

GEORGIA REGION 5 EMERGENCY MEDICAL SERVICES REGIONAL TRAUMA PLAN

Developed by the Georgia Region 5 Regional Trauma Advisory Committee

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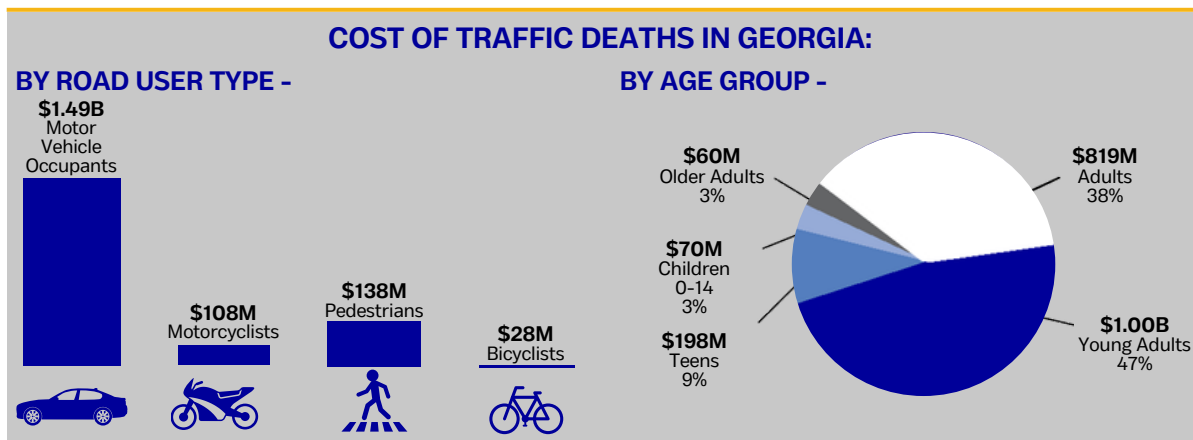
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EXECUTIVE SUMMARY

Traumatic injuries represent a serious health concern for Georgia. While falls are the leading cause of traumatic injury in Georgia, motor vehicle crashes (MVCs) account for the majority of injury-related deaths in the state, followed by firearm injuries and fall-related injuries. From 2015-2020, MVCs were a leading killer of children, teens, and young adults (ages 5 to 24) and among the top ten causes of death for all ages. In 2020, over 1,700 people in Georgia were killed in MVCs. The CDC has estimated the total crash-related death cost in Georgia in one year to be \$2.10 billion, \$18 million of that total in medical costs alone (Figure 1). While trauma patients account for a small percent of the total emergency system response, trauma accounts for a large percentage of total years of potential life lost. Studies show that trauma systems work to save lives and provide the best possible outcomes through improved trauma care and injury prevention. An inclusive trauma system incorporates all emergency response resources into a system to match the needs of the trauma patient with the appropriate emergency and trauma care resources.

The Georgia Trauma System is comprised of integrated regional systems and plans. Each region represents a trauma service area that accommodates overlapping and traditional patient catchment areas and state-wide EMS Regional infrastructure. The Region 5 Plan organizes existing resources to provide a comprehensive trauma care system to care for patients from the moment of injury through rehabilitation. This plan will address both urban and rural concerns. Rural trauma care is complicated by issues associated with geographic isolation, including but not limited to time from injury to discovery, extrication issues, distance to immediate healthcare, and local healthcare resource availability. The development, implementation, and operation of a trauma system is a complex process requiring concerted efforts from all healthcare providers. Coordination of system activities, data-driven planning, a well-defined infrastructure, and stable funding are critical to the success and cost-effectiveness of the system.

The following pages describe the essential components of the Region 5 Trauma Plan and Regional Trauma Advisory Committee (RTAC).



Children: 0-14, Teens: 15-19, Young Adults: 20-34, Adults: 35-64, Older Adults: 65+
 Source: CDC WISQARS (Web-based Injury Statistics Query and Reporting System), 2018

Figure 1

MISSION, VISION, GOALS, AND OBJECTIVES

MISSION

The mission of the Region 5 Trauma Plan and RTAC is twofold. First, they aim to reduce the burden of trauma through injury prevention efforts focused on injury data and statistics specific to Region 5 and other regional plan participants. Second, they will strive to ensure that victims of trauma receive care across the continuum from prehospital through rehabilitation that is of the highest quality to provide the best possible outcome.

VISION

- The Region 5 Trauma Plan and RTAC provide leadership regarding the care of trauma patients within the region and across regional and state boundaries where appropriate.

GOALS

- Reduce the number of preventable deaths
- Improve outcomes from traumatic injury
- Reduce medical costs through the appropriate use of resources.

OBJECTIVES

- Collaborate with participating agencies and organizations to provide oversight and guidance for system evaluation, education and training programs, and public education and prevention strategies.
- Work in conjunction with the State Office of EMS & Trauma (OEMS&T) to monitor the availability of resources, assure compliance with system standards, and develop a process for review of trauma care.
- Evaluate patient outcomes at a system level.
- Ensure that resources within Region 5 and appropriate resources in surrounding regions are fully incorporated into the Trauma Plan to enable access to care when needed.
- Analyze the impact and results of the system and make recommendations for change as appropriate to assure quality outcomes.

REGIONAL TRAUMA ADVISORY COMMITTEE

The Region 5 RTAC is established to act as a local resource for input to and support of the Georgia Trauma System. The committee aims to assist in reducing human suffering and the cost associated with preventable morbidity and mortality resulting from trauma. In addition, the RTAC is instrumental in analyzing local trauma care trends and in promoting regional injury prevention activities and quality improvement actions to reduce the incidence of trauma and, when an injury occurs, deliver appropriate and timely trauma care across the continuum. The duties of the RTAC are as follows:

- To promote cooperation and support communication among trauma care providers, organizations, and hospitals;
- To promote education, public awareness, and prevention activities regarding regional trauma;
- To identify and analyze trends and patient care outcomes based on trauma registry and other available epidemiologic data; and,
- To assure quality improvement activities within the system to achieve the highest level of trauma care.

AUTHORITY, STRUCTURE, AND FUNDING

The Region 5 RTAC is a committee of the Region 5 EMS Advisory Council. The RTAC works collaboratively with the Region 5 EMS Council, the Georgia Office of EMS and Trauma (OEMS&T), and the Georgia Trauma Care Network Commission (GTCNC). In 2009, the Georgia Trauma Commission established the RTAC Framework to guide the development of the regional trauma plans necessary for a cohesive statewide trauma system. The GTCNC also manages and distributes financial resources for the trauma system. The Georgia OEMS&T, under the Department of Public Health, serves as the authoritative structure for the Regional Plan, with the Region 5 EMS Advisory Council as the regional authority. The RTAC has joint reporting responsibility to the GTCNC and the region’s EMS Council. (Figure 2).

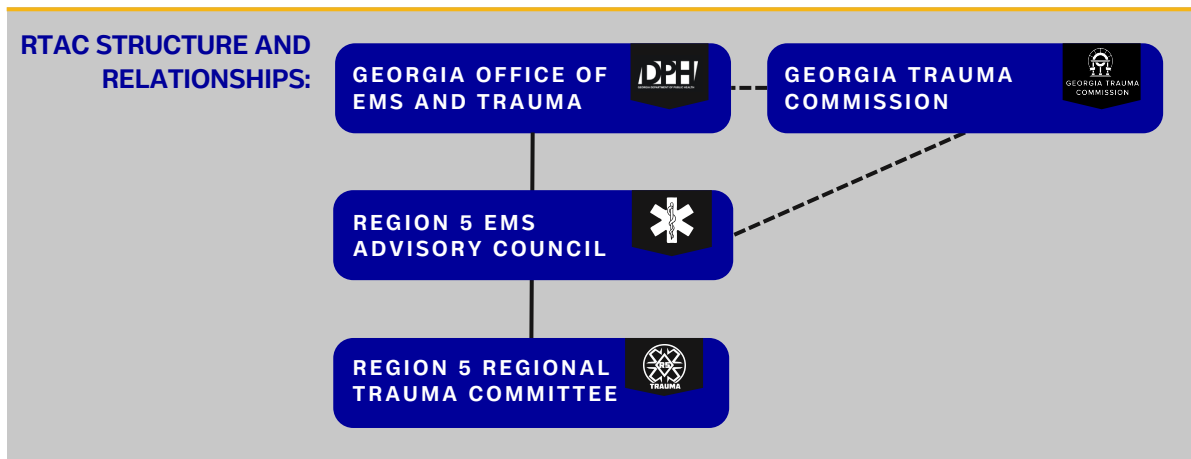


Figure 2

MEMBERSHIP

The Region 5 EMS Advisory Council Chair appoints RTAC members. There will be a minimum of fifteen (15) members appointed. The RTAC functions under the bylaws of the Region 5 EMS Council. The members of the RTAC are essential to the success of the Regional Plan and state-wide trauma system development. The RTAC comprises stakeholders who are representative of the Region's demographics and the components of the Regional Trauma System. The membership includes representation from each of the following categories. A single member may represent more than one category:

Trauma Center Representative(s) – at least one representative from each designed trauma center within the Region.

Hospital Members (minimum of 3) – at least one representative from senior hospital management, at least one who is a direct patient care provider, at least one from a critical care access hospital, and at least one from a rural hospital.

EMS Members (minimum of 3) – at least one representative from an urban 911 EMS service area, at least one from a rural 911 EMS service area, and at least one who is a direct patient care provider.

Physician Members (minimum of 3) – at least one rural physician actively providing trauma care at a designated or non-designated participating hospital and one trauma surgeon.

Nurse Members (minimum of 3) – at least three nurses who have knowledge of prehospital and hospital care and, ideally, experience in trauma-related education or injury prevention.

EMSC Representative (1) – at least one regional EMSC representative who has knowledge of pediatric-specific trauma care considerations.

At-Large Members - additional members include but are not limited to representatives from the following areas: fire service, law enforcement, emergency management, air ambulance service, business, industry, public health, emergency preparedness, and local government.

RTAC EXECUTIVE COMMITTEE

The RTAC Chair presides over RTAC meetings. The chair sets the meeting agenda and facilitates RTAC discussion. The chair is a voting member of the Region 5 EMS Council.

The Vice-chair performs the duties of the chair when the chair is absent from a meeting. The Vice-chair is not required to be a Region 5 EMS Council member.

The Secretary determines if a quorum is present, maintains meeting minutes, and distributes them to the general membership. The Secretary reviews and maintains copies of RTAC correspondence and assists in disseminating information to the general membership.

PREHOSPITAL COMPONENT

Achieving the best patient outcomes requires expeditious transport to an appropriate trauma center. In 2009, the American College of Surgeon’s Trauma System Consultation Program determined that “EMS is often a critical link between the injury-producing event and definitive care at a Georgia trauma center. It was determined that EMS delivered 89% of all critical trauma patients into the system. (Figure 3) Although a critical link, EMS providers do not provide definitive care. Critical trauma patients require a fully functioning system with a well-equipped, well-trained EMS component working hand-in-hand with physicians, nurses, and other trauma care professionals trained and dedicated to this task.

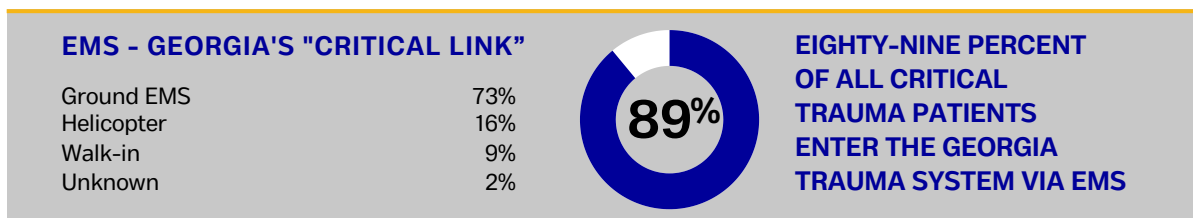


Figure 3

REGION 5 911-ZONED GROUND EMS AGENCIES

Central Georgia’s Region 5 comprises 23 counties and spans 8257 square miles. Twenty 911-Zoned Ground EMS agencies serve the regional community. (Appendix A)

- **Atrium Health Navicent EMS** provides 911 coverage in Bibb, Jones, Treutlen, and Twiggs Counties.
- **Community Ambulance** provides 911 coverage in Bibb and Crawford Counties.
- **Dodge County EMS** provides 911 coverage in Dodge County.
- **Grady EMS** provides 911 coverage in Baldwin and Hancock Counties.
- **Heartland EMS, Inc** provides 911 coverage in Bleckley and Pulaski Counties.
- **Houston County EMS** provides 911 coverage in Houston County.
- **Jasper County Fire Rescue** provides 911 coverage in Jasper County.
- **Johnson County EMS** provides 911 coverage in Johnson County.
- **Laurens County EMS** provides 911 coverage in Laurens County.
- **Monroe County Emergency Services** provides 911 coverage in Monroe County
- **Peach County EMS** provides 911 coverage in Peach County.
- **Putnam County EMS** provides 911 coverage in Putnam County
- **Taylor Regional Hospital EMS** provides 911 coverage in Pulaski County.
- **Telfair County EMS** provides 911 coverage in Telfair County.
- **Toombs-Montgomery County EMS** provides 911 coverage in Montgomery County.
- **Treutlen County EMS** provides 911 coverage in Treutlen County.
- **Washington County EMS** provides 911 coverage in Washington County.
- **Wheeler County EMS** provides 911 coverage in Wheeler County.
- **Wilkinson County EMS** provides 911 coverage in Wilkinson County.
- **Wilcox County EMS** provides 911 coverage in Wilcox County.

