

# Georgia Trauma/Burn Program Manager

## Essential Tools

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## Georgia Committee for Trauma Excellence

### Welcome Letter

Welcome!

Congratulations on your role as a trauma and burn program leader within the Georgia trauma team. What an exciting journey you have ahead to impact the care your medical and support teams provide to your community.

Throughout this document, you will see references to trauma care. Because burn is a type of trauma, when you see trauma mentioned, it includes burn program discussion as well, unless otherwise noted. There are some burn specific requirements, and we will try to include those as needed.

The trauma program manager role is one that is multi-faceted and interfaces with a large, diverse team that ranges from your nursing team members, physicians of all specialties, emergency room leadership, ICU leadership, hospital leadership, and Department of Public Health and the Georgia Trauma Commission. There is a lot to learn and a lot of relationships to build, but this document was created to serve as a resource to you as you onboard in your new role.

The wonderful news is that you are not alone! You have a large and effective team throughout the state who are committed to providing the best care possible for trauma patients. We are all here to help support you as you transition into a new role. You'll hear us say that "Trauma is a team sport" and in Georgia we believe that is the case.

This handbook is developed to provide some foundational information that will help you learn your role and will help to connect you with key members of the Georgia Trauma community.

We're so excited to have you as a part of our trauma family and the Georgia trauma team. Welcome!

**Thank you to the following for their input into this document:**

**GCTE Education Subcommittee**

**GCTE Education TPM Workgroup**

**The many dedicated trauma and burn care providers across the State of Georgia who have contributed to this document!**

# Georgia Trauma Organization

## Organization

Georgia has 2 state agencies supporting our trauma and burn centers: The Georgia Trauma Commission and the Office of EMS and Trauma (OEMST) that is a part of the Department of Health. The OEMST is the state regulatory program for the designation of Georgia Trauma Centers and administration of the Georgia Trauma System. This office is responsible for the designation of trauma centers in Georgia. The OEMST trauma division is led by the state trauma program manager.



GEORGIA TRAUMA  
COMMISSION

## Georgia Trauma Commission

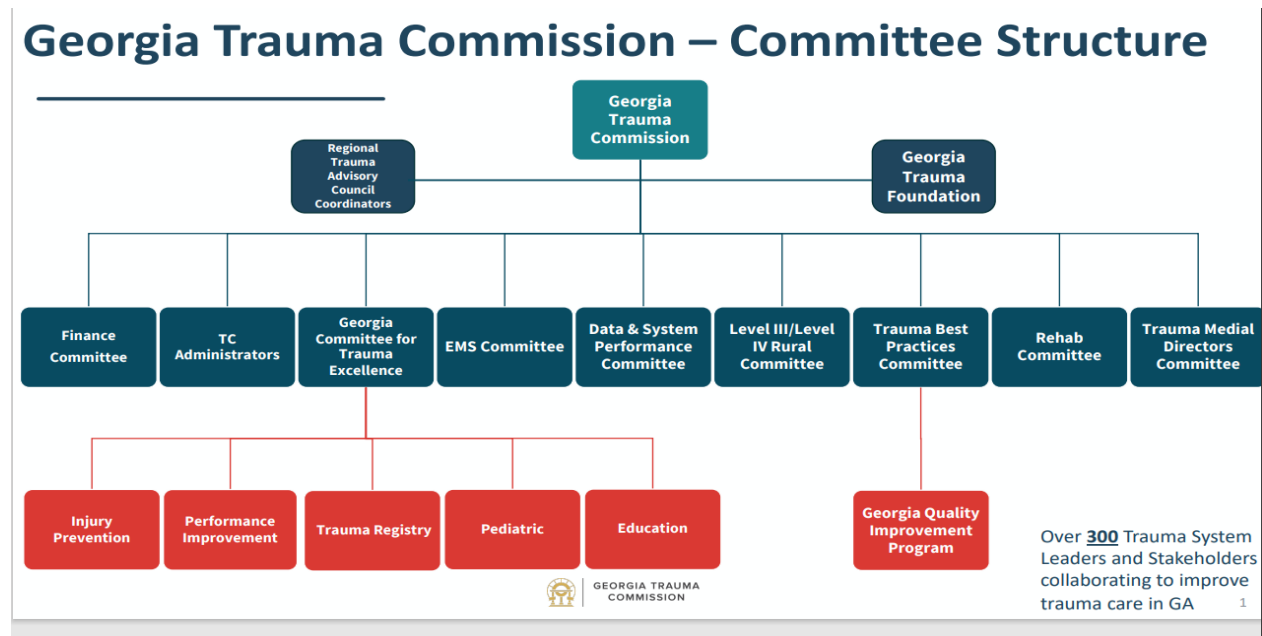
The Georgia Trauma Commission (GTC) was formed in 2007 and is charged to “establish, maintain and administer a trauma center network, to coordinate the best use of existing trauma facilities and to direct patients to the best available facility for treatment of traumatic injury and participate in the accountability mechanism for the entire Georgia trauma system, primarily overseeing the flow of funds for system improvement” (About Us: Georgia Trauma Commission , 2024).

The Commission consists of nine members appointed by the Governor, Lieutenant Governor and Speaker of the House and includes trauma physicians, EMS representatives and trauma system leaders from around the state. To see the GTC members, click the following link:

<https://trauma.georgia.gov/about-us/georgia-trauma-commission-members>

In addition to the GTC appointed members, several staff members support the work of the GTC. The following link can take you to the staff page: <https://trauma.georgia.gov/about-us/georgia-trauma-commission-members/georgia-trauma-commission-staff>

The current GTC structure is below:



The Georgia Trauma Commission meets quarterly.

Important contacts for the GTC team:

Phone: 706-841-2800

Email: [gtcbusinessops@gtc.ga.gov](mailto:gtcbusinessops@gtc.ga.gov)

### Georgia Committee for Trauma Excellence (GCTE)

GCTE is the committee of the GTC for the Trauma/Burn Program leadership around the state. Trauma/Burn Program managers, performance improvement staff, registry staff, outreach and education staff and injury prevention staff from programs around the state work together to improve trauma/burn care around Georgia.

