Minutes approved 15 September 2011

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 11 August 2011

Scheduled: 10:00 am until 1:00 pm
Medical Center of Central Georgia
Peyton Anderson Health Education Center
Weaver Board Room 4th Floor
877 Hemlock Street, Macon, GA 31208

CALL TO ORDER

Dr. Dennis Ashley, Chair, called the scheduled monthly meeting of the Georgia Trauma Care Network Commission to order at 10:00 a.m.

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Linda Cole, RN Ben Hinson Dr. Joe Sam Robinson, rotating off Elaine Frantz, RN, new member Dr. Leon Haley, via teleconference call Kurt Stuenkel, via teleconference call Kelly Vaughn, RN, via teleconference call	Bill Moore (excused) Rich Bias (excused)

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Office Coordinator	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
Mike Watts, TCC Coordinator	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Scott Sherrill	GTRI
Regina Medeiros	GHSU
Lawanna Mercer-Cobb	SOEMS/T – Region 6
Marie Probst	OEMS/T
Renee Morgan	OEMS/T
Rana Bayakly	DPH/Chronic Disease
Tanya Simpson	Doctors Hospital
Gigi Goble	GPT
Kim Brown	Hamilton Medical Center
Gina Solomon	Gwinnett Medical Center
Dr. Romeo Massoud	Gwinnett Medical Center
Richard Lee	Upson /EMS

Scott Maxwell	GTRI
Greg Pereira	CHOA
Karen Waters	Georgia Hospital Association

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT

Mr. Jim Pettyjohn confirms Commission members who are present on the conference phone, Dr. Leon Haley, Kelly Vaughn, and Kurt Stuenkel. Also present are Dan Walsh with the Georgia Attorney Generals Office sitting in for Alex Sponseller. Dr. Dennis Ashley confirms quorum.

Dr. Ashley states that one of the Commission members is rotating off today, Dr. Joe Sam Robinson. Dr. Robinson was appointed by the governor and has served the Commission well for the last four years. Dr. Ashley thanks Dr. Robinson and speaks for all the Commission members stating it has been an honor to serve along with him, and he appreciates all his hard work, and dedication. Dr. Joe Sam Robinson thanks Dr. Ashley and states that he thinks the Commission has done very well, and continues to be dedicated to the citizen's of the state of Georgia in establishing a better trauma operation.

Dr. Ashley introduces Ms. Elaine Frantz and welcomes her as a new member to the Commission. Dr. Ashley states that Ms. Frantz has been attending Commission meetings for at least a year, and is well versed in our actions. Ms. Frantz comes from Memorial in Savannah and is the Director of Trauma Services there. Ms. Frantz thanks the Commission for their support and looks forward to the challenges ahead.

APPROVAL OF THE MINUTES OF THE 19 May and 01 June 2011 MEETING

MOTION GTCNC 2011-08-01:
I move that the minutes of the 19 May and 01 June meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Mr. Ben Hinson**

DISCUSSION: None

ACTION: The motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org*

ADMINISTRATIVE REPORT REVIEW

Mr. Jim Pettyjohn goes over the Administrative Report

FY 2012 2% Budget Reduction

This is FY 2012 2% budget reduction, which was required by Governor Nathan Deal. The budget document is in included in the Administrative Report –Page 33-38.

FY 2011 Budget Review

The Commission will be providing a review and the final rap up of the FY 2011 budget and the money that was left over. Ms. Judy Geiger who has long been a budget and accounting person within state government and worked with the Department of Community Health, and Division of Public Health most

recently before July 1, as their budget officer. Ms. Geiger has handled the Commission's budget since the very beginning. Ms. Geiger will be talking today about the governor's zero based budgeting and presenting the FY 2011 budget report rap-up. *(Document attached to Administrative Report- Page 51)*

Request for Advice to Attorney General's Office

Mr. Pettyjohn states that we have Mr. Dan Walsh on the conference line. Mr. Walsh works with Mr. Alex Sponseller from the Attorney General's office, and he will be describing the issues in the letter that resulted in Dr. Ashley's request to DPH on clarification that DPH could charge the Commission for Administrative support. *(The letter documents are included in the Admin. Report page 24-32)*

Trauma Communications Center Update

Mr. Pettyjohn states we have Mike Watts at the TCC, and he is our new Trauma Communications Coordinator. Mr. Watts was a paramedic for many years and worked in the field for some of those years. Most recently Mr. Watts was in a supervisory position with the city of Covington 911 dispatches. Mr. Watts has been on board since July 16, 2011, working with Mr. Scott Sherrill. They will be talking about their activities to get the Georgia Public Safety Training Center, TCC site up and running.

Trauma Center and Physician Funding

Dr. Leon Haley will be speaking on the trauma center physician-funding budget, concerning the distribution formulas and opportunities for those funds. *(Document attached to Admin. Report page 57)*

Strategic Planning Process

Mr. Greg Bishop will be presenting a strategic plan update, as well as talking about the Commission's performance measures. *(Documents attached to meeting minutes)*

EMS Subcommittee of Trauma

Mr. Ben Hinson will be speaking to the Commission and discussing the 09 August meeting of the EMS Subcommittee on Trauma.

DPH OEMST

Mr. Keith Wages, Ms. Renee Morgan and Dr. Pat O'Neal will be presenting the Department of Public Health Office of Emergency Medical Services and Traumas report. *(Commission-Directed Budget Proposal attached to Admin. Report page 66)*

Regional Trauma Advisory Committees Updates

Mr. Pettyjohn states that beginning today and at future Commission meetings we will be presenting our RTAC reports. The presentation today will be on RTAC regions 5, 6, and 9. *(Region VI Emergency Medical Services Council letter from Mr. Rich Bias attached to Admin. Report page 16)*

Presentations:

eBroselow Demonstration

Mr. Greg Pereira from Children's Hospital in Atlanta will be providing a demonstration of the eBroselow System. The Commission has been working with Dr. Jim Broselow for the past two years to roll out this system into our hospitals has well as EMS. *(Contract report attached to Admin. Report page 10)*

Trauma Registry Data

Ms. Rana Bayakly and Dr. Danlin Luo will be presenting their third in a series of three registry data reports.*(Power point and handouts attached to meeting minutes)*

Request for Advice to Attorney General's Office

Mr. Pettyjohn introduces Mr. Dan Walsh who is in a supervisory position with the Attorney Generals office. Mr. Pettyjohn states that on the June 28th he received notification from the folks who were going to become leadership of the new Department of Public Health, beginning July 1, that as of July 1, the DPH would be charging the Commission for administrative support. These were services that the Department of Community Health had been providing without a charge, such as contract review, grants review, procurement, and all those things that DCH did for the Commission. Mr. Pettyjohn communicated back with them, and arranged a meeting with Dr. Dennis Ashley, Mr. Alex Sponseller, and himself. They met with Mr. Sid Barrett who is the chief legal counsel for the DPH, and Ms. Janie Brodnax who is the Chief of Operations for the new DPH. What resulted from that meeting was Dr. Ashley's request of the Attorney Generals office to provide an opinion. Mr. Sponseller his unable to attend the meeting today and Mr. Walsh has come in his place to explain the process.

Mr. Dan Walsh states that the request asks two questions; the first question is whether the Trauma Commission is required to pay for administrative services provided by DPH. The letter analyzed Georgia code section 50-4-3 regarding the rights and obligations of an assigned agency, and the department to which that agency is assigned. The conclusion was that DPH must provide some but not all of the services that were being requested for the Trauma Commission. Specifically the letter identifies vacation, sick leave, bookkeeping, job posting, budgetary assistance, payroll bookkeeping and accounts payable as functions that DPH should be required to provide, because these services were either related to the Trauma Commission budget input or are administrative and clerical duties related to the general maintenance of records and reports. In contrast it did not appear that DPH should be required to provide those services that relate to substantive aspects of procurement advise and contract and grant writing. The second question was whether DPH is permitted to charge for those administrative duties that it is mandated to provide under statute. Mr. Alex Sponseller concluded that DPH is not authorized to charge for such services. The letter relied upon the general principal that administrative agencies only have those powers that the legislature had expressly or by necessary implications conferred upon it. The letter analyzes some of the prior Attorney General opinions regarding this issue in different context, that an administrative body is not authorized to collect fees for duties mandated by the statute unless the collection of such fees was itself expressly authorized. While these opinions generally address the ability to impose charges on private companies or citizens, Mr. Sponseller did not see any reason why the principal articulated in those opinions would not apply in this context as well, and so he reached the conclusion that DPH is not authorized to charge for those services that it is mandated to provide under the statute.

Mr. Pettyjohn states that there were some services like procurement services and contract and grant review that is not uncovered under 50-4-3, and so DPH does not have to provide those services, and if they do provide those services they are not allow to charge us for those services. The question is if we requested them to provide that service could DPH refuse?

Mr. Walsh states that yes Mr. Pettyjohn is correct there are some services that the letter concludes that DPH is not required to provide. Those were services that did not fall within services that were related to

administrative and clerical functions for the agency. The letter goes into a fair amount of detail in defining what each of those record keeping, and reporting means. The letter acknowledges in a difficult question, that those would not fall within that area. Mr. Walsh states that that given that they are not required to provide those services there is the possibility that they would not provide it, although the letter does not really get into the question of charging for services outside those services that they are required to provide. Mr. Walsh can relay that question back to Mr. Sponseller and we can discuss that some more.

Mr. Ben Hinson requests that the Commission get a list of what DPH will do and will not do.

Mr. Pettyjohn states that he will get back with Mr. Sponseller and have further conversations regarding this letter, and maybe we could discuss the results of that at the 11 September Commission meeting.

Mr. Pettyjohn states that he has been working with Ms. Judy Geiger and they have been talking with the Office of Planning and Budget and are looking forward to inviting the audit agencies of the State to come to the Commission and do a volunteer performance audit to make sure that we are indeed doing the right thing, and doing it the best we can in utilizing the services that are afforded to the Commission. We hope to do that the first of the year. The Commission is striving to maintain transparency and get the best return on our dollars, and establish a return on investment program for all the funds that the Commission puts out.

FY 2012 2% Budget Reduction

Ms. Judy Geiger states that the governor has come up with his recommendations for the 2% budget cuts in 2012 and 2013, and along with those instructions, which are on page 42 of the Administrative Report, is the zero based budgeting philosophy. The state of Georgia used to provide zero based budgeting, which is basically building your budget from zero up. This also includes your strategies and performance measures so at the year-end you have to tie the money that you spent back to those performance measures to show how you spent the money. This was a tool used up until about 2003. Then it was replaced with program based budgeting thinking that it would be sufficient, and apparently it has not. So now the governor is interested in getting a few agencies as a pilot program to develop zero based budgeting. The OPB analyst Paula Brown has indicated that the Georgia Trauma Commission may very well be selected. Ms. Geiger states that Mr. Pettyjohn and she are very excited about this because that gives the Trauma Commission an opportunity to get the budget out there for everyone to see, and the plans of the Commission, and how we are going to implement them. To further explain zero based budget, you go along with what you have to do, the statutory responsibilities that the Trauma Commission set forth in Senate Bill 60, and then you go through your purpose, and what the cost is to obtain your goals and objectives. The governor wants us to align the Trauma Commission budget with these three measures: 1. How much did we do? 2. How well did we do. 3. Is anyone better off? Along with the zero based budget the state also has a strategic planning piece, which Mr. Greg Bishop has been working on for the Trauma Commission, which contains long term and short term plans. We will be implementing this into the Trauma Commission's Strategic Plan to show the OPB in their system called Horizon. Along with that there is also annual performance plans that are entered into the states budget net system. Ms. Geiger goes on to say that the state of Georgia has four different budget tools that are used to not only present budgets to the governor, but they are used for tracking and performance measures they are, Horizon, which is the strategic planning piece, Budget Net, which is OPB's system for tracking the annual operating budget, subsequence amendments and the cuts, and then Budget Tools which is basically a data base where the budget enters the 2% reductions in 2013 for this coming two years. Budget tools also allow OPB to generate a report to the governor for the recommendations on the 2% budget cuts. Ms. Geiger states that the nuts and bolts system is PeopleSoft, which is the states accounting system, which allows agencies to budget and spend their funds. Mr. Pettyjohn states that if things do not balance in PeopleSoft it is not balanced. Mr. Pettyjohn states that we have a strategic planning tool that is going to tie in with the zero based budget, and requirements and it will be on the

Trauma Commissions website. This tool will be updated monthly, quarterly, or every other month. We will be developing our budget based on our strategic plan and our plan is supporting our budget.
Mr. Pettyjohn states that the Commission has to decide on a 2% budget cut for the budget we approved in June.

MOTION GTCNC 2011-08-02:
I move to approve the FY 2012 2% Budget Reduction as it has been presented.

MOTION BY: **Dr. Leon Haley**
SECOND BY: **Ms. Elaine Frantz**

DISCUSSION: Ms. Linda Cole wants to know if on page 36 where you see Bishop & Associates $98,900.00 is that what is in there this year or is that the original amount.

Mr. Pettyjohn states that that amount is what is in there right now.

Ms. Cole states that on page 33 for Commission Operations you have no change, but on page 34 it looks like there were changes. Do they net out or is that just realignment?

Ms. Geiger states that that is realignment.

Ms. Cole states that it makes it easier to look at a budget that shows the original amount, the change, and what we actually end up with.

Ms. Geiger acknowledges Ms. Coles comment on the budget document.

Ms. Frantz states that the budget follows the budget that was submitted in June, and she thinks reductions were done very fairly.

Mr. Pettyjohn states that we could realize more reductions and more cost savings, and that we are going to have a hard budget review in January.

Ms. Geiger states that on a monthly basis she will be supplying the Commission with an expenditure analysis, which will show where we stand as far as how we are spending the money, and in what categories.

ACTION: The motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org*

Fy 2011 Budget Review

Mr. Jim Pettyjohn states that he did talk to the Commission last year about redistributing the dollars that were realized in savings the first month of the forth quarter, but if does not show in PeopleSoft then we do not have it. Ms. Judy Geiger will talk about how that influenced last years budget.

Ms. Geiger states that PeopleSoft is the nuts and bolts of how the state of Georgia spends the money. In the forth quarter of the FY 2011 there were contract reductions that had not been completed in People Soft, and because those reductions had not been taken out of the budget, thereby reducing the expenses, they were already encumbered for the full amount. So when they were cut $264,000, that money had to be taken out as expenditures to free up the budget. That was not accomplished in a timely manner. Ms. Geiger states that at one point she called Mr. Pettyjohn and told him that there is a problem, we have negative availability of a budget right now, and we are stuck in the water and cannot

pay anything, until purchasing and the DPH reduces this contract. As a result we were not able to redistribute the funds to another contract because we could not get anything entered, and ended up lapsing $159,435.00.

Mr. Pettyjohn states that we worked very hard to get the contracts written and approved. Then in January we received a 53% reduction, and had to go back and amend all those contracts that we lost money on. When you get contracts executed there is a purchase order created which encumbers funds, and so those funds are no longer available for the black line. When we had to reduce the contracts we had to get new purchase orders, go in and free those funds in PeopleSoft and then encumber it back leaving a new balance. It was not the process for the centers and staff in getting that work done, it was the work of having the dollars disencumbered from the purchase order, the new dollars reencumbered, and the bottom line finally balancing that would of allowed us to have more dollars realized and redistributed. We tried but we failed. Mr. Pettyjohn states that Ms. Geiger as our business operations official will be working the purchase orders, entering the budget, be responsible for PeopleSoft, Budget Net, Horizon, and all the software entities that the state uses for us to do our budgeting. This will allow Ms. Geiger to understand how much money the Commission has in the cash flow that resides now and stat. On page 51 of the Administrative Report, it shows where the Commission had to turn back money.

