Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

4th ANNUAL STRATEGIC PLANNING WORKSHOP AND RETREAT

24 – 25 January 2013
Day One Scheduled: 9:00 am until 05:00 pm
Stuenkel Conference Center
Floyd Medical Center
304 Turner McCall Boulevard
Rome, Georgia 30165

Staff Performance review scheduled from 9:00 am to 11:00 closed to the public under O.C.G.A. Section 50-14-3(6)

DAY ONE: 24 January 2013

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

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Office Coordinator	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
Michelle Martin, TCC Operations Specialist	Georgia Trauma Care Network Commission
John Cannady, TCC Manager	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Regina Medeiros	MCG Health
Debra Kitchens	MCCG
Renee Morgan	OEMS/T
Scott Maxwell	M & M Inc.
Jim Sargent	North Fulton
Gina Solomon	Gwinnett Medical Center
Russ McGee	Region 5 OEMS/T
Hayward Wells	Doctors Hospital
Susan Bennett	JMS Burn Center
Greg Pereira	CHOA
Jeremy Stewart	Rome News-Tribune
Courtney Terwilliger	GAEMS Emanuel Medical
Alex Sponseller	Assistant Attorney General

CALL TO ORDER AND QUORUM ESTABLISHED

Dr. Dennis Ashley, Chair, called the meeting of the Georgia Trauma Care Network Commission to order at 11:39 and thanked everyone for attending, extending an extra thank you to Mr. Kurt Stuenkel for hosting the meeting.

Dr. Ashley stated that the Commission was in closed session earlier in the morning to discuss staff performance and perform evaluations. Mr. Alex Sponseller the Commissions legal counsel was aware of that meeting and it met the appropriate guidelines *(Attached to the meeting minutes Affidavit of Presiding Officer).*

Dr. Ashley stated that the open meeting of the full Commission was in session and quorum had been established.

CHIARMAN'S REPORT

Dr. Ashley stated that the Commission would be discussing the tremendous amount of work that had been accomplished in the past year and decisions to be made surrounding that work, which includes developing the strategic plan for the next year.

Dr. Ashley commented that a lot of work had taken place involving the Regional Trauma Advisory Committees. Mr. Jim Pettyjohn and he have been traveling across the state speaking with various committees and sharing information concerning the formation of RTAC's. They have had good support from the EMS counsels and program directors in those regions helping to facilitate those discussions.

AGENDA REVIEW

Dr. Ashley informed everyone that the first discussion would be about the Georgia Trauma System Regionalization Pilot Project Evaluation Report Review and the pilot with the TCC (Trauma Communications Center), which was started about a year ago this month. Ms. Pierce we will be evaluating what was accomplished and what needs to be accomplished. That report will tie in with Mr. John Cannady's report. He will be discussing the past, the present and the future of the TCC.

The next discussion would concern the DOAA audit report which came out recently and is posted to the Commission website as well as the DOAA website.

PILOT PROJECT EVALUATION REPORT REVIEW

Ms. Carol Pierce reviewed the Georgia Trauma System Regionalization Pilot Project and the information concerning the three regions that participated. The purpose of the evaluation was to access the degree of accomplishment of the four plus two goals that were part of the Pilot Project. Ms. Pierce explained that the first four goals were very specifically related to the Pilot Project activities and the latter two were future goals and added that she would talk about those next steps in Framework Provisions. Ms. Pierce explained that the goal was not to judge the regions, but to find out what they have learned collectively from their experience and to highlight the contributing factors of their success. *(Georgia Trauma System Regionalization Pilot Project Evaluation December 2012 PowerPoint Attached to the Admin).*

Dr. Ashley commented that the Commission had learned a lot about the various regions in their forming of their RTAC's, they each went about it a little bit differently, but the plans all worked. Dr. Ashley suggested that it might be helpful to write down some examples of those plans so that people could choose the one they want or even come up with a new plan.

Ms. Pierce stated that Dr. Ashley made a great point and that very conversation had come up yesterday at the Statewide RTAC meeting. People acknowledged there is no one model in the formation of an RTAC for every region, because regions are different and have a different assets and resources. It is important not to say this is how you do it, but this is what has worked for a variety of regions.

Dr. Regina Medeiros stated that in the process of forming their RTAC they called other states with well established RTAC's and were pleased to find out they were all more then willing to provide copies of documents, and share their information. Dr. Medeiros thinks that in order to not reinvent the wheel it would be helpful when other regions come on board to have similarities with them.

Dr. Medeiros recommended that as other regions start forming their RTAC's we encourage them to bring mix of people together, EMS, and hospital personnel to share information. Dr. Medeiros believes that understanding their differences would help everyone come together to create something that is a win-win for both sides.

Ms. Pierce informed everyone that the Statewide RTAC meeting was held the day before and they discussed the results of the Pilot Project, what worked well, what needed to be improved before expansion occurs, and what the next steps would be to introduce the regional trauma system planning statewide and the Trauma Communications Center. The hope was that they would continue to meet on a quarterly basis and over time expand to include representatives from all regions.

Ms. Pierce stated that one of the goals was to keep the dialog open between the Commission and OEMS/T and to strengthen and clarify those goals and responsibilities in the ongoing work to develop the regional trauma plan. People would need to know where they fit in and how important it is for everyone to be involved in its development.

Dr. Ashley stated that keeping the dialog open is one of the most important goals. Dr. O'Neal and he conversed before the Commission meeting and agreed that that OEMS/T and the Commission need to work together to get clarification of those goals and responsibilities and write them out and add them to the Framework.

Mr. Hinson stated that the Commission must be sure that the definitions of what is going into the metrics were clear and objective, so that anybody could understand them.

Dr. Ashley stated that it is the RTAC's responsibility to identify what they can use and those metrics get developed for performance improvement. It is OEMS/T and the Commissions job at that level to make sure that the metrics line up and are approved.

Dr. Medeiros stated that the goals of the PI process needed to be identified. What is the RTAC measuring, why are they measuring it, and what are they going to do with the results?

Dr. Ashley stated that outcomes needed to be reviewed. Number one could be time to definitive care, which is made up of EMS as well as hospitals. Number two, can we improve that time, and number three, how do we do that.

Ms. Medeiros stated that every subcommittee needed to be aware of each other's projects so that they can be efficient and not be working on the exact same thing.

Dr. Ashley added that the RTAC's need to use the same definitions so that data can be compared.

Mr. Pettyjohn stated that this report is in draft form and to manage the closure of the prior project and move forward he asked the Commission if they so desire to accept it in the form it is written or with some changes, so the next steps can be taken.

Ms. Elaine Frantz wanted to know if the report was accepted what the next steps would be.

Mr. Pettyjohn replied that they would determine the next steps and come back to the Commission with that based on the acceptance of this evaluation.

Ms. Frantz clarified that the next steps would be reformatting the framework. Ms. Frantz also stated that she had some edits to the report and had previously discussed those with Ms. Pierce. They are minor edits that would not have a major impact.

Mr. Pettyjohn wanted to know if the report could still be accepted now.

Ms. Frantz stated that she saw no reason for those changes to affect the acceptance of the report right now, because it would not change the results.

MOTION GTCNC 2013-01- 01:
I make the motion to accept the draft Pilot Project report in the form it is written.

MOTION BY: **Mr. Kurt Stuenkel**
SECOND BY: **Dr. Leon Haley**

DISCUSSION: Dr. Ashley wanted to clarify what the next steps would be once the motion was approved and wanted to know if responses here today would be reviewed, researched and put together in a report.

Mr. Pettyjohn stated that they would come back to the Commission in March with a proposal concerning the next steps moving forward for the Statewide RTAC and that report and evaluation would be based on the discussion made at the meeting today.

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

GEORGIA TRAUMA COMMUNICATIONS CENTER REPORT

Mr. John Cannady reported on the TCC's past, present and future *(Attached to the meeting minutes TCC PowerPoint Update)*.

Ms. Frantz stated that when the TCC made the announcement that they were going statewide, EMS and some of the hospitals were not even aware that the TCC existed. Ms. Frantz stated that there needs to be more training, education and discussion on the TCC's benefits, challenges, obstacle's and on the needs of EMS in the region and the advantages of smaller hospitals ER's placing a call to the TCC.

Mr. Cannady explained that the statewide announcement was sent out as a result of anticipation of future RTAC development and as a response to communication and trials that were made with various EMS services and hospitals outside regions 5, 6, and 9 across the state. They wanted to know if they could call the TCC. Instead of replying individually they sent out a blast email stating that if anyone would like to call the TCC they were available. There was no intent to force usage.

Mr. Ben Hinson expressed his opinion stating that Mr. Cannady should not only inform hospitals and EMS providers how the TCC can solve some of their problems, but also ask them what problems are they facing.

Dr. Medeiros wanted to know how Mr. Cannady planned to educate and train the non-pilot regions.

Mr. Cannady responded stating that his involvement with future RTAC's and their development and the RTAC coordinating group as well as the TCC subcommittee work would help with education and that also makes

himself available as much as he can to visit individual hospitals staff and EMS Directors. Mr. Cannady does see education as being the biggest challenge and finding solutions to that would require help from numerous groups.

Mr. Kurt Stuenkel asked Mr. Cannady if the TCC contacts the hospitals about updating their hospital resource availability displays.

Mr. Cannady stated that the hospitals update at set times, 12 midnight, 8:00 am, and 4:00 pm. On the display the name of that center would turn from black to red and show the time they last updated. They give the hospital an hour window before they start calling them about updating the display. If they notice that the hospital has turned their trauma resource to red indicating they cannot take a trauma patient, staff will give the hospital a call to make sure that is correct and get an estimated time of when they might be available again.

Ms. Karen Waters stated that Public Health and the Office of EMS and Trauma are responsible for certain emergency service functions and she wanted to know where Mr. Cannady sees the TCC fitting in.

Mr. Cannady responded stating that he sees the TCC as having a supporting role, because they are available 24/7 and how the TCC is defined and incorporated into the plan would be up to those agencies that are responsible for that.

DOAA SPECIAL EXAMINATION REPORT

Dr. Ashley explained that the House Appropriations requested that DOAA complete a performance audit on the Commission. He went on to say that this was a common procedure at the Capital when legislators have questions. A list of four questions was sent to DOAA. The DOAA then assigned an agent or analyst by the name of Ms. Emily Denis to research those questions. Ms. Denis's main focus for six months was to collect data and interview people in order to generate this document. The report was generated and is now on the Capitals website and the Georgia Trauma Commissions website. Mr. Pettyjohn and Ms. Carol Pierce have summed up those report findings, recommendations, and the responses from the Commission as well as OEMS/T, and what our current plan shows. *(Attached to the Admin. Report, DOAA Report and Discussion worksheets pgs. 70-77).*

Ms. Pierce presentation addressed the five recommendations in the DOAA document and compared them to the actions identified in the Strategic Plan. Ms. Pierce purpose for this discussion was to find out if the actions that were identified in the Strategic Plan were enough to respond to the DOAA findings or if other actions were needed.

Discussion on Finding #1 Service Delivery

Ms. Pierce stated that the Commissions plan over the next year and beyond was to establish a Trauma System Evaluation Committee consisting of various representatives from, GTCE, OEMS/T, and the RTAC's, in order to look at performance and quality measures.

Ms. Linda Cole wanted to know if that was a 2013 goal.

Ms. Pierce replied that it was indeed a FY 2013 goal. The Commission agreed that overall those actions fall under a goal that says: Establish System wide metrics to evaluate system performance and implement improvements to the Georgia trauma system by June of 2014. While some of those actions are in place in this current physical year the Commission has till June of 2014 to fully meet those goals.

Dr. Regina Medeiros stated that based on the report from DOAA she thinks that it is reasonable to identify 1 or 2 measurements for overall systems performance and for the Commission to request that we all look at that data together. Those measurements must be a solid quantitative measurement of improvement and she does not think those have been identified yet. Then those measurements should be disseminated through the RTAC's for them to work on.

Ms. Pierce stated according to the Strategic Plan the lead on that were the Commission, GTCE members, OEMS/T, RTAC representatives, and the state Epidemiologist. Ms. Pierce asked whether that was the group

that should come up with consistent measures, which would then be reviewed by the Commission before approval.

Dr. Ashley stated that he thought that process sounded reasonable and the Commission agreed.

Mr. Keith Wages stated that GEMSIS would have to have a specific description of what data elements or reports were needed before they would be able to make an educated guess. They would be glad to provide anything that is necessary, but with respect to the workload and not knowing what the scope of the request is he cannot provide a credible answer.

Dr. Ashley stated the first step would be for the workgroup to come with the metrics or criteria and a design and send it to Mr. Wages for review, get feedback, and then bring that before the Commission.

Mr. Wages and Ms. Renee Morgan agreed with that plan.

Discussion on Finding #2: Service Delivery

Dr. Ashley volunteered to be on the Trauma System Evaluation Committee and appointed Dr. Fred Mullins, and Mr. Ben Hinson. Dr. Regina Medeiros will recommend someone. Ms. Renee Morgan and Ms. Marie Probst will represent OEMS/T and Ms. Morgan will work on contacting the state epidemiologist. It was decided that the RTAC's would be brought in after the preliminary discussion.

Dr. Regina Medeiros suggested bringing in Kristal Claxton Smith as a representative from one RTAC to begin with, because she has done so much with data analysis related to the TCC. Then when the larger group meets Ms. Smith could bring information back to that meeting.

Mr. Keith Wages stated that he would like Mr. Russ McGee to represent the regional directors.

Mr. Bill Moore suggested that first step for the Committee would be to establish what they want to look at and he would encourage they start with very big picture ideas and figure out how to get the data to make it happen, so ten years from now we can look back and ask did we improve trauma mortality.

Dr. Ashley supports that idea and wants the first Trauma System Evaluation Committee to meet with that charge and bring back their recommendations to the Commission for approval.

Dr. Ashley expressed his opinion that the Data Subcommittee plays a very important role putting metrics together that would help answer the question, "How would a trauma center coming into the system affect the number of patients being seen or going to a trauma center?" One of the performance measures would be, "How many patients are going to a trauma center?" and then we could also get into mortality. This is how he sees writing some metrics that would help OEMS/T as well as the Commission in determining which hospitals would have the biggest impact and discern which hospitals to fund.

Dr. Ashley does not want to just focus on trauma centers, but also the areas where there are not going to be trauma centers, because they cannot put a trauma center on every corner. Those hospitals need to be educated with the Rural Trauma Team Development Course so they can identify critically ill patients in order to decrease the time it takes to evaluate and treat that patient or get them to the closest trauma center. If there is not a trauma center nearby they need to tie into EMS to find out what the transport protocols are.

Ms. Renee Morgan reminded the Commission that there is a process in place for the approval of trauma centers to be designated. It is going through the Regional Counsels with formation of the RTAC's. With education and representation on the regional counsels that can be used as a tool for an open discussion as to whether there is a need for that hospital to become designated. The Hospital must provide six months of data before they can even send in their application.

Ms. Pierce summed up the discussion stating that the Commission must identify pre and post data for new trauma center designations and then once the core focus is identified by the Evaluation Committee the group

will need to identify who is doing what related to the measurement of those trauma system goals. The other option would be to go to the General Assembly to put forth a piece of legislation.

Dr. Ashley sees no need at this point in time to go to the legislators as long as everyone works on the exercises we have discussed. Over the next year the Commission would see what they could accomplish and if it became apparent that legislation was required go in that direction.

Ms. Linda Cole wants to make sure that future Commission members have clear clarification on the functions and specific roles of OEMS/T, GTCNC and the RTAC's.

Dr. Ashley relayed that he would like Trauma Commission Evaluation Committee to hold their first meeting in April to start working on those clarifications.

Discussion on Finding #3 Number of Trauma Centers

Dr. Ashley stated that this finding correlates with what had been discussed previously in findings 1 & 2 concerning putting numbers and metrics together to determine the number of trauma centers required.

Ms. Pierce asked whether there was enough distinction between the Data Subcommittee and the Trauma System Evaluation Subcommittee. How do they differ?

Dr. Ashley replied that the Data Subcommittee is pulling together the GHA Data Base, putting ISS scores with it and figuring out that process and how it works, where the patients are and how sick they are. The System Evaluation Committee deals with what is going to be measured.

Discussion on Finding # 4: Uncompensated Care

Dr. Ashley made clarification that the 65% of uncompensated care costs incurred by participating EMS providers included only those services that had transported patients to a trauma center, and submitted claims. It is not 65% of all EMS across the state, because the Commission only funds services taking care of trauma patients entered on the trauma registry.

Mr. Courtney Terwilliger stated that some of the largest providers in the state do not participate in the uncompensated care program, because they are concerned about how much control the Trauma Commission will exert over their program. A lot of the smaller services do not, because the amount of money that they will receive is not worth the work for them to get it.

Ms. Elaine Frantz expressed that she was disappointed that those services do not participate, because if they did it would add more data to the registry.

Mr. Terwilliger reported that only 44 services participated out of about 170, 911 providers. He thinks that if you look at the services that did participate and their total call volume and compared that percentage against the statewide call volume you could come up with what percentage of the uncompensated care costs are actually being funded.

Ms. Pierce stated that it would be valuable data for the Commission to know.

Dr. Ashley stated that it is in Senate Bill 60 that the Commission is supposed to fund uncompensated care as well as readiness costs, but there was some concern a few years ago that the uncompensated care would become an entitlement program and get out of hand. The Commission is only funding 24% of uncompensated care, which shows that we have held true to being good stewards of those dollars.