The GCTE Chair for 2024 – 2026 is Lynn Grant – [Dianna.grant@hcahealthcare.com](mailto:Dianna.grant@hcahealthcare.com)

The Vice-Chair is – Kyndra Holm – [Kyndra.Holm@wellstar.org](mailto:Kyndra.Holm@wellstar.org)

The GCTE Committees include:

Committee Name	Chair and Contact information
Performance Improvement	Rayma Stephens – <a href="mailto:rayma.stephens@northside.com">rayma.stephens@northside.com</a>
Registry	Kelli Vaughn – <a href="mailto:kvaughn@archbold.org">kvaughn@archbold.org</a>
Education	Julie Freeman Mosher – <a href="mailto:Julie.freeman@wellstar.org">Julie.freeman@wellstar.org</a>
Injury Prevention and Outreach	Kristal Smith – <a href="mailto:region5rtac@gmail.com">region5rtac@gmail.com</a>
Pediatrics	Kellie Rowker – <a href="mailto:kellie.rowker@choa.org">kellie.rowker@choa.org</a>

GCTE meets quarterly in February/March, May, August, and November. All Level I and II facilities are required to participate in at least one subcommittee. The subcommittees meet monthly. If you are interested in serving on one of the subcommittees, reach out to the chair to be added to the team.

### Georgia Quality Improvement Program (GQIP)



GQIP is a collaborative of Georgia hospitals working together to improve trauma and burn care delivery throughout the state. Participating trauma and burn programs receive GQIP and BCQP Benchmarking reports with the Spring and Fall TQIP reports. Burn Programs will need to register with the American Burn Association BCQP database to receive benchmarking reports. Case reviews at the Spring and Fall meetings provide collegial best practice discussions about care provision (GQIP: Georgia Trauma Commission, 2024).

For more information about GQIP, reach out Gina Solomon, GQIP Director. [Gina.solomon@gtc.ga.gov](mailto:Gina.solomon@gtc.ga.gov). For more information about BCQP, email the American Burn Association (ABA). [BCQP@ameriburn.org](mailto:BCQP@ameriburn.org)



The Georgia Trauma Foundation’s mission is “investing in trauma care to save lives in Georgia”.

For more information, contact Georgia Trauma Foundation Executive Director – Cheryle Ward – [cheryle@georgiatraumafoundation.org](mailto:cheryle@georgiatraumafoundation.org)

### **ACS Verification vs Georgia State Designation**

In Georgia, all Level I – III trauma centers are required to be ACS verified. All Level IV centers are required to be state designated.

The American College of Surgeons (ACS) is the reviewing/accrediting agency for trauma centers in the United States. Level I – III centers in Georgia are required to be ACS verified. Level IV centers are required to be state designated. The standards for ACS verification can be found here: <https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/> *Resources for the Care of the Injured Patient*. Level I – III centers need to meet the standards outlined in the 2022 Standards (affectionately known as “The Gray Book”) and Level IV centers must meet the standards in the 2014 version of the book (affectionately known as “The Orange Book”). They will be your go-to resource as you make sure your program remains in compliance with ACS standards.

Burn centers are verified by the American Burn Association (ABA). The standards for burn centers are also found in the Gray Book. <https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/> *Resources for the Care of the Injured Patient*.

Both The Gray Book and Orange Book are considered living document, so be sure to review the change log to make sure that you are working from the most current version of the standards. The Standards Resources Repository can be found here: <https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/2022-resources-repository/>

### **Important Information and things you’ll need access to:**

#### **Contracts**

All verified and designated trauma programs sign an annual contract with the GTC for trauma center funding. These contracts vary from year to year and provide funds for readiness costs, uncompensated care, registry, and performance-based reimbursement. 80% of the funds is at-risk.

The Commission must vote to approve additional centers to be added to the funding. When new centers are designated, they are not automatically added to the funding. As funds allow, the GTC will award one-time readiness grants to centers without current contracts. The GTC is required to submit the budget to the Governor’s office 9 months before the fiscal year start so newer centers may not have been designated by that submission.

Georgia state contracts and pay for performance criteria information can be found here: <https://trauma.georgia.gov/system-development/trauma-and-burn-center-funding> You can also contact Katie Hamilton at the Georgia Trauma Commission office – [katie.hamilton@gtc.ga.gov](mailto:katie.hamilton@gtc.ga.gov) Katie can help you understand the different contractual obligations such as meeting attendance, report submission, and data collection.

### **Required Reports**

All centers are required to submit quarterly and annual OTCPE reports to the Georgia state license management system. State reports are a part of your pay for performance criteria. More information about those reports can be found on page 11 under the Trauma Registry section. Reach out to Stacey Smith at DPH to get access to the DPH portal to submit your state reports. [Stacey.smith2@dph.ga.gov](mailto:Stacey.smith2@dph.ga.gov) The DPH portal can be found here: <https://www.mygemsis.org/lms/public/portal#/login>

### **Mandatory meetings**

GCTE meetings - quarterly

GCTE committee participation – committee dependent

TMD/BMD/TPM/BPM calls – quarterly

GQIP Spring meeting –

GQIP Summer/Fall meeting -

### **Trauma Department Team Roles**

Within the trauma program there are many roles. In smaller programs these roles may be combined with one person doing more than one job. The American College of Surgeons and/or Georgia Department of Public Health has specific requirements for some of these roles.

#### **Trauma Medical Director (TMD)/Burn Medical Director (BMD)**

The Trauma/Burn Medical Director has the responsibility for ensuring that the care of the injured patient meets appropriate standards of care. The TMD and BMD develop and monitors care policies/procedures and serves to coordinate the efforts of the clinical services involved in the care of the trauma patient. Other areas of involvement and responsibility include professional and public trauma education, regional trauma system development, participating in or chairing the trauma operational and trauma peer review committee, and assuring that the Trauma Department is represented throughout the facility and system.

The TMD must meet all requirements as outlined in current standards. The qualifications, responsibilities, and authority of the role are defined in the 2022 edition of *Resources for the Optimal Care of the Injured Patient* and applicable state regulations. It is important to note the TMD is responsible for maintaining the quality of all injured patients in the trauma/burn center and not just those patients on the trauma or burn service. The breadth of responsibility and authority is defined in the current standards.