Ms. Geiger states that she does understand the Commissions frustration on the contracts process and why it takes so long and, and is not done right.

Mr. Ben Hinson states that he is delighted Ms. Geiger is here. Mr. Hinson wants to know if this problem can be prevented in the future? Mr. Hinson wants to know if Ms. Geiger has access to encumber and disencumber funds with new PO's or are you just an extra person pushing the rock up the hill?

Ms. Geiger states that she is pushing the rock up the hill. Ms. Geiger states that she has developed relationships throughout Public Health for over ten years, and knows whom to go to be able to get the job done.

Ms. Linda Cole wants to know if Ms. Geiger will have the authority to go into PeopleSoft and make changes?

Ms. Geiger states no she will not be able to do that, because as long as the Trauma Commission is administratively supported from DPH that is one of their administrative duties that they will not let us do.

Mr. Pettyjohn states that Ms. Geiger is located at 2 Peachtree, and a full time employee for the Commission. Ms. Geiger does have PeopleSoft access. The Commission will not have to knock on someone's door and wait for them to answer in order to get into PeopleSoft to see how much money we need. Ms. Geiger's access will allow her to see problems or potential problems. For example if there is a purchase order still hanging out there and there has been an amendment to a contract a month ago that should of changed that, Ms. Geiger can access the person that needs to get that done.

Ms. Geiger states that she will be the facilitator now and she knows who to go to directly to get things done correctly.

Trauma Communications Center Update

Mr. Sherrill states that in addition to bringing Mr. Watts on board and trained as the new Trauma Communications Center Coordinator, they have been preparing the physical building of the TCC for installation of our system as well as continuing in the development and customization of the software system itself. Physical implementation, the actual hardware, and software system, will take place next week. In about a three-week timeframe we expect to have all that installed and operational in GPSTC. In addition to that over the next six too eight weeks we expect to be staffing and training the TCC, rolling out to the hospitals that are going to be participating, all of the trauma systems in the state and non-designated participating hospitals in regions 5 & 6, and maybe a couple of adjacent hospitals as well. We

are also developing the policies and procedures and training that the TCC will be providing for EMS and the agencies. Mr. Sherrill states that the current goal is to be operational by October 1.

Mr. Ben Hinson wants to know who is in charge, Mr. Sherrill or Mr. Watts? Who is writing the policy and procedures you or Mr. Watts?

Mr. Pettyjohn states that he is ultimately in charge of the TCC, until Mr. Watts is oriented completely to the position and understands the history and knows the framework backwards and forward, knows the software, knows the scripts, understands the scenarios from the field from interfaculty transfers. Mr. Scott Sherrill is side-by-side shouldering the responsibilities with Mr. Watts to get the TCC up and running.

Mr. Hinson wants to leverage Mr. Watts experience as quickly as possible. Mr. Hinson does not want the Commission explain how we want to do it, and then way down the road Mr. Watt's have to make it work. Mr. Hinson thinks Mr. Watts should help create how it will work.

Mr. Sherrill states that Mr. Watts is definitely going to be responsible for the writing and implementation of the policy and procedures. Mr. Watts was involved in the discussions of staffing, and taking the feedback from the EMS Subcommittee. We are reanalyzing that and reconsidering it and Mr. Sherrill thinks that you will be happy the decisions that we came to. Mr. Sherrill states that he himself is responsible for the setting up of the physical infrastructure and the software, and he has been asked to help bring Mr. Watts up to date on that information. Mr. Sherrill states that when the TCC is actually up and running without a doubt Mr. Watts is going to be the person that is responsible for the center itself.

Dr. Dennis Ashley comments that the TCC has been a long time coming and at certain stages we thought it would never happen. Do not underestimate how huge this is. Things are moving, things are happening, people are talking. Getting people in the room together, EMS, doctors, nurses, hospital administrators, and talking. This is the most movement we have had in years with people working together to pull regions together. The communications center is going to be a hub for all that action. Real progress is being made and Dr. Ashley gives his thanks to everyone making that happen.

Trauma Centers and Physicians Funding Report

Dr. Leon Haley states that the document begins on page 57 of the Administrative Report, where you will see the Commission FY 2012 budget for trauma center physician allocation. Dr. Haley states you can see the amount of dollars that were allocated for trauma center readiness payments, the performance based payments, and then you can see how we have split that based upon the discussions with Mr. Pettyjohn and the rest of the Commission. Also the dollars that are available for the uninsured payment, and the total amount of dollars that are available for trauma center allocation. Below that are the 75/25-hospital physician split that we have traditionally worked through, and the breakdown. Behind that on page 58 and the subsequent pages are how those dollars break down to each of the respective institutions. You can see the dollars were allocated for the trauma centers, level fours, threes, twos and the level ones, and noting obviously the new fours and threes that have been added and the changes from a level two that has been added and a level one that has moved from a two to a one. You can see the respective funding levels, the percent of the overall dollars, where the readiness payments will be, the potential for the paid for performance payments, which we will come back to, and then the total dollars that are available and allocated to the respective institutions for trauma center readiness. On page 58 goes into the uninsured patient care payments, sort of the same system we have seen in the past, self pay requirements meeting the SB 60 requirements, the various breakdowns at the various institutions for their ISS scores, adjusted cost norms, the total dollars that are based upon that. Where the percentage lays that has not changed much. Then on the following page you have the total dollars that are available to each of the institutions for readiness, paid for performance and of uninsured. Following that document is the Trauma Registry Funding and what the recommendations are for the different institutions for FY 2012. Behind that is where we ended up for FY 2011.

Mr. Pettyjohn wants to clarify that on page 62 of the Administrative Report is the purposed trauma registry funding per hospital by OEMS/T in FY 2011 if they had received the full $754,000, in essence each hospital only received 50% of that.

Dr. Haley states that page 63 of Administrative Report shows the subtotals based upon the individual centers. The final page 64 walks you through the individual bucket responsible for the performance-based payments. You can see the requirements listed for each of the institutions to receive their performance-based payments.

Dr. Haley states that he thinks this needs a motion for approval.

Mr. Pettyjohn states that since this is the Subcommittees recommendation it does not need a motion, only a second.

Mr. Hinson states it does not even need a second.

If this is approved we will precede beginning Monday mourning in writing yet another amendment to the trauma centers, and put these deliverables in the contract.

Mr. Hinson asks Mr. Pettyjohn concerning the 75/25 split, is it 75% hospital and 25% physician.

Mr. Pettyjohn replies yes in the Readiness and Uncompensated Care.

Mr. Hinson states that at one point it was 50/50 is that correct?

Mr. Pettyjohn states that in the dollar amounts available for the hospitals 50% goes to the hospital for readiness, 50% goes to uncompensated care; of the money that comes to the hospitals they keep 75% and then they give 25% to the physicians.

Ms. Elaine Frantz has a question concerning page 64 of the Administrative Report at the bottom under uncompensated care funding there is a note that says possibly adjusted and then distributed after the audit. Ms. Frantz wants to know if the Commission will be having an audit done again.

Mr. Pettyjohn replies that yes we will, and inside the report there is a description of the audit. Mr. Pettyjohn states that last year we did an audit and we saw that there was adjustment that was needed in the ISS scoring buckets and we made that adjustment. We had to reconfigure the numbers that were provided in the uncompensated care spreadsheet. This year we are doing the audit very quickly on the heels of the data that was submitted to Bishop & Associates, who shared it with us. We now have the audit firm Gifford Hillegass & Ingwersen. They will begin a week after we send this letter out which is on page 18 of the Administrative Report, describing the audit process to the trauma centers.

Ms. Frantz suggests that prior to the next audit it would be helpful to have some type of training that would help us to improve based on our audit.

Mr. Pettyjohn agrees and states that last year there was a procedure for the Level 1 centers. We brought in Mary Coble who is a nationally known registrar. Ms. Coble sat down with the Level 1's and reviewed their ISS process and found that there were inconsistencies between the Level 1's. The recommendation that was provided in the report was that the Commission funds an AAAM course, with employee training for all the hospitals trauma centers, as well coordinators of registrars. We encouraged the Georgia Committee for Trauma Excellence Subgroup, Tag Trauma Associates of Georgia to petition the Commission for funds via a grant to offer that. In June the Commission approved those funds. Mr. Pettyjohn states that he received the grant request from TAG last week. The course has been scheduled for October 10, 11, 2011. Once everyone is trained then maybe in an out year we will go back and do an ISS determination review.

Strategic Planning Process

Mr. Greg Bishop states that having helped the Commission with their initial strategic plan we will be looking at the progress we made and refining strategies for the future. Mr. Bishop relates that he knows there is a little frustration with some issues the Commission is dealing with, but overall we developed the most expansive, comprehensive, strategic plan for not just a trauma system, but in building an infrastructure for emergency care of any state in the nation. The Commissions emerging vision has emerged and it is being addressed on all fronts. Mr. Bishop gives and update on the burn center issue. Mr. Bishop states that essentially what we are doing is replicating in the process we did with the trauma centers, across the board. We are looking at what other states do for burn centers in comparison to trauma centers. We are doing the economic survey that we had done for several years with a more expansive version with readiness costs for burns this year. We want to find out whether burn patients are getting to burn centers, and what the hospital is doing in regards to burns. The physician compensation as part of the formula with how you deal issues, because we do not have data physician compensation for burns, so we need to develop that with the burn centers. We want to compare trauma center finances needs with burn center finances needs. We want to look at alternatives for bringing the burn centers into the system. Such as do they get built into the Communication System? We want to work with them, talk with them, and work out what kinds of interactions, and role they will have with the system, and them we will present the report. We covered a lot of issues that may or may not pan out to be readiness costs, but we wanted to make sure we captured everything. Then once we have the data we will go through it what is appropriate. So you may see some things on this survey that should not be included in readiness costs for burn centers, but we will eliminate those as part of the processes concerned. *(Attached to the minutes Burn Center Survey & Burn Work plan)*

Mr. Ben Hinson states that one of the things that strike him are that Burns are different then other trauma in the financial area because so many of them are workers compensation, and it is determined by law how much you get paid, per the fee schedule for hospitals. Mr. Henson states that he thinks that looking at workers compensation within your survey would be helpful. Mr. Hinson states that also within the Medicare piece, the question to be asked is how many patients once they are at the burn center are ruled eligible for Medicare because of short or long-term disability. Because that is another big piece that is different than normal trauma patients. If you get a trauma patient in your hospital and they do not necessarily qualify for Medicare, but if you get a long-term burn they are probably going to be disabled and move to Medicare fairly quickly.

Mr. Bishop thinks that Mr. Hinson has a good point and he will do exactly what he suggested, and as the process goes on we will modify and expand it.

Dr. Dennis Ashley states that ISS scores do not work on burns, and we have to come up with scoring for the burn, and also figure out what we would consider a trauma patient and what we would consider a burn patient, and he thinks that what Mr. Bishop is trying to accomplish. Dr. Ashley likes what Mr. Bishop has presented to the Commission, and his organization of it. Dr. Ashley also states that Dr. O'Neal has registry guidelines for the state with very stringent criteria for what constitutes what is going on the registry, so we need to standardize that for burn patients also.

Mr. Greg Bishop goes over the Strategic Work plan, which is broken down into a series of pieces. The very first packet is a summary that the Commission provided to the legislator; it is progress report on the initial strategic plan on 2009 *(Our Emerging Vision: A New Public Service for Georgia attached to the meeting minutes)*. Then we get into the Strategic Plan looking forward. The next handout is titled A Comprehensive Trauma System for Georgia. Mr. Bishop states that this is what was developed out of the workshop that was held several months ago on the Strategic Plan. It is focused on a ground up approach using the RTAC'S within the regions to develop systems that then form a statewide system. They need to be uniform enough to be integrated, but then again emphasis is on building them on a local basis at a local level, and then building up from there. *(A Comprehensive Trauma System for Georgia 2011-14 Strategic Plan Summary attached to the meeting minutes)*. Then there are two more pieces, which are

planning tools, *(Build Basic Trauma System Infrastructure & Build Basic Trauma System Infrastructure attached to the meeting minutes)*. Mr. Bishop states that this is a draft and will remain a draft forever as it evolves.

Mr. Hinson wants to know since it is a draft do we need to approve this?

Mr. Pettyjohn states that we will need to use this as a discussion as we move forward with our zero based budgeting approach for the Governors office, and just review it and ask more questions over the next month, and then come back and review it as a permanent draft. We will have another opportunity to review it again at the Commission Workshop in January. We would also like to use it as a training tool on the web to provide and also develop performance measures. Mr. Bishop will be back in January also.

EMS Subcommittee of Trauma

Mr. Ben Hinson states that EMS Subcommittee met Tuesday of this week and we had some good reports and great conversation. The Subcommittee did take action on the budget and there has been some change in what we would like to do. This year we have taken into consideration the 2% budget cut that the governor's office has instructed, with some of the big changes that we have made. We reduced the number of ambulances we were considering giving grants to by six. We took that money and did some very good things with it. We changed some of the trauma care allowed equipment. In the past the grants have only been for equipment that was not on the state mandated list, it was only when you bought enhanced equipment. The feeling was whether we like it or not some of the basic equipment that is on the ambulances for trauma care is outdated, worn out and not where it should be. So we are going to broaden the purchase to $445.00 per ambulance, this will allow them to buy splinting material, and supplies like that, which are needed to stay up to date. We are doing the first responder training classes and that has gone well. Mr. Courtney Terwilliger presented us with a map so there is a visual of where they are spread all over the state, with a heavy concentration in rural areas. *(Map attached to the meeting minutes)*. The first responder training has actually helped to discover some people that want to become EMT's. Another thing we would like to use trauma funds for is to provide some EMT B courses across the state, ten classes and there is going to be multi county grants. This will be a real step towards the regionalization that we talked about in the past. So we have moved the money that we got out of the reduction of the number of ambulances basically into EMT B courses into doing 32 PHTLS and ITLS classes across the state. The Subcommittee has really focused on training in a lot of the places where people are to far away to get it.

MOTION GTCNC 2011-08-03:
I move to approve the amended FY 2012 EMS Subcommittee budget.

Motion By: **Mr. Ben Hinson**
SECOND BY: **Ms. Elaine Frantz**

DISCUSSION:

Ms. Linda Cole states to Mr. Hinson that she thinks this is good and likes to see the education. Ms. Cole states she thinks that one thing that we should think about is that we are moving more towards pay for performance, and to start challenging the Subcommittee to think through looking at more of the quality of a piece of what they are doing.

Mr. Hinson states that in Mr. Keith Wages Office of EMS and Trauma, in particularly using Mickey Moore to do some surveys to get some hard numbers on cost of ambulance service. It is fascinating that there really is kind of a void that's never been gathered anywhere in the country. The problem comes up as to not what the cost is but what the cost should be, because there are ambulance services that have a wide range of quality, that have a wide range of cost, and high cost does not mean high quality. We have got to regionalize some of the small county EMS operations just for them to survive.