Discussion on Finding #5: Ambulance Replacement Grants

Dr. Ashley stated that the EMS services grant program criteria is set up to answer the questions: population of the county, distance to a trauma center, mileage on the vehicle and was to set up to help identify old vehicles far away from trauma centers in sparsely populated areas. Mr. Pettyjohn did an analysis about a year ago and looked at all those areas of criteria to find out what the averages were on day one. Then he looked at the grant awards on year three and they were very similar. There were not many variations year to year with the data.

Based on those metrics there was still need. This is the only data that the Commission has concerning the impact of those ambulance grants.

Dr. Ashley wanted to know if the Commission feels that it is time to end the EMS Ambulance grant program, or possibly modify the program?

Mr. Ben Hinson pointed out that the data on that analysis suggests that the original criteria were good. The question is are we still following good criteria. Our goal is to reduce death from traumatic injury and he thinks that we need to review everything we do with that goal in mind. If the Commission is trying to increase the availability of ambulances, we must also figure out a way to put more crews on those ambulances. Mr. Hinson is not convinced that the grants are reducing mortality in traumatic injuries. This is his personal opinion and not from the EMS Subcommittee. He wants to find a way to improve response times and he does not see where a new ambulance solves that problem. Years ago he proposed a mutual aide agreement between counties. If both counties have two ambulances on duty and both ambulances from one county are already on a call, the other county would cross county lines to cover the call. That would improve response time.

Mr. Courtney Terwilliger responded that he did not agree with Mr. Hinson, he is of the mindset that if you replace an ambulance with very high mileage with a new ambulance and new equipment you would enhance the services capabilities, because the ambulance would be more reliable and the diagnostic equipment would be superior. He thinks that they have a good handle on response times, but he is concerned with transport times.

Mr. Bill Moore suggested that a helicopter service in rural areas would make more impact on mortality.

Mr. Terwilliger is in an area that is a long way from a trauma center and has two helicopters available 35 miles east, one 35 miles west, and two 35 miles south of him. Right now those resources are available to him, but there is a lot of competition between those services and he is afraid that in a few years they will put each other out of business.

Mr. Hinson suggested that the 911 services call the TCC to find out information such as the weather, traffic and how long it would take the helicopter to get there and then someone else decide whether to use the helicopter service or transport by ground. Then all the other helicopters become more viable, because the best ones survive.

Dr. Ashley suggested starting a Pilot Project that would address Mr. Hinson's suggestion of providing mutual aide between counties and tracking the data to see what a difference it made.

Mr. Hinson responded stating that politically it would be difficult to accomplish that, because they might give people the impression that they are trying to take over. The Commission would have to have more conversation about what should be looked in its presentation.

GEORGIA TRAUMA FOUNDATION

Dr. Fred Mullins reported that at the last meeting the Commission approved a motion to assign a Special Assistant Attorney General to give advice on the formation of a Trauma Foundation. Dr. Mullins introduced Ms. Laura Wartner, attorney Smith, Gambrell & Russell, LLP, stating that she would be answering questions concerning the formation of a foundation.

Dr. Mullins asked about the grant application that was submitted to the Georgia Health Foundation and wanted to know if there had been any response yet.

Mr. Pettyjohn responded that the application was pulled back until the Commission got more organized and could leverage that opportunity for specific tasks.

Dr. Mullins stated that the first decision to be made would be what kind of foundation the Commission wanted to form with the choices being a 501C3 or a 501C4 foundation.

Ms. Wartner wanted to know what the Commission was trying to accomplish through a foundation.

Dr. Mullins stated that the Commission wanted to establish a foundation to improve trauma care in Georgia by educating public via research.

Ms. Wartner asked how the Commission anticipated receiving funds.

Dr. Mullins replied through soliciting private foundations, and through the general public.

Ms. Wartner surmised that the Commission would want to form as a 501C3, because it is a charitable organization and there would be incentives for making a contributions in the form of income tax deductions.

MOTION GTCNC 2013-01- 02:
I make the motion that the Georgia Trauma Foundation be formed as a 501C3.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Ms. Elaine Frantz**

DISCUSSION: Dr. Ashley wanted to know if it would be outside the jurisdiction or illegal for the 501C3 to lobby with the public for support of a Bill that would provide additional funding to the Trauma Commission.

Ms. Wartner stated that you cannot advocate for the election of particular people, but you can be in support of legislation that benefits the public.

Dr. Ashley asked whether a Trauma Bill which was not a particular legislature could have a public awareness campaign, bumper stickers, advertisements or a billboard stating that the foundation supports that bill because it is in the publics best interest.

Ms. Wartner replied that was correct as long as it was not a significant part of what the foundation did.

Dr. Ashley wanted to know if there was a definition for significant.

Ms. Wartner replied that she would get back to the Commission with that definition, because that is getting into regulations with some specific guidelines.

Mr. Ben Hinson made clarification that Dr. Mullins asked for the Motion as the Chairman of the Foundation Subcommittee, Mr. Hinson made the motion and Ms. Frantz seconded the motion.

Motion has been copied below:

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

Ms. Wartner stated that the next step would be to form a corporation to be the entity that is going to apply for the tax exemption. Then you would fill out the application, which is called form 1023, and submit it to the Internal Revenue Service. Once the IRS receives an application they are sorted into different piles. The first pile is for applications that clearly meet all the guidelines for a charitable organization and receives approval within 30-60 days of submission, pile two is for minor questions and should not be held up to long, but pile three is for more serious questions and could hold up the process for months.

Dr. Mullins asked for a motion to name the corporation.

MOTION GTCNC 2013-01- 03:
I make the motion to name the Foundation the Georgia Trauma Foundation.

MOTION BY: **Mr. Ben Hinson**

SECOND BY: **Mr. Bill Moore**

DISCUSSION: None
ACTION: Passed the motion **PASSED** with no objections, nor abstentions. (Approved minutes will be posted to www.gtcnc.org)

Dr. Mullins stated that a board must be formed.

Ms. Wartner stated that she is not aware of any requirement stating that you must have a particular number of board members. Commission members can be board members, but it is best not to have the entire board consist of Commission members. She would suggest keeping an odd number.

Dr. Mullins stated that the Commission would also need to name the Executive Director of the foundation.

Ms. Wartner stated that the Board members must be put on the initial application, but you do not have to hire an Executive Director right away, as long as you note on the application he will be hired in the future.

Ms. Wartner stated that you did not have to choose all your board members right away. You could start out with five board members then put in the bylaws that the board is going to be between 5-25 members and name the initial members of the board.

Dr. Mullins suggested that the Commission choose 3 members today and then look into finding 2 more non-Commission members.

Mr. Pettyjohn will work with Ms. Wartner on any specifics she might need concerning the application. The goal would be to have the complete package back to the Commission for the March meeting so the Commission could approve the bylaws. Then once everything is approved the application would be submitted to the IRS.

Dr. Ashley named Dr. Robert Cowles, Dr. Mullins and Ms. Elaine Frantz as the initial board members.

Ms. Cole suggested that future GTF board members have experience in grant writing and fund raising.

Dr. Ashley wanted to know if there could be any conflicts of interest concerning Commission members that have been chosen that would draw red flags with the IRS and cause the application process problems.

Mr. Sponseller stated that there could be a potential problem because they would be raising money for the foundation and a lot of the money would be going back to some of the institutions that they represent.

Ms. Wartner stated a conflict of interest policy should be drawn up that stating if you are a member of the GTC and some dollars are going back to the institution you are involved with, you would not be allowed to participate in that decision. That also would be part of the application.

Ms. Wartner asked how future board members would be appointed.

Mr. Alex Sponseller stated in order to maintain control over the foundation the Commission would want to have the authority to appoint the majority of the board members. He would not make it self-perpetuating.

Dr. Ashley would like to have two passionate outside people as members on the initial GTF board and asked that as soon as Dr. Mullins found those two members the Commission would have a conference call, vote, add those two names to the GTF board and make it official with a public notice.

Dr. Ashley announced that Mr. Alex Sponseller is leaving the Commission. He has provided legal counsel to the Commission since 2008. Dr. Ashley thanked him for all his hard work and presented him a plaque in commemoration.

Mr. Sponseller expressed his appreciation of the amazing amount of progress the Commission had made since he came on board and thanked everyone.

Dr. Ashley also announced that Mr. Bill Moore's last meeting as a Commission member was today. He presented him with a plaque in Commemoration of all his hard work and guidance through the years.

Mr. Moore thanked the staff for making the Commission members jobs easier, and extended an extra thanks to the five board members he started with in 2007.

Day One adjourned: Dr. Dennis Ashley, Chair of the Georgia Trauma Commission declared the meeting adjourned 4:44

Minutes crafted by Lauren Noethen

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

4th ANNUAL STRATEGIC PLANNING WORKSHOP AND RETREAT
24 – 25 January 2013
Day Two Scheduled 08:00 am until 04:00 pm
Stuenkel Conference Center
Floyd Medical Center
304 Turner McCall Boulevard
Rome, Georgia 30165

DAY TWO 25 January 2013

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley	Dr. Robert Cowles (excused)
Bill Moore	Dr. Fred Mullins (via conference line)
Dr. Leon Haley	
Kurt Stuenkel	
Linda Cole, RN	
Ben Hinson	
Elaine Frantz	

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Office Coordinator	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
Michelle Martin, TCC Operations Specialist	Georgia Trauma Care Network Commission
John Cannady, TCC Manager	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Regina Medeiros	MCG
Karen Waters	GHI
Debra Kitchens	MCCG
Scott Radeker	Hutcheson Regional
Dwayne Morgan	Baldwin County Fire/Rescue
Renee Morgan	OEMS/T
Keith Wages	OEMS/T
Russ McGee	Region 5 OEMS/T
Randy Pierson	Floyd EMS
David Foster	Region 1 OEMS/T
Kim Brown	Hamilton Medical Center
Bud Owens	Floyd Medical Center
Greg Pereira	CHOA
Jeremy Stewart	Rome News-Tribune
David Loften	Retired/OEMS/T
Scott Maxwell	M&M Inc.
Tim Boone	GTRI
Tina Saunders	GEMA/Homeland Security
Ann Carpenter	GTRI
Elaine Frantz	Memorial

CALL TO ORDER AND QUORUM ESTABLISHED

Dr. Ashley, Chair, called the second day of the Georgia Trauma Care Network Commission's 4th Annual Strategic Planning and Workshop Retreat meeting to order at 8:25 a.m., and established that there was quorum. Dr. Ashley announced that Dr. Fred Mullins would be joining the meeting by conference call and confirmed he was on the line.

Mr. Pettyjohn announced that the 15 November 2012 meeting minutes were included in the Administrative Report.

APPROVAL OF THE MINUTES OF THE 15 NOVEMBER 2012 MEETING

MOTION GTCNC 2013-01- 01:
I move that the minutes of the 15 November meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Dr. Leon Haley**

DISCUSSION: None

ACTION: Passed

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

CY 2013 MEETING SCHEDULE APPROVAL

It was decided by the Commission members that the Georgia Trauma Commission meetings would be held quarterly (four a year) the first meeting March 21st 2013 would be a budget teleconference call. The succeeding meetings would be held face to face, May 16th in Atlanta, August 15th in Macon, and November 21st in Atlanta. The Annual Workshop would be in Columbus on January 23 & 24 of 2014. It was also decided that part of the meeting would include a tour of the trauma Center.

AFY 2013 EXENDITURE REVIEW

Ms. Judy Geiger stated that the Budget Subcommittee held their first meeting on January 10th and reviewed and approved the budget *(Georgia Trauma Commission FY 2013 Budget review attached to Admin. Report pgs. 168-175).* Ms. Geiger stated that she would be preparing for the March meeting with the Budget Subcommittee to go over expenditures, and any surpluses and deficits to potentially realign the budget.

Mr. Jim Pettyjohn added the 2014 budget that has been drafted using the Budget Subcommittees influence would be presented for the Commissions consideration at the March teleconference call, which may possibly result in the redirecting funding.

Mr. Pettyjohn stated that once the Appropriations Bill is approved sometime in March, April or May, we would know what our budget is. The Governors call was that the Commission would have a budget of $15,900,000 and a 3% cut taken to that left us $15,423,000. We were up for petition to the Office of Planning and Budget for an enhancement. The Commission asked for 2 million dollars from the increase in funding from Super Speeder Bill revenues. As a result of that enhancement request we received $477,000, which was added back into the budget, which brings us back to a budget of $15,900.000.

CY 2011 READINESS COST ASSESSMENT REPORT & TRAUMA SYSTEM PERFORMANCE TOOL UPDATE

Dr. Haley reported that Mr. Bishop would present some thoughts around the Readiness Cost Survey and how to use it potentially as a way to think about funding the Trauma Centers in the future. The next steps would be for the Commission to review Mr. Bishop's report as we are working through the budget in March, April, and May so the Commission could make some decisions concerning the FY 2014 budget. *(Attached to the Admin Report Readiness Cost Survey & Assessment pgs. 176-180)*.

Ms. Elaine Frantz questioned the difference between Level 1 and Level 2 dollars spent for Education and Outreach referring to page 176 under 2011 Trauma Center Readiness Cost Survey Results. Ms. Frantz thought it unusual that Level 2 education costs were so much higher then Level 1 when that is not a requirement of a Level 2 trauma center.

Dr. Ashley responded stating that if you add up all the Level 2 centers dollars there would be more money because there are more Level 2 centers then Level 1's, but looking at the averages between the two he admitted they do work out to be very close.

Dr. Ashley asked Mr. Bishop if he would take another look at those survey numbers under Education and Outreach to make sure the numbers are accurate between Level 1's and Level 2's.

Mr. Bishop stated he would research it further and present a clearer picture on how the breakdown works and the difference between 2008 and 2011 Survey Results.

Ms. Cole wanted to know how many trauma centers there were in 2008 verses 2011.

Mr. Bishop stated that there was a total of seventeen trauma centers this year and fifteen in 2008 and there were nine Level 2 Centers for both years

Dr. Ashley made a point that grant funding cannot be counted on one particular line item on the Readiness Survey and suggested that Mr. Bishop make sure that people are aware of that.

Ms. Cole suggested that since there are costs not included in the Readiness Report we might need a separate number to represent things that were grant funded.

Mr. Bishop stated that he appreciated the importance of the issue and would look into it further.

Mr. Hinson in referring to the chart on page 5 of the report wanted to know if it cost 6.4 times as much to be ready for the sickest patient or if that was to treat the sickest patient *(attached to the meeting minutes FY 2011 Readiness Analysis Readiness Costs by Volume additional information added to the original report)*.

Mr. Bishop stated that it was to treat the sickest patient and also having more patients makes your Readiness Costs go up.

Mr. Bishop further explained the 2011 Readiness Analysis Readiness Costs by Volume spreadsheet and stated that trauma centers that have columns containing figures in red are losing dollars. Based on that the implications are that the funding for Readiness is not aligned with actual Readiness costs. Mr. Bishop will be working with Dr. Haley's Trauma Center and Physicians Funding Subcommittee to discuss formulas that might address this.

A discussion ensued around the increase in the cost of Readiness when comparing 2008 to 2011.

Dr. Medeiros wanted the Commission to take into consideration when comparing 2008 to 2011 costs that 2008 was very early in the development of the Commission and the infusion of funding stabilized a very fragile system. The increase in funding is related to an increase in administrative and clinical infrastructure to provide better care, and is reflected in the numbers that Mr. Bishop is reporting. Adding registry staff, increased support

staffing, and hiring more physicians drives up the costs. Dr. Medeiros sees this as a positive thing because trauma centers were fragile and unstable before, and now reflect more what Readiness costs should be.

Dr. Ashley stated that Dr. Medeiros made a very good point and asked Ms. Renee Morgan if she has noticed a difference in the centers since the funding began.

Ms. Morgan stated there was a significant increase in personnel at the trauma centers, and that is across the board.

Ms. Elaine Frantz suggested any decision with regards to Readiness costs for Level 2's should deliberated over, because she believes 2011 Readiness Survey is more accurate then the one done in 2008 and added that it was not a scientific study, but there were different surveyors. Ms. Frantz believes the tool may be the same and the definitions may be similar, but there has to be some skewed data.

Dr. Haley thought it was important to note that this report was not a proposal. The Commission asked Mr. Bishop to go back and look at what would happen to the Readiness Costs if we truly allocated them based upon reality and this is what it showed. Now that we have this information it is up to the Commission to decide what to do with it.

Ms. Cole stated that we need more Level 1's and Level 2's in South Georgia and those hospitals probably have much lower volume. For example if they were told they could receive $80,000 dollars would they even consider it with all the work involved. They probably could not even hire a trauma coordinator with benefits for that amount of money.

Mr. Bishop reported on Defining An Uncompensated Care Factor For An All Readiness Budget. The purpose of the report was to show the affects of removing the Uncompensated Care funding process and go to an all Readiness budget with an Uncompensated Care factor based upon audited results. The chart on page 6 shows what that would look like.

Dr. Ashley stated that the complexity of funding the Uncompensated Care piece and making sure it is correct is very burdensome on the hospitals for the limited amount of Uncompensated Care funding they receive. If the Commission could come up with a way to simplify that process for the hospitals they should. It might be better to shift more funding to Readiness to take care of the trauma centers as opposed to Uncompensated Care. It is a good theory, but we need to take into account that some hospitals have a threshold and would have a very difficult time taking care of their patients without Uncompensated Care.

