Redefining Trauma Care
EXTENDING CARE BEYOND THE PHYSICAL WOUND
ADULT LEVEL I TRAUMA CENTER ANNUAL REPORT 2020-2021
Providing unmatched trauma care to adult residents of eastern Wisconsin and beyond  Published 2021
Trauma in a Pandemic

UNPRECEDENTED CARE IN UNPRECEDENTED TIMES

The only adult Level I Trauma Center in eastern Wisconsin, the Froedtert & the Medical College of Wisconsin Trauma Center at Froedtert Hospital provides the highest level of specialty expertise to treat severe injuries. As a Level I facility, it maintains an operating room dedicated solely to trauma patients and affords prompt access to a range of specialists from orthopaedic surgeons to neurosurgeons. Operating around the clock, 365 days a year, it sees thousands of patients annually. And like every hospital, clinic and emergency room, it has experienced great challenges during the COVID-19 pandemic.

“With COVID, we saw a massive increase in penetrating trauma, which means stab wounds and gunshot wounds,” said Marc de Moya, MD, trauma surgeon, Medical College of Wisconsin faculty member and chief of the Division of Trauma and Acute Care Surgery. “This has occurred not just in Milwaukee, but in all major cities in the United States. And it is thought to be related to the loss of jobs, closed schools, evictions and the increased drug activity that have characterized the pandemic.”

With the increase in patients, Dr. de Moya and colleagues have been very busy. “It is like running on a military schedule — by necessity,” Dr. de Moya said. “But trauma staff are always prepared to meet the unexpected and move on a dime.”

COVID-19, of course, added another layer of concern for Dr. de Moya and the surgeons, nurses, anesthesiologists, radiologists, technicians and other specialists who provide vital care at the Trauma Center. “The virus community spread was high enough that we were seeing it on a regular basis in our trauma patients. COVID-19 infections had direct implications as to how we managed these patients on top of their traumatic injuries,” Dr. de Moya said. “With our Trauma Center becoming increasingly busy, making difficult decisions became even more a part of our usual environment. We expanded our knowledge about how to triage patients from outside hospitals. COVID forced us to reevaluate who really required the services of a Level I trauma center because our resources were being stretched to the limit.”

Preventing as well as treating traumatic injury is central to the Trauma Center’s mission — and that mission includes violence prevention. In 2018, the Trauma Center launched Milwaukee’s first hospital-based violence interruption program. Developed to help stem violence and save lives, the program provides medical support for 414LIFE — a City of Milwaukee Health Department Office of Violence Prevention initiative. While Milwaukee County staff work with community members who serve as “violence interrupters” in their neighborhoods, the Trauma Center focuses on interventions in the hospital setting to change behavior patterns and address issues such as mental illness and substance abuse that contribute to violence. (See Page 6.)

“There is evidence that injuries arising from violence act very much like a virus in that they have reasons for initiation, they have reasons for spread, and they have reasons for getting worse,” Dr. de Moya said. “And as with a virus, we need to find treatments. These are not going to look like a syringe and a needle. They are going to look like other public health measures that have a multitude of different approaches, including addressing post-injury issues that have an impact on healing.”

NEW TRAUMA PROGRAM MANAGER

The Trauma Center welcomed Ashley Servi, DNP, RN, PCNS, CPN, as its new Trauma Program manager. In this role, Servi oversees the full range of trauma services and programs for injured patients — from patient care and rehabilitation to research, quality improvement, trauma education, injury prevention and community outreach.

“In addition to our support for prevention and trauma care in surrounding communities, our Trauma Center is vital to the 4,000 patients who come to the hospital every year,” Servi said. “I feel fortunate to be part of this great team. When it comes to severe injury, Froedtert Hospital is the best place to be taken care of in our community.”
Fall-Related Injuries

NO. 1 FATALITY FOR OLDER PATIENTS

A serious injury or sudden illness is unsettling at any age. But for older people and the physicians treating them, the unexpected can be especially challenging.

Fall-related injuries are by far the most common in people age 65 and older and are the leading cause of fatal injury among older adults.1 Falls cause anything from a head injury to broken bones. But each patient’s overall condition is different. A geriatric trauma specialist is attuned to the nuances that require specific interventions.