## Trauma/Burn Program Manager or Director (TPM/BPM or TPD/BPD)

The Trauma Program Manager (TPM/BPM) works in collaboration with the Medical Director of the Trauma/Burn Center to lead the trauma/Burn program. In some centers, the title will be Trauma Program Director and may or may not have a TPM reporting to them. The TPM/BPM usually reports to the Chief Operating Officer or his/her designee. ACS requires that the TPM have a reporting structure that includes the TMD with a minimum of a "dotted line to the TMD. Moreover, a good relationship between the TPM and TMD are key to a successful trauma program.

The trauma/burn program manager is a health professional, usually a registered nurse, who has:

- Excellent interpersonal and communication skills
- Demonstrates leadership experience
- Relevant clinical experience
- Maintains membership in a national or regional trauma/burn organization
- Maintains at least 36 hours of trauma-related or 24-32 hours of burn-related continuing education during the verification cycle
- A baccalaureate or master's degree is preferred

In small centers, roles may be combined. The TPM/BPM may have to perform the duties of a trauma or burn coordinator, outreach coordinator, or injury prevention coordinator.

Components of the Role (Please check your job description for specifics)

- Supervision of trauma program staff
- Institute and maintain all the requirements for ACS verification and Georgia state designation.
- Institute and maintain all the requirements for ACS/ABA verification and Georgia state designation.
- Develop and maintain a trauma or burn registry
- Develop and maintain a Performance Improvement and Patient Safety Program
- Develop and maintain policies, procedures, and guidelines for the trauma/burn program
- Assure the regular meetings of the Trauma/Burn Operations Committee and Trauma/Burn Peer Review Committee including minutes and loop closure
- Development and monitoring of the trauma/burn program budget
- Assures a robust injury prevention program
- Serves as a liaison with hospital departments and regional/state agencies
- Serves on system and state committees
- Participates in professional organizations

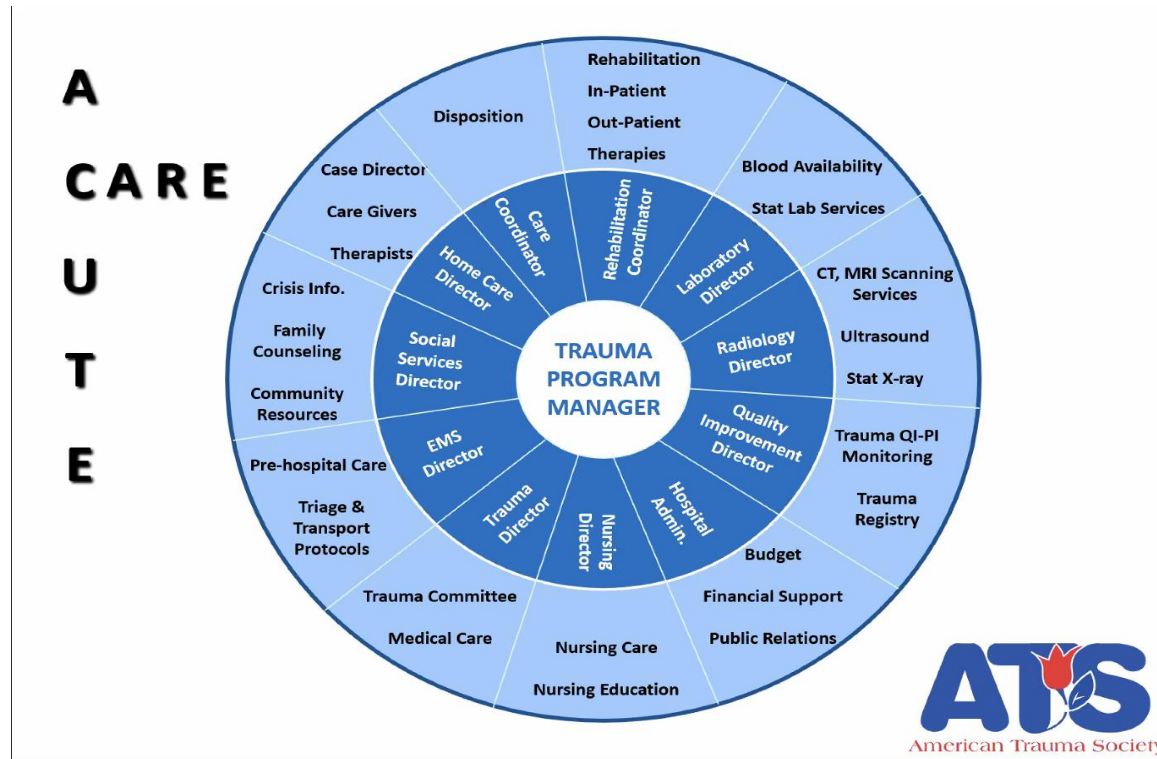
The Society of Trauma Nurses (STN) offers a course called OPTIMAL (The Optimal Trauma Center Organization and Management Course) that is extremely useful to help Trauma Program Managers and Medical Directors understand and improve a trauma center system of care and improvement of patient care. To learn more, follow the link below:

<https://www.traumanurses.org/education>

The Trauma Center Association of America (TCAA) has published a list of Trauma Program Manager Core Competencies that can be found here: [https://tcaa.klas.com/www/edocs/TPM\\_Core\\_Competencies.pdf](https://tcaa.klas.com/www/edocs/TPM_Core_Competencies.pdf) The competencies are also attached as an Appendix to this document – See Appendix 1. TCAA also provides a variety of useful education and resources for Trauma leaders.



Trauma Program Manager Role in Picture form from the American Trauma Society:



**Other Trauma and Burn Essential Roles:**

**Performance Improvement Coordinator**

The Performance Improvement Coordinator (PIC) often shortened to Trauma/Burn Coordinator works in collaboration with the Trauma/Burn Medical Director (TMD) and Trauma Program Manager (TPM) to improve the quality of trauma care encompassing all areas and disciplines of the hospital that participate in the care of the injured patient. The PIC is responsible for coordination and facilitation of the multidisciplinary trauma performance improvement program including data collection, analysis, trending and benchmarking of data and outcomes.

