



ADMINISTRATIVE REPORT

September 2010

FY 2011 Commission Account:

4% withhold remains. Weekly allotment of \$409,177 continues.

As of 04 September: \$3,756,733 in Commission's "account."

Contracts' Purchase Order encumbrances = \$2,555,598.33 with \$12,455 paid out

Accounts payable invoice payments = \$34,632

FY 2010 Trauma Commission Contracts and Budget-to-date Report (16 September 2010)

(Report provided as separate document)

FY 2011 Contracts, Grants and Agreements report

(Attached).

07 September 2010 DRAFT EMS Subcommittee on Trauma Minutes

(Attached)

FY 2011 Contracts, Grants and Agreements Updates						September 2010
	Vendor	Amount	Purpose	Type	Status	Identifier
	OEMS/T	\$548,524	#5 Positions salaries and travel OEMS/T	MOA	Executed	41900-034-11110424
Commission Operations (excluding staff)						
	Gifford Hillegass & Ingwersen	\$55,000	TC audit	Exempt Contract	SOW under development	
Communications Center						
	Software purchase within GTRI Contract. RFP process proceeding.					
System Development						
	GTRI	\$1,073,774	TCC software and support	contract	Executed	41900-034-11110438
	Bishop Associates	\$103,950	Consultation	contract	Executed	41900-034-11110423
	TCAA	\$1,500	Membership	membership	Paid	Through August 2011
	GP Telehealth	\$50,000	Fees for 6 rural facilities	Amendment to FY 2010 Grant	Submitted on 01 September	
	Broselow-Lutin Solutions	\$50,000	Increase number of hospitals participating and EMS strategy and feasibility study	New sole brand contract	SOW under development	
	Trauma System Regionalization Agreement	\$150,000	provide funding for MCG (\$75K) and MCCG (\$75K) for RTAC and regional trauma system plan development in EMS Region 5 and 6	Agreement will be a deliverable for each hospital in FY 2011 contract	TCs' SOW under development	
Stakeholder Funding						
Trauma Centers & Eligible Physicians	Contract with 16 Individual Trauma Centers	\$13,078,166	Readiness/Uncompensated Care	exempt contracts	TCs' SOW under development	
EMS	Medical College of Georgia	\$858,469	EMS Uncompensated Care	deliverable in contract	Awaiting Commission approval	
EMS	#25 grant awards going to primary 911 zone providers	\$1,824,654	EMS Vehicle Equipment Replacement Grant Awards	competitive grants	Awaiting Commission approval	
EMS	GAEMS	\$290,508	Competitive First Responder Training Grants	exempt contract	Awaiting Commission approval	
EMS	GAEMS	\$290,508	Trauma Care-related Equipment Purchases	exempt contract	Awaiting Commission approval	



Georgia Trauma Care NETWORK COMMISSION

EMS SUBCOMMITTEE ON TRAUMA

MEETING MINUTES
Tuesday, September 7, 2010
Scheduled: 10:00 am until 2:00 pm
GTRI Conference Center
(Georgia Tech Research Institute)
250 14th St. NW
Atlanta, Georgia 30318
Meeting Room 119 A/B

CALL TO ORDER

Mr. Ben Hinson called the September monthly meeting of the EMS Subcommittee on Trauma to order at the GTRI Conference Center 10:05 a.m.

SUBCOMMITTEE MEMBERS PRESENT	SUBCOMMITTEE MEMBERS ABSENT
Ben Hinson, Chair Subcommittee & GA Trauma Commission Member Rich Bias, GA Trauma Commission Member Ralph McDaniel – EMS Region One Chad Black – EMS Region Two Pete Quinones – EMS Region Three Richard Lee – Region Four Lee Oliver – Region Five Blake Thompson – Region Six Jimmy Carver – EMS Region Seven Huey Atkins – Region Ten Courtney Terwilliger – EMSAC	Craig Grace – Region Eight David Moore – Region Nine Dr. Pat O'Neal - SOEMS
OTHERS SIGNING IN	REPRESENTING
Jim Pettyjohn Ryan Goodson Carol Dixon Renee Morgan Russ McGee Josh Mackey Scott Sherrill Keith Wages Karen Waters Keith Wages Dr. Dennis Ashley Arthur Yancey	Georgia Trauma Commission, Executive Director Georgia Trauma Commission, Communications Lead Georgia Trauma Commission, Administration OEMS/Trauma Region 6 EMS Brock Clay/GaEMS GTRI GaEMS GHA GaEMS Georgia Trauma Commission Chair Grady EMS

Alex Isakov Mark Chapman Michelle Archer Bryan McNally Kim Whitley Jill Mabley Bradley Demetu L. Vaidyanathan	Emory CHOA Region 5 OEMS Emory Flight MCCG Region 1 OEMS GaEMS
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Welcome and Introductions

Mr. Hinson welcomed all present at the meeting. Mr. Hinson stated that originally the meeting was scheduled until 12:00 noon; however, the time has been extended until 2:00 p.m. if necessary. Mr. Hinson recognized a quorum of the voting members were present. Mr. Hinson stated that Linda Cole, Scott Sherrill, and Ryan Goodson are on the agenda but Linda will be running late so we will move some things around on the agenda and keep moving.

Approval of Minutes from August 3, 2010 meeting

The first order of business was the approval of the minutes from the 3 August 2010 subcommittee meeting presented by Mr. Pettyjohn. Mr. Ralph McDaniel questioned the meeting for today's date was stated in the minutes as to be held at CHOA. Mr. Hinson stated this was the original plan and then meeting was moved to new location. Minutes will remain "as is".

MOTION EMS Subcommittee 2010-9-07-01:

I make the motion to approve the minutes from the 3 August 2010 meeting as written.

- MOTION BY:** Rich Bias
- SECOND:** Blake Thompson
- ACTION:** The motion **PASSED** with no objections, nor abstentions.

Mr. Hinson stated there were some questions in the minutes regarding the AVLS with there being a repository of data would it open up more of a liability. He talked with Alex Sponseller from the Attorney General's office and with his brief review, felt it did not open up more of a liability since what we do is public record anyway. Mr. Hinson responded that this was far more data than what we normally do. Alex agreed to look into this and will report to us at the next trauma commission meeting to be held September 19 and will be available for questions. He did say that some minor modification to some of the laws we have now could fix that. Our decision at the last meeting was for the data will be kept for two weeks and then discarded. Mr. Scott Sherrill confirmed this.

FY 2009 AVLS Program Update *(Spreadsheets for Regions 5 & 6 attached to minutes)*

Mr. Pettyjohn reported that 31 units have been received in Region 5 and 41 units received in Region 6. In Region 5 there are few more applications and we are working to get them on board. Mr. Lee Oliver requested an updated number of services on board. By request of Mr. Hinson, Mr. Pettyjohn will be attaching a recap spreadsheet for Regions 5 and 6 to these minutes via email to the EMS Subcommittee for review, as this is public record information. Mr. Pettyjohn added that Mr. Ryan Goodson will be taking on the follow up and follow through responsibilities for the EMS Regions 5 & 6 participating services to provide the necessary contact they need between GTRI and themselves.

Mr. Hinson also stated that as soon as the people saw the capabilities of this service, questions arose as to whether the units can be provided to the supervisor's vehicles. Mr. Hinson thinks some discussion is warranted and wants to present to the Georgia Trauma Commission for their opinion. Mr. Hinson stated the first question is, "does the supervisor's vehicle qualify like an ambulance and if so, how do we designate what a supervisor's vehicle is", second, "if they don't get an AVLS like they do in an ambulance, should they be able to buy one through the GTRI contract and can they get the airtime contributed if they buy the hardware".

Mr. Hinson states that the money is there because it would be one of the 300 units we have in the first round and believes there will be more in the future. Mr. Chad Black states that this would be a very useful tool in supervisor vehicles. Mr. Ralph McDaniel questions if there will be adequate funds to equip all ambulances and supervisor vehicles. Mr. Hinson states we have a certain number in year one, another number in year two, and the GEMA funds will kick in to help us build the entire system out. The FY2009 funds do come out of Trauma budget and have been encumbered for this purpose (through GTRI contract) and must be spent by 31 December 2010. One question that has to be resolved is, from a GEMA perspective; whether they would they want the units in a supervisor's vehicle. We need to clarify to be sure when we go over to use the GEMA funds that this would be in line. We need to clarify the definition of a supervisor's vehicle and how many units each service area would be entitled to as well. Mr. Hinson stated the criteria could be a marked vehicle or other vehicle could qualify as supervisor's vehicle, and if it is not marked, describe the use of the vehicle and the EMS Subcommittee will review definition of a supervisor's vehicle.

