Meeting Minutes

Meeting Title	Mississippi Trauma Advisory Committee (MTAC)
Meeting Location	VTE/In-Person
Meeting Date	06/6/2025
Called to Order @	10:00 am
In Attendance "☒" *Bold denotes committee members	☒ **Dr. Duncan Donald (Chair)** ☒ **Ms. Amber Kyle** ☐ **Mr. Ben Shrivner** ☒ **Mr. Billy Taylor** ☒ **Dr. Clyde Deschamp** ☒ **Mr. David Grayson** ☐ **Dr. Hans Tulip** ☒ **Dr. Hugh Gamble** ☒ **Dr. Jason Stacy** ☐ **Dr. Jeremy Rogers** ☒ **Dr. Jonathan Wilson** ☒ **Dr. Kendall McKenzie** ☒ **Mr. Mark Galtelli** ☒ **Ms. Pam Wallace** ☒ **Mr. Ryan Wilson** ☒ **Ms. Suzanne Joslin** ☒ **Mr. Tyler Blalock** ☒ Ms. Amber Nessenson ☒ Mr. Benji Sessums ☒ Dr. Bob Galli ☒ Mr. Brandon Robinson ☒ Ms. Brandye Vance ☒ Ms. Catherine Tyrney ☒ Ms. Christina Batton ☒ Mr. Jeff Tabor (guest) ☐ Dr. Juan Duchesne ☒ Dr. Juvonda Hodge ☒ Dr. Michelle Goreth ☒ Ms. Michelle Templeton ☒ Mr. Norman Miller ☒ Mr. Patrick Graham ☒ Mr. Scott Stinson
MSDH and MTCSF Staff Members Present "☒"	☒ Ms. Teresa Windham ☒ Ms. Elaine Coleman ☒ Ms. Tammy Wells ☒ Ms. Elizabeth "Courtney" Day ☒ Ms. Katianne High ☒ Mr. Andrew Nguyen ☒ Mr. Edwin Mitchell ☒ Ms. Stacey Maurer ☒ Mr. Matt Edwards ☒ Ms. April Walker ☒ Mr. Josh Dawson ☒ Mr. Sam Burdine ☒ Ms. Victoria Hickerson ☒ Mr. Jon Wright

Meeting Minutes

	AGENDA TOPIC	NOTES
I	Call to Order	Dr. Donald called the meeting to order at 10:00
II	Roll Call	Quorum met.
III	Old Business a. Review Minutes of Previous Meeting b. Follow up items from previous meeting	M: Ms. Kyle 2nd: Dr. Gamble Minutes approved. 1. Develop a 5-year strategic plan outlining the goals above in this plan: Group met but not finalized the plan. 2. Set up MTAC workgroup for a special meeting for Rules and Regulation discussion: workgroup formed but has not met since the last MTAC meeting. 3. Set up a workgroup for Repatriation of Patients to their communities: Workgroup formed and has met a couple times and is not finalized. 4. Schedule Training for the Death Review form process: protocol training took place last week and will discuss further in this meeting. 5. Add Dr. Juvonda Hodge to the MTAC agenda for Burn PI Subcommittee: DONE 6. Develop specific CHARLIE criteria to bring back to MTAC committee: Will report on this meeting.