ACTION: The motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org*

Dr. Pat O'Neal would like to announce that the Trauma Commission members will be receiving an invitation to attend a conference on November 9th, called the Tale of Cities. There are five different individuals from across the world; most of those speakers are trauma surgeons that are going to be talking about how their cities responded to bombing attacks or shootings. The point of this presentation is to encourage cities here in the United States to have a plan for what they would do if in fact we came under some kind of attack. Dr. O'Neal also mentions that Dr. Brenda Fitzgerald expresses her support for the activities of the Trauma Commission and would like to meet with Dr. Ashley, and hear more about what the Trauma Commissions plans are for the future. Dr. O'Neal also states the Office of OEMS/T lost the Preventive Health Block grant. That was over $750,000 dollars of funding. The districts now only have EMS program directors, we lost all the other physicians, and all the funding for the regional offices. This met the EMS personnel in those offices had the option of either working from home or getting a free office donated to them by Public Health or whatever agency is willing to donate it. Dr. O'Neal states that the lady in uniform that you see with him today is Dr. Linda Capewell. Dr. Capewell is from the CDC, and is a preventive medicine fellow. Dr. Capewell has been assigned two projects, one to look at OEMS/T's original supposition, that for an optimal trauma system we would need approximately between 25-30 trauma centers around the state strategically located, second the major project of looking at that supposition and determining whether there is any real science behind it. Dr. O'Neal will be sharing the information on this study with the Trauma Commission when Dr. Capewell completes her project on June 30, of 2012.

Mr. Ben Hinson states that the GPS system is being rolled out. The second and third phase is through GEMA. Mr. Hinson states that it needs to be understood as a member of the Trauma Commission, that region three, which is the greater Atlanta area, is suppose to get funding for that system through a different program named the Urban Area Response Initiative. This program is basically a different federal bucket for major cities for homeland security. If Atlanta can get funding through that program, it will free up more dollars for the FEMA grant through GEMA to do more of the State. We are rolling these things out really fast, just none of them in Atlanta right now. A lot of people in Atlanta already have this type of capability; this is just a new way to do it. Mr. Hinson wants everyone to know he thinks we are going to end up with a very uniform statewide system in about 18 months. This is something the Trauma Commission started and GEMA picked it up.

Mr. Keith Wages states that on the pre hospital side we are making steady progress in our transition to the new scopes of practice, through educational standards in new levels of licensure's for the pre hospital community. One element of the update is that every medic is required to receive an orientation in awareness of the CDC trauma triage guidelines. We took this opportunity for the first time to mandate that as part of their update and are very pleased to expose them to some of the work that is taking place around trauma.

Ms. Renee Morgan states that Georgia now has 21 designated trauma and specialty centers. The 3 facilities that are the pilot project, that are still in process are; Wills Memorial, Emanual Medical Center, and Kennestone Hospital, and they are still moving forward. We have a lot of inquires from other centers. Ms. Marie Probst is scheduled to visit Phoebe Putney Memorial Hospital next week to train on the registry. *(List of Georgia Designated Trauma & Specialty Care Centers attached to the Meeting Minutes)*

MOTION GTCNC 2011-08-04:
I move to approve the FY 2012 DPH OEMST Commission-directed Budget Proposal.

MOTION BY:	**Ms. Linda Cole**
SECOND BY:	**Mr. Ben Hinson**
DISCUSSION:	**None**
ACTION:	The motion ***PASSED*** with no objections, nor abstentions. *(Approved minutes will be posted to www.gtcnc.org*

Regional Trauma Advisory Committees Updates

Dr. Ashley states that region 5 is having their first meeting Monday August 15, in Macon at the Anderson Conference Center, and everyone is invited. Dr. Ashley states that Ms. Debra Kitchens, Mr. Lee Oliver, Ms. Crystal Braxton-Smith, and he have gone around as a steering committee to all the hospitals and EMS services trying to get the information out on RTAC. With all that legwork being done we are ready to have our first real meeting. Dr. Ashley states they will start to work on their plan based on the framework the Commission has provided over the last couple of years.

Ms. Regina Medeiros states that on behalf of Mr. Rich Bias, chair of the Emergency Advisory Counsel group in region 6, we would like to thank the Commission for the opportunity to participate in this pilot. We feel very strongly that this is a significant step in the direction to solidify the trauma system throughout the state of Georgia. Ms. Medeiros states that the counsel has completed the development of a foundational plan to roll out the RTAC, and appointed RTAC members to the group. Ms. Medeiros states that the counsel utilized the framework that was provided by the Commission as the backbone as to what they did. The multidisciplinary approach was used as they developed the major components of their plan on hospital-to-hospital performance improvement, and injury prevention and outreach. They set up task forces and each task force was interdisciplinary in nature so that we had representations from all stakeholders, and they as a group worked together to develop the content of each section. This was then sent to the Steering Committee for review, editing, and to put all the pieces together. They had three major stakeholder meetings where development and review took place. Everybody from the very beginning had impute. They now have the appointed members who will move forward to implement the plan, and nobody can say that they did not have the opportunity to participate in the development. It truly feels like it is a plan that is encompassed by all the counties within region 6, as well as being successful at bringing in across the board participation. We now have a hospital member of our RTAC from South Carolina, and we are also trying to facilitate the appointment of an EMS provider from South Carolina as well.

Mr. Pettyjohn mentions that Mr. Rich Bias will be presenting the regional plan to the full Commission at the September meeting, and we are excited to see that. The full Commission will request the approval at that time.

Ms. Medeiros would like to mention that they utilized the standardized framework of the HRSA (Heath Resources Administration) document which is a federal standard document based on public health law, which the college uses to evaluate verification of trauma centers. Ms. Medeiros would recommend that the Commission consider using this document as a deliverable for each RTAC so that the way that we measure our resources is exactly the same as the other regions measure theirs.

Dr. Ashley states that his region 5 is looking at that as a tool but is very lengthy document. Dr. Ashley states that they are going to score the document, but he is probably not going to put it out at the first meeting for every member to score. We are going to approach it more strategically having certain people score, because it does take so much time, and it is so long.

Mr. Pettyjohn requests that Ms. Medeiros send him the final document that she wants the Commission to consider so he can put it on the GTCNC website so folks can review it in preparation for Mr. Rich Bias presentation. Mr. Pettyjohn states that he is looking to develop a webpage within some of the Commissions sites for each of the 10 RTAC's.

Ms. Elaine Frantz of Region 9 RTAC states that Dr. Gage Ochsner and she just completed their financial assessment of the hospitals, visiting 17 out of the 19 in Georgia and one in South Carolina. Their first Region 9 RTAC meeting is scheduled for October 28, and they anticipate about 80 people; all the EMS council members will be invited, select hospital administrators, emergency department physicians, and lead nursing leaders. That meeting is scheduled and the invitations will be sent next week. The first RTTDC (Rural Trauma Team Development Course) is scheduled for November 3rd. This is also part of the RTAC, as one of the deliverables. We are excided about this meeting because it will be at Meadows Regional Hospital, a brand new facility. Ms. Frantz has been working with them very closely with this course. Ms. Frantz announces that there are two centers that have full administrative support to move forward to seek designation as a level 4 that is at Meadows Regional, and Effingham Hospital. Ms. Frantz states that she is also speaking to Southeast Regional in Brunswick, thinking that they could also be a level 3.

eBroselow Demonstration

Mr. Greg Pereira who is Trauma Program manager of Children's Hospital of Atlanta has been working with the Dr. Jim Broselow, Mr. Peter Lazar, and Dr. Robert Luten, and the trauma centers via the trauma coordinators to implement the eBroselow system statewide. This system addresses the problem of safe dosing pediatric patients. Mr. Pereira states that they have met with all the primary stakeholders, level 1 trauma centers with pediatric commitment; Memorial, MCCG, MCG as well as Columbus, and Children's. A group of pharmacists went through the eBroselow System and made sure that all the concentrations were what was being used at those facilities. Mr. Pereira states that this took a little longer than he had anticipated to get pharmacists to all agree, but he thinks we are finally there and we have come up with solutions. The second phase of the rollout was to get all the other designated trauma centers to start using the system, and in order to do that Mr. Pereira sent out all the information to the pharmacists not to get consensus but to get an FYI in case they had some off brand drug that they needed an additional concentration added to. Mr. Pereira states that at the last GTCE meeting he educated and orientated all the trauma coordinators from all the designated trauma centers so that they can start implementing the system within their facilities. *(Contract Report Attached to Administrative Report)*

Dr. Ashley asks Mr. Pereira whether he got all the trauma centers and pharmacists on the same page?

Mr. Pereira states that yes, but it was not because they agreed to everybody using the same concentration. What we did was come up with a way around the system by adding the concentrations that they used at their facilities onto the system.

Ms. Linda Cole states that part of that was because they have different contracts with different vendors, so they might be able to only obtain that concentration. Ms. Cole states that Mr. Pereira tried to get them with those groups in the end goal to get as much standardization they could possibly draw.

Mr. Pereira states that the system the furthest along is a MCCG where Ms. Debra Kitchens has already started orientating all her staff, and they will probably be the ones first up and running and using this system. The other level 2 trauma centers that have started implementing already are Hamilton and North Fulton. Mr. Pereira states that he is scheduled to do orientation at AMC on September 7, and then Grady. A lot of level 2 may already be up and running because they do not have to get the entire consensus from their pharmacists.

Dr. Ashley wants to know if in order to use this system if you need a computer at the patient's bedside.

Mr. Pereira states that is correct or you can use an I-pad, IPhone, and Android & Blackberry. There is also an e-learning component for the eBroselow so that each facility can log in and set up their e-

learning. The nurse that is doing the e-learning testing CDT clicks on the facility that they are working at. Mr. Pereira mentions that this system is all hooked up into whatever system you want it to be, so if your hospital gives their IP address to Mr. Peter Lazar at Artemis he will work with them to set it up so that anybody that clicks into the eBroselow System will not have to have a user ID, or password. *(www.ebroselow.com)*

Ms. Renee Morgan wants to know if there will be a way in this system to eliminate the medications that your hospital does not carry doses of.

Mr. Pereira states no it will show them all and the reason is because we have 50 licenses within the state of Georgia and he would have had to individualize the system for 50 different centers.

Ms. Linda Cole mentions that there is a component to this system that has not been purchased it is a little wand that scans the bar codes, and you can carry it in your pocket. This would help you to know exactly what dosage and concentration you had.

Trauma Registry Data

Ms. Rana Bayakly presents Trauma Registry Part II to the Trauma Commission. *(PowerPoint & handouts attached to the meeting minutes)*

Ms. Cole wants to know if there is a way to look at just the shear volume of trauma, especially year to year as we do more and more for the Trauma Commission, because our overall goal is to decrease trauma, and severity.

Ms. Bayakly states that yes the data is available all the way back to 2004, but the data is cleaner as you come closer to 2009-2010. What they have decided to do in the report is use 2004-2009 as one group, and then 2009-2010 to keep on the trend, because we know 2009 data is way superior than previous years. This will allow us to carry the trend of 2009 forward.

Mr. Pettyjohn asks Ms. Bayakly if the work they been doing to clean up the registry data, and understand the information that the data is providing, is going to be bound into a report.

Ms. Bayakly states that yes they are actually planning the report and the report is going to be as of August 30th downloads, because we are waiting on one hospital to submit their data.

Old business: None

NEXT MEETING: Thursday 15 September 2011, Atlanta Medical Center, Letton Auditorium

MEETING ADJOURNED: Hearing no call for additional business or concerns for the Commission to address, Dr. Dennis Ashley declared the meeting adjourned at 1:44 PM.

Minutes crafted by Lauren Noethen

CY 2009 FINANCIAL ASSESSMENT OF GEORGIA BURN CENTERS
Georgia Trauma Care Network Commission

August 2, 2011

To Georgia Burn Centers,

This survey replicates the trauma center financial surveys conducted for four years to benchmark their financial performance and identify uninsured patients eligible for funding. It covers calendar year 2009 and the due date is September 2, 2011.

Please confirm receipt of this survey by replying to the email from Karla@traumacare.com.

Please also identify your staff who will be involved in compiling this information and arrange a conference call with Greg Bishop at (949) 754-9080 X115 or Greg@traumacare.com to review the survey and answer any questions. Contact Greg at any time with questions.

When completed, please email survey to Karla@traumacare.com.

Please provide the following information:

Burn Center: _____

Name of person who completed this Survey: _____

Phone Number: _____

Email Address: _____

All hospital data will be kept confidential and will not be publicly reported except on a consolidated basis that precludes the disclosure of sensitive hospital information.

This survey should be reviewed by your CFO and signed to indicate his/her review:

_____ CFO

SECTION 1 – BURN REGISTRY AND PATIENT COST INFORMATION

A. Volume & Severity of All Admitted Patients With LOS > 1 day

Only include burn patients who were admitted to the hospital during the 12 months of 2009, and had a length-of-stay of at least 48 hours unless they were transferred in or died after admission. Please sort them by following Total Burn Surface Area (TBSA) categories:

TBSA Category	# of Patients	Total Costs*	Total Hospital Days	Total ICU Days**
% TBSA 0 – 4				
% TBSA 5 - 9				
% TBSA 10 – 14				
% TBSA 15+				
Totals				

Burn Admissions < 48 hours
Please indicate number of burn patients who were admitted but discharged in less than 48 hours and were not included in table: _____.

*Total costs include fully allocated patient treatment costs ** Include in total hospital days

B. Volume & Severity of Admitted Patients With Inhalation Injury Requiring Ventilator Use

This is a subset of Table A and may be used to develop a burn patient severity classification method.

TBSA Category	# of Patients	Total Costs*	Total Hospital Days	Total ICU Days**	Ventilator Days
% TBSA 0 – 4					
% TBSA 5 - 9					
% TBSA 10 – 14					
% TBSA 15+					
Totals					

C. Volume & Severity of Admitted Patients With a Deep Burns

This is a subset of Table A and may be used to develop a burn patient severity classification method.

TBSA Category	# of Patients	Total Costs*	Total Hospital Days	Total ICU Days**
% TBSA 0 – 4				
% TBSA 5 - 9				
% TBSA 10 – 14				
% TBSA 15+				
Totals				

SECTION 2– PATIENT TREATMENT COSTS & PAYMENTS

A. Patient Treatment Costs And Payments

In this table please include all and only patients included in the table in section 1A.

Payer Type	# of Patients	Total Charges	Total Allocated Patient Costs	Total Payments
Commercial				
Medicare				
Medicaid				
Self Pay				
Other				
Totals				

SECTION 3 - SELF PAY VOLUME AND SEVERITY MIX

Please identify patients included in the table in Section 1A (in-patients only, 48 hour LOS) who meet state trauma center Uncompensated Care Services Program requirements. These requirements are attached and include uncompensated care contract language and patient eligibility clarifications adopted by the Georgia Trauma Commission. Please review each patient against these requirements, then include only such patients in the table below.

CY 2009 Uninsured Patients Meeting State Requirements

Admitted Patients By TBSA	# of Pts	Total Patient Costs
% TBSA 0 – 4		
% TBSA 5 - 9		
% TBSA 10 – 14		
% TBSA 15+		
Total Admitted Patients		

SECTION 4 - BURN CENTER READINESS COSTS

This portion of this survey is designed to define the costs of resources necessary to ensure burn center readiness at all times as required by the American College of Surgeon's *Resources For Optimal Care Of The Injured Patient*. They are non-patient care costs the hospital would not have to pay if it were not a burn center. The following survey was developed for Georgia's trauma centers and has been modified to reflect burn center requirements.