Mr. Huey Atkins questioned what happens if we are allocated 250 units but only give out 200. What will happen to the 50 that were not assigned and the money that was allocated to purchase them? Mr. Pettyjohn said the money could probably be applied to increased airtime. Mr. Pettyjohn stated if every Region 5 & 6 service purchased a unit for their vehicles, this would total 239 units. Other areas such as Gold Cross in Augusta, who already has a service, contains approximately 60. Mr. Pettyjohn requested that the Subcommittee begin discussions among themselves on how to define a supervisor's vehicle and add to the October EMS Subcommittee meeting agenda.

Mr. Hinson requested the following information for the next meeting in October.

1. What is the number of units that can be purchased in first round?
2. How many ambulance services in Regions 5 & 6 have ordered the ALVS units?
3. What can the remaining budget be used for once all purchases have been made? Can it be used to purchase additional airtime?

It was suggested that a survey be created to see how many units would be needed to cover each supervisor's vehicle in Regions 5 & 6. We could then identify the number of units/vehicles needed. Mr. Ryan Goodson will provide a written definition and provide this information to Blake Thompson and Lee Oliver.

UPDATE FY 2010 EMS FUNDING PROGRAMS SPENDING UPDATE

First Responder Training/Trauma Care Related Equipment Distribution:

Mr. Courtney Terwilliger reports that the First Responder Training/Trauma Care Related Equipment applications have been sent out and some have been approved. People have until the end of September to apply. The equipment is not a competitive grant. In other words, the services must apply in order to receive the money. Applications will be looked at over the next two days and courtesy calls will be placed to services that have not applied. Please remind everyone in your regions about both programs if you

have not so done already. As soon as the applications have been reviewed, we will invoice the Georgia Trauma Commission with an open amount. Our goal is to have the money in hand the middle of next month so that when grants are done, all we have to do is the math. The director will provide an invoice for the equipment purchased and then a check will be written for reimbursement.

Mr. Pete Quinones questions how the grant will be disbursed depending on whether the provider whether is a one-ambulance county service or multimillion services. Courtney confirms this as yes, that if they are a 911-zoned ambulance, they will get the grant money. The only requirement is to purchase equipment that is not required by the state. Mr. Pete Quinones' stated this is a hard pill to swallow when small services and multi-million dollar services are treated the same.

Mr. Terwilliger stated the First Responder Grant has to be approved before initial money is sent. At the end of the course and after all requirements of the state have been met with ending roster submitted, they will be reimbursed for final teaching costs and the cost of one jump bag for each student who successfully completes the course. Courtney encourages all regions to apply for these when you return home.

EMS Vehicle Equipment Replacement Grant: *(Award list hand out & attached to minutes.)*

Mr. Jim Pettyjohn reported DCH Award Letters have not been received by awardees to date. A work plan has to be submitted for what the money is to be used for then approval by the Trauma Commission will be sought. Once approved, an invoice with copy of approved contract or commitment will be sent to DCH and a check will be issued for up to \$73,000.00 for purchase of a new vehicle or remount of vehicle.

EMS Uncompensated Care Program:

Mr. Jim Pettyjohn reported that as of August 17, 2010, all applications have been filed with one billing service requesting an extension. The commission met and granted an extension thru September 3, 2010. All invoices should have been submitted and are in the hands of MCG. Regina Medeiros will be working over the next two to three weeks accumulating the applications, verifying the claims, and checks will be issued. A full report will be given next month. As of August 17, 2010, there have been 1.2 million in applications submitted.

FY 2011 EMS Uncompensated Care Recommendations:

Mr. Huey Atkins reports that he and Blake Thompson have looked into this issue with emails being sent out to respective providers in their regions and asked them for some feedback on issues that they had. He reports that there were three main issues that kept coming up.

Issue 1: The first issue was ease of the process. There were so many hoops to go through and a lot of services do not know where their patients end up. Whether they transport to a particular facility and someone else transfers to a larger facility, a patient is flown out by helicopter; they do not know which hospital to contact to see where the patient ended up. We need to come up with a simpler process. We know that the data is collected on a statewide basis. Perhaps something as simple as having the trauma registry report back to each service as to where the patient ended up instead of the services trying to figure out where they went could work.

Mr. Ben Hinson states that where we have found a problem is that if the hospital doesn't know which service brought the patient to them, that that is where the breakdown is. If the service did not leave a PCR or if the PCR got misplaced then the state says, under HIPPA, that they cannot give us a list on the traumas registry and we identify what we want, so if there is not a numeric tie, it has been very difficult to match. Another problem is that the Trauma Registry was not designed to keep up with financial

information and that is a problem. Mr. Hinson thinks Mr. Atkins is exactly on, but we have struggled with that and would love to hear a solution.

Mr. Atkins states that JEMSIS is collecting a lot of data as well and suggests that maybe there is a way to cross reference with them. Personally, he feels that if his medics leave a PCR at the hospital and they don't leave the service number and other pertinent information, then they probably shouldn't be reimbursed for that call for lack of paperwork.

Mr. Hinson questions what if the hospital loses it? Mr. Pete Quinones responds to that stating after the first of the year the PCR will be totally electronic and there will be no paperwork and paper issues should go away.

Ms. Renee Morgan states that the Trauma Registry uses one vendor for all hospitals but there are multiple vendors for services. Their data is only as good as the data they receive. She states that when all the kinks are worked out, they should be able to go into the registry and track that patient as to where they ended up. Mr. Ben Hinson states that the hospital has to make sure that the service is noted on paperwork so that the Trauma Registry can match up. Mr. Huey Atkins states it is easier for some services to do that but for counties that have one or two trucks, they do not have the capabilities to follow these patients. In rural areas especially, we are missing out on a lot of money. The intent is to get the money to the providers of services, but the process is so polluted and there is money being left on the table for small services.

Mr. Ben Hinson states that he thinks the solution is for the Trauma Registry to have a way to have the name and date the patient came into the hospital and if EMS was sending all of their stuff to JEMSIS, you could match the name and then send the EMS a note saying this person is on the Trauma Registry and it would be up to us to keep up with it. Back to Mr. Huey Atkins' point, that takes some sophistication at the provider level and we need to be able to find a way that is very simple. If EMS knew when they took a patient through the door and that this patient was on the trauma registry, which would solve a lot of issues. Mr. Rich Bias states we need to be thinking of what the future will be as well as a solution. Hospitals and a number of agencies across the country are all charged with developing capabilities to making changes. Mr. Bias feels that the process is not vendor specific and it must be generic.

Mr. Huey Atkins questioned whether everyone could contact the Trauma Registry and ask where every patient in a particular service ended up, whether or not they meet the trauma criteria or regardless of the hospital. Ms. Renee Morgan states we can pull up service numbers and what hospital the patient went to now, but it would be up to the service to call the hospital to find out end result. Mr. Hinson responds that presently it only captures final agency and not initial agency and questions whether there is another system used other than Trauma Registry. The law says the money is to be used for trauma patients and later on it states trauma patients are those on the Trauma Registry. Mr. Hinson asks Mr. Atkins to look at whether or not we need to redefine that so it is easier to understand. Mr. Atkins replied that in Region 10, National was the only service who applied for it and that the other services stated it was a nightmare trying to understand what needed to be done.

Issue 2: The second issue of concern was having one uniform rate of reimbursement. Mr. Atkins is unclear as to what that uniform rate should be. He suggested that it should follow the Medicare rate with some type of rural modifiers. Mr. Ben Hinson agrees with using the Medicare piece and that is probably the easiest way begin and suggested that everyone see how that works. Another thing is to include the rural modifier for mileage. Another challenge is the people in Atlanta get paid one rate while the rest get another payment rate. We need to decide if this is helping the rural areas and should everybody get paid the same rate.

Mr. Pete Quinones states we need to simplify the process. Mr. Hinson agrees that if everybody gets paid the same, send them the fee schedule, everyone would have to send in the procedure code, but that could be run through a screen and easily assigned the numbers. This would solve a lot of discussion so

we are saying we are going with looking at the Medicare rate plus Medicare mileage rate-use the differential according to Medicare to help the rural people.

