



REGION 2 EMERGENCY MEDICAL SERVICES

Regional Trauma Plan



Table of Contents

- Executive Summary
- Mission and Vision
- Region 2 Board of Directors
- Georgia Trauma Commission
- RTAC Authority and Structure
- RTAC Bylaws and Membership
- Pre-hospital Care
 - Communications
 - Triage and Facility Selection
 - Ground Transport
 - Air Medical Transport
- Hospital Care
 - Trauma Centers
 - Non-Trauma Facilities
 - Inter-facility Transfers
 - Pediatric and Burn Care
- Performance Improvement
- Injury Prevention and Community Outreach
- Emergency Preparedness
- RTAC Subcommittees
 - Education
 - Injury Prevention and Community Outreach
 - Medical Oversight
 - Performance Improvement
 - Pre-hospital and Communications
- Appendices
 - Georgia Trauma Centers
 - Counties in Region 2
 - EMS Providers in Region 2
 - Primary Triage Decision Scheme
 - Aircraft Response Distances
 - Hospitals in Region 2
 - Indications for Trauma Patients Requiring Transfer to a Major Trauma Center
- Glossary of Terms

Executive Summary

Trauma represents a serious health concern for Georgia's citizens with the death rate from injury being eight percent higher than the national average. Studies have shown that many of these deaths are preventable and that the implementation of a cohesive, statewide trauma system can improve trauma patient outcomes and reduce deaths.

Currently, only one in four patients in Georgia who require the services of a trauma team are being treated at designated trauma centers. This statistic alone demonstrates the need for Georgia to continue developing its statewide trauma system of which the regional trauma systems are key components.

The American College of Surgeons Committee on Trauma (ACS-COT) notes that an ideal trauma system includes the following components:

- Leadership
- System development
- Pre-hospital care
- Definitive hospital care
- Data collection and trauma system evaluation
- Public policy and information
- Education and prevention
- Human resources
- Legislation and finance

To this end, Region 2's Regional Trauma Advisory Committee (RTAC) has been charged with creating a trauma plan that addresses the needs of the region's 13 counties and approximate 700,000 residents. The purpose of Region 2's *Regional Trauma Plan* is to define the resources and processes necessary to provide comprehensive care to trauma patients from the moment of injury through rehabilitation. The plan addresses the concerns of both the urban and rural areas of Northeast Georgia; including its unique geographic and transport challenges. A well-defined infrastructure, data driven planning, stakeholder collaboration and a stable funding source are the keys to the plan's ongoing success.

REGION 2 EMS REGIONAL TRAUMA SYSTEMS

Mission and Vision

MISSION

To be a model regional trauma system in Georgia; reducing the morbidity and mortality of injured patients

VISION

To strive for excellence in trauma patient care by providing evidence-based trauma care, provider education and community injury prevention

MOTTO

The right patient to the right place in the right time, and by the right means

Region 2 Board of Directors 2017

Chair: Chad Black

Vice Chair: Deb Battle

Secretary/Treasurer: Lisa Farmer

Education: Sam Stone

Injury Prevention: Donna Lee

Medical Oversight: Nathan Creel, MD

Performance Improvement: Jesse Gibson

Pre-hospital Communication: Kyle Powers

Georgia Trauma Commission

The Georgia Trauma Commission (GTC) was created by the Georgia Legislature in 2007. The Commission is charged with establishing, maintaining, and administering a statewide trauma center network; including overseeing legislative funds provided for trauma system improvement. The Commission consists of the following subcommittees:

- Georgia Trauma Medical Directors
- Georgia Committee for Trauma Excellence
- EMS Subcommittee on Trauma

The GTC Executive Director is Dena Abston. Georgia Trauma Commission members are appointed by the Governor (5 members), Lieutenant Governor (2 members) and House Speaker (2 members) for four year terms. Members can be reappointed. Current members include:

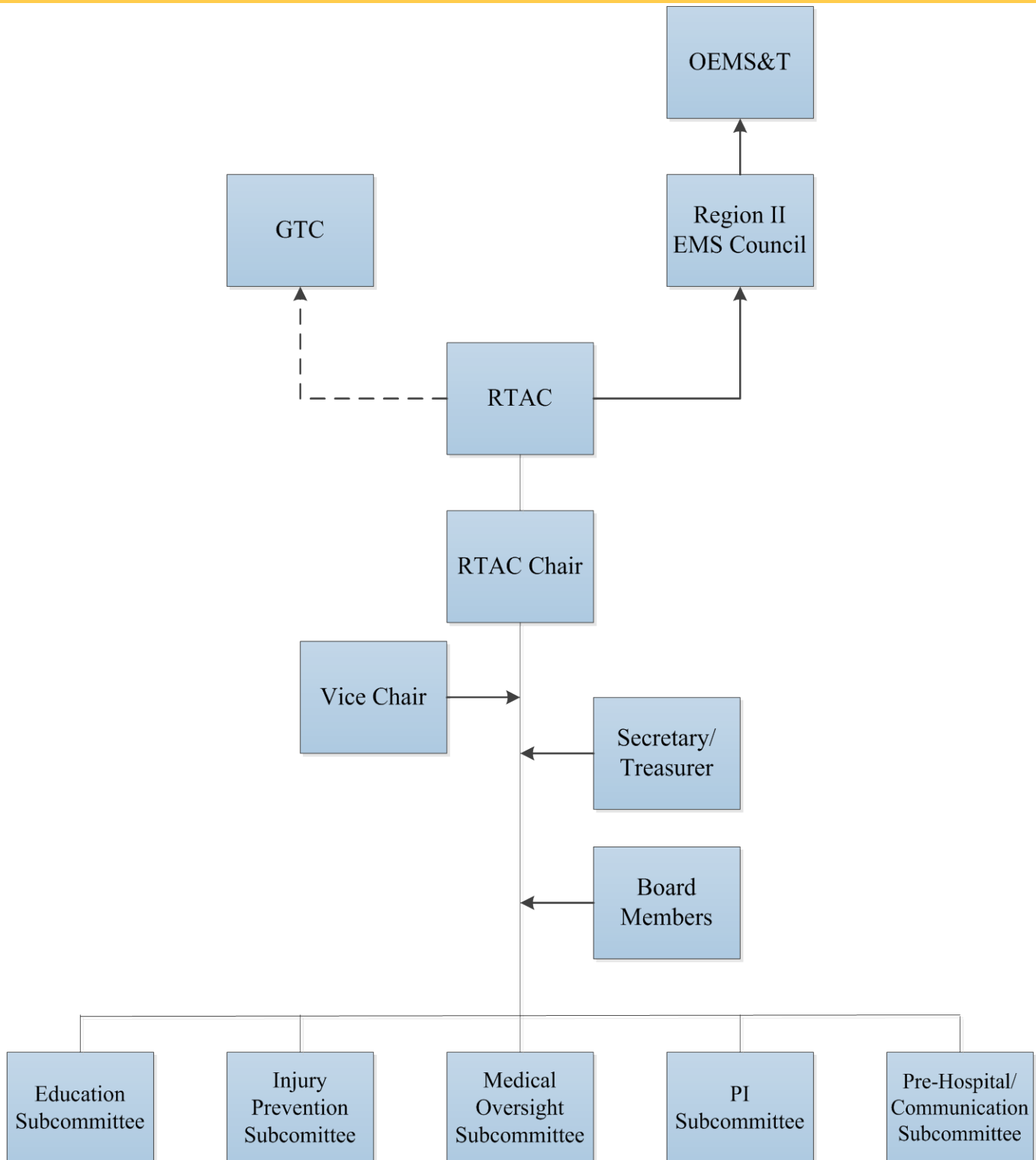
- Dennis Ashley, MD - Chair
- Fred Mullins, MD – Vice Chair
- Victor Drawdy – Secretary/Treasurer
- Mark Baker
- John Bleacher, MD
- Robert Cowles, MD
- James Dunne, MD
- Jeffrey Nicholas, MD
- Courtney Terwilliger

