GEORGIA TRAUMA COMMISSION

APPROVED 05.13.2022

Level III/Level IV/Rural Committee Meeting
Tuesday, March 1, 2022
3:45 pm to 4:45 pm
Barnsley Resort
Meeting Minutes
Link to Meeting Material

COMMITTEE MEMBERS PRESENT	REPRESENTING
Greg Patterson	**Committee Chair/**Emmanuel Medical Center, TMD
Alicia Register	**Committee Vice-Chair/**Crisp Regional, TMD
Ashley Bullington	Crisp Regional Hospital, TPM
Ralph Castillo	Morgan Medical Center, CEO
Brian Delashmitt	Hamilton Health Care System, EVP-CMO
Lynn Grant	Fairview Park Hospital, Trauma Program Director
Judean Guinn	Hamilton Medical Center, CNO
Stacey Howard	Fairview Park Hospital, COO
Tifani Kinard	Polk Medical Center, Administrator
Karrie Page	Memorial Health Meadows Hospital, Trauma Coordinator
Courtney Terwilliger	Emanuel Medical Center, Emergency Manager
Jan Tidwell	Piedmont Cartersville, CNO
Frances Van Beek	Wellstar, AVP, Neuro & Trauma Services
Marty Wynn	Piedmont Walton, CFO
Olalekan Akinyokunbo	Emanuel Medical Center, Trauma / Emergency Medical Director
Riley Benter	Adventhealth Redmond, Trauma Program Director
Michelle Benton	Morgan Medical Center, Trauma Program Manager
Kim Brown	Hamilton Medical Center, Trauma Manager
Kerry Carter	Wellstar, TPM
Ranger Curran	Wellstar, TMD
Mary Beth Goodwin	John D Archbold, PI Coordinator
Rachel Hand	Wellstar West Ga Medical Center, TPM
Sharon Hogue	Polk Medical Center, TPM
Karen Hust	Piedmont, Trauma program coor
Richard Jacob	Piedmont, MD
David Kiefer	Effingham Health System, Trauma medical director
Lindsey Lewis	Effingham Health System, Trauma Nurse Coordinator
Christie Mathis	Morgan Medical, Rn, trauma coordinator
Ashley Orr	Wellstar West Georgia, MD
Steven Paynter	Hamilton Medical Center, TMD
John Polhill	Fairview Park, TMD
John Pope	Piedmont Cartersville, Director of Trauma Svcs
Damien Scott	Emanuel Medical Center, CEO

Tamra Skinner	Wellstar Cobb, RN Trauma Coordinator
Gail Thornton	Emanuel Medical Center, Trauma Coordinator
Awharitefe Urhuogo	Morgan Medical Center, ED Medical Director/ Trauma Director

STAFF MEMBERS & OTHERS SIGNING IN	REPRESENTING
Elizabeth V. Atkins	GTC, Executive Director
Gina Solomon	GTC, GQIP Director
Gabriela Saye	GTC, Executive Assistant
Katie Hamilton	GTC, Finance Operations Officer
Dr. Dennis Ashley	GTC, Chair
Renee Morgan	OEMST, Trauma Program Director
Jessica Story	Warren Averett, Sr manager

Call to Order: (00:00:05 on the recording)

Dr. Greg Patterson called the meeting to order at 00:00:05 on the recording. Dr. Patterson introduced the committee vice-chair, Dr. Alicia Register, and pointed out today's impressive attendance.

Approval of August 13, 2021 meeting minutes: (00:00:38)

Dr. Patterson asked the Committee for a motion to approve the August 13, 2021 meeting minutes.

> **MOTION LIII/IV Committee 2022-03-01:**
> **Motion to approve the August 13, 2021 meeting minutes as submitted.**
>
> **MOTION BY**: Dr. Alicia Register
> **SECOND BY**: Damien Scott
> **VOTING**: All members are in favor of the motion.
> **ACTION**: The motion ***PASSED*** with no objections nor abstentions.

Grants Update (00:01:22)

Dr. Patterson stated we're continuing to work on some initial grants to fund some of our projects. There are no updates at this point.

LIII/IV Readiness Cost Overview: (00:02:50) ***Presented by Dr. Dennis Ashley***

Dr. Patterson asked Dr. Ashley to present the recent Level III and IV Readiness Cost Survey Results (ATTACHMENT A). Dr. Ashley went into detail the following information:

- ACS Readiness Costs Definition
- Survey Purpose, Definitions, Limitations, and Methods
- Results: Overall, Administrative, Program Support, Clinical Medical Staff, and Education and Outreach

The Level III/IV Readiness Cost Readiness Costs Summary:

Trauma Center	Average annual readiness cost	Most significant cost	Lowest Cost
Level III	$ 1,715,025	Trauma Surgeon Staff	Education and Outreach
Level IV	$ 81,620	Trauma Director	TMD Participation Costs

Dr. Patterson asked the Committee if there were any questions regarding the presentation, which was intended to give you a footprint of where we are and what it's costing us. In the past, our group discussed how we could be on the same footing as the Level I and IIs and make our concerns known. One of the things we need to show them is what it costs us and what we're putting into this. Dr. Ashley mentioned earlier it was seven centers on the dollar for the average readiness costs and seventeen cents for uncompensated care. The Level IV numbers appear very low. I think it's due to this being the first time we have done the survey, but also some fear about reporting some of these numbers to your administration. Maybe Level III costs are a bit higher than what is indicated in the survey results. We need to report these costs to understand where this money comes from and ask for more funding, so the Georgia Trauma Commission can advocate for us during the legislative session.

MARCH PAWS: (00:16:47) ***Presented by Dr. Patterson***

You heard about MARCH PAWS this morning. Some of us met for a two-day meeting at Lake Blackshear to review the initial draft of the course. It will be something we can teach every rural center on how to handle trauma. One of the significant issues is transfer times and transfer equipment. We don't have EMS units or the right transfer system. MARCH PAWS teaches you to handle these situations and provides education to improve patient outcomes. We asked Courtney Terwilliger to join us today, MARCH PAWS was his project, and he obtained the original grant through his facility, Emanuel Medical Center. Courtney Terwilliger discussed the background behind starting MARCH PAWS and the ultimate goal for all disciplines, nurses, doctors, medics, to work together.

Dr. Patterson mentioned that hopefully, we could roll out a prototype course by August; have a few test courses done, give a report and then roll it out to the rest of the state. Once we facilitate train-the-trainers, we're looking at a one-day course and mannequins just like ATLS or TNCC. We are trying to go to individual hospitals and have enough trainers such as physicians, EMTs, and nurses to teach the course to speak to all levels.

Courtney added that through EMS training, cadaver labs are available across the state. It's a free resource, and if you are interested in attending, please let me know.

ACS Consult Process: (00:28:00) ***Presented by Dr. Patterson***

We have engaged the ACS to have the first rural consultative state initiative in the nation. We have come up with questions we want to work with them on. Dr. Patterson reviewed the proposed framework of what the visit could focus on (slide 22):

- Rural best practice states/regions/territories to replicate
- Risks/benefits of TC waivers for specialty services/equipment
- Acute care facility incentivization for trauma system participation
    1. Trauma center or;
    2. Non-designated, participating center
- Telemedicine models specific to trauma
- Ensuring clinical competency in live-saving procedures in the rural environment
- Interfacility transport – contractual arrangements
- Efficient utilization of blood in rural centers to minimize waste
- Optimal level of training/licensure of the rural medic
- Optimal size of rural regional areas for effective system integration

Liz Atkins added that the ACS agreed to do this consult visit as a pilot. They are putting together a proposal for us, and we requested a target date of this fall, but they have not set a date yet. Dr. Patterson also mentioned we have the level IV consult visits with Pennsylvania Trauma Systems Foundation (PTSF). The dates of the visits will be October 11-15. Dr. Ashley stated typically, with reviews, everyone wants to make themselves look good, but this is the time to be honest. If you don't have something, say you don't have it because we want to help you get what you need.

Your report is yours, and we're not getting access to that. PTSF is set to come to our November Commission meeting and give an aggregate report of strengths, opportunities, and recommendations. We want you to see that aggregate report and be the ones that make decisions about what recommendations come forward. The orange book and the upcoming grey book are lean in IVs because it doesn't specialize in them. Texas and Pennsylvania have additional criteria for their level IV centers, and if we made additional criteria for you, it would cost you more than the 81,000 indicated in the survey/

Access to Specialty Care: (00:36:05) ***Presented by Dr. Patterson***

Access to specialty was one of our first projects within our Committee. We would like to start formally updating that quarterly. We don't know who does what, and there are certain times of the month they may not be doing it. We need to know things such as who has ECMO, who does pediatrics, their age limits, who does burns, and contact information. We did create a spreadsheet with this information, and laminated copies were sent out to everybody. We will continue to update and, hopefully, develop a widget or app that the Trauma Medical Directors can participate in. Maybe we could apply for a grant and have a research fellow build something.

Web-based Registry & Contracted Abstraction Services: (00:37:50) ***Presented by Dr. Patterson***

Liz Atkins updated the Committee that the web-based registry costs have been put in the amended budget for a vote. Utilizing a web-based registry will alleviate some of the maintenance, and IT burdens with registry updates. We will have to work out how to get it to you this fiscal year because we will need to determine where you all are in your registry contracts. Essentially, it will be an additional registry supplement to cover the costs since web-based is a little more expensive.

For contracted services, maybe we need a workgroup of Trauma Program Managers or the industry folks from this group to say what we can do. We cannot pay outright to a contracting service because you have to have BAA agreements between the service and your hospital, but we can set up for reimbursement. Dr. Patterson added that the Arbormetrics projects would include real-time data from the level IVs.

Committee Projects/Committee Suggestions: (00:41:21) ***Group Discussion***

We have table two projects we had talked about at our late meeting, hip fracture and geriatric trauma care. We can come up with some workgroups to see what we can come up with to improve care and initiate guidelines. I will send an email to see you want to be involved with those two workgroups. Dr. Patterson asked for any other projects for consideration.

Dr. Awharitefe Urhuogo started a discussion around level IVs having difficulty reaching a trauma center for consults. It helps to have a system where someone can reach out for a consult and obtain feedback on whether to keep a patient in-house rather than transferring a patient in an overwhelmed system.

Our current process is to call a transfer center and have an ER doctor talking with another ER doctor rather than having the ability to speak with a trauma surgeon who can help make a better-informed decision. Rather than jumping to transferring a patient, they may advise how the facility can stabilize the patient.

Dr. Ashley recommended creating a system to pair up Level IVs with their appropriate facility and establish a mainline of contact to get past the barriers and straight to the trauma surgeon. Dr. Patterson suggested updating the working tablet of all the trauma centers and identifying where Level III and IV would transfer patients to. Hospitals can individually reach out to their nearest centers to pair up and have a primary and secondary catchment hospital. I would like to put together a transfer workgroup that tries to identify the different processes we have problems with, such as not enough EMS units, accepting facility issues, and telemedicine.

Dr. Urhuogo advised a solution of having a tele-trauma protocol, where a trauma doctor from the remote list can comment on a case and make a note that goes into the chart. It can provide help and take some responsibility on that case and ultimately maintain those funds in those hospitals. Dr. Patterson noted

many level III and IV centers have telemedicine equipment available. Maybe we can work on grants to get you the equipment if you don't.

Another comment stated was that hospitalist education is also a significant component. It comes down to the willingness of the hospital to admit the patients. The single note may make the ER or surgeon feel comfortable, but it does not secure the hospitalist that will be primarily responsible. That would be huge if we could figure out some statewide education to include them.

Dr. Patterson summarized the following steps: creating workgroups around geriatric, hip fracture, and transfer-related issues. We would like to set up another meeting in conference call format to give you some updates three months before the next August Meeting. We may want to consider April since the next Commission meeting is in May.

Liz asked if members would be interested in an Optimal Course in August that teaches you about the new ACS criteria. If they release by August 1, you can have that course during the Summer Meeting. I will set that up, which could be an extra day of travel.

Meeting adjourned at 00:56:09 on recording

Minutes Respectfully Submitted by Gabriela Saye