Issue 3: Mr. Huey Atkins states that many services on Georgia state borders must take patients to larger facilities outside the State of Georgia, due to no fault of their own, and they feel they are getting penalized by not qualifying for reimbursement because of crossing the state line. There needs to be some process for these services to get some reimbursement. Mr. Atkins states he is not sure what the criteria are. Mr. Pettyjohn states it has to be to a Georgia designated trauma center. Mr. Hinson states that this is what the Trauma Commission says. Mr. Atkins requests assistance in this area as they have not had any success in recouping expenses as his service area is in a part of the state where many patients go out of the state.

Mr. Rich Bias questions that if we believe this is important and makes sense, then we need to look at ultimately extending our boundaries with specifically identified sites, possibly asking the commission to consider these sites by thinking beyond the Georgia boundaries.

Mr. Huey Atkins questions whether services from bordering states that bring patients into Georgia receive payment. Mr. Ben Hinson states you must be a licensed Georgia service but that is a valid question. Mr. Ben Hinson states we need to investigate the law and see if the definition of a trauma patient says Georgia Trauma Registry transports to a Georgia Trauma Center and we need to look at that. Dr. Ashley, Georgia Trauma Commission Chairman, added that before the first budget was approved, Erlanger Hospital from Chattanooga, TN was inquiring how they could get some of the Georgia Trauma money. When the communication center gets going and if Erlanger provides the care in northwest Georgia and we exclude them from participation, we have a dark spot up there that is not getting the advantage. Mr. Atkins states he believes that if you limit it to Georgia based providers; again, you have those services surrounding Georgia.

Mr. Ralph McDaniel added that we need to look at facilities outside of Georgia to receive potential reimbursement for Georgia ambulances services transporting outside of Georgia, if they are bypassing Georgia facilities, I think we have to say that we cannot approve those dollars if you are bypassing Georgia when we are talking about trauma center. Mr. Jimmy Carver questions are you talking about a facility you are bypassing that cannot provide the care the patient needs? Is it a lower level? Mr. Blake Thompson states there are counties such as Elbert, Hart, Stephens, Franklin and others that transport to Greenville, South Carolina.

Mr. Ben Hinson questions Mr. Atkins if we need to take action on this. Mr. Atkins thinks that everyone agrees that we would like to pay for the transport to the out-of-state centers if we could figure out how to do it. It was suggested that Mr. Atkins investigate options with Ms. Renee Morgan and he will get further information in writing and e-mail to everyone. Mr. Hinson thanks Mr. Atkins for his work on this.

GEORGIA TRAUMA COMMUNICATIONS CENTER (GTCC) PRESENTATION: *(attached to minutes)*

Dr. Dennis Ashley emphasized the tremendous amount of work that has been done over the last 1-1/2 year in developing the Trauma Communications Center. There have been so many changes, meetings, emails, etc. He stated how the AVLS program is totally independent from the GTCC and are two totally separate programs. If the AVLS program, for some reason went away tomorrow, it would not affect the development of the GTCC. Dr. Ashley added how future may involve those two projects coming together as technology evolves. I will turn the program over to Ms. Linda Cole for her presentation.

Mr. Ben Hinson introduced Ms. Linda Cole, Chair of the GTCC Subcommittee and Georgia Trauma Commission member, to present the Georgia Trauma Communications Center presentation.

Discussion highlights from PowerPoint Presentation:

- Looking at BREMSS, which is a voluntary trauma system in the Birmingham, Alabama Region that began in 1996, we felt we could use their information to model the Georgia Trauma Commission.
- Beginning a pilot program in Region 5 and Region 6.
- We will be evaluating this pilot program after the first year with focus on recommendations for Framework improvement and GTCC operational improvement.
- Establishing a Regional Trauma Advisory Council, which will develop and implement a Regional Trauma System Plan.
- The GTCC will coordinate the transport needs of EMS providers with the capacity of all Trauma Centers.
- Maintaining a Trauma Center Communications database with updated and current information for all resources that are available.

Mr. Hinson discusses ways of how to make sure the hospitals keep their information current and up-to-date and with the resources we have now, we should be able to manage this. We also have to find a way to keep it updated with hospital participations. Mr. Hinson states that we are beginning to see how this can be real value and we can't overload the medic with data.

Ms. Linda Cole presents a scenario with a 911 call, which describes each step of the decision process of whether or not the patient meets GTCC criteria. *(A copy of the handout is attached as "Primary Triage Decision Scheme".)*

Ms. Linda Cole states they have completed the framework and the pilot project has been approved. We are at the point of working with Region 5 and Region 6 to start the pilots. One of the things we recognized in order to do this, the regions need resources to do it. The Trauma Centers nor EMS Council do not have the extra resources to pull this off. We need funding. Our biggest challenge is how do you get funding from the Trauma Commission to the region. We looked at several avenues and found challenges with each. We are developing a contract with MCG and MCCG with Region 5 and Region 6 because we can transfer the funds to them and they have agreed to administer 100% of the funds without an administrative fee *(see Agreement Attached)*. Their goal would be to work closely with the EMS regions and their councils in their area to begin developing a regional trauma advisory council and then create regional trauma guides. Each region will have their own set of issues; some will be inbound, some will be outbound.

Mr. Rich Bias states that within his region, the EMS Advisory Council prohibits out-of-state agencies from being part of the council. Ms. Cole responds that this could be a sub-committee or separate group. Configuration of logistics are needed on how to get representation on that council, work through the EMS council, and report to OEMS and Trauma Council. Mr. Ben Hinson is confident this EMS group would be beneficial in this area since they have fought those battles with the regional EMS council. Ms. Cole states this representative must be able to communicate with the hospitals and larger groups as well.

Mr. Scott Sherrill discusses the TCC physical location. We are presently working on obtaining a signed agreement at the GPSTC site. We have met with them and they indicate a willingness to house us and toured a physical location within GPSTC. We will be located at the old fire training facility near the racetrack and the TCC will be the occupant in that building. We hope to have our Software RFP this month and realistically speaking, hope to have the winning vendor selected and contract awarded by the end of the calendar year with 60-day implantation. We are looking at opening sometime within a February/March timeframe. That is where we stand in terms of logistics.

Mr. Rich Bias makes a suggestion since, a solid decision for site location has been made, to request there be communication with Columbia County as it is on their upcoming commission meeting agenda and we ought to let them know we are proceeding elsewhere. Mr. Scott Sherrill asked Ryan Goodson to be in touch with their EMA Director regarding this. Mr. Ben Hinson states that we need to push to get a signed contract before we pull the plug with Columbia County. Mr. Scott Sherrill states that would be a good idea even though he does not anticipate any problems.

Ms. Linda Cole responds to the question of whether or not there has been discussion as to how rotor services fit into this plan by stating that they have talked a little bit about it that they would be treated like an EMS unit on scene. Ms. Cole also states she does not anticipate a delay with the ground unit while they are awaiting their assignment.

Mr. Lee Oliver questions what communications media will be used. Mr. Scott Sherrill states that radio and telephone will be used. EMS providers will contact TCC directly and if they cannot, they will contact their local dispatch center and be then patched through. Mr. Scott Sherrill confirmed they anticipate there will be a designated frequency in the future.

Mr. Ben Hinson states there are a lot of pieces that we will be looking at as we go forward. There will have to be some discussion regarding contacting the TCC, whether it be through cell phone, Southern Linc, etc. Every conversation with the TCC will be recorded, and you will have access to this. Testing this process in a pilot program will give us an idea of the demographics and how it will work. Ms. Linda Cole states that the medic on scene can override the TCC where the patient goes. No matter what the TCC suggests, the bottom line is the medic can override this. Mr. Ben Hinson states that we have to leave that decision with the medic.

Mr. Huey Atkins asked if there are goals in place after the first year pilot program is over and have we set criteria that would consider this program to be successful. Is there an exit strategy? What is the plan? Mr. Ben Hinson responds that Mr. Atkins has a good point and we don't anticipate the entire idea failing. This is why we are completing in small steps and we have a better shot at making good progress doing it in small steps such as Region 5 and 6. Mr. Rich Bias also responds that Region 5 and 6 are a good starting point since they are overlapping regions. Ms. Linda Cole responds that accountability is part of this program's objective. The exact criterion has not been established today, but will be with the help of the regional advisory councils

MOTION EMS Subcommittee 2010-9-07-02:

I make the motion that this sub-committee makes a recommendation to the Georgia Trauma Commission that they develop outcome studies and quality assurance studies on everything the Trauma Commission does to measure value of this investment of the Trauma System.

MOTION BY: Mr. Pete Quinones
SECOND: Mr. Ralph McDaniel
ACTION: The motion **PASSED** with no objections, nor abstentions.