Dr. Ashley proposed that the Trauma Center and Physicians Funding Subcommittee meet to discuss what the states responsibility for Readiness and Uncompensated Care is and come back to the Commission with an answer to that question.

Mr. Bishop stated he would have an initial report ready for the next Data Subcommittee meeting regarding what kind of trauma volume hospitals throughout Georgia are receiving.

Mr. Ben Hinson stated that Mr. Bishop's program might allow the Commission to look at discharge data, ICD9-10 codes and assign ISS scores to all the patients discharged from a hospital, thus determining the true trauma volume over the years. This would provide real baseline data that the Commission never had access to before and help determine where patients went and how sick they were. It would also determine the Commissions success rates since they starting funding trauma centers in relation to how many trauma patients are surviving.

Mr. Hinson asked Mr. Bishop if there was any discharge data if a patient were to die in the hospital.

Mr. Bishop stated if the patient dies in the OR they typically would be admitted and included in the data set, but if the patient dies in the ED or was dead on arrival they would not be included, and added that there is an outpatient report that would include those cases. Now they only looking at the In-patient data sets, but if in the future that information was needed it could be added.

Data Subcommittee

(Attached to the Admin. Report, Data SubCommittee meeting notes December 2012 & January 2013 pgs. 310-321)

RTAC REPORTS

REGION 5

Ms. Debra Kitchens reported to the Commission that Ms. Krystal Claxton-Smith and she are doing one on one education with EMS concerning placing calls to the TCC *(Attached to the Admin. Report, Region 5 January–December 2012 Trauma Regionalization Pilot information).*

Ms. Linda Cole wanted to know if Ms. Kitchens RTAC is receiving good participation from non-designated EMS and other stakeholders.

Ms. Kitchens stated that they had not been meeting as frequently, but things have picked back up. Ms. Kitchens stated that they did not have as much hospital participation as she would like to see, a few attend, but it seems to be more EMS and Air Evac. They are reaching out to the hospitals to try and get them to participate more.

Ms. Kitchens announced that Mr. Chris Hobbs changed responsibilities and job duties and has stepped down as RTAC Chair, and from the Region 5 council. Mr. Allen Smith from Washington County was appointed the new Chair, and he is also a member of the Region 5 council.

Ms. Cole asked what Ms. Kitchen's needs were concerning injury prevention and if there were any resources that they might be unique to Region 5.

Ms. Kitchens stated MCCG has an Injury Prevention person who is funded from the Coles grant. Their safety checks have increased, and they have the standard health fairs. Ms. Claxton-Smith, RTAC Coordinator, is involved with EMS Save the Children, which will be offering some free classes on pediatric education. Safe Kids is in their area now and they are investigating involvement with that program.

REGION 9

Ms. Elaine Frantz reported that Region 9 had three subcommittees meet in December and their annual meeting will be February 8th. They have been very active with Safe Kids and injury prevention.

NORTHWEST GEORGIA-REGION I EMS REGIONAL TRAUMA SYSTEM PLAN PRESENTATION

Dr. Ashley welcomed Mr. David Foster who represented the RTAC in Region 1 and reported on its initial development and plan *(Attached to the Admin Report Region 1 EMS Regional Trauma Plan pgs. 186-242 and PowerPoint pgs. 242-253).*

Mr. Russ McGee wanted to know if Region 1 had any communications problems such as 911 providers that have restrictions on their cell usage, or problems with cell coverage.

Mr. Foster stated that they have no problems with restrictions on cell phone usage, but they do have coverage issues based on the providers, especially with Sprint in the more mountainous areas. Just the geography of Region 1 can affect communications and the ability to communicate.
Dr. Ashley asked whether all 911 providers were going to use cell phones to contact the TCC.

Mr. Foster replied that they have not totally addressed that issue, but plan to in their education. He does know that it would be service specific.

Dr. Ashley would like Mr. Foster to keep him posted on that issue so it can be monitored and compared to other areas also.

MOTION GTCNC 2013-01- 02:
I make the Motion to approve the RTAC 1 plan as presented.

MOTION BY:	**Mr. Kurt Stuenkel**
SECOND BY:	**Ms. Elaine Frantz**

DISCUSSION: None

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

MITCHELL COUNTY AMBULANCE DISPOSITION REQUEST

Mr. Jerry Permenter the Mitchell County Administrator, joined the meeting via teleconference call to discuss the request to dispose of an ambulance that they received from an ambulance grant through the Commission in May of 2009. The amount of the grant was approximately $72,000 and the cost of the vehicle was about $115,000. Through a change in business practice with the County Commission and their 911 services they have made a request of the Commission to dispose of that ambulance. The grant stipulated that if a vehicle was disposed of within the first five years of the grant they would need to receive permission from the Commission for that disposition *(Attached to the Admin. Report disposition request documents pgs. 254-277)*.

Mr. Pettyjohn confirmed with Mr. Permenter that an estimate was done on the vehicle in the amount of $12,000, but it was in need of repair.

Mr. Permenter stated that the vehicle is still drivable, but it needs transmission work.

Ms. Cole wanted to know if an estimate had been done for the cost to repair the ambulance.

Mr. Permenter stated that it was not, but the $12,000 estimate of the vehicle took into account that it will need repairs.

MOTION GTCNC 2013-01- 03:
I make the motion that Mitchell County sells the ambulance and the portion that the Commission funded is returned to the Commission and the portion that that Mitchell County purchased be retained by Mitchell County out of the proceeds of the sale.

MOTION BY:	**Mr. Kurt Stuenkel**
SECOND BY:	**Ms. Elaine Frantz**

DISCUSSION: Mr. Pettyjohn clarified that $72,000.00 of the $115,000 is about 60%. If the vehicle sold for $12,000, 60% of that would be $7,200.00.

Dr. Ashley asked Mr. Sponseller if the motion on the floor would meet legal qualifications.

Mr. Sponseller responded that it that it did meet legal qualifications and he thought it was the best way to handle it.

Mr. Permenter stated that the motion was acceptable to him.

Dr. Ashley made clarification that whatever the vehicle sold for the Commission would take 60% from that sale and Mitchell County would keep the rest.

Mr. Permenter stated he was in agreement and upon completion of the sale he would forward the portion of proceeds to the Trauma Commission and provide the paperwork that supports the actual price they received for it.

ACTION: Passed — the motion PASSED with no objections, and one abstention from Ben Hinson. (Approved minutes will be posted to www.gtcnc.org)

Mr. Pettyjohn stated that he would be in touch with Mr. Permenter to confirm the Commission's actions.

TRAUMA MEDICAL DIRECTORS

Dr. Ashley reported that the Medical Directors Subcommittee is working closely with the Georgia Committee on Trauma and the Chair, Dr. Chris Dente. Dr. Dente is a Trauma surgeon at Grady for the American College of Surgeons. Georgia is the second state to go statewide with a Trauma Quality Improvement Program (TQIP) through the American College of Surgeons. TQIP is made up of individual trauma centers that enter data into the registry specifically related to trauma. TQIP did not have forms to address the Commissions needs because no statewide data has been generated to this point. The Commission is leading the way.

Dr. Dente's group made up of coordinators as well as trauma medical directors formed a Performance Improvement group that can help the Commission start to look at that problem. This is so important because everything that comes through the Commission is open record, including data generated through outcomes. They are just now learning how to get the data, how to interpret reports, and how to build the reports for the state. It will take them around a year to get up to speed and trust that data, but they are on the right track. Dr. Dente's group will look at that data and identify areas for improvement *(Attached to the Admin. Report pgs. 283, Trauma medical Directors November 19th meeting notes)*.

Part of the TQIP project is to meet once a year at a national meeting where the best performers present what they did and how they got to that point, and share the information with other trauma centers.

The first trauma center group educational meeting will take place on August 9th and will include the trauma medical directors, trauma coordinators and the Trauma Performance Committee.

The Trauma Commission has been recognized as one of the leaders and has been asked to present next month in Philadelphia at the National Trauma Quality Improvement Program. They are going to present the Georgia Story which is about the process of getting all the Level 1 and 2 trauma centers in the state involved with TQIP. Dr. Ashley reminded everyone that we are only the second state to accomplish that.

GCTE

Dr. Regina Medeiros reported that their last meeting was held December 18th in Madison Georgia. The main purpose of the meeting was to discuss the registry software platform that is currently in use and the quality of that data. It was decided that in order to be able to compare data within and amongst facilities or aggregate that data to compare against actual benchmarks, a clean data set with standardized definitions would be required.

Digital Innovations is creating V5, which is brand new platform software for their registry, which is stable, uniform, and enables more functionality.

At some point ENTRACS will be phased out and centers will need to migrate to the new platform. FoxPro, the platform for the report writer, which does the PI, is definitely going away, which makes it the perfect time to transition.

The National Trauma Data Bank has a National Trauma Data standard, and it is a preset group of definitions that every hospital that participates uses all over the nation. Those definitions will populate the drop down

screens within V5 and will be locked so no facility can change them, and they will remain standard. We have a working group for the non-data standard elements and they are coming up with a consensus of how those elements will be defined. That will then go to the medical directors who will review it, support it, and once everyone agrees it will be locked down so no changes can be made. There would have to be a formal request made to make any changes to the registry. If a request were granted all registries would be updated at the same time.

We are making the recommendation that we transition to V5 platform software, and are going to update the medical directors on their next conference call meeting. A summary will be sent to Dr. Ashley prior to the next call explaining why we are requesting the transition. There is a licensing fee, and they are negotiating the software developer's fee, because it is being customized. The proposed costs from DI were calculated and it was determined that each trauma center could afford it. Each trauma center would cover the cost of the software with the funding they already are receiving for registry. The total cost is somewhere around $12,000 per facility and the maintenance is somewhere around $3,000-$4,000.

Dr. Ashley concluded that the Commission would be able to tie in PI from the ground level with OEMS/T, and the RTAC's, so everyone could be on the same page.

Dr. Medeiros responded stating that it is very complicated to run a report, but as part of the negotiation with Digital Innovations they are going to give them 20 or so standard reports. They want to start with the verification reports, which everyone should be running, and tracking. Those reports would be written the same for everyone and because they will be using the same definitions can be compared against each other's, and the dashboards for the RTAC's that are being developed could be standardized too.

EMS SUBCOMMITTE

Mr. Ben Hinson reported that there had been conversations concerning how to spend funding in the future. Some of that conversation was around Ambulance Grants and whether that was a good place to spend the money. We are working hard to improve outcomes with trauma patients in the EMS system. One of the big challenges is that EMS services are so radically different. There are counties in Georgia with 210 square miles, and counties with 890 square miles, but every county has their own EMS system. If we could get some of the smaller counties to run as one system they would not need to be geographically big as some of the big companies. Everything we do is based on county so it is very difficult to have one solution. That is why the ambulance grants are good for some and not that good for others.

We are going to meet the first week of the month that the Commission is holding a meeting, so we can have the minutes completed for the Commission meeting. Then if there are any actions that need to be made the minutes will be available (*Attached to the Admin. Report EMS Subcommittee on Trauma Meeting Minutes 03 January 2013 pgs.290-309).*

Dr. Ashley stated that one of the items in the DOAA report was about the Ambulance Replacement Grants. If we are going to continue that program there are going to have to be some outcome metrics to look at. The EMS Subcommittee is going to need to discuss this at some point.

Mr. Hinson stated the EMS Subcommittee has relayed to him that they need some absolute parameters from the Commission about what they should be trying to accomplish. Is it to give counties relief from purchasing ambulances, to train First Responders, or is the bigger picture to reduce trauma and morbidity among trauma patients. At the next Commission meeting he would like to have a discussion concerning this.

Ms. Cole suggested since the next EMS Subcommittee meeting is two weeks prior to the Commission meeting that the members of the Commission who are also part of the EMS Subcommittee meet and offer guidance before that meeting.

Mr. Hinson replied that he would set up a call with Ms. Cole, Dr. Haley, and Dr. Ashley.

Mr. Hinson stated the biggest problem is trying to get data from EMS that can be compared with other agencies. For instance response times are measured differently from one agency to another.

Ms. Frantz suggested measuring the time that the ambulance arrived at the scene, or left scene and arrived at the first hospital.

Mr. Hinson defines response time as from when the call is first received at the 911 center, until somebody in their system knows there is a call, and the medics are at the patients side, they are on route to the hospital, and then how long it takes to get to the hospital. Then they hope the hospital will relay that time taking into consideration, diversion time. All this should be reviewed and then improvements made on every segment of that process.

Dr. Ashley made the comment that EMS needed to get very serious about focusing on a definition for response times. They need to pick a time they are happy with, and not get bogged down with counties that cannot participate, because perhaps they do not have the sophistication, they can be dealt with later. If even 80% of the services can participate in the plan then at least that is a start.

Mr. Hinson stated that the EMS Subcommittee will need Mr. Keith Wage's office, and EMSAC's (Emergency Medical Services Advisory Committee) involvement or nothing can be accomplished.

Mr. Wages stated that the GEMSIS system has all of the increments that Mr. Hinson referenced. All of the incremental times are included, but the issue is compliance by the service or individual completing the report properly. Mr. Wages could run a report, which may or may not be accurate. The definitions are there, but the Trauma Commission has to decide what they want to look at.

Dr. Ashley wanted to know if they decided to have Mr. Wages run a particular report if he could run that report only on the reports that were completed.

Mr. Wages replied that they would need to experiment with some different filters. If the right filters were put on a report there would be a higher level of confidence in its accuracy and its usefulness. Just because a report is complete does not mean that it is accurate. We would want to exclude information on a report that is clearly entered wrong. As we go through the reports and we start supplying the feedback to the 911 services, they would see where they have opportunity to improve on their reports, because they want to do a good job. This will take some teamwork, and it is very important to OEMS/T, and important to the EMS profession in general. In partnership with the Georgia Trauma Commission we can work on these reports with the goal of making things better for trauma patients, and in turn, all patients.

Mr. Hinson stated that he would be in touch with Mr. Wages to set up some time to work on this. Mr. Hinson mentioned that the magnitude of data scrubbing is overwhelming, because Mr. Wages is going to have to look at millions of records to narrow down which ones relate to EMS.

GEORGIA TECH RESEARCH INSTITUTE PRESENTATION

Mr. Pettyjohn introduced Dr. Tim Boone, a research associate at GTRI. Dr. Boone introduced Ms. Ann Carpenter, Senior Research Associate at GTRI and the person responsible for the five year planning and work associated with the report.

Ms. Carpenter reported that GEMA Homeland Security has sponsored this project since about 2008. The grant is appropriated to the Association of EMS and administered by GTRI. They have also had a great partnership with the division of Public Health office of EMS and Trauma. The funding was started to take a look at strategic resources and planning for increasing the capabilities of EMS within the state of Georgia. Each year they perform an annual baseline assessment of EMS performance in Georgia within the state and that is accomplished by sending out an annual survey to private based, county based, fire based, military based, Hazmat teams and EMS based services to help identify and determine gaps in EMS capabilities and resources. They also sponsor Tabletop Exercises. Ms. Carpenter went through the objectives, methodology and

recommendations from the study. *(Attached to the meeting minutes PowerPoint Year 5 Georgia EMS Strategic Resource Planning Project)*.

Ms. Carpenter stated that Project five is nearing completion, all the data has been compiled and analyzed, and the plan is to disseminate it in a couple of months. At that time if you would like a copy you can email her at (acarpenter@gatech.edu).

Dr. Ashley directed a question to Mr. Hinson concerning the recommendations from the report and how they might tie in with the EMS Subcommittee.

Mr. Hinson responded stating the report was previously presented to the EMS Subcommittee and they were so encouraged by it that they wanted the Commission to hear the presentation. He thinks the report can be scrubbed for information that might be helpful to 911 providers. Mr. Hinson stated that one of the huge benefits of the report is the work that the EMS community does with GTRI analyzing information, determining its effectiveness, and preforming Tabletop Exercises.

Dr. Boone reported on the various tools being utilized and how protocols could be developed so everyone who is using those tools can provide feedback on which tools might be most useful for certain kinds of situations and goals that they may have. He went on to say that they are just getting started on this study. These systems are all in one way or another designed and built to help multiple people in multiple locations get a common perspective of what is going on and understanding how to influence that with decisions about resources in the event of in incredible incident *(Attached to the meeting minutes handout: Need for and Benefit from Healthcare Capacities and Emergency Response Systems Integration*).

Dr. Boone reported that they are involved in a practical effort to identify and document the best uses of those communication tools. They have created a spreadsheet that lists the tools and their features and uses and they are beginning to talk to the people who are experts in the use of those tools. They have them fill out the spreadsheet so they can catalog what the key capabilities of all those systems are. They will then bring that information back to everyone. They also want to clarify what the opportunities are for mutual support of those systems and draft initial protocols suggesting what systems would be best utilized for certain situations. In a couple of months they are going to run a Tabletop facilitated conversation where they will get the stakeholders together and run some scenarios based on what they learned from everyone to come up with a draft plan. In July they hope to run an actual functional exercise where the FOC would go on alert and then the various other agencies would go through the process of using the tools and testing them out to see if it works and what might need to be changed.