AIR AMBULANCES

Currently, thirty-two air medical helicopters are based in Georgia. The AirEvac LifeTeam locations in Dublin, Milledgeville, and Perry are the only helicopter base stations in Region 5. However, many of the Air Ambulance service providers listed respond to the region regularly.

- **AirEvac LifeTeam** has base locations in Americus, Carrollton, Douglas, Dublin, Fayetteville, Jesup, LaGrange, Milledgeville, Perry, Snellville, Statesboro, Tifton, and Vidalia.
- **AirMethods/AirLife** has base locations in Blairsville, Cornelia, Griffin, Jasper, Kennesaw, Newnan, Oxford, Springfield, and Valdosta.
- **Augusta University Health AirCare** has a base location in Augusta
- **Children's Healthcare** has a base location in Atlanta.
- **Life Force Air Medical** has base locations in Calhoun and McCaysville.
- **Med-Trans Corporation** has a base location in Elberton.
- **Survival Flight, Inc** has a base location in Colquitt.

A more complete listing of the resources operated by these services in Region 5 is located in Appendix B. A map of air ambulance base locations in Georgia is available in Appendix C.

TRIAGE AND FACILITY SELECTION

Ensuring the right patients get the right care, in the right place, at the right time, and using the right means is a principal aim of the State and Regional Trauma System (Figure 4). Patient presentation, resource availability, geography, and transport time affect trauma patient triage and facility selection. The National Study on the Costs and Outcomes of Trauma (NSCOT) reinforces the importance of on-scene triage decisions made by EMS providers. The NSCOT identified a 25% reduction in mortality for severely injured patients who received care at a Level I Trauma Center rather than a non-trauma center. However, not all injured patients can or should be transported to a Level I Trauma Center. Patients with less severe injuries might be served better by transport to a closer facility. Transporting all injured patients to Level I Trauma Centers, regardless of severity, could burden those facilities unnecessarily and make them less available for the most severely injured. The National Guideline for Field Triage of Injured Patients, developed by the American College of Surgeons Committee on Trauma (ACS-COT), assists in identifying the most severely injured patients (Appendix D). The Field Triage Guideline is utilized by prehospital personnel to determine which patients are preferentially transported to a trauma center. The ACS-COT's Field Triage Guideline is the basis for the Region 5 Prehospital Trauma Destination Guideline (Appendix E).



Figure 4

HOSPITAL COMPONENT

The Regional Trauma System is inclusive of all hospitals within the region. All trauma and non-trauma facilities have an integral role in trauma system development and the provision of trauma care. Hospitals participate in the State and Regional Trauma System on a voluntary basis, either as state-designated trauma centers or as non-designated participating hospitals. The Region 5 Regional Trauma Plan provides a framework for communication and collaboration between hospitals, EMS agencies, and other trauma system stakeholders. Together, trauma system partners work to ensure that patients receive optimal care, given the available resources, across all phases of care.



Figure 5

DESIGNATED TRAUMA CENTERS

Georgia Trauma Centers are designated by the State Office of EMS and Trauma (OEMS&T) using standards based on the American College of Surgeons Trauma Center Verification Standards. The OEMS&T defines the process for trauma center designation, re-designation, and regulation. As a condition of designation, trauma centers participate in regional trauma system planning and performance improvement. Therefore, trauma centers are de-facto participants in the Georgia Trauma System and thus the Regional Trauma Plan. Four designation levels are established by OEMS&T, with Level I being the most resource-intensive and Level IV being the least resource-intensive (Figure 6).

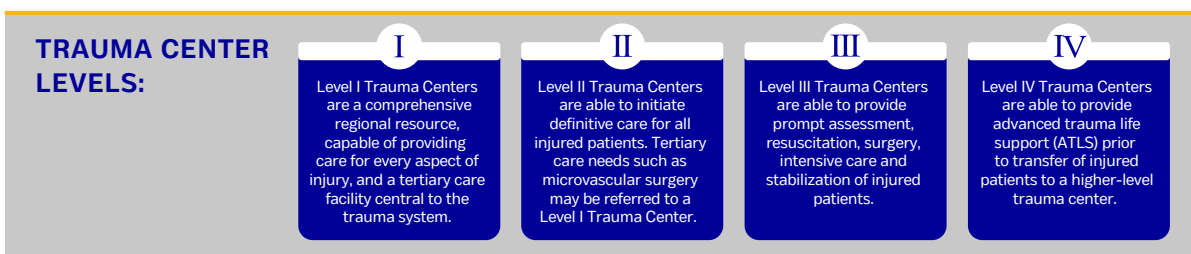


Figure 6

Source: American Trauma Society.

See also: Appendix F Georgia Designated Trauma Centers and Specialty Care Centers (List); Appendix G Georgia Designated Trauma and Specialty Care Centers - Map; Appendix H Georgia Designated Trauma Center Level Descriptions.

NON-DESIGNATED PARTICIPATING HOSPITALS

Non-designated participating hospitals are Georgia licensed hospitals with an emergency department, varying specialty physician coverage, and service line capabilities to treat, stabilize and admit low-acuity trauma patients. These hospitals are active participants in the system but have elected not to seek designation as trauma centers.

REGION 5 ACUTE CARE HOSPITALS

Sixteen acute care hospitals serve the 691,930 residents of the Central Georgia Region 5 community. Presently, there are only two designated trauma centers in the region; Atrium Health Navicent The Medical Center (Level I) and Fairview Park Hospital (Level III).

- **Atrium Health Navicent Baldwin** – Baldwin County/Milledgeville
 - Trauma Designation: Non-Designated
- **Atrium Health Navicent Peach** – Peach County/Byron
 - Trauma Designation: Non-Designated
- **Atrium Health Navicent The Medical Center** – Bibb County/Macon
 - Trauma Designation: Level I (Nationally Verified)
- **Bleckley Memorial Hospital** – Bleckley County/Cochran
 - Trauma Designation: Non-Designated
- **Dodge County Hospital** – Dodge County/ Eastman
 - Trauma Designation: Non-Designated
- **Fairview Park Hospital** – Laurens County/ Dublin
 - Trauma Designation: Level III
- **Houston Medical Center** – Houston County/ Warner Robins
 - Trauma Designation: Non-Designated
- **Jasper Memorial Hospital** – Jasper County/Monticello
 - Trauma Designation: Non-Designated
- **Monroe County Hospital** – Monroe County/Forsyth
 - Trauma Designation: Non-Designated
- **Perry Hospital** – Houston County/Perry
 - Trauma Designation: Non-Designated
- **Piedmont Macon Medical Center** – Bibb County/Macon
 - Trauma Designation: Non-Designated
- **Piedmont Macon North Hospital** – Bibb County/Macon
 - Trauma Designation: Non-Designated
- **Putnam General Hospital** – Putnam County/Eatonton
 - Trauma Designation: Non-Designated
- **Taylor Regional Hospital** – Pulaski County/Hawkinsville
 - Trauma Designation: Non-Designated
- **Washington County Regional Medical Center** – Washington County/Sandersville
 - Trauma Designation: Non-Designated

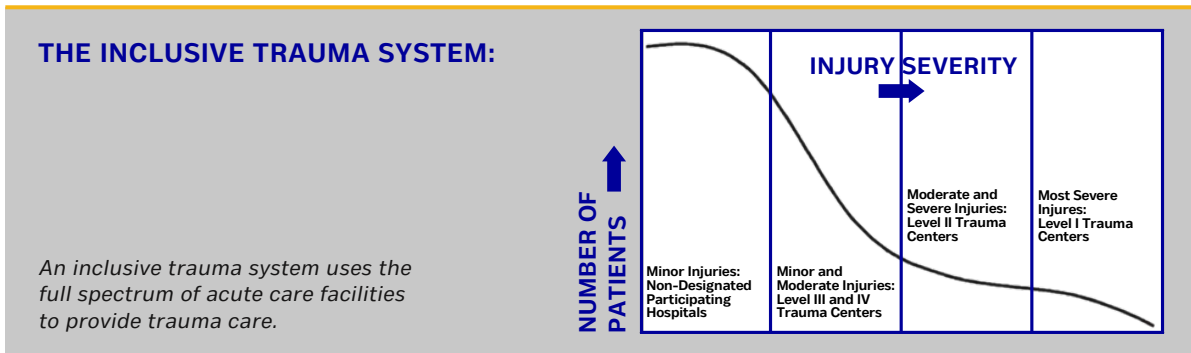
PEDIATRIC AND BURN RESOURCES

Atrium Health Navicent Beverly Knight Olson Children's Hospital is the only dedicated pediatric hospital in Region 5. However, Atrium Health Navicent The Medical Center is an adult Level I Trauma Center with pediatric commitment. Memorial Health University Medical Center in Savannah is also an adult Level I Trauma Center with pediatric commitment. Presently, Children's Healthcare of Atlanta at Egleston, Children Healthcare of Atlanta at Scottish Rite, and Children's Hospital of Georgia at Augusta University are Georgia's only Pediatric Trauma Centers.

Region 5 does not have a burn specialty center. Georgia's burn centers are the Joseph M. Still Burn Centers in Augusta and Austell and the Grady Health System Burn Center in Atlanta.

INTEGRATION OF ACUTE CARE HOSPITALS

All participating hospitals are invested in providing consistent, high-quality care to the injured. Region 5 RTAC works to ensure that all regional hospitals, regardless of designation status, are integrated into the Trauma System. Regional resources are available to assist all partnering hospitals in their preparations to provide immediate care for injured patients at a level commensurate with their resources and capabilities. Integrating all system partners enables the Regional Trauma System to make the best use of available resources, match patient needs to facility resources, engage all acute care hospitals in managing injured patients, and improve regional surge capacity in mass casualty events.



Source: Resources for Optimal Care of the Injured Patient 2014, Committee on Trauma, American College of Surgeons.

Figure 7

INTER-FACILITY TRANSFER

Ideally, patients needing the resources offered at a trauma center will be identified quickly so as not to delay definitive care. The Region 5 Hospital Guideline for the Inter-facility Transfer of Trauma System Patients (Appendix I) assists practitioners in identifying the injured patients most likely to benefit from early transfer to a designated trauma center. The National Guideline for Field Triage of Injured Patients and the American College of Surgeons' 2014 Resources for Optimal Care of the Injured Patient (Table 1) serve as the basis for the Region 5 Guideline for the Inter-facility Transfer of Trauma System Patients (Appendix I).

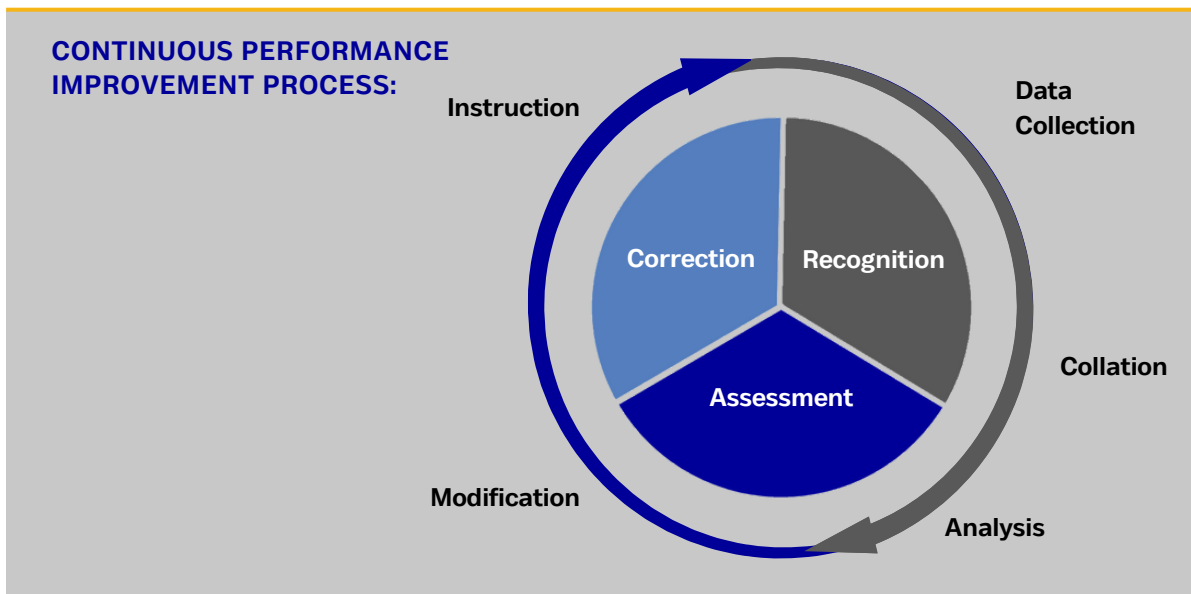
CRITERIA FOR CONSIDERATION OF TRANSFER FROM LEVEL III CENTERS TO LEVEL I OR II CENTERS
1. Carotid or vertebral arterial injury.
2. Torn thoracic aorta or great vessel.
3. Cardiac rupture.
4. Bilateral pulmonary contusion with Pao2 :Flo2 ratio less than 200.
5. Major abdominal vascular injury.
6. Grade IV or V liver injuries requiring transfusion of more than 6 U of red blood cells in 6 hours.
7. Unstable pelvic fracture requiring transfusion of more then 6 U of red blood cells in 6 hours.
8. Fracture or dislocation with loss of distal pulses.
9. Penetrating injuries or open fracture of the skull.
10. Glasgow Coma Scale score of less than 14 or lateralizing.
11. Spinal fracture or spinal cord deficit.
12. Complex pelvis/acetabulum fractures.
13. More than two unilateral rib fractures or bilateral rib fractures with pulmonary contusion (if no critical care consultation is available).
14. Significant torso injury with advanced comorbid disease (such as coronary artery disease, chronic obstructive pulmonary)

Source: Resources for Optimal Care of the Injured Patient 2014, Committee on Trauma, American College of Surgeons.