**Registrar**

The trauma or burn registrar is responsible for identifying trauma patients, capturing accurate and complete information, and entering them into the registry. In addition, trauma registrar must assure accuracy by performing data validation including interrater reliability. The trauma registrar prepares data for state database and National Trauma Database (NTDB) submission and prepares data for internal meetings, performance improvement, and other uses. The ACS requires 0.5 FTE (full time equivalent) dedicated to trauma registry for every 200 – 300 annual patient entries. The ACS also requires:

- At least one registrar must be a current Certified Abbreviated Injury Scale Specialist
- Participate in and pass the most recent version of the AAAM Abbreviated Injury Scale (AIS) Course

- Participate in an ICD-10 course or ICD-10 refresher every five years
- Participate in a trauma registry course that includes abstraction, data management, reports/reports analysis, data validation, and HIPAA
- Accrue 24 hours of trauma-related continuing education during the verification cycle.

### **Injury Prevention Coordinator**

All trauma and burn centers are required to have an injury prevention program lead by a designated professional. This role may be included in another job description, however in a Level I trauma center, the injury prevention coordinator must be someone other than the TPM or PI personnel. This person must provide injury prevention activities based on the trauma registry and local epidemiological data. The ACS requires at least two activities over the course of the verification cycle with specific objectives and deliverables. The injury prevention coordinator must develop partnerships with community organizations to support their injury prevention efforts.

### **Outreach Coordinator**

An outreach coordinator is responsible for interfacing with the trauma/burn program’s external customers including referring facilities, EMS and public safety services, and community organizations. This may include providing feedback on cases, education, complaint management, and marketing.

### **Additional support roles**

#### **Research Coordinator**

Level I trauma centers, and burn centers have an obligation to conduct and publish trauma or burn research. A research coordinator coordinates the efforts of the research program. This may include seeking and maintaining research grants, supporting the research committee, supervising research assistants, and preparing research results for publication.

#### **Administrative Assistant**

Larger programs may have administrative assistants to support the TPM, TMD and others in their roles.

#### **Fellowship Director and Coordinator**

Level I trauma centers with trauma or surgical critical care fellowship programs need an infrastructure to support that program. These programs are led by a surgeon director and an administrative coordinator to support them.

### **Transfer Agreements**

Trauma and Burn centers must have transfer agreements in place with appropriate centers. Examples include:

- Centers that provide higher level care
- Centers that provide specialty care or care that is not available continuously at the “home” center (ie: Microvascular/reimplantation care, Ophthalmology, Pediatric Trauma, Burn)

## Trauma and Burn Registry

### Introduction to the Trauma Registry

The Registry is one of the most important and powerful tools to help track and evaluate the care we provide our trauma patients. Each trauma program is required to keep a trauma registry and in Georgia, programs are contractually required to use ESO. Your program is required to purchase the registry and maintain an annual contract with ESO DI for updates and product support. ESO DI Support can be contacted at [supportdi@eso.com](mailto:supportdi@eso.com) or call 512-593-6376. They can help you login for the first time if you need that help. Burn centers have the option to use the American Burn Association (ABA) BCQP registry or the ESO registry.

Our registry data provides critical program information about our trauma and burn patient population, and it helps to guide our performance improvement activities for our program. The registry connects our data to statewide and national platforms that allow us to see our risk adjusted program data when compared to other similar trauma and burn centers around the state and throughout the US.

### Registry Staffing

The *ACS Resources for the Optimal Care of the Injured Patient* establishes a variety of standards for trauma registry staffing, certification, and ongoing education expectations. Standards 4.31, 4.32, 4.33 and 4.34 define the staffing and education requirements for trauma centers across all levels.

### Data Reporting and Feedback

The *ACS Resources for the Optimal Care of the Injured Patient* also establishes standards for data quality and submission requirements. Standards 6.1, 6.2 and 6.3 discuss the data quality and submission requirements. These are all considered Type II deficiencies and failing to meet those standards will impact a center's ability for verification/designation.

While trauma centers have requirements from the ACS for verification, centers are also contractually required to have 80% chart closure rate within 60 days of patient discharge through our state performance base pay expectations.

Data is downloaded to the state and to TQIP on a regular basis throughout the year. State reports are downloaded quarterly to the following programs:

- V5 download to the GA Offices of EMS-Trauma (OEMST) Image Trend Patient Registry (download instructions:
- V5 download to GQIP
- OEMST License Management System quarterly reports

### Data definitions

In order to ensure that data is useful and meaningful, it is important that trauma centers document patient data consistently. There are two main resources that help define the different data points and what information is used in the data collection – the National Trauma Data Bank (NTDB) Data dictionary and the Georgia state Trauma Data dictionary. They provide useful information about which patients should be included in your registry, definitions of specific data elements and help clarify the hierarchy for the source documents.

## NTDB –

<https://www.facs.org/quality-programs/trauma/quality/national-trauma-data-bank/national-trauma-data-standard/data-dictionary/>

## Georgia State Trauma Data dictionary –

[file:///C:/Users/kholm/Downloads/2023%20GA%20Trauma%20Data%20Dictionary%205.2.2023%20APPROVED%20\(1\).pdf](file:///C:/Users/kholm/Downloads/2023%20GA%20Trauma%20Data%20Dictionary%205.2.2023%20APPROVED%20(1).pdf)

### Georgia state inclusion criteria: 2023 Georgia Trauma Registry Inclusion Criteria

Include patients presenting with a traumatic injury occurring within 14 days of initial hospital visit and with an ICD-10\_CM diagnosis code below:

- S00-S99 w/ 7th character modifiers of A, B, or C ONLY. Injuries to specific body parts – initial encounter (see exclusions below)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T20-T28 with 7th character A only or T30-T32 (only with a non-burn trauma dx meeting inclusion criteria)
- T79.A1 – T79.A9 w/ 7th character modifier A ONLY (Traumatic Compartment Syndrome – initial encounter)
  