	a. Office of EMS and Acute Care Systems i. MSDH/Office of EMS/ACS Report	Ms. Windham- • Ms. Windham updated the group regarding a national survey sent to level 4's across the United States to provide feedback on the designation process. Feedback received stating some states are using APP's. We don't address that in our rules and regs and wants to know if we should start. Dr. Donald asks if it is only staffing Emergency Department. Ms. Windham states staff but also for Medical Directors. Also states the use of blood by EMS ground units. Some services are providing blood on ground ambulances. Dr. Donald states our rules and regs state a physician must be used. Ms. Kyle states the question is do we need to change that. Nationally there's a shift that is occurring. Dr. Goreth states the state of Mississippi requires APP to have a collaborating physician. Ms. Kyle states there is a clinical aspect and an administrative aspect. Mr. Blalock asks what the advantage would be and Ms. Kyle responded the problem is little physician engagement with the program development side. Ms. Day- • Clinical Updates: Updated committee regarding education visits and designation surveys. ◆ 1 Level 2 designation visit completed ◆ 2 Level 3 designation visits completed ◆ 3 Level 4 designations completed. ◆ 10 open corrective action plans, 7 Level 1-3's, 3 Level 4's. ◆ 5 Level 3 education visits scheduled ◆ 4 Level 3 designation visits scheduled. ◆ 7 Level 4 designations pending ◆ 1 level 3 education visit completed, and 1 Level II education visit for fall of 2025. Dr. Donald reiterated that we have 5 freestanding ERs in MS and those facilities will function as a level IV trauma center. ◆ Death Review form released. Updated Alpha and Bravo criteria were also released. ◆ None Non designated facilities in the state.

	ii. Sub-Committee/Task Group Reports a. Trauma Funding Task Group b. Trauma Rules and Regulations	Dr. Duncan Donald: The State of the State Trauma System: CEC Developed "Charlie Activation Criteria"-- 1. Single system trauma injury with a low energy mechanism such as an isolated fracture or an isolated pneumothorax or an isolated head injury that does not meet for a Bravo criteria 2. Low energy mechanism with stable vital signs 3. Pregnancy greater than 20 weeks with a significant traumatic mechanism. 4. Patients who are 65 or older on anticoagulation or an oral anti platelet agent.(excluding Aspirin alone) 5. MD Judgement Discussion: Who makes up the team if the surgeon isn't required. Dr. Donald states committee couldn't reach a consensus for a response time frame. Response time would be left up to individual facilities. Mr. Blalock asks if these patient would be tracked in registry. Yes. These criteria would be added to the appendix as to not require regulation change. ***MOTION*** Mr. Galtelli-follow 5 criteria presented for Charlie Criteria. ***2nd***-Ms. Kyle with comment-these should be recommendations and not required for a third-tier activation that is not these criteria. Ms. Kyle explained the injury alone (ICD 10) does not automatically qualify for input into registry. There must be a qualifying injury PLUS one other criteria me (activation) before qualifying for registry input. ***Motion withdrawn***: Table discussion to allow for further investigation regarding downstream effects of Charlie Activation Criteria. ***2nd***-Dr. Gamble. None opposed. Dr. Donald states PI committees are utilizing patients or individual hospital complaints about patient throughput and patient care issues with individual cases and has been beneficial. Also identified issues with patients going to Level 3 hospitals that were hemodynamically unstable and then being transferred to a higher level of care without receiving stabilization treatment. Care has improved. Dr. Wilson – Trauma Funding Task Group: • Has not met since last MTAC Ms. Kyle – Trauma Rules & Regulations: • Summary: did not meet due to conflicting schedules. Will

	c. Burn Subcommittee	have separate meetings for Level 3's and 4's and another for 1's and 2's. These meetings will be lengthy. Significant look and revision of rules and regulations. Dr. Hodge –Burn PI Committee: • Met with great representation of facilities statewide. • At the meeting-discussed metrics to track: Complications, time to OR, etc., and unnecessary transfers.
	d. Trauma Registry	Ms. Day for Ms. Langston – Trauma Registry Subcommittee • Only met one time • Presented new Mississippi Trauma System Dashboard that will be used for PI reporting. The fields can be changed depending on requested data elements. • Data migration is in progress-just not as quickly as we had hoped. • "Blank" elements will decrease once data is entered into registry. • Image trend will replace old Inclusion criteria with updated version-should be by August 1st. • Reinstating 60+6 as of July 1st.
	e. Mississippi Trauma Care System Foundation	Mr. Edwards – MS Trauma Care System Foundation: o Received June Trauma Care Trust Fund Distribution. o Multiple Stop the Bleed classes across the state o Discussed the success of the Trauma Symposium held in Natchez on May 5th -May 7th. Multiple pre-symposium options. Approximately 170 registered attendees. Informed the committee of the awards that were handed out. o Multiple educational offerings with a continued rise in number. o The upcoming ICS 10 coding class is June 17-19th.
IV	New Business	Mr. Tabor spoke regarding Arkansas's Regionalized Call Center. Introduced program: formed multidisciplinary group to look at a statistical sampling of every trauma death in Arkansas. Various criteria are used. Not a mandatory participation system. Benefits: money and patients coordinated through the trauma system. Call center coordinates and facilitates trauma patients to the most appropriate trauma center based on patient condition and system resources identify by hospitals via Em resource (EMS and Transfers). Patients are not transferred by the call center to non-