Table 1

PERFORMANCE IMPROVEMENT

Ongoing evaluation and improvement of the trauma care system essential throughout the patient care continuum. Regional prehospital and hospital stakeholders are responsible for maintaining internal performance improvement (PI) programs. Additionally, each designated trauma center is required to demonstrate a structured, continuous process for improving care for injured patients. While there is no precise prescription for trauma system improvement, the ACS-COT calls for each trauma program to demonstrate a continuous process of monitoring, assessment, and management to improve care (Figure 7).



Source: Resources for Optimal Care of the Injured Patient 2014, Committee on Trauma, American College of Surgeons.

Figure 7

DATA-DRIVEN PERFORMANCE IMPROVEMENT

Fundamental to the Regional Trauma System PI process is monitoring and measurement of available data to improve efficiency, increase effectiveness, and reduce real or potential harm. Thus, a data-driven PI program is critical to achieving optimal patient outcomes. The RTAC utilizes prehospital patient care reporting and trauma registry data to monitor system performance, identify opportunities for improvement, and drive regional programming efforts. Trends in care and outcomes are identified, and the appropriate system response is initiated to improve the quality and timeliness of trauma patient care.

The Region 5 RTAC also utilizes the Trauma System Self-Assessment Supplemental Tool to periodically evaluate the status of the trauma system based on national benchmarks and indicators. The results of this assessment serve as a foundation for measuring regional success while providing additional insight into the overall health and maturity of the regional trauma system.

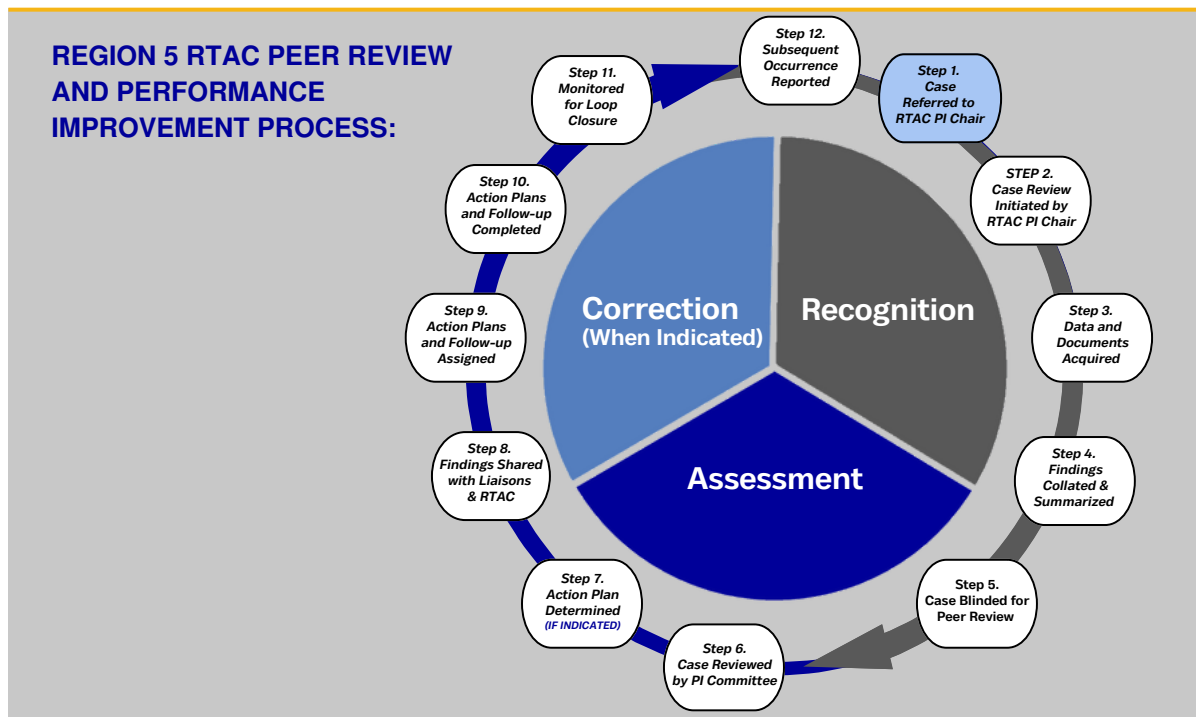
PERFORMANCE IMPROVEMENT SUBCOMMITTEE

The Region 5 RTAC PI Subcommittee is a multidisciplinary team of trauma system stakeholders tasked with identifying opportunities and implementing action plans to drive regional system improvement (Figure 8).

The Region 5 RTAC PI Subcommittee collaborates closely with the Regional Education Committee and the Emergency Medical Services for Children program to ensure that trauma education offerings are responsive to identified needs and advance the overall improvement of the trauma system.

Responsibilities:

- Develop processes and guidelines to facilitate a structured, continuous process for improving care for injured patients (Appendix J)
- Review available data and patient care documentation to monitor system performance, identify opportunities for improvement and drive regional programming efforts.
- Utilize the Trauma System Self-Assessment Supplemental Tool to periodically evaluate the status of the Regional Trauma System based on national benchmarks and indicators
- Conduct regional multidisciplinary peer review in accordance with the confidentiality provisions of O.C.G.A Section 31-7-31 (2) and (3) and O.C.G.A. Sections 31-7-132 and 31-7-133 shall also apply to the monitoring and PI activities of the Region 5 RTAC and Region 5 EMS Advisory Council (Appendix K)
- Implement action plans and programs to address identified regional needs.
- Disseminate educational resources to advance trauma system improvement.



Modified Continuous Performance Improvement Process - Resources for Optimal Care of the Injured Patient 2014, ACS-COT

Figure 8

INJURY PREVENTION AND OUTREACH

One of the primary goals of any trauma system is the development of programs to prevent unnecessary injuries and deaths due to trauma. Prevention and outreach programs aim to reduce behavioral and environmental risks by mobilizing targeted communities through citizen involvement and expanded partnerships. Education and awareness strategies encourage individuals to protect themselves from harm. The Region 5 RTAC and its collaborative partners strive to increase the regional capacity to deliver injury prevention and outreach programs. A multifaceted approach consisting of primary, secondary, and tertiary injury prevention initiatives enables the trauma system to reduce injury prevalence, morbidity, and mortality (Figure 9.)

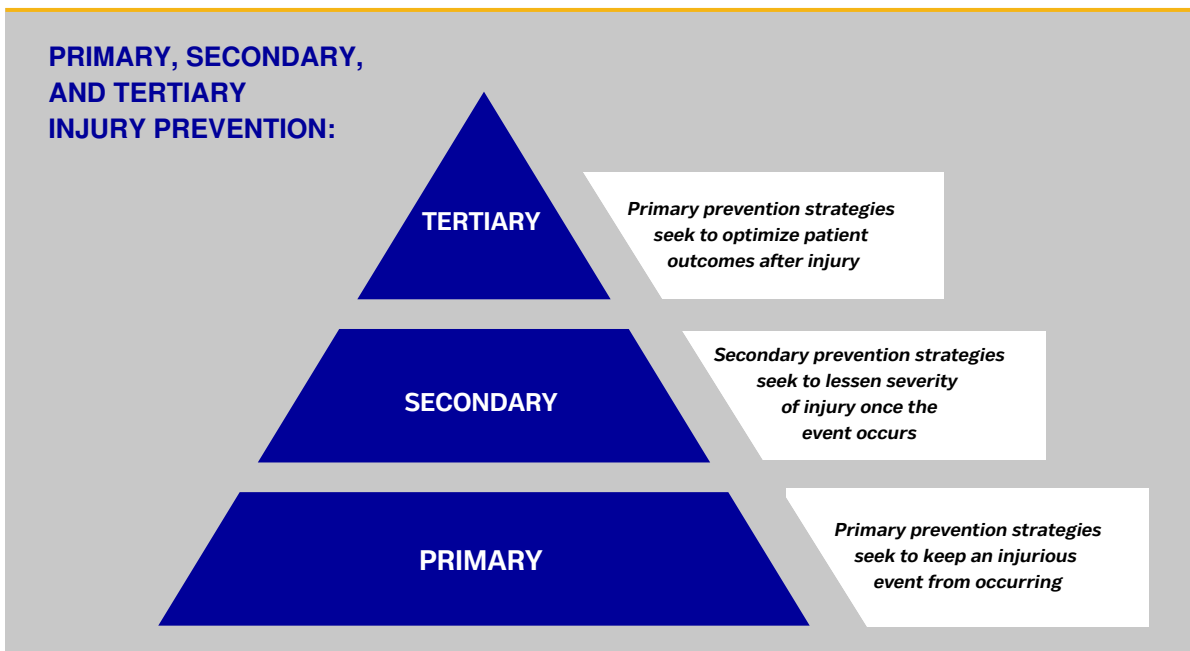


Figure 9

DATA-DRIVEN INJURY PREVENTION

A review of data from multiple sources is necessary to describe the burden of traumatic injury accurately. The public health framework views injury as a disease that can be prevented or managed in a way that reduces the severity. Using a public health approach, the Region 5 RTAC determines areas of concern based on available data; identifies risk and protective factors; develops and implements prevention strategies; then reevaluates subsequent data to assess the effectiveness of programming. The RTAC collects and analyzes injury data from the trauma registry, EMS run data, and other trusted sources. This information is then used to characterize the frequency and patterns of injury within the community, identify high-risk populations, and establish regional priorities.

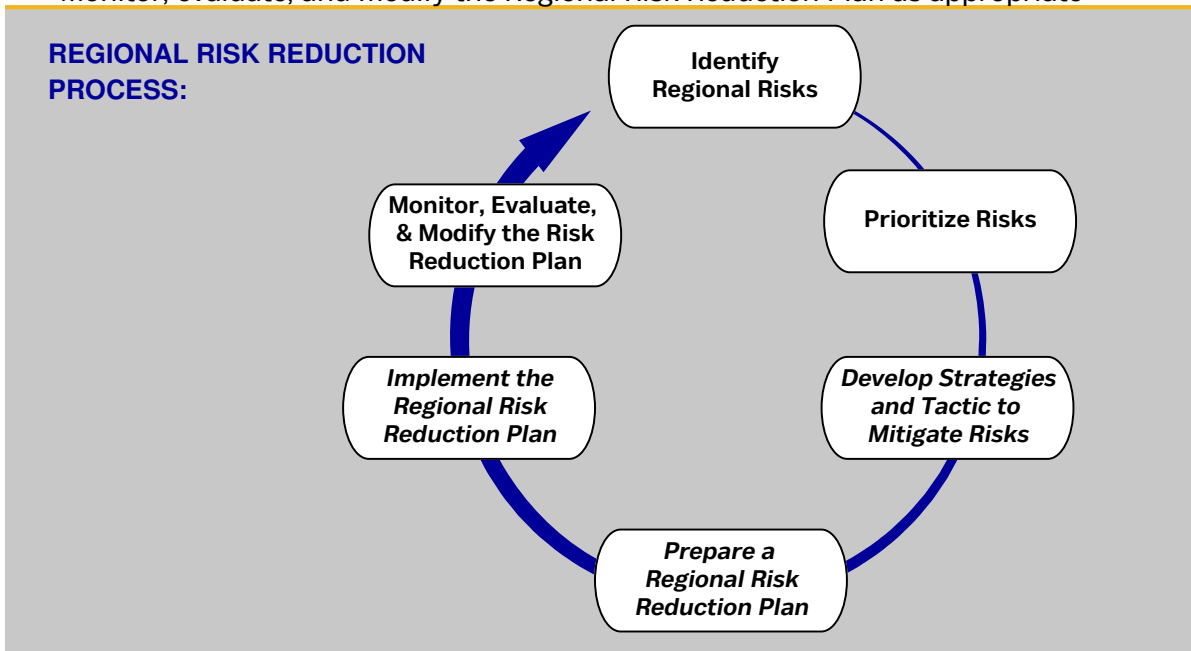
INJURY PREVENTION AND OUTREACH SUBCOMMITTEE

The Region 5 RTAC Injury Prevention and Outreach Subcommittee is a multi-disciplinary team of community partners and trauma system stakeholders tasked with the development and implementation of programs that seek to reduce the incidence of notable injury and death.