In 2020, the Froedtert & the Medical College of Wisconsin adult Level I Trauma Center at Froedtert Hospital treated 789 people in this age group for fall-related injuries, followed by the second most common — 127 individuals — treated for motor vehicle crash injuries. Additionally, white females and males sustained the largest number of fall injuries overall. (See page 11 for more information on fall disparities by age, gender and race).

“We might see a 67-year-old who runs every day and has a physiology similar to that of a 50-year-old,” said Anu Elegbede, MD, trauma and acute care surgeon and Medical College of Wisconsin faculty member. Dr. Elegbede specializes in geriatric trauma. “And we might see a 65-year-old whose heart or kidney disease makes them seem much older. Treating traumatic injuries in the geriatric population is particularly complex.”

Older people may brush off a mishap. But traumatic injuries should not be ignored; they are one of the top 10 reasons for mortality among Americans age 65 and older.

Without consideration of underlying medical issues, injuries can be underestimated and this affects outcomes — even for patients who have survived 60 days after injury. That timeframe is important because elderly patients die more often than younger people after being discharged from the hospital.

“If an older individual’s vital signs are normal and their injuries seem minor, they may not be taken to a trauma center,” said Dr. Elegbede. “But an injury that may not significantly harm a younger person can severely injure an older person. Treatment by a trauma team is often the right call. It can be key to achieving the best outcome.”

Understanding how critical access to specialized trauma care is, Dr. Elegbede works with Emergency Medical Services (EMS) providers to more precisely evaluate older people. In the Trauma Center, patients receive a comprehensive geriatric assessment that examines not just the injury, but also underlying medical issues, medications and how these impact a patient’s condition. Orchestrating follow-up care is important in the trauma care equation. Physical, occupational and speech therapists explore adjustments that may be needed in a patient’s home or routine.

“Older patients are becoming more prevalent in the trauma population. We are here to offer assessment and care that is geriatric-focused and addresses their needs to increase quality of life and survival.”

1 U.S. Centers for Disease Control and Prevention
“You can’t keep a good man down.” That old saw springs straight to mind when speaking with Barry Blackmore, who lives near Los Angeles. The 79-year-old British-born Angeleno seems up for anything, even after a crash that dramatically changed his life.

An avid race car driver for over 60 years, Barry was a regular at Road America in Elkhart Lake. “It’s one of my favorite racetracks in the country, almost like a country club. Sometimes, we had 50,000 spectators.” In July 2020, eager to rock the road in his vintage single-seater Formula 5000 car, Barry headed east with his No. 1 fan, his wife, Karen Blalack.

Before the big event, Barry hit the track for a practice session. It was a damp, overcast morning. “I wasn’t going full speed, maybe 100 or 125, making sure the car was working properly and getting to know the road again.” Coming down a straightaway, he tried to pass a driver who was moving more slowly ahead of him. “He obviously wasn’t looking in his mirrors when he moved over right in front of me at the very last moment,” Barry said. “I tried to get away from him because I knew if I hit him, it would be a very bad crash for both of us. As it turned out, I put two wheels in the grass, and my car instantly veered off and hit the wall on the side of the track.

“Racing can be dangerous, and hitting a concrete wall with a 1960s aluminum race car is not the thing to do,” he said, laughing. The impact of that collision proved devastating, leaving Barry with a ruptured eye and multiple fractures to his face, spine and legs. He ultimately lost his left eye, and his right leg had to be amputated below the knee.

It took more than 30 minutes to extract Barry from the wreckage of his race car and, because the skies were too cloudy for helicopter transport, another hour to transport him by ambulance to the Froedtert & the Medical College of Wisconsin adult Level I Trauma Center at Froedtert Hospital. When Barry arrived, Marc de Moya, MD, trauma surgeon and Medical College of Wisconsin faculty member, and the trauma team conducted their primary survey, checking Barry’s heart and lungs and assessing his blood loss and injuries. Once he was stabilized, a full complement of medical specialists — including a neurosurgeon, orthopaedic surgeon and eye surgeon — converged to initiate immediate treatment.

“A CT scan showed us there was bleeding around the brain,” said Nathan Zwagerman, MD, neurosurgeon, MCW faculty member and Director, Pituitary and Skull Base Surgery. “Bleeding can irritate the surface of the brain and cause seizures, so we started Barry on anti-seizure medication. The other problem with a brain injury is swelling. And just like when you roll your ankle, that swelling may not peak for a few days.”