The GTC requires each EMS region to establish a Regional Trauma Advisory Committee (RTAC). Committee members include trauma care providers, administrators and community members from throughout the specific EMS region and trauma service area. The primary purpose of the RTAC is to develop, implement and maintain a trauma system plan that meets the needs of the region and improves trauma care across the healthcare continuum.

For more information on the GTC, please refer to www.georgiatraumacommission.org

RTAC Authority and Structure

In 2009, the Georgia Trauma Commission established the RTAC framework in an effort to develop the regional trauma plans necessary for the development of a cohesive statewide trauma plan. As demonstrated in the below diagram, the RTAC has joint reporting responsibility to the Georgia Trauma Commission and the region's EMS Council.



Bylaws

The RTAC adheres to all Region 2 EMS Council bylaws. Please refer to the Region 2 EMS website, <http://www.garegion2ems.org>, for additional information:

RTAC Membership

- **General Membership**
The RTAC consists of pre-hospital providers, hospital administrators, physicians, hospital staff, local governments and community members interested in improving trauma care in Region 2. Members may represent agencies within Region 2 or its contiguous counties.
- **RTAC Board of Directors**
The RTAC Board of Directors consists of the Chair, Vice Chair, Secretary/Treasurer and each of the Subcommittee Chairs. Although the RTAC encourages participation and input from all members, voting is the responsibility of the RTAC Board of Directors.
- **Term Limits**
Each Board member serves a two year term and can be reappointed one time. The term begins with the first meeting of each calendar year.
- **Resignation and Removal**
A Board member may resign by giving written notice to the RTAC Chair. The resignation is effective at the time notice is given. A Board member who misses three consecutive RTAC meetings will be removed from the Board.
- **Vacancies**
Any Board vacancy caused by resignation, removal or other means will be filled by the Chair for the remainder of the unexpired term.

Meeting Frequency

The RTAC meets on a quarterly basis in January, April, July and October. Subcommittee meetings are at the discretion of the Subcommittee Chair.

Meeting Minutes

- **RTAC**
 - Meeting minutes are the responsibility of the RTAC Secretary and will be disseminated to all RTAC members no later than two week after the meeting. The minutes will then be approved at the next quarter's meeting.
- **Subcommittee**
 - Meeting minutes are the responsibility of the subcommittee chair, or designee, and will be submitted to the RTAC Secretary for dissemination to all RTAC members no later than two weeks after the subcommittee meeting.

Confidentiality

All information, data and proceedings of the RTAC are confidential. Knowledge gained at these meetings shall not be used for personal benefit or the detriment of the RTAC.

Pre-hospital Care

In 2009, during a consultative visit to review Georgia's trauma system, the American College of Surgeons Committee on Trauma's Consultative Team identified that 89% of all critical trauma patients in Georgia were delivered into the system by Emergency Medical Services (EMS) personnel. The Team stated "EMS is often a crucial link between the injury-producing event and definitive care at a trauma center."

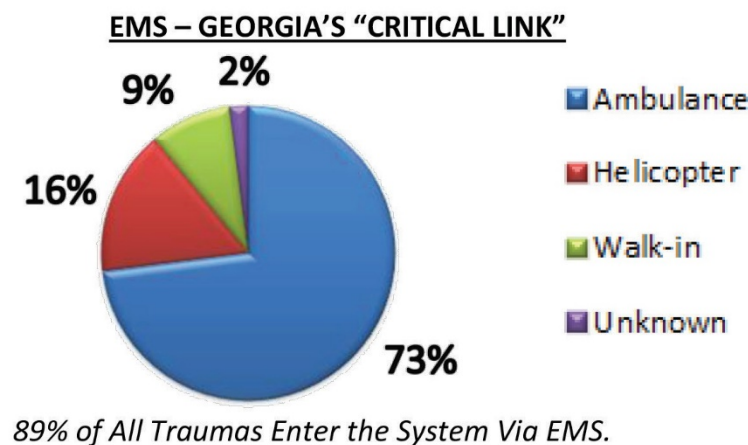


Figure 2

Although a critical link, EMS providers do not provide definitive care and therefore, trauma patients require a fully functioning trauma system; including pre-hospital providers, physicians, nurses and support staff who are committed to care for this population of patients.

Pre-hospital Communications

In order to get the trauma patient to the appropriate facility capable of providing the necessary care in a timely fashion, it is essential there be clear communications between pre-hospital providers themselves, as well as between pre-hospital and hospital personnel. This communication process is included in Region 2's Regional Communications Plan which is currently undergoing revision.

Triage and Facility Selection

In order to get the right patient to the right place in the right time, it is important Region 2 pre-hospital and hospital trauma providers understand and utilize Georgia's *Primary Triage Decision Scheme* (Appendix D) when determining if a patient requires the services of a trauma center. The criteria used to assist the provider in making this determination include:

- Vital signs
- Level of consciousness
- Injuries
- Mechanism of injury
- Special patient considerations

Adult trauma patients (greater than or equal to 15 years old) who meet trauma center criteria are to be transported to the closest available trauma center for evaluation and management.