DPH OEMST REPORT

Dr. Pat O'Neal reported that after many years of anticipation the Office of EMS and Trauma have finished the current version of the guidelines that the state provides for clinical care of patients by pre-hospital providers. Dr. O'Neal wanted to make everyone aware that although they provide those guidelines the ultimate decision on how the medics will operate in the field is left to the service medical director. The Medical Director has to stay within the scope of practice that the medics are permitted to practice under. He would be signing off on those guidelines Tuesday of next week at the Directors Advisory Council meeting in Columbus.

Dr. O'Neal and Dr. Ashley have had several conversations over the last several months and it very important to them, the office OEMS/T and the Trauma Commission that communication continues to improve, because we all need to work together and be prepared to respond to questions from policy makers as forthrightly as we can. He also made it clear that it was not a very good year legislatively for trauma, so he thinks it would be best to avoid introducing anything new and different that they have not had time to understand and adjust to. Dr. O'Neal does not think it would be to anyone's benefit to move forward with a strong legislative agenda for trauma this year.

Dr. Ashley and he have agreed that if either one was to speak before committees at the legislature that they would make each other aware of the topic so they can both discuss it and determine what the consensus is on that matter.

Dr. O'Neal referred to the Audit Report and questions that may arise from that report. One of the issues that might come up is the question that was raised concerning a lead Agency. Dr. O'Neal personally does not like that terminology, because he does not think a single entity should be in total control of the trauma system. He feels very strongly that the regulatory function needs to be separate from the other functions of the trauma system to avoid criticism and bias. It is not good from an academic perspective either. He hopes we will focus on being very clear on what roles the different party's play and not focus on a lead agency. Dr. O'Neal mentioned another issue in the report referenced the ambulance grants, he suggested that we keep in mind what the auditors recommended and follow those recommendations. We are here to work together to come up with the best trauma system for Georgia and we want to continue to focus on that goal.

Ms. Renee Morgan reported that they have five hospitals that are currently participating in the registry program who are not designated. She does not see them moving forward with the designation process. Trinity Hospital in Augusta has made an application to them for a Level 3, and she hopes that designation will take place within the next 60 days. They are still communicating with Northeast Georgia Medical Center in Gainesville, but she has not received a formal application. Crisp Regional who is in Cordele, has not made a formal application, but they are moving forward very quickly, and their designation will probably take place before June.

Dr. O'Neal stated that there is a system in place that needs to be strengthened for determining if it is appropriate for a hospital to become a designated trauma center, and that is through the EMS councils. He would like to see the RTAC's become so strong that they could make recommendations on trauma centers placement. What is required is an actual functional trauma plan that works; of course it would never be finalized because it would change over time. We need to incorporate the plans for mass casualties, and the three levels of surge plan under a single umbrella. He would like to see the state trauma plan be the basis for that. They could use the EP Planner in writing the state plan to. They also have an EP funded person in the office of EMS who has an excellent background in emergency management who could contribute to the writing of that plan. If we put those assets together it will help us along the way, but he thinks they still need a fulltime planner who can help format it the plan. They are going to get started with what they have and do the best they can to have that plan by June 2013.

LAW REPORT: None

NEW BUSINESS: None

DAY TWO ADJOURNED: Dr. Dennis Ashley, Chair of the Georgia Trauma Commission declared the meeting adjourned at 2:25.

Minutes crafted by Lauren Noethen

County of Floyd
State of Georgia

AFFIDAVIT OF PRESIDING OFFICER

Personally appeared before the undersigned officer, duly authorized to administer oaths, Dennis W. Ashley, M.D., Chairman of the Georgia Trauma Care Network Commission, who, after being sworn, deposes and states under oath the following:

1. THAT affiant is the duly appointed Chair, is over the age of eighteen years, and has personal knowledge of the facts contained in this Affidavit.

2. THAT this Affidavit is given as required by that portion of the Georgia Open Meetings Act (O.C.G.A. § 50-14-1, *et seq.*) codified at O.C.G.A. § 50-14-4(b).

3. THAT the Board met in an open meeting, as required by O.C.G.A. § 50-14-1(b), on the 24th day of January, 2013, and during the course of that meeting it became necessary for the Board to close the meeting to the public pursuant to the provisions of Chapter 14 of Title 50 of the Official Code of Georgia Annotated.

4. THAT affiant presided over the closed portion of the meeting of the Board.

5. THAT, as reflected in the minutes of the open meeting to which this Affidavit is attached, upon a majority vote of a quorum of members of the Board present for the meeting, the meeting of the Board was closed for the specific reason set out in the minutes, the specific exception to the Open Meetings Act being O.C.G.A. § 50-14-3(b)(2).

6. THAT during the portion of the meeting of the Board which was closed to the public no public matter, official business, or policy was discussed or presented, no official action was taken, and no recommendations on any public matter, official business or policy were formulated, presented or discussed **EXCEPT** as such discussion, presentation, recommendation or action related to the specific exceptions to the Open Meetings Act for which the meeting was closed to the public, as set out in Paragraph 5 of this Affidavit.

FURTHER AFFIANT sayeth not, this 13 day of February, 2013.

DENNIS W. ASHLEY, M.D.
CHAIRMAN, GEORGIA TRAUMA CARE
NETWORK COMMISSION

Sworn to and subscribed
before me this 13 day
of February, 2013.

Notary Public
My Commission Expires: March 10, 2014

(Notary Seal Here)

January 24, 2013

TCC
1st Year
Review

Today's Objectives

- **Discussion on the TCC's Past and Present and Future**
- **Discussion on the TTC's Future; To Include Commission Input and Guidance on the Future Role of the TCC as a Part of Ongoing Commission Activities.**

TCC Past

SB 60

- Passed in 2007
- Established a nine member commission, Georgia Trauma Care Network Commission (GTCNC)

SB 60 charged Commission to:

- "Establish, maintain, and administer a statewide trauma care network (trauma system)":
- "Coordinate the best use of existing trauma facilities";
- "Direct patients to the best available facility for treatment of traumatic injury";
- Oversee Fund dispersal into the entire Georgia trauma system, fairly and effectively.

Regional Trauma System Planning Framework

A Regional Trauma System Plan consists of five components:

- **Pre-Hospital Component**
- **Hospital Component**
- **Communications Component**
- **Data Driven Performance Improvement Component**
- **Regional Trauma Advisory Council/ Committee**

Communications Component

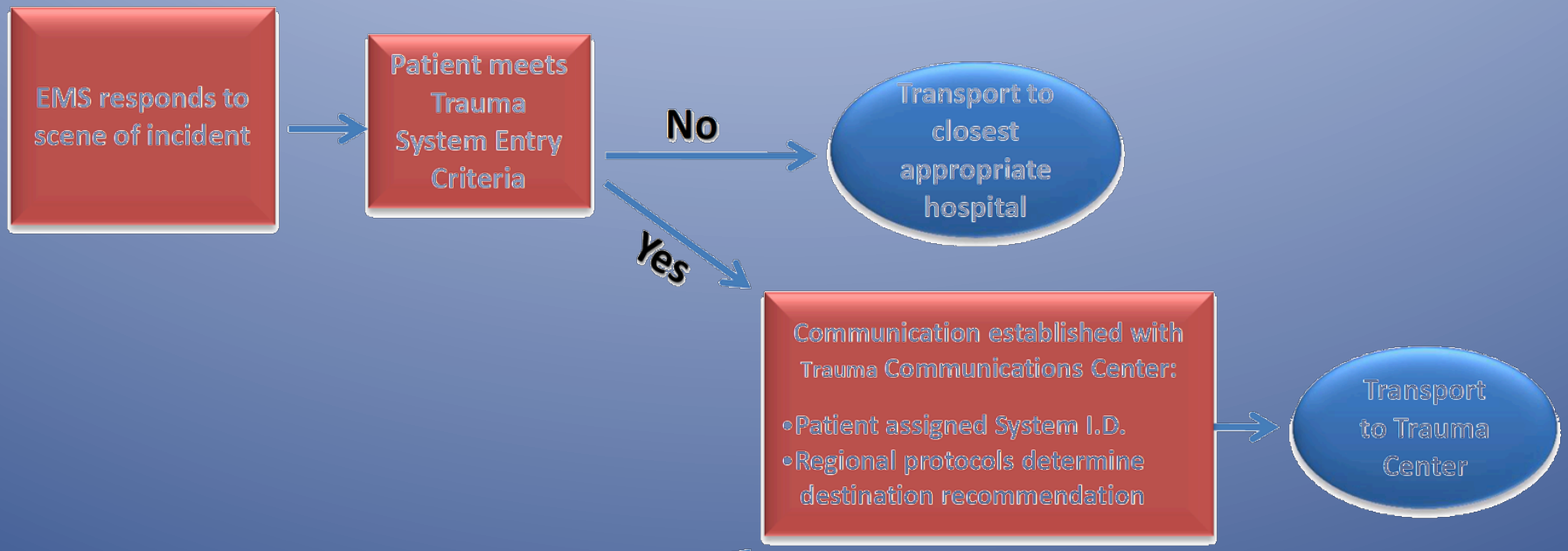
The communications component is vital to the operation of the Georgia Trauma System as the link between all components of the System. Communications must provide:

- **Essential information regarding the status of pre-hospital capabilities and Trauma Center and non-designated participating hospital resource availability on a constant basis.**
- **Access to Trauma System Information i.e., Regional Protocols and Trauma System Entry Criteria.**
- **A linkage between the injury scene and definitive care for the rapid exchange of the injured patients care needs and the required resources.**
- **Support for System-wide data collection to ensure System compliance for regional performance improvement activities.**

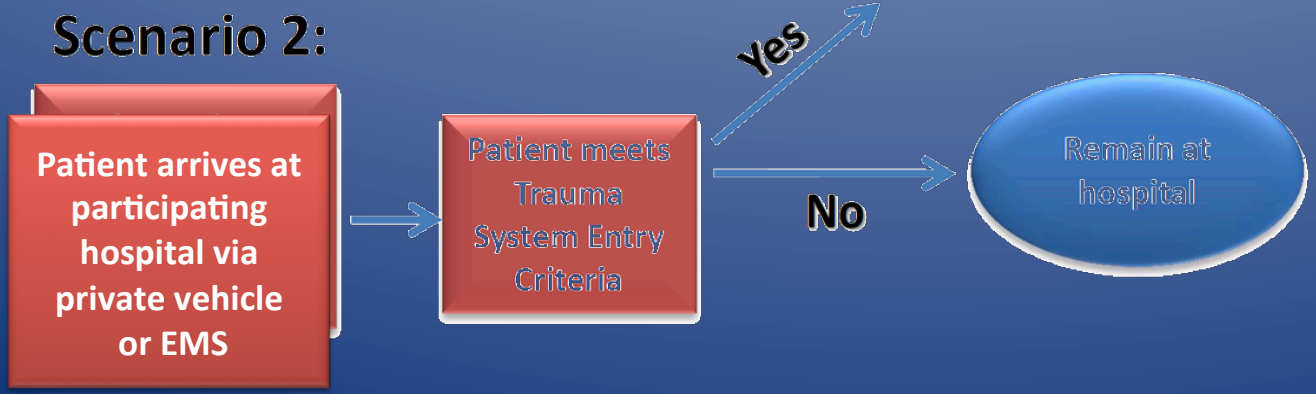
Planned TCC Operations

- **TCC to be centrally located and available 24/7.**
- **TCC Coordinator – responsible for management and oversight of TCC personnel and operations.**
- **24/7 coverage by 2 Call Agents. Originally no requirement for medical background.**
- **RAD – Trauma centers and hospitals maintain a RAD and provide service line availability information to the TCC.**
- **Using TCC software, Call Agents to provide destination recommendations to EMS and hospital providers for patients meeting TSEC criteria.**
- **Data maintained and archived at the TCC (Including the Unique Patient Identifier and Hospital History of Resource Availability) to be a part of the Data-Driven Performance Improvement Component.**
- **Regions 5 and 6 chosen as the first two Pilot Regions.**

Scenario 1:



Scenario 2:



Past TCC Software Requirements

RFP for TCC Software Included the following requirements:

- **The ability to facilitate voice communications between EMS/hospital providers and the TCC.**
- **The ability to assign a Unique Patient Identifier for each patient meeting TSEC criteria.**
- **The ability to collect a brief description of patient injuries and demographic information.**
- **The Ability to recommend Trauma System destinations.**
- **The Ability to facilitate inter-facility transfers of trauma system patients between trauma centers and non-designated hospitals.**
- **The ability to record and store all voice and electronic communications between the TCC and/or hospitals and EMS providers.**
- **HIPAA/HITech compliant .**
- **The ability to display real-time hospital resource availability.**

Data Driven Performance Improvement Component (Past)

- **Data maintained and archived at the TCC to be a part of the Data Driven Performance Improvement Component.**
- **Intent for sharing and utilization of both OEMS&T and trauma registry data as part of the Data Driven Performance Improvement Component.**

Past RTAC Development

EMS Regions 5 and 6 Chosen to Participate in the Pilot Project.

As stated in the Commission's Response to the DOAA Report on the Commission:

"These two regions were chosen for the pilot project, in part, for the limited number of trauma centers contained within the two regions. In the majority of instances within the two chosen regions, medics should know the most appropriate destination for their trauma patient. This parameter provided the best environment to test the functionality of the TCC and its systems."

Past Challenges

- **Buy-in for RTAC development.**
- **Identification of key stakeholders for RTAC development.**
- **RTAC development planning (Framework and HRSA BIS Assessment key in RTAC plan development.)**
- **Obtaining cooperation among stakeholders.**
- **TCC development (Including: site location, software development and installation, employee identification and hiring, employee training.)**
- **TCC policy creation (developed in coordination with RTAC Plan development.)**

Past Accomplishments

- RTAC Plans in Regions 5 and 6 approved by Trauma Commission.
- Site for TCC located on the campus of GPSTC in Forsyth (Centrally located.)
- Saab chosen for software development. Software installation complete in October, 2011.
- TCC employees identified and hired. Training completed by December 2011.
- Cooperation between TCC and Region 5 and 6 RTACs to develop TCC protocols for patient destination recommendations.
- TCC Operationalized on January 1, 2012.

TCC Present

Communications Component (Present)

***Georgia Trauma System Regionalization Pilot Project Evaluation*, Pilot Project Goal 3:**

"Operationalize the Georgia Trauma Communications Center as the interoperable statewide communication component of the System."

Goal 3A: "The GTC developed the TCC as the state-wide communications component of the Georgia Trauma System."

Goal 3B: "The TCC is actively in use in each Pilot Project region measured by its utilization for patient transport and destination recommendations. "

Communications Component (Present)

***Georgia Trauma System Regionalization Pilot Project Evaluation*, Pilot Project Goal 3:**

"Operationalize the Georgia Trauma Communications Center as the interoperable statewide communication component of the System."

Results of the Evaluation:

- **Goal 3A) "Goal met. The GTC developed the TCC as the statewide communication component of the Georgia Trauma System."**
- **Goal 3B) "Goal partially met. Based on the data below, the TCC is actively in use in Region V, not actively used in Region VI and not implemented yet in Region IX."**

Communications Component (Present)

Result Support:

- **The TCC is actively utilized in Region V and the majority of counties in the Region have used the TCC.**

- **The TCC is in use in Region VI; however, it is used on a limited basis because of the inability of the largest EMS Service to contact the TCC. (Cell Phone Use Prohibited)**

- **All three regions introduced the concept of the Trauma Communications Center to trauma system stakeholders at individual and/or group face-to-face meetings. (relevant to all three regions)**

- **Regional trauma plans describe the TCC, but protocols for TCC use are not included in regional trauma plans. (Relevant to Region V and VI)**

Present TCC Operations

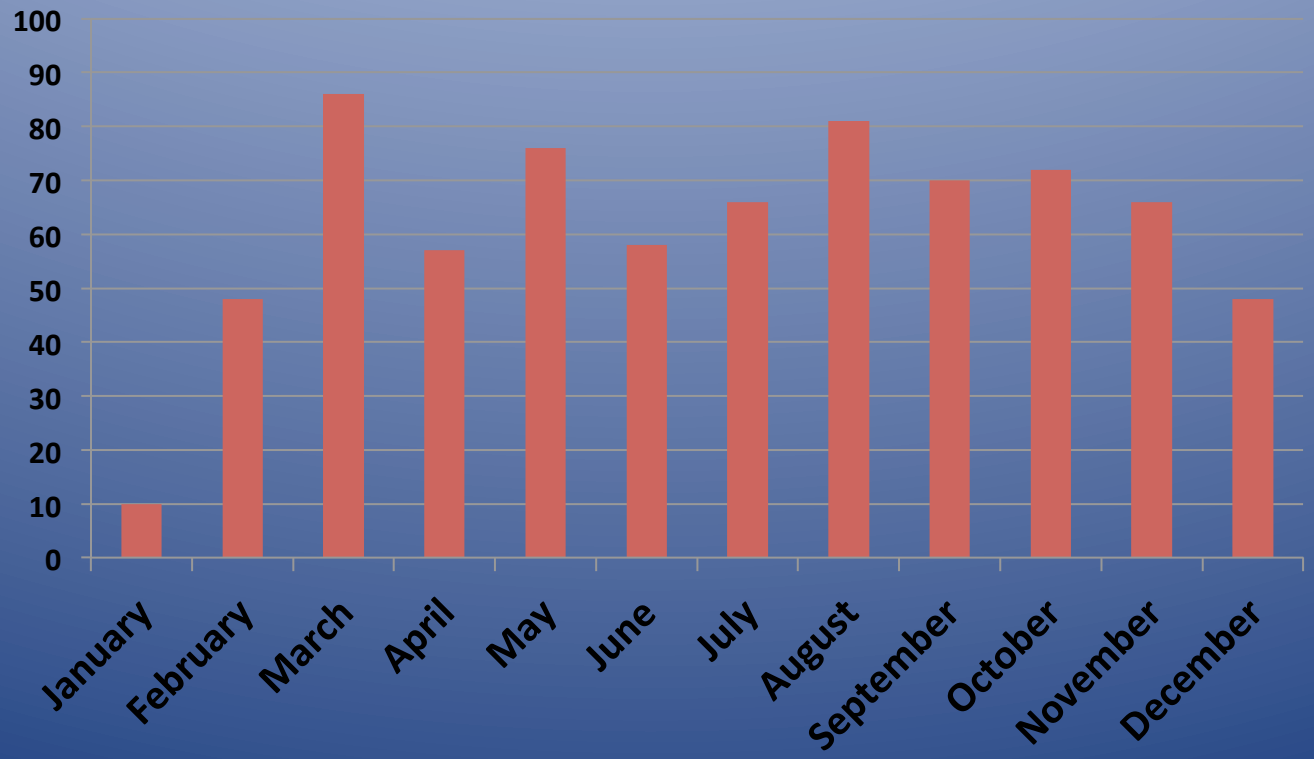
- **TCC Operational January 1, 2012 (Primarily in Regions 5 and 6)**
- **TCC Manager – Responsible for oversight and management of the TCC, assisting in overall system development.**
- **Operations Specialist – Direct supervision of call agents, development and supervision of QA program. Responsible for all data management. Serves as back-up call agent as needed.**
- **Call Agents – Coverage managed to reflect call volume needs. Assist with administrative duties including: recording meeting minutes, data collection and QA.**
- **TCC Became Available State-wide on July 1, 2012.**