DISCUSSION: Mr. Blake Thompson questions, "is this all trauma work or just EMS?". Mr. Quinones responds that this is all trauma work. Mr. Blake Thompson directs question to Linda Cole if the TCC would have a problem with the Trauma Commission as a whole. Ms. Linda Cole responds that they don't have a problem with it and that it is a challenge as to what data. Mr. Pete Quinones questions data from the pilot. Ms. Linda Cole responds absolutely. She states that when she looks at it this is the best place to start. Mr. Pete Quinones states, "does it save lives, does it reduce days in the hospital?". Ms. Linda Cole states we have a lot of data and we need the resources to pull that data so I agree that we are all on the same page.

Mr. Ben Hinson responds again to Mr. Atkins point about "how you will know if this will work". The comment was made, when it gets down to one phone call and that simply says the system is working. Mr. Quinones' concern is in addition to being consistent to saving lives; let's reduce mortality and morbidity. Mr. Pete Quinones states this should be our mission. Mr. Chad Black states that he feels the biggest missing info is going to be from the medic on the scene and they don't call because they will not want to call the TCC to let them know where they transport the patient. Dr. Dennis Ashley stated this is an excellent motion.

ACTION: The motion **PASSED** with no objections, nor abstentions.

Rotor Wing Services:

Mr. Ben Hinson states there was an email sent out to the group regarding questions about the rotor wing industry and Mr. Ralph McDaniel and Mr. Chad Black responded to my questions. I asked Mr. McDaniel if he has any comments and that my goal is to make a sub-committee out of this group to include and Mr. Chad Black and Mr. Ralph McDaniel as Chair. This sub-committee will look at how we can impact the trauma care of Georgia with the helicopter resources including what we should do and what we need to look at. We wanted helicopters involved at the very start but we haven't had a firm ground to stand on.

Mr. Ralph McDaniel states this group would use its influence to move licensure and regulations on helicopter services forward before we proceed because nobody in the State of Georgia has any influence on the helicopters in Georgia due to non-licensure. Mr. Ben Hinson questions "where does the process stand right now on the licensure?". Mr. Ralph McDaniel reports that from a legislative prospective, licensure was to begin as of 01 June of this year; however, there are no regulations established or licensure requirements. Mr. Mark Chapman, CHOA, states that licensure has started in Georgia and that on 02 September 2010; CHOA was inspected and issued a license. All the Rules and Regulations are included on the State web site.

Mr. Ralph McDaniel directs a question to Russ McGee as to what is the requirement for non-license helicopter services to operate in Georgia. He also suggests that the committee needs to meet to discover the facts.

Mr. Ben Hinson states that we will hold all further discussions on this until the next monthly meeting. Mr. Ben Hinson also stated that they are trying to get income and outcome data on a helicopter study. He encourages everyone to look at the information sent out.

FY 2011 EMS Vehicle Equipment Replacement Grants Awards Program recommendations:

Mr. Courtney Terwilliger reports that he sent out a document two months ago and re-sent one month ago with subject recommendations. Mr. Terwilliger makes the following motion:

MOTION EMS Subcommittee 2010-9-07-03:

I make the motion that this document is passed as a recommendation to the Georgia Trauma Commission. With some clarification, any 911 service can apply for this grant money since there are some services that do not hold a zone-hospital holds zone. Requirement would be if they provide the 911 service, then they would be available for funding. The other caveat would require the purchase or delivery of the EMS vehicle, which is July 2010 through June 2011.

MOTION BY: Mr. Courtney Terwilliger

SECOND: Mr. Lee Oliver

ACTION: The motion **PASSED** with no objections, nor abstentions.

DISCUSSION: Mr. Pete Quinones asked if a \$B (billion) provider would have the same eligibility as a small service. Mr. Courtney Terwilliger said this is an example of what the committee would need to review. Mr. Ralph McDaniel questions where does the financial need fit. Mr. Terwilliger responds in the subjective criteria, (how much county is putting into program, should state subsidize that service, what is the need for this county based on population, distance from trauma center, how many ambulances should a county have, how much does it cost to run it?). Mr. Huey Atkins states that you can have two identical county services with one service being run efficiently and the other not, so are you going to award an ambulance to the one that is not ran efficiently?

Mr. Ben Hinson states that one of the challenges is to look at the percentage of county budget allocated to EMS. If they have a high percentage of the budget, are they committed to helping, or if they help very little, do we need to help the EMS system and give them an ambulance? Mr. Courtney Terwilliger responds with the question that should an inefficiently run service get the same dollars for ambulances that apply and get the same score as other services that are efficiently run. We want to make sure that the resources are used wisely. Our goal is to put the vehicles where they need to be.

Mr. Jim Pettyjohn asked whether the county tax digests are readily available or the county subsidy available. Mr. Ben Hinson states that the county subsidy could be tough.

Mr. Pete Quinones expressed that the financial need must be demonstrated. Mr. Courtney Terwilliger states that this would be a subjective criterion. Mr. Jim Pettyjohn states this is the third year we are doing this; we need to identify criteria up front, we need to be more objective and up-front, and can we look at years 1 and 2 and take what was good for these and build off this. The state agency criterion has been clear. Mr. Pete Quinones states in order to be fair, we need to ask them to show financials for all services. Mr. Jim Pettyjohn responds that in January of last year we lost complete control and how in January he received an email to cease and desist conversations on any of this and that DCH was taking the selection process over. Mr. Pettyjohn never saw one application. I have seen only the same sheets that I have shared with you. Why can't we repair what happened last year? We need to have subjective pieces in the process.

Mr. Rich Bias states he appreciates what is being said but if we do not have subjective criteria in place, we will fall flat at next level. Mr. Courtney Terwilliger states that the first year was subjective and the second year was not.

Mr. Rich Bias states that everything about the first year was learning opportunities and there were things done in various arenas by the commission in its new life that weren't possible going forward and there has got to be total transparencies. I would encourage us, as much as possible, to find those elements concretely on the front end in a way that we are comfortable with and get as close to that as possible. Otherwise the subjective process, I think, opens the door for legal action by anyone who didn't receive. Mr. Ben Hinson added that the challenge we have is trying to get one size fits all because EMS is so different all over the state and trying to get vehicles appropriately is difficult to do. I think the subjective piece at end is a good thing, but I understand why the DCH people want it absolutely objective Mr. Huey Atkins states he sees no way to do the process that makes everybody happy.

Mr. Jim Pettyjohn responds what if we use the same criteria this year as the second year, but limit one ambulance per service, one ambulance per 911 zone? Limit only one per agency and one per 911 zone. Mr. Courtney Terwilliger states that if you got one last year, maybe you shouldn't get one this year.

Mr. Ben Hinson states this is the motion on the table and it has been seconded.

Mr. Rich Bias states the way this is written allows a lot of opportunity between approval of this recommendation and turning it into "whatever". As much as I am hearing a strong voice to address the rural areas of the state there is nothing to prevent whether it is subjective or objective, this sub-

committee making very concrete recommendations about weighting the scoring criteria, looking at distance, looking at population, but we weren't concrete about areas that were just black holes of coverage. I would prefer something more concrete from this group in line with this.

Mr. Ben Hinson reports that one of the big challenges with this is that when you get a GEMA grant is to increase capacity and in all the vehicles we have done. We have not increased capacity at all. Mr. Courtney Terwilliger interrupts and states that at the end of day when you put extra ambulances in counties, you have increased capacity. If a service has a vehicle that doesn't crank and the one we gave those does, we have increase capacity. Mr. Hinson agrees with this point. Mr. Huey Atkins states that this is just an observation but if you eliminate the subjective portion of this then everybody is in agreement with remainder.

Mr. Rich Bias asks for clarification on who constitutes the objective group. He states he is real clear on what constitutes subjective. Mr. Courtney Terwilliger responds with the same group as last year.

Mr. Bias questions, "is it through DCH or the Commission having to follow DCH guidelines?" Mr. Pettyjohn responds we can do either. My recommendation is that we use a modified approach where we are there guiding the process, utilizing their services, their capabilities to issue out and receive the applications, gather them together, while they are not the leadership of the program but they are providing administrative support to the commission.

AMENDED MOTION EMS Subcommittee 2010-9-07-03:

Mr. Ben Hinson states there is a motion on the table to adopt as distributed with two amendments; one being 01 July 2010 to 30 June 2011 Purchase Order or delivery date to qualify; and two, under the subjective criteria, financial need can be a consideration that the financial need can be demonstrated.

