *
LEVEL I (4)
LEVEL II (7)
LEVEL IV (2)
* No Level III Centers
EMS Regions
Counties
25 0 25
Miles
Georgia Department of Human Resources
Division of Public Health
Health Planning and Assessment Unit
Created: April 2008
Source: Office of Emergency Medical Services
Projection: Georgia Statewide Lambert Conformal Conic
Map originally printed in color

Increasing Number of Trauma Centers

- **FY 2008:**
  - 4 Level I and 9 Level II Centers
- **FY 2009:**
  - 4 Level I and 10 Level II Centers
    - Athens Regional added as a Level II
- **FY 2011:**
  - 6 Level I and 9 Level II Centers
    - Atlanta Medical and Egleston upgraded from Level II to Level I
    - WellStar Kennestone added as a Level II
- **FY 2013:**
  - 6 Level I and 9 Level II Centers
  - 2 Burn Trauma Centers added
- **FY 2014: (All Centers)**
  - 6 Level I and 10 Level II Centers
    - Northeast Georgia added as a Level II
  - 2 Burn Trauma Centers
  - 3 Level III and 6 Level IV Centers
- **FY 2015/FY2016: (All Centers)**
  - 6 Level I and 10 Level II Centers
  - 2 Burn Trauma Centers
  - 5 Level III and 5 Level IV Centers

Location of (2014) Level 1 & 2 DTC with 50 Mile Buffers and 2010 U.S. census Population Density



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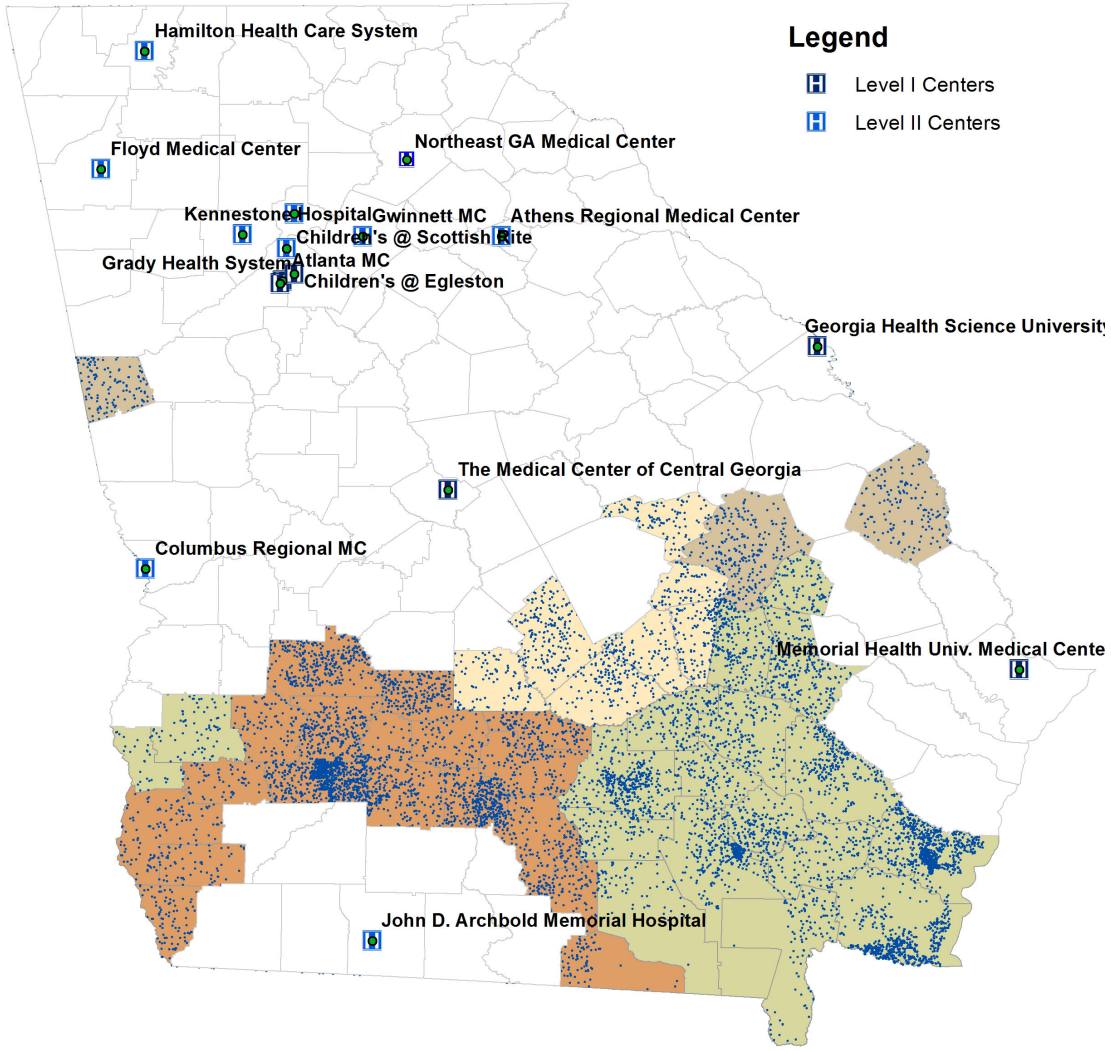
"An Analysis of the Georgia Trauma System"
Etienne Pracht, Ph. D. December 2013

Counties with Over Half of Their Territory More Than 50 Miles from Nearest Level I or II DTC



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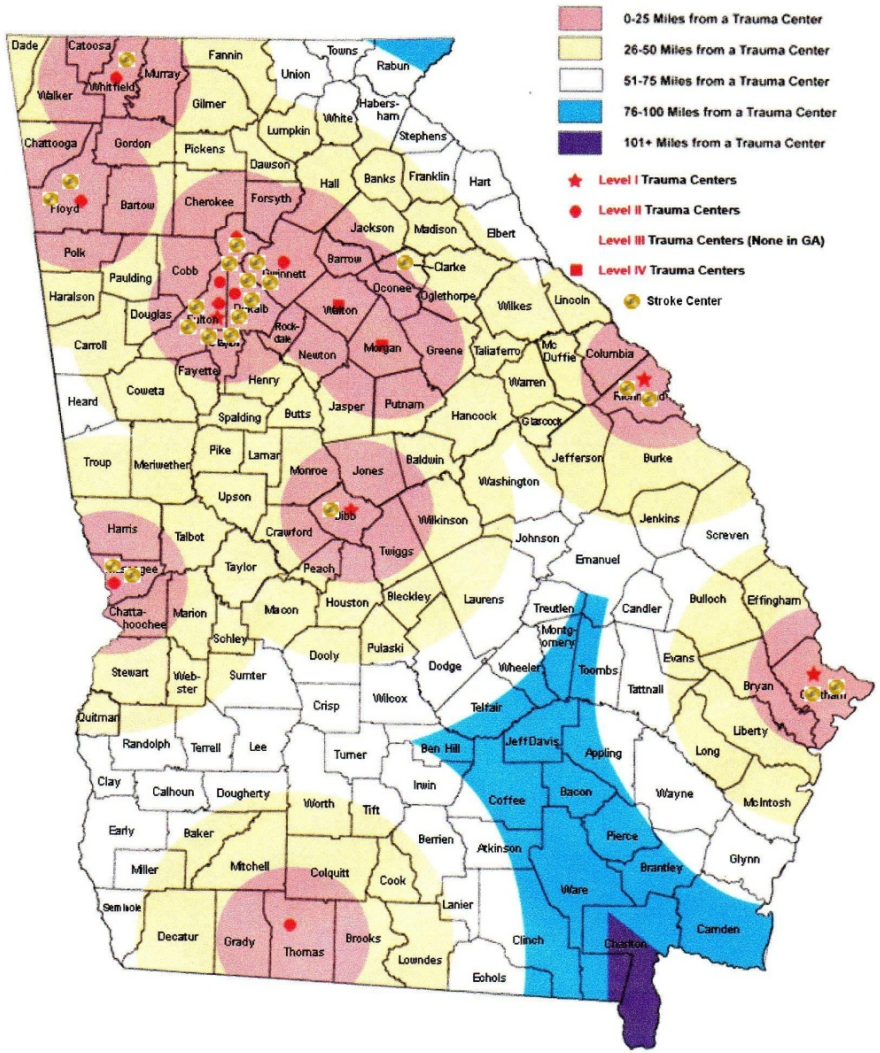
"An Analysis of the Georgia Trauma System"
Etienne Pracht, Ph. D. December 2013

Trauma and Stroke Centers in Georgia



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J.S. Robinson, Toward Healthcare Resource Stewardship. 2011

An Analysis of the Effectiveness of a State Trauma System: Treatment at Designated Trauma Centers is Associated with an Increased Probability of Survival

Dennis W. Ashley, MD[1], Etienne E. Pracht, Ph.D[2], Regina S. Medeiros, DNP, RN[3], Elizabeth V. Atkins, BSN, RN[4], Elizabeth G. NeSmith, Ph.D, APRN-BC[5], Tracy J. Johns, MSN, RN-BC, CPHQ[1], Jeffrey M. Nicholas, MD[6]

[1]Department of Surgery, Mercer University School of Medicine and the Medical Center, Navicent Health
[2]Department of Healthcare Policy and Research, University of South Florida College of Public Health
[3]Department of Surgery, Georgia Regents University
[4]Department of Surgery, Grady Memorial Hospital
[5]Department of Physiological and Technological Nursing, Georgia Regents University
[6]Department of Surgery, Emory University School of Medicine and Grady Memorial Hospital

Ashley, et.al. J Trauma Acute Care Surg. 2015

Survival Advantage Associated with Treatment at a DTC Versus NTC

	Improvement in probability of survival when treated at a DTC versus NTC	P-Value
All severe trauma (ICISS < 0.85)	9.6%	<0.01
Most critical (ICISS < 0.25)	16.5%	<0.01
Intermediate critical (0.25 ≤ ICISS < 0.5)	22.0%	<0.01
Least critical (0.5 ≤ ICISS < 0.85)	8.3%	<0.01

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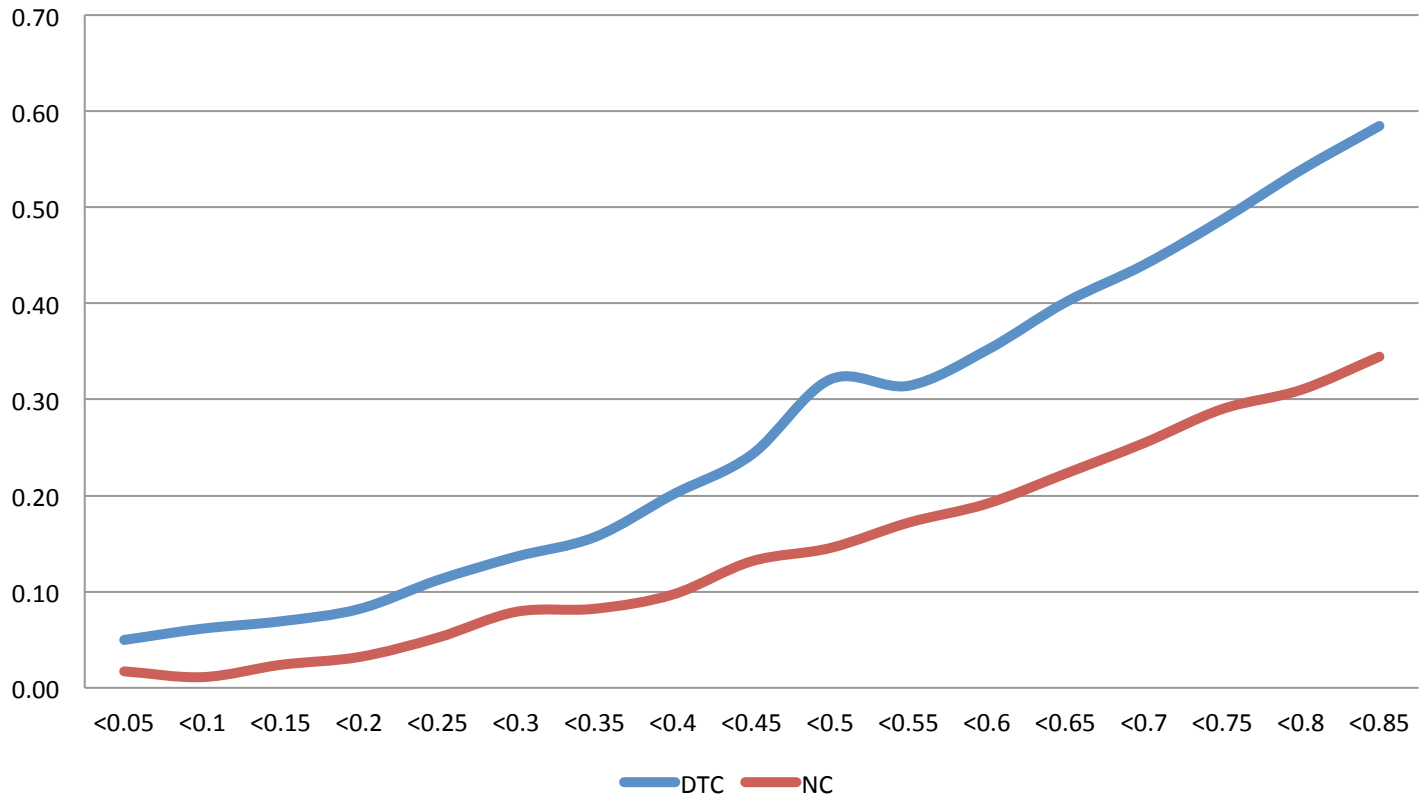
Ashley, et.al. J Trauma Acute Care Surg. 2015

Probability of a Normal Discharge



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"An Analysis of the Georgia Trauma System"
Etienne Pracht, Ph. D. December 2013