The Region 5 RTAC Injury Prevention Subcommittee collaborates closely with the Regional Education Committee, Emergency Medical Services for Children Program, and other state and regional partners to ensure that prevention efforts are data-driven and targeted.

Responsibilities:

- Identify risks using available data to accurately describe the burden of injury.
- Prioritize risks in consideration of communities and populations with the highest risk.
- Develop prevention and outreach strategies and tactics to mitigate risks and address the leading causes of injury.
- Prepare a Regional Risk Reduction Plan in coordination with trauma system stakeholders.
- Implement the Regional Reduction Plan and provide resources and support to local communities engaged in prevention and outreach efforts.
- Monitor, evaluate, and modify the Regional Risk Reduction Plan as appropriate



Modified: Community Risk Assessment Process - Community Risk Assessment Process: A Guide for Conducting a Community Risk Assessment Version 1.5

Figure 10

EDUCATION AND TRAINING

Trauma care knowledge and skills must be continuously updated, refined, and expanded through targeted trauma care training such as Advanced Trauma Life Support®, Prehospital Trauma Life Support®, Trauma Nursing Core Course, and age-specific courses. The Region 5 RTAC works in collaboration with the Georgia OEMS&T, Region 5 EMS Education and Training Committee, and trauma system stakeholders to assess the region's educational needs and address any identified gaps to drive regional trauma system improvement.

All trauma centers must meet the professional education requirements specified by the American College of Surgeons Committee on Trauma and Georgia OEMS&T. Additionally, Level I and II Trauma Centers work to support regional educational initiatives by engaging in multidisciplinary training opportunities and patient care reviews. Also, all participating acute care hospitals are encouraged to collaborate with the Regional Trauma System and assist in developing, implementing, and evaluating needs-based educational initiatives (Figure 11).

It is essential that all persons involved in the care of trauma patients have a basic knowledge and awareness of the Regional Trauma Plan and the Regional Trauma System's function. Participating EMS agencies and hospitals are responsible for ensuring caregivers are competent in providing trauma care and that there is understanding and compliance with trauma field triage, patient destination, and interfacility transfer guidelines.

The RTAC, RTAC PI Subcommittee, and Education and Training Committee work to ensure that trauma education offerings are responsive to identified needs and advance the overall improvement of the trauma system. To assist in the realization of trauma system objectives, advance trauma system improvement, and standardize course offerings, the RTAC develops and disseminates educational resources to system stakeholders. Additionally, the RTAC will assist in coordinating on-site training on request.

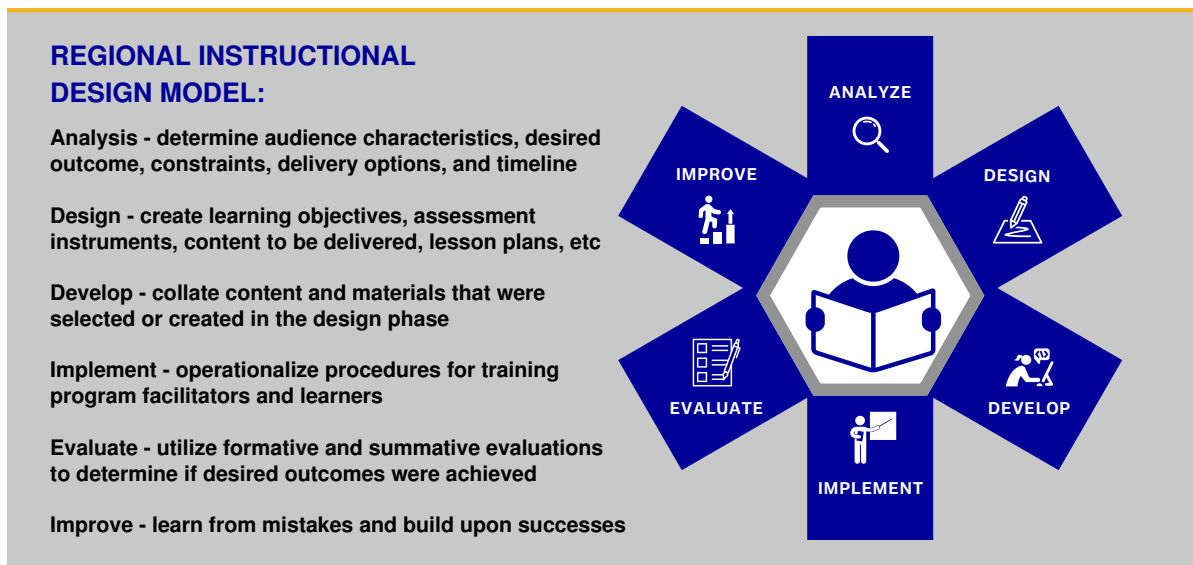


Figure 11

COMMUNICATION

Communication serves an essential function within the Regional Trauma System as the RTAC is structured to provide a framework for communication and collaboration between hospitals, EMS agencies, and other trauma system stakeholders. In addition, the RTAC acts as a forum for regional issues within the trauma care continuum so that we might work as partners to ensure that patients receive optimal care, given the available resources, across all phases of care. Therefore, it is imperative that all members of the trauma system are aware of their role, communicate effectively, and are able to operate in an atmosphere of mutual trust.

Effective communication is also essential in successfully assessing and resuscitating critically ill trauma patients. Maximum outcome potential is only achieved when there is efficient and rapid patient movement through prehospital assessment and treatment, transport, and hospital resuscitation, evaluation, and definitive care. Communication throughout the system is vital to this activity occurring efficiently and completely.

EMS COMMUNICATION

Prehospital communication is an important first step toward ensuring efficient management of critically injured patients during trauma resuscitation. Communication en route and upon a trauma patient's arrival at the Emergency Department is essential. All EMS providers transporting trauma patients, including those engaged in interfacility transports, are asked to establish early communication with regional trauma centers to provide a patient report or update a patient status at least 10 minutes before arrival whenever possible. Early prearrival notification helps ensure that trauma patients arriving at regional trauma centers are matched with appropriate resources.

On arrival, the Trauma Team will perform a brief "EMS Time Out" to enable EMS providers to provide their hand-off patient care report (Appendix L). Information transfer for trauma patients is especially crucial, as the interdisciplinary team must provide potentially life-saving interventions and make decisions very quickly. The EMS Time Out allows for a seamless transition of care, prevents the omission of relevant or critical patient information, and demonstrates mutual respect for all members of the prehospital and interdisciplinary patient care team.

The EMS Patient Care Report (PCR) is an invaluable component of EMS communication as it contains vital information regarding the scene conditions, mechanism of injury, the patient's condition, and treatment provided in the field. Ideally, the PCR should be submitted on the patient's arrival at the designated trauma center. A minimum data set MUST be left with the patient. The EMS Quick Report Form (Appendix M) meets the minimum data set and can be used by EMS personnel to provide patient care information to the receiving facility upon delivery of the patient until a PCR can be completed and delivered to the receiving facility and submitted to GEMSIS Elite. Additionally, the PCRs of initial scene EMS providers should be provided to the trauma center in the event of helicopter transport or interfacility transfer.

HOSPITAL COMMUNICATION

Continued engagement and collaboration among all the hospitals in a regional trauma system is crucial to the optimal interhospital transfer of patients. Strong, lasting relationships built on mutual trust and understanding improve overall communication. As a result, all system participants have a better understanding of individual roles and awareness of shared goals, the ability to cooperate on a personal and professional level, and resilience and flexibility under stress. Ultimately, coordination between referring and receiving hospitals facilitates a smoother and more timely interfacility transfer process.

Developing mutually agreed-upon written guidelines for transferring trauma patients between institutions also facilitates interhospital communication and is essential for optimal trauma system function. These agreements define which patients should be transferred and the process for doing so. Crafting trauma transfer guidelines and agreements begins with the identification of each hospital's treatment capabilities, as well as regional transportation options. This information is used to develop guidelines for resuscitation, identify critically injured patients meeting trauma system criteria, and a process for early activation of trauma system resources. Additionally, trauma patient transfer guidelines define, at a minimum, (1) the identification of patients/injuries requiring transfer; (2) requirements and methods for physician-to-physician communication between facilities; (3) guidelines as to when to consider ground vs. air medical transportation and; and (4) documentation requirements.

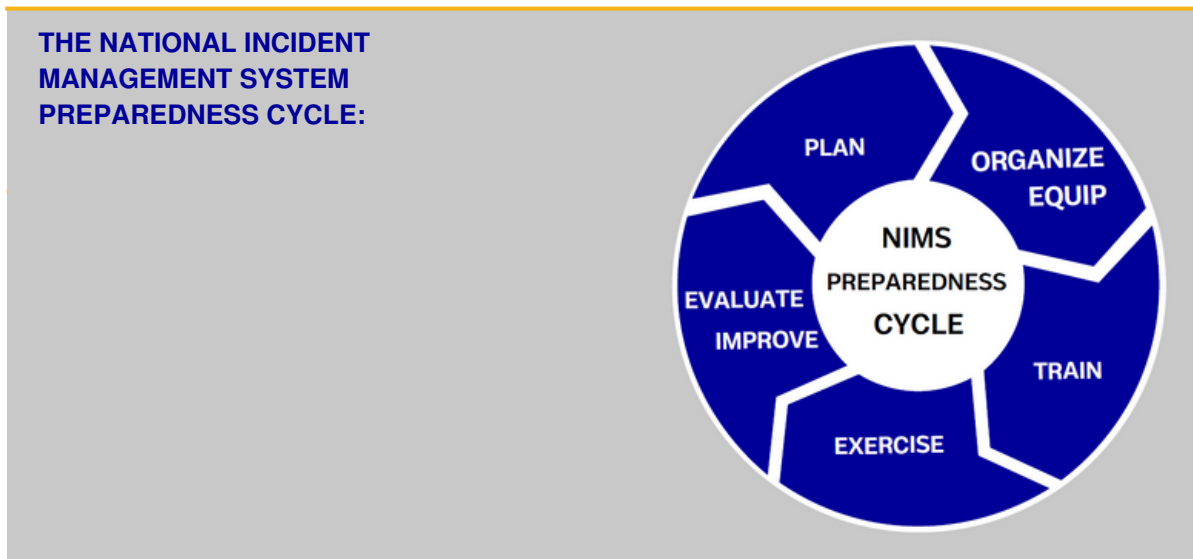
Effective spoken and written communication between care teams is essential in successfully caring for critically ill trauma patients. While it is necessary for the referring and accepting physicians to be in close contact during the interfacility transfer of a critically injured patient, it is also critical for the nurses from receiving and transferring facilities to communicate patient care details and provide patient status updates. Inadequate communication is a significant, preventable source of medical errors. Standardized medical handoffs help facilitate a smooth transition of care, minimize disruptions, and prevent the omission of relevant patient information. The prehospital PCR's, transfer documentation, and available medical records are also invaluable components of interfacility and are essential to preserving care continuity. Any prehospital documentation available at the time of transfer should be sent with the transfer paperwork to the receiving facility.

SYSTEM COMMUNICATION

The importance of effective communication cannot be overstated. Therefore, all regional EMS agencies, participating hospitals, and system stakeholders are asked to designate at least one trauma system liaison. The provision of a dedicated RTAC liaison allows for ongoing communication of regional opportunities specific to funding, education, performance improvement, and injury prevention. Prehospital and Hospital designees should have the knowledge and authority necessary to participate in regional trauma system performance improvement activities when appropriate. Liaisons must also understand and acknowledge their responsibility to maintain the confidentiality of the RTAC's performance improvement proceedings in accordance with O.C.G.A. Sections 31-7-132 and 31-7-133.

