Georgia Trauma Commission

Georgia Trauma Care Network Commission

Right Patient, Right Hospital, Right Time, Right Means

MEETING MINUTES

Thursday, 15 August 2013

Scheduled: 10:00 am until 1:00 pm

Georgia Public Safety Training Center
Library Resource Center
1000 Indian Springs Dr.
Forsyth, GA

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Mr. Courtney Terwilliger Dr. Robert Cowles Ms. Elaine Frantz Dr. Fred Mullins Dr. Leon Haley Mr. Ben Hinson	Ms. Linda Cole, RN *(Excused)* Mr. Kurt Stuenkel *(Excused)*

STAFF MEMBERS SIGNING IN	REPRESENTING
Mr. Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Ms. Michelle Martin, TCC Operations Specialist	Georgia Trauma Care Network Commission
Mr. John Cannady, TCC Manager	Georgia Trauma Care Network Commission
Ms. Dena Abston, Business Operations Officer	Georgia Trauma Care Network Commission
Ms. Tammy Smith	Georgia Trauma Care Network Commission
Ms. Lauren Noethen, Office Coordinator *(Via Conference Line)*	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Ms. Brittany Jones	Assistant Attorney General
Dr. Regina Medeiros	Georgia Regents Health Center
Mr. Marty Billings	Metro Atlanta Ambulance Service
Ms. Renee Morgan	OEMS/T
Mr. David Bean	EMS Consulting Service
Ms. Karen Grabenstein	Air Evac Georgia
Mr. Chris Criswell	Air Evac Georgia
Mr. Scott Maxwell	Mathews & Maxwell, Inc.
Ms. Marie Probst	OEMS/T
Ms. Elizabeth Atkins	CHOA
Mr. Huey Atkins	National EMS/Region 10 Council
Ms. Gina Solomon	Gwinnett Medical

Dr. Pat O'Neal	OEMS/T
Ms. Bonnie Brantley	Meadows Regional Medical Center
Ms. Diana Sowell	Meadows Regional Medical Center
Mr. Blake Monroe	Meadows Regional Medical Center
Brandon Fletcher	Southern Regional EMS
Jason Troupe	Southern Regional EMS
Susan Bennett	JMS Burn Centers
Kim Littleton	Georgia Association of EMS
Keith Wages	OEMS/T

CALL TO ORDER AND QUORUM ESTABLISHED:

Dr. Dennis Ashley, Chair, called the scheduled meeting of the Georgia Trauma Care Network Commission to order at 10:18 AM. Dr. Ashley then confirmed with Ms. Brittany Jones that a quorum was established.

CHAIRMANS REPORT

Dr. Ashley reported that Mr. Ben Hinson has made the decision to resign from the Trauma Commission. Mr. Hinson has sold his EMS business and feels that someone who is more involved should accept the position. Dr. Ashley thanked Mr. Hinson for his support of the Commission, reflecting on the years of service to the Commission. Dr. Ashley then presented Mr. Hinson with a plaque which he read aloud;

"*From the Trauma Commission, Presented to Ben Hinson: in appreciation for your extraordinary record of achievement in support and development of the Georgia Trauma System.*"

Mr. Hinson thanked the Commission and extended his appreciation.

ADMINISTRATIVE REPORT and APPROVAL OF MINUTES

Mr. Jim Pettyjohn reviewed the meeting agenda for the Commission, providing a brief review of the scheduled discussions *(see admin report)*.

Mr. Pettyjohn indicated that there would be discussion regarding the work of the Trauma System Evaluation Committee, and a discussion regarding the future of the TCC. On page 23 an end of the year memo is included for FY 2013 closing budget which allowed $13,744 to be returned to the general fund. The first quarterly report from eBroselow is found on page 24; it is part of the Artemis Safe Dose System. Mr. Pettyjohn reminded the Commission of the work of Dr. Jim Broselow, advising that he would be present at the next Commission meeting in November to provide a report regarding the status of the program. Mr. Pettyjohn explained that there are fifty hospitals funded this year, based on participation in FY 2015 the plan is to fund up to fifty additional hospitals. If there are hospitals that choose not to utilize this program during the current fiscal year, those licenses will not be funded; this is a commitment of four more years.

Dr. Fred Mullins questioned participation requirements regarding the usage of the system; Mr. Pettyjohn replied this would be determined by the Commission.