Two days later, Dr. Zwagerman introduced a catheter to drain the fluid around the brain and decrease pressure in Barry’s head. “I worry about swelling and pressure in these situations, but Barry did fairly well and recovered nicely,” Dr. Zwagerman said.

John Rhee, MD, facial plastic and reconstructive surgeon, MCW faculty member and chair, Department of Otolaryngology and Communications Sciences, attended to Barry’s facial injuries, which included a broken maxilla, the upper jaw bone. It had been pushed back into his face, disrupting dental occlusion so his upper and lower teeth didn’t line up. This is usually corrected by putting wires around individual teeth and attaching them to stabilizing bars to restore alignment. Barry’s bridgework made this a challenge, and Dr. Rhee employed a relatively new device called the MatrixWAVE™ MMF system. Undulating metal plates are placed above and below the teeth and...
Nathan Zwagerman, MD
John Rhee, MD
Deborah M. Costakos, MD
Greg Schmeling, MD
Thomas Carver, MD

fastened to the maxilla with screws. “Then, we fix the bony fractures in the face itself. Once the bones heal in position and the teeth are well aligned — about four weeks later — we take off those bars,” Dr. Rhee said.

Teamwork is essential in the Trauma Center, especially when treating patients with multiple injuries. For Dr. Rhee, teamwork meant coordinating closely with Deborah M. Costakos, MD, ophthalmologist, MCW faculty member and chair of the MCW Department of Ophthalmology and Visual Sciences. Dr. Costakos operated on Barry’s ruptured eye. “It was very important that I did not manipulate bones around the eye when repairing the facial fractures, because that could have exacerbated the eye injuries. Communication with Dr. Costakos was critical,” Dr. Rhee said.

Although the likelihood of saving Barry’s vision in that eye was slim, Dr. Costakos immediately closed the wound to preclude the possibility of sympathetic ophthalmia, a condition in which the body’s immune system not only attacks the injured eye but also the healthy one, which can lead to more vision loss. “Saving vision in a ruptured globe is not the norm, but we repair these injuries to avoid the sympathetic response,” Dr. Costakos said.

Arguably, the most life-changing result of Barry’s crash was the removal of his right leg below the knee. “On the evening of his arrival at the Trauma Center,” said Greg Schmeling, MD, orthopaedic trauma surgeon and MCW faculty member, “Mr. Blackmore was taken to the operating room, where his wounds were washed and he was outfitted with an external fixator, a framework from which pins are screwed into the tibia to hold bone in place.” After several days, doctors determined they could not save Barry’s leg due to the extent of his injuries. The best option was to amputate.

In spite of his injuries, Barry made remarkable progress. “He spent 11 days in the Surgical Intensive Care Unit, which is much less time than our team expected given his injuries and age. We were all amazed,” said Thomas Carver, MD, the trauma surgeon and MCW faculty member who managed Mr. Blackmore’s care while he was in the SICU. “If Barry had not been brought to a Level I Trauma Center, it is unlikely he would have seen this outcome.”

“Medicine right now is so specialized that sometimes, it is hard to have a holistic view of the patient. But in a Level I trauma service, all players know the patient’s overall status, and there is great coordination between all the teams,” Dr. Rhee said.

“From the moment I got to the hospital, the people were unbelievable,” Karen said. “They kept me filled in on everything. Everyone was so kind and thoughtful, not only about Barry, but about how I was doing. He healed unbelievably quickly, and I think that’s because of all the support. They were always there for him.”

Back in California, Barry’s get-on-with-it attitude sustains him. He is keeping up with physical therapy and managing well with his prosthesis. “I walked over a mile without any assistance a month or so ago, which I was very proud of,” he said. “I’ve got one eye, but it’s working pretty well. It’s just a matter of getting used to everything.” Between sailing off to San Diego and taking a trip to France, among other things, it seems Barry is back in the driver’s seat.
Violence as a Disease

INNOVATIVE PROGRAM AIMS TO STOP THE SPREAD OF GUN INJURIES

What is a disease? Most people would be hard-pressed to define it precisely, but they have a firm idea about what does — and what does not — fit the description. Health problems like transmissible infections, cancer and genetic conditions are diseases. Gunshot wounds are not.

But according to David Milia, MD, trauma surgeon, Medical College of Wisconsin faculty member and medical director of the Froedtert & MCW adult Level I Trauma Center at Froedtert Hospital, trauma experts view violent injury through a different lens.