EMERGENCY PREPAREDNESS

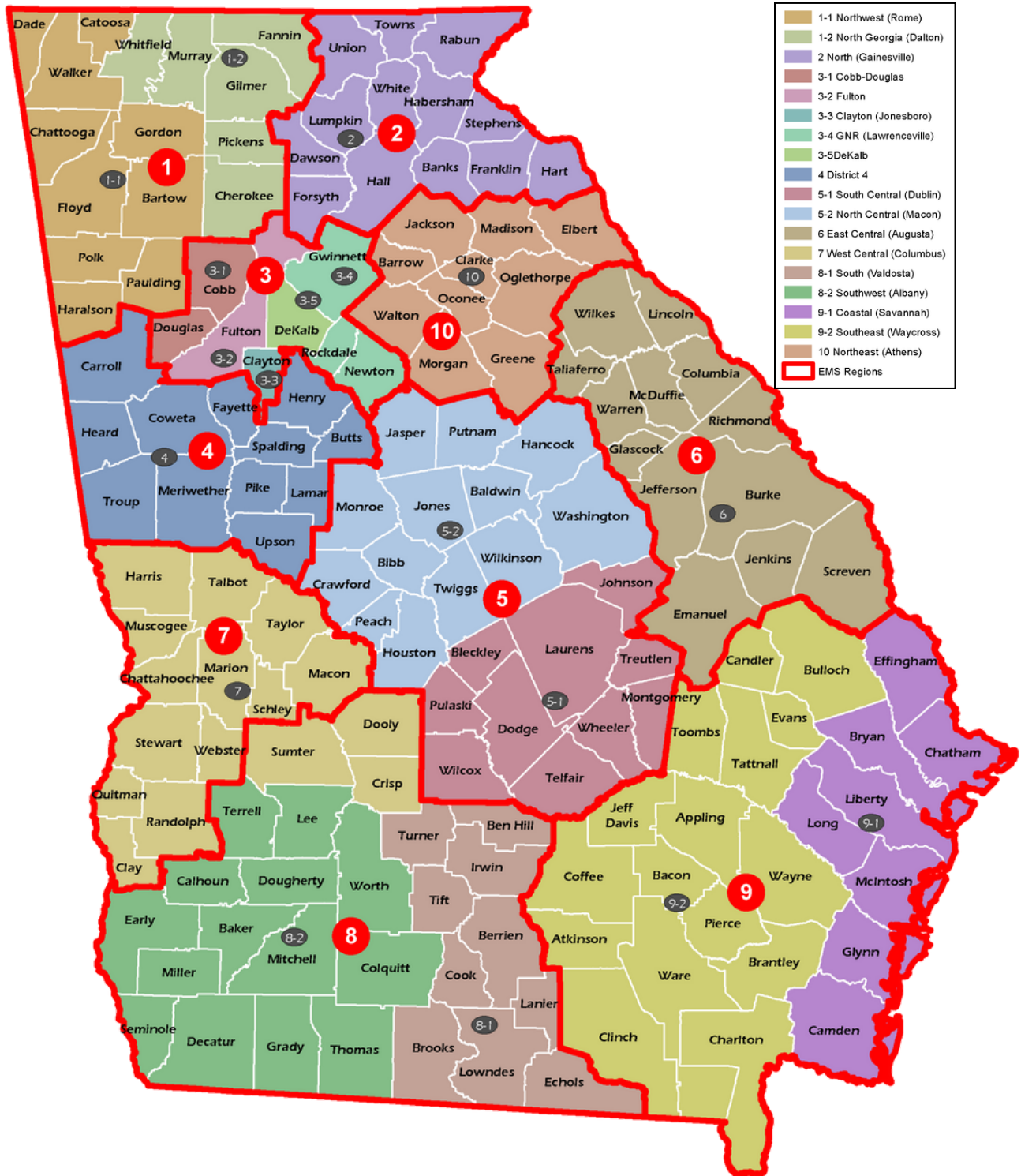
The National Incident Management System (NIMS) defines preparedness as “a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action to ensure effective coordination during incident response.” The Region 5 RTAC works in close collaboration with the Office of EMS and Trauma, Offices of Emergency Preparedness and Response with both the North Central Health District and South Central Health District, the Regional EMS Council Central Georgia Medical Reserve Corps, Region F Healthcare Coalition, Region H Healthcare Coalition, and the Georgia Emergency Management Agency in assuring community members, healthcare providers, and organizations throughout the region are prepared to respond to multiple or mass casualty events. Each stage in the Preparedness Cycle (Figure 12) relates to one or more of the five mission areas in the National Preparedness Goal, as outlined by the U.S. Department of Homeland Security (2015). Although the RTAC currently has no specific role in the regional emergency response plans, the Region 5 RTAC is available to assist all trauma system partners with their education, outreach, and preparedness efforts. The RTAC is currently engaged in several educational initiatives designed to enhance the Regional capacity to respond in the event of a disaster. I.e., STOP THE BLEED®, Tactical Emergency Casualty Care, Law Enforcement Mutual Aid Response, Hospital Surge Readiness, and Rescue Task Force. Through these programs, we have trained and equipped thousands of Central Georgians to care for life-threatening bleeding emergencies. Additionally, the RTAC currently maintains two mobile trauma and disaster response equipment caches. These mobile caches are designed to be staged in advance of large events and can be made available to trauma system partners on request.



Source: *The National Preparedness Guidelines*, U.S. Department of Homeland Security

Figure 12

GEORGIA PUBLIC HEALTH DISTRICT AND EMERGENCY MEDICAL SERVICES REGIONS:



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

REGION 5 RESOURCE DESCRIPTION:

Baldwin County

Includes: City of Milledgeville
 Population: 43,799 Area: 258.5 square miles

EMS Provider: Grady EMS
 560 West Martin Luther King Jr. Dr, Milledgeville, GA
 Distance to AHNMC: 31.5 miles

HEMS Provider: Air Evac Lifeteam 140
 131 Britt Waters Rd NW, Milledgeville, GA
 Distance to AHNMC: 27.3 miles

Hospital: Atrium Health Navicent
 821 N. Cobb St. Milledgeville, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 32.2 miles

Bibb County

Includes: City of Macon
 Population: 157,336 Area: 250 square miles

EMS Providers: Atrium Health Navicent EMS
 675 New St, Macon, GA
 Distance to AHNMC: 0.1 mile

Community Ambulance
 242 Holt Ave, Macon, GA
 Distance to AHNMC: 1.1 mile

Hospitals: Atrium Health Navicent The Medical Center
 777 Hemlock St, Macon, GA
 Trauma Designation: Level I
 w/Pediatric Commitment

Piedmont Macon Medical Center
 350 Hospital Dr, Macon, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 2.4 miles

Piedmont Macon North Hospital
 400 Charter Blvd, Macon, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 4.6 miles

Bleckley County

Includes: City of Cochran
 Population: 12,583 Area: 217.4 square miles

EMS Provider: Heartland EMS
 256 Lucas Rd, Cochran, GA
 Distance to AHNMC: 37.5

Hospital: Bleckley Memorial
 145 E Peacock St. Cochran, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 39.9

Crawford County

Includes: Cities of Knoxville and Roberta
 Population: 12,153 Area: 325.1 square miles

EMS Provider: Community Ambulance
 191 S Dugger Ave, Roberta, GA
 Distance to AHNMC: 26.7 miles

Dodge County

Includes: Cities of Chauncey, Chester, Eastman, Milan, and Rhine
 Population: 19,759 Area: 500.6 square miles

EMS Provider: Dodge County EMS
 440 Legion Dr, Eastman, GA
 Distance to AHNMC: 57 miles

Hospital: Dodge County Hospital
 901 Griffin Ave, Eastman, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 59

Hancock County

Includes: City of Sparta
 Population: 8,630 Area: 473.3 square miles

EMS Provider: Hancock County EMS
 52 Spring St, Sparta, Ga
 Distance to AHNMC: 55 miles

Houston County

Includes: Cities of Centerville, Perry and Warner Robins
 Population: 166,829 Area: 376.8 square miles

EMS Provider: Houston Medical Center EMS
 1553 Watson Blvd, Warner, Robins, GA
 Distance to AHNMC: 19.0 miles

HEMS Provider: Air Evac Lifeteam 154
 1116 Morningside Dr, Perry, GA
 Distance to AHNMC: 26.3 miles

Hospitals: Houston Medical Center
 1601 Watson Blvd, Warner Robins, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 19.4 miles

Perry Hospital
 1120 Morningside Dr, Perry, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 31.3

REGION 5 RESOURCE DESCRIPTION:

Jasper County

Includes: Cities of Monticello and Shady Dale
 Population: 15,278 Area: 370.5 square miles

EMS Provider: Jasper County EMS
 185 Highway 212 W, Monticello, GA
 Distance to AHNMC: 40.0 miles

Hospital: Jasper Memorial Hospital
 898 College St, Monticello, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 39.8 miles

Johnson County

Includes: Cities of Kite and Wrightsville
 Population: 9,189 Area: 304.4 square miles

EMS Provider: Johnson County EMS
 2573 Idylwild Dr, Wrightsville, GA
 Distance to AHNMC: 60.0 miles

Jones County

Includes: City of Gray
 Population: 28,347 Area: 393.8 square miles

EMS Provider: Atrium Health Navicent EMS (no ems substation)
 Jones County Government Center
 166 Industrial Blvd, Gray, GA
 Distance to AHNMC: 19.0 miles

Laurens County

Includes: Cities of Cadwell, Dexter, Dublin, Dudley, East Dublin, Montrose and Rentz

Population: 49,570 Area: 812.6 square miles

EMS Provider: Laurens County EMS
 646 County Farm Rd, Dublin GA
 Distance to AHNMC: 52 miles

HEMS Provider: Air Evac Lifeteam 102
 661 County Farm Rd, Dublin, GA
 Distance to AHNMC: 47.6 miles

Hospital: Fairview Park Hospital
 200 Industrial Blvd, Dublin, GA
 Trauma Designation: Level III
 Distance to AHNMC: 52 miles

Monroe County

Includes: Cities of Forsyth and Culloden
 Population: 27,957 Area: 395.7 square miles

EMS Provider: Monroe County Emergency Services
 693 Juliette Rd, Forsyth, GA
 Distance to AHNMC: 23.4 miles

Hospital: Monroe County Hospital
 88 Martin Luther King Jr. Dr, Forsyth, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 25.4 miles

Montgomery County

Includes: Cities of Ailey, Alston, Higgston, Mount Vernon, and Uvalda.

Population: 8,610 Area: 245.3 square miles

EMS Provider: Toombs-Montgomery EMS
 400 Earth Saver Rd, Ailey, GA
 Distance to AHNMC: 90 miles

Peach County

Includes: Cities of Byron and Fort Valley
 Population: 27,981 Area: 151.1 square miles

EMS Provider: Peach County EMS
 1770 Highway 341 N, Fort Valley, GA
 Distance to AHNMC: 27.8 miles

Hospital: Atrium Health Navicent Peach
 1960 GA Highway 247 Connector, Byron, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 19.5 miles

Pulaski County

Includes: City of Hawkinsville
 Population: 12,010 Area: 247.4 square miles

EMS Provider: Taylor Regional EMS (Heartland EMS Division)
 16 Old Perry Hwy, Hawkinsville, GA
 Distance to AHNMC: 43.1 miles

Hospital: Taylor Regional Medical Center
 222 Perry Highway, Hawkinsville, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 42.8 miles

REGION 5 RESOURCE DESCRIPTION:

Putnam County

Includes: City of Eatonton
 Population: 22,047 Area: 344.5 square miles

EMS Provider: Putnam County EMS
 882 Oak St, Eatonton, GA
 Distance to AHNMC: 41 miles

Hospital: Putnam General Hospital
 101 Lake Oconee Pkwy, Eatonton, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 43.9 miles

Telfair County

Includes: Cities of Helena, Lumber City, McRae, Milan and Scotland
 Population: 12,477 Area: 441.2 square miles

EMS Provider: Telfair County EMS
 274 E. Willow Creek Ln, McRae-Helena, GA
 Distance to AHNMC: 78 miles

Treutlen County

Includes: City of Soperton
 Population: 6,885 Area: 200.7 square miles

EMS Provider: Atrium Health Navicent EMS
 5552 N 3rd St, Soperton, GA
 Distance to AHNMC: 75 miles

Twiggs County

Includes: Cities of Danville and Jeffersonville
 Population: 8,022 Area: 142.6 square miles

EMS Provider: Atrium Health Navicent EMS (no ems substation)
 Twiggs County Commissioners Office
 425 Railroad St, Jeffersonville, GA
 Distance to AHNMC: 25.1 miles

Washington County

Includes: Cities of Davisboro, Deepstep, Harrison, Oconee, Riddleville, Sandersville and Tennille
 Population: 19,988 Area: 680.5 square miles

EMS Provider: Washington County EMS
 124 Hospital Cir, Sandersville, GA
 Distance to AHNMC: 62 miles

Hospital: Washington County Regional Medical Center
 610 Sparta Rd, Sandersville, GA
 Trauma Designation: Non-Designated
 Distance to AHNMC: 61 miles

Wheeler County

Includes: Cities of Alamo and Glenwood
 Population: 7,471 Area: 297.7 square miles

EMS Provider: Wheeler County EMS
 18 NW 3rd Ave, Glennwood, GA
 Distance to AHNMC: 79.4 miles

Hospital: Lower Oconee Community Hospital
 111 N. 3rd Street, Glenwood, GA
 Trauma Designation: Level IV
 Distance to AHNMC: 84.9 miles

Wilcox County

Includes: Cities of Abbeville, Pineview, and Rochelle
 Population: 8766 Area: 380.4 square miles