- EXCLUDING:
  - Patients with isolated superficial injuries- Diagnosis codes of ICD-10-CM superficial injuries: S00, S10, S20, S30, S40, S50, S60, S70, S80, S90
  - Late effect codes w/ the 7th character modifier of D through S
  - Patients w/ isolated burn injuries T20-T28 w/7th modifier A or T30-T32 (NTDS 2021)
  - Patients admitted to a medical or social service w/ a minor trauma injury that would not have been otherwise admitted for their injury. Inclusion decisions are at the discretion of each facility. \* (GA 2023)
  - Patients w/ injuries older than 14 days from first ED/hospital arrival date. (NTDS 2021)
  - Patients admitted for elective and/or planned surgical intervention. (NTDS 2022)
  - Patients w/ an In-House trauma injury sustained after the initial ED/Hospital arrival and before ED/Hospital discharge. This exclusion involves all data related to the In-House injury. (NTDS 2022)
  
- AND must include one of the following in addition to a valid trauma diagnosis code from the listed above
  - Admitted to the hospital after discharge from the ED or directly admitted to the hospital, regardless of
  - length of stay
  - Transferred to or from another acute care facility\*\*

- Died, regardless of length of stay
- DOA: defined as a patient that died from a traumatic injury before hospital arrival and was pronounced dead by a physician in the emergency department.
- Additional criteria/notes:
- The Georgia data collection standard for blood utilization includes data for any blood products administered
  - within the first 4 hours from the patient arrival time.
- Unplanned readmissions must be associated with the initial trauma injury, have a trauma diagnosis, ISS total and be readmitted within 72 hours of discharge from the first visit.
- Dictionary Data Sources are simply a guide; Centers should use the most reliable source at their center.

\* Indicates a difference between the Georgia Criteria and the NTDS Criteria

### **Burn Data Dictionary**

The American Burn Association's (ABA) BCQ Data Dictionary applies to all patient data submitted to the ABA registry, whether data is collected using the ABA Burn Care Quality Platform or other software. The Burn Service should be responsible for or co-managing the care of the patient for the case to be included in the registry. This includes patients who are initially seen by the burn service and patients who are initially seen by another service and then transferred to the burn service. The Burn Service should be responsible for the care of the patient for the case to be included in the registry. This includes patients who are initially seen by the burn service and patients who are initially seen by another service and then transferred to the burn service.

### **Additional Burn Registry requirements**

#### **Burn program inclusion criteria**

The burn population constitutes all hospital burn admissions, burn transfers, and burn deaths.

Registry inclusion criteria follow the National Burn Data Standard with International Classification of Diseases (ICD-10-CM)

- S00-S99 with 7th character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter)
- T07 (unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T20-T28 with 7th character modifier of A ONLY (burns by specific body parts – initial encounter)
- T30-T32 (burn by TBSA percentages)
- T79.A1-T79.A9 with 7<sup>th</sup> character modifier of A ONLY (Burn & Traumatic Compartment Syndrome – initial encounter)

## Included Burn Diagnoses

Burn centers or burn units should submit data on all patients admitted for treatment of a burn injury, including thermal burn, corrosion, smoke inhalation injury, or carbon monoxide poisoning. These diagnoses are indicated by one or more of the following codes from the International Classification of Diseases, **Tenth Revision, Clinical Modification (ICD-10-CM)**.

T20-T32 OR T58 OR T59

Additionally, some facilities treat patients with acute dermatologic conditions or other injuries that affect the integrity of the skin. Data on these patients may be included in the ABA registry. Records would likely include at least one of the following ICD-10-CM diagnosis codes.

S00, S10, S20, S30, S40, S50, S60, S80, S70, S90, S07, S17, S28, S38, S47, S57, S67,

S77, S87, OR S97

OR L51 OR L12

OR M72.6 OR D65

## Length of Stay

Burn centers should submit data from any case with an eligible diagnosis (above) if that patient:

- Had a surgical operation at your hospital,
- Died at your hospital\*, or
- Had a hospital length of stay of 24 hours (1 day) or more.

\*If the patient arrives in the ER with no pulse without return of spontaneous cardiac circulation, then do not include in the registry. Burn centers may, at their discretion, submit case data for patients who were admitted and discharged home alive after a hospital length of stay of less than 24 hours (including Observation status patients admitted to the burn service). For the present time, this does not include patients who were not admitted to the hospital (hospital length of stay = 0) and were treated only in an outpatient setting.

## Essential Trauma and Burn Program Components

### Performance Improvement Programs (PIPS)

Performance Improvement (PI) is the foundation for a trauma program and is a key component of the program verification process. The following discussion applies to both trauma AND burn centers. Learning how to do PI effectively is a process and there are multiple resources available to help PI Coordinators learn the art of effective performance improvement. Chapter 7 of *Resources for the Optimal Care of the Injured Patient* is dedicated to Performance Improvement and includes the standards that apply to the trauma PI process. Many trauma centers will have a designated Performance Improvement Coordinator.

TOPIC and Rural TOPIC – TOPIC is the Trauma Outcomes and Performance Improvement Course. It is offered by the Society of Trauma Nurses. Rural TOPIC is a version of the TOPIC course that

is more focused for the rural or non-designated centers. To learn more or register for a course, please visit the link below:

<https://www.traumanurses.org/education>

### **PIPS Plan**

All trauma centers are required to have a PIPS plan. You can reach out to others in the state to get examples of PI plans from other programs to use if you need assistance in developing your PIPS plan. The Trauma PIPS program must tie into your hospital's quality department for tracking and quality issues.

### **Required PIPS Committees**

Two committees are required for all trauma centers – Trauma Operations Committee and Trauma Performance Improvement and Patient Safety Committee.

The Trauma Operations committee should be a multidisciplinary committee with representation from all areas that impact trauma patient care. Trauma process/program issues should be discussed or presented in the Operations committee meetings. Examples of Operations committee-appropriate discussions include quality dashboard presentations, trauma workgroup presentations/report-outs, clinical practice guideline development/approval, and any system or process-related PI issues.