Mr. Pettyjohn continued the report, indicating that Mr. John Cannady will provide a report for the Trauma Communications Center, including a six month report of patient involvement. A Georgia Trauma Service Line report will also be provided, indicating essential service lines availability by hospitals across Georgia.

Mr. Pettyjohn indicated that these items, including the meeting minutes, are available on the Commission web page.

MOTION GTCNC 2013-05-01:

I make the motion to approve the minutes of the May and June minutes of the Georgia Trauma Commission.

MOTION BY: **DR. FRED MULLINS**
SECOND BY: **DR. LEON HALEY**
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

VOTING:

Dr. Dennis Ashley	Yes	Mr. Kurt Stuenkel	Absent
Ms. Linda Cole	Absent	Ms. Elaine Frantz	Yes
Dr. Leon Haley	Yes	Mr. Courtney Terwilliger	Yes
Dr. Robert Cowles	Yes		
Dr. Fred Mullins	Yes		

GEORGIA TRAUMA FOUNDATION, INC UPDATE

Mr. Pettyjohn reported that the GTF has submitted application for 501c3 status earlier this week. At this early stage there is not much to review; it is mostly based on what is being planned at this point. This has a ninety day turn around; once it comes back the GTF will be organized under the IRS code as a non-profit, 501c3. Conversations with Dr. Fred Mullins have indicated the need for appointing an Executive Director or Administrative Support; for that position $150,000 is approved in the FY 2014 budget.

Dr. Ashley asked Dr. Mullins if there was anything else he would need; Dr. Mullins replied that he felt the $150,000 should be enough to get things started.

TRAUMA SYSTEM EVALUATION COMMITTEE UPDATE

Dr. Ashley reported, reminding the Commission of the decision to establish the Trauma System Evaluation Committee during the previous retreat in Rome. Dr. Ashley and Dr. Pat O'Neal are Chair and Co-Chair of the Committee, and the meeting minutes indicate the wide representation among participants *(see admin report*

page 3). This is tied directly into the Governor's Office with the assistance of Alice Zimmerman, who as acted as the strategic planner. Ms. Zimmerman works closely with the Governor regarding metrics, and has been working with the Committee to ensure that the proper data is collected. There have been two meetings so far; the first of which Ms. Zimmerman explained the logic model and the preferences of the Governor. The second meeting worked to narrow down the top five metrics. These have been identified as metrics that the Commission can look at to identify needs in funding. The Governor and legislators can also review the results for a return on investment. Dr. Ashley then reviewed the metrics which were chosen *(see admin report page 11)*.

Dr. Ashley indicated that the next meeting which is scheduled to take place on 29 August 2013; will discuss definitions. These will be taken back to the Commission to review for evaluation, consideration, and discussion. Dr. Ashley indicated that he was proud of the work that has been accomplished during these meetings, and extended appreciation to Ms. Alice Zimmerman for her assistance.

Mr. Courtney Terwilliger commented that he was pleased with the work of Ms. Zimmerman, and he has enjoyed the meetings. Ms. Elaine Frantz added this is a comprehensive, collaborative effort, and that she was impressed with the final metrics, and the work that has been completed.

Dr. Robert Cowles questioned Metric 1; asking if the time would represent a median time from the time the 911 call is received, or from the time 911 dispatched the call to EMS; Dr. Ashley responded that this would be determined at the next meeting as the metrics are defined. Dr. Cowles commented that the he has recently been appointed by the Governor to work with the 911 Commission and there a lot of similar issues that mesh with the Trauma Commission. How the 911 calls are routed, and the time from the initial call to dispatch could indicate if this is a 911 problem. Dr. Mullins ascertained if this was tracked by 911 now; Dr. Cowles responded that the 911 system has no regionalization and is utilized from county to county; his recommendation will be for a centralized or regional 911 system. Dr. Cowles added that there are some counties that do not have 911, and most 911 centers are running in the red. These metrics will be important to define for the 911 Commission as well. Mr. Terwilliger indicated that these issues would also be discussed at today's Statewide RTAC Coordinating Group meeting.

TRAUMA COMMUNICATIONS CENTER UPDATE

Mr. John Cannady provided the TCC report, indicating that he would begin with the charts at the end of the Administrative Report. The first page of the Georgia Trauma Service Line Availability *(see page 46 of the admin report)* shows a green bar graph indicating the average time that each service line was available throughout the state. These numbers are self-reported by the hospitals and updated three times daily. The various service lines which data was collected from correlates to essential service lines for Level 1 and 2 trauma center designations. The last two, Re-implantation and Cardiac Surgery are for Level 1 only.