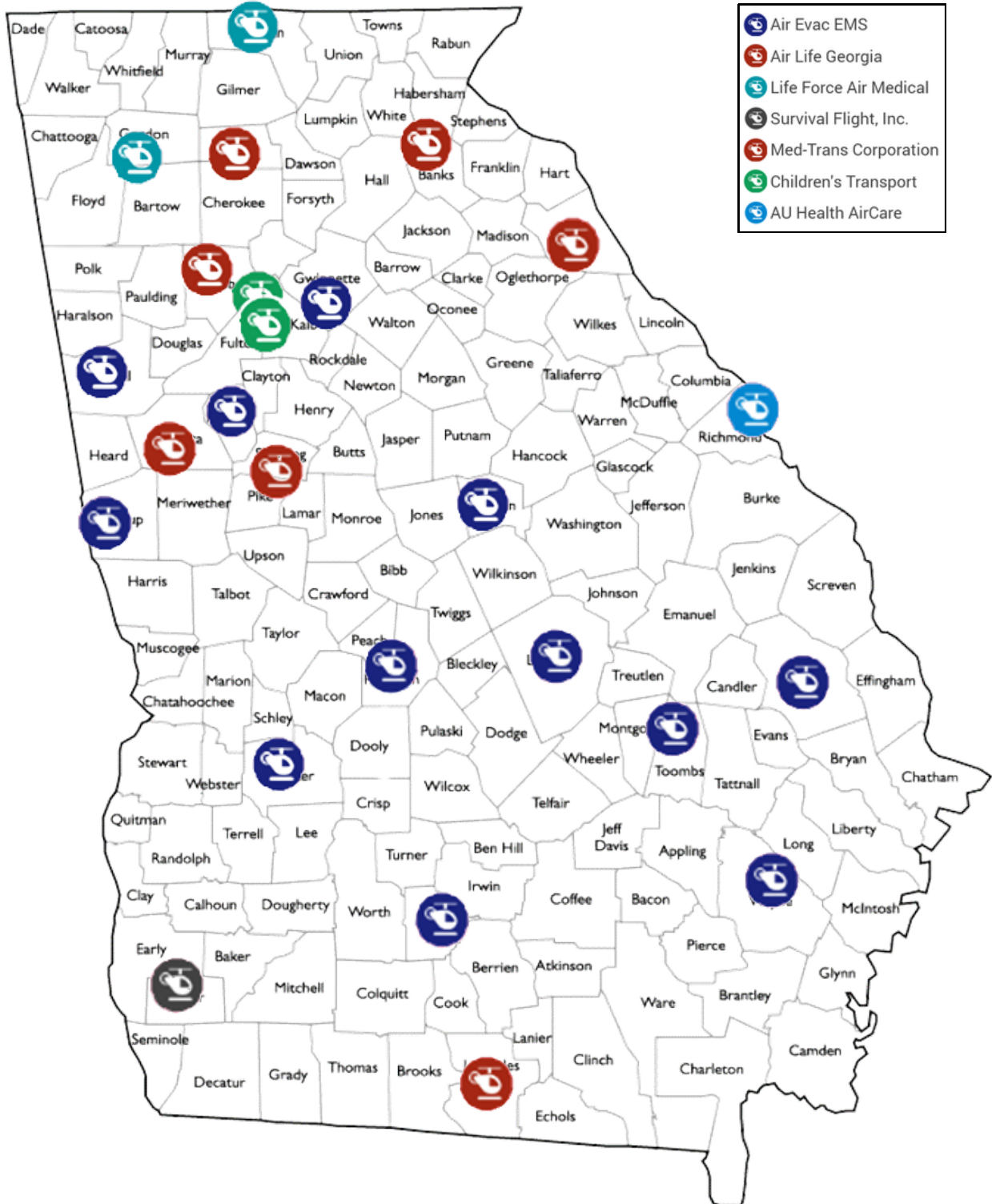
EMS Provider: Wilcox County EMS
 687 County Farm Rd, Rochelle, GA
 Distance to AHNMC: 72 miles

Wilkinson County

Includes: Cities of Allentown, Gordon, Irwinton, Ivey, McIntyre and Toombsboro
 Population: 8,877 Area: 446.6 square miles

EMS Provider: Wilkinson County EMS
 3101 Bellwood Road, Irwinton, GA
 Distance to AHNMC: 25.8 miles

GEORGIA AIR AMBULANCE BASE LOCATIONS:



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

National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
<ul style="list-style-type: none"> • Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure 	<p>All Patients</p> <ul style="list-style-type: none"> • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% <p>Age 0-9 years</p> <ul style="list-style-type: none"> • SBP < 70mm Hg + (2 x age in years) <p>Age 10-64 years</p> <ul style="list-style-type: none"> • SBP < 90 mmHg or • HR > SBP <p>Age ≥ 65 years</p> <ul style="list-style-type: none"> • SBP < 110 mmHg or • HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA

Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
<ul style="list-style-type: none"> • High-Risk Auto Crash <ul style="list-style-type: none"> - Partial or complete ejection - Significant intrusion (including roof) <ul style="list-style-type: none"> • >12 inches occupant site OR • >18 inches any site OR - Need for extrication for entrapped patient - Death in passenger compartment - Child (age 0-9 years) unrestrained or in unsecured child safety seat - Vehicle telemetry data consistent with severe injury • Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) • Pedestrian/bicycle rider thrown, run over, or with significant impact • Fall from height > 10 feet (all ages) 	<p>Consider risk factors, including:</p> <ul style="list-style-type: none"> • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use • Suspicion of child abuse • Special, high-resource healthcare needs • Pregnancy > 20 weeks • Burns in conjunction with trauma • Children should be triaged preferentially to pediatric capable centers <p>If concerned, take to a trauma center</p>

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

Source: [facs.org/fieldtriageguidelines](https://www.facs.org/fieldtriageguidelines)

REGION 5 PREHOSPITAL TRAUMA DESTINATION GUIDELINE:

INDICATIONS - Trauma patients who meet any of the following trauma triage criteria should be transported to the closest appropriate trauma center. If an extended ground transport time is expected, then air transport to the closest appropriate trauma center may be considered. If direct ground transport to the appropriate level trauma center cannot be performed and air medical evacuation cannot be done, the patient should be transported to the closest appropriate hospital. Transport all patients with an unmanageable airway or uncontrolled hemorrhage to the closest appropriate hospital.

RED CRITERIA - Patients meeting any one of the **RED CRITERIA** below are considered at High Risk for Serious Injury and should be transported to the highest level of care within the trauma system. (Level I or II)

- **Injury Patterns -**
 - Penetrating injuries to head, neck, torso, and proximal extremities
 - Skull deformity, suspected skull fracture
 - Suspected spinal injury with new motor or sensory loss
 - Chest wall instability, deformity, or suspected flail chest
 - Suspected pelvic fracture*
 - Suspected fracture of two or more proximal long bones
 - Crushed, degloved, mangled, or pulseless extremity
 - Amputation proximal to wrist or ankle
 - Active bleeding requiring a tourniquet or wound packing with continuous pressure
- **Mental Status & Vital Signs -**
 - All Patients
 - Unable to follow commands (motor GCS < 6)
 - RR < 10 or > 29 breaths/min
 - Respiratory distress or need for respiratory support
 - Room-air pulse oximetry < 90%
 - Age 0–9 years
 - SBP < 70mm Hg + (2 x age in years)
 - Age 10–64 years
 - SBP < 90 mmHg or HR > SBP
 - Age ≥ 65 years
 - SBP < 110 mmHg or HR > SBP

YELLOW CRITERIA - Patients meeting any one of the **YELLOW CRITERIA BELOW, WHO DO NOT MEET RED CRITERIA**, are considered at Moderate Risk for Serious Injury and should be transported to a trauma center, as available within the geographic constraints of the trauma system (need not be the highest-level trauma center)

- **Mechanism of Injury-**
 - High-Risk Auto Crash
 - Partial or complete ejection
 - Significant intrusion (including roof)
 - >12 inches occupant site OR
 - >18 inches any site OR
 - Need for extrication for entrapped patient
 - Death in passenger compartment
 - Child (age 0–9 years) unrestrained or in an unsecured child safety seat
 - Vehicle telemetry data consistent with severe injury
 - Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
 - Pedestrian/bicycle rider thrown, run over, or with significant impact
 - Fall from height > 10 feet (all ages)
- **EMS Judgement -**
 - **Consider risk factors, including:**
 - Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
 - Anticoagulant use
 - Suspicion of child abuse
 - Special, high-resource healthcare needs
 - Pregnancy > 20 weeks
 - Burns in conjunction with trauma
 - Children should be triaged preferentially to pediatric capable centers
 - **If concerned, take to a trauma center**

**ISOLATED PELVIC FRACTURES - In patients having an isolated pelvic fracture without a significant Mechanism of Injury and does not meet RED criteria, agency protocols, in consideration of local resource availability, may direct the EMS provider to contact medical control or refer to agency protocols to determine hospital destination.*

PROCEDURES – Patient presentation, geography, availability of resources, and other factors, will limit the ability of some agencies to perform direct transport to a Level I or II Trauma Center. The primary objective of the procedures outlined below is designed to ensure that patients identified as meeting trauma system criteria are transported to an appropriate Trauma Center within an optimal time.

- **If an extended ground transport time to a trauma center is not anticipated:**
 - Provide appropriate care.
 - Initiate immediate transport towards (scene time <10 minutes) appropriate level trauma center.
 - When appropriate (at least 10 minutes prior to arrival whenever possible), establish communications with the receiving hospital to provide a patient report and/or update patient status.
- **If an extended ground transport time to a trauma center is anticipated:**
 - Provide appropriate care.
 - Field transports by helicopter of trauma patients should be considered:
 - If the patient meets the clinical triage criteria for transport and should be transported to the closest appropriate level Trauma Center AND can be delivered to an appropriate Trauma Center more rapidly by air ambulance than by ground transport.
 - If ground ambulance availability is not sufficient to provide transport to the closest appropriate Trauma Center or the utilization of local ground ambulance leaves the local community without ground ambulance coverage.
 - If the patient requires a level of care greater than can be expected by the local ground provider AND if the air ambulance can be on the scene in a time shorter than the ground unit can initiate transport.
 - If air transport is not elected, delayed, or unavailable, initiate immediate ground transport towards (scene time less than 10 minutes) the appropriate level trauma center.
 - When appropriate (at least 10 minutes prior to arrival whenever possible), establish communications with the receiving hospital to provide a patient report and/or update patient status.
- **If an agency cannot perform a ground transport directly to a Level I or II Trauma Center:**
 - Provide appropriate care.
 - Field transports by helicopter of trauma patients should be considered:
 - If the patient meets the clinical triage criteria for transport and should be transported to the closest appropriate level Trauma Center AND can be delivered to an appropriate Trauma Center more rapidly by air ambulance than by ground transport.
 - If the patient requires an immediate life-saving intervention at a level of care greater than can be expected by the local ground provider AND if the air ambulance can be on the scene in a time shorter than the ground unit can transport to the closest hospital.
 - If air transport is delayed or unavailable, transport patients meeting trauma center criteria to the closest appropriate hospital.
 - When appropriate (at least 10 minutes prior to arrival whenever possible), establish communications with the receiving hospital to provide a patient report and/or update patient status.

ADDITIONAL CONSIDERATIONS:

- Transport all patients with an **unmanageable airway** or **uncontrolled hemorrhage** to the closest hospital emergency department.
- **Traumatic cardiac arrest patients with any electrical cardiac activity** -Transport to a designated trauma center if transport time is less than a 10-minute difference from the closest hospital. Otherwise, transport the patient to the closest hospital emergency department.
- Obstetric (> 20 weeks) patients that **do not** meet trauma criteria should be transported to the closest hospital with obstetrical resources.
- If patients meet Mechanism of Injury criteria but **do not** meet Physiologic and/or Anatomic (**RED**) criteria, the EMS provider should contact medical control or refer to agency protocols to determine hospital destination.
- Ground ambulances **should not** excessively delay transport waiting for a helicopter to arrive. If the patient is ready for transport and air transport is delayed, the EMS service may consider initiating transport to the hospital or reassigning the landing zone.
- Under Georgia law, the patient has the right to determine to which hospital they choose to be taken. If the patient is a minor or incompetent, the parent or legal guardian has the right to exercise that authority.
- Contact medical control to address concerns about patient care, destination, or air transport decisions.
- The EMS Patient Care Report (PCR) contains vital information regarding the scene conditions, mechanism of injury, patient condition when contact was first made by the EMS personnel, and treatment provided in the field. Ideally, the PCR should be submitted on patient arrival to the designated trauma center.
- The EMS Quick Report Form can be used by EMS personnel to provide patient care information to the receiving facility upon delivery of the patient until a PCR can be completed and delivered to the receiving facility and submitted to GEMSIS Elite. This EMS Quick Report complies with the EMS Rule 511-9-2-.14.
- The PCRs of initial scene EMS providers are extremely important and should be provided to the designated trauma center in the event of helicopter transport or interfacility transfer.
- Patients who do not meet any of the above triage criteria should be transported to the most appropriate medical facility as outlined in local EMS protocols.