Present TCC Operations

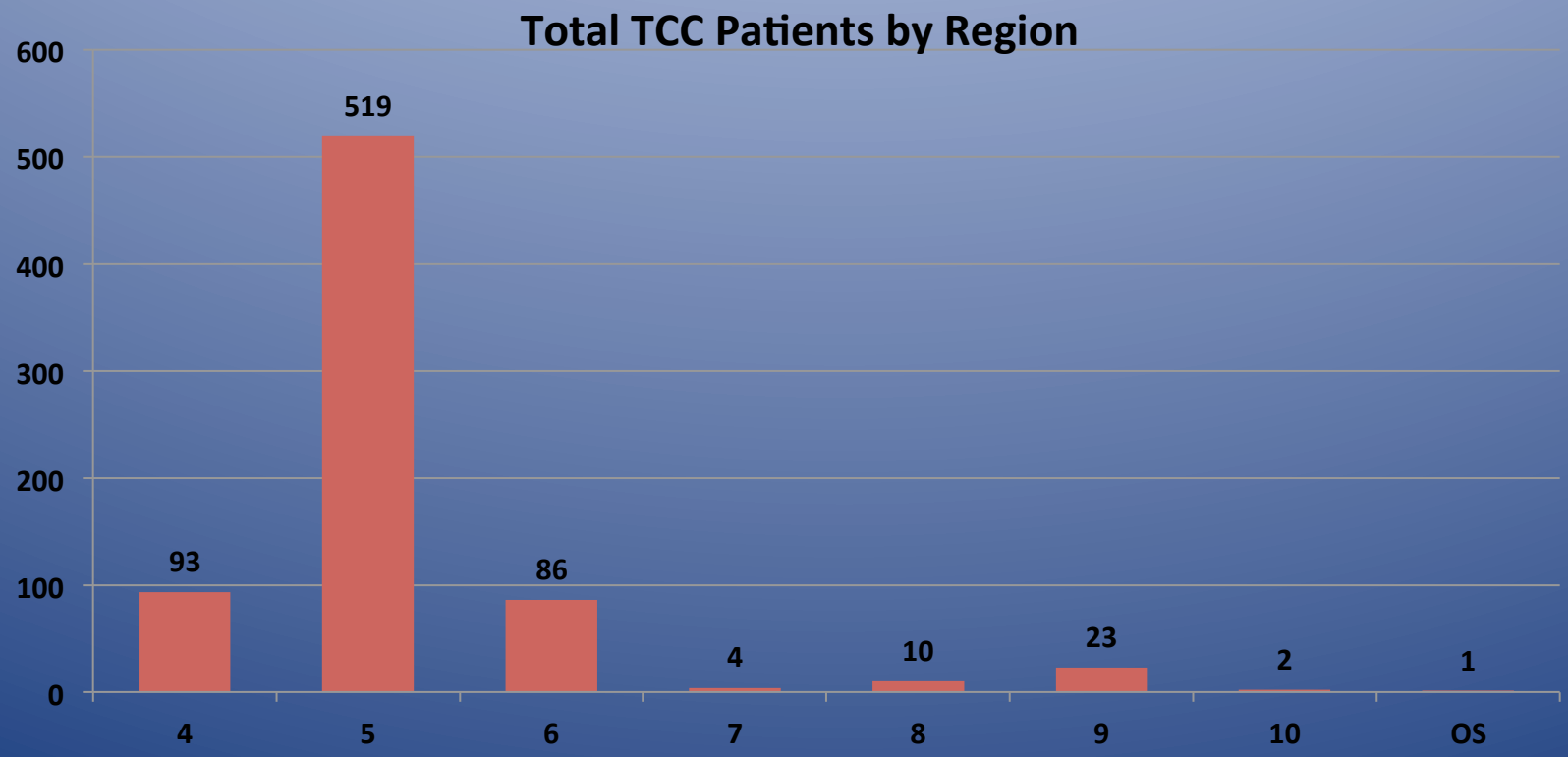
- **All designated trauma centers updating resource availability on the RAD at a minimum of 3 times per day.**
- **Hospital Participation Agreements with all designated trauma centers**
- **All Non-Designated Participating Hospitals within regions 5 and 6 updating resource availability on the RAD at a minimum of 3 times per day.**
- **3 Non-Designated hospitals outside of an approved RTAC updating resource availability on the RAD.**
- **TCC has received calls in reference to trauma patients from 7 out 10 EMS regions.**

Present TCC Operations

- **738 patient transports reported to the TCC from January 1, 2012 through December 31, 2012**



Present TCC Operations



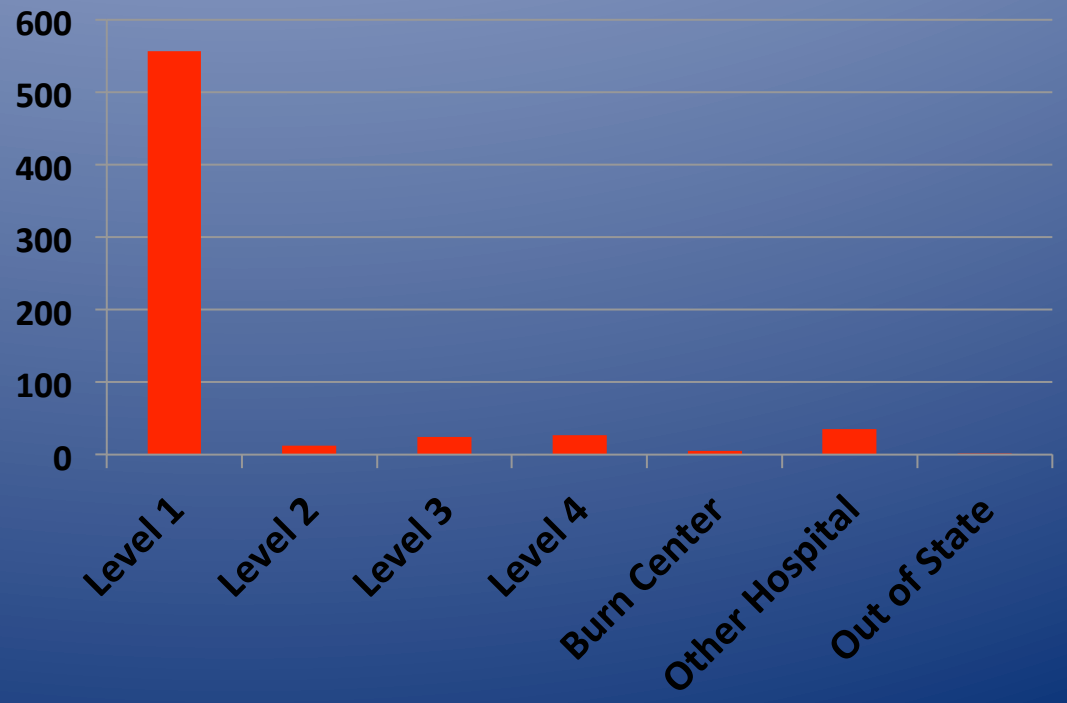
TCC Operations

661 Patients Met TSEC Criteria or Were Burn Patients (22 Burn Patients)

77 Patients Did Not Meet TSEC Criteria

TSEC Patients by Destination Hospital Designation

Level 1	556
Level 2	12
Level 3	24
Level 4	27
Burn Center	5
Other Hospital	35
Out of State	2



Present TCC Operations

Hospital to Hospital Transfers: 33

Helicopter Transports: 69

Patient/EMS Location Upon TCC Notification:

- **EMS On Scene: 113**
- **EMS En-Route to Scene: 46**
- **EMS En-Route to Destination Hospital: 312**
- **Post-Patient Arrival Notification to TCC: 236**

TCC Recommendation Information:

- **574 TSEC Patients - No destination recommendation requested**
- **64 TSEC Patients - Destination recommendation was requested and followed****
- **23 TSEC Patients - Destination recommendation requested and not followed**
- **22 Non TSEC Patient - Destination recommendation was requested (21 Followed)**
- **55 Non TSEC Patient - Destination recommendation not requested**

***** Equals TCC Performance Indicator***

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

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

- **Trauma system patients are patients meeting TSEC criteria.**
- **Definitive care hospital is defined as an appropriate level designation trauma center.**
- **A transport facilitated by the TCC is defined as a destination recommendation requested from the TCC and followed.**
- **FY 2013 is the Baseline Year.**

Present TCC Software Enhancements

- **Merge Migration – Created a virtual redundant server for continuous uninterrupted operations.**
- **Enhanced to allow non-designated hospitals to receive patient recommendations in response to regional Plan development. (See *Georgia Trauma System Regionalization Pilot Project Evaluation)***
- **Enhancement to allow the ability to match specific injuries with specific available specialties.**
- **Designated burn center added.**
- **Additional information pages are being added to allow for the collection of additional patient related data.**
- **EMS User is being created to allow EMS access to the RAD.**
- **Underwent and passed an external Threat Assessment and Penetration Test by Sage Data Security**

Sage Data Security, Inc.

External Vulnerability Assessment and Penetration Test

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

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

HIPAA/HITECH Information Security Policy Assessment and Update

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

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

Data Driven Performance Improvement Component (Present)

- All data received and stored at the TCC is collected in a HIPAA compliant environment. In addition, all data is validated through a thorough Quality Assurance Program.
- TCC receives basic patient demographics and injury information as reported by EMS and hospital providers.
- TCC provides reports to RTACs for RTAC performance improvement activities.
- Data is limited to the information received from hospital and EMS providers.
- At present, no ability to match TCC data with data from OEMS&T and the state trauma registry. (See DOAA Report on the Georgia Trauma Commission)

Present RTAC Development

Below is a summary of current RTAC development across the state:

- **Region 1: RTAC Plan approved by EMS Council, awaiting Commission approval.**
- **Region 2: Presentation by Dr. Ashley to Region 2 EMS council scheduled. (*Trauma System Regionalization Possibilities*.)**
- **Region 3: Long standing trauma advisory subcommittee of the Region's Council. At this point no plan submission to the Commission.**
- **Region 4: Presentation by Dr. Ashley to Region 4 EMS Council (Voted to begin RTAC Process.)**
- **Region 5: Approved and functioning RTAC.**
- **Region 6: Approved and functioning RTAC.**
- **Region 7: Outreach to Columbus Regional and Region 7 EMS Council is on-going.**
- **Region 8: Presentation by Dr. Ashley to Region 8 leadership being scheduled.**
- **Region 9: Business Plan approved. Annual RTAC meeting scheduled Feb 8, 2013.**
- **Region 10: Presentation by Dr. Ashley to Region 10 EMS Council.**

Present Challenges

- **Education on the TCC – Lack of knowledge on TCC and it's operations (Both Hospital and EMS.)**
- **Continued misconceptions about the TCC.**
- **Feelings that EMS providers "Already know where to take their patients." Perceived lack of value in contacting the TCC. (See *Georgia Trauma System Regionalization Pilot Project Evaluation.)***
- **Communications with the TCC can be limited. (Cell phone policies.)**
- **Need for cooperation with OEMS&T. (See DOAS Report on the Georgia Trauma Care Network Commission.)**
- **Lack of Data - TCC Is limited to data received by those contacting the TCC. No way to compare and accurately measure effectiveness of TCC. (See DOAS Report on the Georgia Trauma Care Network Commission)**

Present Accomplishments

- On-going communications with regional stakeholders have led to numerous
- software enhancements (Current and Pending) and policy changes.

- TCC available state-wide on July 1, 2012.

- High levels of compliance with RAD by hospitals.

- Integration of AVLS system into TCC operations.

- High levels of TCC staff participation in RTAC development across the state.

- Creation of TCC database with a robust QA Program.

- TCC staff participation in state-wide disaster planning exercises.

- Acknowledgment of the TCC as a valuable asset in emergency response due to manned 24/7 Coverage.

- Working with OEMS&T staff, have received GEMSIS codes for TCC data. (Such as Transporting Agency, Receiving Facility, and Injury Type.)

TCC Future

Communications Component (Future)

- **The TCC will continue to fill the role of the communications component of future Regional Plans as described in the framework document.**
- **Increased RTAC development will result in further evolution of the TCC's operations.**
- **Work with the TCC Subcommittee and the RTAC Leadership Group will further assist in the evolution of the TCC's operations.**
- **Each RTAC will define the role of the TCC as the communications component of their individual plan.**

Future TCC Operations

- **Anticipated increase in call volumes as the number of approved RTACs increases.**
- **Staffing levels and responsibilities will be managed as call volumes increase.**
- **Increased utilization of TCC staff for administrative type duties.**
- **Increased utilization of the TCC as a "Communications and Resource Center."**
- **Evolving role in disaster response.**

Future TCC Software Development

- Communication and cooperation with stakeholders will play a role in defining future software enhancements.
- Role-out of EMS user for the RAD expected during FY13.
- Role-out of additional pages for TCC patient reports expected during FY13.
- Possible development of a web based mobile application for EMS users.
- Communications with Global Emergency Resources (GER) to find ways to integrate the Patient Tracking System into TCC operations have taken place.
- GER has communicated with their partners and have relayed an interest for cooperation with the TCC.

Data Driven Performance Improvement Component (Future)

- **The need for data sharing and cooperation will continue to be a top priority.**
- **Further development and examination of TCC data to measure TCC utilization.**
- **TCC will continue to provide feedback and reporting to each approved RTAC as requested.**
- **RTAC development will drive data requirements in accordance with individualized RTAC plans.**
- **RTAC Leadership Group will also drive data requirements.**

Future RTAC Development

- **TCC staff will continue to participate in RTAC development and planning.**
- **Anticipation of Region 1 Plan approval and participation within FY13.**
- **Anticipation of full participation of Region 9 within FY13.**
- **Anticipation of continued steps toward RTAC development in 5 additional regions within FY 14. (EMS Regions 2, 3, 4, 8, 10.)**

Future Challenges

- **EMS and hospital education on the TCC and it's mission.**
- **Continued efforts to add value for EMS and hospital providers utilizing the TCC.**
- **Incorporating new technologies into TCC Operations.**
- **Identifying ways of incorporating data from various "silos" in order to measure TCC and regional plan performance.**
- **Continued efforts to find areas of cooperation with other stakeholders.**
- **Continued defining of the TCC's role in emergency response.**
- **Continued incorporation of and cooperation with air transport services.**

The TCC as an Asset for Future Trauma System Accomplishments

- Continued real time trauma resource monitoring.
- 24/7 staffed, centrally located communications center.
- Ability to function as a regional and state-wide resource center.
- Hospital Participation Agreements.
- Future funding and management of the AVLS system.
- HIPAA and HITech compliance.
- Support for OEMS&T and cooperation with Regional EMS Councils.
- History of being a full cooperating partner in Regional Plan development.

The TCC as an Asset for Future Trauma System Accomplishments

The TCC stands ready to not only cooperate with all involved agencies and organizations in the care of trauma patients across the state, but to bring to bear all of its assets as a full participant in state-wide patient care and emergency response.

