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**GEORGIA TRAUMA  
COMMISSION**

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Rural Survey Feedback Webinar Summary  
Webinar Hosted November 4<sup>th</sup> and 7<sup>th</sup>, 2024

# Background

- Recommendation from the ACS Trauma Systems Consultation and Rural Focused Review
- A joint effort between GTC, SORH, GRHIC
- Participants:
  - 66 Rural Hospitals in GA with Emergency Services
  - Data collected March 11 – April 5, 2024
  - 94% Response Rate (62/66)
  - Presented by Chris Scoggins May 22, 2024, GTC meeting at Chateau Elan

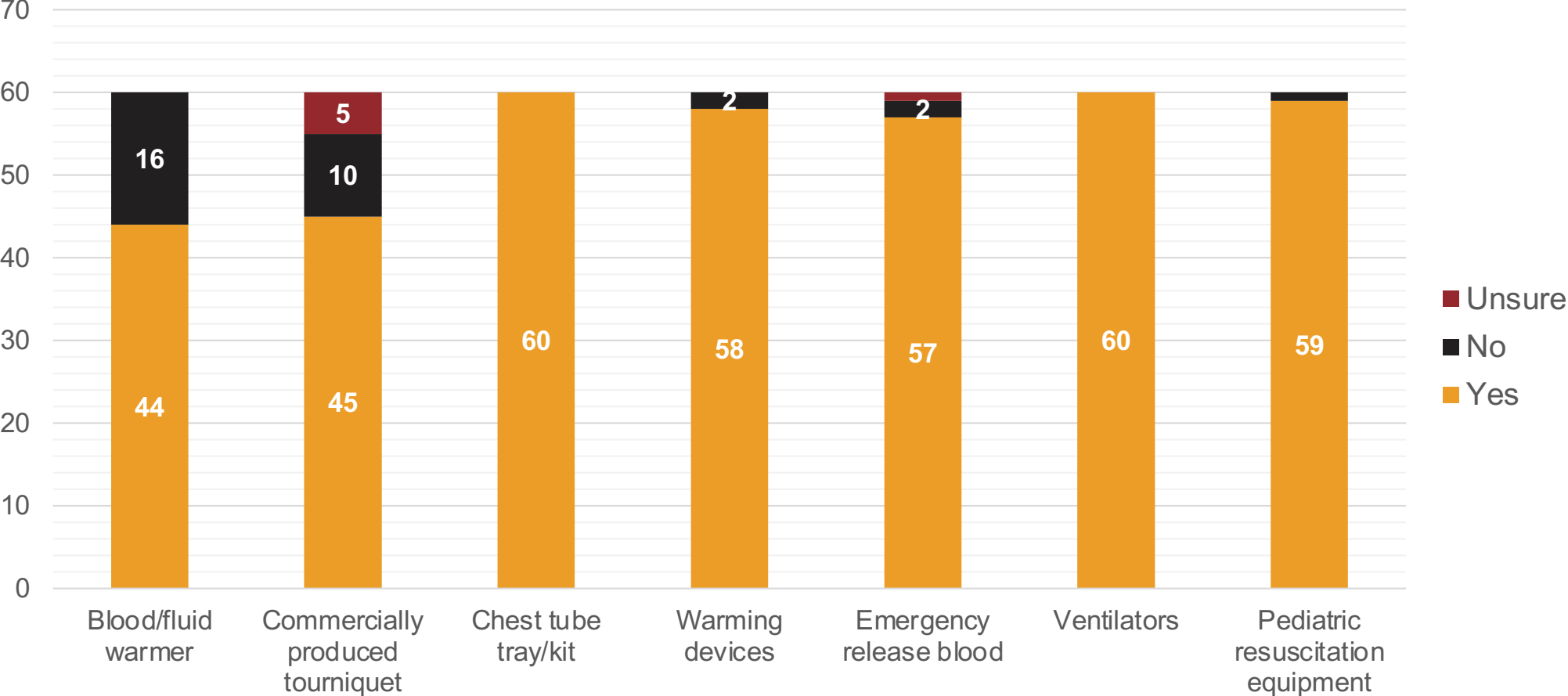


# Background

- Demographics:
  - 82% were non-trauma centers
  - 46% had < 25 licensed facility beds
  - 52% had fewer than 10 Emergency Department beds
  - 87% are not admitting
- Questions focused on