Access to Trauma Centers

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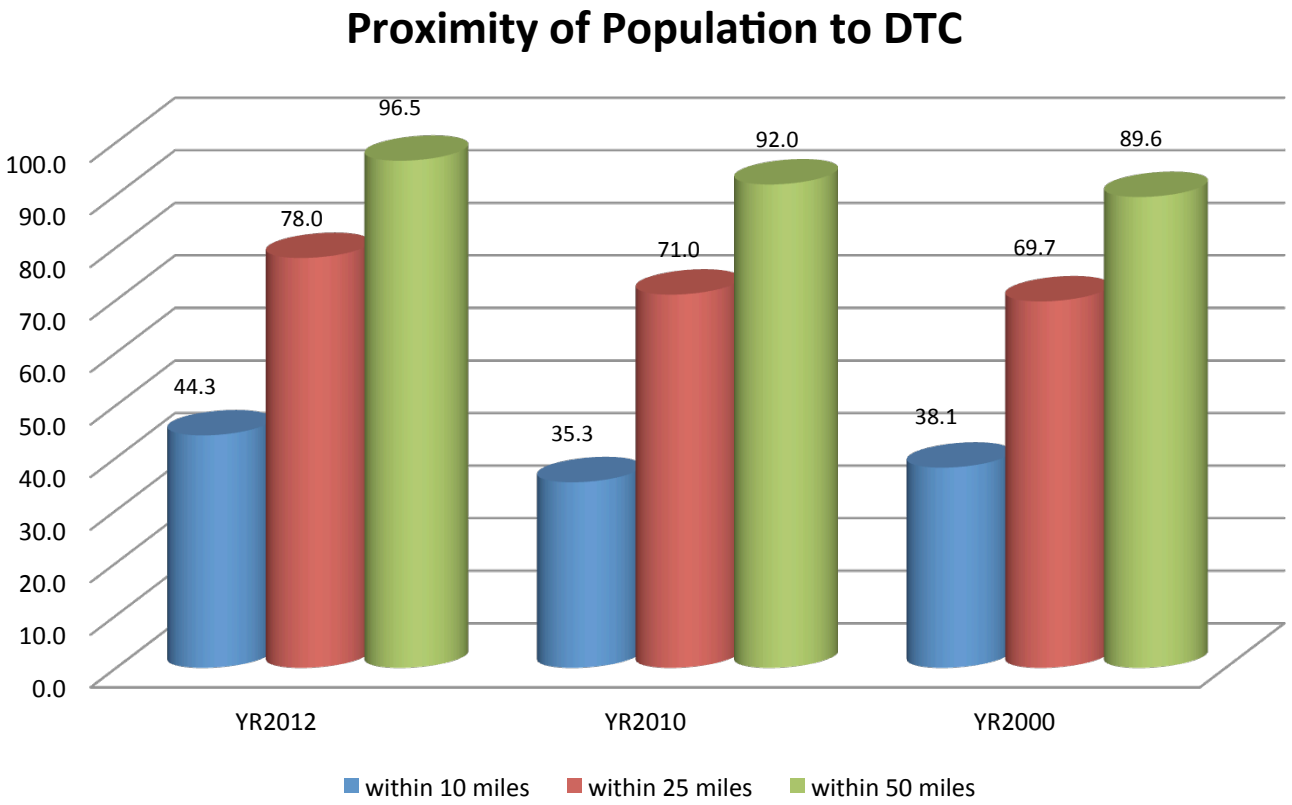
Proximity of the population to a DTC in 2012, 2010, and 2000



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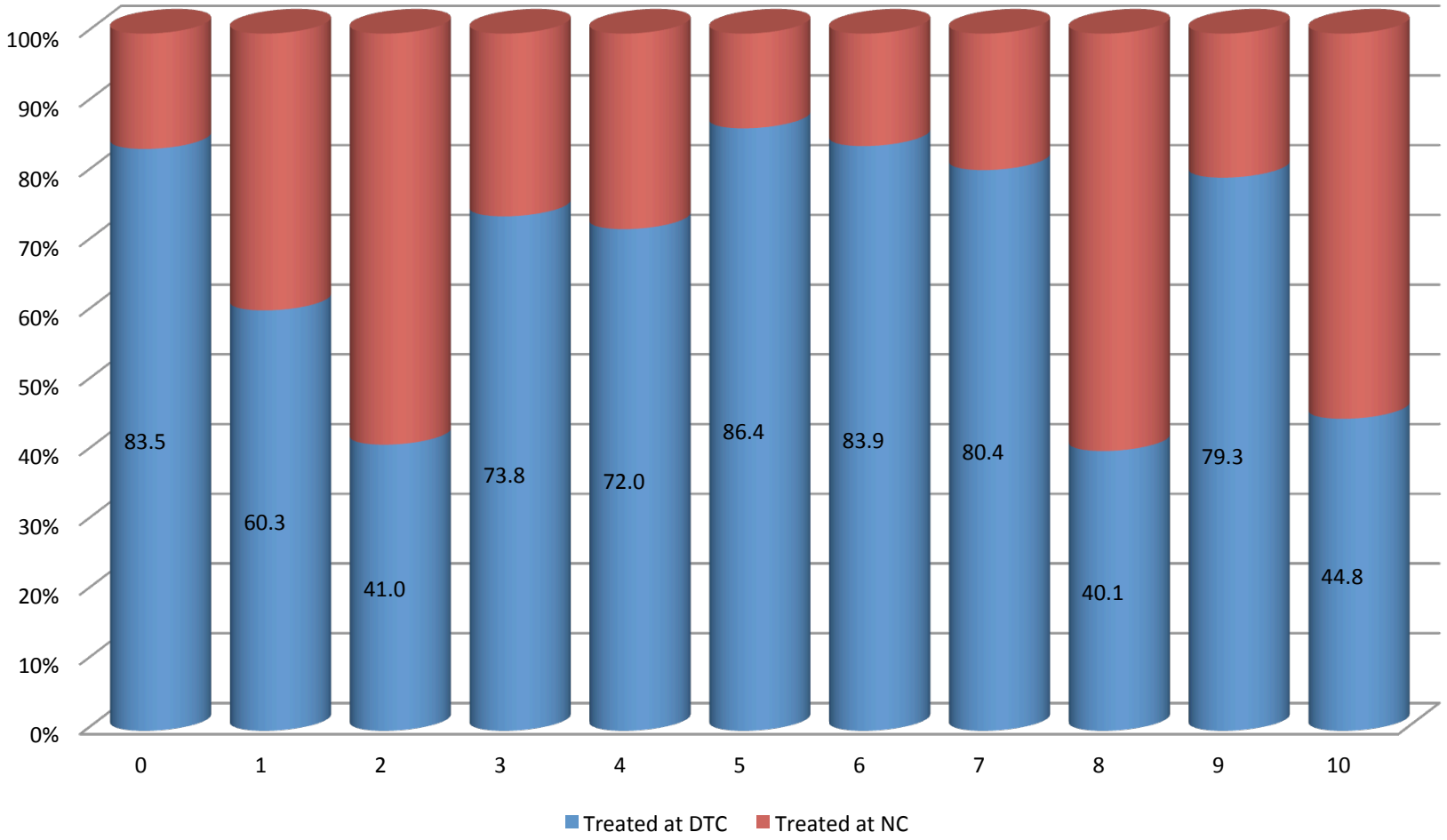
Severe Injury by Region & Hospital Type (2003 – 2012)



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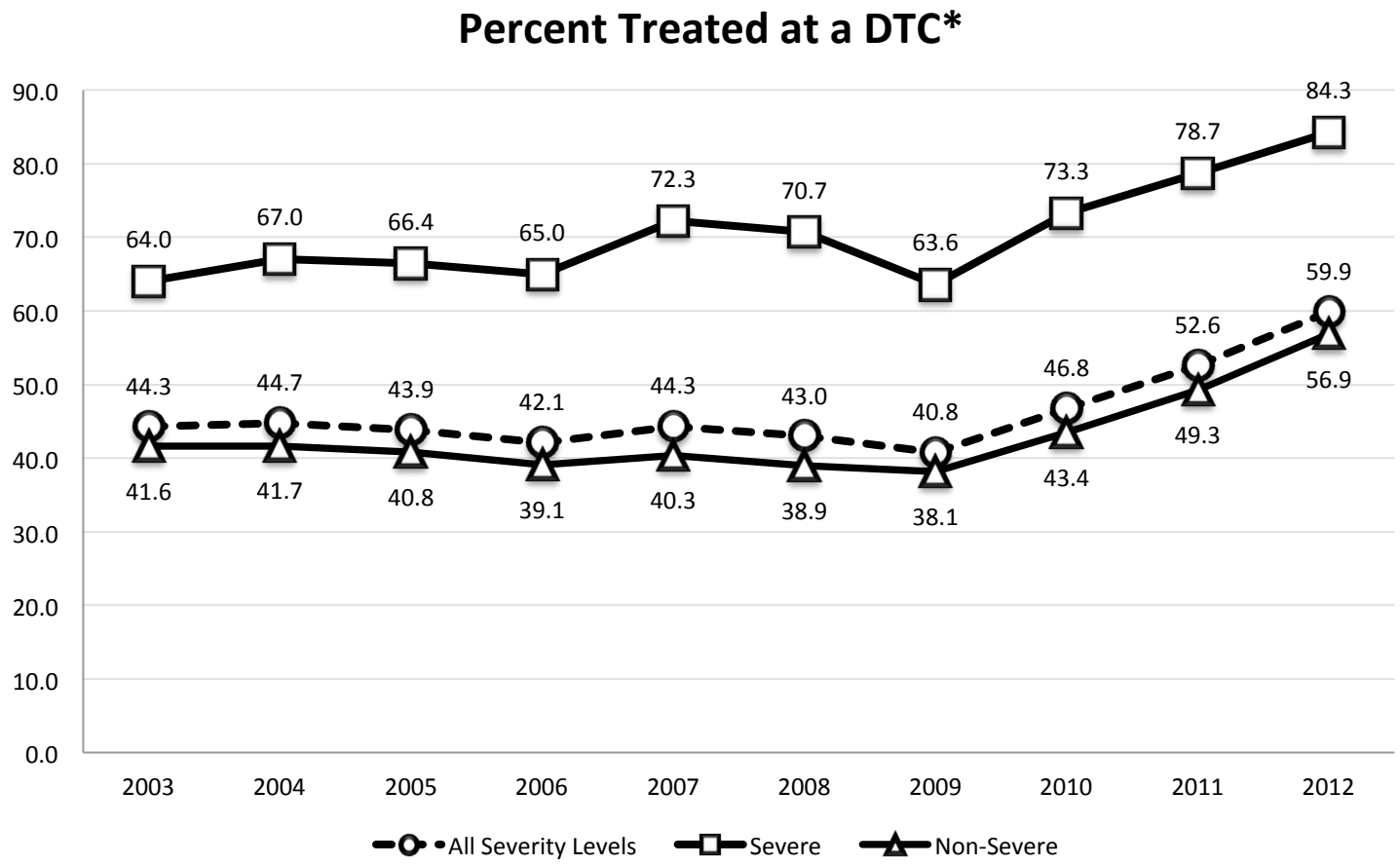
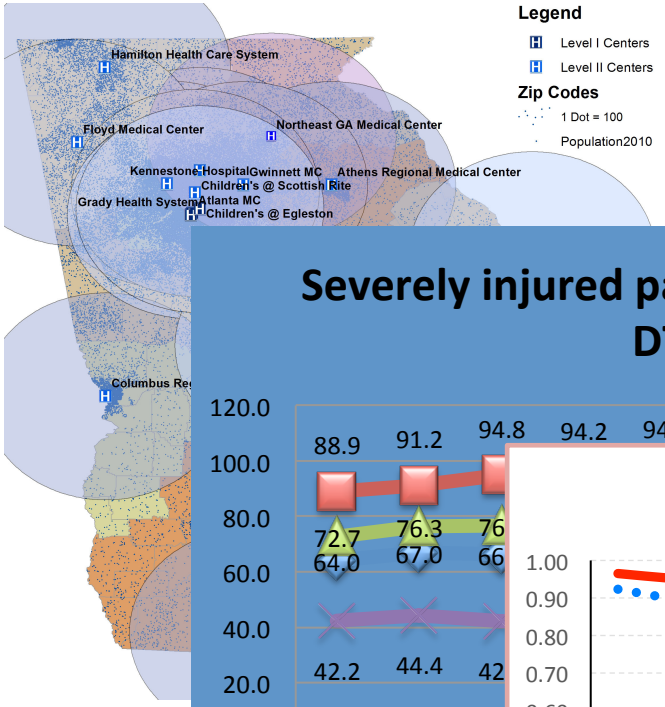
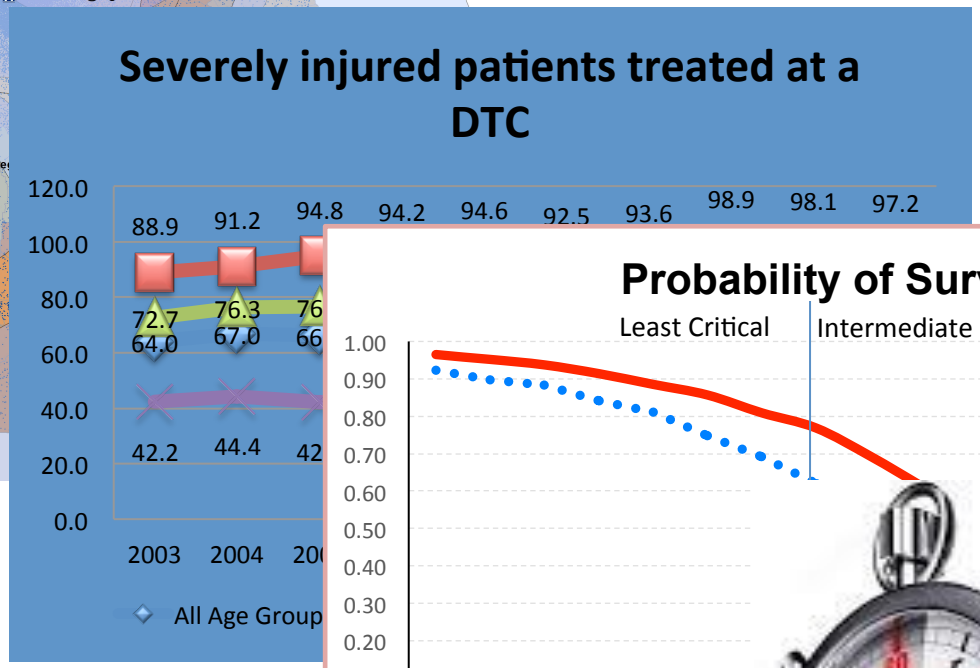
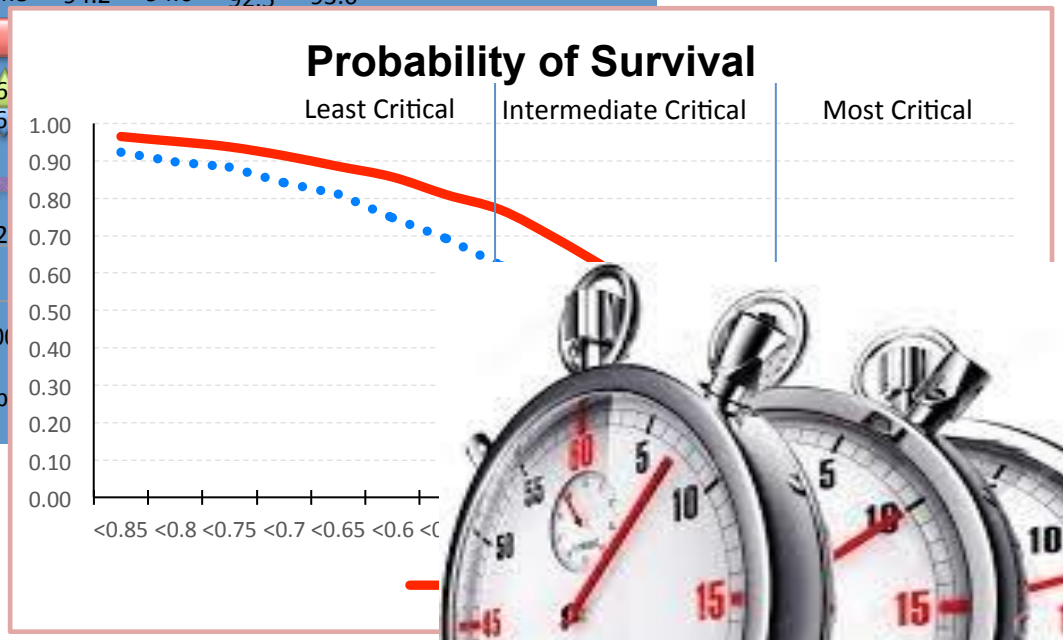


* The improvement in triage to a DTC of severely injured patients was observed for all age groups. The increases in all and severely injured treated at a DTC from 2003 to 2012 were, respectively, 16 and 21 percentage points







Time from Injury to Definitive Care

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Journal of the American College of Surgeons

Article in Press

Heterogeneity in Trauma Registry Data Quality: Implications for Regional and National Performance Improvement in Trauma

Presented as a Poster at the 74th Annual Meeting of the American Association of Trauma, Las Vegas, NV, September 2015.

Christopher J. Dente, MD FACS, Dennis W. Ashley, MD FACS, James R. Dunne, MD FACS, Vernon Henderson, MD, Colville Ferdinand, MD FACS, Barry Renz, MD FACS, Romeo Massoud, MD FACS, John Adamski, MD FACS, Thomas Hawke, MD, Mark Gravlee, MD FACS, John Cascone, MD FACS, Steven Paynter, MD FACS, Regina Medeiros, RN, Elizabeth Atkins, RN, Jeffrey M. Nicholas, MD FACS on behalf of the GRIT Study Group*

* Collaborators in the GRIT Study Group are listed in the Acknowledgement.

Descriptive Analysis of VTE in Georgia TQIP Centers Using Retrospective TQIP Data

Randi L. Lassiter, MD; Dennis W. Ashley, MD; Regina S. Medeiros, DNP; Bao-Ling Adam, PhD; Elizabeth G. Nesmith, PhD; Tracy J. Johns, MSN; Elizabeth V. Atkins, BSN; Christopher J. Dente, MD; Colville H. Ferdinand, MD

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

Georgia Trauma Patient Transfer Guidelines

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

Indications for Trauma Patients Requiring Rapid Transfer to a Major Trauma Center

The objective is to identify and then transport Trauma System patients to an appropriate hospital for definitive care within an optimal time. These patients should preferentially be transported to the appropriate level of trauma center within the trauma system.

"WHEN IN DOUBT...TRANSFER OUT!"

TRAUMA TRIAGE CRITERIA (ADULT AND PEDIATRICS)*

Neurologic

- GCS < 14 or lateralizing neurological signs
- Penetrating injury to head/neck or open skull fracture
- Spinal fracture or spinal neurological deficit
- Paralysis

Hemodynamic

- Hemodynamic instability
- SBP <90mm/Hg or age appropriate hypotension
- RR <10 or >29 (Adults)
- RR <20 (Infants <1 y.o.)

Cardio-vascular/Thoracic

- Injury to carotid, vertebral artery, aorta or great vessels.
- Cardiac rupture
- Pulmonary contusion with P/F <200
- Flail Chest
- Penetrating injuries to torso associated with energy transfer

Abdominal/Pelvic

- Penetrating injuries to abdomen or groin associated with an energy transfer
- Pelvic fractures, as evidenced by positive "pelvic movement" exam

Extremities

- Fracture or dislocation with loss of distal pulses
- Two or more obvious proximal long-bone fractures
- Crushed, de-gloved, or mangled extremity
- Amputation proximal to wrist and ankle

***Criteria based on CDC Field Triage Criteria and ACS *Resource for Optimal Care of the Injured Patient* (2006)**

If your trauma patient meets any of the above criteria
OR
Care for an injury exceeds local capabilities,
Transfer patient to a trauma center.

Georgia Trauma Foundation

2015 Goals and Objectives:

Goal: Develop an extensive marketing plan to launch a brand the Foundation for 2015.
Objective: Create and initiate all parts of marketing plan.

Goal: Develop Board Of Directors.
Objective: Increase the number of Board of Directors from 3 to 9 (max. 13).

Goal: Increase revenue.
Objective: Develop fundraising plan.

Goal: Identify problems, causes, and solutions to reduce trauma.
Objectives: Develop Research Advisory Board
Research trauma, its causes, and trauma system.
Create solutions to problems identified in research.

Goal: Provide educational opportunities in the area of trauma.
Objective: Conduct a statewide trauma symposium.

Goal: Increase community awareness and involvement.
Objectives: Partner with other organizations and agencies for prevention and overall trauma care.

Staff and Board

Lori Mabry | Director
lori@georgiatraumafoundation.org

Fred Mullins, M.D., FACS | President
President & Medical Director
Joseph M. Still Burn Centers, Inc.
fred.mullins@jmsburncenters.com

Robert S. Cowles III, M.D., FACS | Vice President
Founder of Cowles Clinic
drcowles@plantationcable.net

John C. Bleacher, M.D., F.A.A.P., F.A.C.S. | Secretary/Treasurer
Chief, General Pediatric Surgery
Medical Director, Trauma Services
Children's Healthcare of Atlanta
john.bleacher@choa.org

Contact:
Georgia Trauma Foundation
PO Box 1477
Kennesaw, GA 30156
404.990.2980
www.georgiatraumafoundation.org
contact@gergiatraumafoundation.org

2009 Sustainable Funding

Georgia's *new* law tacks-on
Two-hundred-dollar *state*-fines
Each time speeders are caught
Running seventy-five on *two-lane* roads
Or speeding 85-and-over *anywhere* in Georgia

HB 160 "*SuperSpeeder Law*" Revenues

Fiscal Year	Revenues	Commission Budget
2011	$14,167,499	$10,384,017
2012	$18,390,393	$17,303,758
2013	$18,593,040	$15,459,098
2014	$19,120,186	$15,345,972
2015	$23,219,975	$16,360,468
2016	$20,000,000*	$16,372,494
2017	$21,000,000*	$16,385,913

**Projection*: Department of Driver Services

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

Percent of Trauma Center Readiness Costs Reimbursed Level I and II Centers FY 2008 – FY 2016

Fiscal Year	Budget	# Level Is	# Level IIs	Level I & II Combined Est. Ave. Readiness Costs	Level I & II Combined Readiness Funding	% Readiness Costs Funded for Level I & II Trauma Centers*
FY 2008/2009	$58,902,769	4	9	$40,835,201	$23,851,385	**58.4%**
FY 2010	$20,340,888	4	9	$40,835,201	$7,456,990	**18.5%**
FY 2011	$10,543,460	4	9	$40,835,201	$2,228,670	**5.5%**
FY 2012	$17,303,758	5	9	$46,037,200	$5,665,390	**12.4%**
FY 2013	$15,159,097	6	9	$61,924,401	$4,553,837	**7.4%**
FY 2014	$15,345,972	6	9	$61,924,401	$4,383,231	**7.1%**
FY 2015	$16,360,468	6	10	$64,257,514	$4,773,784	**7.4%**
FY 2016	$16,372,494	6	10	$66,590,647	$4.686,185	**7.0%**

Percent of Qualifying Uncompensated Care Claims (QUCC) Reimbursed Level I and II Centers FY 2008 – 2016

Fiscal Year	Number of QUCC submitted	Total Costs of QUCC submitted	Amount available for program	Percentage of QUCC costs reimbursed
FY 2008/2009	3,029	$38,787,061	$23,851,385	**61%**
FY 2010	3,286	$52,918,230	$6,696,610	**12.7%**
FY 2011	2,674	$36,862,099	$2,262,100	**6.1%**
FY 2012	2,451	$36,596,176	$5,828,814	**18%**
FY 2013	2,279	$29,555,083	$5,192,331	**17.5%**
FY 2014	2,580	$32,525,025	$5,092,725	**15.6%**
FY 2015	3,008	$35,579,766	$5,431,599	**15.2%**
FY 2016	3,381	$39,995,073	$5,484,005	**13.7%**

Thankful Georgia trauma patient

Attachment 2

Medical Association *of* Georgia

MAG MRC Update

Georgia Trauma Commission
Macon, GA
January 21, 2016

What is the MAG MRC?

- First state-wide medical society and physician led Medical Reserve Corps approved by the Assistant Secretary for Preparedness and Response, US Department of Health and Human Services (11/2014).
- Sponsored by the Medical Association of Georgia in cooperation with the State of Georgia Department of Public Health Emergency Preparedness and Response Unit.
- Designed to be activated under the direction of the State of Georgia Public Health Department.
- The unit will supplement and not supplant the existing emergency medical response system or its resources including locally based MRC units.

What does the MAG MRC do?

- Its primary role is to set up the surge hospital system
- Its secondary responsibility may be to provide an important "surge" capability usually performed by emergency medical response teams who have been mobilized, including support staff

Building Capacity for Growth and Success

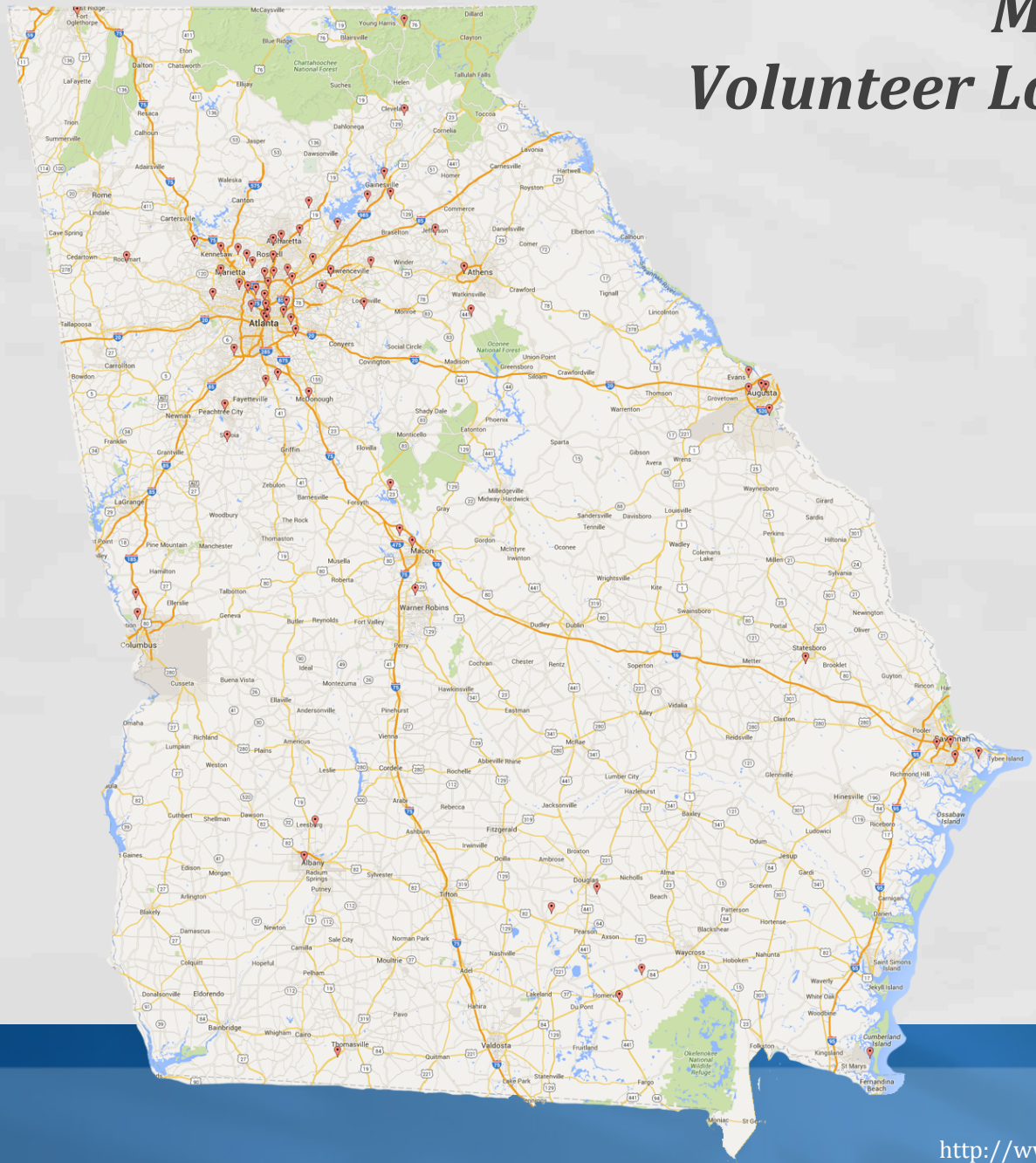
- The leadership of MAG and the MAG MRC thanks the Georgia Trauma Commission for providing funding in the amount of 75 K to support its inaugural year.
- The following activities and accomplishments would not have been feasible without these funds.
- The MAG MRC is in its infancy and we hope the Commission will continue to support our mission as we become more robust.

MAG MRC Accomplishments June, 2015-Present

- **Branding**. Web site created. MAG MRC logo. Banners. Table cloths. Lanyards.
- **Capacity Building**. Monthly leadership meetings, policies and Volunteer Manual.
- **Volunteers.** ServGA registered volunteers from 50 to over 125 individuals since June, 2015.

medical reserve corps
Medical Association *of* Georgia

MAG MRC
Volunteer Locations



http://www.mag.org/affiliates/mrc

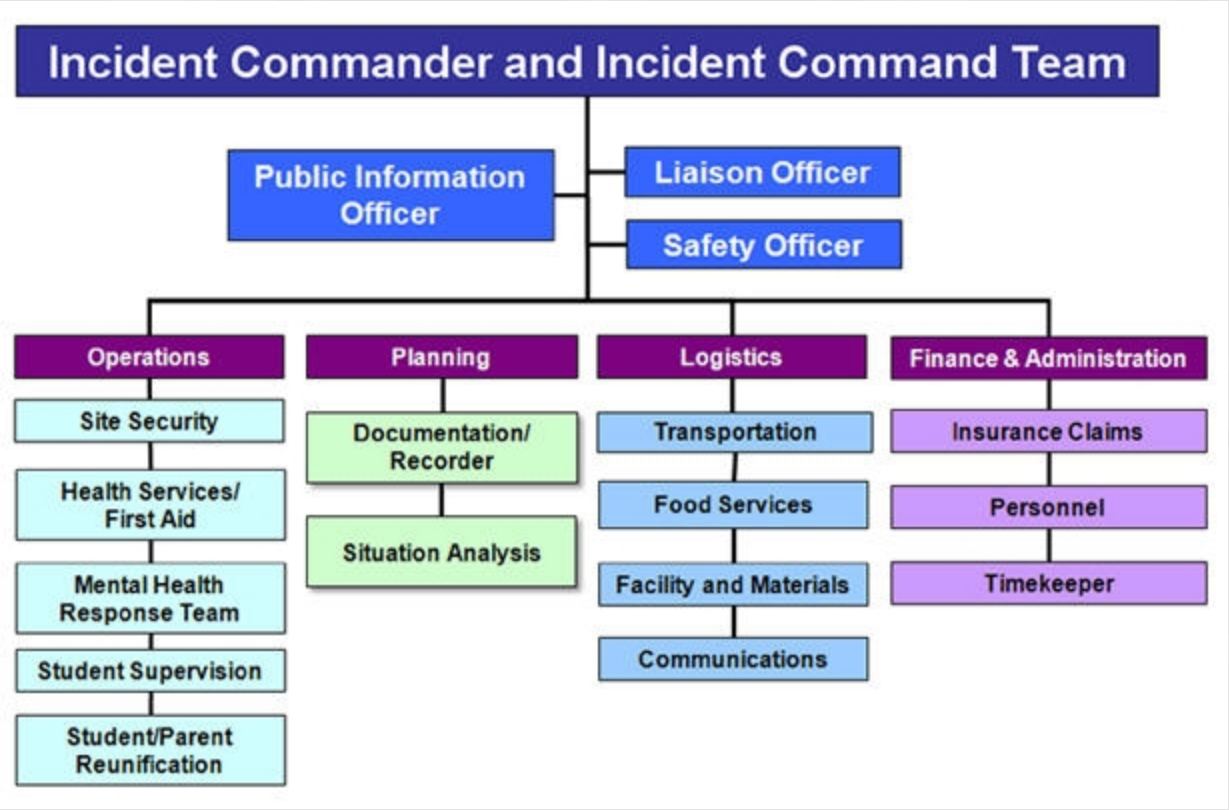
MAG MRC Accomplishments June, 2015-Present cont'd.

- **Venues.** Official launch and recruiting effort at the 2015 MAG Annual Meeting
- MAG MRC sponsored an educational session and lunch to inform and recruit MAG leadership
- Effort to recruit physician regional coordinators and local volunteers, including non physicians
- The MAG MRC partnered with the State MRC Coordinator-Department of Public Health to staff an MRC booth where attendees had the chance to ask questions about the MRC and sign up in the state volunteer registry.

MAG MRC Accomplishments June, 2015-Present cont'd.

- **Space.** Secured storage and meeting space for MAG MRC use.
- **Uniforms and Gear.** Identified vendors and executed purchase for MAG MRC leadership.
- **Training.** Two events planned for 2016.
- **Leadership.** Established an organizational leadership chain of command.

MAG MRC
Leadership Organization Chart



MAG MRC Accomplishments June, 2015-Present cont'd.

- **#1-** MAG MRC will conduct day long training in April at Grady that will begin with team building and will be followed by hands- on guided instruction on standing up a surge hospital. The initial exercise will be followed by a second, reinforcement session where attendees will perform the work with minimal guidance.

- **#2-** The MAG MRC will conduct a full exercise in October in Savannah. The MAG MRC will work in conjunction with the Georgia Defense Force and multiple state and local agencies and organizations to deploy the portable hospital in the context of a larger response team.

medical reserve corps
Medical Association *of* Georgia

Mobile Surge Hospital Set-up

medical reserve corps
Medical Association *of* Georgia

Questions?

Contact:

John S. Harvey, M.D
MAG MRC Medical Director
johnharveymd@gmail.com

Susan Moore
MAG MRC Administrator
smoore@mag.org

Arianna Afshari
MAG MRC Coordinator
aafshari@mag.org

Attachment 3

School Response - Immediate Care for the Injured
Region 5 RTAC Report
Kristal Claxton Smith, BS, NREMTP
January 21, 2016

The School Response Program (SRP) was developed by the Region F Healthcare Preparedness Coalition as a component of the School Response Program. The SRP is a school-based public health/emergency preparedness initiative being jointly administered by the Region 5 Regional Trauma Advisory Committee (RTAC) and the Region F Healthcare Coalition (Coalition). Program materials are provided through funding from the Georgia Trauma Care Network Commission (GTCNC) and Georgia Department of Public Health (GDPH) Healthcare Preparedness Program grants.

Purpose

SRP was designed a to -

- Provide emergency medical supplies for a healthcare crisis in which traumatic injuries may need to be stabilized by available school staff members while waiting for emergency services;
- Implement a training program to enable school staff members to render immediate, potentially life-saving medical aid to injured students or co-workers while they await the arrival of professional responders.

Funding

$20,600.00 Georgia Department of Public Health (GDPH) Healthcare Preparedness Program
$28,700.00 Georgia Trauma Care Network Commission
Total: $49, 300

Expenditures

Phase 1	$20,744.30	2-19-15 Rescue Essentials (41 School Response Bags, 266 IRKs)
Phase 2	$28,396.00	7-13-15 Rescue Essentials (40 School Response Bags, 610 IRKs)
	$ 339.13	7-22-15 Training Supplies
	$65.20	11-12-15 Postage
	Total: $49,544.63	

School Response Program Highlights

- Schools participating in the School Response Program (SRP) issued a School Response Bag and Individual Response Kits (IRKs).
  - The School Response Bag is designed to treat multiple victims and should remain on-site and readily accessible to recipients of SRP training.
  - The Individual Response Kits are designed for in-classroom use and should remain on-site and readily accessible to an individual recipient of SRP training.
- These materials designed for mass casualty events in which EMS response may be delayed or when immediate first aid might be warranted.
- Schools requested to train at least ten employees in the use of the bag's contents, basic management of airway and breathing, CPR, and hemorrhage control.
- SRP training is designed for "non-traditional" lay responders to enable them to render medical aid while they await the arrival of professional responders.

School Response Training

- 2 hours
- Facilitated by Volunteer "Trainers"
- Designed for "non-traditional" lay responders
- Intended for Small Groups
- Large Group Presentation Developed
- Outline:
  - Program highlights and overview of components
  - First aid and scope of course defined
  - Step 1 - Assuring scene and personal safety
  - Step 2 - Checking the injured person's response
  - Step 3 - Checking breathing and providing CPR
  - Step 4 - Finding and controlling bleeding
  - Ongoing care of the injured person
  - Putting it all together
  - Final thoughts
  - Evaluations

Results

- 71 Schools in 24 counties participating
- 545 Individuals trained at the "responder" level
- 426 IRKs issued
- 35 Bags issued

Course Evaluation

- 204 Participants in "responder" level offerings
- 185 Evaluations submitted

Content:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1 The teaching strategies were appropriate for the activity.	0	0	2	45	138
2. The objectives were consistent with purpose and goals.	0	0	0	43	142
3. Overall course met my expectations.	0	1	1	49	134
Presenter Effectiveness:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
4. The presenter demonstrated mastery of the topic.	0	0	1	34	150
5. Instructors provided adequate and helpful feedback	0	0	1	36	148

Self Evaluation

How would you rate your…		Very Poor	Poor	Fair	Good	Very Good
1. Overall knowledge of the information covered in this training.	Before this training	9	15	64	66	31
138 of 185 respondents reported improvement (75%)	After this training	0	0	1	50	134
2. Ability to perform the skills taught during this training.	Before this training	14	17	63	63	28
142 of 185 respondents reported improvement (77%)	After this training	0	0	1	51	133
3. Ability to manage an injury resulting in significant bleeding.	Before this training	11	25	68	53	28
141 of 185 respondents reported improvement (76%)	After this training	0	0	2	52	131
4. Comfort level utilizing the equipment in the School Response Bag.	Before this training	17	24	56	63	25
145 of 185 respondents reported improvement (78%)	After this training	1	1	2	50	131

Note: 165 of 204 (80%)Reported previous CPR and First Aid Training

Georgia Trauma Commission DART Funding Report
January 21, 2016
Macon, GA

DART Evolution

- **Concept Summer 2011**
- **Small group or EMS Directors and GSAR 6 Command Staff – 2012**
- **Leadership Team formed 2013**
- **Trauma Commission Grant and GEMA Area 1 All Hazards Grant requests 2014**
- **DART Education Team formed and course developed Winter/Spring 2015**
- **DART Funding secured (TCC -&102,036.00 – GEMA – $24,890.00)**

2015 Activities –

- **Purchased 78 – 5.11 EMS Tactical Bags**
- **All soft supplies/bandages/airway/etc for each**
- **Non Ballistic EMS Field Tactical Vest for each**
- **Lime Green USAR Tactical Helmets for each**
- **Magnetic Door Decals with DART Logo**
- **128 Channel field programmable radios for each bag and 1 additional for each truck (100)**
- **Supplied 22 units between 4 strike teams in July 2015**
- **DART Commander/Deputy Commanders (2) and Strike Team Leaders (4) provided a 5.11 Command Bag with paperwork/radios and reduced patient care supplies. Still need to provide those to Deputy Strike Team Leaders (8)**
- **Taught 1st DART Course in Cartersville – July 15th & 22nd, 2015 – 106 attendee's – 104 competed course**
- **Reviewed and revised Course August 2015 – based of course evaluations**
- **Taught 2nd course (revised) Nov 4-10 – 100 attendee's 95 completed course**
- **Completed all grant requirements**

2016 Initiative

- **Meet with Ronnie Register from GEMA and GSAR 6 Command staff –**
- **Will meet with Hospitals about possible restocking of pharmaceuticals in large scale needs**
- **Have 19,396.87 left on grant – Would like to spend it on**
    - **Additional radios for training and back ups**
    - **4-5 additional 5.11 bags for deputy strike team leaders command bags**
    - **1-2 Communication (Comm L/CommT) Bags with programming flash drive and mast radio**
    - **3rd DART Course**
    - **Unit Decals for every participating EMS Services (like TC Funding decal on Ambulances purchased with TC funds)**
    - **Remaining on soft supplies for re-stocking**

4 Strike Teams –

#1 - Catoosa, Dade, Walker & Chattooga Counties
EMS Services – Dade Co ES, Puckett EMS (Dade and Walker Co) Angel EMS, Redmond EMS (6)

#2 – Gordon Co, Floyd Co, Murray Co, Whitfield Co)
EMS Services - Gordon EMS, Floyd EMS, Redmond EMS, AMTRAN, Murray EMS, Whitfield EMS) (5)

#3 – Cherokee Co, Pickens Co, Gilmer Co, Fannin Co.
EMS Services - Cherokee Fire/EMS, Pickens EMS, Gilmer Fire/EMS, HOPE Ambulance, Fannin Co Fire/EMS (6)

#4 – Polk, Bartow, Paulding, Haralson Co.
EMS Services – Bartow Co EMS, Redmond EMS, Floyd EMS, AMBUCARE, Metro Atlanta Ambulance Service (5)

DART Bag Equipment (each)

- USAR/Caving Helmet Eye/Ear protection
- Trauma Shears/Scissors
- Stethoscope
- Thermometer - oral, electronic
- Thermometer - oral, hypothermic
- N95n Masks
- Respirator
- Airways - NPA, OPA
- Small pocket mask,
- Collapsible BVM
- Suction, potable with tonsilar tip
- Eye Patches, (cotton individually wrapped)
- Alcohol wipes (box 100-200 individually wrapped)
- Swabs, cotton sterile long wrapped pair
- Jelly, Lubricant, single use packets
- Tongue depressors, sterile, individually wrapped, box
- Elastic Bandages - 3" -4 and 6" -4 (ace wrap type)
- Triangular bandages (4)
- 4" roll gauze, (6) individually wrapped
- heavy duty 2" tape (2) (e.g. compression type tape)
- Moldable Splints - SAM type (2)
- Multi-Trauma Dressing 12x30 (2)
- Trauma Dressing - 5x9 or equivalent (4)
- Sponges, Sterile, 4x4 (2) 25 pack
- Tape 1" silk (4)
- Tape 2" Cloth (2)
- Blister Dressing - 4x3 Mole Skin (3 packs)

- Vaseline Gauze, (6) individually wrapped
- Hemostatic dressing - (6) Quik Clot gauze or equivalent
- Assorted band aids
- 2 tourniquets (CAT or equivalent)
- Chest decompression kit
- 2-3 open chest seal - (occlusive Dressing or HALO)
- Glucometer and strips (1 box/bottle)
- Mini-Pulse Ox
- Blanket, Mylar Survival Blankets (2)
- Chemlight stick (4)
- Hand sanitizer
- Headlamp (1) (helmet Mountable
- Clipboard, Metal
- Patient Contact Forms
- Markers, Felt tip, black permanent
- Portable Radio with Nicad Battery/AAA battery Clamshell, Speaker Mic/AAA batteries pack

AGENDA (course 1)

Day 1 - 0800-1700

0800 Welcome & Sign In	
0815 Introduction	David Foster, R1 OEM&T Director
0840 Operations	Courtney Taylor, Director, Gordon EMS
0910 Communication	Kevin New, Division Chief, Paulding Co Fire
1000 BREAK 10 MIns	
1010 SALT/Triage	National Course Video
1030 Austere Environments Safety & Sufficiency	Will Pitt, Chief Medical Officer, Walker Co EMS/Fire
1230 - Lunch (On your own)	
1330 - Hazardous Materials Medical Management	David Foster, R1 OEM&T Director
1420 - Radiological Emergencies Overview	David Foster, R1 OEM&T Director
1450 BREAK 10 MIns	
1500 - Specialized Burn Care	Jocelyn Hills, NP, J.M. Stills Burn Center

Day 2 - 0800-1700

0800 - Sign in	
0815 - Search & Rescue Guidelines	Glenn Susskind, Lifeforce/USAR Medic
1000 BREAK 10 MIns	
1010 - Search & Rescue Guidelines (Continued)	
1200 - Lunch (On your own)	
1300 - Tactical Operations Medical Roles	Danny West, EMS Division Chief, Cherokee Co Fire
1450 BREAK 10 MIns	
1500 - Tactical Operations Medical Roles (Continued)	
1530 - Course Review / Question & Answers	
1630 - Course Evaluations - Distribution of DART Shirts and Decals.	

AGENDA (revised/Final)

Day 1 - 0800-1700

0800-**Welcome & Sign In**

0810-Module 1 - DART Overview - Intro David Foster, R1 OEM&T Director

0905-Module 2 - **Operations and DART Personnel Roles** DeWayne Wilson, Angel EMS, CEO

1000-1010 BREAK 10 MIns1010-Module 3 – Communication Kevin New, Division Chief, Paulding Co Fire

12-Lunch (On your own)

1100-Module 4 - The Behavioral Aspect of People Exposed to Disasters and how to interact
Dr Jill Mabley, Medical Director, Cherokee Co Emergency Service

1300-Module 5 - SALT/Triage National Course Video David Foster, R1 OEMST&T Director

1400-Module 6 - Austere Environment Will Pitt, N.GA. Operation Manager, Puckett EMS

1300 BREAK 10 MIns

1310-Module 7 - Tactical Operations Danny West, EMS Division Chief, Cherokee Co Fire

Day 2 - 0800-1700

0800 - Sign in

0810 - Module 8 - Medical Management of the Contaminated Patient
Darren Vandegriff – Flight Medic – Airlife

0905 - Module 9 - Mass Burn Care - Field Management Jocelyn Hills, NP, J.M. Stills Burn Center

1000 BREAK 10 MIns

1010 - Module 10 Search & Rescue Guidelines Glenn Susskind, Lifeforce/USAR Medic Instructor

1200 - Lunch (On your own)

1300 - Table Top exercise All Faculty

1600 - Course Review / Question & Answers

1630 - Course Evaluations - Distribution of DART Shirts and Decals.

Attachment 5

EMS Subcommittee

Report to the Georgia Trauma Commission
January 21, 2016

Automatic Vehicle Location System

- Original Units (Region 5&6) Purchased by GTC
- Subsequent Units Purchased by GEMA
- Different MOUs used when Distributing the Units
- AVLS Working Group was Established to Give Guidance
  - GEMA
  - GTC
  - GAEMS
  - GTRI
  - SOEMS/T

Automatic Vehicle Location System

- Two Issues
  - Data Usage
  - Units Not Being Used

Data Usage

- Meeting On December 3
  - Dena Abston – GTC
  - Timothy Boone – GTRI
  - Sean Ford – Verizon
  - Tanya Morrison – Sierra Wireless
  - Courtney Terwilliger – GTC

Data Usage

- Identified High Users
  - Contact and ask to monitor use – change passwords
- Discussed Moving All Units to Unlimited Data
  - Determined Not to Move All Units – High Users Identified and Will be Move to Unlimited
  - Low Data Users Will Stay on the 2GB Plan and We Will Monitor for Need to Change

Data Usage

- Identified Need For:
  - Better (one) MOU for Future Use
  - Regular Monitoring of Data Use/Non-use
    - Communicate that Information to Directors, Committee and GTC
  - Newsletter to Inform Directors of Responsibilities
  - Better Understanding of Responsibilities and Needs of Stakeholders
    - GTC
    - GEMA
    - GTRI
    - EMS Community

Units Not Being Used

- Eighty three (83) Units Not Used in Six Months 8% of Total Units
- Forty Eight (48) Different Services
- All Regions Involved
- Some Had Never Been Turned On
- Many Are Identified as “Spare Vehicles”
  - Original Plan encouraged Directors to put the Devices on All Vehicles – Would be Needed in a Disaster Situation – Work Group May Reconsider

Units Not Being Used

- Letter Sent To All Directors Involved
- Time Frame to Respond
- Of 48 Services 42 Have Responded
  - Other 6 Will Be Contacted Directly by Phone
- All Wish to Keep the Service but Several Not Opposed to Dropping “Spare” Units From Plan
- Many Issues Where Maintenance was the Issue
- Two Directors Did Not Know they Had the Units
  - Became Directors immediately after the units were received

Units Not Being Used

- Twenty One Percent Are Back On-line
- Several Services Are Purchasing New Units (Most in Region 5&6) Units Cannot be Repaired
- Many Services Are Involved in Repairs
  - We will Monitor This Progress Through Sierra Wireless
- Three Services Will Drop the Units Not Being Used

Future Plans

- AVLS Working Group to Develop:
- Better Understanding of the Roles of:
  - GTRI
  - GTC
  - GEMA
  - Policies on Monitoring of Use and Non-Use of Data

EMS Subcommittee Budget

AVLS	$570,748
Leadership	104,000
Regional Improvement	298,743
EMR/EMT	338,085
Just Culture Training	9,840
GEMSIS	30,099
CAT to Current FRs	60,193
EMS Redesign	90,000
TECC	60,000
Triage Kits	626,224

EMS Subcommittee Budget

PHTLS/ITLS/EPC	$121,300
EVOC	25,000
Extrication	102,000
Child Seat Technician	70,000
AVLS Units (40)	117,833
Upgrade AVLS Units	110,320
EMT Instructor Course (2)	22,400
AV Project	135,117
Trauma Symposium	25,000

Questions?

EMS Subcommittee Budget

- Motion to Approve the EMS Budget

Approved 17 March 2016

Georgia Trauma Commission

Right Patient, Right Hospital, Right Time, Right Means

GEORGIA TRAUMA COMMISSION
6th Annual Strategic Planning Workshop

Friday, 22 January 2016
8:30 AM to 3:00 PM

DAY 2

Macon Marriott City Center
240 Coliseum Drive
Macon, Georgia 31217

Magnolia Banquet Room A & B

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

STAFF MEMBERS & OTHERS SIGNING IN	**REPRESENTING**
Dena Abston	Georgia Trauma Care Network Commission, staff
Lisa McDowd	Georgia Trauma Care Network Commission, staff
Dr. Greg Starr	Georgia Trauma Foundation, Phoebe Putney
Dr. Pat O'Neal	DPH SOEMS/T
Marie Probst	DPH SOEMS/T
Renee Morgan	DPH SOEMS/T
Keith Wages	DPH SOEMS/T
Ernie Doss	DPH SOEMS/T
Rana Bayakly	DPH
Danlin Luo	DPH
Lori Mabry	Georgia Trauma Foundation
Scott Maxwell	Mathews & Maxwell, Inc.
Jim Sargent	North Fulton Hospital
Karen Hill	CHOA
Tracie Walton	CHOA
Jesse Gibson	Northeast Georgia Medical Center
Deb Battle	Northeast Georgia Medical Center
Gina Solomon	Gwinnett Medical Center
Fran Lewis	Atlanta Medical Center
Jo Roland	Archbold
Susan Bennett	JMS Burn Centers
Heyward Wells	JMS Burn Centers
Laura Garlow	Kennestone

Liz Atkins	Grady
Dr. Regina Medeiros	GRU Health
Paul Beamon	Region 4
Kristal Smith	Region 5
Billy Kunkle	Region 3
Kim Littleton	GAEMS
Karen Waters	GHA

Call to Order: 8:56 AM

Quorum Established: 8:57 AM, 8 of 9 commission members present at this time. Mark Baker was excused from the meeting.

Welcome Remarks Dr. Dennis Ashley

Dr. Ashley welcomed members of the Commission and the public to the strategic planning workshop.

RTAC Updates

Region 1 please see minutes from 21 January, GTC meeting day 1

Region 2 update

Ms. Deb Battle reported on region two's progress. We have been meeting for about a year and a half now, quarterly. We have established our subcommittees: education, PI, and pre-hospital. We have a 1st draft of our plan and our goal is to have our plan completed by the end of calendar year 2016 and present it to everyone at that time. Our current activities, we are planning our 1st RTAC trauma symposium that will be in November. Now EMS would like the same component for trauma, we will have that in the fall. Our PI subcommittee is beginning to look at some regional data to guide us with some issues we are having with transport times. We just did a small study with the use of helicopters, where patients are going, and how we can provide opportunities in that area. Some of our challenges, we have a very robust group of about 10 to 12 people who consistently meet, have fairly good input from our EMS services, but our challenges seem to be with our smaller outlying facilities and hospitals. We are not getting good representation from them. Since we are a very young RTAC our request would be that some of the more mature RTAC's give us guidance in how to get these smaller facilities and hospitals to participate.

Region 3 update

Mr. Billy Kunkle reported on region three's progress. February of last year I was brought on as RTAC coordinator to continue the work that was already done, they have been established for quite a while. The first part was to do our assessment and I received great participation. Our region is fairly large with 7 different trauma centers and 19 EMS providers. Working together we developed a plan. We have about 50 people in our group that are very interested in being involved and this number is growing. As we developed a plan, it was decided we should have a more organized component of this, so we started to do our bylaws. This has brought up some questions regarding organization abilities for us, how we relate to the Trauma Commission and our regional council. We are looking to form committees, but we want to have our bylaws and plan in place. We feel this will help to create a driving force and know what direction we are going with everything.

Region 4 update please see minutes from 21 January, GTC meeting day 1

Region 5 update

Ms. Kristal Smith reported on region five's progress. We are meeting two times a year face to face; other meetings in between are by conference call. We have developed our plan; it has been in place since 2011. We

are now going back to review our plan to ensure that everything is as it should be and aligned with the state trauma plan. Our goal is to have a revised plan by our April meeting that everyone can review. We do have a couple subcommittees. Our PI subcommittee meets every other month and is going well. We are looking at specific benchmarks, tracking transfers that have taken to long to get to the trauma center and some individual cases that are referred to the RTAC through our RTAC PI. We have spent a great deal of time on our School Response program, it has been good for us in terms of building partnerships, establishing in roads and connections with EMA directors, law enforcement, and schools.

Region 6 update

Dr. Regina Medeiros reported on region six's progress. Please see handout attached. **Attachment 1**

Region 7 update

Ms. Dena Abston for Ms. Ashley Forsythe, reported on region seven's progress. Region seven is in the process of hiring a RTAC coordinator to help write their plan. Their subcommittee is meeting to complete the BIS assessment. They are updating their EMS board members. Their main focus is on their trauma plan and getting it completed.

Region 8 update

Ms. Dena Abston for Mr. Brandon Fletcher, reported on region eight's progress. They have a meeting set up for 17 February to begin work on their BIS assessment. They are also working to obtain their letters of support and complete their timeline. Dr. Ashley asked who is leading. Ms. Abston stated Brandon Fletcher, this is new for them, and I have been working with Mr. Fletcher to help them with their process. I have sent Mr. Fletcher region 5's approved plan, a timeline, and letters of support so he knows what to look for from everyone. I have had conversations with Mr. Fletcher and they are working to get everything done. Mr. Doss stated he attended the EMS region 8 council meeting last week, on Wednesday. They discussed at length the process and BIS assessment. They are making sure they have EMS services, and hospitals representatives as they start the BIS assessment.

Region 9 update

Dr. Jim Dunne reported on region nine's progress. Region nine is very challenging; we have one level 1, two, currently level 4's, and about 17 other critical access hospitals. We have a RTAC meeting scheduled for a full day on April 7th and are combining that with a trauma symposium the following day to reenergize everyone. We have two new hospitals interested in becoming level 4's, Appling, and Winn Army Hospital. We are conducting Rural Trauma Team Development courses at both Winn Army and Appling. We are helping Appling with their PI process and their Registry. Our biggest challenge at this time is all of the hospitals in our region are referring to the level 1. They are not going from a critical access to a level 4. Everything is going to the level 1. We are looking at a research project currently underway to look at referral patterns to get the right patient, to the right hospital, at the right time, so as to not overload the level 1. We are also becoming much more involved in our regional EMS council. One other thing we are looking at is the dicomgrid. The radiology department is really pushing hard to be able to view CAT scans and plain film radiology at all of the outlying hospitals. This will do way with discs and paper reports the do or do not come with the patient.

Region 10 update

Ms. Dena Abston stated she did not receive anything from region ten.

Questions and comments:

Dr. Nicholas stated that he would like to thank Billy Kunkle for the job that he has done with the work in Region 3. I would like to address some of the issues that we have run into in region 3. We are about mid range in the process of development for our RTAC. Hopefully with all regions reporting we have a majority of

representation here from all RTAC's. What is the scope of practice for the RTAC's? What is its role with in the EMS council, the Commission, and how it interfaces with the state office. Do we or do we not have bylaws or guidelines. Example: Scope of practice, there has been some concern in our region, technically we are a subcommittee of the EMS council and if I am not mistaken that should be the structure throughout the state. One of the things we should try to accomplish or at least put on the table, is that all the RTAC's are functioning under a similar structure because ultimately as we look at the state plan and try to coordinate across the regions to link statewide trauma care, and the RTAC's are going to be a critical role. Another thing to consider is funding and where the funding should go. The original funding when set up went to the hospitals. We had start up grants to begin with that came from the Commission to help get the RTAC's launched. I think we need to look at setting money aside for continuation of funding, that the good work of the RTAC's continues and does not fall apart. It will also allow the RTAC's to do some additional PI work. Where would the continuation of funding go? Do the RTAC's need to establish a 501(c)(3).

Mr. Terwilliger stated could I address a couple of these issues. Why most of us in the EMS community have wanted the RTAC's to be associated with the EMS council, we have everyone coming together. I am strongly supportive of it being under the regional council, and should they have their own by laws, subcommittees cannot create bylaws that conflict with the main body it has to be in a subordinate role, however the main body could give them power to do things under the main bylaws that expand that scope to meet their needs. Since John left we have not had a statewide RTAC meeting and I would like to see that happen. I do agree with Dr. Nicholas that we all should have the same structure statewide, but region 3 will be different than region 7, so their council can amend their bylaws to give them a greater scope of practice. As far as funding goes maybe the Foundation, I cannot see 10 regions filing for 501(c)(3).

Dr. O'Neal stated I think you have all raised some important questions, which I do not have the answers to. I do think because the EMS council is a legal body in Georgia code, I think having the RTAC's working under that is a fairly efficient way to go. I would suggest for next steps, having input from the AG's office on some of these questions. With the RTAC's being a new entity and not actually recognized in code it would be wise to get recommendations legally as to what the best structure might be. My feeling is that the 501(c)(3) may be the way to go, but that should be something you get input from the AG's office concerning all of these issues.

Dr. Dunne asked is it possible to rewrite the bylaws for the EMS council or are the bylaws the same for all EMS council? Dr. O'Neal stated No, we tried to encourage as much consistency as possible, but we are not there yet.

Mr. Terwilliger stated in the past they have strongly suggested that the council makeup would include these particular specialties and subspecialties, the majority of the council is appointed by local county commissioners.

Dr. Dunne stated the problem becomes that the RTAC's become severely hampered or more constrained if the EMS council is inefficient or has issues and the RTAC's being a subcommittee of the EMS council has no ability to change that. Dr. Nicholas stated the other side to this if the RTAC's branch out and become stand-alone there is no authority and are with out an avenue to accomplish or effect change.

Dr. O'Neal stated one of the reasons I think it would be wise to talk with the AG's office, with input from the Commission members, are you comfortable with the RTAC's not being a legal entity, would one of your goals be should there be legislation to have the RTAC's recognized from legal prospective and have authorities that they currently do not have.

Dr. Nicholas stated I know that this has been a discussion in our region.

Mr. Kunkle stated again I am not advocating either direction. I have been involved with regional council for a long time. One of our issues, we have 19 EMS providers and 7 different trauma centers, but basically we are down to 3 organizations. The county commissioners do appoint people, but who has more access to those county commissioners, the EMS providers or the hospitals. That is where some of our trauma centers feel they are not included or not as involved. Some of the trauma centers feel like they are out numbered as far as being involved in the EMS council. I have researched other states, and in our region we are vastly different in the state, they have given the RTAC's additional authority.

Ms. Abston asked what other states did you look at. Mr. Kunkle stated Texas is the biggest one I looked at because they have several different metropolises.

Dr. Ashley asked when you say different authority, what would be their role? Dr. O'Neal stated one of the most important roles that you will see in the states that do give authority to the RTAC's is there has to be some controlling entity to the number of trauma centers in any given area and and obviously if you have an open situation where any facility can become a trauma center it gets to the point where you do not have enough volume in a given facility to maintain efficiency. There has to be a decision about what the needs are and right now basically it is wide open, theoretically it rest with the EMS council or has in the past, but it is not enforced and the strength of the council is just not strong enough in many parts of the state to think about exercising that. It basically then falls back to the Commission and OEMS/T and we are not at the point where we have actually said to anybody no don't become a trauma center because we already have enough in this region, but with an RTAC that has legal authority that would be one of the primary roles they would basically determine what needs are for a given region in terms of support for trauma within that region.

Dr. Ashley stated these are all very good questions I believe this would be a good thing for the Trauma System Evaluation committee to work on, discuss, and bring back recommendations to the Commission.

6th Annual Strategic Planning Workshop

Dr. Ashley introduced Alice Zimmerman from Georgia Institute of Technology who will facilitate and review the GTC strategic plan.

Documentation of activities for DAY 2 of Workshop is attached. See attachment. **Attachment 2**

MOTION GTCNC 2016-01-01:
I make the motion to approve funding of $25,000 for the Hospital Hub, pending a proposal and proof of testing data from Imagetrend.

MOTION BY: MR. VIC DRAWDY
SECOND BY: DR. ROBERT COWLES
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

MOTION GTCNC 2016-01-02:
I make the motion to approve Dr. Regina Medeiros as a Board Member of the Georgia Trauma Foundation.

MOTION BY: DR. FRED MULLINS
SECOND BY: MR. COURTNEY TERWILLIGER
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

MOTION GTCNC 2016-01-03:
I make the motion to gain funding to hire a person to analyze TQIP data, direct a team, and be a liaison to the RTAC's.

MOTION BY: DR. FRED MULLINS
SECOND BY: DR. JAMES DUNNE
VOTING: All members are in favor of motion.
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Meeting Adjourned: 1:35 PM

Minutes crafted by: Lisa McDowd

Attachment 1

Region VI RTAC

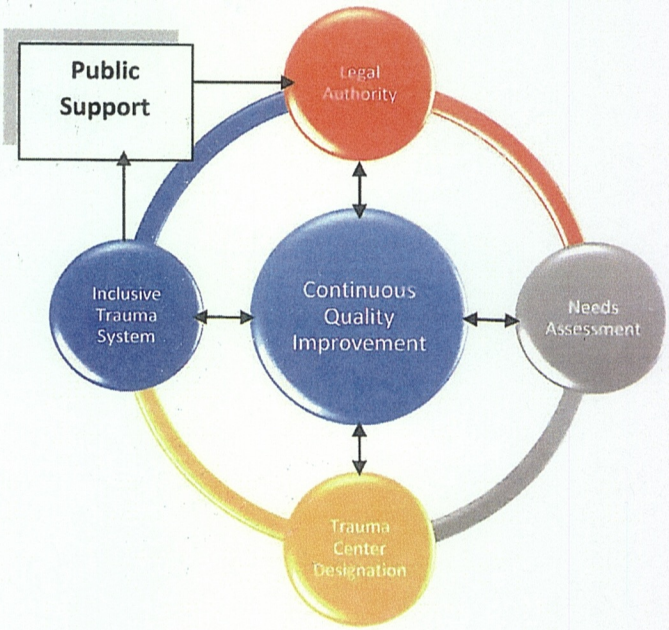
Trauma Commission Update

January 2016

The Region VI RTAC meets quarterly in conjunction with the Region VI EMS Council Calendar. RTAC is an official subcommittee of the council and reports up through council its finding and recommendations.

As you know a trauma system is defined as an organized approach to acutely injured patients in a defined geographical area that provides full and optimal care and that is integrated with the local or regional EMS system. Region VI's geographical area primarily focuses on a 13 county catchment area and surrounding counties in South Carolina. A major goal of a trauma system is to enhance the community's health. Care provided within a system is multidisciplinary and is provided along the continuum of care.

The first Optimal Hospital Resources for Care of the Seriously Injured was published by the American College of Surgeons Committee on Trauma in 1976. This guide has specific information regarding trauma system and trauma center quality and performance improvement.



Moore, E.

The framework above was published by Moore in the Journal of Trauma in 1995 but is still applicable today as the Region VI RTAC moves deeper into their plan implementation anchored by robust PI.

Attached is an examples the Region VI RTAC Performance Improvement metric and tracking statistics. To date the Region VI RTAC has focused on inter-facility transfers with the goal of 120 minutes from time of decision to transfer to arrival at the receiving facility. As we mature in our process we will layer in the other measurements. We have been informally tracking pre-hospital notification time and have seen some improvement.

As a result of case reviews discussed at RTAC a regional Selective Spinal Immobilization guideline for both pediatric and adult patients was developed, inserviced and implemented. Currently two additional guidelines are in the process of development. One will focus on safe transportation during inclement weather and the other on the administration of TXA in the field.

Finally, our group has been asked to begin to review the use of helicopter transports within the region. This process has just begun. More information will be available for the next update.

The Region VI RTAC would like to thank the Trauma Commission for their continued support and the opportunity to provide this update on our efforts to enhance our community's health.

Draft Region VI System Performance Measures

Indicator	Sentinel (S)/ Rate-Based (RB)/ Event-Based (EB)	Threshold/ Benchmark	Collection and Review Schedule/Method	Collection Responsibility	Collaborating Partners
EMS to Hospital Communication: Patients with physiologic or anatomic criteria who arrive at trauma center without ≥ 15 pre-notification	RB	80%	ECC logs reviewed by PI Coordinator/TPM and reported quarterly to RTAC	ECC	Trauma Program/ED/EMS
EMS Record: Pre-hospital care report/transport record is received by trauma registry within 24 hours of patient transport	RB	75%	Registry data reviewed for missing trip sheets and reported quarterly to RTAC	Registry	Trauma Program/EMS
Under-Triage: Patients not transported to the appropriate facility within the regional system based on ISS > 9, transfer from non-designated to designated center	RB	80%	ED admission data reviewed by participating hospitals and trauma registry data for trauma centers – reported quarterly to RTAC	Trauma Registry	Trauma Program/Participating non-designated hospitals
Scene Time: Field personnel on scene time > 30 minutes without prolonged extrication or multi-patient incident for Level I activations for Level I activations	RB	80%	Registry data reviewed and reported quarterly to RTAC	EMS trip sheets/Trauma Registry	EMS/Trauma Program
Inter-facility Transfer: Delay in transfer of trauma patients to higher level of care. Delay = >2 hours from hospital arrival.	RB	120 min	Registry data reviewed and reported quarterly to RTAC	Trauma Registry	Trauma Program/Transferring facility

-FOCUS-

RTAC Delay in Transfer Review:

Sending Facility: _____

Please complete the following table for transfers > 120 minutes

	Packaging Patient	Waiting for Transport	Contacting Accepting Hospital*	Waiting for Diagnostic Test Result**	Waiting for Disposition
# of patients					

*How many facilities did you contact before you had an accepting facility: _____

**Which diagnostic tests were performed?

1.

2.

3.

4.

5.

6.

Did you identify any barriers to transfer other than those listed above? If so what were they?

_____
_____
_____
_____
_____
_____

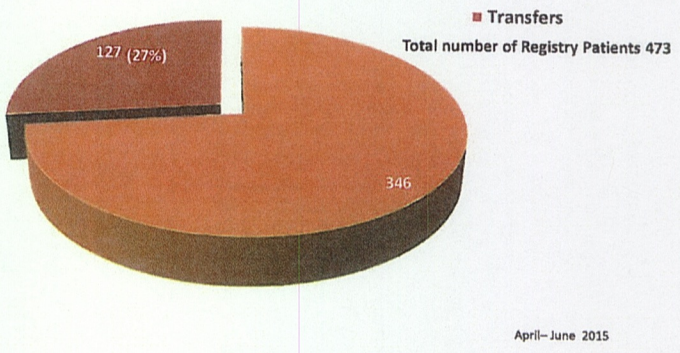
Additional Comments:

_____
_____
_____
_____
_____

RTAC Statistics

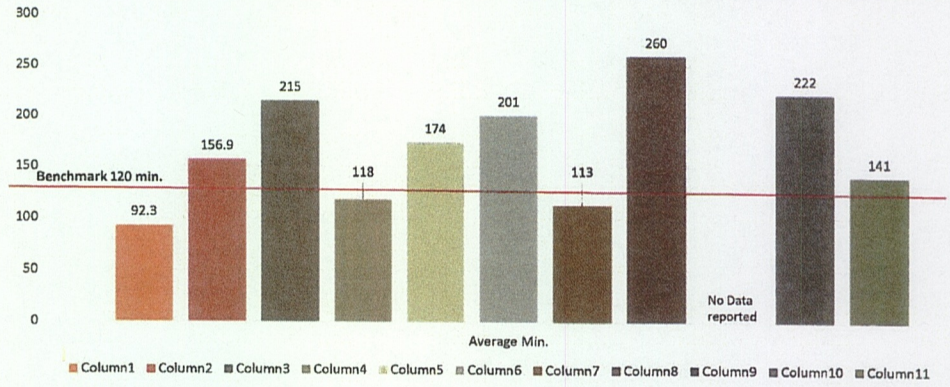
APRIL – JUNE 2015

Transfers to Level I Center



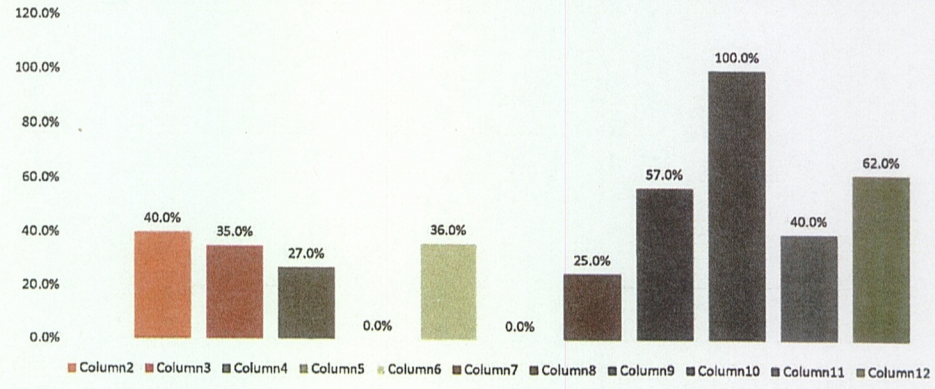
April – June 2015

Average Time Spend at Referring Hosp.



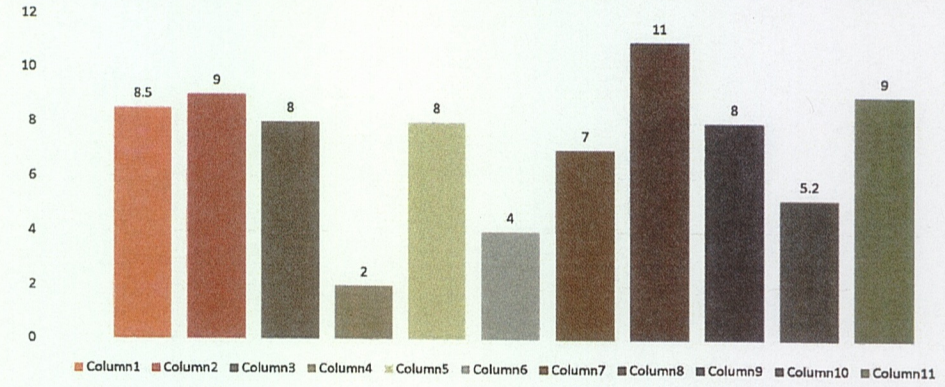
April – June 2015

% Missing Information (no D/C time documented)



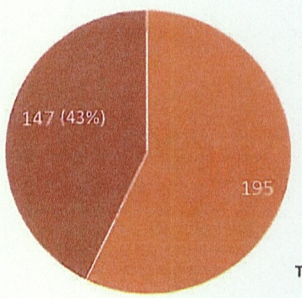
April – June 2015

Average ISS Score of Transfers



Missing EMS Trip Sheets

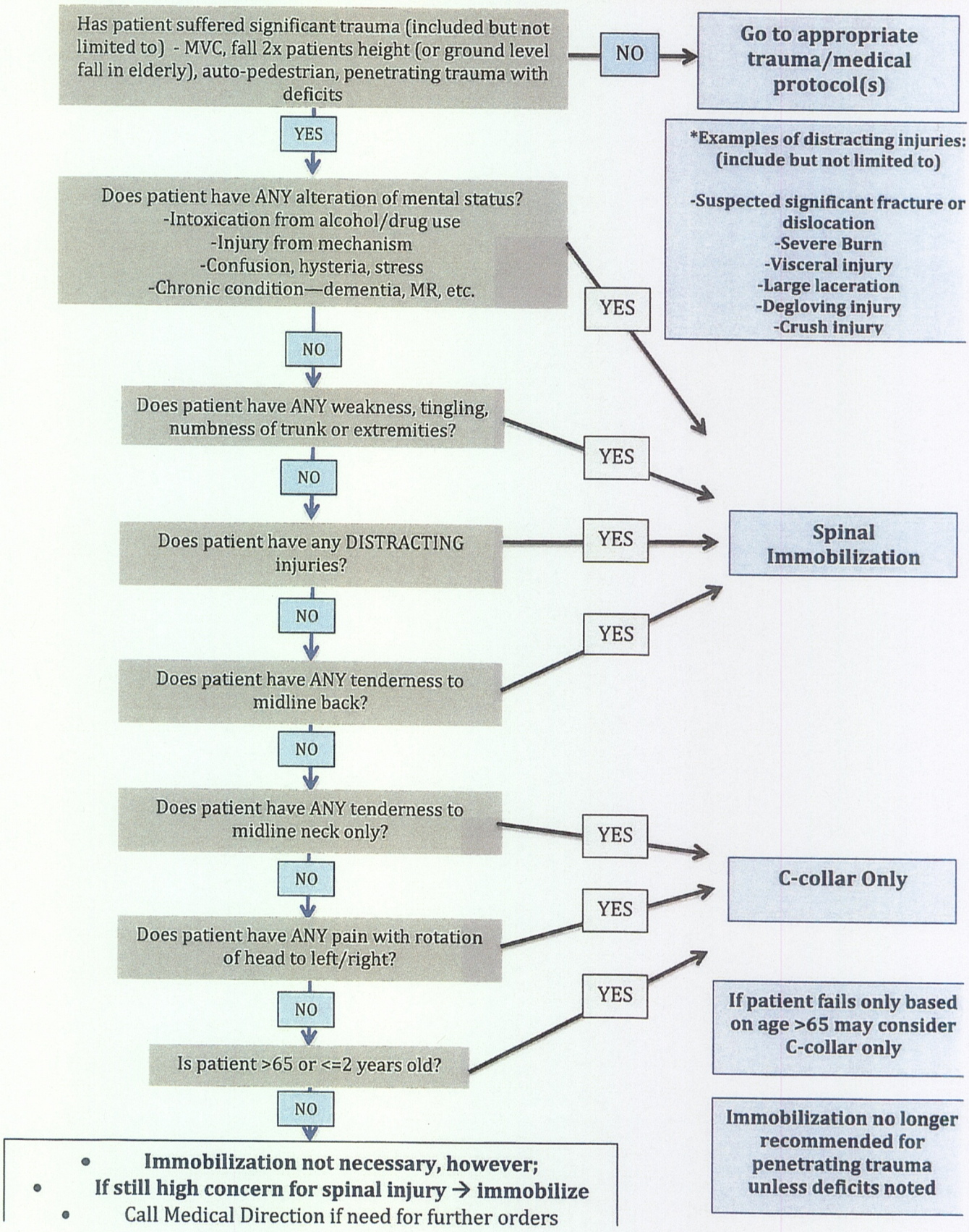
Benchmark: 75%
Trip Sheets: 57%



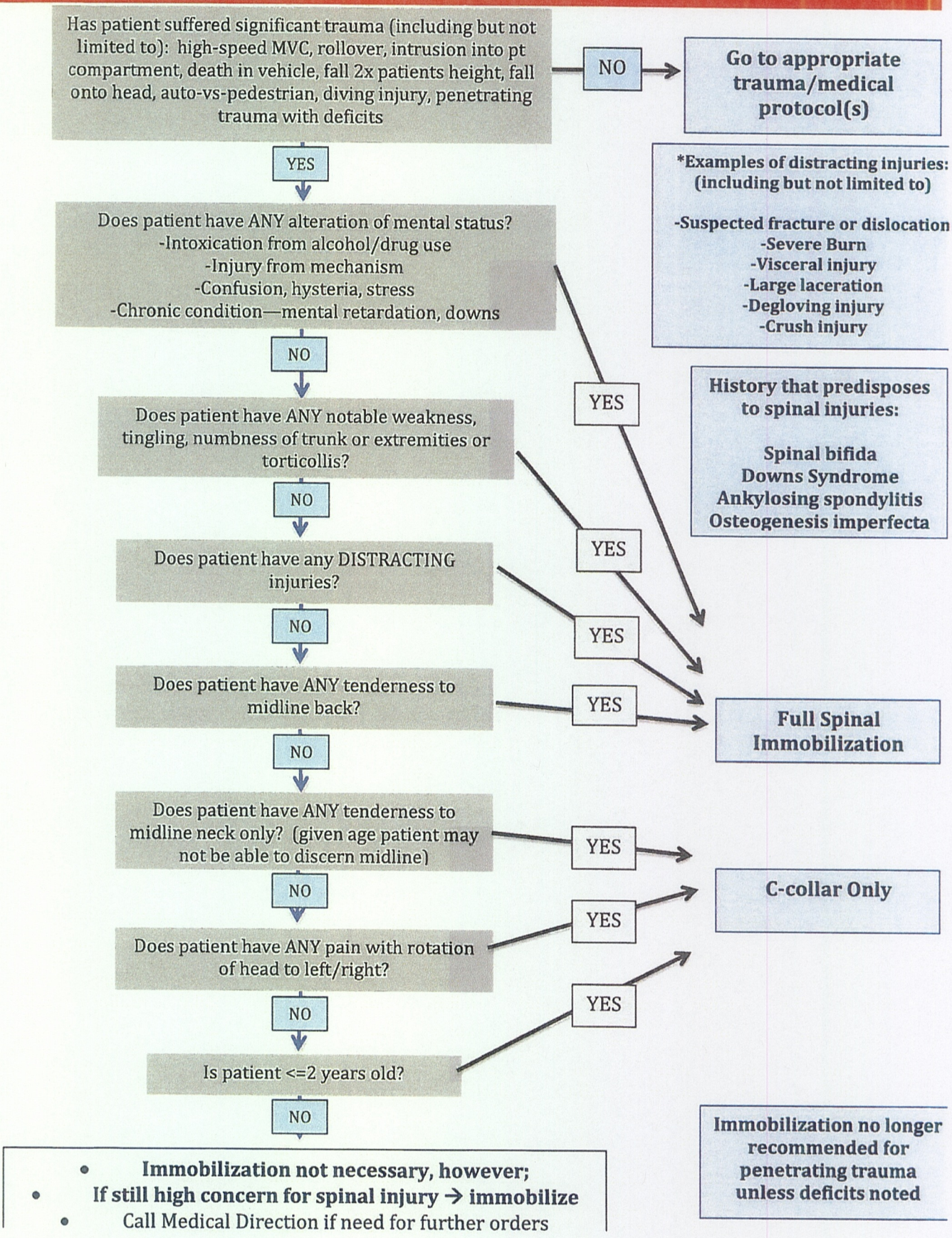
Total EMS Transports: 342

April –June 2015

Selective Spinal Immobilization - Adult



Selective Spinal Immobilization - Pediatric



Attachment 2

Preparation for January 22, 2016
GTC Strategic Planning Session

Planning Overview

Georgia Trauma System Strategic Plan (January 2012)

Mission

To develop and implement a statewide, patient-focused trauma system that fosters the development of policies, procedures, and practices that prevent injuries whenever possible and which provides optimal pre-hospital, hospital, and rehabilitative care when injuries have not been prevented.

Vision

A safe and secure environment in Georgia for all—enhanced and facilitated by a functional, integrated and continuously improving trauma system.

Goals

Goal A: Assess the trauma system and develop plans for improvement

Goal B: Clarify and delineate trauma system leadership role

Goal C: Expand the number of designated trauma centers to achieve access to a Level I, II, or III within one hour for all Georgians by June 2015

Goal D: Develop trauma system regionalization in Georgia

Goal E: Increase trauma system funding

Goal F: Strengthen Emergency Medical Services in rural areas

Goal G: System-wide Evaluation and Quality Assurance

Goal H: Conduct trauma system and care outcomes research

Performance Metrics (January 2014)

Logic Model (Inputs, Outputs, Outcomes)

Metrics, Definitions and FY 2013 Actual Data

1. Number of individuals trained through commission funding
2. Percentage of approved readiness costs funded by the Commission
3. Percentage of severely injured patients treated at designated trauma centers
4. Number of regions with Commission-approved regional plans
5. Average response time from dispatch to destination for trauma patients
6. Average time from ER to arrival at trauma center
7. Average time from dispatch to trauma center

Georgia Trauma System State Plan (March 2014)

Cross walk to GTS Strategic Plan and Metrics

Components with Goals and Objectives

1. Legislation and Finance
2. Public Information, Education, and Prevention
3. Professional Resources
4. Pre-Hospital Resources
5. Definitive Care Facilities
6. Evaluation
7. Research

Georgia Trauma Commission Strategies (January 2015)

Strategies (46 Strategies across Multiple Components)

Today's Exercise

Objectives:

- Assess where we are on the strategies
- Identify barriers to completion
- Prioritize strategies
- Establish plan for accountability to ensure continued progress

Approach:

- Component by Component and Strategy By Strategy
- Re-organized strategies list to be organized by component, then strategy

For Each Strategy

- Someone volunteers to give a 3 minute description of the strategy, accomplishments to date
- As a group, we will identify 1-3 barriers to accomplishment
- Given the "scheduled completion date" We will classify Status Code (BLUE, GREEN, YELLOW, RED, BLACK)

After Lunch

- Finish up the Components
- Prioritize strategies
- Discuss approach to ensure that we complete the top priorities
- ADJOURN

SEVEN FUNDAMENTAL SYSTEM COMPONENTS

I. Legislation and Finance

Legislative action and funding are essential components in the successful development of an optimal Trauma System in Georgia. Although excellent efforts at trauma system planning have occurred in the past, additional progress will be limited without ongoing and specific legislative support and adequate funding.

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prior-ity?
N/A	No Strategies assigned to this Component	N/A	N/A	

II. Public Information, Education and Prevention

Most Americans continue to view injuries, regardless of causes, as “accidents”, resulting in little appreciation of traumatic injury as a public health problem. There is little understanding of the role of public safety and healthcare professionals in addressing this problem. The healthcare community faces a profound lack of public and legislative awareness of the scope of traumatic injury, its financial impact on our society, the value of injury prevention, and the limited financial resources currently available for intervention.

A. Public Information and Education - Goal 1: Use current appropriate data to identify traumatic injury as an entity amenable to injury control countermeasures (G-*d,e,g,h*;M-*3*)

B. Trauma Prevention – Goal 1: Evaluate current injury surveillance tools and programs. (G-*g*)

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Priority ?
8)	Facilitate partnership with Emory Injury Prevention Center to further integrate injury prevention in RTACs. Who: Georgia Trauma Foundation When: December 2015-June 2016	II. Public Information, Education and Prevention, Goal 1, Objective b	Lori: The ECIC has begun restructuring and bringing in new leadership. With that said, we will be working together to integrate injury prevention in the RTACs. We have requested a current contact list for RTACs.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
9)	Provide information about injury prevention evidence-based strategies and validate the system cost savings from injury prevention. Who: Georgia Trauma Foundation and Emory Injury Prevention Center, GTCE Subcommittee for Injury Prevention, EMS Subcommittee, DPH Injury Prevention When: June 2016	II. Public Information, Education and Prevention, Goal 1	Lori: The ECIC has committed to take the lead on this provided their resources. Preliminary work has begun. GCTE: Not aware of GCTE injury subcommittee putting any work into this.	
16)	Potential Goal: Engage the public and organizations in Georgia to contribute to the prevention of traumatic injuries. Identify potential stakeholders to participate in the Foundation (e.g. Tea Party, Auto Insurance companies, Blue Cross/Blue Shield Foundation, Safe Kids of Georgia and auto manufacturers). Who: Georgia Trauma Foundation When: June 2016	II. Public Information, Education and Prevention	Lori: This is an ongoing goal of the Foundation as we continue to engage the public and organizations in Georgia.	
17)	Explore opportunities for federal funding to enhance trauma system development in Georgia. Who: Georgia Trauma Foundation When: Ongoing	II. Public Information, Education and Prevention	Lori: This is an ongoing goal of the Foundation as we begin to look for additional funding sources.	
18)	Develop mechanism for financial contribution from patients and families who have been touched the trauma system. Who: Georgia Trauma Foundation When: June 2016-December 2016	II. Public Information, Education and Prevention	Lori: This has not yet been developed.	
19)	Collaborate with NISQIP to request support from BCBS to fund the process to gather and transmit quality data from TQIP and NISQIP. Note: Georgia is one of two states that has	II. Public Information, Education and Prevention	Lori: We have had some preliminary discussions and are continuing to explore the options.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	adopted the use of TQIP with about 16 hospitals participating. Who: Trauma Foundation When: December 2015		GCTE: Some discussion about this within the TQIP group	
20)	*Potential Goal*: Implement a campaign to create permanent and adequate trauma system funding. Convene a group to conduct a "post-mortem" review of the 2010 referendum to review successes (e.g. It's About Time slogan) from the campaign. Include an agency that has experience working on campaign development. Who: Trauma Foundation When: December 2015	II. Public Information, Education and Prevention	Lori: This has not yet been developed.	
21)	Determine how much trauma system funding is needed to adequately fund the trauma system by reviewing readiness cost data (available in July), EMS data (because EMS data not included in readiness survey) and Dr. Pracht's report to identify gaps/areas that need to be funded. Who: GTC, OEMS&T, EMS Subcommittee When: December 2015-June 2016	II. Public Information, Education and Prevention	Dena: not started yet.	
22)	Develop a marketing package/concise message, which includes a case statement that describes the connection between the fourteen Public Health Preparedness Regions and the Georgia Trauma System (e.g. the GTS provides critical infrastructure for preparedness) and supports other systems of care (e.g. stroke). Who: Trauma Foundation	II. Public Information, Education and Prevention	Lori: This has not yet been developed.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	When: June 2016			
23)	Develop a grassroots referendum campaign that includes endorsement from the Public Health Preparedness Regions. Who: Trauma Foundation When: June 2016-June 2017	II. Public Information, Education and Prevention	Lori: This has not yet been developed.	

III. Professional Resources

Professional resources are the dedicated team of competent, compassionate individuals with complementary skills and expertise who provide high quality medical care. As in many areas across the country, Georgia is facing a critical shortage of health care professionals in both out-of-hospital and in-hospital settings. Stress and low wages are driving many of these personnel into other professions, while liability and workload concerns are driving physicians and other health care workers away from emergency trauma care. Scarcities of volunteers who provide first responder and EMS coverage for some (mainly rural) areas of the state are also part of the challenge. Small rural communities are finding it more difficult to recruit and retain personnel, because the potential pool of volunteers shrinks as these communities simply do not have residents with the time or money required to train and volunteer for the local EMS service.

A. Trauma Training –

Goal 1: Develop Trauma education programs/resources. (G-a,e,f; M-1)

Goal 2: Mechanisms will be in place for continuing education in trauma care.

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
27)	Explore potential opportunities to implement mobile integrated healthcare based on the pilot project in Spaulding to include both rural and urban areas. Who: EMS Subcommittee When: December 2016-June 2017	III. Professional Resources	Dena: We are going to receive an update on this project at the workshop.	

IV. Pre-Hospital Resources

The Office of EMS/Trauma has responsibility for regulation and oversight of the prehospital providers in Georgia. EMS Councils exist in each of the ten EMS regions of the state. Regional Trauma Advisory Committees are components of those Councils which focus on trauma care and are responsible for crafting a regional trauma plans which fit under the umbrella of the state Trauma System Plan.

A. Communications / Dispatch Priorities - Goal: There shall be a pre-hospital communications system that is fully integrated throughout the EMS and emergency disaster preparedness systems. Beginning with the universal systems access number *911,* the communications system should ultimately provide communication to ensure adequate EMS system response and coordination. (G-*a,f*;M-*5*)

B. EMS Medical Direction in Georgia - Goal: The goal of EMS medical direction is to provide an operational framework for all medical aspects of pre-hospital care such that there is professional accountability in the pre-hospital setting analogous to that in the more traditional settings of medical care. (G-e,f;M-1,4,5)

C. Triage - Goal: The trauma system will be designed to see that the right patient gets to the right facility in the right time. (G-a,d,e,f;M-1,3,4,5)

D. Trauma Communications Center (TCC) (G-a,g,h) - Goal: The TCC shall provide for the expeditious transfer of trauma patients from one medical facility to another and shall thereby assure trauma patients are being directed to the most appropriate level of care. These medical facilities include hospitals, primary care clinics, critical access centers, rehabilitation centers, nursing homes and others.

E. Transport - Goal: The transport goal is for the Office of EMS/Trauma or the EMS Medical Director to define minimum standards of pre-hospital care and transport of trauma patients, taking into account regional resources and capabilities.

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
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. Who: RTACs When: Funding requests should be made to the statewide Trauma Coordination Group and then presented at the January GTC	IV. Pre-Hospital Resources, E. Transport, Objective a	Dena: RTAC 3 was the only group that received sustainment funding during FY 2015.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	workshop for inclusion in the GTC budget.			
2)	Summarize the Pracht data by region for each RTAC to determine needs. Who: GTC via contract with Dr. Pracht (update his Georgia analysis using 2013-14 data) When: December 2016	IV. Pre-Hospital Resources, E. Transport	Dena: Dr. Ashley has been working to publish several papers from the Pracht data.	
3)	Examine the gaps and needs identified in the BIS Assessments completed by the RTACs to identify shared system needs for funding. Who: DPH Epidemiologist to provide analysis to GTC When: June 2016-December 2016	IV. Pre-Hospital Resources, Objective h		
10)	Conduct a review of the TCC changes including communication to hospitals to evaluate the changes. Who: GTC When: December 2015-June 2016	IV. Pre-hospital Resources, D. Trauma Communications Center (TCC), Objective a	Dena: The TCC's pilot project time period lapsed in Spring of 2015. It was proven the TCC was not effective and therefore closed. All hospitals in the state were sent a Trauma Transfer Poster (TMD Subcommittee), which stated Trauma Triage Criteria to go by to determine when to transfer out a trauma patient. Each hospital should be using the RAD or their local transfer centers to determine where to transfer a trauma patient.	
11)	Increase the number of hospitals and EMS using the RAD to communicate trauma center service line availability. Who: GTC When: December 2016	IV. Pre-hospital Resources, D. Trauma Communications Center (TCC), Objective b	Dena: There have been no new hospitals added. One EMS agency has been added.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
12)	Conduct a survey to understand what is working well and could be improved in the use of the RAD. Who: GTC When: December 2015-June 2016	IV. Pre-hospital Resources, D. Trauma Communications Center (TCC), Objective b	Dena: not started yet.	
13)	Continue to make improvements to the RAD by integrating with other systems (e.g. GAEMS.net), include ICU bed availability and to become a cloud-based system to provide direct access via mobile phone and computer applications. Who: GTC and OEMS&T, GAEMS.net When: June 2017	IV. Pre-hospital Resources, D. Trauma Communications Center (TCC), Objective b	Dena: RAD is still in the testing phase for mobile app	
14)	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. Who: OEMS&T, RTAC, EMC When: June 2016	IV. Pre-hospital Resources, Objective f	Renee: None specific to peds but looking at overall data	
15)	Address the lack of health care providers particularly specialists to meet ACS requirements by discussing possible changes to their provider requirements. Who: OEMS&T When: June 2016	IV. Pre-hospital Resources, Objective f	Renee: needs clarification	
24)	Implement model uniform EMS triage criteria to result in consistent practices across the state. Who: EMS Subcommittee	IV. Pre-Hospital Resources, C. Triage, Objective b	Renee: CDC field triage criteria	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	When: June 2016			
25)	Implement a multi- county pilot project to identify efficiencies working together (e.g. policies and procedures, mutual aid agreements). Who: EMS Subcommittee When: June 2017-June 2018	IV. Pre-Hospital Resources, C. Triage	Renee: No	
26)	Identify the number and use of mutual aid agreements. Who: EMS Councils and RTAC When: December 2015-June 2016	IV. Pre-Hospital Resources, C. Triage, Objective b	Dena: not started yet.	
28)	Continue to explore how to track patient outcomes when they have been diverted and need to be transferred through GEMSIS by improving documentation in the EMS trip reports. Who: EMS Subcommittee When: June 2017- June 2018	IV. Pre-Hospital Resources, C. Triage	Dena: not started yet.	
29)	Discuss the Region 1 RTAC DART disaster preparation pilot project results with other RTAC for potential replication in other areas. Who: EMS Subcommittee When: December 2015	IV. Pre-Hospital Resources, C. Triage	Dena: We are going to receive an update on this project at the workshop.	
30)	Review the composition of the EMS Subcommittee and see if any changes need to be made. Who: EMS Subcommittee When: December 2015	IV. Pre-Hospital Resources	Dena: not started yet.	

V. Definitive Care Facilities

The current trauma care system in Georgia provides a limited number of designated Trauma Centers. There are pockets of excellent trauma care in the metropolitan areas and in scattered rural areas. However, many gaps exist within the network. These gaps are believed to contribute significantly to the higher-than-national average trauma mortality rate in our state.

National research indicates that designated Trauma Centers have better clinical outcomes and more cost-effective resource utilization through compliance with established trauma management criteria.

A. Trauma Centers - Goal 1: Identify designation standards for Trauma Centers including required resources and equipment. (G-*a,c,e,g,h*;M-*1,4*)

Goal 2: Georgia shall have a sufficient number of trauma centers and transport capability to meet the needs of the injured public. (G-a,c,e,h;M-3)

Objective: 95% of the population shall have access to a designated trauma

Center within one hour of the injury. (M-3)

Goal 3: Establish the severity of injuries appropriate for definitive care at each [level of] Trauma Center. (G-a,g,h)

B. Other Trauma Facilities - Goal 1: Describe the role and responsibility of other acute care facilities within an inclusive trauma system.

Goal 2: Describe the role and responsibility of Specialty Care facilities (pediatric, burn, spinal cord injury). (G-*a.b.c.e.g.h*)

C. Designation Process (*G-a,b,c,e,g*)

Goal 1: Georgia shall have a standard process for selecting and designating Trauma Centers.

Goal 2: There shall be a process for monitoring designated centers and a process for subsequent re-designation and /or de-designation. (G-*a,c,d,g*; M-*3*)

D. Inter-facility Transfer to Trauma Center (G-*a,c,d,f,g*;M-*3,5*)

Goal: There shall be support for the rapid inter-facility transfer of major trauma patients to Trauma and Specialty Care Centers.

E. Transfer from Trauma Centers to Other Facilities (G-a,g)

Goal: There shall be a process and procedures for transferring patients back to their originating facility.

F. Rehabilitation (G-*a,g,h*)

Goal: Rehabilitation facilities shall be integral to the statewide trauma system.

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
4)	Develop a Resource Document for new Trauma Centers with details for a hospital who is seeking trauma center designation. Who: GTCE and OEMS&T When: June 2016	V. Definitive Care Facilities, Goal 2, Objective c	Renee: In process through GCTE; GCTE: has been long time under construction but do not have anything completed.	
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. Who: GTC and OEMS&T When: June 2016	V. Definitive Care Facilities, Goal 2, Objective c	Renee: needs clarification	
6)	Determine a budget for the redesignation process. Who: OEMS&T When: June 2016	V. Definitive Care Facilities, Goal 2, Objective c	Renee: not submitted, needs clarification	
7)	Reexamine the development of a summary report with information about designation and redesignation (e.g. dates, schedule) to be provided to the GTC. Who: OEMS&T When: December 2015	V. Definitive Care Facilities, Goal 2, Objective c	Renee: will provide specifics requested	
31)	Address the emerging surgery needs of rural Georgia due to the closure and stress on rural hospitals. Who: GHA When: June 2016	V. Definitive Care Facilities, A. Trauma Centers, Goal 2	Renee: No	
45)	Develop rehabilitation standards for rehabilitation facilities. Who: DPH, the regulatory agency When: December 2016-June 2017	V. Definitive Care Facilities. F. Rehabilitation , Objective c	Renee: Being written, draft completed	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Priority ?
46)	Invite rehabilitation people to GTC meetings and emphasize their importance to be a part of the GTS. Who: OEMS&T When: December 2016-June 2017	V. Definitive Care Facilities. F. Rehabilitation,	Renee: Done.	

VI. Evaluation

Evaluation of the State of Georgia Trauma System shall be performed through collection and analysis of data from the many stakeholders (see glossary) in the trauma system. This data will be used to evaluate pre-hospital care, definitive care, and rehabilitative care as well as general system issues. The results of data analysis shall be used to develop performance improvement strategies and to assist in trauma research. Both performance improvement and research strategies shall attempt to improve outcomes, provide cost-effective care, and develop trauma prevention strategies.

A. Data Collection – System Data Requirements (G-*a,b,e,g,h*)

Goal 1: The collection and collation of trauma care data throughout the state and the populations will continue to evolve.

Goal 2: Roles and responsibilities of agencies and institutions for data collection shall be defined. (G-*a,b,g,h*;M-*3,5*)

Goal 3: Develop a process for evaluation of the quality of the data and the reporting process. (G-*a,g,h*;M-*5*)

B. Research (G-*a,g,h*)

Goal 1: Develop plans for trauma research activities, including functional outcome research.

Goal 2: Incorporate research activities as part of the trauma system assessment and utilization review.

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
32)	Identify baseline measure for the response time from dispatch to destination for trauma patients (measure #5). Who: Trauma System Evaluation Committee When: September –December 2015	VI. Evaluation, A. Data Collection, Goal 1	Renee: re-evaluate	
33)	Identify targets for each of the five evaluation measures. Who: Trauma System Evaluation Committee	VI. Evaluation, A. Data	Dena: not started yet.	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Priority ?
	When: September – December 2015	Collection, Goal 1		
34)	Report on evaluation performance measure #3 related to percentage of critically ill patients treated in designated trauma centers. Who: Trauma System Evaluation Committee When: June 2016	VI. Evaluation, A. Data Collection, Goal 1	Dena: Dr. Ashley and several others using Dr. Pracht's data published a paper titled, "An analysis of the effectiveness of a state trauma system: Treatment at designated trauma center is associated with an increased probability of survival" The paper reported the percentage of severely injured patients triaged to a trauma center increased to 84%.	
35)	Assure alignment between regional quality requirements and the system wide performance measures identified. Who: Trauma System Evaluation Committee and RTAC Coordinating Group When: June 2017	VI. Evaluation, A. Data Collection, Goal 2	Renee: In process through RTACs	
36)	Explore data linkages and interface between GEMSIS and the trauma system registry. Who: OEMS&T When: June 2017	VI. Evaluation, A. Data Collection, Goal 1	Renee: being evaluated	
37)	Improve documentation in EMS trip reports as a potential way to collect data about how quickly the patient arrives at a trauma center or if a transfer was done. Who: OEMS&T When: June 2017	VI. Evaluation, A. Data Collection, Goal 1		
38)	Increase the # (or increase the %) of EMS providers providing quality data to the OEMS&T.	VI. Evaluation, A. Data Collection, Goal 3		

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	Continue to improve EMS data quality by reviewing quality measures. Who: OEMS&T Epidemiology When: June 2016-June 2017			
39)	Develop a quality dashboard in GEMSIS. Who: OEMS&T When: June 2018	VI. Evaluation, A. Data Collection		
40)	Establish thresholds for EMS data to receive funding from GTC. Who: Trauma System Evaluation Committee OEMS&T, EMS Subcommittee, GTC, RTAC representatives When: December 2015	VI. Evaluation, A. Data Collection, Goal 3	Dena: This has not been started yet.	
41)	Develop a process/system to routinely examine the quality of trauma registry data for quality data collection. Who: GTCE, OEMS&T When: June 2016	VI. Evaluation, A. Data Collection, Goal 3	GCTE: TQIP centers are doing audits within their centers but no process to routinely examine the quality of data in the registry	
42)	Establish a Georgia Trauma System Research Committee as part of the Georgia Trauma Foundation. Who: Georgia Trauma Foundation When: June 2017	VI. Evaluation, B. Research, Goal 2	Lori: This has not yet been developed.	
43)	Utilize input from the Research Subcommittee of Medical Directors and TQIP to understand potential research agenda for the GTS Research Committee. Who: Georgia Trauma Foundation When: June 2017	VI. Evaluation, B. Research, Goal 2	Lori: Preliminary discussions have begun.	
44)	Collaborate with the Emory Injury Project to identify joint projects for funding and to avoid duplication.	VI. Evaluation, B. Research, Goal 2	Lori: The ECIC and the Foundation are committed to working together and will	

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
	Who: Georgia Trauma Foundation When: June 2016-June 2017		continue to seek collaborative funding sources.	

VII. Research (See VI. Evaluation Component)

Strat-egy #	Strategy Description	Connection to GTS State Plan	Status Update	Prio rity ?
N/A	Goals and strategies associated with research are found under VI. Evaluation.	N/A	N/A	