Discussion And Questions

FY 2011 Readiness Analysis
Readiness Costs By Volume

	In-Patients Meeting Trauma Registry Requirements in CY 2011											
Trauma Center	**ISS 0-8**	**ISS 9-15**	**ISS 16-24**	**ISS >24**	**Total In-Patients**	**Patient Load Factor**	**Patient Load Factor %**	**CY 2011 Readiness Costs**	**Readiness Cost/ Pat Load Fctr**	**Patient Factor Only Distribution**	**Current Readiness Allocation**	**Difference**
4A	17	9	0	0	26	34.8	0.12%	52,003	1,494	5,786	23,474	-17,688
3A	39	39	3	5	86	159.6	0.53%	477,645	2,992	26,526	46,948	-20,422
3B	74	51	12	4	141	245.5	0.82%	114,921	468	40,793	46,948	-6,156
2A	652	213	47	21	933	1,384.2	4.60%	2,621,532	1,894	230,029	281,690	-51,661
2B	439	347	81	65	932	1,846.8	6.14%	4,621,804	2,503	306,900	281,690	25,210
2C	367	175	58	44	644	1,213.2	4.03%	2,411,010	1,987	201,609	281,690	-80,081
2D	216	253	103	38	610	1,345.6	4.47%	2,610,006	1,940	223,619	281,690	-58,072
2E	157	285	82	53	577	1,368.4	4.55%	2,412,300	1,763	227,404	281,690	-54,286
2F	177	190	54	17	438	864.0	2.87%	2,021,358	2,340	143,575	281,690	-138,115
2G	99	108	43	28	278	653.5	2.17%	1,524,954	2,333	108,602	281,690	-173,088
2H	105	97	25	13	240	474.0	1.58%	765,246	1,614	78,769	281,690	-202,921
2I	116	95	14	7	232	401.4	1.33%	2,009,809	**5,007**	66,701	281,690	-214,989
1A	1055	838	396	275	2,564	5,962.1	19.82%	9,464,024	1,587	990,794	469,484	521,310
1B	728	593	225	126	1,672	3,552.5	11.81%	6,245,566	1,758	590,369	469,484	120,886
1C	480	629	333	215	1,657	4,351.8	14.46%	6,998,877	1,608	723,199	469,484	253,716
1D	541	496	200	119	1,356	3,035.2	10.09%	6,680,884	2,201	504,400	469,484	34,916
1E	425	502	231	142	1,300	3,194.8	10.62%	4,715,967	1,476	530,926	469,484	61,443
Totals	**5687**	**4920**	**1907**	**1172**	**13,686**	**30,087**	**100.00%**	**55,747,905**	**1,853**	**$5,000,000**	**$5,000,000**	**0**

Patient Load Factor		
ISS	**Cost Norm**	**Factor**
0-8	$5,267	**1.0**
9-15	$10,428	**2.0**
16-24	$19,626	**3.7**
>24	$33,945	**6.4**

% Per TC Per Level	
I	9.4%
II	5.6%
III	0.9%
IV	0.5%

Defining An Uncompensated Care Factor For An All Readiness Budget

Year Trauma Ctr	2009 UCCC	2009 Total	2010 UCCC	2010 Total	combined UCCC	combined Total	% UCCC	% over 18.60%	Diff X Total X 20%	1 Year (1/2)
2A			1,308,065	5,223,171	1,308,065	5,223,171	25.0%	6.4%	67,311	$33,656
2B	604,265	2,557,312	815,576	3,026,424	1,419,841	5,583,736	25.4%	6.8%	76,253	$38,127
2C	718,976	6,979,736	1,993,522	6,827,533	2,712,498	13,807,269	19.6%	1.0%	28,869	$14,435
2D	440,485	2,222,541	468,181	3,580,650	908,666	5,803,191	15.7%			
2E	1,249,010	9,122,094	2,161,351	10,903,515	3,410,361	20,025,609	17.0%			
2F	200,093	945,536	273,769	1,759,884	473,862	2,705,420	17.5%			
2G	748,027	5,403,184	1,058,010	5,603,302	1,806,037	11,006,486	16.4%			
2H	230,054	6,599,885	340,766	7,612,459	570,820	14,212,344	4.0%			
2I	217,482	5,846,006	287,491	7,268,057	504,973	13,114,063	3.9%			
1A	3,903,564	19,844,774	4,315,075	20,128,080	8,218,639	39,972,854	20.6%	2.0%	156,738	$78,369
1B	9,129,660	35,003,263	8,259,899	37,140,743	17,389,559	72,144,006	24.1%	5.5%	794,155	$397,077
1C	2,211,200	13,950,765	2,822,710	18,653,852	5,033,910	32,604,617	15.4%			
1D	3,255,406	16,356,955	3,180,273	14,524,821	6,435,679	30,881,776	20.8%	2.2%	138,334	$69,167
1E	3,923,025	19,898,042	3,651,482	22,944,700	7,574,507	42,842,742	17.7%			
3A			174,314	1,550,014	174,314	1,550,014	11.2%			
3B			19,119	762,975	19,119	762,975	2.5%			
4A			66,565	184,928	66,565	184,928	36.0%	17.4%	6,434	$3,217
Totals	**26,831,247**	**144,730,093**	**31,196,168**	**167,695,108**	**58,027,415**	**312,425,201**	**18.6%**		**1,268,093**	**$634,047**

GTCNC CY 2011 Readiness Cost Survey Results Summary

Cost Category	LI Total	LI Average	LII Total	LII Average	LIII Total	LIII Average	LIV	Totals
Administrative	Number	5	Number	9	Number	2	Number 1	
Senior Administrative Support	220,825	44,165	576,215	64,024	29,800	14,900	20,301	**847,141**
Trauma Program Manager	620,330	124,066	691,155	76,795	81,000	40,500	20,301	**1,412,787**
State/Reg Participation	16,221	3,244	7,930	881	1,106	553	1,900	**27,157**
Trauma Center Staff Support					-			
Outreach Coor.	19,154	3,831	20,298	2,255	-			**39,452**
Case Mngt/DC Plng	2,103,788	420,758	1,452,245	161,361	-			**3,556,033**
Injury Prev. Coor.	94,460	18,892	873,303	97,034	-			**967,763**
Research/PI Coor.	122,480	24,496	177,662	19,740	-			**300,142**
Trauma Registrar	911,522	182,304	237,203	26,356	-			**1,148,725**
Secretarial Staff	141,710	28,342	76,471	8,497	-			**218,181**
Trauma Med Director	183,377	36,675	279,520	31,058	3,500	1,750		**466,397**
Part. In S/R Activities	40,101	8,020	5,379	598	23	12		**45,503**
ED Medical Director	16,005	3,201	132,010	14,668	12,000	6,000		**160,015**
ICU Surgical Director	153,548	30,710	49,400	5,489	-			**202,948**
Orthopedic Liaison	41,400	8,280	33,250	3,694	-			**74,650**
Neurosurgeon Liaison	2,500	500	51,630	5,737	-			**54,130**
Registry Hard/Software	40,416	8,083	45,642	5,071	4,475	2,238	1,600	**92,133**
Subtotal-Administrative	4,727,837	945,567	4,709,313	523,257	158,904	79,452	44,103	**9,640,157**
Clinical - Medical Staff								
Subtotal-Comp.	24,681,618	4,936,324	12,805,951	1,422,883	419,632	209,816	6,000	**37,913,200**
Payment for Uninsured	219,935	43,987	509,880	56,653	-			**729,814**
Subtotal-Clinical Med Staff	24,901,553	4,980,311	13,315,830	1,479,537	419,632	209,816	6,000	**38,643,014**
					-			
In House OR Availability	3,937,448	787,490	2,155,000	239,444	-			**6,092,448**
					-			
Education & Outreach					-			
Injury Prevention	20,933	4,187	474,978	52,775	-			**495,911**
Community Outreach	243,156	48,631	50	6	2,670	1,335		**245,876**
Prof. Outreach	26,113	5,223	33,407	3,712	-		1,500	**61,020**

	Outlying Hosp. Educ.	1,651	330			-			**1,651**
	16 Hours Trauma CME					-			
	Trauma Med. Dir.	21,269	4,254	12,350	1,372	1,240			**34,859**
	Trauma Prog. Mgr.	10,895	2,179	9,417	1,046	-		400	**20,712**
	ED Trauma Liaison	12,700	2,540	3,433	381	-			**16,133**
	Neurosurgical Liaison	9,000	1,800	7,898	878	-			**16,898**
	Orthopedic Liaison	27,364	5,473	3,500	389	-			**30,864**
	Trauma Education-Hospital Staff					-			
	ED	74,806	14,961	199,480	22,164	10,120	5,060		**284,406**
	ICU	65,302	13,060	41,199	4,578	-			**106,501**
	Surgery	25,291	5,058	32,162	3,574	-			**57,453**
	Subtotal-Educ/Outreach	538,480	107,696	817,876	90,875	10,120	2,425	1,900	**1,363,106**
						-			
	Georgia Totals	**34,105,318**	**6,821,064**	**20,998,019**	**2,333,113**	**592,566**	**296,283**	**52,003**	**55,747,905**

CY 2011 GEORGIA TRAUMA CENTER READINESS COSTS
Georgia Trauma Care Network Commission

August 22, 2012 (Version #4)

To Georgia Trauma Centers,

Attached is the CY 2011 Readiness Cost Survey; it is essentially the same one completed by trauma centers two years ago for CY 2008, with questions regarding outreach, education, injury prevention and your designation status and plans added at the end. It also incorporates changes from our face to face discussion held on August 15, 2012 to further define the line items and come to consensus on how these items will be captured.

The due date is November 30, 2012.

Please provide the following information:

Trauma Center _____ Level _____

Name of person who completed this Survey: _____

Phone Number: _____

Email Address: _____

This survey should be reviewed by your CFO and signed to indicate his/her review:

_____CFO

All hospital data will be kept confidential; it will be reported on a consolidated basis that precludes the disclosure of individual hospital information.

LINE ITEM/	LEVEL				SURVEY INSTRUCTIONS	AMOUNT
Criteria Deemed Essential For Level In ACS Gold Book	I	II	III	IV	**Do Not Respond To Item If Your Trauma Center Level Is This Color***	**Use Actual Costs in 2011**
ADMINISTRATIVE						
Senior Administrator Support					% of time focused on trauma by main senior administrator involved in trauma X salary and benefits	
Program administrator: Trauma Director, Trauma Program Manager , or Trauma Coordinator					Salary & benefits X % of time on trauma (if position has other duties in low volume trauma centers).	
Participation in state, regional and national activities					Trauma program administrator travel costs to meetings	
Trauma Center Staff Support	• If any of the following positions generate reimbursement or are supported by grants, use net hospital costs X time spent on trauma to calculate their costs. • If position employed by trauma program, or if employed by another department which focuses trauma responsibility on few staff, use salary and benefits less revenue and grant support for costs. • If employed by another department which spreads trauma responsibility among most staff, use portion of trauma patient admissions of total admissions X department salary costs.					
Outreach Coordinator			*	*	*** E.g., Level III/IV trauma centers should skip this as not required** Salary & benefits X % of time on trauma	
Case Management, Discharge Planning					Divide your total trauma admissions, including admits less than 48 hours, by 333. This is your estimated FTEs, which you then multiply times your average case manager salary + benefits	
Injury Prevention Coordinator					Salary & benefits (less grant support) X % of time on trauma. (if less than 1 year, multiply times portion of year in place.	
Research/PI Coordinator					Salary & benefits (less grant support) X % of time on trauma.	
Trauma Registrar					Salaries & benefits X % of time on trauma – Limit of 1 registrar per 500 – 1000 patients.	

LINE ITEM/	LEVEL				SURVEY INSTRUCTIONS	AMOUNT
Trauma Program Secretary					Salaries & benefits X % of time on trauma.	
Trauma Medical Director					Board-certified surgeon with specialty interest in trauma care. Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions only.	
Participation in national, state and regional activities					Trauma Medical Director travel costs to meetings.	
ED Medical Director or Liaison					Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions.	
ICU Surgical Director					Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions.	
Orthopedic Liaison					Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center admin functions. Must participate actively with trauma service with documented CME and PI.	
Neurosurgeon Liaison					Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center admin functions. Must participate actively with trauma service with documented CME and PI.	
Registry Hardware and Software					Costs for registry hardware, software and maintenance fees. Use full costs; do not reduce by state grant amount.	

LINE ITEM/	LEVEL	SURVEY INSTRUCTIONS	AMOUNT
CLINICAL – MEDICAL STAFF **Trauma Medical Staff Compensation** Do not include amounts paid for administrative duties.		Includes the costs of maintaining trauma physician support for your trauma center other than the costs of admin functions addressed above. • If you pay specialty a stipend exclusively for trauma call, enter the full amount. • If you pay a stipend to a specialty that is for both trauma and ED call, estimate the portion attributable to trauma care. • If you employ your physicians, determine net cost (salary + benefits – pro fee reimbursement) and estimate portion attributable to trauma. • If you are supported by a faculty practice arrangement, take portion of trauma admissions to overall admissions and apply to overall hospital subsidy provided to faculty practice structures, Or Total number of physicians by specialty and apply AAMC salary database (at 50% of range) for SE region, add estimated benefits, subtract estimated pro fee reimbursement, and then apply portion of trauma admissions to overall admissions to arrive at net cost for specialty support. • Do not include amounts specifically paid to trauma physicians for care of uninsured trauma patients in the amounts for each specialty; you will be asked for a total amount of such pay at the end of this section.	
Trauma Surgery		See above.	
Orthopedics		See above.	
Neurosurgery		See above.	
Anesthesia		Divide trauma surgeries by total hospital surgeries and multiply time hospital's net cost for anesthesia (including CRNA's). This is hospital cost attributable to trauma.	
Hand		See above.	
Microvascular		Include only if hospital pays for support and then only portion attributable to trauma.	
Cardiac		Include only if hospital pays for support and then only portion attributable to trauma.	

LINE ITEM/	LEVEL				SURVEY INSTRUCTIONS	AMOUNT
OB/ GYN					Include only if hospital pays for support and then only portion attributable to trauma.	
Ophthalmology					Include only if hospital pays for support and then only portion attributable to trauma.	
Oral/ Maxillofacial					See above	
ENT/ Plastics					See above.	
Critical Care Medicine					Divide trauma patient days in ICU by total ICU days and multiply time net hospital subsidy for critical care physicians.	
Radiology					Estimate portion of hospital net cost for radiology that is attributable to trauma.	
Thoracic					Include only if hospital pays for support and then only portion attributable to trauma.	
Surgical Resident Support					This applies to surgical residency only. There are two options: Take residency costs and subtract federal funding and apply portion attributable to trauma, or take residents' hourly salary + benefits for time on trauma rotation, and subtract federal funding for this time.	
Payment for uninsured trauma patient care for all specialties					If you paid your trauma medical staff (those listed above) specifically for uninsured trauma patient care in 20011 (with hospital and/or state trauma funds), enter the total amount for all specialties on this line.	
IN HOUSE OR AVAILABILITY	Level I hospitals require in-house 24 hour availability and some Level IIs maintain this as well. • If you maintain a dedicated OR that remains open, staffed and is used exclusively for trauma, please estimate net costs (less reimbursement) below. • If you maintain 24 hour in-house OR availability but do not maintain a dedicated OR that remains open and staffed exclusively for trauma, provide your costs for an RN and OR tech for PM and night shift for 7 days a week.					
Costs Of In House OR Availability					Use cost for night and weekend OR coverage of one OR nurse and one OR tech.	