The Performance Improvement and Patient Safety committee typically serves as the trauma provider peer review process and is generally limited to the trauma program physicians and liaisons. Standard 7.6 in *Resources for the Optimal Care of the Injured Patient* clarifies the requirements for the PIPS committee, including the meeting attendance requirements for the trauma liaisons.

### **Documentation and Loop Closure**

Documentation is the key to the PI process. Your documentation should paint the picture of the event, how the event was recognized, the levels of review for the event, opportunities for improvement (OFI's) identified and steps taken to resolve each of the OFI's identified. True loop closure involves tracking issues to ensure that the steps taken to resolve the OFI have actually addressed and resolved the issue. See Appendix 3 for a sample PI audit form.

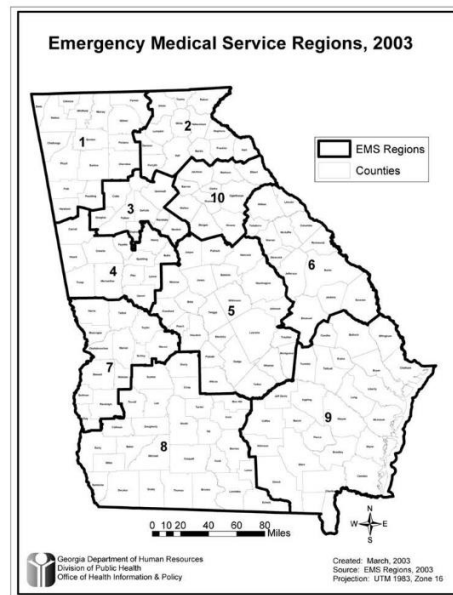
### **Injury Prevention and Outreach**

All trauma centers are required to do Outreach and Injury Prevention. Outreach should include communication with referring hospitals and EMS agencies and should provide feedback about OFI's identified in their care. Injury Prevention efforts should be targeted for the top mechanisms of injury for your specific trauma program. See the discussion about the essential program staff for more information about the specific roles and requirements in the Gray Book.

### **RTACs**

Regional Trauma Advisory Councils (RTACs) are teams of representatives from pre-hospital providers and hospitals throughout the ten state EMS regions. For more information about your RTAC or to contact your RTAC Coordinator, follow this link: <https://trauma.georgia.gov/rtac>

The different regions are highlighted in the map below:



### Tips, Tricks, and Resources

Trauma is generally a very collaborative group, and Georgia's trauma network is a fantastic example of the teamwork. We hope that you have gotten a useful overview of the resources available in Georgia. While we hope that you have learned a lot about the resources available in the state, this is not an exhaustive list of trauma tools. Below are some additional trauma resources that you may find useful.

**STN** - <https://www.traumanurses.org/>

**ATS** - <https://www.amtrauma.org/>

**TCAA** - <https://www.traumacenters.org/>

### Pennsylvania Trauma State Foundation

The PTSF has been an invaluable partner for the Level 4 centers and have helped provide guidance and education for these smaller programs. You can learn more about the PTSF here - <https://www.ptsf.org/>

**ACS** - <https://www.facs.org/>

**ACS Committee on Trauma (COT)** - <https://www.facs.org/quality-programs/trauma/>

**TQIP** - <https://www.facs.org/quality-programs/trauma/quality/trauma-quality-improvement-program/>

**ACS Best Practice Guidelines** - <https://www.facs.org/quality-programs/trauma/quality/best-practices-guidelines/>

**ABA and BQIP** – [www.ameriburn.org](http://www.ameriburn.org)

In addition to the valuable data we receive from our TQIP report, TQIP also sends monthly education to all of the registry staff and program managers at each location. These monthly



offerings are great ways for your registry team to earn needed CE, and to maintain current understanding of the data collected for TQIP.

**Pediatric Trauma Society - <https://pediatrictraumasociety.org/>**

**EAST - <https://www.east.org/>**

**WEST - <https://www.westerntrauma.org/>**

**AAST - <https://www.aast.org/>**

**Key Contacts (Facility, System, and External)**

**DPH Office of EMS and Trauma Contacts:**

April Moss Deputy Director for Systems of Care : [april.moss@dph.ga.gov](mailto:april.moss@dph.ga.gov)

Stacey Smith State Trauma Coordinator : [stacey.smith2@dph.ga.gov](mailto:stacey.smith2@dph.ga.gov)

Marie Probst State Trauma Registrar : [Marie.Probst@dph.ga.gov](mailto:Marie.Probst@dph.ga.gov)

Trauma email : [trauma@dph.ga.gov](mailto:trauma@dph.ga.gov)

**Additional important contacts:**

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## Appendix 1

### Trauma Program Manager Core Competencies

TCAA Education Committee

TCAA's core competencies is a document to assist in your orientation as a Trauma or Burn Program Manager (TPM) as well as developing leaderships skills and growth within your career. Depending on your level of trauma center and the number of FTE's, some of the items may require oversight whereas many of the tasks will be performed by you. These are recommendations. Your state, hospital or other regulatory organization needs may override these suggestions.

#### **ORIENTATION**

##### **Office**

- Learn hospital's office software: Microsoft Office/Google Suite/Office 365
- Hospital's Time & Attendance Software
- Working knowledge of EMR - may have new views as a manager
- Working knowledge of trauma registry (the players, pieces, data dictionary - status of being concurrent), PI database
- Notify State, ACS, TQIP, and NTDB, ABA if required to alert agencies of new TMD/BPM

##### **Communications**

- Hospital Management, Department Heads, C-Suite (meet and greet - build relationships - discover the processes within each service line or department including non-clinical areas such as security and public relations); leadership rounding
- Trauma Team (Meet & Greet)
- Committees (Inquire about hospital committees - quality, organ procurement, ICU, ER); Which committees are mandatory, ad hoc, optional and which ones you will chair
- Learn EMS System(s) - Meet with key players, EMS medical directors

##### **Data**

- Get up to speed with AIS, ICD-10, type of registry software, PI Database
- Location of data dictionaries
- Knowledge of next data submission
- Most centers meet with lead registrar to establish current process of data submission calendar, communication systems, data validation. In smaller centers, this may be your role to complete.
- Review most recent TQIP, BCQP report with PI coordinator and TMD/BPM - establish goals for improvement