Georgia Designated Trauma and Specialty Care Centers

<u>FACILITY</u>	<u>CITY</u>	<u>COUNTY</u>	<u>NUMBER</u>
LEVEL I			
*Augusta University Medical Center	Augusta	RICHMOND	706-721-3153
*Grady Memorial Hospital	Atlanta	FULTON	404-616-6200
*Atrium Health Navicent	Macon	BIBB	478-633-1584
Memorial Health Univ. Medical Center	Savannah	CHATHAM	912-350-8861
(See Specialty Care Centers for Pediatric Center)			
LEVEL II			
Atrium Health Floyd	Rome	FLOYD	706-509-5000
Doctors Hospital of Augusta	Augusta	RICHMOND	706-651-3232
*Northside Hospital Gwinnett	Lawrenceville	GWINNETT	678-312-4321
*Northeast Georgia Medical Center	Gainesville	HALL	770-219-1200
Piedmont Athens Regional	Athens	CLARKE	706-475-3020
Piedmont Columbus Regional	Columbus	MUSCOGEE	706-571-1901
*Wellstar Kennestone Hospital	Marietta	COBB	770-793-5000
*Wellstar North Fulton Hospital	Roswell	FULTON	770-751-2559
(See Specialty Care Centers for Pediatric Center) (*ACS Verified at [] specified)			
<u>FACILITY</u>	<u>CITY</u>	<u>COUNTY</u>	<u>NUMBER</u>
LEVEL III			
Advent Health Redmond	Rome	FLOYD	706-291-0291
Crisp Regional Hospital	Lele	CRISP	229-636-3100
Fairview Park Hospital	Dublin	LAURENS	478-335-2000
Hamilton Medical Center	Dalton	WHITFIELD	706-272-6150
John D. Archbold Memorial Hospital	Thomasville	THOMAS	229-228-2834
*Piedmont Cartersville	Cartersville	BARTOW	770-382-1530
Piedmont Walton	Monroe	WALTON	770-267-1781
Wellstar Cobb Hospital	Austell	COBB	470-732-4000
LEVEL IV			
Atrium Health Floyd Polk Medical Center	Cedartown	POLK	770-748-2500
Effingham Health System	Springfield	EFFINGHAM	912-754-6451
Emanuel Medical Center	Swainsboro	EMANUEL	478-289-1100
Memorial Health Meadows Hospital	Vidalia	TOOMBS	912-535-5555
Morgan Medical Center	Madison	MORGAN	706-752-2261
Winn Army Community Hospital	Ft. Stewart	LIBERTY	912-435-6721
Wellstar Paulding Hospital	Hiram	PAULDING	470-644-7000
Wellstar Spalding Regional Hospital	Griffin	SPALDING	770-228-2721
Wellstar West GA Medical Center	LaGrange	TROUP	706-882-1411

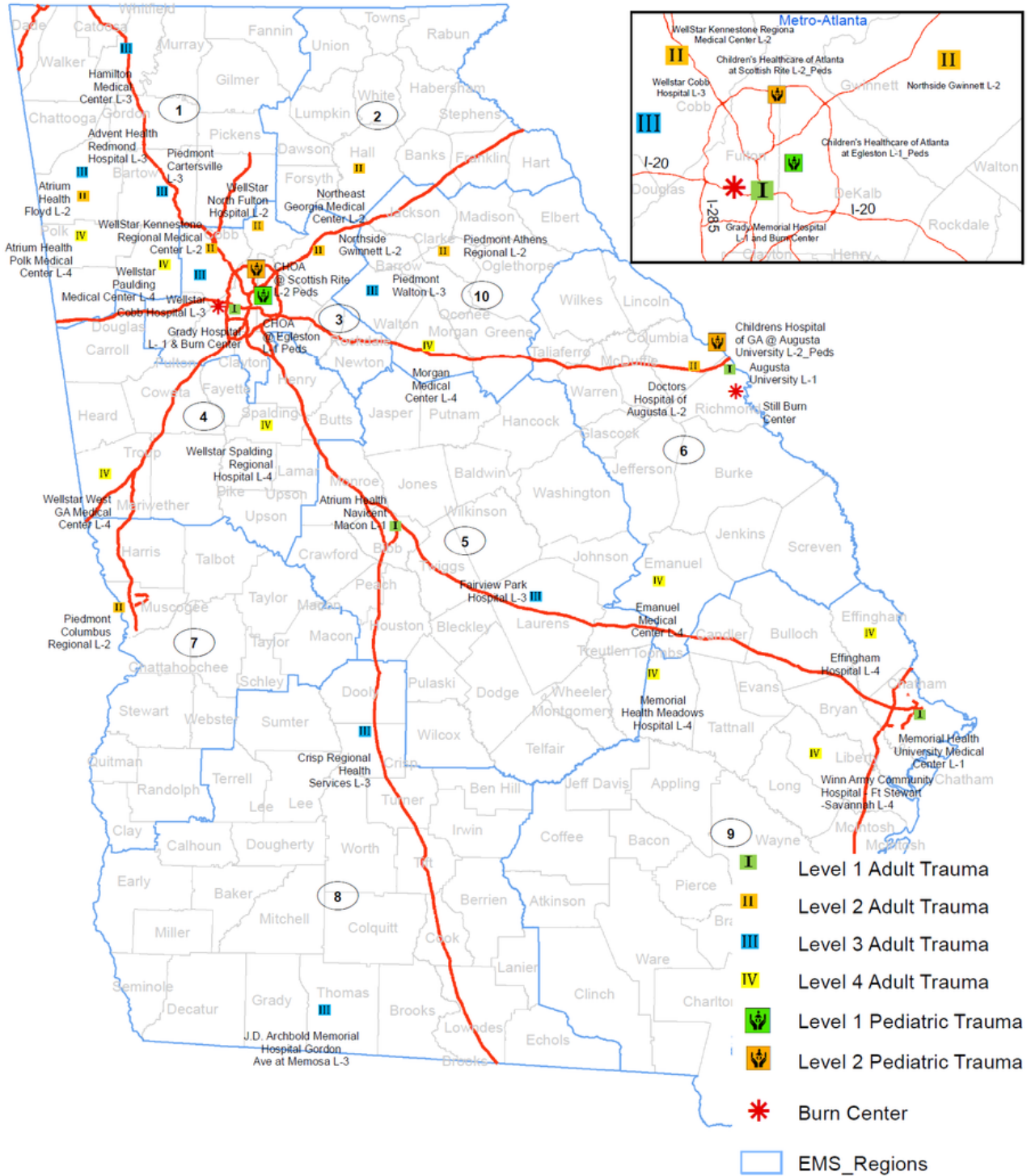


Georgia Designated Trauma and Specialty Care Centers

<u>Pediatric Trauma Centers</u>		<u>Specialty Care Centers</u>		
*Children’s Healthcare of Atlanta@ Egleston (Level I)	Atlanta	DEKALB		404-785-6405
Children’s Healthcare of Atlanta @ Scottish Rite (Level II)	Atlanta	FULTON		404-785-2275
*Children’s Hospital of GA @ Augusta University (Level II)	Augusta	RICHMOND		706-721-3153
<u>Designated Burn Centers</u>				
Joseph M. Still Burn Center	Augusta	RICHMOND		706-651-6399
Grady Burn Center	Atlanta	FULTON		404-616-6178

(See Specialty Care Centers for Pediatric Center)
(*ACS Verified at level specified)
Georgia Department of Public Health ♦ Office of EMS/Trauma
 1680 Phoenix Blvd., Suite 200, Atlanta, GA 30349
 Phone: 404-569-3119 (Updated 10/14/2022)

GEORGIA DESIGNATED TRAUMA AND SPECIALTY CARE CENTERS:



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

TRAUMA CENTER LEVEL DESCRIPTIONS:

Trauma center levels across the United States are identified in two fashions – A designation process and a verification process. The different levels refer to resources available in a trauma center and the number of patients admitted yearly.

Trauma Center designation is a process outlined and developed at a state level. In Georgia, the Department of Public Health, Office of EMS and Trauma has both the legislative and regulatory authority to designate Trauma Centers. Trauma Center verification is an evaluation process done by the American College of Surgeons (ACS). The ACS verifies the presence of the resources listed in Resources for Optimal Care of the Injured Patient. These include commitment, readiness, resources, policies, patient care, injury prevention, and performance improvement.

Facilities are designated as Adult or Pediatric Trauma Centers. It is not uncommon for facilities to have different designations for each group (i.e., a Trauma Center may be a Level I Adult facility and also a Level II Pediatric Facility). Below are common criteria for Trauma Centers.

LEVEL I TRAUMA CENTER

A Level I Trauma Center is a comprehensive regional resource and a tertiary care facility central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation.

Elements of Level I Trauma Centers Include:

- 24-hour in-house coverage by general surgeons, and prompt availability of care in specialties such as orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, internal medicine, plastic surgery, oral and maxillofacial, pediatric, and critical care.
- Referral resources for communities in nearby regions.
- Provides leadership in injury prevention and public education to surrounding communities.
- Provides continuing education to the trauma team members.
- Incorporates a comprehensive quality assessment program.
- Operates an organized teaching and research effort to help direct new care innovations.
- Program for substance abuse screening and patient intervention.
- Meets minimum requirement for annual volume of severely injured patients.

LEVEL II TRAUMA CENTER

A Level II Trauma Center is able to initiate definitive care for all injured patients.

Elements of Level II Trauma Centers Include:

- 24-hour immediate coverage by general surgeons and coverage by specialties such as orthopedic surgery, neurosurgery, emergency medicine, radiology, and critical care.
- Tertiary care needs such as cardiac surgery, hemodialysis, and microvascular surgery may be referred to a Level I Trauma Center.
- Provides trauma prevention and continuing education programs for staff.
- Incorporates a comprehensive quality assessment program.

LEVEL III TRAUMA CENTER

A Level III Trauma Center is able to provide prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients.

Elements of Level III Trauma Centers Include:

- 24-hour immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists.
- Incorporates a comprehensive quality assessment program
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Provides backup care for rural and community hospitals.
- Offers continued education of the nursing and allied health personnel or the trauma team.
- Involved with injury prevention efforts and must have an active outreach program for its referring communities.

LEVEL IV TRAUMA CENTER

A Level IV Trauma Center can provide advanced trauma life support (ATLS) before transferring injured patients to a higher-level trauma center. A Level IV Trauma Center is capable of providing evaluation, stabilization, and diagnostic capabilities for injured patients.

Elements of Level IV Trauma Centers Include:

- Basic emergency department facilities to implement ATLS protocols and 24-hour laboratory coverage. Available trauma nurse(s) and physicians are available upon patient arrival.
- May provide surgery and critical-care services if available.
- Has developed transfer agreements for patients requiring more comprehensive care at a Level I or Level II Trauma Center.
- Incorporates a comprehensive quality assessment program.
- Involved with prevention efforts and must have an active outreach program for its referring communities.

REGION 5 GUIDELINE FOR THE INTER-FACILITY TRANSFER OF TRAUMA SYSTEM PATIENTS:

INDICATIONS - Trauma patients who meet any of the following trauma triage criteria shall be considered Trauma System patients. The objective is to identify and then transport Trauma System patients to an appropriate hospital for definitive care within an optimal time.

RED CRITERIA - Patients meeting any one of the **RED CRITERIA** below are considered at High Risk for Serious Injury and should be transferred to the highest level of care within the trauma system. (Level I or II)

- **Injury Patterns -**
 - Penetrating injuries to head, neck, torso, and proximal extremities
 - Skull deformity, suspected skull fracture
 - Suspected/confirmed spinal injury with new motor or sensory loss
 - Chest wall instability, deformity, or suspected flail chest
 - Suspected/confirmed pelvic fracture*
 - Suspected/confirmed fracture of two or more proximal long bones
 - Crushed, degloved, mangled, or pulseless extremity
 - Amputation proximal to wrist or ankle
 - Active bleeding requiring a tourniquet or wound packing with continuous pressure
- **Mental Status & Vital Signs -**
 - All Patients
 - Unable to follow commands (motor GCS < 6)
 - RR < 10 or > 29 breaths/min
 - Respiratory distress or need for respiratory support
 - Room-air pulse oximetry < 90%
 - Age 0–9 years
 - SBP < 70mm Hg + (2 x age in years)
 - Age 10–64 years
 - SBP < 90 mmHg or HR > SBP
 - Age ≥65 years
 - SBP < 110 mmHg or HR > SBP

YELLOW CRITERIA - Patients meeting any one of the **YELLOW CRITERIA BELOW, WHO DO NOT MEET RED CRITERIA**, are considered at Moderate Risk for Serious Injur. Consider transfer to a trauma center, as available within the geographic constraints of the trauma system (need not be the highest-level trauma center)

- **Mechanism of Injury-**
 - High-Risk Auto Crash
 - Partial or complete ejection
 - Significant intrusion (including roof)
 - >12 inches occupant site OR
 - >18 inches any site OR
 - Need for extrication for entrapped patient
 - Death in passenger compartment
 - Child (age 0–9 years) unrestrained or in an unsecured child safety seat
 - Vehicle telemetry data consistent with severe injury
 - Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.)
 - Pedestrian/bicycle rider thrown, run over, or with significant impact
 - Fall from height > 10 feet (all ages)
- **Provider Judgement -**
 - **Consider risk factors, including:**
 - Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact
 - Anticoagulant use
 - Suspicion of child abuse
 - Special, high-resource healthcare needs
 - Pregnancy > 20 weeks
 - Burns in conjunction with trauma
 - Children should be triaged preferentially to pediatric capable centers

CRITERIA FOR CONSIDERATION OF TRANSFER FROM LEVEL III CENTERS TO LEVEL I OR II CENTERS
1. Carotid or vertebral arterial injury.
2. Torn thoracic aorta or great vessel.
3. Cardiac rupture.
4. Bilateral pulmonary contusion with Pao2 :Flo2 ratio less than 200.
5. Major abdominal vascular injury.
6. Grade IV or V liver injuries requiring transfusion of more than 6 U of red blood cells in 6 hours.
7. Unstable pelvic fracture requiring transfusion of more then 6 U of red blood cells in 6 hours.
8. Fracture or dislocation with loss of distal pulses.
9. Penetrating injuries or open fracture of the skull.
10. Glasgow Coma Scale score of less than 14 or lateralizing.
11. Spinal fracture or spinal cord deficit.
12. Complex pelvis/acetabulum fractures.
13. More than two unilateral rib fractures or bilateral rib fractures with pulmonary contusion (if no critical care consultation is available).
14. Significant torso injury with advanced comorbid disease (such as coronary artery disease, chronic obstructive pulmonary)

Table 1

PROCEDURES - Most critically injured patients meeting trauma system criteria should be identified at the scene by EMS providers. However, a small subset of critically injured patients may present to the local Emergency Room via private vehicle or by EMS. Ideally, those patients needing the resources offered at a trauma center should be quickly identified during their Emergency Department primary survey. At which point, transfer to a Level I or II Trauma Center will need to occur without unnecessary delay. This guideline was developed to meet the needs of this small subset of patients. The primary objective of the procedures outlined below is designed to ensure that patients identified as meeting trauma criteria are transported to an appropriate trauma center within an optimal time. Hospitals without surgical capabilities should not delay transfer to obtain studies that would be needed to identify specific injuries, as the trauma criteria included in these guidelines are intended to prompt consideration for transfer.