Ideally, all pediatric trauma patients (less than 15 years old) meeting pre-hospital criteria for transport to a trauma center should be triaged to Children's Healthcare of Atlanta (CHOA); however, recognizing transport time, availability of AMS and the large number of children requiring CHOA's services, this may not always be realistic. Given these factors, it is appropriate for the pre-hospital provider to take into consideration NGMC's Trauma Team Activation criteria when determining destination with pediatric patients meeting NGMC's Level I or II Trauma Team Activation criteria being transported directly to a pediatric center and pediatric patients meeting NGMC's Level III criteria being transported to NGMC for further evaluation.

Both CHOA campuses (Egleston and Scottish Rite) are to be considered equivalent for the vast majority of pediatric trauma patients. The only exceptions are patients with penetrating trauma to the torso or those with vascular injuries that may require surgical intervention - these patients should be transported to the Egleston campus. CHOA's Dispatch Center can assist in determining the appropriate facility.

If there are questions regarding the transport destination for adult or pediatric trauma patients, the pre-hospital provider will contact Medical Control for guidance.

Pre-hospital Resources

Georgia's Region 2 EMS catchment area is comprised of 13 counties, spans 3,392 square miles and serves a population of over 661,000 people. If one considers the three counties adjoining Region 2 (Barrow, Gwinnett and Jackson), the population grows to approximately 1,674,700.

The region's pre-hospital resources consist of 13 911 EMS services along with additional private EMS providers. There are also a total of six air medical services (AMS) available to the region – two are based in the region (Blairsville and Gainesville) and four others are nearby. A list of both helicopter and fixed wing programs is included in the Appendices.

Helicopter Transport

When a helicopter is being considered for the pre-hospital transport of trauma patients, there are unique factors the pre-hospital team needs to take into account:

- It is imperative for pre-hospital providers to balance the decision-making process regarding waiting for a helicopter versus initiating rapid ground transport. If helicopter arrival is anticipated to be delayed, then the provider must consider ground transport. *The goal is to deliver the patient to the appropriate facility in the shortest amount of time.*

- The majority of trauma patients necessitating air transport can be flown to NGMC rather than a Level I trauma center.
 - The exceptions are burn patients and pediatric patients less than 15 years old. Both these patient populations benefit from immediate transport to a definitive burn/pediatric trauma center.
 - There are other occasions in which transport to another trauma center may be required. These include, but are not limited to, mass casualty incidents, hospital capacity/saturation or patients with unique/complex injuries that may require a specialty service such as reimplantation. In these instances, close communication between the EMS service, helicopter crew and NGMC Dispatch/Emergency Department assures the patient is transported to the most appropriate facility.

Situations Appropriate for Air Medical Services

Air medical transport services is an air ambulance and an extension of EMS. It should be considered in situations wherein:

- The transport of critically ill or injured patient(s) to an appropriate facility will be faster by air medical transport service than by ground ambulance, if time is determined to be a factor in patient care
- If specialized services offered by the air medical transport service would benefit the patient(s) prior to arrival at the hospital
- A patient's condition warrants transportation to a specialty care facility as indicated by specific State or Regional Protocols and the AMS can complete such transportation faster than ground transport
- A multiple casualty incident (MCI) threatens to overload local capabilities
- Ground transportation is compromised
- Difficult access situations such as wilderness rescue, ambulance access or egress impeded at the scene by road conditions, weather or traffic, or other situations cleared by the flight team
- Local EMS resources are overwhelmed and further use of local EMS units will leave response area inadequately covered

Stand By

- The responding EMS service supervisor or 911 center immediately requests helicopter "Stand By" if pre-arrival information leads the provider to believe helicopter transport will be beneficial. This stand by process reduces overall lift, response and transport times opposed to ground crews waiting until arriving at the scene to make this determination.
- Once the ground crew arrives and evaluates the situation, if the highest trained EMS provider on the scene determines air transport is not required, then the stand by is cancelled.

Stand By Criteria

- Gas or other type explosion
- Severe burn injury
- Head-on, Rollover or "T-Bone" collision of motor vehicles
- Motor vehicle crash involving an all-terrain vehicle (ATV), motorcycle, ejection of passenger, or pedestrian struck.
- Any incident with the potential of producing mass casualties or major traumatic injuries.
- Any incident which leaves the local EMS response area inadequately covered keeping in mind the patient meets AMT Criteria.

Hospital Care

Region 2's Trauma Plan is an inclusive plan, meaning both trauma and non-trauma facilities have an integral role in the care of injured patients in the northeast section of the state. The goal in having a regional trauma plan is to assure optimal care for all injured patients by getting them to the right place in the right time by the right means.

The American College of Surgeons Committee on Trauma (ACS-COT) *Resources for Optimal Care of the Injured Patient 2014* is the guiding reference for providers in this region as it clearly delineates both trauma center criteria and the types of patients requiring admission to a trauma center. This reference can be found on the ACS-COT website (www.facs.org) or <https://www.facs.org/~media/files/quality%20programs/trauma/vrc%20resources/resources%20for%200optimal%20care%202014%20v11.ashx>

Trauma Centers

As the only designated trauma center in the northeast region of the state, and as a condition of this designation, Northeast Georgia Medical Center-Gainesville (NGMC), a Level II adult trauma center, acts as the lead agency for the Region 2 RTAC and is the major referral center for adult trauma patients needing transfer from the other hospitals in the region.

Non-Trauma Facilities

All hospitals in the region are encouraged to participate in Region 2's RTAC. Only by active participation will the issues and concerns of these smaller facilities, and their patients, be adequately addressed.

- Chatuge Regional Hospital - Hiawassee
- Chestatee Regional Hospital - Dahlonega
- Habersham Medical Center - Demorest
- Mountain Lakes Hospital - Clayton
- Northeast Georgia Medical Center - Braselton
- Northridge Medical Center - Commerce
- Northside Hospital – Forsyth - Cumming
- St. Mary's Sacred Heart Hospital - Lavonia
- Stephens County Hospital - Toccoa
- Union General Hospital – Blairsville

Inter-facility Trauma Transfers

The Georgia Trauma Medical Directors have established a list of criteria to assist providers in determining which patients benefit from being transferred to a trauma center (Appendix G). Ideally, those patients needing the resources offered at a trauma center will be quickly identified during their Emergency Department primary survey so as to not delay definitive care.