LINE ITEM/	LEVEL	SURVEY INSTRUCTIONS	AMOUNT
EDUCATION & OUTREACH		Includes costs for travel, courses, training, supplies and materials for activities specific to trauma. Personnel costs should have been included in the Administrative Section.	
Injury prevention	I II III IV	Must be specific to trauma, and amount should be reduced by grant funding for program.	
Community outreach	I II III IV	This includes public education.	
Professional education	I II III IV	Net cost (i.e., less participant fees) of offering courses/trauma clinical education to EMS and other hospital staff in your region.	
Outlying hospital education	I II III IV	This addresses the unique responsibilities of Level I trauma centers in supporting outlying hospitals (e.g., Grand Rounds)	
16 hours trauma CME		Includes costs for courses and travel for up to 16 hours of trauma CMEs only for personnel below:	
Trauma Medical Director	I II III IV		
Trauma Program Manager	I II III IV	16 hours of Continuing Education	
ED Trauma Liaison	I II III IV		
Neurosurgical Liaison	I II III IV		
Orthopedic Liaison	I II III IV		
Education – trauma related for hospital staff		Includes cost of courses plus salary costs for educational time.	
Emergency Department	I II III IV		
Intensive Care unit	I II III IV		
Surgery	I II III IV		

Year 5 Georgia EMS Strategic Resource Planning Project

Trauma Commission Strategic Planning Workshop

January 25, 2013

The Georgia Association of Emergency Medical Services
GAEMS
"Dedicated to Quality Pre-Hospital Care"

GEORGIA EMERGENCY MANAGEMENT HOMELAND SECURITY
GEMA

Georgia Tech Research Institute

Project Partners

- ***Sponsorship***:
  - **GEMA/HS**
- ***Survey & Plan Development***:
  - **Georgia Tech Research Institute**
  - **Georgia Association of EMS**
  - **Georgia Department of Public Health, Office of EMS and Trauma**

Georgia Tech Research Institute

Project Background

- Georgia faces a variety of threats requiring robust capability for multi-casualty incident response
- The State recognizes a need for investments that enhance the capabilities and resources of Georgia EMS
- Project has been funded for past 5 years

Georgia Tech Research Institute

Project Objectives

- Assess current levels of EMS performance in Georgia
- Identify significant capability and resource gaps in the EMS community
- Formulate a roadmap for EMS in the State's long range plan

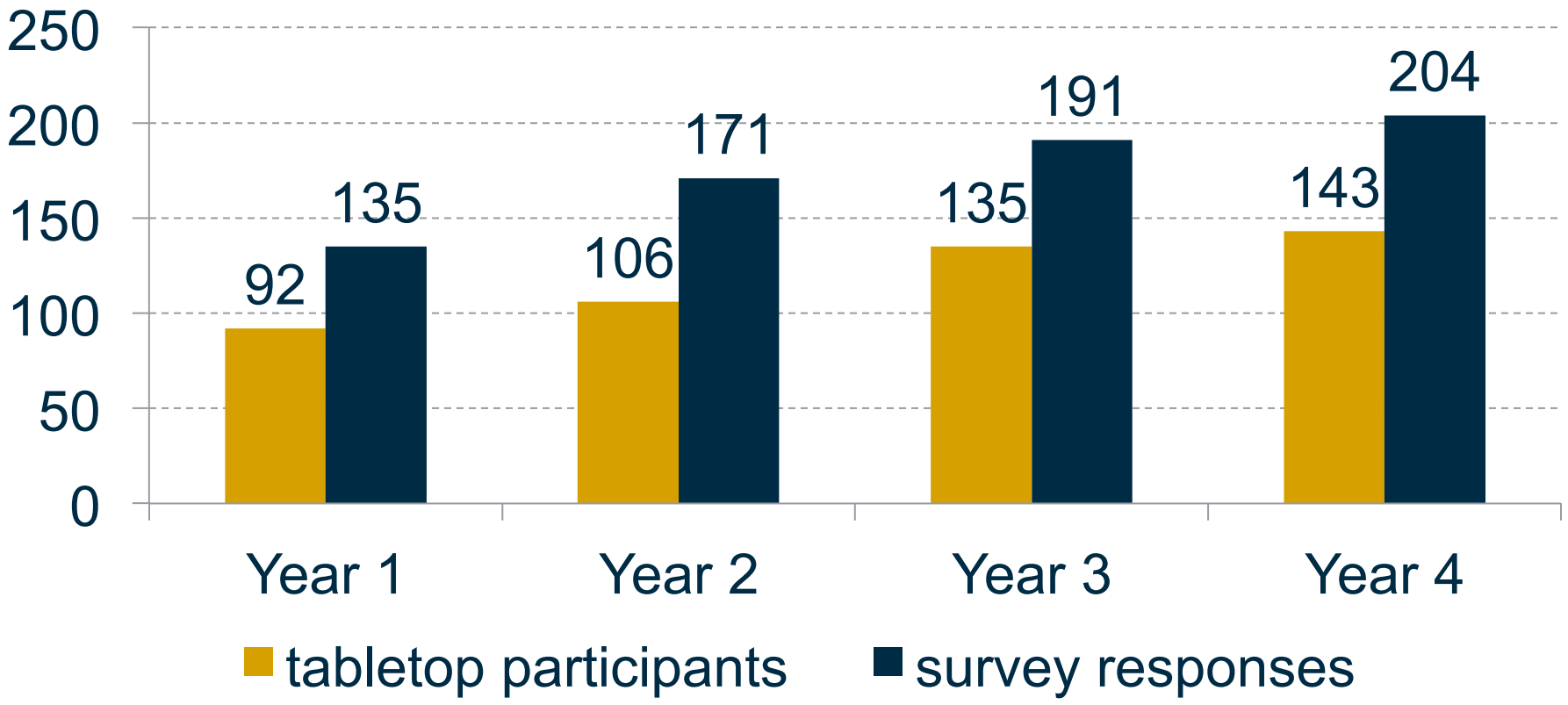
  Recommendations from last four years are now being implemented

Project Methodology

- The team has used the following methods for determining and addressing gaps in EMS capabilities and resources:
  - Annual survey of Georgia EMS providers
  - Statewide tabletop exercises for Georgia EMS providers
  - Additional training and exercises

Georgia Tech Research Institute

Participation in Survey and Tabletops

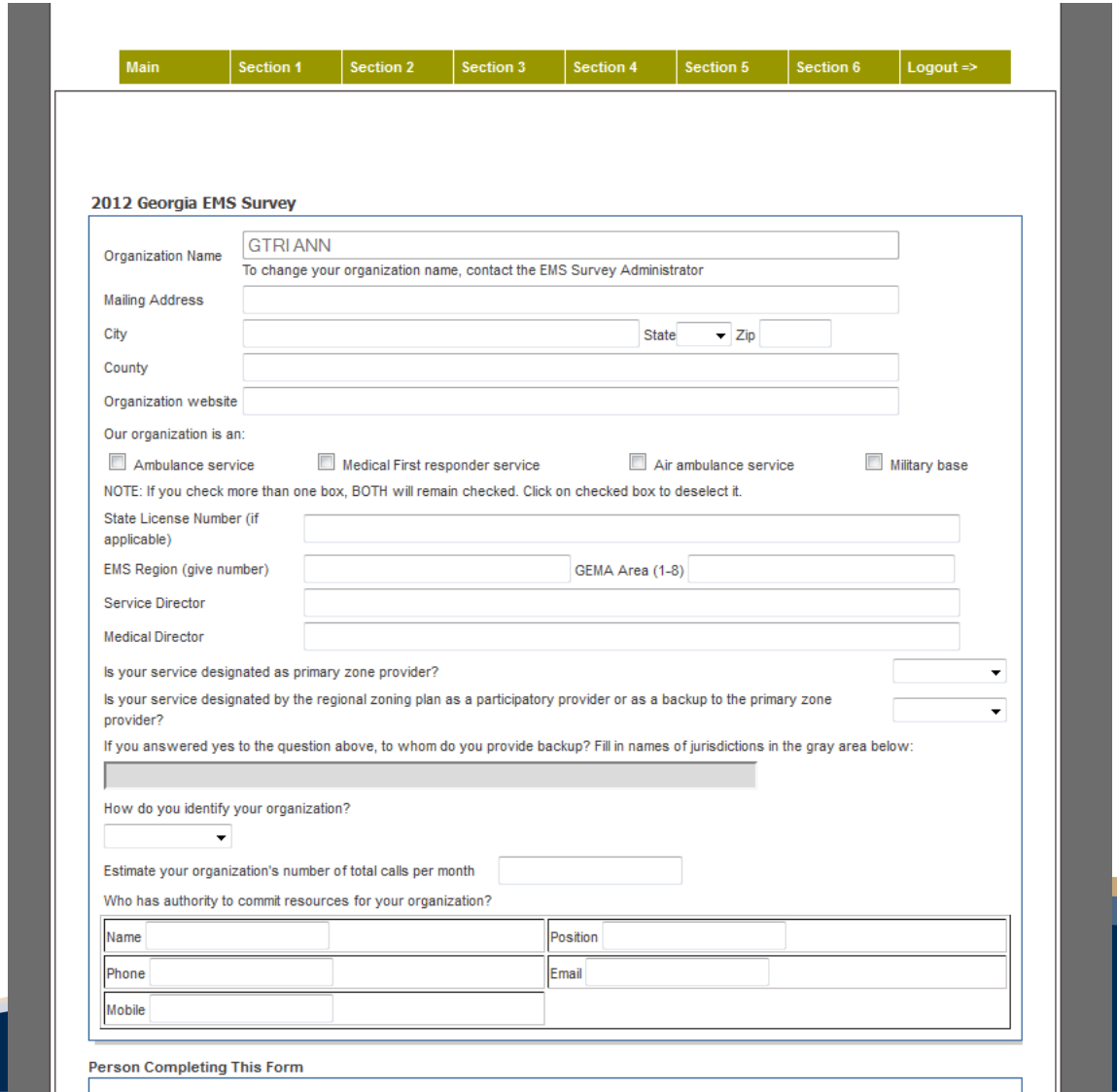


Annual Survey

- **Includes present capabilities and resources and requests in several areas:**
  - **Personnel and Vehicles**
  - **Planning, Policies and Procedures**
  - **Equipment**
  - **Training and Exercises**
  - **Communications**
  - **GEMA Regional Database (RDB) inventory questions**

Annual Survey

- **Since Year 2, survey has been electronic format**
- **Past data are pre-loaded for convenience**



Main | Section 1 | Section 2 | Section 3 | Section 4 | Section 5 | Section 6 | Logout =>

2012 Georgia EMS Survey

Organization Name: GTRI ANN
To change your organization name, contact the EMS Survey Administrator

Mailing Address

City | State | Zip

County

Organization website

Our organization is an:

☐ Ambulance service ☐ Medical First responder service ☐ Air ambulance service ☐ Military base

NOTE: If you check more than one box, BOTH will remain checked. Click on checked box to deselect it.

State License Number (if applicable)

EMS Region (give number) | GEMA Area (1-8)

Service Director

Medical Director

Is your service designated as primary zone provider?

Is your service designated by the regional zoning plan as a participatory provider or as a backup to the primary zone provider?

If you answered yes to the question above, to whom do you provide backup? Fill in names of jurisdictions in the gray area below:

How do you identify your organization?

Estimate your organization's number of total calls per month

Who has authority to commit resources for your organization?

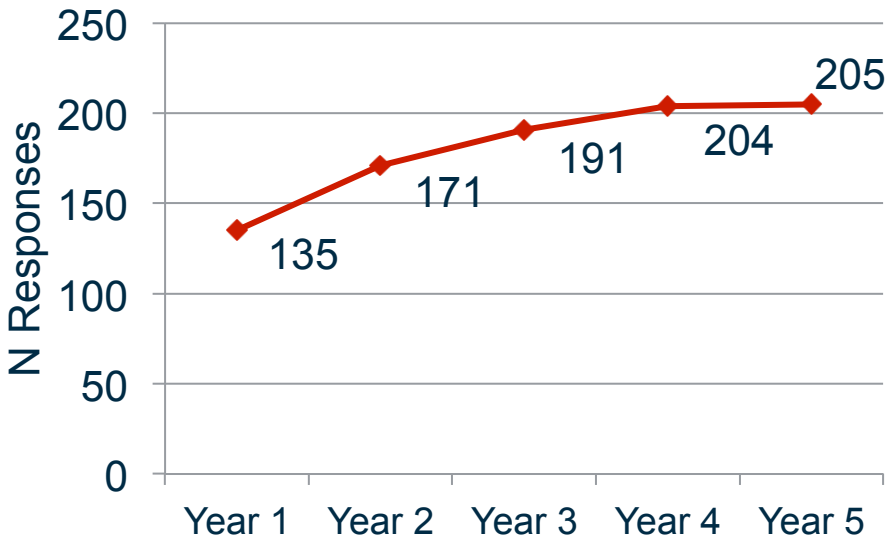
Name	Position
Phone	Email
Mobile	

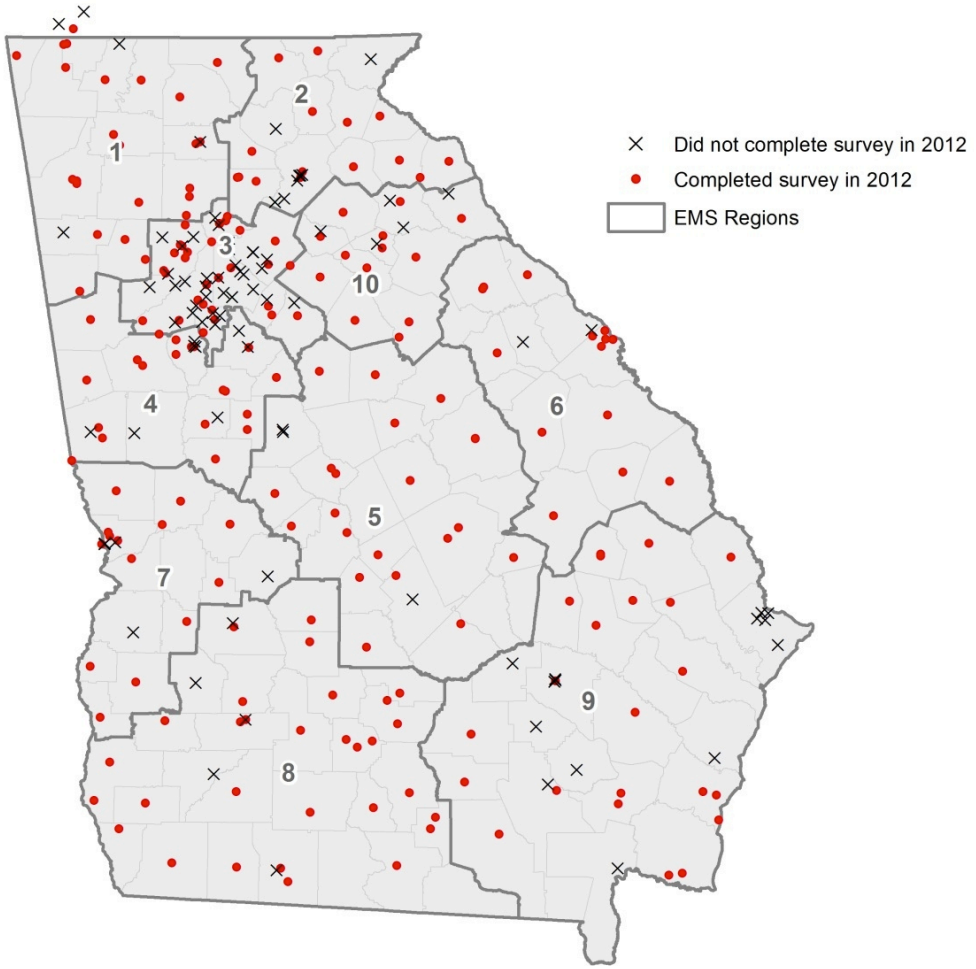
Person Completing This Form

Georgia Tech Research Institute

Year 5 Survey Response

- **Participation increased from 135 responses in Year 1 to 205 in Year 5**

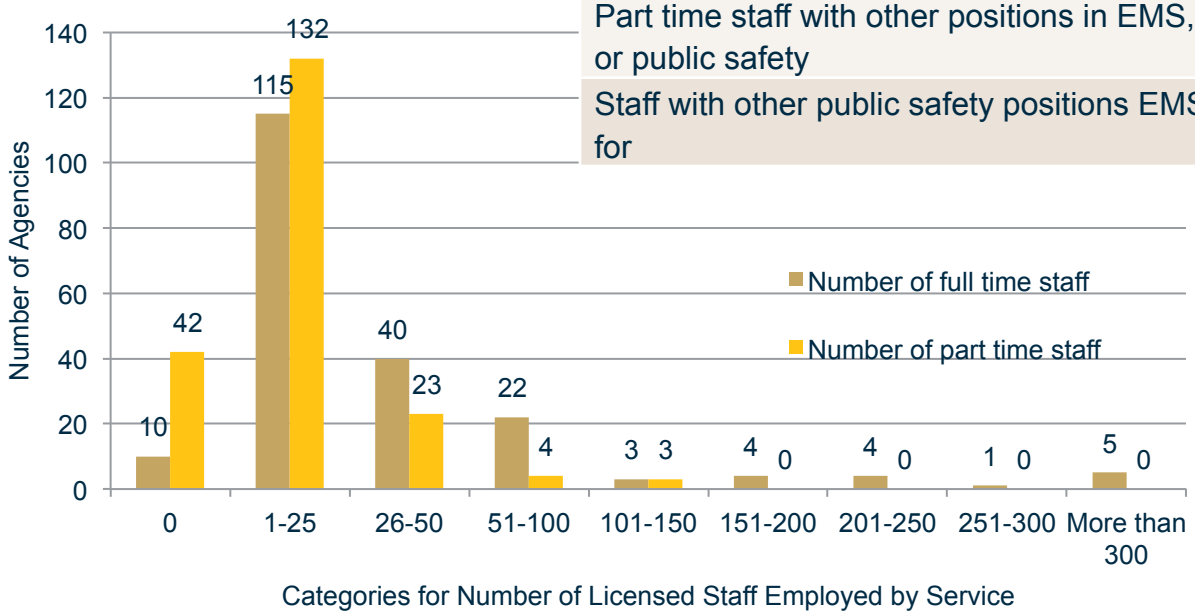




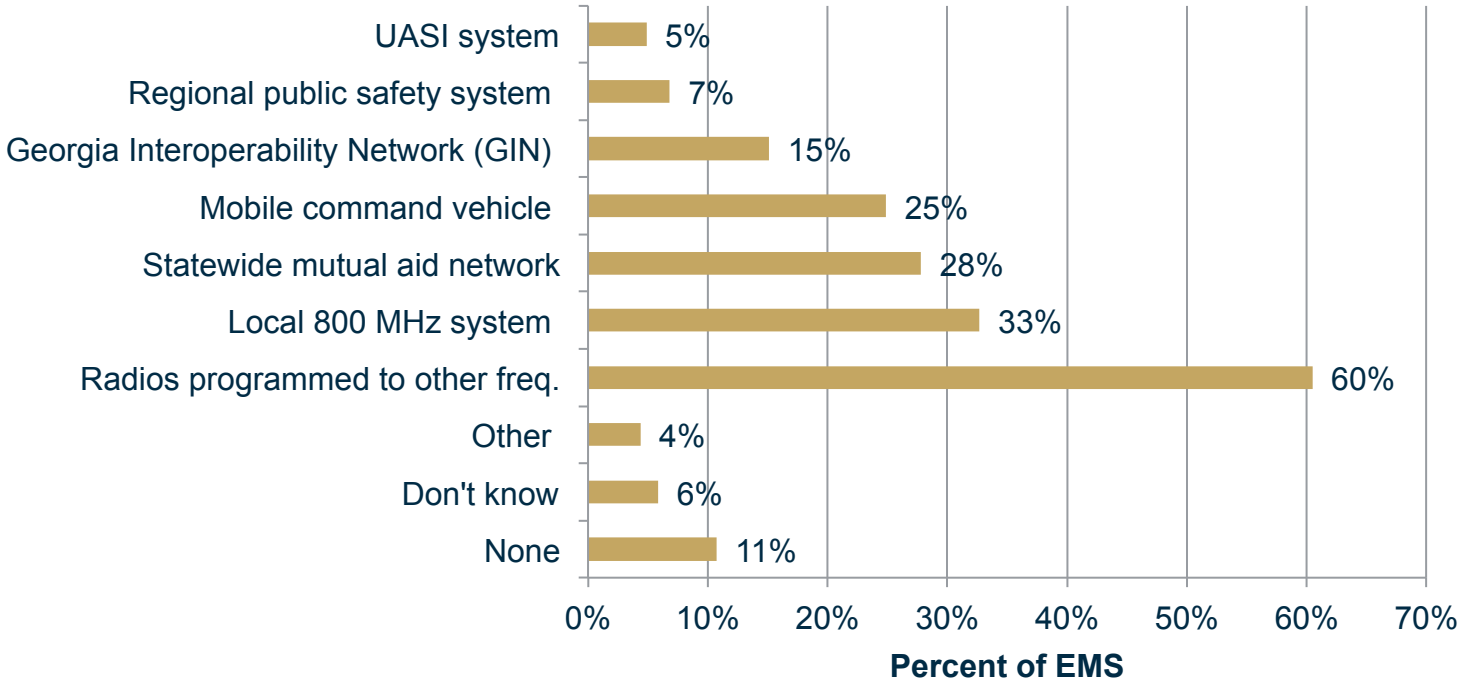
Year 5 Results: Personnel

- **On average, 12 people per service are dedicated elsewhere in an emergency**

	sum (all EMS)	% of total
Full time staff with other positions in EMS, fire, health care, or public safety	1,910	18%
Part time staff with other positions in EMS, fire, health care, or public safety	2,253	68%
Staff with other public safety positions EMS have first claim for	2,405	58%