		trauma centers. ACS Field Triage Criteria is used to classify "major and moderate" for EMS to reduce over/under-triage by data-driven and evidence-based decisions. Hospitals that have a transfer requiring a trauma center, are required to call traumacom for coordination. Trauma system paid for a dedicated radio system in every air and ground ambulance. "Arkansas Wireless Information Network" calls are received from 99% of the state thus aiding in interoperability and communications. AWIN also supports police. Also use Pulsara. Phone calls are discouraged because they don't get priority. Use a Juvare platform to track every designated trauma center. It is required for the hospitals to update in real time. This allows for visualization of available specialties. Use a unique patient identifier arm band. It give a trauma band number and allows linking of the EMS data registry to the trauma registry to the to the spine registry. None of these softwares talk and this allows for linking the data. Now have a barcode on them that cuts down with data entry errors. Traumacom coordination usually averages about 7 minutes 15 seconds. Group of hand surgeons allow telemedicine consults which decreased transfers by about 70%. Also using Burn telemedicine. Trauma Image Repository is a cloud based secure encrypted system that all images from hospitals are uploaded to and the pushed to receiving facility so they can view and make decisions. They are able to review images and bypass the ER and go straight to the OR. Transfer times monitored by Major, minor and moderate levels and volume, transfer decision, admin interval, EMS gap, EMS response and ED LOS. Method of transport is also monitored by each level to include EMS gap, response time and average ED LOS. There is a rule that says if a sending facility declares it to be an urgent trauma transfer, we get our on call medical director on the line, the two doctors talking out. And if our medical director agrees, then we facilitate the transport agency. The call center calls the service are ground EMS. If that EMS agency cannot facilitate a timely transfer, it is up to them to find an agency who can. ***Discussion***: Dr. Donald asks who the authority is over the Trauma System. Mr. Tabor states Arkansas State Department of Health. What is the total annual budget to run the Traumacom? $2Mil. Comes from dedicated trauma funds. Dr. Gamble asks how big the total trauma budget is. About $20M

		(state money). Is it variable or stable year to year? Mr. Tabor states it is stable and the variabilities are carry forward dollars. The hospitals get a set fee based on their designation levels. They apply for their grants and they spend their grants. EMS has a very complex funding formula based on population, and the number of services in a county. And then there's a modifier for the number of patients that they coordinate through traumacom There is a set pot of money, but that pot is never been fully used so it gets carried forward. The EMS training sites is a pot of money that's never been fully executed that gets carried forward and there's a few other little pots of money that get carried forward for the next year to be used for special projects. The last few years they've actually temporarily increased the other pots. Ms. Winham asks who is used for your image repository? Mr. Tabor states he can get the answer but isn't sure at this time. Ms. Winham asks who is used to staff call center. Mr. Tabor states they are a contractor with the state of Arkansas and it is staffed by Paramedics and RN's with at least two years of experience. 2 call takers 24/7. Also have full time data analyst/quality assurance officer. Same call center is used for disasters. Dr. Gamble questions EMS contacting call center. The EMS provider calls from the scene and gives description/report of what patients they have and their intended destination. With the information the dashboard is used to determine closest, most appropriate facility. If it's a major trauma patient, the call center will also notify the receiving hospital and give a heads up/report on what is coming. A different patient example, they give us their recommendation or they give us their destination. And it's either not a designated trauma center or, we know something they may not know based on the version status or just volume that we've just sent to that hospital. Maybe we recommend a different hospital. And so we'll tell them that back and they'll either say show us in route to hospital 2 and they still go to the original hospital. They are questioned why they are still going to that facility with received information to identify barriers. And so patient preference system status, rent an MCI weather that there's reasons that we track and trend why they don't follow our recommendation. That is our biggest issue because heel because we don't know exactly where the ambulances and helicopters are at. Our recommendation is based on where their base is at. So in populous areas, Northwest Arkansas especially,