“Historically, few people have seen trauma, let alone violence, as a disease in itself,” Dr. Milia said. “People perceive violence as the result of a character flaw, a lapse in judgment or simply someone else’s fault.”

However, in recent years, epidemiology research has shown that violence behaves the same way as infectious diseases like cholera and AIDS.

“Violence spreads from one person or one group of people to another. Another characteristic violence shares with spreadable disease is the clustering of cases and patterns of outbreaks,” Dr. Milia said. “As with infectious diseases, exposure to violence increases the risk of future violent injury. Nearly half of patients who arrive in our Trauma Center as victims of violence experience further victimization within five years.”

Framing violence as a disease is a practical strategy for improving patient outcomes. “If you consider violence as a disease process, it becomes something you can study and subsequently treat using a public health model,” Dr. Milia said. “It is incumbent upon us to do this: Violence in any community affects all communities.”

In 2019, the Trauma Center launched a new effort to bring a public health approach to violent injury — the Hospital-Based Violence Interruption Program. It was developed in collaboration with the City of Milwaukee’s 414LIFE initiative, a team of “violence interrupters” who work at the neighborhood level to reduce the impact of violence.

“The Hospital-Based Violence Interruption Program arose from our recognition that treating a victim of violence cannot end with ‘plugging the holes’ and sending the patient on their way,” Dr. Milia said. “Treatment is an opportunity for us to intervene and prevent further acts of violence or victimization.”

HOW THE PROGRAM WORKS

When the Trauma Center receives a patient with a gun injury, staff page Tonia Liddell, the in-hospital coordinator of the program. Liddell meets with the patient, usually within a matter of hours. She also connects with the victim’s family members and friends.

“In my initial assessment, I look for the risk of retaliatory violence,” Liddell said. “Those cases are high priority because violence can have a domino effect and spread like wildfire.”

If a risk of retaliation is present, Liddell counsels victims to take a step back. “My goal is to get the patient or family members to think before they respond,” she said. “I ask them to think about the lives that will be affected by retaliation, including their own.”

If needed, Liddell alerts members of the 414LIFE “street team” to identify other individuals at risk and defuse tensions. “Our boots-on-the-ground team canvasses neighborhoods, letting community members know what’s going on and offering support,” she said. “Sometimes, they can identify key people in an incident and get them to agree to mediation.”

The ultimate aim is to avert the recurrence of violence. “The goal of this program,” Liddell said, “is to prevent
patients from returning with additional injuries stemming from the first incident.

Liddell has changed the course of several potentially dangerous situations. “Tonia and her team are stopping the cycle of violence in real time,” Dr. Milia said. “Before we had access to a violence interruption team and a program, we could not influence this kind of change.”

Liddell also helps patients access social support resources that are critical to avoiding future violence. Another goal is to keep injured victims connected to the health care system.

“In the demographic I work with, for a variety of reasons, there is a huge level of mistrust for health care providers,” she said. “It results in disengagement from treatment. That’s why people don’t want to return for follow-up visits.”

Liddell strives to create understanding. “I try to bridge gaps between patients and families and my health care colleagues.”

Liddell’s credibility as a member of the community is critical to keeping victims of violence engaged with the trauma care team. “Her intervention is key to preventing further issues with our patients’ postoperative course and achieving optimal health outcomes,” Dr. Milia said.

MEASURING SUCCESS

Liddell is a strong advocate for mental health. “It is something we shy away from culturally, but I strongly encourage patients to take advantage of the trauma psychology resources offered at the Trauma Center.”

Terri deRoon-Cassini, MS, PhD, trauma psychologist, MCW faculty member and director of the Medical College of Wisconsin Comprehensive Injury Center, leads the trauma psychology program at Froedtert Hospital. She and her colleagues help violence victims and other trauma patients cope with the after effects of injury, including depression and post-traumatic stress disorder. She is also leading efforts to study the Hospital-Based Violence Interruption Program and rigorously evaluate its outcomes.

The first phase of our study looked at implementation. Our initial data show that roughly 81% of people referred to the program fit the target demographic — young men of color ages 15 to 35,” she said. “We know we are getting to the highest-risk group the majority of the time. We also know we are getting to all highest-risk neighborhoods.”

Going forward, the research team will also assess the effect of the program on individuals and the community. For these studies, trauma registry data will be linked with data from the Milwaukee Police Department and Wisconsin Department of Corrections.