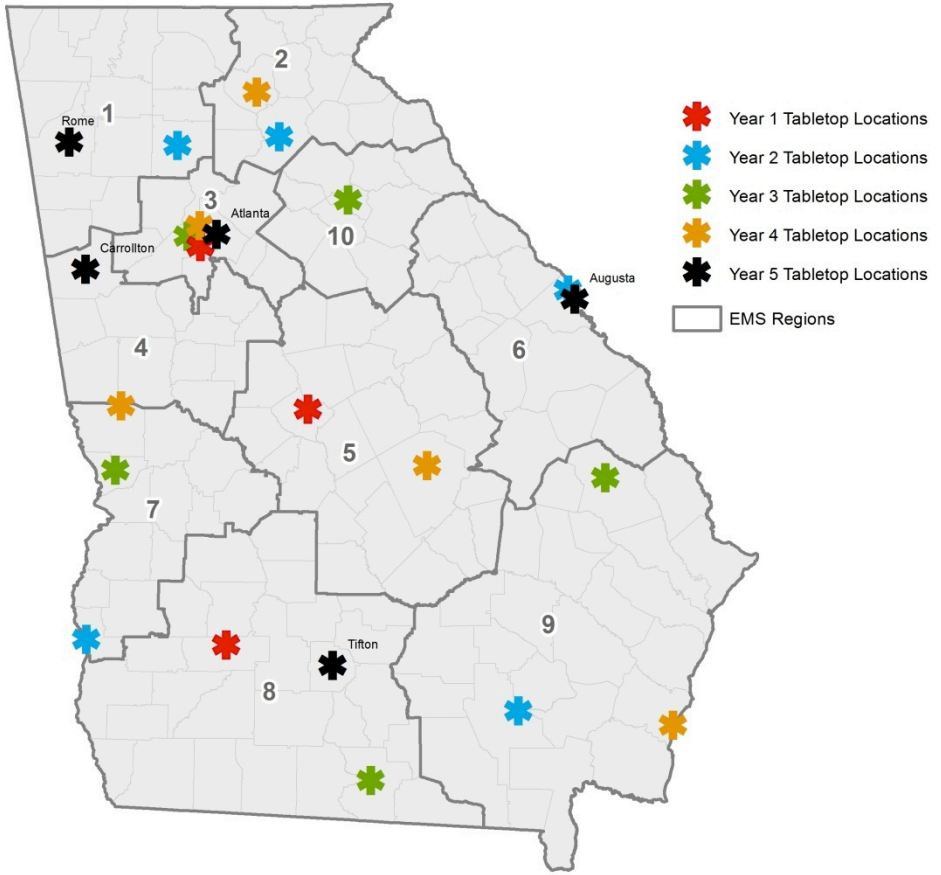
Year 5 Results: Interoperable Communications



Georgia Tech Research Institute

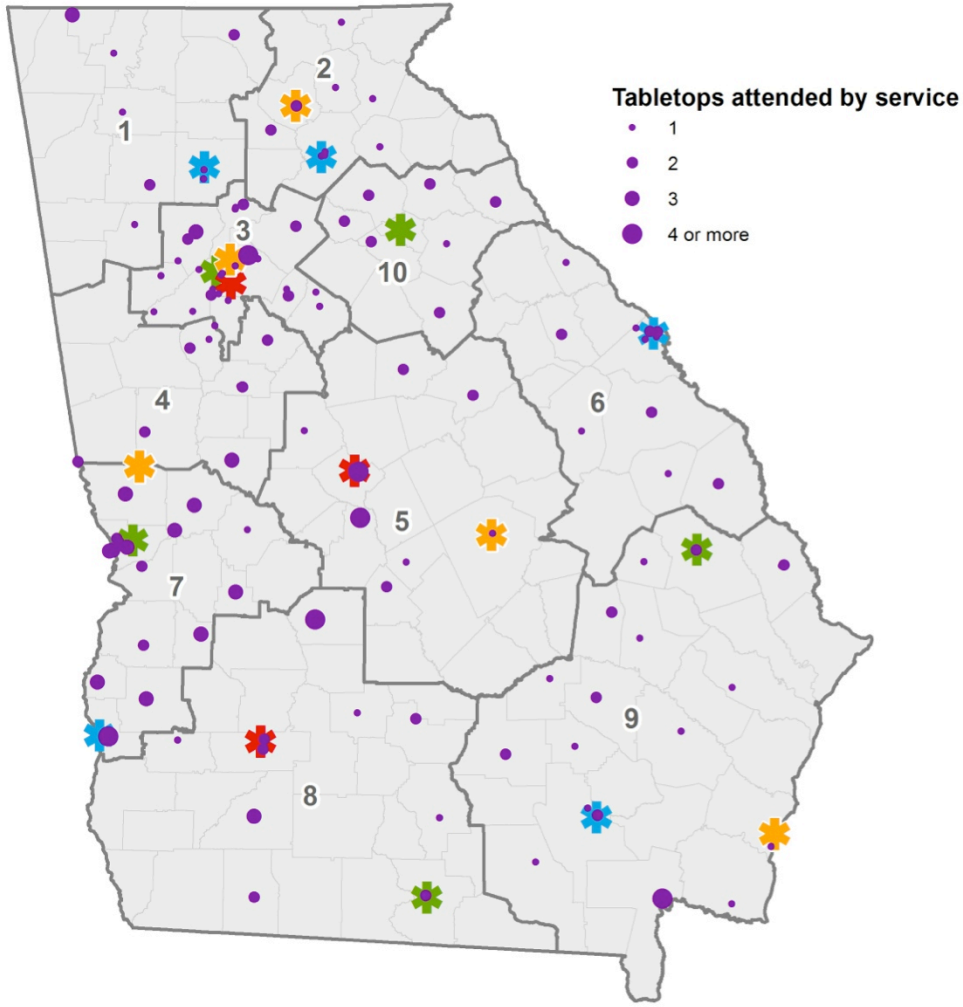
Tabletop Exercises Years 1-5

- Exercises held in 22 cities in Years 1-5, 1 more to be completed Jan. 30 in Augusta
- Types of exercises include airplane crash and dirty bomb drills



Tabletop Participants Years 1-4

- Representation across the state varied by region
- Locations picked to encourage geographic variety



Tabletop Exercise Feedback

- **Common gaps include:**
  - **Interoperable communications**
  - **Inconsistent patient tracking and triage**
  - **Knowledge of available resources**
  - **Personnel shortages**
  - **Training and exercises**

Future of EMS Facilitated Discussion

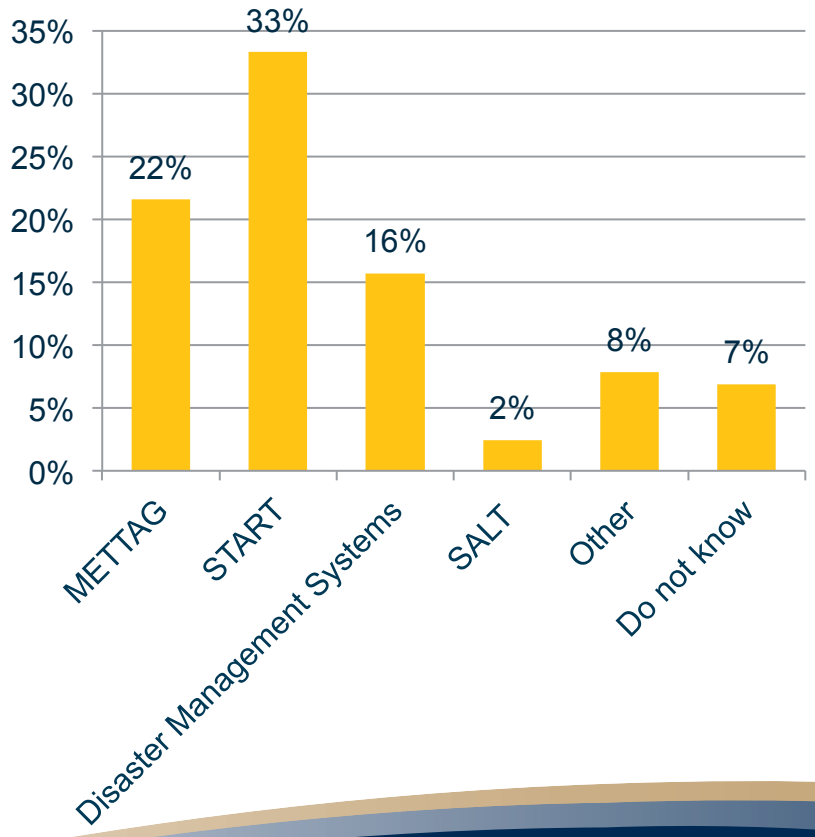
- Top concerns included:
  - Need for ownership and accountability
  - Leadership training
  - Legal coverage for service (for example, treat and release versus transport)
  - Pay disparity (nurses vs. EMTs)
  - Public education on the role of EMS
  - Funding

Additional Training and Exercises

- Training at GAEMS events in Year 3
- Full scale exercise at GPSTC in Forsyth in Year 4
- More full scale exercises planned for Year 5

Year 5 Full Scale Exercise

- Multiple triage tags used across state
- Few opportunities for EMS multi-regional exercises
- Move toward state and national triage standardization



Georgia Tech Research Institute

Full Scale Exercise Overview

- 13 Sept 2012 at GPSTC in Forsyth
- Participants were from 4 different EMS Regions, mainly 5 and 6
- 39 medics from 13 services

Georgia Tech Research Institute

Full Scale Exercise Overview

- Multi-casualty/ explosive device incident
- 44 live “victims” with moulage and 10 mannequins
- 121 total participants, including evaluators, observers, and controllers

Full Scale Exercise Overview

- Exercise primarily involved coordinating triage and transport
- GBI and EOD experts gave law enforcement/ crime scene overview

Full Scale Exercise Objectives

- The effectiveness and efficiency of disparate services triaging with different systems
- The ability to establish a command structure
- The knowledge of available resources, and maximization of care in where victims are transported
- The effectiveness of interoperable communications

Major Strengths

- Interoperable communications
- Effectiveness of incident command
- Using the Trauma Communications Center (TCC), all patients were efficiently guided to an appropriate hospital

Primary Areas for Improvement

- Patient accountability and documentation was uneven
- Triage was conducted in an unsafe area
- Traffic issues, unattended ambulances clogged ingress/egress

Select Year 1 Recommendations

- Develop an EMS disaster-planning template for use throughout Georgia
- Strengthen statewide capabilities for mutual aid through adoption of a mutual aid planning template
- Adopt standardized patient triage, tagging and tracking
- Increase use of GPS and AVL in EMS vehicles throughout the state
- Improve access to and use of interoperable communications

Select Year 2 Recommendations

- Develop alternate standards of care for EMS
- Generate informational materials on when and how to use PPE and when to wait for Hazmat teams.
- Promote NIMS compliance and awareness through additional training and exercises
- Make web-based training portal more robust in order to improve distance-learning opportunities
- Strengthen communications with allied fields such as the medical community, public officials, and utilities through greater EMS involvement in their respective EMAs

Select Year 3 Recommendations

- Manage overworked staff
- Depending on success of current pilot tests, implement Global Emergency Response patient tracking and triage system
- Create standardized protocols for accessing trauma trailers
- Place caches of pre-positioned supplies along evacuation routes
- Provide more multi-agency, multi-jurisdiction exercises and training classes in mental health and stress management

Select Year 4 Recommendations

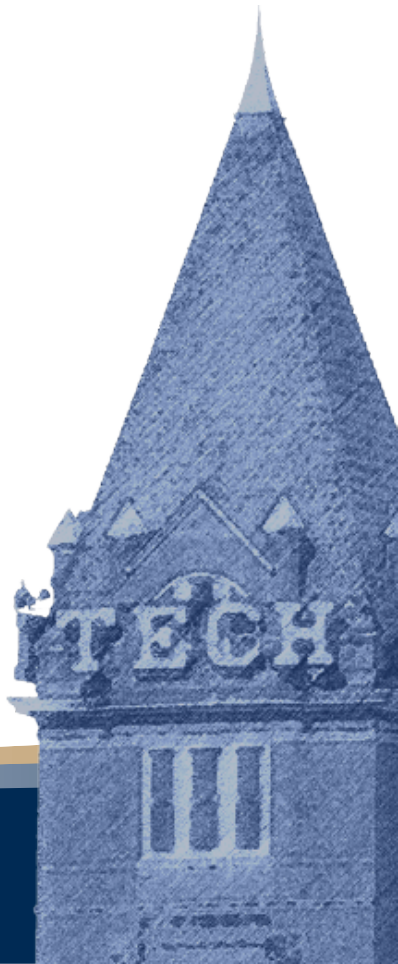
- Continued support of the GAEMS leadership training program and additional regular classes to bolster the professionalism of EMS from the top down
- Training for leaders on financial management should be offered
- Presenting EMS in K-12 curriculum
- Standardized triage and tracking compatible with AVLS Global Emergency Response System
- Need for social media policies

Year 5 Project Status

- Survey data has been compiled
- Tabletops are in progress
- Draft plan is in development
- GTRI will be represented at GAEMS CHANGES Conference in April

For more information, contact:

Ann Carpenter
acarpenter@gatech.edu



Georgia Tech Research Institute

Georgia Tech Research Institute

Problem. Solved.

Need For and Benefit from Healthcare Capacities and Emergency Response Systems Integration

TOOLS

- SAAB Paratus/SAFE
- GTRI GTVC
- InMotion Technology AVLS
- GEMA GODAWGS
- ESI Inc. WebEOC
- GER HC Standard Patient Tracking

Goals

A practical effort to solicit input from all stakeholders that will help to:

- Identify and document best uses of the tools
- Clarify possible mutual support among systems
- Draft an initial protocol suggesting which systems to best be used when, and in what situations
- Contribute to enhanced coordination of response to MCI

Tools to possibly be monitored in each agency when SOC Activation is in **MONITOR** level of Activation

Georgia Tech Research Institute

State level support of Coordination of Medical Services during an MCI using GIS Situational Awareness Technology tools

	GTVC	AVLS	GO-DAWGS	WebEOC	Patient Tracking	Paratus/ SAFE
SOC – ESF8						
Regional EMS Coordinators						
Trauma Communication Center		X				X
Regional Coordinating Hospitals						
911 Contracted EMS Providers		X			X	
Counties						

Tools to possibly be monitored in each agency when SOC Activation is in **PARTIAL ACTIVATION**

Georgia Tech Research Institute

State level support of Coordination of Medical Services during an MCI using GIS Situational Awareness Technology tools

	GTVC	AVLS	GO-DAWGS	WebEOC	Patient Tracking	Paratus/ SAFE
SOC – ESF8	X		X	X		
Regional EMS Coordinators						
Trauma Communication Center	X	X				X
Regional Coordinating Hospitals						
911 Contracted EMS Providers		X			X	
Counties						

Tools to possibly be monitored in each agency when SOC Activation is in **FULL ACTIVATION**

Georgia Tech Research Institute

State level support of Coordination of Medical Services during an MCI using GIS Situational Awareness Technology tools

	GTVC	AVLS	GO-DAWGS	WebEOC	Patient Tracking	Paratus/ SAFE
SOC – ESF8	X	X	X	X		
Regional EMS Coordinators						
Trauma Communication Center		X			X	X
Regional Coordinating Hospitals						
911 Contracted EMS Providers		X			X	
Counties			X	X		