MOTION BY: Mr. Courtney Terwilliger

SECOND: Mr. Lee Oliver

ACTION: The motion ***PASSED*** with objections by Mr. Rich Bias and Mr. Ralph McDaniel; Abstentions from Mr. Chad Black and Mr. Ben Hinson

New Business: None

Next Meeting: Mr. Hinson reported the next meeting is scheduled for Tuesday, 05 October 2010 in Macon, Georgia.

Meeting adjourned at 12:45.

Minutes crafted by Shawn C. Hackney and Carol Dixon

Region 6 - AVLS

Provider's Name	Zoned Y/N?	Director	Telephone	# of Licensed Vehicles	Base Location USPS address	Contact Email	MOA	Order Forms Received	Schedule B	RSVP to user conference	Rep. Attend User Conf?	Units received	
Warren County EMS	yes	Tommy Wolfe	706 465 3351	3	PO Box 46, 169 Highway 80 North, Warrenton Ga.	warrenoes@classicsouth.net	received	received & forwarded to GTRI	received	yes	yes	3	
Gold Cross EMS, Inc.	yes	Frank Lindley	706 860 9100	39	1109 Medical Dr., Bld 4, Augusta, Ga. 30909	frank@goldcrosssems.com		will not participate			no		
Emanuel County EMS	yes	Courtney Terwilliger	478 237 6809	5	PO Box 879, 117 Kite Rd., Swainsboro, 30401	cterwilliger@emanuelmedical.org	received	received & forwarded to GTRI	received	yes	yes	5	
Lincoln County Dept. of Public Safety	yes	Casey Broom	706 359 5518	3	160 School St., Lincolnton, 30817	cbroom@lincolncountyga.com	received	received and forwarded to GTRI	not received as of 01 September. Calls and emails out.	yes	yes	3	
Screven County EMS	yes	Gary Pinard	912 564 7889	4	318 Frontage Rd.West, Suite B, Sylvania, 30467	garypinard@gmail.com	received	Received and forwarded to GTRI	received	yes	yes	4	
McDuffie County EMS	yes	Tim Edwards	706 597 5385	6	521 Hill St., Thompson, 30824	tedwards@mrmc.org	received	received aand forwarded to GTRI	received	yes	yes	6	
Wilkes County EMS	yes	Blake Thompson	706 678 7837	5	105 Marshal St., Washington, 30673	wilkescountyems@lycos.com	received	received & forwarded to GTRI	received	yes	yes	5	
Jefferson Co. EMS	yes	Paul Bryant	912 625 3332	1	1067 Peachtree St., Louisville, 30434	jpcpbryan@bellsouth.net		Covered by Gold Cross			no		
Burke County EMA Agency	yes	Rusty Sanders	706 554 6666	12	277 Highway 24 South, Waynesboro, 30830-4579	rsanders@burkecounty-ga.gov	received	received and forwarded to GTRI	received	yes	yes	12	
Jenkins County EMS	yes	Henry Young	478 982 1133	3	1019 E. Winthrope Ave., Millen, 30442-1600	jenkins_ems@bellsouth.net	received	received & forwarded to GTRI	received	yes	yes	3	
Augusta Fire Department	yes	Howard Willis	706 821 2909	2	3117 Deans Bridge Rd., Augusta, 30901	hwillis@augustaga.gov		Mr Willis;" We only have two units and are only back up to Gold Cross. We will not participate.			no		
Total				83								Total	41

Trauma Commission Approved: FY 2010 EMS Vehicle Equipment Replacement Grant Awards

Number	Organization	Vehicle	Administrative Review	Population Density (Self Reported)	Population Density (Validated)	Distance Points (Self Reported)	Hospital Bed (Self Reported)	Hospital Bed (Validated)	Mileage (Self Reported)	2009 Grant (Self Reported)	2009 Grant (Validated)	Vehicle Age (Self Reported)	Vendor Score (Self Reported)	Confirmed Score
1	Quitman County	2001 Ford Type 11	Y	60	17.1	65	0	0	335,649	X	N	9	162.20	205.75
2	Johnson County (2)	1997 Ford E350 XLT	Y	31	28.1	95.7	0	0	168,361			13	182.94	182.94
3	Clinch County (2)	1995 Ford E350	Y	8.5	8.5	108	25	25	144,532			15	181.90	181.90
4	Clinch County (3)	1990 Ford Econoline 350 Van	Y	8.5	8.5	108	25	25	54,955			20	181.90	181.90
5	Dade County (1)	2003 F450 Coach	Y	87	87.1	55	282	0	252,051			8	139.62	173.82
6	Wayne County	1999 Ford F-350	Y	44.75	41.2	90.82	84	84	184,268			11	169.47	169.47
7	Pike County/ Mid Georgia Ambulance, Inc.	1997 Ford F350 Type 3	Y	76.92	62.7	48.8	0	0	312,184	X	Y	13	166.23	167.53
8	Murray County	1998 E350	Y	106	106	31	42	36	229,783			12	164.49	164.49
9	Lanier County	1996 Ford F-350 Type 1	Y	36.3	38.6	72	25	25	132,921			14	164.41	164.41
10	Telfair County	2001 Ford E350	Y	36.7	26.7	95	0	0	264,859	X	Y	9	164.27	164.27
11	Toombs County	2003 Ford E3500	Y	75	71.1	107	87	69	305,640	X	Y	7	159.92	163.68
12	Burke County (2)	2000 Ford E350 Type II	Y	26.8	26.8	59.59	40	40	317,290	X	Y	10	161.62	161.62
13	Treutlen County	2000 Ford F350	Y	34.1	34.2	88.3	0	0	129,522			10	158.71	158.71
14	Upson County (2)	2002 Ford E450	Y	84.8	84.8	61	115	115	236,278			8	157.58	157.58
15	Webster County	1998 Ford E350	Y	10.9	11.4	65	0	0	131,231			12	157.45	157.45
16	Towns County (2)	2001 Ford 350	Y	60	56	103	23	28	150,000			9	143.00	156.50
17	Decatur County	1997 Ford, Type 1	Y	47	47.3	75	80	80	128,528			13	156.48	156.48
18	Brooks County/Regional EMS	2000 Ford F350 Type 1	Y	33.3	33.3	42	25	25	320,476	X	Y	10	156.18	156.18
19	Turner County	1999 Intl Model 4400	Y	33	33.2	94.88	0	0	222,533	X	Y	11	155.90	155.90
20	Catoosa County / Angel EMS	1992 Ford F-750	Y	328	328.5	112	195	195	178,007			18	155.70	155.70
21	Calhoun County	2001 Ford F350	Y	22.55	22.6	84.05	25	25	162,523			9	155.44	155.44
22	Union County (1)	2001 Chevrolet 3500	Y	64	53.6	92	45	60	165,552			9	157.97	154.87
23	Upson County (1)	2002 Ford E450	Y	84.8	84.8	61	115	115	227,761			8	154.58	154.58
24	Union County (2)	2003 Chevrolet 3500	Y	64	53.6	92	45	60	181,932			7	156.17	153.07
25	Burke County (3)	1997 F350 Type 1	Y	26.8	26.8	59.59	40	40	242,386	X	Y	13	152.58	152.58
26	Meriwether County (1)	2000 Ford F450	Y	46	44.8	77.1	25	25	242,966	X	Y	10	151.26	151.26
27	Burke County (1)	1995 Ford E350 Type II	Y	26.8	26.8	59.59	40	40	215,544	X	Y	15	150.82	150.82
28	Clinch County (1)	2003 Ford E450	Y	8.5	8.5	108	25	25	115,168			7	150.70	150.70
29	Evans County	2002 Ford F350	Y	61	56.7	70	49	39	177,558			8	150.01	150.01

Commission approved: 15 July 2010

Commission Approved 19 August 2010

All Applications were reviewed and scores determined solely by DCH Procurement and Grants Administration

Trauma Commission Vehicle Grant

General Considerations

- Only one vehicle will be awarded per zone on any given year. The grant will also be capped at two units per any one agency per year.
- If an ambulance is awarded to a 911 zoned provider then any grant application for the next fiscal year's award will be scored under the grant applications received from providers who did not receive an award in the previous fiscal year.
- This restriction will be lifted for the next fiscal year.
- The grant will only be awarded to the primary 911 provider in the zone.

Objective Review Committee

There will be an objective review committee which will review the grant applications to insure that information on the grant application is accurate and the vehicle is eligible for replacement. This group will develop a scoring spreadsheet based on the objective criteria in the grant. The Executive Director of the Trauma Commission will facilitate this committee. The makeup of the committee will be recommended by the EMS Subcommittee and approved, or changed by the Trauma Commission. This spreadsheet will be delivered to the Chairman of the Subjective Committee as soon as possible.