Discussion ensued regarding the collected data and the process in which it was analyzed; indicating that this is aggregated data from a time metric which is inclusive to reflect even one center being down.

Mr. Cannady continued his report moving to the second fold-out graph, and explained that this reflects the amount of down time for service lines (which is self-reported by the hospitals). Discussion followed regarding the reasons that an ER might not be available, and what the data means. Ms. Frantz expressed concern regarding definitions, indicating that a hospital showing less than 100% will still accept trauma patients. Further conversation continued regarding what the hospitals are reporting and why, and how reliable this data is. Dr.

Ashley reminded the Commission members that hospitals may have indicated that they were down for various reasons that Mr. Cannady would not have access too, and that this data could be taken back to the hospitals for further evaluation. Dr. Leon Haley provided examples that could explain the numbers which are less than 100%.

Discussion ensued regarding the data and what it means as well as how it was collected. Dr. Ashley commented that this is showing numbers that can be used to show legislators what it is that they are getting. Dr. Mullins suggested breaking this down further on a month by month basis. Mr. Cannady responded that he appreciated the feedback and was open to suggestions regarding how the numbers are reported.

Mr. Cannady continued his report, further explaining the details of the data collected *(see admin report page 43)*. The charts provided explain patient interaction by origin form 2012 and 2013. Mr. Cannady explained that the origin is referring to how the call was initiated; whether by EMT, helicopter, or hospital. The largest difference from 2012 to 2013 are shown through calls which originated from helicopter services; this number has increased significantly from 10% to 43% primarily through one specific helicopter service. Mr. Cannady provided some examples of calls that were received where the TCC was able to assist.

On the next page of the Administrative Report *(page 44)*, the data collected references patient interaction with EMS by region. Mr. Cannady indicated that since the TCC first initiated receiving calls, there have been calls received from every region in the state. This is attributable to information getting out and the RTAC's which have been forming across the state.

Mr. Cannady continued, expressing that while it is one call for the EMT to the TCC, the Call Agent internally could make several calls to provide a service to that agency; examples were provided, further explaining how the acceptance time for patients is far less with the assistance of the TCC. Comparison was made of the TCC to a tool in a toolbox, which can be used by EMS and hospitals that can use the service as they see fit. Mr. Cannady conceded that it is not always useful or appropriate for an EMT to call the TCC; however it does offer a valuable resource for EMT's and hospitals across the state when it is needed, without limitations.

Mr. Cannady further agreed and recognized that there was a need for change at the TCC, and extended appreciation to the Office of EMS and Trauma as well as the Georgia Hospital Association (GHA) and the Georgia Emergency Management Agency (GEMA) for the recent discussions and suggestions. In anticipation of these changes, the Resource Availability Display (RAD) will be put in the hands of dispatchers for EMS agencies to utilize as they see fit. This will be further discussed at the Statewide RTAC Coordinating Group meeting which takes place after this meeting. The RAD will be made available by request, and Mr. Cannady requested that the Office of EMS and Trauma as well as the EMS Program Directors assist in distributing this information. Upon request, the EMS agency will be provided with a username and password as well as over-the-phone training. This resource is available now for those who are interested.

Mr. Cannady requested that Dr. Ashley provide a summary of the discussions regarding the future of the TCC.

DISCUSSION: THE FUTURE OF THE TCC

Dr. Ashley reported that the TCC Pilot Project began with Region 5 and 6, and integrated other regions over time. Two meetings have taken place with Dr. O'Neal, Mr. Keith Wages, and Ms. Renee Morgan from OEMS/T and included Dr. Ashley and Mr. Pettyjohn and Mr. Cannady. During the first meeting it was established that there were three choices for the TCC; it could stay the same, close down or become modified. Discussion with

OEMS/T participants indicated the scene calls from EMS were not necessarily helpful, and paramedics have indicated that they know where to go. There was discussion that indicated that getting the RAD out across the state would be useful. Currently, the RAD is updated three times daily and with accuracy we have a resource that provides real time data regarding available service lines. The ability to put this in the hands of the EMS providers will provide a valuable real time resource. Mr. Cannady and Mr. Pettyjohn have worked with the software distributor (SAAB) to ensure that this resource is now available.

For hospitals, the needs are different. By hospitals calling the TCC they can get access very quickly and know which trauma center is closest by and available. Smaller rural hospitals have limited resources, and this is a valuable tool for those hospitals.