  - Provider coverage, staffing, protocols/PMGs, resources (equipment), EMSC pediatric readiness compliance, education, interest/barriers to becoming a designated trauma center
- Presented results to participants on Nov 4<sup>th</sup> and Nov 7<sup>th</sup> using Mentimeter to get feedback



# Does your facility have the following resources available in the Emergency Department:



# What are the barriers to acquiring blood/fluid warmers?

**Responses = 25**

**None = 13**

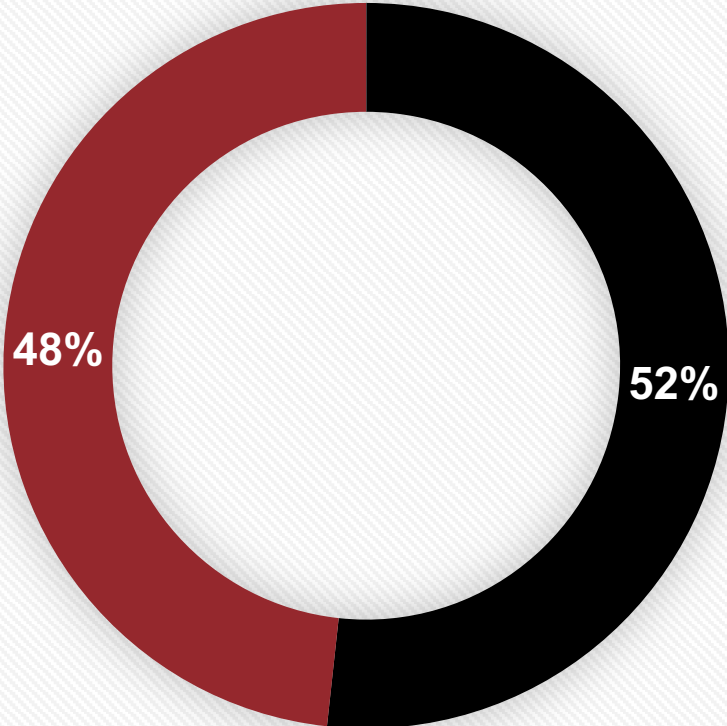
**Cost = 4 (2 reported cost was a barrier initially but they have them now)**

**Aged Units = 4**

**Other = Education on use**



# What is your most used form of transportation when transferring trauma patients?



- Ground ambulance – BLS (basic) crew
- Ground ambulance – ALS (paramedic) crew
- Air – helicopter
- Air – fixed wing