Patient arrives at Participating Hospital via EMS or Private vehicle -

- Provide appropriate care. (Initiating these guidelines should begin while resuscitative efforts are in progress.)
- The ED physician should perform any lifesaving procedures and attempt to stabilize the patient's condition within the capabilities of the facility.
- If on evaluation, the ED physician determines the patient meets trauma system criteria, establish early communication with the transfer center at the appropriate Trauma Center.
- The transfer center will then facilitate communication between the referring and receiving facilities so that an appropriate exchange of information and Physician to Physician communication will occur.
- All documentation mandated by EMTALA and COBRA will still need to be completed. (It is acceptable to fax to the receiving facility.)
- Any prehospital documentation available at the time of transfer should be sent with the transfer paperwork to the receiving facility.
- Decisions regarding the use of full or partial spinal motion restriction (SMR) should be determined by the accepting physician in consultation with the referring physician.
- Transferring EMS units should establish communications with the receiving hospital at least 10 minutes prior to arrival to provide a patient report and/or update patient status.

Source: The National Guideline for Field Triage of Injured Patients and Resources for Optimal Care of the Injured Patient 2014, Committee on Trauma, American College of Surgeons.

REGION 5 REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC) PEER REVIEW AND PERFORMANCE IMPROVEMENT PROCESS:

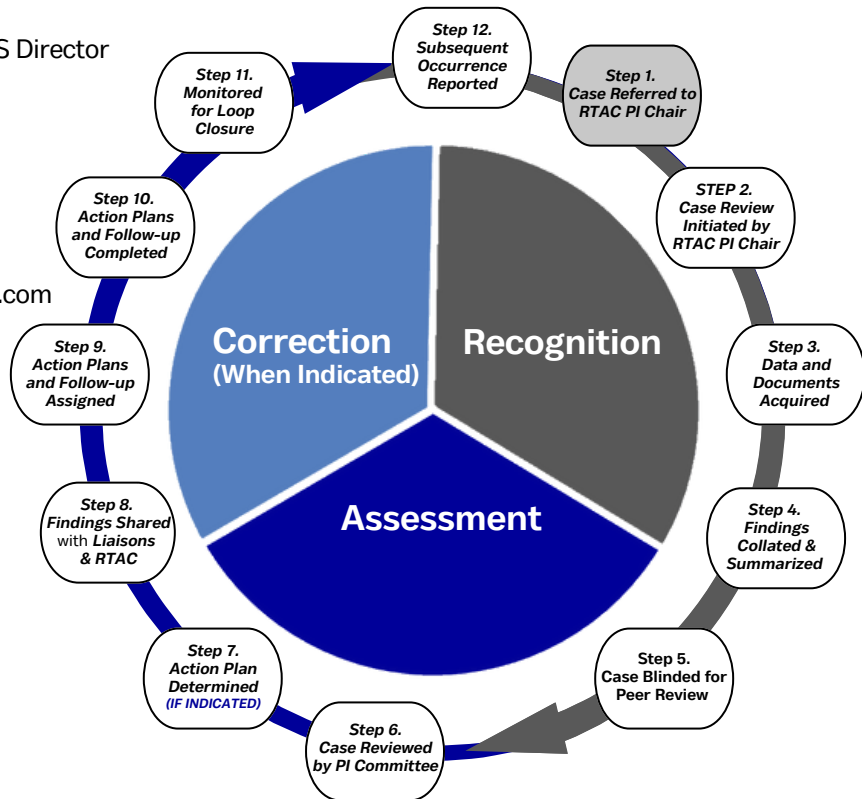
Ongoing evaluation and improvement of the trauma care system are essential throughout the patient care continuum. Therefore, prehospital and hospital stakeholders are encouraged to make Peer Review referrals to the RTAC Performance Improvement (PI) Subcommittee using the contact information below.

Contacts:

Michelle Archer, Regional EMS Director
michelle.archer@dph.ga.gov
678-867-4427

Todd Dixon, RTAC Chairman
todd.dixon@atriumhealth.org
478-454-3500

Lynn Grant, RTAC PI Chair
dianna.grant@hcahealthcare.com
478-274-3194



Modified Continuous Performance Improvement Process - Resources for Optimal Care of the Injured Patient 2014, ACS-COT

Step 1.	System stakeholder provides a case referral to RTAC PI Subcommittee Chair	Step 7.	RTAC PI Subcommittee determines what type of corrective Action Plan is indicated.
Step 2.	Case review is initiated by RTAC PI Subcommittee Chair	Step 8.	RTAC PI Subcommittee Chair or the Regional EMS Program Director shares review findings to appropriate EMS and Hospital liaisons and the RTAC
Step 3.	Pertinent data and documentation acquired <ul style="list-style-type: none"> Regional EMS Program Director acquires EMS documentation RTAC PI Subcommittee Chair acquires hospital documentation 	Step 9.	When appropriate, system action plans and PI follow-up are assigned to an appropriate PI Subcommittee Member
Step 4.	Documentation findings are collated and summarized by PI Subcommittee Chair	Step 10.	RTAC PI Chair is notified when PI Action Plans are completed
Step 5.	Summarized findings are de-identified ("Blinded") and shared with RTAC PI Committee members for Peer Review	Step 11.	Occurrence is monitored for loop closure or reoccurrence
Step 6.	Case is reviewed by multidisciplinary RTAC PI Subcommittee	Step 12.	<i>Subsequent occurrence is reported to the appropriate EMS and Hospital liaisons and the RTAC</i>

STATEMENT OF COMPLIANCE WITH CONFIDENTIALITY REQUIREMENTS FOR REGION 5 RTAC AND PI SUBCOMMITTEE:

PURPOSE

This document aims to ensure that the Region 5 Regional Trauma Advisory Committee (RTAC) and the Region 5 RTAC Performance Improvement (PI) Subcommittee understand and acknowledge their responsibility to maintain the confidentiality of the Region 5 RTAC's performance improvement proceedings.

EMS Trauma Advisory Councils are considered review organizations as defined in O.C. G.A. Section 31-7-131 (2) and (3), and are covered by the immunity and confidentiality provision of O.C.G.A. Sections 31-7-132 and 31-7-133. Data that is received or compiled by the Region 5 RTAC PI Subcommittee in conjunction with Region 5 EMS Council monitoring to ensure the quality of trauma patient care shall be confidential and privileged, non-discoverable, and inadmissible in any proceedings. No person serving on or communicating information to the Region 5 RTAC shall be examined as to any such communications or to the findings or recommendations of the RTAC. A person serving on or communicating information to the RTAC shall not be subject to an action for civil damages for actions taken or statements made in good faith. The confidentiality provisions of O.C.G.A Section 31-7-31 (2) and (3) and O.C.G.A. Sections 31-7-132 and 31-7-133 shall also apply to the monitoring and performance improvement activities of the Region 5 RTAC and the Region 5 EMS Council.

Disclosure by an RTAC member and or RTAC PI Subcommittee member of any investigative information or any discussion of such information with unauthorized persons is a violation of Georgia law and may expose that member to potential liability for the unauthorized release of information.

PROCEDURES

The Region 5 EMS Council has provided the Region 5 RTAC with guidance concerning procedures for conducting PI activities. Members of the RTAC and PI Subcommittee must abide by the following:

- No information discussed and/or distributed for the purposes of regional peer review may be shared or discussed outside of the RTAC PI membership except as assigned by the chair.
- Members may discuss matters brought to the committee's attention only as official business; they may not discuss with others or disseminate confidential information obtained in the course of these meetings or meeting preparation.
- The RTAC PI Subcommittee Chair and Regional EMS Program Director are responsible for obtaining information necessary for PI case review and follow-up.
- All information identifying patients, agencies, organizations, and caregivers shall be redacted during all RTAC PI discussions and correspondence.

STATEMENT OF COMPLIANCE

I, the undersigned, have read and understand the above and agree to comply with requirements regarding confidentiality. Should I not comply with the requirements regarding confidentiality, I agree to resign immediately from the Region 5 RTAC and/or PI Subcommittee. Additionally, I understand that the failure to comply with the confidentiality requirements incumbent upon me may result in my being held personally liable for the unauthorized release of information provided to me in my capacity as a member of the Region 5 RTAC and/or RTAC PI Subcommittee.

This _____ day of _____, 20____

Central Georgia Region 5 Regional Trauma Advisory Committee

Essential Communication: Prehospital TIME OUT Report


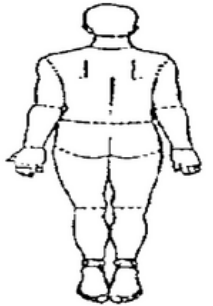


M	<p><u>M</u>ECHANISM OF INJURY: PROVIDE PATIENT AGE, SEX, AND MECHANISM OF INJURY</p>
I	<p><u>I</u>NJURIES: LIST INJURIES OR INSPECTIONS HEAD TO TOE; TIME OF INJURY</p>
S	<p><u>S</u>VITAL <u>S</u>IGNS: PROVIDE FIRST SET AND SIGNIFICANT CHANGES; INCLUDE GLUCOSE</p>
T	<p><u>T</u>REATMENT: DESCRIBE TREATMENT PROVIDED AND PATIENT’S RESPONSE TO TREATMENT</p>

- Procedure:**
- 30 second EMS “TIME OUT” performed on patient arrival
 - Trauma Team members remain silent
 - The patient remains on EMS stretcher
 - Trauma Team listens to EMS MIST report
 - Patient is moved on completion of the EMS report

"Give EMS 30 seconds, we'll tell you everything you need to know."
 — *David Miramontes, MD, NREMT*

Right Patient • Right Place • Right Time • Right Means

EMS Quick Report		Transport EMS Agency: _____	EMS																																																							
Incident Date: ____/____/20____		Incident #: _____ Unit #: _____																																																								
Transport EMS Crew Members: #1 _____ #2 _____																																																										
List all other First Responder Agencies who were present on scene and had contact with the patient:																																																										
PT	Patient Last Name: _____		Age: _____ Sex: _____																																																							
	Patient First Name: _____		DOB: ____/____/____																																																							
Pt's Chief Complaint: _____			Call Type: <input type="checkbox"/> Scene <input type="checkbox"/> Transfer																																																							
Incident <input type="checkbox"/> TRAUMA (Alert given? Yes / No) <input type="checkbox"/> STROKE (Alert given? Yes / No) Type: <input type="checkbox"/> CARDIAC (if STEMI or OHCA, Alert given? Yes / No) <input type="checkbox"/> OTHER : _____																																																										
TIMES	Dispatched: ____:____	Record Date/Time of Injury or Last Known Well: ____/____/20____ @ ____:____																																																								
	On Scene: ____:____	Times as Time of FMC: ____:____ (First Medical Contact)																																																								
	Left Scene: ____:____	Applicable: Time of ALERT: ____:____ (TRAUMA/STROKE/STEMI/OHCA Alert)																																																								
	@Destination: ____:____	(Alert = Pre-notification to hospital) - circle type of alert																																																								
Cardiac Arrest		Time of Initial Arrest ____:____ Time of ROSC: ____:____																																																								
		Time CPR Started ____:____ Initial ECG Rhythm: _____																																																								
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(Print Name)																																																										
Signature of Person Receiving Pt: _____																																																										
This form is to be used by EMS personnel to provide Pt care information to the receiving facility upon delivery of the Pt, and should BE LEFT AT THE RECEIVING FACILITY PRIOR TO DEPARTURE OF THE CREW. THIS FORM DOES NOT REPLACE THE NEED TO SUBMIT AN ePCR. Agencies must submit ePCRs to GEMSIS Elite within 24 hours of call completion, and hospitals may access those patient care reports on Hospital Hub. To gain access to Hospital Hub, please contact your Regional EMS Director (go to https://dph.georgia.gov/EMS and click on Regional EMS Systems) and they will forward your request.																																																										

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