At the conclusion of the first meeting it was decided that the group explore further options. The ability to gain input from other agencies is essential to ensure that everyone's needs are met. Dr. O'Neal made the recommendation to meet with GEMA and GHA and determine what their needs are.

The second meeting took place approximately one week ago with representatives from GEMA, GHA, OEMS/T and GTC. The information was presented for evaluation, and there will be a follow up conference call on 03 September 2013. The meeting will discuss options for GEMA and/or GHA to contract with GTC including deliverables and consideration for funding. Dr. Ashley further expressed that the infrastructure built for trauma with this communications center, in reference to the transporting patients, can be further utilized to include other patient types, such as stroke and cardiac. The Commission has steered away from this because this is not our charge, or our area of expertise. However, with GHA's involvement and the screens remaining up to date, if they chose to do this the software would allow that. There will another discussion with GEMA, Dr. Ashley and Dr. O'Neal to discuss the needs of GEMA. Dr. Ashley suggested that every possibility be closely evaluated before making a decision.

Dr. Ashley opened the floor for discussion. Dr. Cowles expressed concern regarding the involvement of GHA, indicating that they are huge lobbyist. Co-mingling tax dollars within a lobbying organization could create a major problem. Dr. Cowles gave a word of caution regarding partnership with GHA, as they represent the hospitals and the Commission represents the citizens of Georgia.

Dr. Mullins expressed concern regarding the purpose of the TCC; adding that to him, the purpose of the TCC is informing the hospitals of what service lines are available. Dr. Mullins expressed that there should be consideration for the fact that there are people on the ground trying to take care of their patient, and now have to make another call with all of the other things that they have to do. Dr. Mullins recommended eliminating this function, while maintaining the status of the hospitals service lines. This option, as well providing the RAD to dispatch agencies, will allow the dispatcher the ability to direct their EMT's. This will prevent the EMT's from having to repeat their patient report multiple times. Regarding hospitals, they accept a Readiness Cost for the purpose of being ready when the service line is green and they need to have a mechanism for accepting patients for transport. Dr. Mullins felt that the trauma centers should have a direct line available for the purpose of transports so that a doctor can be reached without the need for multiple calls. For the TCC to intervene, the number of calls going out is increased in this process.

Dr. Ashley confirmed that Dr. Mullins was suggesting that the RAD be provided to all hospitals, similarly to the EMS agencies; Dr. Mullins agreed adding that it should be provided to all agencies who wish to utilize it, dispatchers, EMS agencies, hospitals, helicopter agencies, etc. while maintaining TCC personnel to mandate the hospital statuses remain up to date, this would make the TCC more functional. Dr. Mullins expressed the patient care needed to come first.

Discussion ensued regarding the acceptance of patients, and the role of the TCC. Mr. Terwilliger questioned why a transport coming through the TCC would take thirty minutes, assuming the specialty was labeled to green; why would there be a need to interact? Mr. Cannady replied that the TCC does not have the authority to force transport decisions on a receiving hospital, and therefore makes contact with the destination hospital for acceptance. The TCC will make contact with the destination hospital to ensure acceptance of the patient based on the data reported on the RAD. The TCC will make contact with the physicians and then patch them together so that that there are fewer calls between hospitals.

Mr. Terwilliger questioned how discrepancies are resolved; Mr. Pettyjohn replied that there is communication between the TCC, John and the Trauma Coordinators. If there is a disconnect between the status, such as it set to green and the trauma center is unable to take the patient; follow up is also conducted via the TCC Medical Director, Dr. Ashley; however there has not been an incident to date. Mr. Pettyjohn added that if the hospital status is labeled green there is an expectation that the hospital will accept that patient, the TCC tracks that acceptance. Dr. Mullins commented that the TCC should investigate these discrepancies; however he felt that the hospitals should be making the calls themselves. If there is an issue of acceptance, then they should call and report that to the TCC for investigation. If these are habitual offenders, then the Commission should be evaluating the Readiness Funding that is being provided to them.