Arrangements for trauma patients requiring transfer to NGMC-Gainesville are made via NGMC's Transfer Center Line (770-219-6400). Staff in the Transfer Center will coordinate a phone call between the sending provider and the appropriate admitting surgeon (Neurosurgery, Orthopedics, Plastic Surgery or Trauma). Once acceptance has been received, the transferring facility will be advised as to where the patient will be admitted (ED, ICU or Surgical Floor) so that report can be given to the receiving NGMC nurse. To assist in care coordination, it is important the transferring facility send all pertinent components of the patient's medical record, including hard copies or CDs of radiology studies, with the patient at the time of transfer.

Pediatric Trauma and Burn Center Care

There is not a pediatric trauma center or burn center in Region 2. For this reason, pediatric trauma patients *less than 15 years of age* are best served by being transferred directly to Children's Healthcare of Atlanta (CHOA). Inter-facility transfers are arranged via the CHOA Transfer Center line at 404-785-7778. Patients meeting burn center criteria are best served at a designated burn center; either Grady Burn Center (404-616-4061) or Still Burn Center (877-863-9595).

Performance Improvement

Performance Improvement

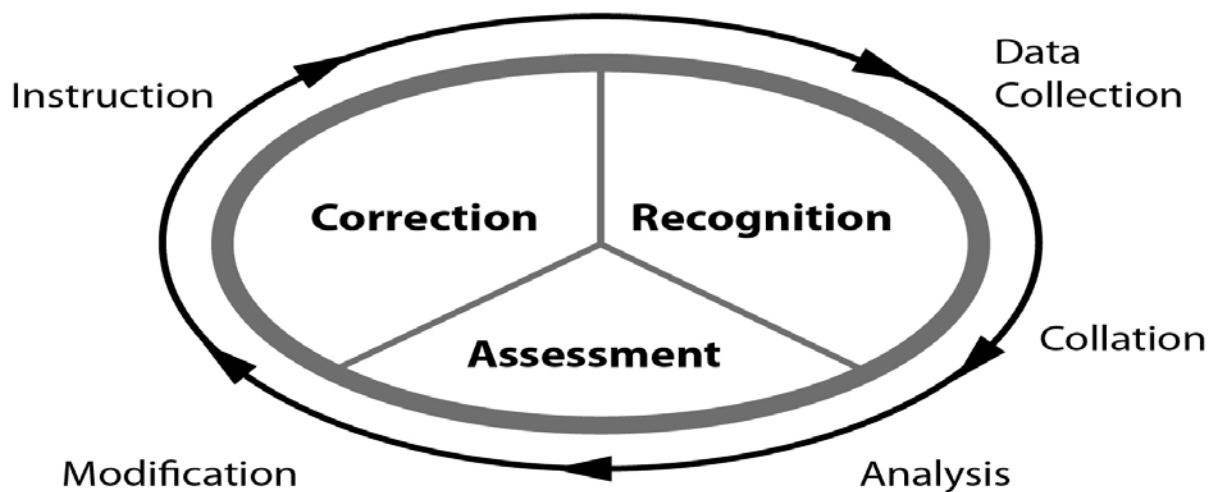
The American College of Surgeons' Committee on Trauma (ACS-COT) requires each trauma center to have a clearly defined, multidisciplinary Trauma Performance Improvement and Patient Safety (PIPS) program that integrates with local and regional trauma system performance improvement (PI) initiatives.

Region 2 trauma system performance improvement, including implementation of improvement plans and evaluation of their effectiveness, is the responsibility of the Region 2 RTAC. Improvement opportunities are identified through various sources:

- NGMC's Trauma Registry
- NGMC's Trauma Case Review Committee (TCRC)
- NGMC's Trauma Steering Committee (TSC)
- Region 2 RTAC

Individual feedback from providers within the region, e.g.: pre-hospital, nursing and physician staff

Once an opportunity for improvement is identified within the region, then an action plan is developed and the appropriate stakeholders take lead on carrying out the plan. Performance improvement is a continuous cycle that does not end when an action plan is complete. Evaluation occurs to ensure the desired effects are accomplished. The Region 2 RTAC is committed to improving care throughout the region using the ACS-COT's continuous process of improvement shown below:



The PI Subcommittee leads the region's PI initiatives; however, PI is the responsibility of all members of the trauma system. The Subcommittee documents PI initiatives and actions and shares progress at quarterly RTAC meetings. The RTAC assists the PI Subcommittee in determining priority focus areas for improvement initiatives, e.g.: injury prevention, community outreach and education. Active participation by all Region 2 EMS agencies and hospitals in trauma system PI is essential to the delivery of high quality trauma care.

Injury Prevention and Community Outreach

According to the Centers for Disease Control and Prevention (*CDC Statistics February 2014*), each year trauma accounts for 41 million emergency department visits and 2.3 million hospital admissions across the United States. Trauma is the number one cause of death between the ages of 1 and 44 and the third leading cause of death in all ages. Trauma is the leading cause of years of productive life lost (YPLL). Trauma is a burden on society's economy (healthcare costs more than \$671 billion annually, decreased productivity, disability costs), on individuals and families (disability, lost wages), and on healthcare (increased resource utilization).

While the statistics can be staggering, each individual affected by trauma is someone's spouse, parent, child, sibling, or loved one. They are people, not simply statistics. While not all injuries can be prevented, many can be.

One of the goals of a trauma system is the development of programs to prevent unnecessary injuries and deaths due to trauma. A key component of these injury prevention programs is to reduce the behavioral and environmental risks through education and awareness strategies. Effective injury prevention programs require a multifaceted approach to include:

- Review of data to accurately identify injury patterns (mechanism of injury, age, gender, etc.), as this will allow the program to target efforts at groups who are at the highest risk for injury
- Form partnerships between a diverse group of citizens who have an interest in injury prevention (EMS, fire and law enforcement agencies, health care providers, public health agencies, etc.)
- Identify local, state and national injury prevention resources
- Identify research-based injury prevention programs which decrease behavioral and environmental risk factors
- Collaboration and coordination at the community level to increase local ability to address needs

Region 2's RTAC is dedicated to making a difference in the community through its injury prevention activities. The first step in the process is analyzing regional data to identify the leading mechanisms of injury and injury patterns, e.g.: age, sex, geographic locations. This data will guide the development and implementation of future injury prevention initiatives; with the ultimate goal being to increase community awareness that injury is preventable and to reduce the incidence of injury in the region.