LINE ITEM/	SURVEY INSTRUCTIONS	AMOUNT
Criteria Deemed Essential In ACS Gold Book		**Use Actual Costs in 2009**
ADMINISTRATIVE		
Senior Administrator Support	% of time focused on burn by main senior administrator involved in burn care X salary and benefits.	
Burn Program Manager	Salary & benefits X % of time on burn care (if position has other duties).	
Participation in burn system activities	Burn Center Manager travel costs to meetings.	
Burn Center Staff Support	• If any of the following positions generate reimbursement or are supported by grants, use net hospital costs X time spent on burn care to calculate their costs. • If position employed by burn center or by another department which focuses burn responsibility on few staff, use salary + benefits - revenue and grant support for costs. • If employed by another department which spreads burn responsibility among most staff, use portion of burn patient admissions of total admissions X department salary costs.	
Outreach Coordinator	Salary & benefits X % of time on burn care.	
Case Mgmt, Discharge Planning	Salary & benefits X % of time on burn care. If support is provided by personnel from a hospital case management department, use burn discharges/total discharges X department salary costs.	
Burn Prevention Coordinator	Salary & benefits (less grant support) X % of time on burn care.	
Research/PI Coordinator	Salary & benefits (less grant support) X % of time on burn care.	
Burn Registrar	Salaries & benefits X % of time on burn.	
Secretarial Staff	Salaries & benefits X % of time on burn care.	
Burn Medical Director	Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on burn center administrative functions only.	
Participation in state and regional activities (e.g., EMS Council)	Burn Medical Director travel costs to meetings.	

ED Medical Director	Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on burn center administrative functions.	
ICU Surgical Director	Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on burn center administrative functions.	
Registry Hardware and Software	Costs for registry hardware, software and maintenance fees.	
CLINICAL – MEDICAL STAFF	Includes the costs of maintaining burn physician support for your burn center other than the costs of admin functions addressed above.	
Burn Medical Staff Compensation Do not include amounts paid for administrative duties.	• If you pay specialty a stipend exclusively for burn call, enter the full amount. • If you pay a stipend to a specialty that is for both burn and ED call, estimate the portion attributable to burn care. • If you employ your physicians, determine net cost (salary + benefits – pro fee reimbursement) and estimate portion attributable to burn. • If you are supported by a faculty practice arrangement, take portion of burn admissions to overall admissions and apply to overall hospital subsidy provided to faculty practice structures, Or Total number of physicians by specialty and apply AAMC salary database (at 50% of range) for SE region, add estimated benefits, subtract estimate salary support from pro fee reimbursement, and then apply portion of burn admissions to overall admissions to arrive at net cost for specialty support. • Do not include amounts specifically paid to burn physicians for care of uninsured burn patients in the amounts for each specialty; you will be asked for a total amount of such pay at the end of this section.	
Surgery	See above.	
Orthopedics	See above.	
Neurosurgery	See above.	
Anesthesia	Estimate portion of hospital net cost for anesthesia that is attributable to burn.	
Radiology	Estimate portion of hospital net cost for radiology attributable to burn care.	
Plastic surgery	See above.	
Otolaryngology	See above.	
Ophthalmology	See above.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty_____.	

Surgical Resident Support	This applies to surgical residency only. There are two options: Take residency costs and subtract federal funding and apply portion attributable to burn care, or take residents' hourly salary + benefits for time on burn care rotation, and subtract federal funding for this time.	
EDUCATION & OUTREACH	Includes costs for travel, courses, training, supplies and materials for activities specific to burn. This does not include personnel costs, which should have been included in the Administrative Section.	
Injury prevention	Must be specific to burn.	
Community outreach	This includes public education.	
Professional outreach	This includes offering ATLS courses and providing burn clinical education to EMS and hospital staff in your region.	
Outlying hospital education	This addresses the unique responsibilities of Level I burn centers in supporting outlying hospitals.	
Required Burn CME	Includes costs for courses and travel for up to 16 hours of burn CMEs only for personnel below:	
Burn Medical Director		
Burn Program Manager		
ED Burn Liaison		
Education – burn related for hospital staff	Includes cost of courses plus salary costs for educational time.	
Emergency Department		
Intensive Care unit		
Surgery		

SECTION 5 - BURN CENTER COST CENTER

If you have a burn center cost center that incorporates some of the costs above and allocates them to burn patients, please summarize the costs allocated in CY 2009 in the table:

Administrative	
Medical staff support	
Education & Outreach	
Total	

UNCOMPENSATED CARE SERVICES PROGRAM REQUIREMENTS*
GEORGIA TRAUMA COMMISSION
March 2011

RELEVANT FY 2011 CONTRACT LANGUAGE

2. DEFINITIONS AND TERMS

Trauma Patient: A patient who is listed in the Georgia State Trauma Registry.

Trauma Center: A facility designated by the Department of Community Health as a Level I, II, III, or IV "trauma center". O.C.G.A. Section 31-11-100 (1)

Uncompensated Care Services: Care provided at a designated "trauma center" in the State of Georgia, by an emergency medical services provider, or physician to a trauma patient as defined by the Georgia Trauma Care Network Commission who:

(a) Has no medical insurance, including federal Medicare Part B coverage;

(b) Is not eligible for medical assistance coverage;

(c) Has no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage;

(d) Has not paid for the trauma care provided by the trauma provider after documented attempts by the trauma care services provider to collect payment. O. C. G. A. Section 31-11-100 (4); and

(e) Where the recipient of services is making payment, any partial payment of less than 10 percent (of charges) on such self-pay accounts will qualify that account to be deemed as "uncompensated" for the purposes of this Uncompensated Care Services Program.

4. SPECIFIC CONTRACTOR RESPONSIBILITIES

III. Uncompensated Care Services Program:

A. Ensure funding provided by this Uncompensated Care Services Program, which is provided to cover an uncompensated care claim, will never exceed the amount of that claim.

B. Ensure Contractor and eligible physicians have made all reasonable collection efforts for payment of trauma care services claims deemed as "uncompensated care." Collection for services will include payments from private insurance or any other public medical assistance program (i.e. Medicaid, Medicare Part B, Workers' Compensation, etc.) or any funding resulting from litigation related to claim or patient's injury.

C. All Uncompensated Care Services Program funding shall be deemed as the "payer of last resort." No funds from this Uncompensated Care Services Program will be made as supplement for any third party payment.

D. Where the recipient (patient) of trauma care services is making payment, any partial payment of less than 10 percent on such self-pay account will qualify that account to be deemed as "uncompensated care" for the purposes of this Uncompensated Care Services Program.

UNCOMPENSATED CARE ELIGIBILITY CLARIFICATIONS AS APPROVED BY GEORGIA TRAUMA COMMISSION*:

1. Claims deemed qualified under Trauma Commission uncompensated care definition

A. Cases where financial counselors at the Trauma Center determined that the patients qualified for a charity program offered by the hospital whereby the account was written off and further attempts to collect were not made.

B. Cases where patients were victims of a crime and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.

C. Cases where patients were undocumented aliens and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.

D. Cases where insurance could not be verified.

2. Claims are deemed NOT qualified under Trauma Commission uncompensated care definition

A. Cases where the patient expired and the Trauma Center did not attempt to collect.

B. Cases where patients received settlements directly but did not pay the Trauma Center after repeated collection attempts.

C. Cases where there was a reciprocal agreement with another party for exchange of services and the Trauma Center did not attempt further collection procedures.

* Approved by the Georgia Trauma Commission on March 17, 2011.

GEORGIA BURN ASSESSMENT WORKPLAN

I. EVALUATE BURN CARE SUPPORT NEEDS FROM GTCNC

The following tasks will be conducted:

A. Assess What Other States Do To Support Burn Care

There are several examples of states funding burn centers and we will evaluate them in comparison to the funding need for trauma centers as perceived by states.

B. Conduct Economic Survey Of Doctors/Grady Memorial Hospital's Burn Centers

This survey will replicate the trauma center economic surveys we have conducted for the past four years in Georgia (see Task II) to the extent possible. Limitations include the lack of a severity measure in burn care (no injury severity score), and few established norms for economic performance.

C. Assess Statewide Hospital Discharge Data On Burn Care

This will be conducted to verify data supplied by Georgia burn centers, determine if burn patients are treated at other hospitals in Georgia, and assess other appropriate factors.

D. Estimate Trauma Physician Participation/Compensation In Burn Care

This will involve a cursory assessment of physician participation in burn care to arrive at an overall estimate of physician costs in comparison to hospital costs.

E. Compare Trauma Center Finances/Needs To Burn Center Finances/Needs

Once the economic analysis is completed, it will be compared to the analysis of Georgia trauma centers to help define Georgia burn center's relative need for state funding.

F. Define Alternatives For Support/Costs

Support may involve funding and/or other Commission support such as adding burn victim triage to Communications Center functions as a means of generating more patient volume for the burn centers.

G. Prepare & Present Report

A report and presentation will be made to the Georgia Trauma Commission.

This assessment will define answers to such questions as:

1. What is the overall volume and severity of burn patients in Georgia?
2. What is current burn center capacity in relation to volume?
3. What is the payer mix, estimated reimbursement and other sources of revenue?
4. What are burn care costs and how do they compare with national cost norms?
5. How do specific payer classes including managed care, Medicare and Medicaid compare in terms of payment?
6. What are the overall losses experienced in burn care, including care of uninsured patients and underinsured patients?
7. What problems do burn centers report in maintaining their capacity and meeting demand?
8. Are their other issues such as inappropriate referrals that add unnecessary burden?

This will produce an objective assessment of the Georgia burn care "market" that defines demand (patient volume & severity), supply (available capacity) and current financing (payer mix, revenue, costs and losses). Survey data will be reported in an aggregate form to protect confidential information.

GEORGIA TRAUMA COMMISSION
Progress Report On 2009 Our Emerging Vision: A New Public Service for Georgia

MAKING PROGRESS ON A BROAD FRONT
In 2008, the Georgia Trauma Commission assessed Georgia's trauma system and found it to be a rich in opportunities, as reflected in the broad range of objectives in the 2009 Trauma Commission strategic plan. Progress has occurred on a broad front:

2008 PRIMARY GOALS
Obtain Permanent Funding
Due to extraordinary economic conditions, Trauma Commission funding declined from $58.9 million (FY 2008/2009) to $17.5 million (FY 2010) to $10.5 million projected for this year (FY 2011), and despite the Car tag fee referendum's loss, the need persists. Revenues from the Super Speeder Law have been helpful but inadequate.

Maintain & Expand Georgia's Trauma Centers
All trauma centers participating in 2007 have maintained their designation, two have upgraded their status, four new centers have been designated and others are in process. South Georgia is the pilot region for the Commission's trauma system development activities with a special focus on trauma center development efforts.

Strengthen Emergency Medical Services
EMS is stronger throughout Georgia for all emergencies due to new ambulances, uncompensated care program for EMS service providers and a robust stakeholder structure within the Trauma Commission. The developing statewide GPS vehicle locater system, trauma communications system, trauma care-related equipment grants and Commission-funded First Responder training programs will continue this progress.

Develop Statewide Trauma Communications System
A state-of-the-art system to assure all injured are quickly transported to the appropriate level of care is planned, Communications Center site has been selected (Georgia Public Safety Training Center in Forsyth) and is implementation is under way in partnership with Georgia Tech Research Institute and SAAB North America, Inc. SAAB operates Sweden's national trauma communications system and has the experience required to assist the Commission in building a state of the art trauma communications system in all the United States. This system could be expandable to other types of health emergency cases and disaster needs.

Build Trauma System Infrastructure
The Trauma Commission has provided 3% of available funding to Office of EMS for the administration of an adequate system for monitoring state-wide trauma care, recruitment of trauma care service providers into the network as needed, and for research as needed to continue to operate and improve the system.

Establish Mechanisms to Assure Exceptional Accountability
A cutting edge performance based payment program to improve quality, system participation and reduce costs with financial incentives has been established and is fostering the needed participation in trauma system development, cost effectiveness, injured patients' access to trauma care, meeting trauma center standards, and most importantly, patient outcomes.

A COMPREHENSIVE TRAUMA SYSTEM FOR GEORGIA

2011-14 Strategic Plan Summary

Vision:

A statewide system of care developed around the trauma care continuum that ensures optimal outcomes for all seriously injured, built in partnerships that make the best use of Georgia's emergency/healthcare resources.

Mission

The Georgia Trauma Commission will establish a comprehensive, inclusive trauma system throughout Georgia that reduces injury and assures injured patients are quickly assessed and transported to the appropriate level of care where they will receive optimum treatment.

Strategy

The Georgia Trauma Commission will partner with Georgia's ten (10) EMS regions to establish Regional Trauma Advisory Committees (RTAC), define regional needs, and develop regional trauma systems that can be integrated into a statewide trauma system. A centralized Trauma Communications Center will provide real time, coordination of trauma patient flow statewide and data needed to ensure optimum system performance, and will be a common component of each regional trauma system. The Commission will also partner with other Georgia organizations to assure full and cost-effective support.

Goals, Objectives and Activities

Objectives and activities may meet multiple goals and objectives.

I. BUILD BASIC TRAUMA SYSTEM INFRASTRUCTURE

A. Obtain Adequate Trauma System Funding

1. Communicate Trauma System Development Progress To Legislature
2. Communicate Trauma System Development Progress To All Georgia
3. Support Full Collection Of Super Speeder Law Revenues

B. Continue Developing Strong Stakeholder Support Structure

1. Expand Collaboration With Trauma Medical Staff, Trauma Centers And Community Hospitals

C. Develop Trauma System Regionalization

1. Coalesce Stakeholders & Form Regional Trauma Advisory Committees (RTAC) In All 10 EMS Regions
2. Develop Regional Trauma System Plans Using "Framework" As Roadmap For Plan Development

D. Develop Centralized Trauma Communications Center

1. Establish Trauma Communications Center With State-Of-Art Technology
2. Collaboratively & Sequentially Implement Utilization Of Communications Center By EMS Region As Associated RTACs Develop
3. Integrate Communications Center With Adjacent State Trauma Systems

E. Enhance Strategic Planning, Budgeting & Performance Evaluation

1. Implement Zero-Based Budgeting
2. Develop Programmatic Performance Monitoring and Reporting Tools
3. Map Program Performance Measures To Planning And Budget Development

II. EXPAND TRAUMA CENTERS TO MEET GEORGIA'S NEEDS

- **A. Maintain Georgia's Existing Trauma Centers**
- **B. Foster Development Of New Trauma Centers Where Needed**
  1. Partner With Regulatory Agency For Unified Plan To Bring On New Centers
  2. Target Trauma Center Funding Utilizing Plan
  3. Improve Trauma Care In All Hospitals & Develop Level IV Trauma Centers
- **C. Demonstrate Rigorous Accountability To Promote Excellence**
  1. Maintain Performance Based Payment Program For Trauma Centers
  2. Maintain Trauma Center Funding Audit Program
  3. Partner With Regulatory Agency For Unified Strategy And Plan For Trauma System Performance Improvement
  4. Institute Trauma Quality Improvement Program (TQIP) In Trauma Centers
- **D. Support Training Of Trauma Physicians For Future Needs**
  1. Support Rural Trauma Team Development Courses Statewide
  2. Utilize Georgia Cot To Identify Physician Training Opportunities