Ms. Elaine Frantz referenced the logic model from the Georgia Trauma System Evaluation Committee minutes, and questioned if the logic model was being applied to this analysis. What is the purpose of the TCC? It is collecting data, a trial project which began with Region 5 and 6 as a pilot project. Ms. Frantz referenced the data spreadsheets provided by the TCC *(see admin report)*; adding that the hospitals are open, and very rarely on diversion; always accepting trauma patients. Ms. Frantz further analyzed the data, conceptualizing that the TCC utilization in Alabama would direct the EMS to the appropriate hospitals based on TSEC criteria and if the hospital were closed it would be able to identify that. Ms. Frantz felt that having the RAD displayed in the hands of EMS was an excellent idea; however she questioned why the EMS was not utilizing this tool. Further recommendations included advising caution regarding any partnership with GHA and GEMA, noting cautions cited by Dr. Cowles. Second, this should be viewed objectively; if the decision is made that the TCC is valid and serving a purpose, then it has to be determined why it is not working in Region 5, and what changes need to be made to make it work.

Discussion ensued regarding the possible reasons that the EMT's are not using the TCC. Ms. Frantz stated that the EMT's knew where they were going. Dr. Mullins added that it was interfering in patient care by adding extra steps, noting that the EMT's communicate with the hospitals and dispatch by radio. Mr. Terwilliger agreed that most of the medic's knew where they were going; adding that for Emmanuel, the RAD is in the ER with the EMS office directly behind it. When the EMT receives a call they are able to see the display on their way out, their primary is MCG; however there are some times when the emergency room at MCG is busy and they know that they need to another direction. Mr. Terwilliger noted concern regarding the hospital to hospital transfers as there are seldom problems with getting the right people to the phone.

Dr. Cowles expressed confusion regarding the TCC's role in hospital to hospital transports. Once the patient has arrived at the hospital, they are then the responsibility of that hospital. Dr. Haley replied that the TCC would then try to assist with the next transport. Dr. Cowles indicated that there are already strict rules in place to prevent long waits for transports.

Discussion ensued regarding the role of the TCC in hospital to hospital transport, and the protocols in which the hospitals handled these decisions; as well as the role of Level 3 and 4 hospitals and how they determine when they should transport.

Dr. Haley advised that he recommended that Mr. Cannady and Mr. Pettyjohn along with the representatives from OEMS/T continue to meet with the stakeholders; while heeding Dr. Cowles caution. These meetings should take place before the November Commission meeting. At that time, Mr. Cannady should be prepared to provide a report to the Commission with his recommendations regarding what the TCC should look like. At that time the Commission will need to be prepared to decide if the TCC will be moved in that direction, or if the program should be terminated. Dr. Ashley agreed.

DPH OEMST

Dr. Pat O'Neal reported that in terms of the data, Dr. Gage Ochsner made the point that there were two needs, data and dollars. Senate Bill 60 emphasizes the dollar piece; with the Commission holding the responsibility for the system development which is guided by the data. Dr. O'Neal commented that the work with Ms. Alice Zimmerman has come from the Governor to ultimately improve the trauma system in Georgia. Ms. Zimmerman had recently requested information from OEMS/T regarding trauma death rates, which can be provided through the registry. However, Dr. O'Neal felt that the data may be more accurate coming from death certificates for all trauma deaths in the state of Georgia, with an age adjustments. The assumption is that only about 50% of trauma patients are going to trauma centers, and this is a problem that the Commission needs to face and the answer is not in the creation of more trauma centers; with the recent increase in the number of trauma centers in Georgia, the number of patients who are seen has not increased. Dr. O'Neal felt that this issue needed to be addressed, and steps should be taken to find out why those hospitals are not seeing more trauma patients.

Dr. Mullins questioned if Dr. O'Neal had the data showing where the patients were seen; Dr. O'Neal replied that there was data based on diagnosis codes which suggest severity. Dr. O'Neal recommended following an example of a Florida study to analyze this information. Discussion ensued regarding the data and the timeline for collecting and analyzing the data. Possible reasons for patients receiving care at non-designated hospitals were also discussed, such as private transports, and the patient's inability to have knowledge of which hospitals are trauma, and simply going to the nearest emergency room.

Further discussion followed in regard to the care that non-designated hospitals are able to provide compared to a trauma center, and the specialties and commitments which accompany these hospitals. Dr. O'Neal advised that he felt it was important to continue collecting data, and felt that it was in the best interest of improved patient care that the analysis continues; Dr. Ashley agreed, and added that he felt that the Data Subcommittee and Trauma System Evaluation Committee were in sync with this work.

EMS SUBCOMMITTEE

Dr. Ashley advised that Mr. Courtney Terwilliger will now act as the new Chair of the EMS Subcommittee, and requested that he provide a report.