Emergency Preparedness

The Region 2 RTAC collaborates with the Region 2 EMS Council and the Region B Unified Healthcare Coalition to assure healthcare providers and agencies throughout the region are prepared to respond to multiple or mass casualty events. Although the RTAC has no specific role in Region B's emergency preparedness plan, RTAC members are available to assist the Region B Coalition in its education and outreach initiatives. The RTAC's own initiatives, such as the Stop the Bleed Campaign, also positively impact the region's ability to respond in the event of a disaster.

For more information on Georgia's Emergency Preparedness program, go to www.gha911.org or contact the District II Public Health Healthcare Liaison.

Education Subcommittee

Purpose

To develop, facilitate and teach trauma related continuing education offerings to trauma care providers in Region 2.

Responsibilities

- Perform needs assessments to determine the trauma educational needs of pre-hospital, physician, nursing and support staff through the region
- Develop and implement trauma educational programs to meet the needs of Region 2 trauma care providers
- Coordinate an annual RTAC Symposium
 - Facilitate ACLS, CATN, ENPC, ITLS, NRP, PALS, PEPP, PHTLS, TNCC and RTTDC courses
 - Work in conjunction with other committees in the development of a yearly trauma symposium.

Injury Prevention and Outreach Subcommittee

Purpose

To reduce the incidence of injury through the implementation of effective injury prevention strategies.

Responsibilities

- Review regional injury data to identify leading mechanisms of injury and other injury patterns, i.e.: age, sex, location, intentional, unintentional
- Review literature to identify research-based injury prevention programs which decrease behavioral and environmental risk factors
- Identify current injury prevention programs/locations in region, noting baseline data (number of programs, locations and attendance rates)
- Explore current injury prevention programs offered in the state and nation
- Identify existing and potential community partners who have an interest in injury prevention
- Build relationships with community partners and encourage participation
- Compare injury prevention programs which will address Region 2's leading mechanisms of injury and identified injury patterns, taking into consideration all resources needed for each program
- Develop an implementation plan (and timeline) for the injury prevention program(s) chosen
- Work collaboratively with community partners to implement injury prevention plan
- Evaluate effectiveness on a regular basis:
 - Develop a mechanism to analyze and identify trends in regional injury data
 - Maintain current list of injury prevention programs/locations and compare to baseline data
 - Identify and address gaps
 - Continually research new evidence-based injury prevention programs
 - Continually work to improve injury prevention program and accessibility to community members

Medical Oversight Subcommittee

Purpose

To standardize and expedite trauma care at hospitals throughout the region.

Responsibilities

- Developing strong relationships between the staff at the outlying facilities and NGMC trauma providers
- Developing evidence-based practice guidelines for staff at the outlying facilities to use in their initial resuscitation and management of trauma patients presenting to their facilities
- Assuring the trauma patient transfer process between the outlying facilities and NGMC remains seamless
- Assisting the other subcommittees (Education, PI, etc.) in identifying and resolving issues impacting the care of trauma patients at the outlying facilities

Performance Improvement Subcommittee

Purpose

To improve the trauma care provided throughout Region 2 via the identification of performance improvement (PI) opportunities and implementation of performance improvement action plans.

Responsibilities

The responsibilities of the Region 2 RTAC Performance Improvement Subcommittee are continually evolving as the system matures and include:

- Identifying, monitoring and reporting improvement opportunities
- Developing and implementing performance improvement activities to address identified opportunities
- Serving as the RTAC liaison to NGMC's Trauma Steering Committee (TSC) and Trauma Case Review Committee (TCRC)
- Obtaining, validating and analyzing data necessary to complete PI initiatives
- Collaborating with the other RTAC subcommittees to obtain information as well as to disseminate new information to the appropriate stakeholders
- Evaluating the effectiveness of RTAC PI initiatives
- Altering improvement plans as necessary to meet the desired outcome
- Acting as the facilitator for RTAC data requests from the Office of EMS & Trauma

Pre-hospital & Communications Subcommittee

Purpose

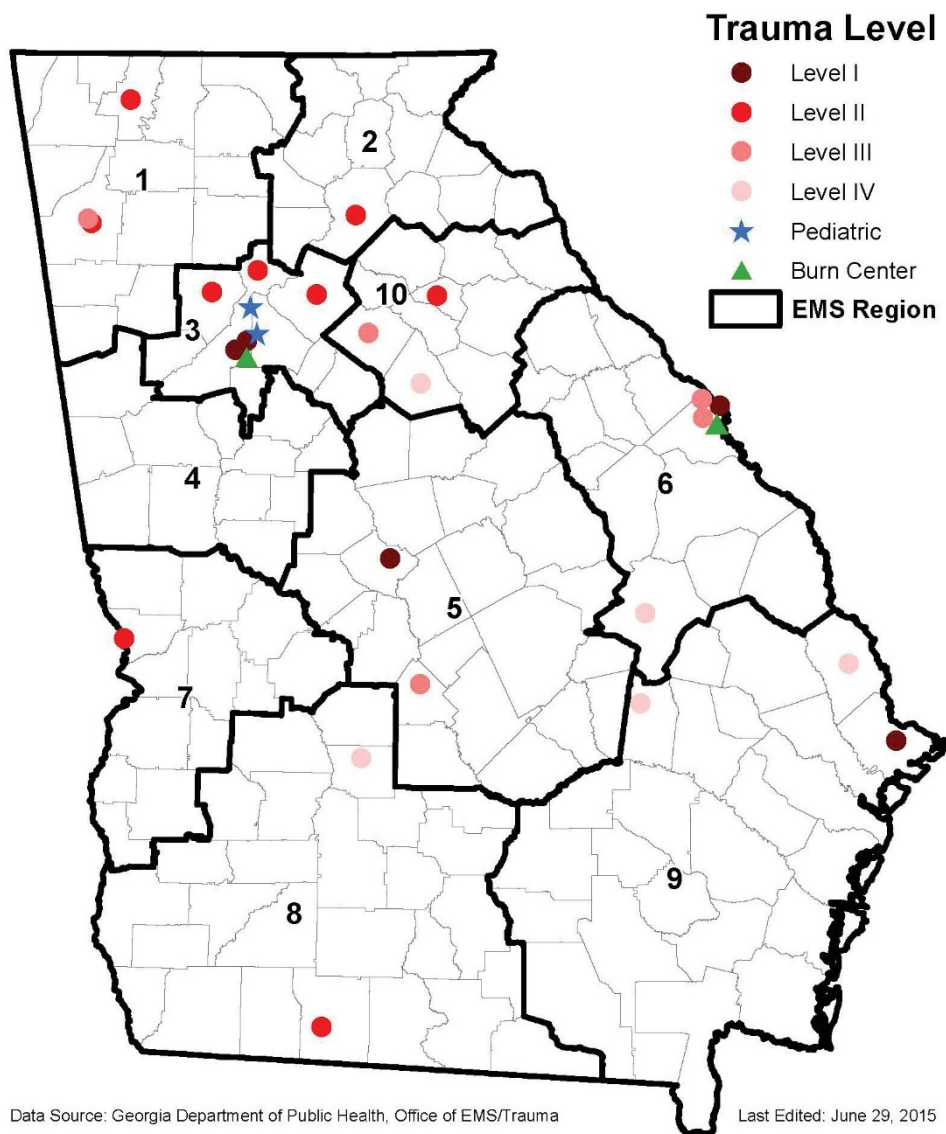
To standardize pre-hospital processes and communication in Region 2 to ensure safe and rapid transports to the most appropriate facility for definitive trauma care