III. STRENGTHEN EMERGENCY MEDICAL SERVICES

- **A. Support Equipment, Training And Financial Needs**
  1. Utilize EMS Subcommittee On Trauma For EMS Needs Identification
  2. Encourage RTAC Assessment Of Each Region's EMS Needs
- **B. Build GPS Automatic Vehicle Locator System With GEMA**
  1. Identify Best Use And Incorporate AVLS System Into The Trauma Communications Center
- **C. Foster Optimal Use Of Rural EMS Resources**
  1. Utilize RTACs To Identify Need And Foster Adequate Air Transport Services Throughout State
  2. Utilize RTACs To Foster Efficiency of Local EMS Systems
- **D. Implement EMS Performance Based Payment Program To Foster Excellence**
  1. Develop And Utilize EMS Funding Audit Program

IV. BUILD ESSENTIAL TRAUMA SYSTEM COMPONENTS

- **A. Build Trauma Telemedicine System**
- **B. Enhance Pediatric Trauma Subsystem**
  1. Fully Implement eBroselow System With EMS And Hospitals
- **C. Assess Rehabilitation And Burn Care Issues**
  1. Assess Burn Care Needs And Assist With Support
  2. Assess Rehabilitation Needs And Issues
- **D. Utilize Injury Data To Drive System Development Decisions**
  1. Utilize DPH Trauma Epidemiology Services
  2. Incorporate Trauma Communications Center Data In Decision Process
- **E. Assist In Initiatives To Reduce Traumatic Injury**
  1. Partner With State And Federal Injury Prevention (IP) And Risk Reduction (RR) Programs
  2. Encourage RTACs To Assess And Address Regional IP And RR Needs
- **F. Integrate Trauma System With Disaster/Terror Response**
  1. Utilize Trauma Communications Center And AVLS As Assets For Statewide Incident Response To Mass Casualties And Medical Surge

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
I. Build Basic Trauma System Infrastructure to provide the framework and support necessary for a system to develop and operate. This infrastructure needs an adequate funding mechanism, a strong stakeholder network, an effective regional structure, a state-of-the-art trauma communication system, and an informed relationship with Georgia and its legislature similar to all other essential public services.						
A. Obtain Adequate Trauma System Funding. Without an adequate and stable funding mechanism, trauma system development will be constrained, the ability of existing trauma centers to maintain strong programs weakened, and prospects for recruiting new trauma centers where they are most needed will be further diminished.	2008 funding of $59 million stabilized Georgia's trauma centers, but this amount has declined dramatically. While the 2010 vote on the $85 million car tag fee measure failed, the clear sentiment of the legislature and voters was that George's trauma system needs this level of support.	Governor, Lt. Governor, Speaker of the House, State Legislature, trauma and EMS stakeholders, business community, philanthropic groups, and the people of Georgia.	Stable annual funding of $85 million.	Adequate, stable funding. Resulting measures are trauma patient mortality rates outcomes, number of trauma centers, time for injured patients to arrive at a trauma center.	1. Stay the course on planning and developing the best possible trauma system for Georgia. 2. Communicate progress to Georgia and its Legislature. 3. Assess four year old SB 60 and recommend changes to legislature.	
1. Communicate Trauma System Development Progress To The Legislature	The Georgia Legislature is clearly impressed by the work of the Georgia Trauma Commission. This relationship needs to be strengthened during this ongoing period of tight resources.	The Georgia Legislature and its champions of trauma care, and the Executive Branch as well.	This will require the development of a state-of-the-art public service communication system. Such systems today are characterized as "social marketing", and are relatively inexpensive to develop.	Knowledge and support for trauma care in the legislature.	1. The GTCNC recently reconstructed its website. The next step will be a social marketing system using Facebook, You Tube, Twitter, etc. to network with its stakeholders and all of Georgia. 2. A variety of states have developed "trauma foundations" to support the work of their statewide Trauma Commissions. The GTCNC will explore this concept.	
2. Communicate Trauma System Development Progress To All Georgia	Georgia is used to hearing from its law enforcement and fire personnel, and knows what they do and how they function. Georgia needs to know the same about trauma and EMS personnel.	This should engage stake holders in telling their story to their communities as well as the GTCNC communicating progress on trauma system development to all Georgia.		Knowledge and support for trauma care among the public. The public's knowledge of how to respond when they or someone they see is seriously injured.		
3. Support Full Collection Of Super Speeder Revenues	The core issues of the super speeder law are injury prevention and funding for the Georgia trauma system. Its effective implementation requires a consistent commitment among police and sheriffs to enforcing its provisions.	The GTCNC should support the work of police and sheriff personnel by promoting its value to Georgia and victims of serious injury.	Significant staff time and that of GTCNC volunteers.	Number of super speeder tickets issued. Proportion of tickets with an accurate speed indicated. Other measures that indicate proper enforcement.	1. Connect with Georgia police and sheriff organizations to determine how the GTCNC may be most helpful. 2. Plan and carry out such tactics, and promote their work through objectives 1 & 2 above.	
B. Continue Developing Strong Stakeholder Support Structure by enhancing collaboration with EMS, and Trauma Program Managers and expand collaboration to trauma surgeons, emergency physicians and hospitals.	The GTCNC, EMS community and the Trauma Program Managers have together built a very strong structure to maximize their mutual benefit from collaboration. This needs to be expanded to more stakeholders.	All trauma system stakeholders are potential partners.	Significant staff time on an ongoing basis as well as a significant amount of GTCNC volunteer time.	Collaborative activities with stakeholder organizations that enhance the overall trauma system.	1. Enhance collaborative relationships with EMS community and trauma program managers with additional initiatives that strengthen the trauma system.	
1. Expand Collaboration with Trauma Medical Staff, Trauma Centers and Community Hospitals	Trauma surgeons, emergency physicians and executive trauma center and hospital managers are stakeholders that can add substantial value to Georgia trauma system development.	The Georgia Committee on Trauma, Georgia College of Emergency Physicians, Georgia Hospital Association and the Medical Association of Georgia.	Significant staff time on an ongoing basis as well as a significant amount of GTCNC volunteer time.	Collaborative initiatives that develop with trauma surgeons, emergency physicians and hospital managers.	1. Discuss opportunities with the Georgia Committee on Trauma, Georgia College of Emergency Physicians, and the Georgia Hospital Association. 2. Define collaborative plans.	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
C. Develop Trauma System Regionalization. This is one of the major components of the trauma system infrastructure. It requires collaboration at and between all levels, and essentially will be pursued by implementing the Georgia Trauma System "Framework."	The GTCNC will partner with each of Georgia's 10 EMS Regions to establish regional trauma systems meeting their needs.	All trauma system stakeholders at the local and regional level will need to be partners.	Each EMS/Trauma Region will need administrative and some operational support from the GTCNC.	Performance measures are incorporated in the Georgia Trauma System "Framework."	1. Continue working with EMS Regions 5, 6 & 9 to pilot trauma system development activities. 2. Bring new GTCNC and regional staff on board.	
1. Coalesce Stakeholders & Form Regional Trauma Advisory Committees (RTAC) In All 10 EMS Regions	EMS Regions 5, 6 & 9 have been working with the GTCNC to pilot the development of local trauma regions.	Trauma system stakeholders at the local and regional level will need to be partners.	Administrative funding to support EMS Regions 5, 6 & 9, and GTCNC staff support.	Representation/participation of local and regional trauma system stakeholders.	As defined by EMS Regions 5, 6 & 9.	
2. Develop Regional Trauma System Plans Using "Framework" As Roadmap For Plan Development	The framework provides a roadmap for regionally-based development of a trauma system within basic statewide parameters.	All trauma system stakeholders at the local and regional level will need to be partners.	Included in above.	Performance measures are incorporated in the Georgia Trauma System "Framework."	As defined by EMS Regions 5, 6 & 9.	
D. Develop Centralized Trauma Communications Center. Another pillar of the Georgia Trauma System, it will use state-of-the-art technology to streamline trauma patient triage, transfer and transport. It can redirect patients statewide should facilities become saturated.	A communications system is essential to ensure the injured are quickly transported to the most appropriate trauma facility. It will also keep patients with minor injuries in their own community for care at less cost.	Being developed with the Georgia Tech Research Institute. There are a broad range of participants and partners, including mass casualty response.	Trauma communication center funding is anticipated at $_____ for development and $_____ annually for operations.	Initially performance measures will be start up and rollout dates, and then participation and time from injury to definitive treatment in a trauma center.	1. Finish developing statewide communication center. 2. Consider developing mobile app for EMS that would augment/extend the trauma communication center concept.	
1. Establish Central Communications Center With State-Of-Art Technology	This will function like an air traffic control system for ground EMS units and medical air transport. The Georgia Public Safety Training Center in Forsyth will be the site and its implementation is under way.	(Georgia Public Safety Training Center in Forsyth) and its implementation is under way and SAAB North America, Inc.	See above.	Target date for system implementation in EMS Regions 5, 6 & 9 is _____.	1. Establish Communication Center facility, equipment and staffing. 2. Adapt SAAB system to Georgia and implement.	
2 Collaboratively & Sequentially Implement Utilization Of Communications Center By EMS Region As Associated RTACs Develop	This task will integrate the trauma system regionalization initiative described in objective C and the Trauma Communication System.	Partners are EMS Regions 5, 6 & 9 that will essentially pilot these major pillars of the Georgia Trauma System.	Funding addressed above and in objective C. Develop Trauma System Regionalization.	Performance measures are development milestones drawn from the Georgia Trauma System Framework.	1. Implement Georgia Trauma System Framework in EMS Regions 5, 6 & 9. 2. Implement Trauma Communication in EMS Regions 5, 6 & 9.	
3. Integrate Communication Center With Adjacent State Trauma Systems	In northwest Georgia, many trauma patients are transported across state lines to Erlanger. Trauma centers on George's East border see significant patients cross state lines.	Adjacent states and hospitals that receive trauma victims from Georgia, and Georgia hospitals that receive trauma patients from out-of-state.	GTCNC and EMS Region staff time will be required to arrange a system interface to be implemented by the Communications Center.	Initial performance measures will be development dates, and then time from injury to treatment in a trauma center across state lines.	1. Prepare initial plan for integrating trauma system across state lines.	
E. Enhance Strategic Planning, Budgeting and Performance Evaluation to demonstrate a commitment to excellence in accountability and to meet state regulations and guidelines.	The GTCNC has already developed a strong tract record on accountability with its cutting edge performance based payment program, and the new Governor is strengthening these functions throughout state government.	The state is giving the GTCNC the opportunity to shine in accountability. This will be a challenge for the GTCNC and stakeholders and system support functions it funds.	This is about optimizing the impact of all GTCNC funding, and it will only require a small amount of funding to enhance the GTCNC's existing planning, evaluation and budgeting.	The basic measure will be the state's regulations and guidelines regarding planning, evaluation and budgeting. The next will be the actual performance of the GTCNC and its programs.	See below.	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
1. Implement Zero-Based Budgeting	The Governor is requiring all state agencies to Implement zero-based budgeting.	GTCNC, Governor's Office of Planning and Budget, and Department of Community Health.	A significant amount of staff time will be required.	Meet state requirements for zero-based budgeting and improving the GTCNC budgeting process	1. Develop zero-based budgeting. 2. Implement zero-based budgeting plan.	
2. Develop Programmatic Performance Monitoring and Reporting Tools	Measurable objectives have a high priority in Georgia state government strategic planning and many will need to be developed for the trauma system	GTCNC, trauma centers, EMS, hospitals, RTACS, and Trauma communications Center.	A significant amount of staff time will be required.	The development of effective performance measures and reporting processes.	1. Develop trauma system performance measures. 2. Develop monitoring and reporting processes.	
3. Map Program Performance Measures To Planning And Budget Development	This GTCNC is developing programs and infrastructure simultaneously, so developing and implementing measurable objectives will be both a major challenge and opportunity.	GTCNC, Governor's Office of Planning and Budget, and Department of Community Health.	A significant amount of staff time will be required.	Their effective use in GTCNC planning and budget development.	1. Develop measurable objectives. 2. Use in GTCNC planning and budget development.	
II. Expand Trauma Centers To Meet Georgia Needs for access to a Level I, II, or III trauma center within one hour for all seriously injured, ensure that all hospitals provide optimal treatment of trauma victims, continue to establish rigorous accountability for the use of public funds and begin addressing the increasingly problematic physician shortage for trauma care.						
A. Maintain Georgia's Existing Trauma Centers to prevent further closures, and strengthen them so they can meet state standards. All trauma centers participating in 2007 have maintained their designation, two have upgraded their status, and four new centers have been designated.	State funding in 2008 reduced the trauma centers' annual loss by half. This funding was then cut in half, and then cut in half again. Adequate, reliable funding will be required to maintain these trauma centers.	Georgia's trauma centers, which are all striving to maintain their programs despite poor revenue on un/under insured patients and high added costs to maintain 24/7 readiness.	The 2008 funding level, which cut their losses in half, is a minimum threshold for funding existing trauma centers.	No new trauma center closures is the basic measure. See Objective C below for specific trauma center performance measures.	See objective IA - Obtain Adequate Trauma System Funding.	
B. Foster Development Of New Trauma Centers Where Needed. South Georgia is the pilot region for the Commission's trauma system development activities with a special focus on trauma center development efforts.	The key challenges facing hospitals assessing a trauma center include funding, a functional trauma system that directs patients to their best destination, and a sufficient number of new trauma centers to accommodate overall demand.	Hospitals with a significant volume of trauma patients are likely partners. EMS Regions, working with the GTCNC, must also establish a regional system to support a new trauma center.	Stable annual funding of $85 million (see Objective IA) will be necessary to support existing trauma centers as well as the new ones that are needed.	The number of new trauma centers established is the basic measure. The proportion of Georgia's population within one hour travel distance of a trauma center is another.	1. Continue to recruit new trauma centers in South Georgia. 2. Obtain adequate funding (IA), develop regionalized structure (IC), and establish Communication Center (ID).	
1. Partner With Regulatory Agency For Unified Plan To Bring On New Centers	Developing trauma centers is a major challenge and the GTCNC and OEMS/T will need to collaborate on a plan to do so. This should include the widespread development of Level IV trauma centers, or an equivalent.	GTCNC and OEMS/T, and ultimately hospitals with potential of becoming trauma centers.	Significant GTCNC staff time.	Development of a viable plan for new trauma center development and its effective implementation.	1. Work with OEMS/T to prepare a plan for new trauma centers. 2. Implement plan.	
2. Target Trauma Center Funding Utilizing Plan	Allocating scarce trauma system resources to foster the development of new trauma centers in regions with the greatest need will be difficult, but goes to the heart of the GT CMC mandate.	GTCNC and new trauma centers, as well as existing trauma centers	Significant GTCNC staff time.	The allocation of sufficient funds to foster the, center development, and their effective targeting.	1. Follow-through on targeting trauma Center funding at new trauma center development based upon plan.	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
3. Improve Trauma Care In All Hospitals & Develop Level IV Trauma Centers	All hospitals must be part of an inclusive trauma system to ensure optimal care for the injured. This will require a plan and incentives for their participation.	Key partners will be the Georgia Hospital Association and Georgia's hospitals.	Significant funding will be necessary to incentivize the participation of all hospitals in an inclusive trauma system.	An ideal measure would be the portion of hospitals that meet at least Level IV trauma center standards.	1. Prepare plan to foster the participation of all Georgia hospitals in the trauma system.	
C. Demonstrate Rigorous Accountability To Promote Excellence. A cutting edge performance based payment program has been established and is fostering the needed participation in trauma system development, injured patients' access to trauma care, meeting trauma center standards, and most importantly, patient outcomes.	The GTCNC has taken an aggressive approach to assuring accountability with the development of a performance based payment program and a trauma center auditing program. These will be strengthened along with the trauma center review process.	The key partners are the GTCNC and trauma centers, and ultimately the Georgia State Legislature and people of Georgia.	See below.	A key measure is a robust program for assuring trauma center accountability with respect to public funding that establishes a high degree of credibility among state policymakers.	See below.	
1. Maintain Performance Based Payment Program (PBP) For Trauma Centers	This program has been established and will complete its second year, and is experiencing a high degree of compliance by trauma centers. It is designed to steadily increase requirements over time.	The GTCNC and Georgia's trauma centers.	Funding for GTCNC staff time to administer the PBP is included in the administrative component of the GTCNC budget.	Measures include the operational effectiveness of this program, and the degree to which requirements are ramped up over time.	1. Maintain PBP program as planned. 2. Enhance PBP to become state performance evaluation model.	
2. Maintain Trauma Center Audit Program	An auditing program has been established to ensure that trauma centers accurately report trauma patients eligible for uninsured funding and their injury severity score.	The GTCNC, trauma centers, and the contracted auditing firm. The first year has evolved into a learning process for all involved.	Funding for contracted audit is part of the administrative component of the GTCNC budget.	The audit's effectiveness in determining trauma center compliance with regulations, and trauma center compliance with regulations.	1. Add patient specific documentation to audit requirements. 2. Direct trauma centers to verify eligibility of reported patients.	
3. Partner With Regulatory Agency For Unified Strategy And Plan For Trauma System Performance Improvement	During a long period of deep losses, Georgia trauma centers were not able to meet all standards, and state enforcement was relaxed to avert additional trauma center closures.	The Office of Emergency Medical Services/Trauma, and Georgia's trauma centers.	GTCNC and OEMS/T staff time to plan a more rigorous review process.	The number of deficiencies identified in the trauma center review process, and the number that are resolved due to the review process.	1. GTCNC and OEMS/T to collaborate on a plan for strengthening the trauma center review process.	
4. Institute Trauma Quality Improvement Program (TQIP) In Trauma Centers	TQIP was developed by the American College of Surgeons and is a cutting-edge tool for measuring trauma center outcomes.	Georgia's trauma centers and the American College of Surgeons. Georgia can be 1st to implement TQIP statewide	Significant funding is required for Georgia trauma centers to participate in TQIP.	Measuring trauma patient outcomes is the ultimate performance measure.	1. Become first state trauma system to participate in the American College of Surgeon's Trauma Quality Improvement Program	
E. Support Training Of Trauma Physicians For Future Needs. This task will address the essential challenge of strengthening trauma medical staff support in the face of declining numbers of surgical specialists interested in trauma care, especially in rural areas.	There are no simple solutions for addressing this problem. However, alternatives such as developing a corps of physician extenders and expanding trauma surgeon training/retraining should help.	Partners may include medical and nursing schools, the Georgia Board for Physician Workforce, Georgia COT, and Medical Association of Georgia.	Major funding should come from existing sources for clinical education, perhaps with seed funds from the GTCNC.	Measures will include trauma center shortages of key surgical specialists, and the supplier qualified trauma physician extenders.	1. Assess trauma physician needs and opportunities with the Medical Association of Georgia.	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
1. Support Rural Trauma Team Development Courses Statewide	Rural regions generally cannot support trauma specialists. Therefore it is essential in to train all available medical and nursing personnel in trauma care processes	Physicians and nurses and hospitals in rural regions, their EMS region, training organizations, and the GTCNC.	Significant funding would be required.	Initial measures would include number of personnel trained and corresponding development of trauma programs in local hospitals.	1. Continue piloting courses in Regions 5 & 6. 2. Develop plan for rural trauma team courses statewide. As	
2. Utilize Georgia COT To Identify Trauma Physician Training Opportunities	Trauma surgeons, who make up the Georgia Committee on Trauma, are most familiar with both the needs and potential sources regarding trauma medical personnel.	Georgia Committee on Trauma.	No funding implications.	Participation in Georgia COT, and COT support of trauma system needs.	1. Encourage Trauma Medical Director membership In the Georgia COT. 2. Engage COT in assessing needs and identifying solutions (see II. E.)	
III. Strengthen Emergency Medical Services. Due to the integral relationship between EMS and trauma care, the Commission has placed a major emphasis on strengthening EMS. Major initiatives include support for readiness, resources targeted at rural regions, a GPS/Automatic Vehicle Locator System, and performance based payment. The goal is to fully develop an integrated, statewide EMS/Trauma system that assures high quality emergency care for all.						
A. Support Equipment, Training & Financial Needs. Previous support for ambulance purchases to replace aging vehicles was successful in meeting a priority EMS need. This approach should be continued.	Georgia is largely a rural state with 160 local EMS systems, many with insufficient population bases to support basic EMS readiness and operations.	The GTCNC and EMS stakeholders represented by the EMS Subcommittee.	The GTCNC budget has been reduced drastically, requiring prioritization of EMS's most essential needs.	A key milestone will be the prioritization of EMS needs. Other measures will be developed in objective III E below.	1. Assess EMS equipment and training needs in conjunction with the EMS subcommittee. 2. Fund most essential needs.	
1. Utilize EMS Subcommittee On Trauma For EMS Needs Identification	Buy in from local EMS providers will only come if their true needs are met, and only they know what they are.	The GTCNC and EMS stakeholders represented by the EMS Subcommittee.	No funding implications.	A constructive plan produced by the EMS Subcommittee on Trauma.	1. Request EMS needs assessment from EMS Subcommittee on Trauma.	
2. Encourage RTAC Assessment Of Each Region's EMS Needs	At the local regional level, all system participants should be engaged in determining EMS needs through the RTAC structure.	RTAC's in collaboration with their stakeholders and EMS. When you will	A needs assessment is a basic RTAC function with no new funding implications		1. Assess EMS needs in Regions 5, 6 & 9 through RTACs. 2. Expand to other RTACs as they develop.	
C. Build GPS Automatic Vehicle Locator System With GEMA in conjunction with the Trauma Communication Center and disaster and preparedness programs.	Knowing where an EMS unit is located is essential to determining destinations that best meets patient needs.	EMS, GEMA, Trauma Communication Center, Georgia Tech, and GHA.	Funding is from homeland defense sector.	Development milestones and efficient use of EMS ground and air resources	1. Continue AVLS development with GEMA. 2. Implement GPS AVLS statewide.	
1. Identify Best Use And Incorporate AVLS System Into The Trauma Communications Center	The benefits of AVLS will be enhanced when integrated into the Trauma Communications Center.	GEMA, GTRI, GTCNC.	There may be small funding implications.	The degree to which AVLS is used by the T him rauma communication Center.	1. Define plan for integrating AVLS with Trauma Communication Center.	
D. Foster Optimal Use Of Rural EMS Resources. This will include training of first-responders, arranging for adequate air transport, and consolidation of local EMS systems.	The optimal use of available resources should be the first priority in addressing rural EMS resource scarcity.	Local EMS systems, EMS Regions, and the GTCNC.	Some funding will be required and needs will need to be assessed.	Development milestones, measures will include patient outcomes and transport time to definitive care.	See below.	
1. Utilize RTACs To Identify Need And Foster Adequate Air Transport Services Throughout State	The availability of air medical transport is very limited in South Georgia where there is a high need due to inadequate trauma center capacity.	The GTCNC, EMS, trauma centers and air medical transport providers.	A regulatory approach to ensuring full coverage of air medical transport should be considered before funding.	The availability of air medical transport, and time from the scene to definitive trauma care for the seriously injured.	1. Assess Georgia's needs for air medical transport in conjunction with air transport providers. 2. Prepare plan for full state coverage.	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
2. Utilize RTACs To Foster Efficiency of Local EMS Systems	Due to a political anomaly, Georgia has 160 counties, each with its own EMS system, creating opportunities for regional pooling, sharing, coordinating, etc. of EMS resources.	The GTCNC, EMS Regions and local EMS systems.	Funding of restructuring costs will need to be considered as a financial incentive.	The cost-effectiveness of small EMS systems in Georgia.	1. Assess opportunities in Regions 5, 6 & 9 to improve EMS resource use efficiency through integration of local EMS systems.	
E. Implement Performance Based Payment To Promote Excellence. The approach taken with trauma centers will be replicated with EMS.	Public funding requires a high degree of public accountability. The GTCNC is taking a proactive approach and is ready to extend it to EMS.	The GTCNC and EMS.	This project would require a small amount of funding.	A robust program for assuring EMS accountability with respect to public funding.	1. Develop plan for performance based payment to EMS that dovetails with state performance evaluation guidelines.	
1. Develop And Utilize EMS Funding Audit Program	The trauma center audit has proven essential in ensuring that funds are spent appropriately.	GTCNC, EMS and the state of Georgia.	This project would require a small amount of funding.	An effective audit that assures EMS accountability regarding expenditures.	1. Develop EMS funding audit program.	
IV. Build Essential Trauma System Components, to include a telemedicine system, pediatric trauma subsystem, integration with burn and rehabilitation care, data-based system design, injury prevention and disaster preparedness.						
A. Build Trauma Telemedicine System. This will make scarce trauma subspecialty surgical resources available to rural regions in a highly cost-effective manner. It can also support patient stabilization and definitive care in local emergency departments.	Telemedicine is relatively strong in Georgia, and it is being added to trauma care initially on a pilot basis. Other potential uses are multi-facility QA and disaster response.	GTCNC, GA Partnership for TeleHealth; MCG, Level I trauma centers and rural hospitals.	Federal grants will buy equipment & health insurer payment will be sought for consults. Some planning funding may be needed.	Pilot program's physician participation is initial measure, its replicability in other regions is next, and ultimately it will be patient outcomes.	1. Finish pilot program with Georgia TeleHealth. 2. Form GTCNC Telemedicine Workgroup. 3. Steadily expand system statewide.	
B. Enhance Pediatric Trauma Subsystem. Georgia enjoys a strong complement of pediatric trauma centers, which are collaborating on optimizing pediatric trauma care throughout the state.	The GTCNC Pediatric work group has been very active in establishing a pediatric trauma subsystem.	CHOA, all peds trauma centers, all trauma centers, all hospitals and EMS led by the GTCNC pediatric work group.	There are a variety of possible funding sources for pediatric trauma initiatives in addition to the GTCNC.	Program development milestones and improved pediatric trauma patient outcomes.	1. Identify additional opportunities to strengthen pediatric trauma care in Georgia.	
1. Fully Implement eBraselow System With EMS And Hospitals	The eBraselow system provides standardized information and equipment that enhances the emergency resuscitation of babies and children.	Pediatric trauma centers, trauma centers, hospitals and EMS led by the GTCNC pediatric work group.	Funding provided by grant from _____.	Outcomes for babies and children in need of resuscitation.	1. Continue implementing with pediatric trauma centers, all trauma centers and all hospitals and EMS, with an initial focus on EMS Regions 5, 6 & 9.	
C. Assess Burn Care & Rehabilitation Issues. Integrating rehabilitation and burn centers into Georgia's trauma system will help assure optimum care through the full continuum for all trauma victims, and appropriate use of these costly healthcare resources.	A key issue is cost, particularly when GTCNC's funding has been reduced by 80%. Other issues are the capacity, viability and access to burn and rehabilitation centers.	See below.	Funding implication can be substantial, although other states provide little support for these sectors.	Patient access to care. Reduction of days Medicaid/uninsured patients are in trauma centers rather than rehabilitation facilities.	See below.	
1. Assess Burn Care Needs For Georgia	As with Georgia's trauma centers, the capacity in relation to need and financial viability of Georgia's burn centers needs to be assessed.	The GTCNC and Doctors Hospital in Augusta and Grady Hospital in Atlanta, Georgia's two burn centers.	Any funding should be based on need.	Burn center capacity and financial viability will be initial measures, and ultimately burn patient outcomes.	1. Assess the financial viability of Georgia's burn centers and their capacity in relation to need	