# What is the primary driver of use of HEMS when transferring trauma patients out of your facility?

**Responses = 28**

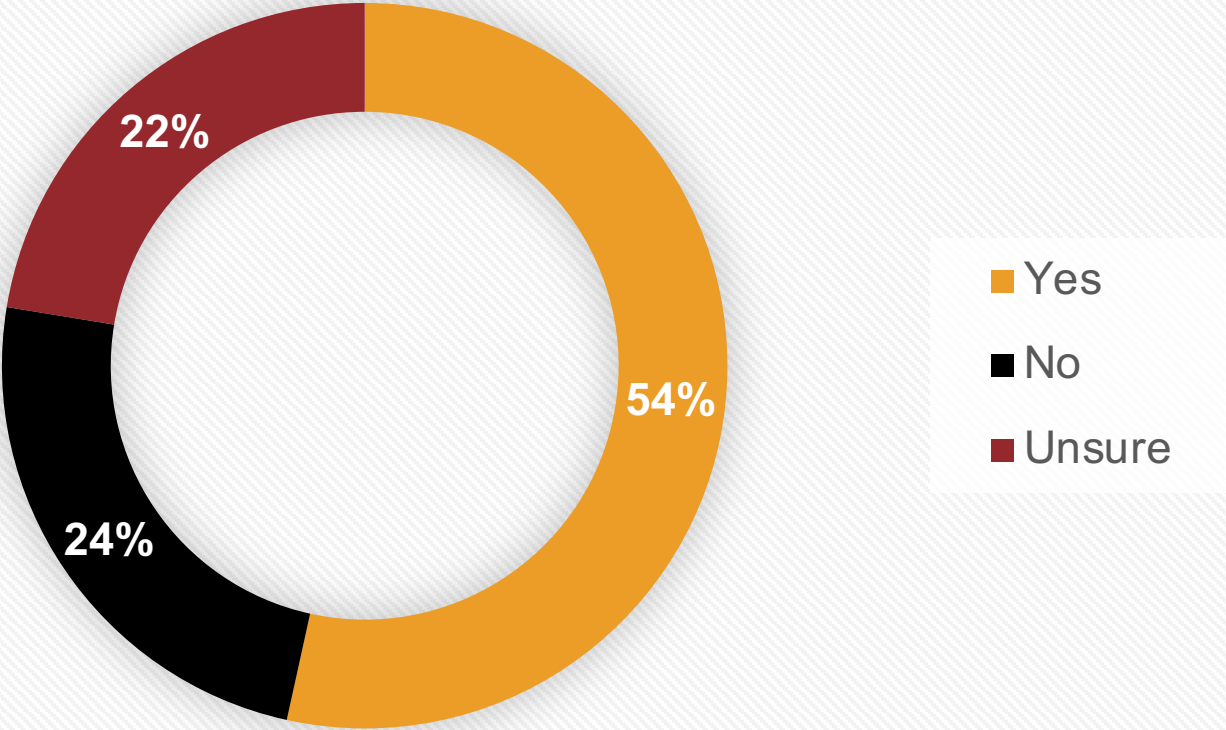
**Ground unit not available or delayed = 19**

**Other = 4**

**Distance = 5**



# Is Advanced Trauma Life Support (ATLS) education required for providers in your emergency department?



# If your providers aren't required to have ATLS, what are the barriers?

**Responses = 17 (free text)**

**Common themes: Availability of Courses, scheduling (time away), cost**

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Really no barriers. Some docs are just difficult to adjust their schedule

Access to course and time for provider away from work to take the class. If had onsite or close by would help

We are now requiring ATLS, but cost and location are big factors limiting certification

Funding, Availability, and allowing staff time away to take it. Also, difficult to help get classes close as facility is responsible to provide lunch. Funding again is the issue there.

MDs are required but not required by NP/PA

Low Availability of classes in our Region and not required by the facilities by-laws

We do require it for them, but they do complain that they have trouble finding the class.

Opportunity to get the training, costs, not in the contract

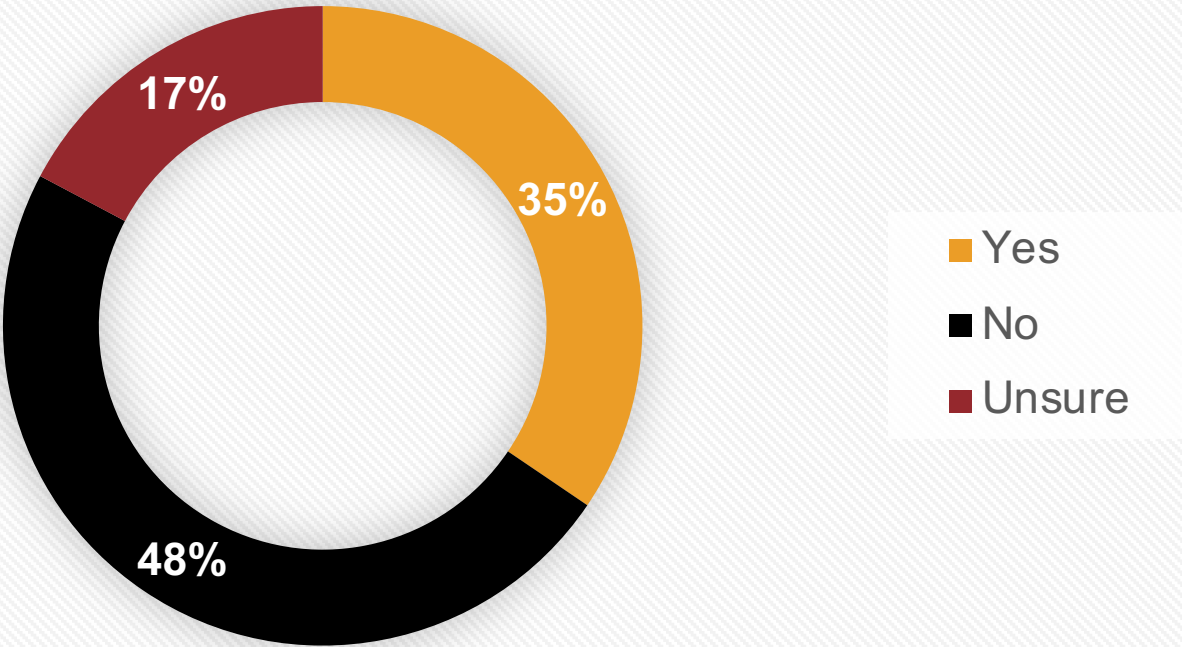
We require ATLS, same problem with trouble getting classes.

Time, costs,, not in contract

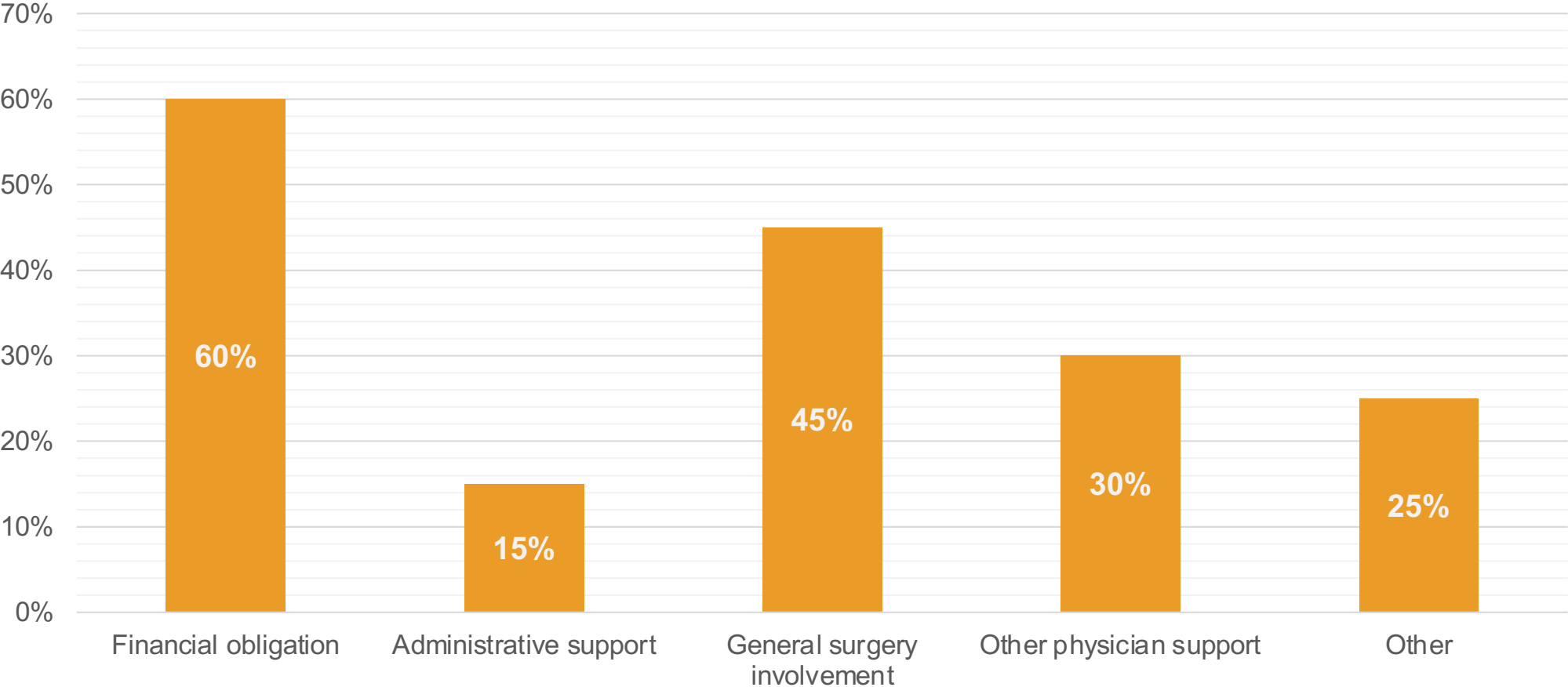
Physicians willing to spend their few days off in class



Do you believe your hospital could meet the criteria for a trauma center designation or move to a higher level of trauma designation?



# What has prevented your hospital from pursuing a higher level of trauma verification/designation?



What would be most helpful in supporting you to determine if trauma centers designation/and or upgrade is feasible?

**Responses = 20**

**Themes: Cost, Resources (funding/grants, subspecialists, data entry, training)**

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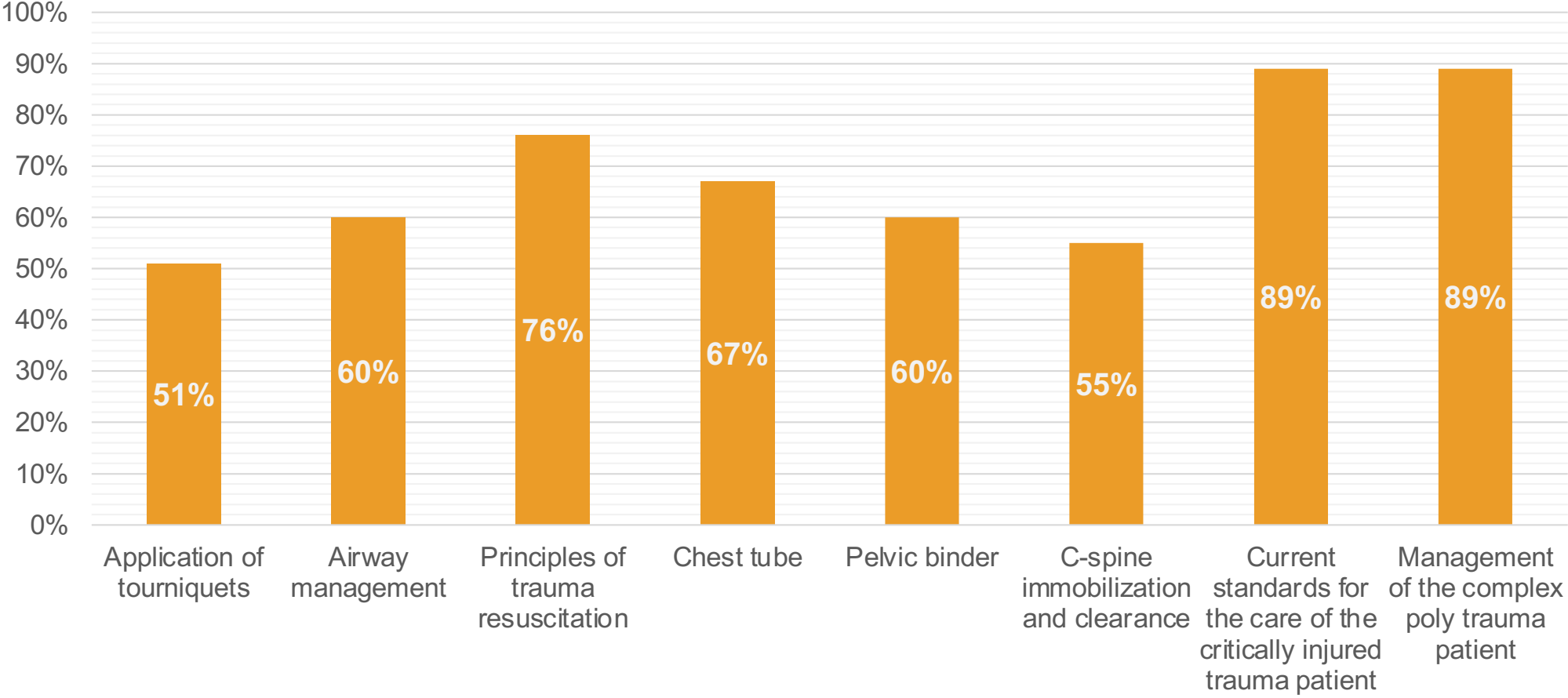


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Cost of specialist recruitment to rural areas.	Financial resource help Conversation about the resources it would take.	How to recruit specialists	A review of what expectations would be. Financial assistance to offset the cost of the facility.	Application; cost
Regulatory requirements	We are a designated level four. Would need additional resources if upgraded	Our barriers are a mix of the financial costs for the data abstractor and database/registry, staff training, and close guidance for application assistance. We are working on it, and it is a goal of ours.	Cost, resources, training.	Not feasible for us
Our Csuite and general surgeons are supportive	upgrade not feasible we do not have 24/7 surgical services	An outline of all the requirements needed for each level. What data is needed? And how to obtain those as a CAH. Grant funding would be great!	Upfront costs and additional personnel needed to get started.	Outline of requirement to begin level 4 designation.
Support from CEO, CNO, medical staff and hospital staff	Colquitt-we tried a few years ago and put on hold due to surgery/OR/internal issues. Restarting the process this fiscal year!	Our C-suite and general surgeons are supportive	We want to pursue level 4 but struggle is associated with the costs to get going	



# Would your staff benefit from additional training in any of the following areas?



# What is the best way to meet these educational needs for your ED staff?

**Responses (Multiple Choice) = 35**

**We come to you for small, team-based, scenario-based educational experiences = 18**

**Virtual interactive scenario-based learning = 12**

**Pre-recorded videos targeting each training need = 2**

**You come to a regional location, e.g., EMS regions 1-10 = 4**



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# How often can you spare ED Nursing and ancillary staff to attend educational training?

**Responses = 20**

**Quarterly = 9**

**Twice annually = 8**

**Annually = 2**

**I can't spare staff, we are spread too thin = 1**



# How often can you spare ED Physicians to attend educational training?

**Responses (Multiple Choice) = 35**

**We come to you for small, team-based, scenario-based educational experiences = 18**

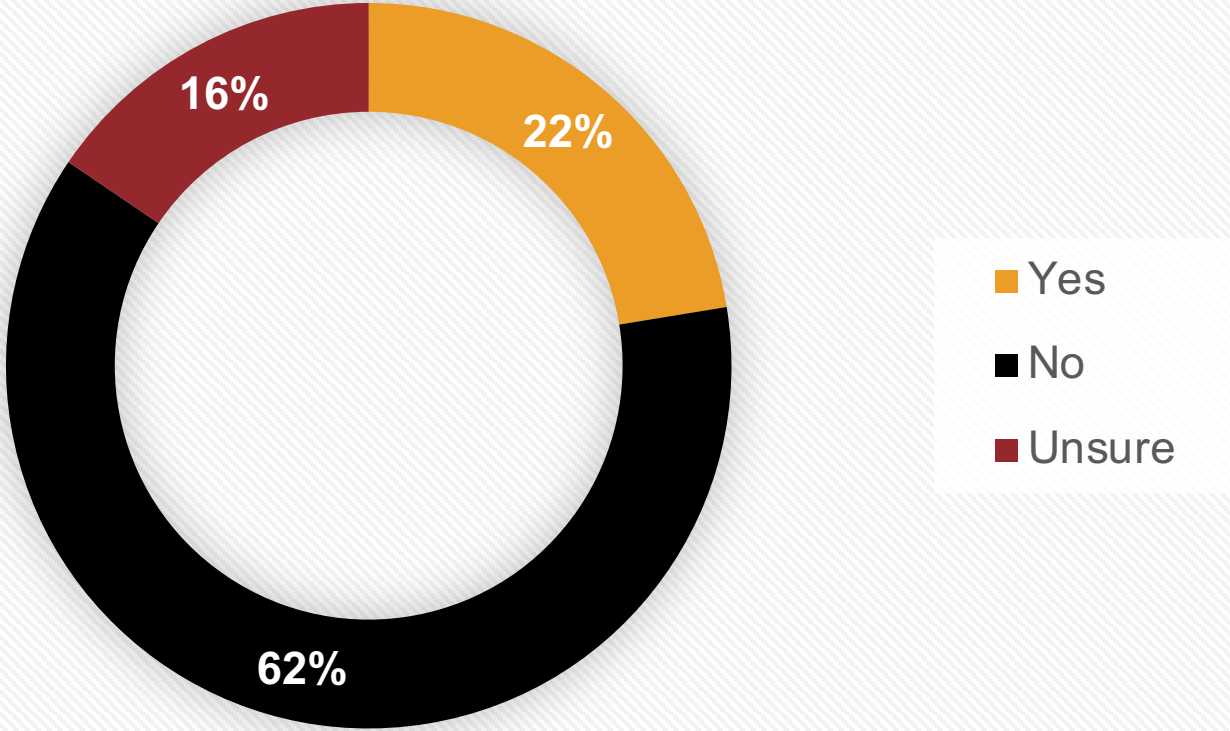
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# Have staff at your facility participated in a Rural Trauma Team Development Course (RTTDC)?



As we close the webinar, was there anything we didn't ask in the survey that's important you?

**Responses = 13**



Do rural ED physicians respond to in-house codes in all rural settings?

I would like to know if the rural areas use air because ground takes too long, what ambulance service they have, or if it is county-based.

As a rural hospital the main barriers to a lot of programs comes down to resources. partnerships from the larger facilities with the ability to share resources ie. data abstractors/platelets, etc.

Transportation (EMS) is very hard for us. We are waiting hours with critical patients declining in our ER. We are great at stabilizing the patient, but we need help getting to a high level of care.

Need ACS update on Level IV standards

Are there patient outcome data summaries that will be available to measure our care against?

Are level IVs going away in the future, since we are not in the ACS gray book?

As costs have been identified multiple times, it would've been good to see the costs and those numbers in a survey.

The biggest thing for our hospital would be educating staff. We would also like to participate in any grants..

What is the most common barrier to designation?

Critical care transport teams from the tertiary care centers to come and get patients

Successful incentives for specialist recruitment



## Summary and Next Steps...

- We have tremendous stakeholder engagement that we can leverage
- Grant programs are now in place for Level IV startups
- Small, facility-based educational efforts will work best
- Will need support from Level I – III Centers



# Questions/Comments/Ideas Welcome!

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