“In the second phase of research, we’ll discover if patients in our Hospital-Based Violence Interruption Program are reinjured less compared to others who were not in the program,” Dr. deRoon-Cassini said. “The third phase will look at community impact — does this program translate into less violence in our city? That’s what we’re all hoping for, but answers are a number of years down the road.”

Dr. deRoon-Cassini believes the Hospital-Based Violence Interruption Program is having a positive impact. “The program is helping put the focus on understanding the root causes of violence,” she said. “It is moving health care away from assigning blame and moving everyone toward learning how to uplift patients and provide better care.”

NOW MORE THAN EVER

Liddell believes the disease model is key to understanding and stopping the spread of gun injury. “Gun violence is a significant public health problem, and the traditional approach is not meeting the needs of those affected by violence,” she said.

So far, none of the patients Liddell has worked with have returned to the hospital because of retaliatory violence: “I want to say it is because we identify and address problems patients face after they leave the hospital.”

According to Dr. Milia, these efforts are critical. “With the pandemic, we saw a horrendous rise in violence in the City of Milwaukee,” he said. “Milwaukee suffered the greatest percentage increase in violence of any major urban center in the country. Now, more than ever, we need to go at this on all eight cylinders.”
Suicide rates in the U.S. have increased steadily during the last 20 years. Unfortunately, early data suggests the COVID-19 pandemic has only exacerbated the problem.

“Suicide is the second leading cause of death in Wisconsin for youth and young adults, so it is definitely a public health crisis,” said Andrew T. Schramm, PhD, trauma psychologist and Medical College of Wisconsin faculty member. “However, it is important to understand that it is a preventable one.”

Dr. Schramm recently joined the Froedtert & the Medical College of Wisconsin adult Level I Trauma Center at Froedtert Hospital and leads its new suicide prevention initiative. He is also president of the Wisconsin division of the American Foundation for Suicide Prevention.

“We need to develop innovative ways to prevent suicide and intervene in the lives of people who have been affected by suicide in some way,” he said. “The Trauma Center is on the front lines of that effort.”

UNDERSTANDING THE PROBLEM

Dr. Schramm and his colleagues are approaching the suicide crisis from several angles. First, they are using injury data from the Trauma Center’s extensive trauma registry to study patterns of suicide death. “These patterns will help inform our approach to suicide risk screening,” he said.

Trauma Center leaders have also launched the Milwaukee Suicide Review Commission, a group of local health care leaders who meet monthly to review cases of suicide death. The commission was co-founded by Dr. Schramm and Sara Kohlbeck, director, Division of Suicide Prevention of the Medical College of Wisconsin Comprehensive Injury Center.

“At each meeting, we examine one or two cases in depth,” Dr. Schramm said. “We look at factors like acute stressors prior to the event, social support network, points of contact with the health care system and any barriers that kept people from getting the services they needed.”

The commission also reviews aggregate data on suicides in the Milwaukee area. “Our goal is to disseminate our findings so they can inform suicide prevention efforts in our community.”

DESIGNING EFFECTIVE INTERVENTIONS

Have the isolation and stress of the COVID-19 pandemic increased suicide rates? “The solid epidemiological data lags about one year, so it is too early to make any firm conclusions,” Dr. Schramm said. “However, I can tell you that last year, the number of patients treated for self-inflicted injuries at the Trauma Center increased 70% and referrals to our trauma psychology program doubled.”

Froedtert Hospital is the first hospital in the nation to embed psychologists within its trauma team. One of the psychology group’s roles is to work with patients admitted for self-inflicted injury.

“Folks treated for self-inflicted trauma here have very serious injuries,” Dr. Schramm said. “This is an important population to screen for suicidality and to intervene with to prevent future suicidal behavior.”

Dr. Schramm is also working to educate trauma caregivers on suicide prevention. “We have offered informal training in our trauma surgery follow-up clinic on how to assess patients for suicidality,” he said. “Down the road, we would like to create a standardized process in which every trauma patient gets screened for suicidality before they walk out the door.”

To learn more about suicide prevention and resources to help, visit froedtert.com/suicide-prevention.
The Froedtert & the Medical College of Wisconsin adult Level I Trauma Center at Froedtert Hospital is one of a handful of elite trauma centers that are part of a partnership with the U.S. Department of Defense. Under this program, military surgeons are “embedded” within the Trauma Center.