Mr. Terwilliger reviewed the meeting notes of the EMS Subcommittee, advising that a recent audit was conducted GH&I Consultants to review Uncompensated Care claims; Mr. Paul Lundy and Ms. Jessica Story

attended the meeting and provided a presentation of the findings. Additional reports were provided for the TCC, grants, and courses; as well as the funding that was provided. Details regarding the number of classes and students *(see EMS Subcommittee Minutes)* were provided to the Commission members. Mr. Terwilliger indicated that he had met with Keith Wages and Angie Rios regarding the re-implementation of the GEMSIS meetings. Ms. Rios requested that group consider assisting with travel expenses for personnel who may be able to assist in the training of the system. The EMS Subcommittee was in favor of this recommendation.

Mr. Terwilliger advised that the EMS Subcommittee has made the decision to review possible improvements to the trauma care response. Suggestions were made, and the members were asked to take those back to their respective regions for further discussion and recommendations from the Subcommittee.

Additional discussions within the Subcommittee regarded the development of a statewide timeframe that could be used from the time of dispatch until the patient receives definitive care, and a feasibility study. Mr. Terwilliger added that he has had some conversations with Jay Fitch, a national consultant, and some other consultants. There is a meeting scheduled to take place with stakeholders to review if the study should be conducted, and if so how should it be done, and how do you make the changes.

DPH OEMST (Continued)

Ms. Renee Morgan provided a handout *(see attached)*, and reviewed the new designated trauma centers. She informed the Commission members that there are some other hospitals that have expressed interest in becoming designated, but have not yet moved forward. OEMS/T is working with the Trauma Coordinators regarding data elements and updating and refining policies. OEMS/T hopes to become a resource for EMS Councils, to assist with guidelines in their areas. Stricter requirements are in place; the registration and application process will now take a year instead of six months. Gainesville is currently in review to become a Level 2 trauma center.

GCTE

Ms. Elaine Frantz began her report by providing a brief history of the group, advising that this has been a successful Subcommittee; further extending appreciation to Ms. Regina Medeiros for her work with the group. Ms. Frantz advised that she felt that the work this group has accomplished has enhanced the care of the trauma patient. Ms. Frantz announced that Ms. Medeiros' term as Chair will expire with the November meeting and Ms. Debra Kitchens will become the new Chair.

Ms. Regina Medeiros extended appreciation to the Commission and to Ms. Frantz, and advised that she is proud of the work that has been accomplished. Ms. Medeiros reported that the Special Projects Subcommittee has worked hard to put together an electronic news-letter, with the assistance of Mr. John Cannady. The news-letter will come out in September and will contain statewide news for all trauma centers in the state of Georgia. There will be hardcopies, and a link on the TAG website.

The Specialty Care Group covers rehabilitation, burns and pediatrics; the group would like to be recognized as members of the trauma system. Dr. O'Neal has been working with them and approved them to move forward with determining designation levels; they will mirror our Level 1 and 2 trauma centers and the Burn Centers. Within the pediatric group, EMSC has requested assistance to provide content for the new website, and will provide links.

The Education Group, led by Ms. Debra Kitchens and TAG, received funds from both the Trauma Commission and ASPER; they will be holding a wide range of adult and pediatric courses in urban and rural hospitals. Ms. Medeiros explained the various courses, and the requirements. A research project is being conducted through the Education Group; it will evaluate the confidence in delivery of care as statistically driven data outcomes for the dollars spent. This will be standardized across the state.

The PI Registration has been launched as of 01 July 2013; this is the first standardized registry program and is the same from center to center with no variation. Centers are not able to alter the drop down menus, however if they have a concern or suggestion they can bring it to the group for consideration.

Ms. Medeiros advised that GCTE had a motion to bring to the Commission, requesting that snake bites be removed from the trauma registry. The code for snake bites falls outside the ICD-9 code range which is acceptable for trauma registry and inclusion criteria. Ms. Medeiros requested that this be brought to the Trauma Medical Directors for consideration.

Ms. Medeiros continued her report, advising that the Resource Group has been working with OEMS/T to develop resource guides for hospitals seeking to reach trauma center designation status, and also those preparing for re-designation. There will be information on the TAG website to include items such as frequently asked questions and policies.

Ms. Medeiros advised that during the November meeting the group will choose a new Vice-Chair, there are currently three candidates. Ms. Frantz commended the work of the group, adding that there are several in this group that are members of the national organization, and Georgia is well represented; Dr. Ashley agreed that this group has done good work.