STRATEGY/OBJECTIVES	KEY ISSUES	PARTNERS	FUNDING	MEASURES	FY 2011-2012 TASKS	FUTURE TASKS
2. Assess Rehabilitation Needs for Georgia	Without access to rehabilitation, patients remain in high cost trauma centers without the care they need and occupy scarce trauma beds.	GTCNC and Georgia's rehabilitation centers and trauma centers.	Funding should provide access to patients who otherwise will remain in a high-cost trauma center.	The number of patients occupying trauma center beds who could have been transferred to rehabilitation.	1. Assess Georgia trauma center issues with indigent patients needing transfer to a rehabilitation center.	
D. Utilize Injury Data To Drive System Development Decisions. This will involve a plan to fully develop and utilize data in defining the system, including trauma registry data.	Trauma care has an exceptionally strong tradition with an evidence-based approach to developing internal systems of care. The Georgia Trauma System is using the same approach.	All stakeholders and the OEMS/T, Centers for Disease Control, American College of Surgeons, and other potential data partners.	Primarily a coordination issue, GTCNC staff time and some planning support will be required.	The key measure will be whether the GTCNC can support its decisions on system design with data.	1. Prepare plan to strengthen statewide trauma registry/data system. 2. Prepare plan to fully develop and utilize data in defining trauma system. 3. Focus on performance measures.	
1. Utilize DPH Trauma Epidemiology Services	DPH epidemiology support can enable the GTCNC to effectively tap a range of data sources in the public health arena.	The Georgia Department of Public health and GTCNC.	Minimal funding implications.	The degree to which GTCNC is able to utilize DPH epidemiology support.	1. Develop plan to utilize DPH epidemiology services.	
2. Incorporate Trauma Communications Center Data In Decision Process	After implementation, the Trauma Communications Center will produce essential data on trauma patient care and provider performance.	Trauma Communication Center and GTCNC.	Minimal funding implications.	The degree to which GTCNC is able to utilize Trauma Communication C him and enter data.	1. Develop plan to incorporate Trauma Communication Center data in GTCNC decision process.	
E. Assist In Initiatives to Reduce Traumatic Injury. The first goal is for the Georgia state trauma system that is an active partner in a statewide coordinated system for reducing injury-related morbidity and mortality.	Reducing injury is the holy grail of trauma care, and trauma centers have a specific responsibility to do so. The GTCNC will take a coordinated, collaborative approach statewide.	Collaborative partners will include trauma centers, injury prevention groups like Georgia SafeKids and data sources like the CDC.	Major funding will be from existing sources for injury prevention including GTCNC readiness funding to trauma centers.	Program development milestones and a documented reduction in injury due to trauma system initiatives.	1. Form Commission workgroup to develop statewide initiative. 2. Work with CDC to define data based injury prevention targets. 3. Collaboratively develop strategic plan for significantly reducing injury.	
1. Partner With State And Federal Injury Prevention (IP) And Risk Reduction (RR) Programs	Federal injury prevention resources are headquartered in Atlanta at the CDC and state resources reflect a state goal of reducing loss of life and injury on Georgia's roads.	All federal and state injury prevention resources should be identified for collaboration	Minimal funding should be required to tap available to injury prevention resources	The extent to which federal and state resources are utilized.	1. Prepare plan to partner with state and federal IP and RR programs.	
2. Encourage RTACs To Assess And Address Regional IP And RR Needs	RTACs are positioned to monitor unique regional causes of injury and proactively seek to mitigate them.	RTACs and a regional stakeholders along with injury prevention programs.	Funding requirements will need to be determined.	The extent to which RTACs address regional IP and RR needs.	1. Work with Regions 5, 6 & 9 to assess IP and RR needs. 2. Assist regions in collaborating with IP programs to address local needs.	
F. Integrate Trauma System with Disaster/Terror Response. The GTCNC has made a major commitment to Georgia's homeland security and disaster preparedness with the EMS AVLS system and the Trauma Communication Center.	One of the most cost-effective GTCNC initiatives is integrating systems being developed for trauma care, which are tested and operate daily, with Georgia's homeland security and disaster response.	Partners will include GEMS, GTRI, GEMA, GHA, Office of EMS/Trauma, federal agency partners, and Georgia TeleHealth.	Major funding will be from existing sources for disaster preparedness, telemedicine, and the GTCNC (Trauma Communications Center).	The value the GTCNC can add to disaster response.	See below.	
Utilize Trauma Communications Center and AVLS as assets for statewide incident response to mass casualties and medical surge.	See above.	Above and GTCNC and Trauma Communications Center.	See above.	The extent to which the Trauma Communications center and AVLS are used in disaster response.	Prepare plan for utilizing Trauma Communications Center and AVLS in statewide incident response to mass casualties and medical surge.	

STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
I. Build Basic Trauma System Infrastructure	1						
A. Obtain Adequate Trauma System Funding. Without an adequate and stable funding mechanism, trauma system development will be constrained, the ability of existing trauma centers to maintain strong programs weakened, and prospects for recruiting new trauma centers where they are most needed will be further diminished.		1. Stay the course on planning and developing the best possible trauma system for Georgia. 2. Communicate progress to Georgia and its Legislature. 3. Assess four year old SB 60 and recommend changes to legislature.				Efficiently and effectively deliver health care programs	
1. Communicate Progress on Trauma System Development To The Legislature		1. The GTCNC recently reconstructed its website. The next step will be a social marketing system using Facebook, You Tube, Twitter, etc. to network with its stakeholders and all of Georgia. 2. A variety of states have developed "trauma foundations" to support the work of their statewide Trauma Commissions. The GTCNC will explore this concept.					
2. Communicate With All Georgia On Trauma System Development							
3. Support Full Implementation Of Super Speeder Law		1. Connect with Georgia police and sheriff organizations to determine how the GTCNC may be most helpful. 2. Plan and carry out such tactics, and promote their work through objectives 1 & 2 above.				Reduce loss of life and injury on Georgia's roads	
B. Continue Developing Strong Stakeholder Support Structure by enhancing collaboration with EMS and Trauma Program Managers and expand collaboration to trauma surgeons, emergency physicians and hospitals.		1. Enhance collaborative relationships with EMS community and trauma program managers with additional initiatives that strengthen the trauma system.					
1. Expand Collaboration with Trauma Medical Staff		1. Discuss opportunities with the Georgia					

STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
and Hospitals.		Committee on Trauma, Georgia College of Emergency Physicians, and the Georgia Hospital Association. 2. Define collaborative plans.					
C. Develop Trauma System Regionalization. This is one of the major components of the trauma system infrastructure. It requires collaboration at and between all levels, and essentially will be pursued by implementing the Georgia Trauma System "Framework."		1. Continue working with EMS Regions 5, 6 & 9 to pilot trauma system development activities. 2. Bring new GTCNC and regional staff on board.				Efficiently and effectively deliver health care programs	Staff
1. Coalesce Stakeholders & Form Regional Trauma Advisory Councils		As defined by EMS Regions 5, 6 & 9.					
2. Implement Georgia Trauma System "Framework"		As defined by EMS Regions 5, 6 & 9.					
D. Develop Trauma Communications Center Statewide. Another pillar of the Georgia Trauma System, it will use state-of-the-art technology to streamline trauma patient triage, transfer and transport. It can redirect patients throughout the state should one or more facilities become saturated.		1. Finish developing statewide communication center. 2. Consider developing mobile app for EMS that would augment/extend the trauma communication center concept.				Efficiently and effectively deliver health care programs Reduce loss of life on roads	
1. Establish Central Communications Hub With State-Of-Art Technology		1. Establish Communication Center facility, equipment and staffing. 2. Adapt SAAB system to Georgia and implement.					IS, Staffing, Facility
2. Collaboratively & Sequentially Implement System By Region		1. Implement Georgia Trauma System Framework in EMS Regions 5, 6 & 9. 2. Implement Trauma Communication in EMS Regions 5, 6 & 9.					

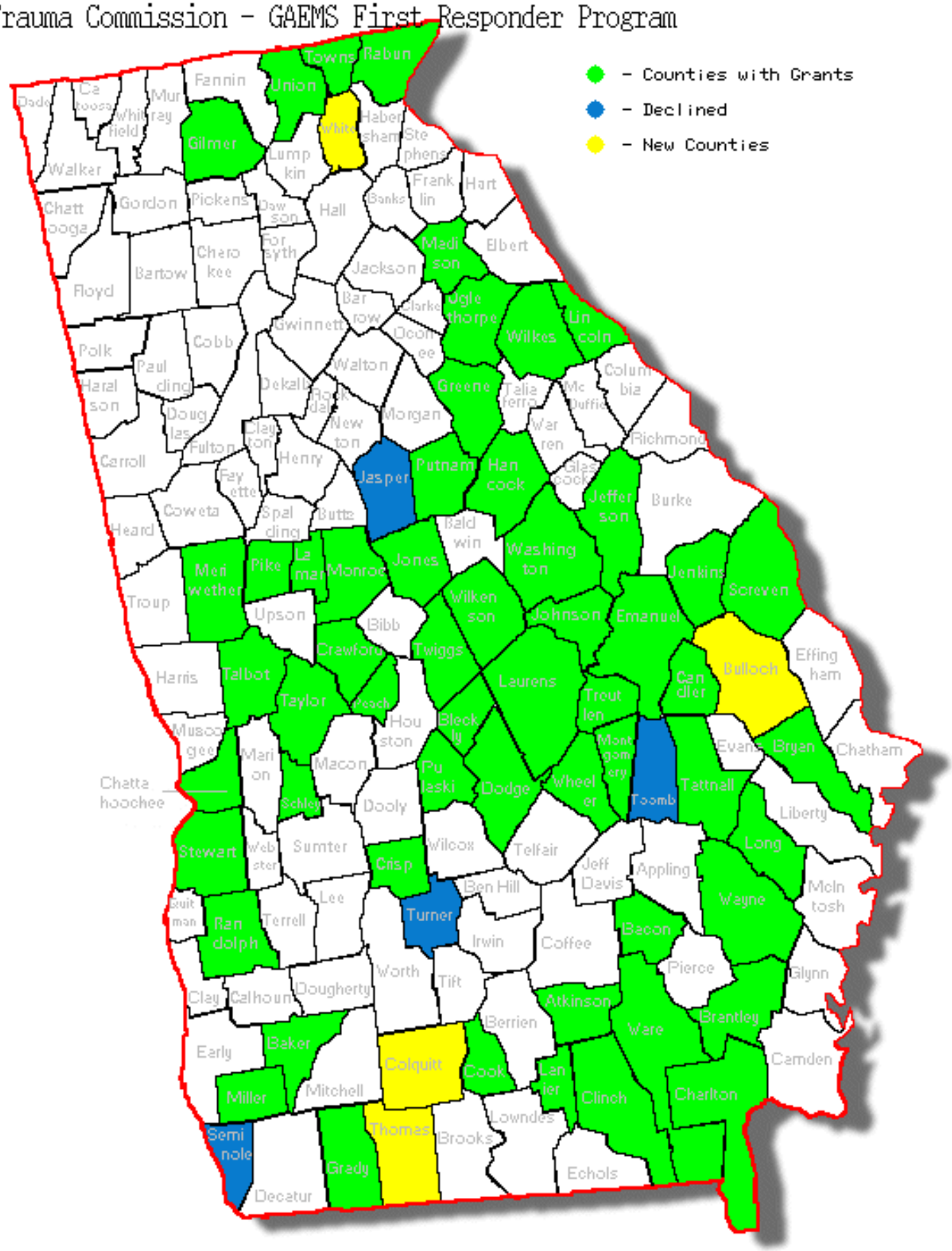
STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
3. Integrate With Adjacent State Trauma Systems		1. Prepare initial plan for integrating trauma system across state lines.					
E. Enhance Strategic Planning, Budgeting and Performance Evaluation to demonstrate a commitment to excellence in accountability and to meet state regulations and guidelines.		1. Meet state strategic planning guidelines. 2. Meet state performance evaluation guidelines. 3. Meet state budgeting requirements.				Efficiently and effectively deliver health care programs	
II. Expand Trauma Centers To Meet Georgia Needs	**2**						
A. Maintain Georgia's Trauma Centers to prevent further closures, and strengthen them so they can meet state standards. All trauma centers participating in 2007 have maintained their designation, two have upgraded their status, and four new centers have been designated.		See objective IA - Obtain Adequate Trauma System Funding.				Efficiently and effectively deliver health care programs	
B. Foster Development Of New Trauma Centers Where Needed. South Georgia is the pilot region for the Commission's trauma system development activities with a special focus on trauma center development efforts.		1. Continue to recruit new trauma centers in South Georgia. 2. Obtain adequate funding (IA), develop regionalized structure (IC), establish Communication Center (ID).				Efficiently and effectively deliver health care programs Reduce loss of life on roads	
C. Demonstrate Rigorous Accountability To Promote Excellence. A cutting edge performance based payment program is fostering the needed participation in trauma system development, injured patients' access to trauma care, meeting trauma center standards, and most importantly, patient outcomes.		See below.				Efficiently and effectively deliver health care programs	
1. Maintain Performance Based Payment Program		1. Maintain PBP program as planned.					

STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
(PBP).		2. Become first state to participate in the American College of Surgeon's Trauma Quality Improvement Program 3. Enhance PBP to become state performance evaluation model.					
2. Maintain Trauma Center Audit Program		1. Add patient specific documentation to audit requirements. 2. Direct trauma centers to verify eligibility of reported patients.					
3. Strengthen Trauma Center Review Process		1. GTCNC and OEMS/T to collaborate on a plan for strengthening the trauma center review process.					
D. Improve Trauma Care In All Hospitals, since often the most important treatment is that provided in the local hospital that initially receives the seriously injured trauma patient.		1. Prepare plan to foster the participation of all Georgia hospitals in the trauma system.				Efficiently and effectively deliver health care programs	
E. Support Training Of Trauma Physicians For Future Needs. This task will address the essential challenge of strengthening trauma medical staff support in the face of declining numbers of surgical specialists interested in trauma care, especially in rural areas.		1. Assess trauma physician needs and opportunities with the Medical Association of Georgia.					
III. Strengthen Emergency Medical Services.	**3**						
A. Support Equipment And Training Needs. Previous support for ambulance purchases to replace aging vehicles was successful in meeting a priority EMS need. This approach should be continued.		1. Assess EMS equipment and training needs in conjunction with the EMS subcommittee. 2. Fund most essential needs.				Efficiently and effectively deliver health care programs	
B. Support EMS Financial Needs. Previous direct support for uninsured patients should be considered with other alternatives.		1. Determine strategy for supporting EMS in a cost-effective manner. 2. Fund if possible.					
C. Build GPS Automatic Vehicle Locator System in conjunction with the Communication Center and disaster and preparedness programs.		1. Define plan for full development and integration with transfer system.				Efficiently and effectively deliver health care programs Promote emergency preparedness	IS

STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
D. Foster Optimal Use Of Rural EMS Resources. This will include training of first-responders, arranging for adequate air transport, and consolidation of local EMS systems.		See below.				Efficiently and effectively deliver health care programs	
1. Train First-Responders		1. Develop a plan for training first responders through EMS.					
2. Foster Adequate Air Medical Transport		1. Assess Georgia's needs for air medical transport in conjunction with air transport providers. 2. Prepare plan for full state coverage.					
3. Use Regions To Support EMS And Foster Maximize Use Of Scarce Rural EMS Resources		1. Assess opportunities in Regions 5, 6 & 9 to improve EMS resource use efficiency through integration of local EMS systems.					
E. Implement Performance Based Payment To Promote Excellence. The approach taken with trauma centers will be replicated with EMS.		1. Develop plan for performance based payment to EMS that dovetails with state performance evaluation guidelines.				Efficiently and effectively deliver health care programs	
IV. Build Essential Trauma System Components	**4**						
A. Build Trauma Telemedicine System. This will make scarce trauma subspecialty surgical resources available to rural regions in a highly cost-effective manner. It can also support patient stabilization and definitive care in local emergency departments.		1. Finish pilot program with Georgia TeleHealth. 2. Form GTCNC Telemedicine Workgroup. 3. Steadily expand system statewide.				Efficiently and effectively deliver health care programs	IS
B. Enhance Pediatric Trauma Subsystem. Georgia enjoys a strong complement of pediatric trauma centers, which are collaborating on optimizing pediatric trauma care throughout the state.		1. Identify additional opportunities to strengthen pediatric trauma care in Georgia.					
1. Fully Implement Braselow System With EMS And Hospitals		1. Continue implementing with pediatric trauma centers, all trauma centers and all hospitals and EMS, with an initial focus on EMS Regions 5, 6 & 9.					