Objective Criteria

- Hospital Bed Capacity
- Population Density
- Distance to Level I or II Trauma Center
- Vehicle Mileage

Subjective Review Committee

There will be a subjective review committee appointed to review grants after the objective scoring of the Grant. This committee will be made up of persons with expertise in EMS, County Government, State procurement and Trauma data. The Chairman of this group will be a member of the Trauma Commission who has no conflict as to the awards of these grants.

Subjective Criteria (suggested)

- County Subsidy per capita
- County Tax Digest
- Current Staffing Pattern (number of staffed units per population or area)
- Percentage of County Budget allocated to EMS

Subjective Review Committee

- Must be independent of any grant applicant
- Knowledgeable concerning EMS profession
- Knowledgeable concerning County operations and capabilities

Suggested membership on Subjective Review Committee

Director of the State Office of EMS

Selected Regional Program Manager (with detailed knowledge of grant a
applicants)

Representative from the ACCG

Director Office of Trauma

Member of the Trauma Commission


Representative from the DCH

The Progress

1. Objective Criteria is reviewed by EMS Sub-Committee of the Trauma Commission. This sub-committee will recommend criteria for the objective scoring of the grants. The Trauma Commission will approve these criteria or recommend changes to the document. The Trauma Commission, by majority vote will determine the criteria used for the grant awards
 2. The EMS Sub-Committee of the Trauma Commission will recommend names to the full Trauma Commission for the subjective committee. Committee chair will be a member of the Trauma Commission with no conflict concerning the selection of the grant winners. The Chairman of this group will be responsible to report to the Trauma Commission the list of grant awardees. The selection of these awardees will be made by the subjective committee in a manner agreed to in advance by the members of the committee. This selection method will be determine and agreed upon before any grant documents are reviewed. This method should be used throughout the process unless there is a unanimous agreement of the group to change the selection method.
 3. Grant application is developed and sent to EMS Community with a set time frame for return of the application.
 4. Grants are received by the Executive Director of the Trauma Commission.. These should remain sealed and given to the Independent evaluation committee as soon as possible after the grant application date is closed.
 5. Independent group meets to insure that all applications meet criteria.
 - a. Information contained in the application will be verified using independent information sources to insure the accuracy of the grant
 - b. Vehicle information, including mileage, VIN and VID will be validated by the Regional Program manager. A document to be used by the Regional Program manger to validate this information will be developed and will be a part of the grant package.
 - c. The application will be validated to insure that the vehicle listed in the application is a qualified unit for replacement. This includes: listed as a currently licensed vehicle, has not be “replaced” by previous grant awards
 6. This independent group will score the documents and provide a spread sheet of the validated scores to the subjective committee.
 7. The Subjective Committee will utilize this scoring sheet as a start for their decision on grant awards. The Subjective committee may move vehicles up or down on this listing depending on their perceived needs of the county involved.
 8. The Trauma Commission will review and, if appropriate, vote to award the grants based on the work of the two groups
- It is the desire of the grant process to improve the ability of the EMS agency to care for trauma victims in this zone therefore these vehicles should be dedicated to the 911 zone. In the event that an agency feels a need to move the vehicle out of this zone then this need will be reported to the Trauma Commission. The Trauma Commission will determine to resolve this issue



Georgia Trauma Commission



Commission formed December 2007

Current Members:

- **Dennis Ashley**, chair – Trauma Surgeon, The Medical Center of Central Georgia
- **Kurt Stuenkel**, vice-chair – CEO, Floyd Medical Center
- **Linda Cole**, secretary/treasurer – VP, Trauma and Emergency Services, Children’s Healthcare of Atlanta
- **Joe Sam Robinson** – Neurosurgeon, The Medical Center of Central Georgia
- **Rich Bias** – VP, Ambulatory and Network Services, The Medical College of Georgia
- **Leon Haley** – Medical Director of Emergency Services, Grady Memorial Hospital
- **Kelli Vaughn** – Trauma Coordinator, Archbold Memorial Hospital
- **Bill Moore** – CEO, Atlanta Medical Center
- **Ben Hinson** – Owner, Mid-Georgia Ambulance Service

Jim Pettyjohn – Commission Executive Director

Year 1 Priorities



- Obtain Permanent Funding
- Expand Georgia's Trauma Centers
- Strengthen EMS
- **Develop a Statewide Trauma Communications Center**
- Build Trauma System Infrastructure
- Establish Mechanisms to Assure Exceptional Accountability

BREMSS



- Voluntary trauma system started in the Birmingham Region in 1996
- Between 1996 and 2005 over 23,000 patients treated for major trauma
- 12% decrease in the death rate from trauma in this region during this time
- Decrease average length of stay for ISS 15+
from 16 days to 9 days
- No change for the rest of the state

Pilot Project for Georgia Trauma System Regionalization



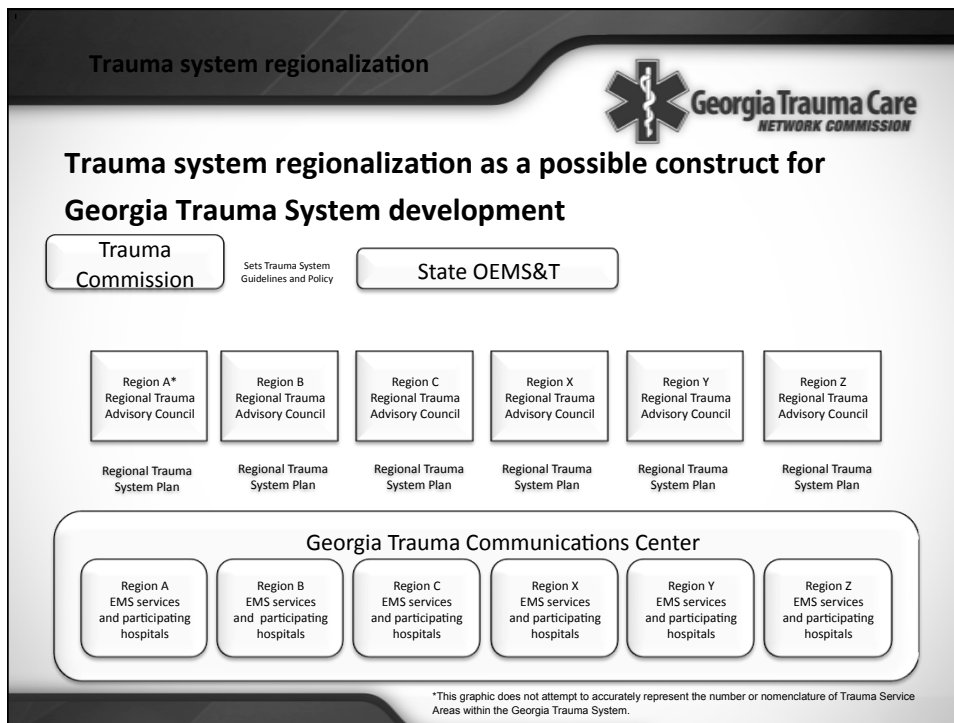
- **Oversight:** Will be funded and developed by the Trauma Commission; Department of Community Health-Office of EMS and Trauma will provide regulatory oversight
- **Timeline:** One-year period
- **Location:** EMS Region 5 and 6
- **Evaluation:** Will be evaluated after the one-year period with focus on recommendations for Framework improvement and Georgia Trauma Communications Center operational improvement

Pilot Project for Georgia Trauma System Regionalization



The proposed pilot will introduce:

- Trauma system regionalization
- A Regional Trauma Advisory Council
- A Regional Trauma System Plan developed using the Regional Trauma System Planning Framework
- **The Georgia Trauma Communications Center**



Regional Trauma Advisory Council

Georgia Trauma Care NETWORK COMMISSION

A Regional Trauma Advisory Council

- Council comprised of regional trauma system stakeholders
- Will develop and implement a Regional Trauma System Plan
- Will oversee continued function of Plan and conduct regional performance improvement

Participating hospitals and regional stakeholders



Participating hospitals and regional trauma system stakeholders

- All stakeholders have a role to play in the regional trauma system, including
 - Trauma Centers,
 - Non-designated participating hospitals,
 - EMS,
 - Physicians,
 - Hospital leadership,
 - Local government, and
 - The public
- **Trauma Centers** will admit patients who meet standardized Trauma System Entry Criteria (TSEC)
- **Non-designated participating hospitals** will admit lower-acuity patients per service line availability