Responsibilities

- Develop a regional plan for pre-hospital triage of trauma patients
- Develop a regional plan for diversion and bypass of trauma patients
- Collaborate with outside agencies to conduct disaster preparedness drills to evaluate the region's readiness state in the event of a regional disaster
- On an annual basis, work with other local agencies to review and revise the regional disaster plan
- Develop and maintain a current listing of all hospital and agency contact numbers

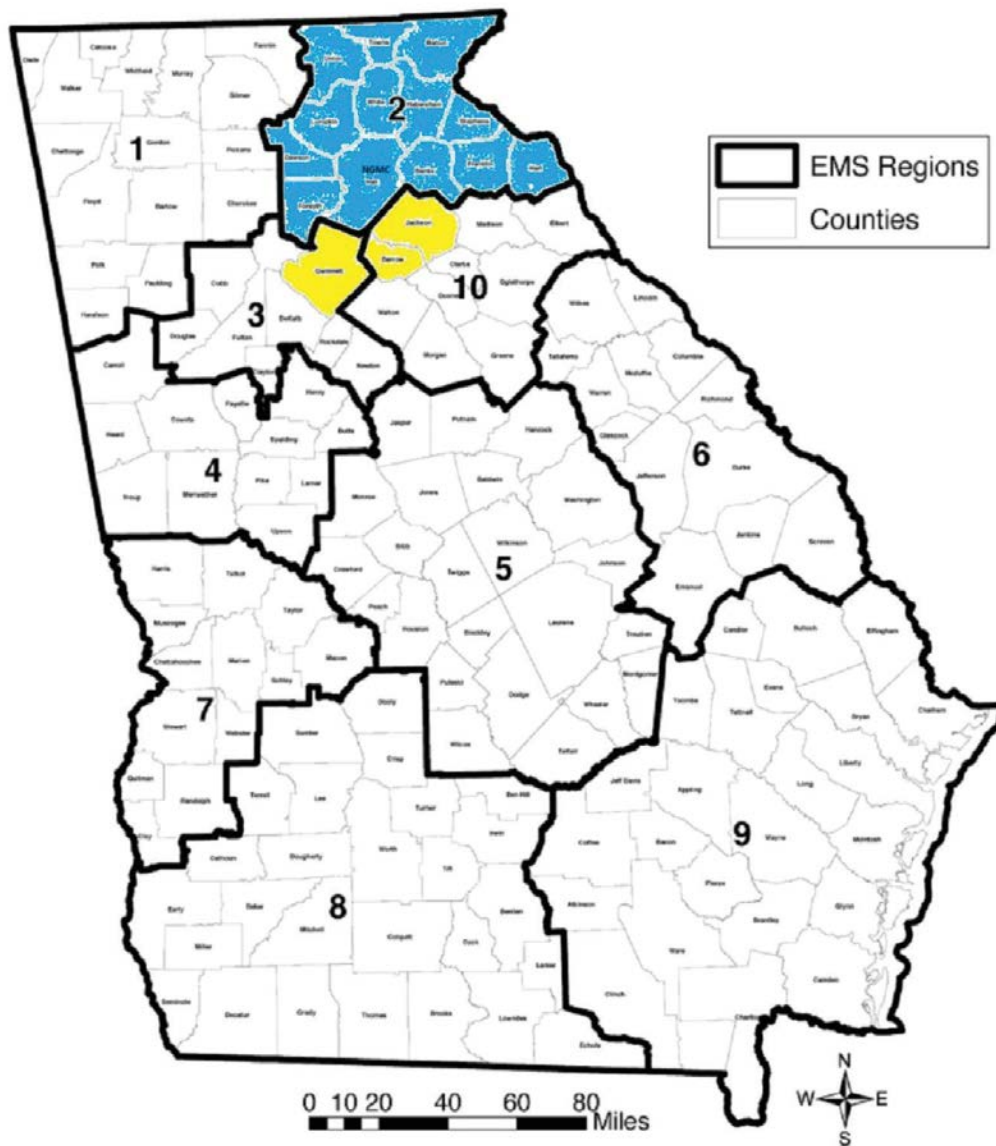
Appendix A

Georgia Trauma Centers



Appendix B

Counties in Region 2



<u>COUNTY</u>	<u>POPULATION</u>	<u>SQ MILES</u>
Banks	18, 495	232.09
Dawson	23,312	210.83
Forsyth	212,438	224.02
Franklin	22,311	261.50
Habersham	43,996	276.74
Hall	193,535	392.78
Hart	25,534	232.39
Lumpkin	31,408	282.93
Rabun	16,281	369.99
Stephens	25,586	179.13
Towns	11,182	166.56
Union	22,267	321.93
White	28,319	242

Contiguous Counties

Gwinnett	895,823	430.38
Jackson	63,360	339.66
Barrow	75,370	160.31

Appendix C

EMS Providers in Region 2

AmeriMed EMS

Dixon Marlow, CEO
5012 Bristol Industrial Park
Suite 110
Buford, GA 30515-8145
770-904-4040

Banks County Fire & EMS

Chief
144 Yonah Homer Road # 1
Homer, GA 30547-2614
706-677-2256

Central EMS – Forsyth County

Operations Commander
3406 Oakcliff Rd., Suite D-8
Doraville, Ga. 30340
404-851-9911

Dawson County Emergency Services

Lanier Swafford, Chief
393 Memory Lane
Dawsonville, GA 30534
706-344-3666

Forsyth County Fire Dept.