##### **Verification Designation**

- Review past PRQ/reports (if not available request from ACS/ABA/State)
- Relationships - Contacts and links to ACS, ABA or state
- ACS, ABA or state designating information - download materials/purchase books

##### **Human Resources**

- Schedule weekly “1-Up” (direct reporting person)
- HR forms, hospital’s orientation program
- List of hospital required courses

## TPM/BPM Core Competencies

### ORIENTATION

#### Other

- Initiate Stakeholder relationships - (For example: Pre-hospital (air and ground), Regional Trauma Advisory Committee, State Trauma Committee, Local Emergency Preparedness Committee, State Trauma Program Manager, State Funding Authority)
- Locate Policies/Procedures & Clinical Practice Guidelines
- Locate transfer agreements
- Goal setting meeting with TMD - What are the top 5 issues facing the trauma center/burn center?
- Locate National Membership Information

#### Notes:

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## TPM/BPM Core Competencies

### Beginner (1-2 Years)

#### Office

- Trauma/Burn Registry Software - Abstract Process, the training level of registrars, validation process and exporting to outside agencies
- Elevate your project management skills - polish off or develop as needed

#### Education

*Depending on level of center, may be oversight, instructor, or director of the different programs. Some may be an optional status depending on your level of trauma center.*

- TNCC - Instructor Status
- ATCN - Instructor status
- ATLS Coordinator
- ABLIS (Burn Leaders)
- ABLIS Instructor (Burn Leaders)
- CBRN course (Burn Leaders)
- Working knowledge of education provided by hospital
- PHTLS - Provider Status
- Take TOPIC Course
- Take ATS Trauma Program Manager Course

#### Communications

- How does trauma fit into each service line/department
- Job shadow each team member to learn high level portion of job and key communication skills
- Meet and greet EMS, Fire, Police, ME, trauma contacts at hospitals
- Attend appropriate hospital/regional committees. Develop an understanding of one's own role on each committee. Understand how sub-committees report and function. Experience with writing peer review minutes, peer review documents, etc.
- Team Rounding - will vary based on volume and level of center
- Inquire about State/National organizations

#### Data

- AIS - Attend course
- ICD-10 - Attend trauma or burn specific course
- Working knowledge of all trauma data and trending data
- Working knowledge of registry software

- PI methodologies and linkage to quality department
- Understanding of TQIP/BCQP or state specific reports - inclusion, reporting cohorts, etc.
- Review of current audit filters, update as needed

### **Verification/Designation**

- Review past PRQ/reports, act on results
- Working knowledge of ACS, ABA or state designating information (Resources for Optimal Care of the Injured Patients - Currently known as the Orange book, moving to Gray book)
- Gap analysis of programs - compare hospital equipment/process/needs to designating CD
- Working knowledge of Loop Closure
- Working knowledge of data validation tool
- Working knowledge of PI Plan

### **Finances**

- Develop program budget - may vary based on hospital
- Working knowledge of hospital budget
- Working knowledge of trauma/burn billing
- Writing business plans
- Hospital Foundations - varies by hospital - Meet and Greet
- Finance Department - Meet and Greet

### **Human Resources**

- Obtain conflict resolution skills
- Learn how to facilitate crucial conversations
- Initiate coaching and mentoring skills for yourself/staff
- Develop a working knowledge of emotional intelligence and its importance for yourself as well as your trauma/burn team
- Meet with "1-Up" monthly
- Begin Leadership Training

**TPM/BPM Core Competencies  
Beginner (Continued)**

**Personal Leadership Skills**

*Self analysis & 1-up analysis, evaluate which of the following you may need education and full working knowledge of:*  Marketing skills

- Public speaking
- Shared decision-making
- Communication skills

**Research**

*Dependent on level of trauma center (Burn Centers do not have assigned levels)*

- Meet and greet research team
- Working knowledge of process
- Working knowledge of current research
- Working knowledge of proposed research

**Injury Prevention**

*Varies based on level of trauma Center*

- Evaluate the effectiveness of trauma presentation activities
- Gap analysis of programs
- Relationships with IP Partners
- Collaborate with Public Health Department
- Stop the Bleed Program
- Stop the Burn Program
- Safe States
- Gap analysis of standards and your IP program

**Other**

- Identify succession plan for any potential leadership changes in program per facility guidelines
- Develop relationships with stakeholders
- Working knowledge of state and federal trauma laws, EMS triage rules
- Develop 1-5 yr. program strategic plan, working knowledge of hospital's strategic plan, mission statement and how trauma fits into it
- Develop program goals
- Review Policies/Procedures & Clinical Best Practice Guidelines - schedule for revisions
- Review transfer agreements
- Join a national trauma/burn organization and/or professional association
- Attend national and state conferences as travel permits

- Working knowledge of integration with disaster preparedness and trauma
- Research and review recent posters, abstracts, and articles
- Advocacy

**Notes:**

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**TPM/BPM Core Competencies**  
**Intermediate (3-5 Years)**

**Office**

- Learn how to create filters, run reports, validate information on reports in your trauma registry software Education
- Work towards course director status in TNCC
- Provide input into hospital-wide mandatory days
- TCAA DYAD Course
- TCAA Finance and Business Course - Basic and Advanced

**Communications**

- Foster relationships with hospital management, department heads, C-suite
- Grow relationship with trauma team
- Develop relationships with outside teams
- Become more involved with regional/state/national committees

**Data**

- In-depth knowledge of trending data and impact on program
- Develop annual report
- Drill down TQIP/BCQP data for opportunities

**Verification/Designation**

- Gap analysis of programs/PI/data to enhance your program
- Monitor and improve your data through validation

**Finances**

- Application of trauma/burn finance knowledge - review hospital's finance processes
- Process for obtaining possible funds for program from hospital foundations - varies by hospital
- Identify who can pull financial data from the Finance Department and create a financial dashboard

**Human Resources**

- Further skills in facilitating crucial conversations
- Actively utilize coaching and mentoring skills for yourself and staff
- Continue meeting with "1-Up" on quarterly schedule
- Continue growing your leadership skills