The initiative is known as the Army Military-Civilian Trauma Team Training Program (AMCT3). According to David Milia, MD, trauma surgeon, Medical College of Wisconsin faculty member and medical director of the Trauma Center, the goal is to make sure military surgeons can maintain their trauma skills during peacetime.

“If you look back at all the wars the U.S. has been involved with — World Wars I and II, Korea, Vietnam — you see that our ability to provide medical care improved dramatically over the course of those conflicts,” Dr. Milia said. “However, when we returned to peacetime, we slipped back. Then, when a new war started, our care wasn’t as good as it was when we ended the previous war. This partnership helps ensure our care is top-notch at all times.”

The AMCT3 program allows military surgeons to get the real-life trauma experience that can only be found in urban Level I trauma centers. Currently, the Trauma Center is hosting a U.S. Army surgical team.

“It is not just a brief rotation for the military surgeons,” Dr. Milia said. “They practice side by side with us, gaining from the experience of caring for our patients and from our experience as a fully mature trauma system.”

In return, the Army team helps translate the lessons of military injury care to the Trauma Center staff. “They are not only learning from our patients, but we are also learning from them,” Dr. Milia said. “They are helping us make sure our practices are state-of-the-art and our guidelines are in line with what forward surgical teams are doing overseas.”

One example is the use of whole blood in trauma resuscitation, a common practice that fell out of favor years ago. Angela Treml, MD, MCW faculty member and medical director of Transfusion Medicine at MCW explains:

“For many years, patients who needed a blood transfusion received it as separate units of red cells, plasma and platelets,” Dr. Treml said. “Recently, however, military data suggested that in trauma situations, we should go back to using whole blood.”

Informed by the military experience, the Trauma Center incorporated whole blood into its massive transfusion protocol in 2018.

“Now, instead of transfusing three separate products, we use one unit of whole blood,” Dr. Treml said. “It is less exposure for the patient, and it saves time for the trauma team.”

Dr. Milia said the partnership benefits military and injured patients in southeastern Wisconsin.

“It is a two-way street,” he said, “a chance for the military to secure consistent, sustainable training for its surgical teams. And our patients benefit from military knowledge gained overseas from practicing trauma surgery in austere environments.”
### 2019 Race and Sex Summary
(Number of Patients Admitted)

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<tr>
<td>Other</td>
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<td>43</td>
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<tr>
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<td>1,676</td>
</tr>
<tr>
<td>Unknown</td>
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<td><strong>1,124</strong></td>
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2019 PATIENT DISCHARGE DESTINATIONS

- Deceased: 6%
- Mental Health Facility: 1%
- Correctional Facility: 2%
- Skilled Nursing Facility: 10% (includes community-based residential facility/assisted living, long-term care, nursing home, acute care facility, inpatient facility and intermediate care facility)
- Rehabilitation: 20%

Home: 61% (includes home, home with services and left against medical advice)

2020 PATIENT DISCHARGE DESTINATIONS

- Deceased: 4%
- Mental Health Facility: 1%
- Correctional Facility: 2%
- Skilled Nursing Facility: 6% (includes community-based residential facility/assisted living, long-term care, nursing home, acute care facility, inpatient facility and intermediate care facility)
- Rehabilitation: 16%

Home: 71% (includes home, home with services and left against medical advice)

2020 FALL DISPARITIES

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<tr>
<th>Age</th>
<th>Black Male</th>
<th>Black Female</th>
<th>White Male</th>
<th>White Female</th>
<th>Hispanic Male</th>
<th>Hispanic Female</th>
<th>Asian Male</th>
<th>Asian Female</th>
<th>Other Male</th>
<th>Other Female</th>
<th>Totals Male</th>
<th>Totals Female</th>
<th>Totals</th>
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<td>3</td>
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<td>329</td>
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<td>504</td>
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<td>Total</td>
<td>117</td>
<td>76</td>
<td>520</td>
<td>567</td>
<td>48</td>
<td>20</td>
<td>6</td>
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<td>13</td>
<td>7</td>
<td>704</td>
<td>675</td>
<td>1,379</td>
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</tbody>
</table>
Redefining
Trauma Care

EXTENDING CARE BEYOND THE PHYSICAL WOUND
ADULT LEVEL I TRAUMA CENTER ANNUAL REPORT 2020-2021

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