Regional Trauma System Plan



A Regional Trauma System Plan developed using the Framework

- Provide a comprehensive regional trauma care system
 - Ensure care for patients from the moment of injury through rehabilitation
 - Utilize existing resources and working to fill any identified gaps
- Develop and implement a regional program for injury prevention
- Framework recommends
 - Component and organization standards,
 - Protocols for regional trauma system function, and
 - Process for regular Plan revision


Georgia Trauma Communications Center



The Georgia Trauma Communications Center will:

- Coordinate the transport needs of EMS providers with the capacity of all Trauma Centers
- Assign a unique System I.D. to patients meeting Trauma System Entry Criteria
- Maintain Trauma Center Communications Database,
- Recommend patient destination based upon RAD status and regional protocols
- EMS makes the final transport decision

TCC

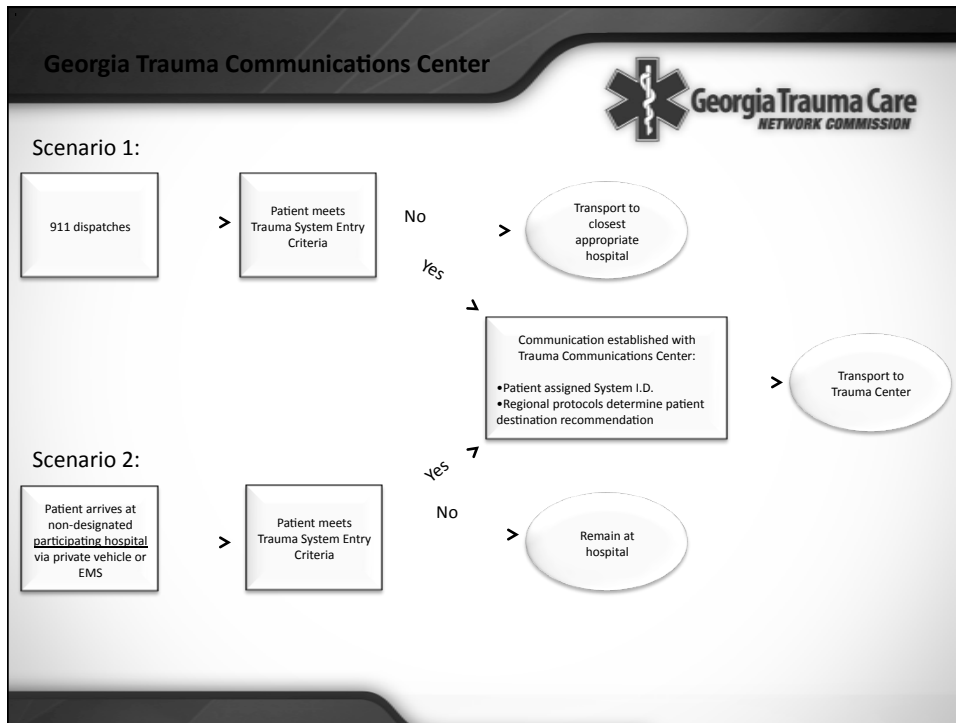


LifeTrac™ Version 4.0rc1 © 1996-2008 by LifeTrac Technologies - LCC - Status

Status Patients Bio/Chemical Reports Messages EPI EPI Disaster About CENTRAL

	Systems			Cardiac, Stroke and Trauma System Resources																
	T	S	C	ED-T	ED	ANES	OR	X-RAY	TICU	TS	SS	OS	NS	CT	SICU	Neuro	CCU	Card	CLab	
Brookwood	3																			
Carraway	3																			
Childrens	1																			
Cooper Green	4																			
Medical Center East	3																			
Princeton	3																			
Shelby	3																			
St. Vincents																				
Trinity	3																			
UAB Highlands																				
UAB Medical West	3																			
University	1																			
VA Bham	4																			
Walker	3																			

Helicopters Change Status





Questions?

Pilot Project White Paper
and Framework can be downloaded at
www.gtcnc.org

PRIMARY TRIAGE DECISION SCHEME*

GEORGIA TRAUMA SYSTEM

1

Measure vital signs and level of consciousness

Glasgow Coma Scale	≤ 13 or
Systolic blood pressure	< 90 or
Respiratory rate	< 10 or > 29 (<20 in infant < one year)

YES

NO

Steps 1 and 2 attempt to identify the most seriously injured patients. These patients meet *Georgia Trauma System Entry Criteria*.
Take to a trauma center.

Assess anatomy of injury

2

- All penetrating injuries of the head, neck, torso, or groin associated with an energy transfer
- Flail chest
- Two or more obvious proximal long-bone fractures
- Crushed, degloved, or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvic fractures, as evidenced by a positive exam
- Open or depressed skull fracture
- Paralysis

YES

NO

Steps 1 and 2 attempt to identify the most seriously injured patients. These patients meet *Georgia Trauma System Entry Criteria*.
Take to a trauma center.

Assess evidence of high-energy impact

3

- Falls**
- Adults: > 20 ft. (one story is equal to 10 ft.)
 - Children: > 10 ft. or 2-3 times the height of the child
- High-Risk Auto Crash**
- Intrusion: > 12 in. occupant site; > 18 in. any site
 - Ejection (partial or complete) from automobile
 - Death in same passenger compartment
 - Vehicle telemetry data consistent with high risk of injury
- Auto v. Pedestrian/Bicyclist Thrown, Run Over, or with Significant (>20 MPH) Impact**
- Motorcycle Crash > 20 MPH**

YES

NO

These patients meet *Georgia Trauma System Entry Criteria*.
Take to a trauma center.

Assess special patient or system considerations

4

- Age**
- Older Adults: risk of injury death increases after age 55
 - Children: Should be triaged preferentially to pediatric-capable trauma centers
- Anticoagulation and Bleeding Disorders**
- Burn**
- Without other trauma mechanism: Triage to burn facility
 - With trauma mechanism: Triage to trauma center
- Time Sensitive Extremity Injury**
- End-Stage Renal Disease Requiring Dialysis**
- Pregnancy > 20 Weeks**
- EMS Provider Judgment (to include known patient medical history)**

YES

NO

These patients meet *Georgia Trauma System Entry Criteria*.
Take to a trauma center OR other appropriate hospital identified in protocols.

Transport according to protocol

*Adopted largely from the National Trauma Triage Protocol of the U.S. Department of Health and Human Services Centers for Disease Control and Prevention

When in doubt, transport to a trauma center.

Trauma System Regionalization Agreement

Overview:

This document represents an agreement to be added to the FY 2011 Readiness and Uncompensated Care Contract between Georgia Trauma Commission (GTCNC) and “trauma center” for \$75,000.00 in return for (trauma center) fulfillment of the objectives, tasks, activities and deliverables associated with this agreement. Subsequent year funding will be determined. For FY 2011, the trauma centers identified for this regionalization agreement are: The Medical Center of Central Georgia (EMS Region 5) and The Medical College of Georgia (EMS Region 6).

Acceptance of this agreement constitutes a specific EMS Region’s participation in the **Pilot Project for Georgia Trauma System Regionalization**. The tasks, activities and deliverables associated with this agreement will fulfill the Pilot Project objectives of:

- 1) Established Regional Trauma Advisory Council
- 2) Regional implementation of a Regional Trauma System Plan
- 3) Regional and full participation in Trauma Communications Center (TCC) activities

GTCNC expects (trauma center) will accomplish the tasks, activities and deliverables associated with this agreement by working in collaboration with the EMS Region (region number) Program Office. Although this is a collaborative relationship, fiduciary responsibility and the obligations of the agreement rest with (trauma center). It is also expected all objectives, tasks, activities and deliverables associated with this agreement will be assigned to and managed primarily within each trauma center’s Trauma Service program.

Conditional Nature of Agreement

This agreement is only valid upon (trauma center) submittal and GTCNC approval of a (trauma center) Proposal for Pilot Project Implementation. An acceptable proposal will involve the following components:

- Proposed schedule of submittal of all tasks, activities and deliverables associated with this agreement’ a to GTCNC;
- Evidence of regional capacity and support to implement the strategic initiatives of the objectives, tasks, activities and deliverables associated with this agreement represent;
- Letter of support from EMS Region (region number) Program Office, signed by the EMS Regional Coordinator, indicating willingness to support the tasks, activities and deliverables associated with this agreement; and
- Letters of support from Regional Community Hospitals and EMS Services.

Appropriate Use of Funds

The \$75,000 figure is payment to (trauma center) in order to make possible successful completion of the objectives, tasks, activities and deliverables associated with this agreement. Appropriate uses of funds include but are not limited to:

- Hire (or contract by “trauma center” or other GTCNC-approved entity) of administrative support and costs associated with that hire;
- Per diem expenses for RTAC members’ attendance at regularly scheduled meetings as scheduled in bylaws; and
- Meeting-related expenses.

Deliverables

Completion of the Step One Activities and Tasks

Deliverables: Completed Step One documents (templates provided by GTCNC)

- Step One: Establish a Regional Trauma Advisory Council (RTAC)
 - Activity 1.1: Identify RTAC membership (*makeup of RTAC could be prescribed by GTCNC*)
 - Task 1.1.1: Determine RTAC membership based upon composition requirements in Contract
 - Task 1.1.2: Obtain Commission approval of RTAC membership
 - Activity 1.2: Formalize RTAC structure and operation
 - Task 1.2.1: Formalize relationship between EMS Regional Office and Commission via agreement delineated in contract
 - Task 1.2.2: Approve or modify RTAC bylaws as proposed in Contract (*draft bylaws document to be provided by GTCNC*)
 - Task 1.2.3: Obtain Commission approval of finalized bylaws
 - Task 1.2.4: Establish method/mechanism to integrate RTAC representation within existing local, regional, and state-level emergency preparedness efforts.
 - Activity 1.3: Educate RTAC members on roles and responsibilities
 - Task 1.3.1: Familiarize RTAC with regionalization concepts as set forth in the Regional Trauma System Planning **Framework and White Paper**

Completion of the Step Two Activities and Tasks

Deliverables: Completed Step Two documents (templates provided by GTCNC)

- Step Two: Perform Regional Assessment
 - Activity 2.1: Collect existing trauma-related plans
 - Task 2.1.1: Document current practices of trauma patient transport in the region (this may include collection of transfer agreements among hospitals, protocols for hospital bypass, diversion, etc.)
 - Activity 2.2: Identify specific areas for improvement of the regional trauma system
 - Task 2.2.1: Identify strengths of existing processes/current practices of trauma patient transport
 - Task 2.2.2: Identify obvious barriers to effective operation of the regional trauma system (e.g. absence of trauma center, frequent diversion, lack of capacity to transport)
 - Task 2.2.3: Identify metrics by which to gauge trauma system weaknesses, and data sources for metrics (does group have data to demonstrate that current practices are effective or ineffective?)

Completion of the Step Two Activities and Tasks

Deliverables: Completed Step Three documents (templates provided by GTCNC)

- Step Three: Write Regional Trauma System Plan
 - Activity 3.1: Set trauma system goals and strategy
 - Task 3.1.1: As part of statewide regionalization effort, introduce functions of system components as described in the Regional Trauma System Planning Framework
 - Activity 3.2: Define plan for pre-hospital component
 - Task 3.2.1: Implement Trauma System Entry Criteria (TSEC) as pre-hospital transport standard
 - Task 3.2.2: Introduce protocol for EMS to enter Trauma System patients via the TCC
 - Task 3.2.3: Write region-specific protocol for transport based on secondary triage criteria
 - Task 3.2.4: Designate (to EMS Council or other entity) responsibility to educate and ensure compliance to plan as described above
 - Activity 3.3: Define plan for hospital component
 - Task 3.3.1: Implement Trauma System Entry Criteria
 - Task 3.3.2: Introduce protocol for hospital to enter Trauma System patients via TCC
 - Task 3.3.3: Write region-specific protocol for transfer based on secondary triage criteria
 - Task 3.3.4: Introduce responsibilities of Trauma Centers and non-designated participating hospitals
 - Task 3.3.5: Designate responsibility to educate and ensure compliance to this plan
 - Activity 3.4: Define plan for communications component
 - Task 3.4.1: Identify Trauma Centers and non-designated participating hospitals for Resource Availability Display (RAD) installation
 - Task 3.4.2: Identify individual or department responsible to maintain up-to-date RAD status at each RAD installation
 - Task 3.4.3: Specify interval and type of data for TCC to supply to RTAC for performance improvement
 - Activity 3.5: Define plan for Performance Improvement component
 - Task 3.5.1: List metrics to be used to measure progress toward building an effective regional trauma system
 - Task 3.5.2: Determine data collection mechanism and intervals for RTAC consideration and evaluation
 - Activity 3.6: Define plan for RTAC?
 - Task 3.6.1: Monitor implementation of all tasks listed in Step Three
 - Task 3.6.2: Record RTAC progress toward goals
 - Task 3.6.3: Based on progress toward goals, revise the Activities of Step Three.

TASK TABLE

Developing the Regional Trauma System Plan

A record of the Activities and Tasks specified in Goals One, Two, Three, and Four serves as the Regional Trauma System Plan for the Pilot Region

<p>STEP 1 Establish a Regional Trauma Advisory Council (RTAC)</p>		
<p>Activity 1.1 Identify RTAC membership</p>	<p>Activity 1.2 Formalize RTAC structure and operation</p>	<p>Activity 1.3 Educate RTAC members on roles and responsibilities</p>
<p>Tasks 1.1.1 Determine RTAC membership based upon composition requirements in Contract 1.1.2 Obtain Commission approval of RTAC membership</p>	<p>Tasks 1.2.1 Formalize relationship between EMS Regional Office and Commission via agreement delineated in Contract 1.2.2 Approve or modify RTAC bylaws as proposed in Contract 1.2.3 Obtain Commission approval of finalized bylaws 1.2.4 Establish method/mechanism to integrate RTAC representation within existing local, regional, and state-level emergency preparedness efforts</p>	<p>Tasks 1.3.1 Familiarize RTAC with regionalization concepts as set forth in the Regional Trauma System Planning Framework and White Paper</p>

STEP 2 Perform Regional Assessment	
Activity 2.1 Collect existing trauma-related plans	Activity 2.2 Identify specific areas for improvement of the regional trauma system
Tasks 2.1.1 Document current practices of trauma patient transport in the region (this may include collection of transfer agreements among hospitals, protocols for hospital bypass, diversion, etc.)	Tasks 2.2.1 Identify strengths of existing processes/current practices of trauma patient transport 2.2.2 Identify obvious barriers to effective operation of the regional trauma system (e.g., absence of trauma center, frequent diversion, lack of capacity to transport) 2.2.3 Identify metrics by which to gauge trauma system weaknesses, and data sources for metrics (do you have data to demonstrate that current practices are effective or ineffective?)

STEP 3 Write Regional Trauma System Plan					
Activity 3.1 Set trauma system goals and strategy	Activity 3.2 Define plan for pre-hospital component	Activity 3.3 Define plan for hospital component	Activity 3.4 Define plan for communications component	Activity 3.5 Define plan for Performance Improvement Component	Activity 3.6 Define plan for RTAC?
<p>Tasks</p> <p>3.1.1 As part of statewide regionalization effort, introduce functions of system components as described in the Regional Trauma System Planning Framework</p>	<p>Tasks</p> <p>3.2.1 Implement TSEC as pre-hospital transport standard</p> <p>3.2.2 Introduce protocol for EMS to enter Trauma System patients via the TCC</p> <p>3.2.3 Write region-specific protocol for transport based on secondary triage criteria</p> <p>3.2.4 Designate (to EMS council or other entity) responsibility to educate and ensure compliance to plan as described above.</p>	<p>Tasks</p> <p>3.3.1 Implement Trauma System Entry Criteria</p> <p>3.3.2 Introduce protocol for hospital to enter Trauma System patients via TCC</p> <p>3.3.3 Write region-specific protocol for transfer based on secondary triage criteria.</p> <p>3.3.4 Introduce responsibilities of Trauma Centers and non-designated participating hospitals</p> <p>3.3.5 Designate responsibility to educate and ensure compliance to this plan</p>	<p>Tasks</p> <p>3.4.1 Identify Trauma Centers and non-designated participating hospitals for RAD installation</p> <p>3.4.2 Identify individual or department responsible to maintain up-to-date RAD status at each RAD location</p> <p>3.4.3 Specify interval and type of data for TCC to supply to RTAC for performance improvement</p>	<p>Tasks</p> <p>3.5.1 List metrics to be used to measure progress toward building an “effective” regional trauma system</p> <p>3.5.2 Determine data collection mechanism and intervals for RTAC consideration and evaluation</p>	<p>Tasks</p> <p>3.6.1 Monitor implementation of all Tasks listed in Step 3</p> <p>3.6.2 Record RTAC progress toward goals</p> <p>3.6.3 Based on progress toward goals, revise the Activities of Step Three</p>