		there's several towns and that one big pocket, several hospitals. And so they know much better than we do where the closest hospital is. Dr. Gamble asks if the hospital the agency usually transports to is on diversion or doesn't offer needed services, can you direct them to bypass that facility and go to a presumable higher level of care? Yes, but "direct" isn't used, we recommend they go to the closest most appropriate based on their report and the dashboard. Geographic distance play a role? No. Dr. Stacy asks if normal GPS tracking is done and #2 what was the thought behind having no ability to make a formal direction? Mr. Tabor states there are 215 different licensed ambulance services in Arkansas, not all ambulances have GPS systems and there isn't enough trauma money to have them installed. Mr. Tabor to share neuro trauma criteria with Dr. Stacy. Main reason can't direct, Arkansas law states patient preference is the deciding factor. Ms. Windham asks who calls the hospital. For major trauma, generally, traumacom calls but it is still up to EMS to call a report. Dr. Donald asks for any action items from Mr. Tabor's presentation. Dr Gamble pointed out he stated it took 7 minutes 15 seconds to arrange a transfer but then the slide for time to get patients out of the ER was averaging 3-5 hours. So they have the same problems. Dr. Gamble also states the commercial program, Pulsara, helps with EMS planning and stated that entire system runs for $2,000,000 a year 24/7 including all the personnel, it may be we want to get into this. Ms. Windham states we have Pulsara for Stroke and STEMI currently. We also have Juvare that we use during disasters. Ms. Windham states there is a task group currently reaching out to all hospitals to find out their number of transfers for Trauma, STEMI, Stroke and OB so we can get a quote on the price of the image repository system. Mr. Blalock stated the presenter said they do not participate with Stroke or STEMI and we would need one centralized system instead of separate systems. Discussion: there are simple programs that could tell someone where a cell phone is for location purposes. Directing someone to a facility is also an issue because of legalities of taking someone to a place they didn't want to go. Ms. Kyle states issue with tertiary level facilities is some outside images do not come there or in a format that cannot be opened by the receiving facility which causes delay in care and more of a financial burden because the images have to

		be redone. An image repository would be greatly beneficial for evaluation and possible admission to those patients who may not necessarily need transfer. Dr. Donald asked if there was any other new business. Bring back quote from centralized imaging system Dr. Donald and Ms. Kyle discussed with the group-a trauma systems consultation as discussed in Mr. Tabor's presentation. Ms. Windham states there is a group that comes in and identifies issues but then assist with correcting the issues. Explore cost items for trauma System consultation and ask committee to consider, in the future, a consultation. Mr. Galtelli asks if it is possible to allocate a percentage of that into an account to keep for projects. Discussion regarding possibilities of obtaining funds for technological advancement for the state. Mr. Blalock expressed disappointment due to being at a major state event (trauma symposium) and missing other important meetings. Dr. Donald states conversations regarding changing the date of the symposium are occurring.
V	Announcements	None
VI	Adjourn to Executive Session	The meeting was adjourned at 11:50 am for the Executive Session.
	Next MTAC	Next Meeting: September 5th, 2025 Meeting Calendar Dates: 9/5/2025; 12/5/2025

ACTION ITEMS			
#	Step	Person (s) Responsible	Due Date
1.	Bring back quotes for centralized imaging system	OEMSACS	Before Next Meeting