RTACs

Mr. Cannady reported that the Statewide Coordinating Group made a decision to combine their respective reports in the interest of time.

Region 1: Has formed a Data Committee which will examine what data should be collected and analyzed as a region. Their Education Committee is rolling out their education program over the next two months, with a goal of reaching all services, hospitals and EMS by the end of the year.

Region 3: Information was not provided.

Region 4: Has formed an RTAC and has initial leadership in place, they are taking steps to identify stakeholders and membership.

Region 5: Has a meeting scheduled to take place on 11 September 2013 and will be re-evaluating their plan.

Region 6: Their PI Improvement Committee recently supported a PI process which identifies issues from the various stakeholders and analyzes and validates any issues and makes recommendations to

Region 6 Council for their action plan. They also held a TNCC course at Emanuel Medical recently.

Region 8: There EMS Council has voted to form an RTAC and has appointed their Chair and Co-Chair.

Region 9: All of their hospitals are trained and participating in transfer protocol guidelines, and using two different formats. There transfer survey will be fully implemented in September, and several subcommittees are scheduled to meet. The Ochsner Institute for Injury Research and Prevention will be collaborating with the RTAC Injury Prevention Subcommittee regarding injury prevention and education efforts.

NEW BUSINESS:

Mr. Jim Pettyjohn reported that the new Senate Bill 60 funding for July of 2013 reporting $1.5 million, an increase from July 2012 which was $1.4 million.

Dr. Ashley reported that for the first time the Trauma Medical Directors and Trauma Coordinators met last Friday. This was the first face to face meeting which allowed everyone an opportunity for everyone to meet; this was planned by Dr. Chris Dente, Chair of the Georgia Committee on Trauma, and several speakers were in attendance. This was Commission funded, the next meeting will be held 08 August 2014 in Augusta.

Meeting adjourned: Dr. Dennis Ashley, Chair of the Georgia Trauma Commission declared the meeting adjourned 12:23 PM

The Next meeting of the Georgia Trauma Commission will take place on 21 November 2013, at AMC South Campus.

Minutes Crafted By Tammy Smith

Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

Peachtree Street NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

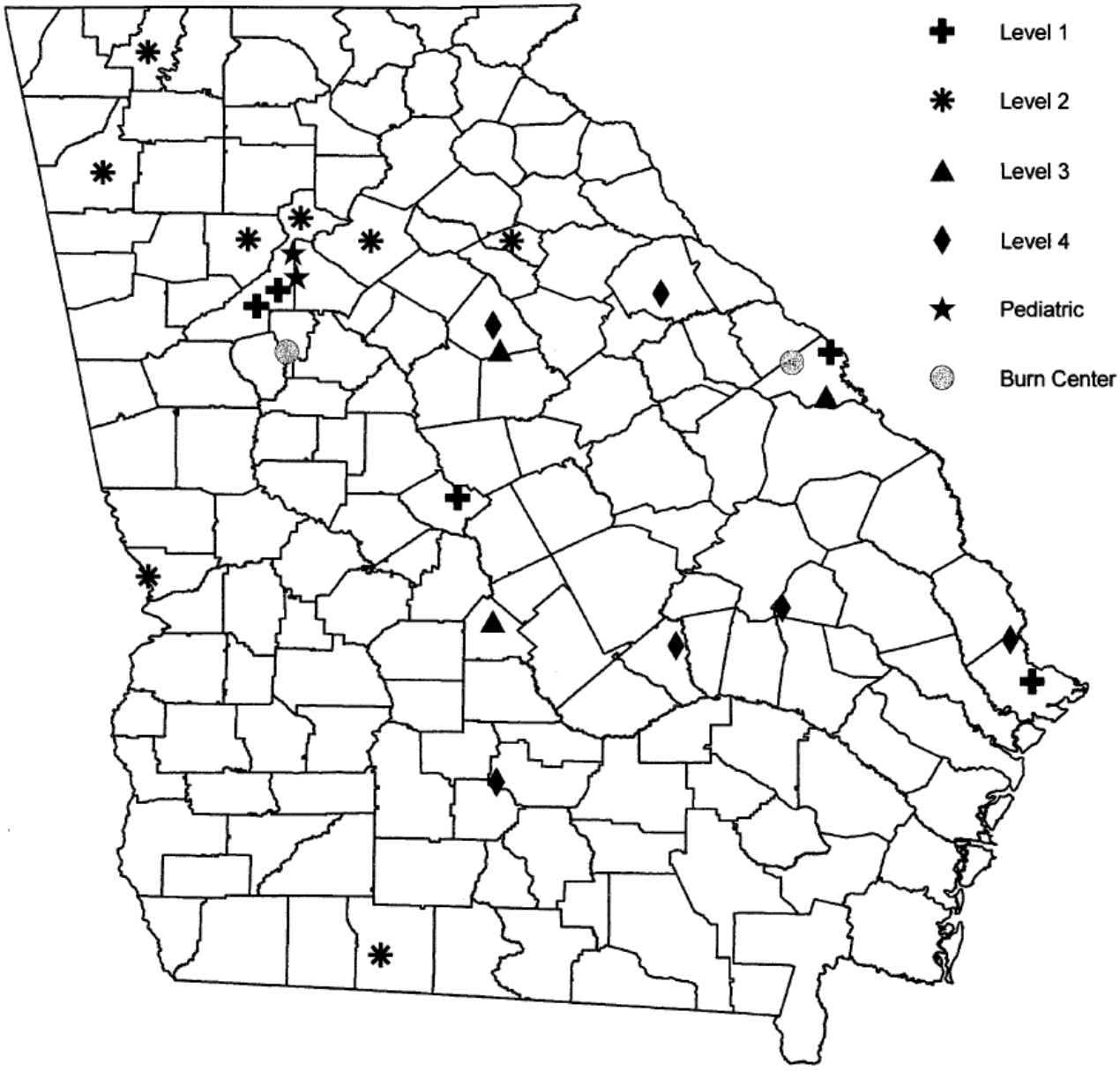
GEORGIA DESIGNATED TRAUMA & SPECIALTY CARE CENTERS