**Other**

- Succession Planning - identification of future leaders for trauma and mentor
- Continue to foster stakeholders
- Remain current with state and federal trauma laws
- Drive strategic plan based on data, research, and program/hospital needs
- Enhance program goals, driving program to next level of maturity
- Revise policies/procedures & Clinical Best Practice Guidelines - based on research & current best evidence
- Transfer agreements - review for revisions
- National Memberships - participate/attend their annual conference as travel permits
- Increase participation in research
- Advocate for trauma/burn at state and national level
- Submit a best practice abstract at regional, state, or National Conference

**Injury Prevention**

- Gap analysis of programs and data, evaluate the need to enhance, drop or change

**Notes:**

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**TPM/BPM Core Competencies  
Advanced (6+ Years)**

**Office**

- Data analysis of FTE, lean processes, comparison of fields in registry and fields being reported on

### **Education**

- Evaluate need to become state faculty for TNCC
- Teach courses at hospital, regional conference
- Mentor a team member to submit a best practice abstract at regional, state, or national conference

### **Communications**

- Mentor growth of team members
- Actively be involved as member on a nominating seat at regional/state or national committee

### **Verification/Designation**

- Gap analysis of programs in order to advance your program
- Monitor and improve data through validation and TQIP/BCQP reports

### **Finances**

- Analyze trauma/burn billing and collections
- Future forecasting of budget

### **Human Resources**

- Meet with your "1-Up" quarterly
- Meet monthly with leads in your program
- If considering an advancement to director, VP, CNO or retirement, begin mentoring with person identified to be your replacement by facility guidelines

### **Other**

- Obtain CITI, Train in research
- Develop grant writing skills
- Advocate for trauma/burn funding
- Attend a lobby/hill day, become more active with trauma/burn legislation
- Assist senior leadership with strategic plans for hospital and integration with trauma/burn program

## Appendix 2 Resources

[TCAA](#)

[U-Demy](#)

[Trauma Center Finance & Operations Resource Manual](#)

[ENA](#)

[TNCC](#)

### **TCAA Webinars:**

- [Key Elements of Effective Trauma Charges and Billing 2017](#)
  - [Emotional Intelligence: : A Critical Ingredient for Right Path Resources Leadership Assessment Healthcare Worker Well-Being](#)
  - [Grantsmanship 101 Seminar](#)
  - [Generations in the Workforce](#)
- [STN's TPM Role Delineation Study](#)
- [TeamSTEPS®](#)

### **Registry Software:**

[TCAA Dyad Course](#)

- [ESO](#)

[TCAA Finance and Business Course](#)

- [Lancet Technology](#)

[ATS TPM Course](#)

- [ImageTrend](#)

[STN TOPIC Course](#)

- [TraumaOne](#)

[STN Optimal Course](#)

[AAAM AIS Course](#)

[ACS Advancing Leadership in Trauma Center Management Course](#)

### **Books:**

- *Good to Great* by James C. Collins

\* *Getting Things Done* by David Allen

**ICD-10 Courses:**

- [KJ Trauma Consulting](#)
- [Pomphrey Consulting Comprehensive Trauma Specific ICD-10 Course](#)
- [ATS ICD-10 Trauma Injury Coding Course](#)

### Appendix 3

#### Sample PI Audit Form

Patient Name:		Age:	Medical Record # or FIN		
Admit Date:		Review date :		Trauma Name/ Number	
<b>PI Case Summary:</b>					
<b>Clinical Indicator:</b>			<b>Determination</b>	<b>Preventability</b>	<b>CF/J (1-7)</b>
<input type="checkbox"/> EMS scene time < 20 minutes					
<input type="checkbox"/> Intubated in the field					
<input type="checkbox"/> EMS run sheet not left with patient					
<input type="checkbox"/> Delayed activation					
<input type="checkbox"/> Trauma patients with ED dwell > 2 hours					
A. <input type="checkbox"/> Delay in decision to transfer patient					
B. <input type="checkbox"/> Delay in laboratory testing or imaging results					
C. <input type="checkbox"/> Delay from receiving hospital					
D. <input type="checkbox"/> Delay in transportation to receiving hospital					
<input type="checkbox"/> Trauma team activation criteria not followed					
<input type="checkbox"/> Surgeon response > 30 minutes					
<input type="checkbox"/> Incomplete nursing documentation					
<input type="checkbox"/> Patient Transferred to a non- designated trauma center without justified documentation					
<input type="checkbox"/> Patient death					
<input type="checkbox"/> Pediatric patient not assessed for maltreatment					
<input type="checkbox"/> Injuries transferred 24 hours after admission					
<input type="checkbox"/> Trauma patient that returned to ED within 72 hours					
<input type="checkbox"/> Other (specify)					
<input type="checkbox"/> Other (specify)					
<b>Determination:</b> SR = System Related DR = Disease Related PR= Provider Related		<b>Death Preventability:</b> UM= Unanticipated Mortality with OFI AM= Anticipated Mortality with OFI M= Mortality without OFI CD= Cannot be determined	<b>Contributing Factors/ Judgment:</b> <ol style="list-style-type: none"> <li>1. Delay in diagnosis</li> <li>2. Error in diagnosis</li> <li>3. Error in management</li> <li>4. Communication issue</li> <li>5. Timeliness/ Availability</li> <li>6. Equipment Issue</li> <li>7. Triage Issue</li> </ol>	<b>Opportunity for Improvement (OFI):</b> <input type="checkbox"/> Yes  <input type="checkbox"/> No	

PERFORMANCE IMPROVEMENT REVIEW FORM

Secondary review by physician required :  Yes  No

Physician/ Medical Director Review:

Signature:

Date:

Performance Improvement Action (s):

Date Completed:

Trend Evaluation:

None Required

Trend

Guideline or Protocol

Letter with Follow up Required

Education (specify)

M&M Peer Review/ Operational Committee

Privilege or Credentialing Action

Referral to

Re-evaluate in 3 months  
 Re-evaluate in 6 months  
 Monitor until resolved

Action Plan Documentation:

RE-EVALUATION DATE(S):

Corrective action follow- up notes:

LOOP CLOSURE DATE: