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

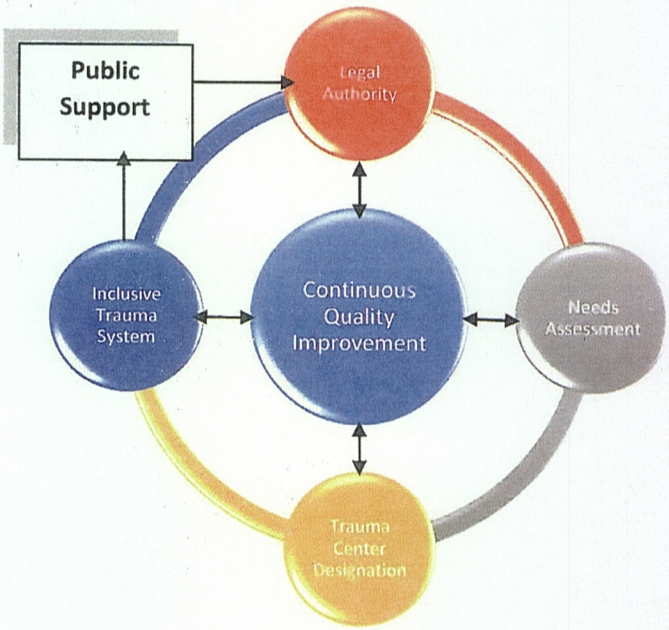
Trauma Commission Update

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?

_____
_____
_____
_____
_____
_____

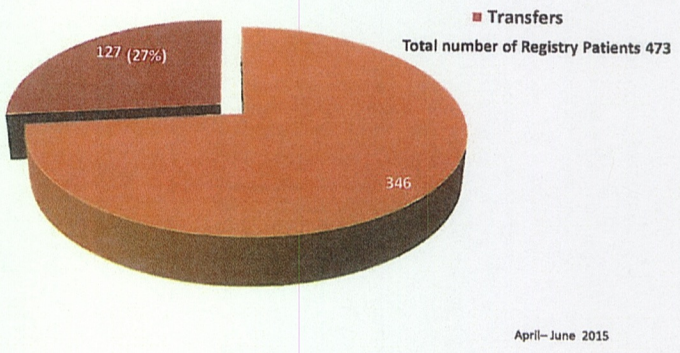
Additional Comments:

_____
_____
_____
_____
_____

RTAC Statistics

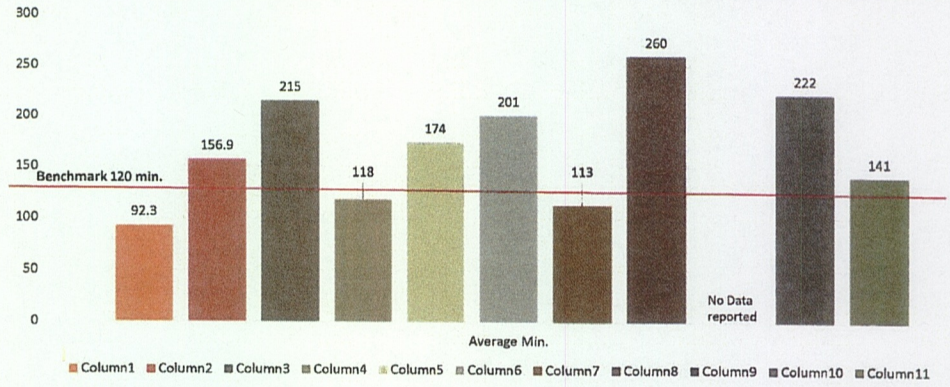
APRIL – JUNE 2015

Transfers to Level I Center



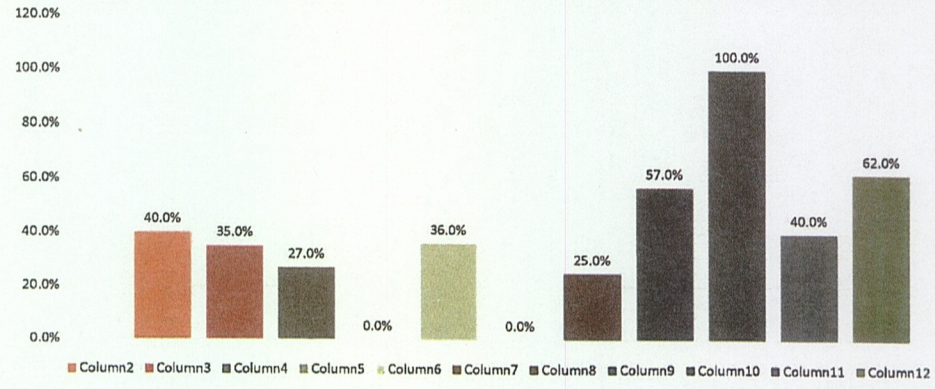
April – June 2015

Average Time Spend at Referring Hosp.



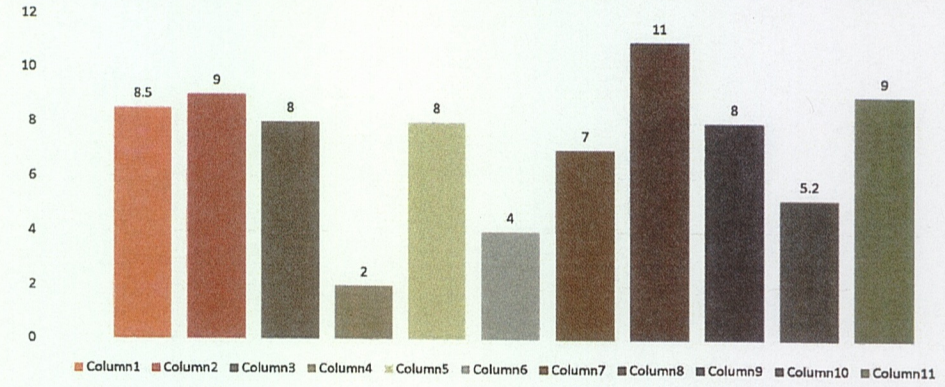
April – June 2015

% Missing Information (no D/C time documented)



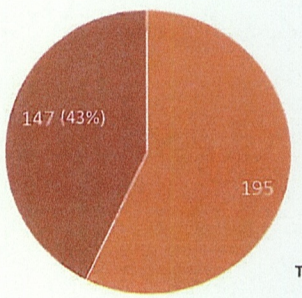
April – June 2015

Average ISS Score of Transfers



Missing EMS Trip Sheets

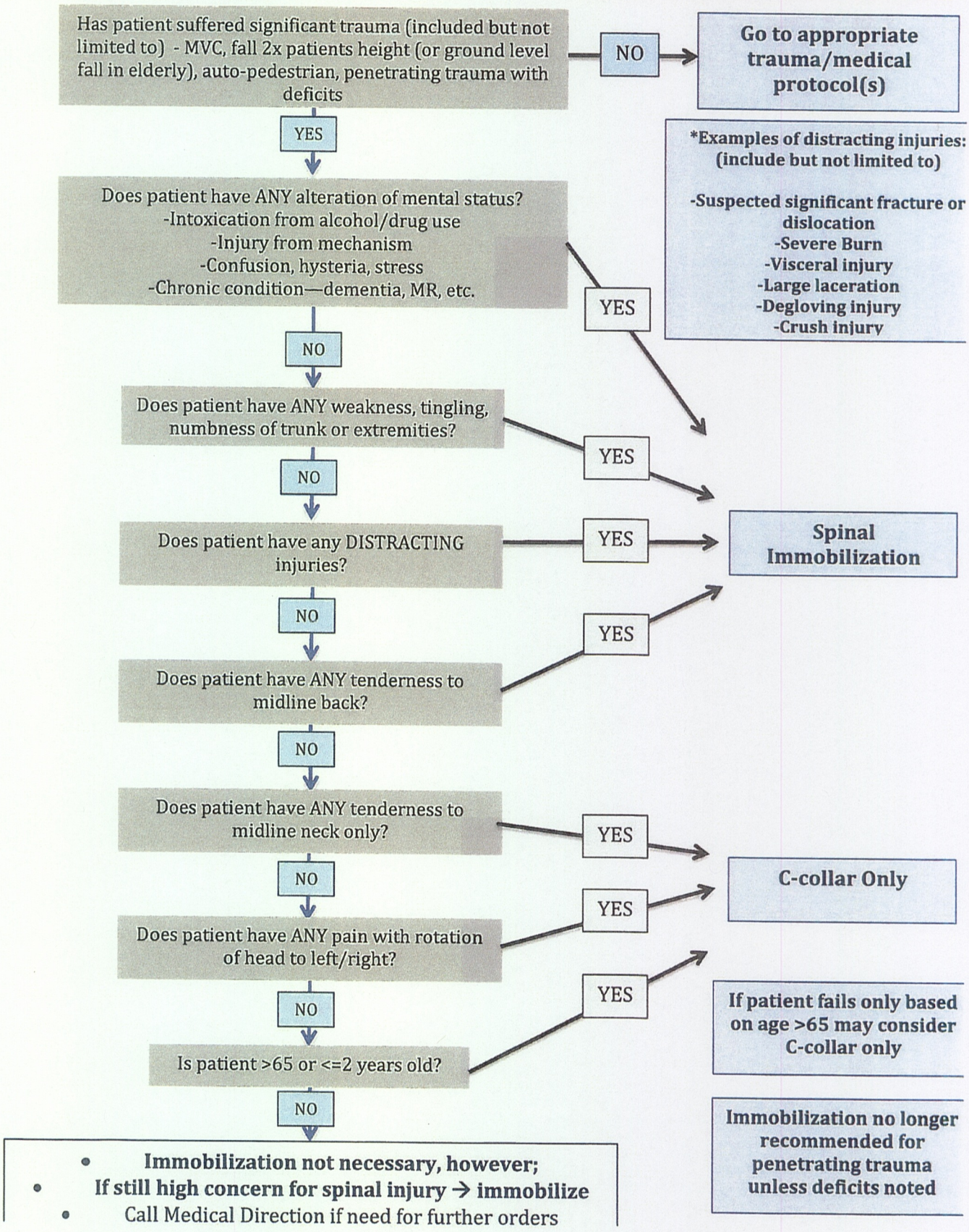
Benchmark: 75%