FACILITY	CITY	COUNTY	NUMBER
LEVEL I			
Atlanta Medical Center	Atlanta	FULTON	404-265-6577
Grady Memorial Hospital	Atlanta	FULTON	404-616-6200
Medical Center of Central Ga. Inc.	Macon	BIBB	478-633-1584
GA Regents Medical Center	Augusta	RICHMOND	706-721-3153
Memorial Health Univ. Medical Center	Savannah	CHATHAM	912-350-8861
(See Specialty Care Centers for Pediatric Center)			
LEVEL II			
Athens Regional Medical Center	Athens	CLARKE	706-475-3020
Floyd Medical Center	Rome	FLOYD	706-509-5000
Gwinnett Medical Center	Lawrenceville	GWINNETT	678-312-4321
Hamilton Medical Center	Dalton	WHITFIELD	706-272-6150
John D. Archbold Memorial Hospital	Thomasville	THOMAS	229-228-2834
Medical Center-Columbus	Columbus	MUSCOGEE	706-571-1901
North Fulton Hospital	Roswell	FULTON	770-751-2559
Wellstar Kennestone Hospital	Marietta	COBB	770-793-5000
(See Specialty Care Centers for Pediatric Center)			

We Protect Lives.

FACILITY	CITY	COUNTY	NUMBER
LEVEL III			
Clearview Regional Medical Center	Monroe	WALTON	770-267-1781
Taylor Regional Hospital	Hawkinsville	PULASKI	478-783-0369
Trinity Hospital of Augusta	Augusta	RICHMOND	706-481-7513
LEVEL IV			
Crisp Regional	Cordele	CRISP	229-276-3100
Effingham Health System	Springfield	EFFINGHAM	912-754-6451
Emanuel Medical Center	Swainsboro	EMANUEL	478-289-1100
Lower Oconee Community Hospital	Glenwood	WHEELER	912-523-5113
Morgan Memorial Hospital	Madison	MORGAN	706-752-2261
Wills Memorial Hospital	Washington	WILKES	706-678-2151
	Specialty Care Centers		
Pediatric Trauma Centers			
Childrens Healthcare of Atlanta@ Egleston (Level I)	Atlanta	DEKALB	404-785-6405
Childrens Healthcare of Atlanta @ Scottish Rite (Level II)	Atlanta	FULTON	404-785-2275
Designated Burn Centers			
Joseph M. Still Burn Center	Augusta	RICHMOND	706-651-6399
Grady Burn Center	Atlanta	FULTON	404-616-6178

Georgia Designated Trauma & Specialty Care Centers



Source: Georgia Department of Public Health, Office of EMS/Trauma

August 9, 2013