Rick Hamilton,
EMS Coordinator
3520 Settingdown Road
Cumming, GA 30028
770-781-2180

Franklin County EMS

Terry Harris, EMS Director
7011 Highway 145
Carnesville, GA 30521
706-245-7312

Georgia MedPort LLC

Jeremy Lord, COO
1002 Chestnut St. Suite A
Gainesville, GA 30501
770-535-2601

Habersham County EMS

Jack Moody, EMS Director
P. O. Box 37
Demorest, GA 30535
706-754-6263

Hall County Fire & EMS

Jeff Hood, Fire Chief
P. O. Box 907730
Gainesville, GA 30501
770-531-6838

Hart County EMS

Terrell Partain, EMS Director
800 Chandler Street
Hartwell, GA 30643
706-376-3930

Lumpkin County Fire & EMS

David Wimpy, Chief
57-A Pine Tree Way
Dahlonega, GA 30533
706-864-3633

Medical Transport, NGHS

Scott Masters, Director
743 Spring Street
Gainesville, GA 30501
678-343-4303

Memorial Ambulance Service

3446 Winder Highway Ste. M177
Flowery Branch, Ga. 30542

North Georgia Medical Transport

Richard Savage, Director
P. O. Box 2795
Gainesville, GA 30503
770-536-9625

Rabun County EMS

Mike Carnes, EMS Director
36 Emergency Drive
Clayton, GA 30525
706-782-6251

Stephens County EMS

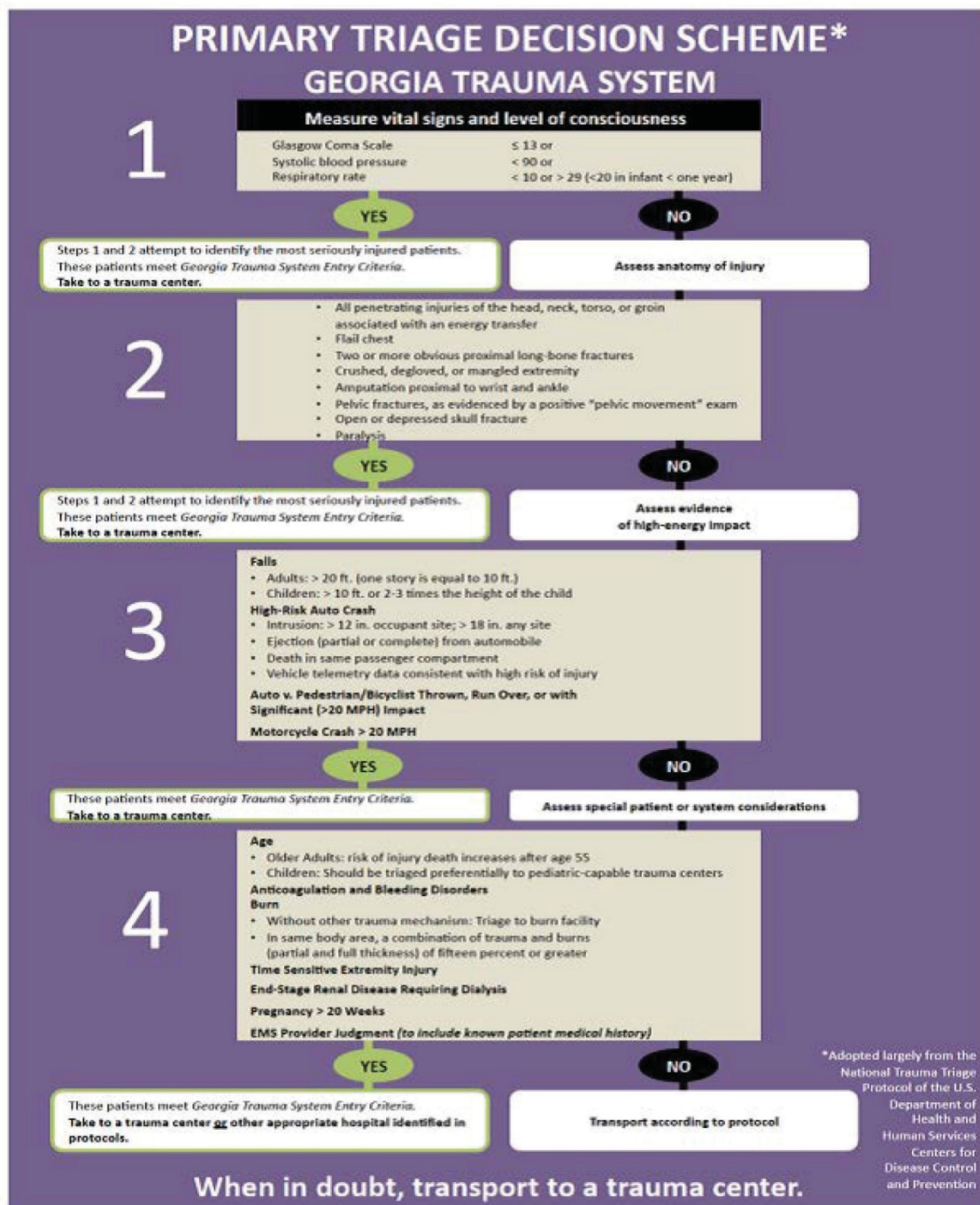
Aaron Wilkinson, EMS Director
2003 Falls Road
Toccoa, GA 30577
706-886-9495

Superior EMS

Jerry Adams, EMS Director
P.O. Box 3000
Cumming, GA 30029
770-886-2222

Appendix D

Primary Triage Decision Scheme



Appendix E

Region 2 Aircraft Response Distances

Rule of thumb for ETAs: 2 Nautical miles = 1 minute

Banks (Homer)

1. AirLife 2, Gainesville (15 NM)
2. AirEvac, Snellville (38 NM)
3. AirLife 14, Blairsville (40 NM)
4. AnMed, Anderson SC (44 NM)

Dawson (Dawsonville)

1. AirLife 3, Jasper (17 NM)
2. AirLife 2, Gainesville (17 NM)
3. AirLife 14, Blairsville (29 NM)
4. AirEvac, Snellville (33 NM)

Forsyth (Cumming)

1. AirLife 2, Gainesville (18NM)
2. AirLife 3, Jasper (22NM)
3. AirEvac, Snellville (21NM)
4. AirLife 5, Kennesaw (26 NM)

Franklin (Carnesville)

1. AirLife 2, Gainesville (28NM)
2. AnMed, Anderson S.C. (30NM)
3. AirLife 14, Blairsville (47NM)
4. AirEvac, Snellville (49NM)

Habersham (Clarkesville)

1. AirLife 2, Gainesville (22NM)
2. AirLife 14, Blairsville (27NM)
3. MAMA 2, Franklin N.C. (35NM)
4. AnMed, Anderson S.C. (44NM)

Hall (Gainesville)

1. AirLife 2, Gainesville (2 NM)
2. AirEvac, Snellville (27 NM)
3. AirLife 3, Jasper (33NM)
- 4 AirLife 14, Blairsville (36 NM)

Hart (Hartwell)

- 1 AnMed, Anderson S.C. (17NM)
- 2 GHS, Greenville S.C. (36 NM)
- 3 AirLife 2, (43 NM)
- 4 AirLife 14, Blairsville (60NM)

Lumpkin (Dahlonega)

- 1 AirLife 2, Gainesville (15NM)
- 2 AirLife 14, Blairsville (21NM)
- 3 AirLife 3, Jasper (24NM)
- 4 LifeForce 4, McCaysville (33NM)

Rabun (Clayton)

- 1 MAMA 2, Franklin N.C. (18NM)
- 2 AirLife 14, Blairsville (28NM)
- 3 AirLife 2, Gainesville (38NM)
- 4 AnMed, Anderson S.C. (43NM)

Stephens (Toccoa)

- 1 AirLife 2, Gainesville (28NM)
- 2 AnMed, Anderson S.C. (34NM)
- 3 AirLife 14, Blairsville (36NM)
- 4 MAMA 2, Franklin N.C. (36NM)

Towns (Macedonia)

- 1 AirLife 14, Blairsville (12NM)
- 2 MAMA 2, Franklin N.C. (23NM)
- 3 LifeForce 4, McCaysville (32NM)
- 4 AirLife 2, Gainesville (36NM)

Union (Blairsville)

- 1 AirLife 14, Blairsville (1 NM)
- 2 LifeForce 4, McCaysville (21 NM)
- 3 AirLife 2, Gainesville (34 NM)
- 4 MAMA 2, Franklin N.C. (34 NM)

White (Cleveland)

- 1 AirLife 2, Gainesville (17 NM)
- 2 AirLife 14, Blairsville (20 NM)
- 3 AirLife 3, Jasper (36 NM)
- 4 LifeForce 4, McCaysville (37 NM)

Appendix F

Hospitals in Region 2

NAME	CITY	COUNTY	STATE	BEDS	TRAUMA CENTER
Chatuge Regional Hospital	Hiawassee	Towns	GA	137	
Chestatee Regional Hospital	Dahlonega	Lumpkin	GA	49	
Habersham County Medical Center	Demorest	Habersham	GA	137	
Mountain Lakes Medical Center	Clayton	Rabun	GA	24	
Northeast Georgia Medical Center	Gainesville	Hall	GA	557	Level II
Northeast Georgia Medical Center	Braselton	Hall	GA	100	
Northside Hospital	Cumming	Forsyth	GA	231	
St. Mary's Sacred Heart	Lavonia	Franklin	GA	56	
Union General Hospital	Blairsville	Union	GA	45	

OTHER HOSPITALS AVAILABLE TO REGION 2 EMS SERVICES

Gwinnett Medical Center	Lawrenceville	Gwinnett	GA	576	Level II
Eastside Medical Center	Snellville	Gwinnett	GA	249	
Barrow Medical Center	Winder	Barrow	GA	80	
Northridge Hospital	Commerce	Jackson	GA	90	
AnMed Health	Anderson	Anderson	SC	401	Level II

Appendix G

Indications for Trauma Patients Requiring Transfer to a Major Trauma Center

Neurologic

- GCS <14 or lateralizing neurological signs
- Penetrating injury to head/neck or open skull fracture
- Spinal fracture or spinal neurological deficit

Hemodynamic

- Hemodynamic instability
- SBP<90mm/Hg or age appropriate hypotension
- RR<10 or >29 (Adults)
- RR<20 (Infants<1 y.o.)

Cardio-vascular/Thoracic

- Injury to carotid, vertebral artery, aorta or great vessels
- Cardiac rupture
- Pulmonary contusion with P/F <200
- Flail Chest
- Penetrating injuries to torso associated with energy transfer

Abdominal/Pelvic

- Penetrating injuries to abdomen or groin associated with an energy transfer
- Pelvic fractures, as evidenced by positive “pelvic movement” exam

Extremities

- Fracture or dislocation with loss of distal pulses
- Two or more obvious proximal long-bone fractures
- Crushed, de-gloved or mangled extremity
- Amputation proximal to wrist and ankle

***Criteria above based on CDC Field Triage Criteria and ACS Resource for Optimal Care of the Injured Patient (2006)*

Glossary

EMS region

One of ten established geographic programmatic regions established by the Georgia Department of Public Health's Office of Emergency Medical Services and Trauma

Georgia Trauma System

The collective body of regional trauma systems throughout the State of Georgia organized to ensure statewide access to high level trauma care and decrease trauma patient morbidity and mortality throughout the State

Performance improvement

A data-driven, documented, methodical and reviewable process for identifying and achieving component-specific, regional, or state-level system improvements

Regional Trauma Advisory Committee (RTAC)

A subcommittee of the Regional EMS Council endorsed by the Georgia Trauma Commission to develop, implement, and oversee a Regional Trauma System Plan within a specific service area

Regional Trauma System Plan

The document developed by the Trauma Advisory Committee to define the resources, components and processes necessary to provide high quality trauma care in the region

Transfer center

The department within a hospital tasked with coordinating inter-hospital patient transfers

Transport time

The time from when the patient leaves the scene to arrival at the hospital

Trauma center

A hospital designated by the Georgia State Office of EMS & Trauma as meeting Level I, II, III, or IV criteria and standards as set forth by the American College of Surgeons Committee on Trauma

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