Trip Sheets: 57%



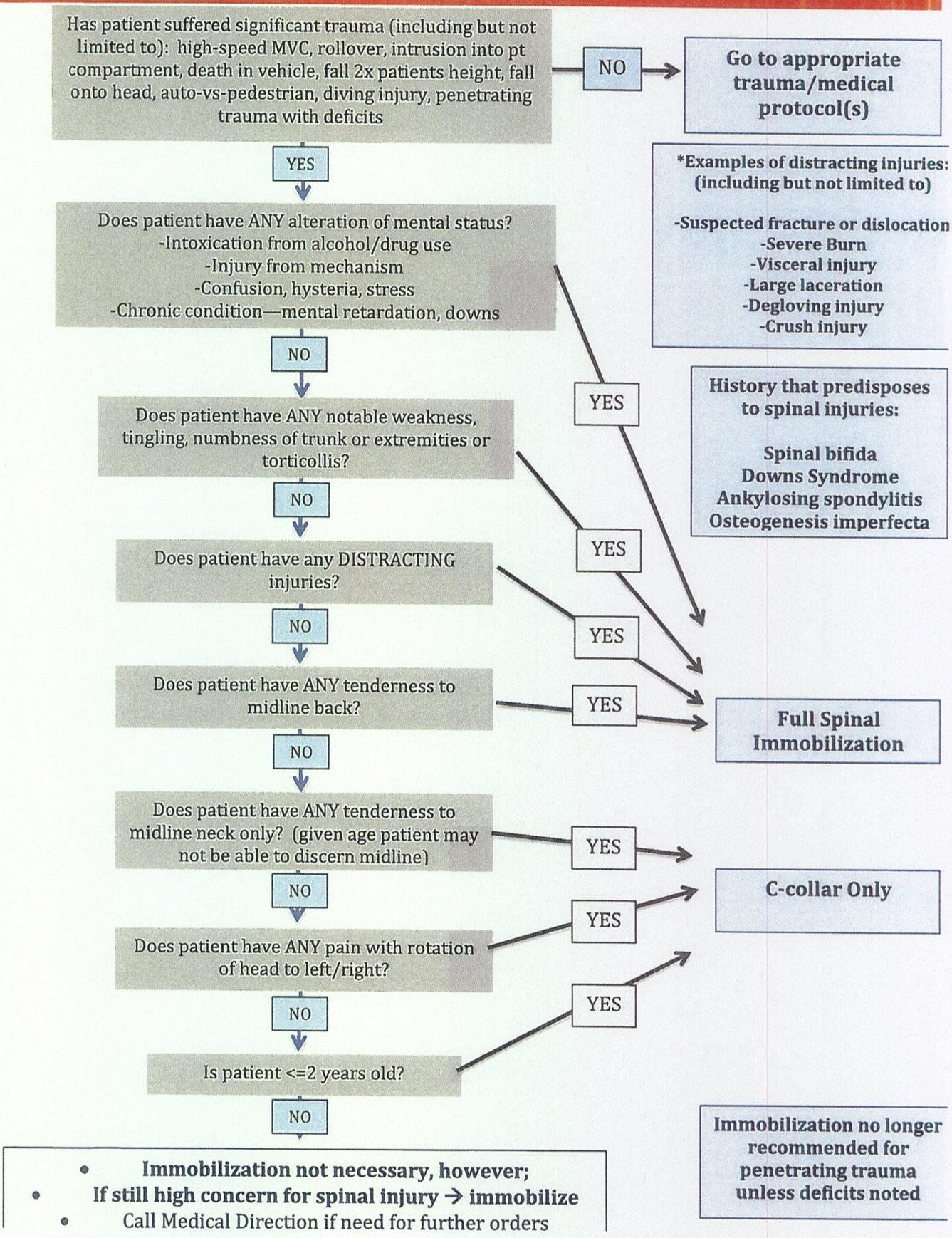
Total EMS Transports: 342

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	Priority ?
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	Priority ?
	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	