STRATEGY/OBJECTIVES	PRIORITY	FY 2011-2012 TASKS	FY 2012-2013 TASKS	FY 2013-2014 TASKS	MEASURABLE OBJECTIVE	STATE GOAL	IS, STAFF, FACILITY
C. Assess Burn Care & Rehabilitation Issues. Integrating rehabilitation and burn centers into Georgia's trauma system will help assure optimum care through the full continuum for all trauma victims, and appropriate use of these costly healthcare resources.		See below.				Efficiently and effectively deliver health care programs	
1. Assess Burn Care Needs For Georgia		1. Assess the financial viability of Georgia's burn centers and their capacity in relation to need					
2. Assess Rehabilitation Needs for Georgia		1. Assess Georgia trauma center issues with indigent patients needing transfer to a rehabilitation center.					
D. Utilize Injury Data To Drive System Development Decisions. This will involve a plan to fully develop and utilize data in defining the system, including trauma registry data.		1. Prepare plan to strengthen statewide trauma registry/data system. 2. Prepare plan to fully develop and utilize data in defining trauma system. 3. Focus on performance measures.				Efficiently and effectively deliver health care programs	
E. Assist In Initiatives to Reduce Traumatic Injury. The first goal is for the Georgia state trauma system that is an active partner in a statewide coordinated system for reducing injury-related morbidity and mortality.		1. Form Commission workgroup to develop statewide initiative. 2. Work with CDC to define data based injury prevention targets. 3. Collaboratively develop strategic plan for significantly reducing injury.				Reduce loss of life on Georgia's roads Encourage healthy lifestyles through prevention	
F. Integrate Trauma System with Disaster/Terror Preparedness. The GTCNC has made a major commitment to Georgia's homeland security and disaster preparedness with the EMS GPS system and the Trauma Communication System.		1. Implement EMS GPS System With GTRI And GEMS. 2. Define disaster preparedness opportunities for Communications Center and telemedicine system.				Promote emergency preparedness for disasters or terrorism	

Trauma Commission - GAEMS First Responder Program



5-9-11

Brenda Fitzgerald, MD, Commissioner Nathan Deal, Governor
2 Peachtree St NW, 15th Floor
Atlanta, Georgia 30303-3142
www.health.state.ga.us

GEORGIA DESIGNATED TRAUMA & SPECIALTY CARE CENTERS

FACILITY	CITY	COUNTY	NUMBER
LEVEL I			
Atlanta Medical Center	Atlanta	FULTON	404-265-6577
Grady Memorial Hospital	Atlanta	FULTON	404-616-6200
Medical Center of Central Ga. Inc. *	Macon	BIBB	478-633-1584
Medical College of Georgia *	Augusta	RICHMOND	706-721-3153
Memorial Health Univ. Medical Center *	Savannah	CHATHAM	912-350-8861
LEVEL II			
Athens Regional Medical Center	Athens	CLARKE	706-475-3020
Floyd Medical Center	Rome	FLOYD	706-509-5000
Gwinnett Medical Center	Lawrenceville	GWINNETT	678-442-4321
Hamilton Medical Center	Dalton	WHITFIELD	706-272-6150
John D. Archbold Memorial Hospital	Thomasville	THOMAS	229-228-2834
Medical Center-Columbus	Columbus	MUSCOGEE	706-571-1081
North Fulton Regional Hospital	Roswell	FULTON	770-751-2559
LEVEL III			
Taylor Regional Hospital	Hawkinsville	PULASKI	478-783-0369
Walton Regional Medical Center	Monroe	WALTON	770-267-1781
LEVEL IV			
Lower Oconee Community Hospital	Glenwood	WHEELER	912-523-5113
Morgan Memorial Hospital	Madison	MORGAN	706-342-1667

FACILITY	CITY	COUNTY	NUMBER
Pediatric Trauma Centers (Designated Under Level II Criteria)			
Childrens Healthcare of Atlanta@ Egleston	Atlanta	DEKALB	404-785-6405
Childrens Healthcare of Atlanta @ Scottish Rite	Atlanta	FULTON	404-785-2275
Designated Burn Centers			
Joseph M. Still Burn Center	Augusta	RICHMOND	706-651-6399

* Designated Adult Level 1 Trauma Centers with Pediatric Commitment

(Updated 8-1-11)

Trauma Registry Part II

Presented By: Trauma Registry Team

August 11, 2011

Georgia Trauma Care Network Commission

Macon, Georgia

Presentation Outline

- Data Analyzed
- Length of Stay (LOS)
- Severity and Length of Stay
- Mechanism, Severity, and LOS
- Severity, LOS, and Disposition

Data Parameter

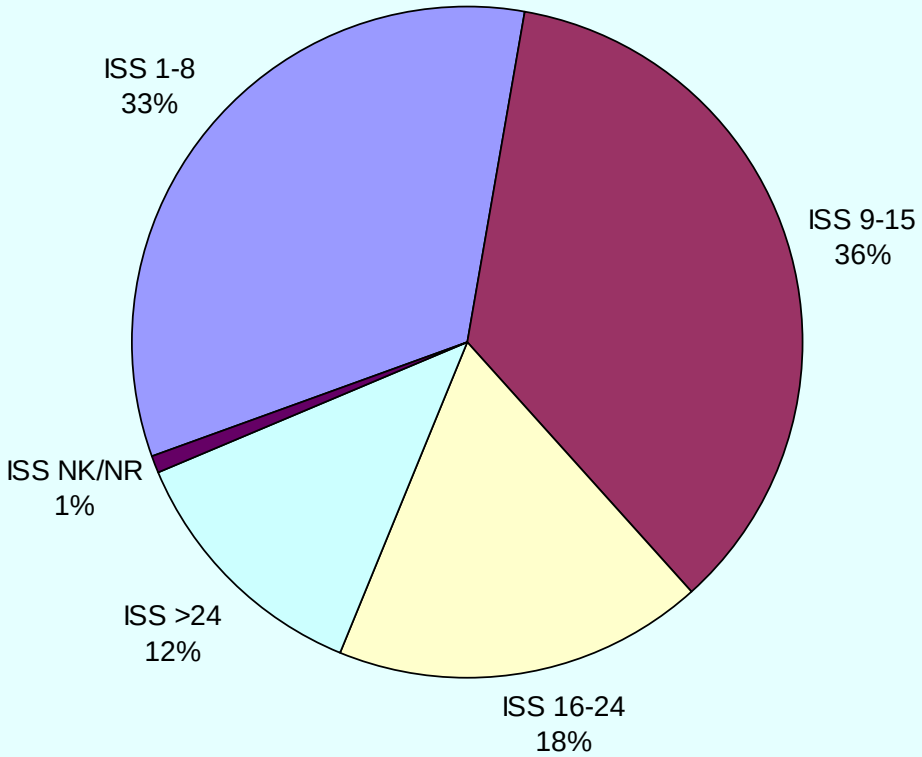
- Data Years 2004 – 2009
  - Provide stability
  - Include only ≥ 15 years of age
  - Exclude Death on Arrival (DOA)
  - Exclude Adverse Effect from Mechanism of Injury
  - Analysis based on the Dec 28, 2010 Download

Overall Length of Stay

	Male	Females
Hospital (Days)	4	5
ICU (Days)	3	3
ED (Hours)	4	5

Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

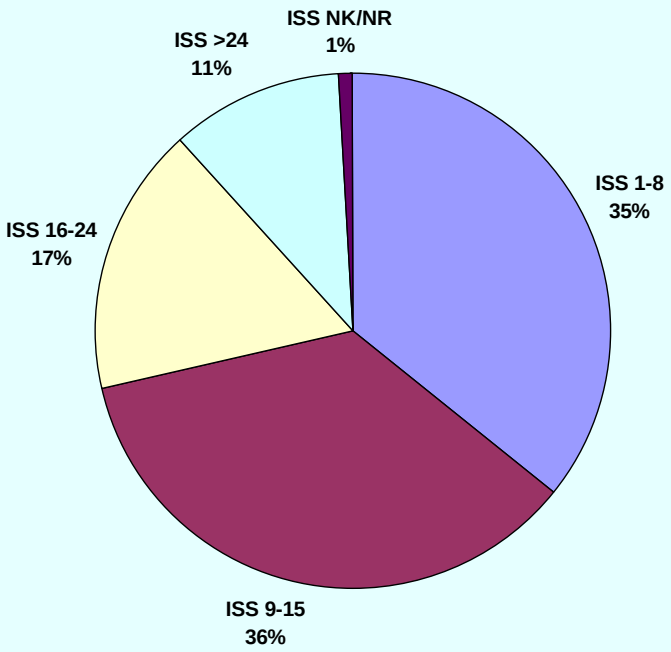
Overall Injury Severity Score



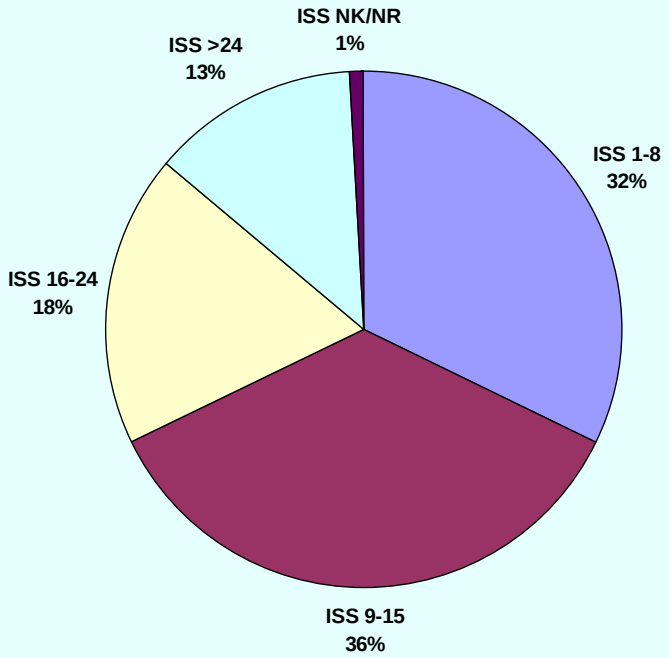
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Overall Injury Severity Score

Females

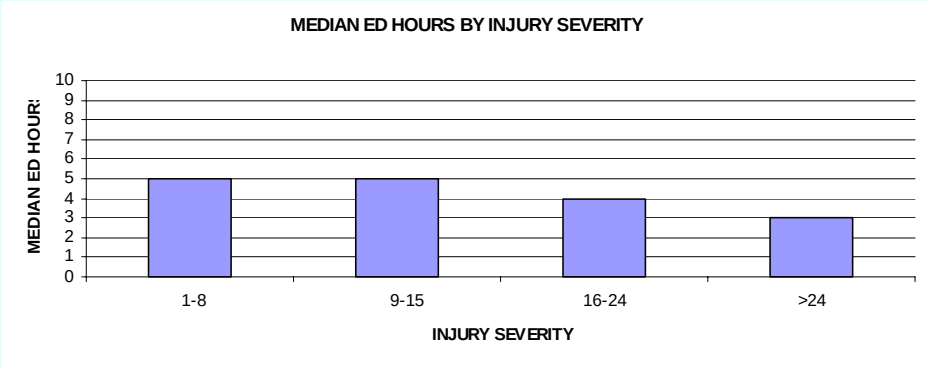


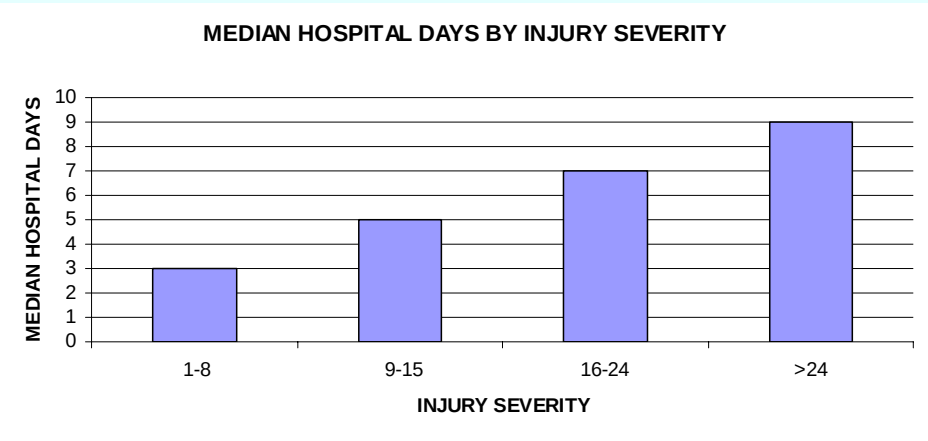
Males

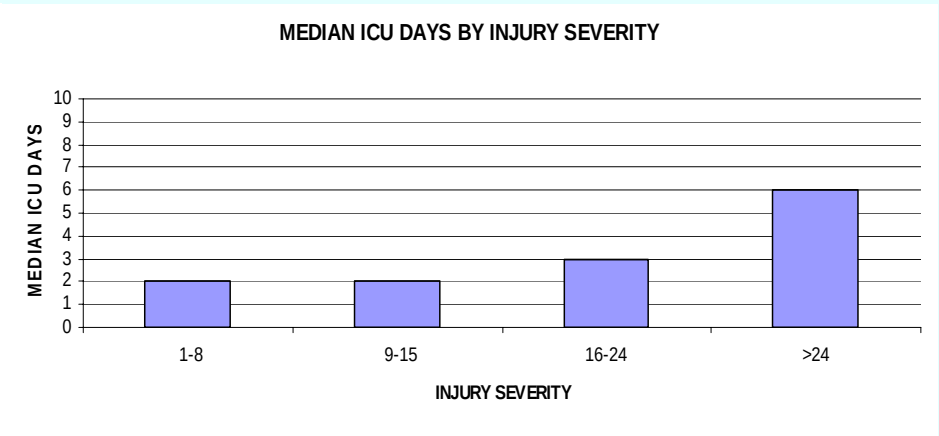


Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

LOS by Severity by Hospital Department



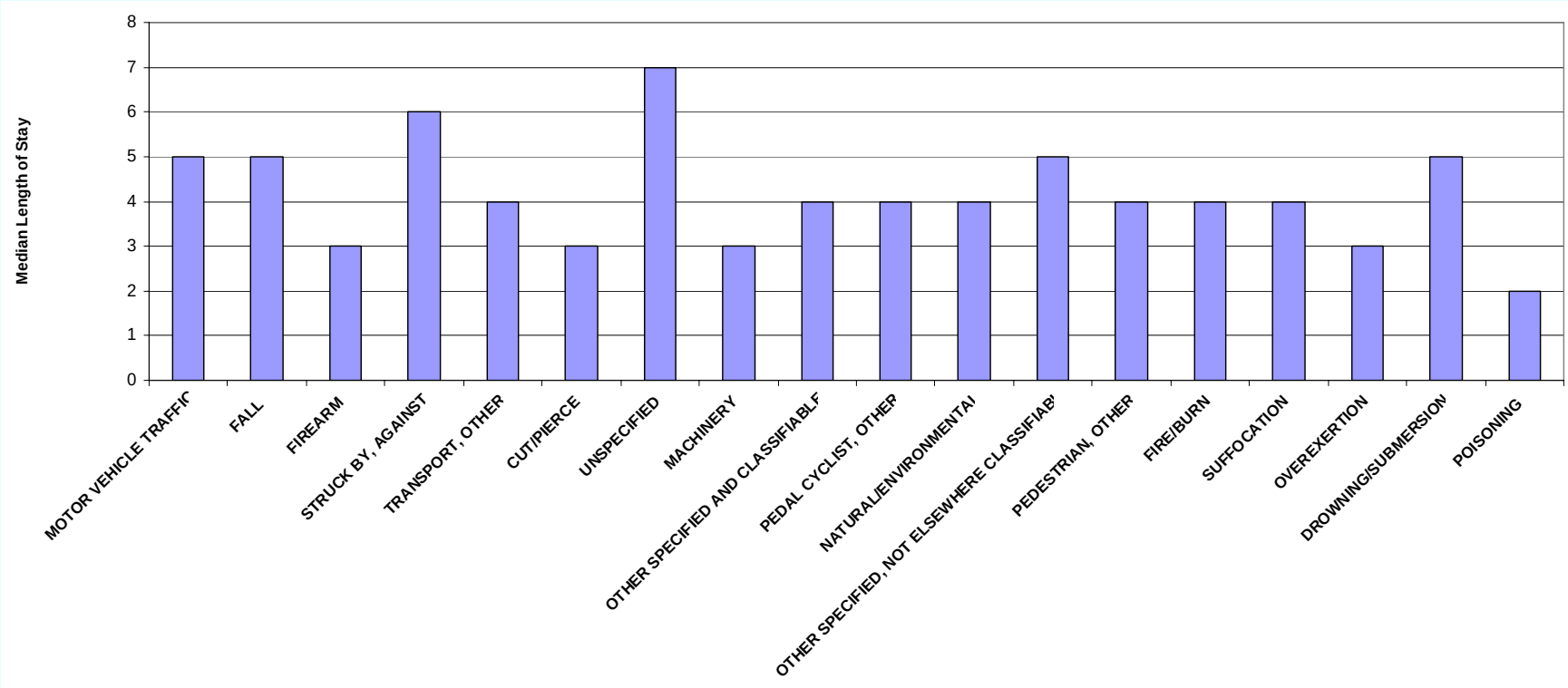




Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

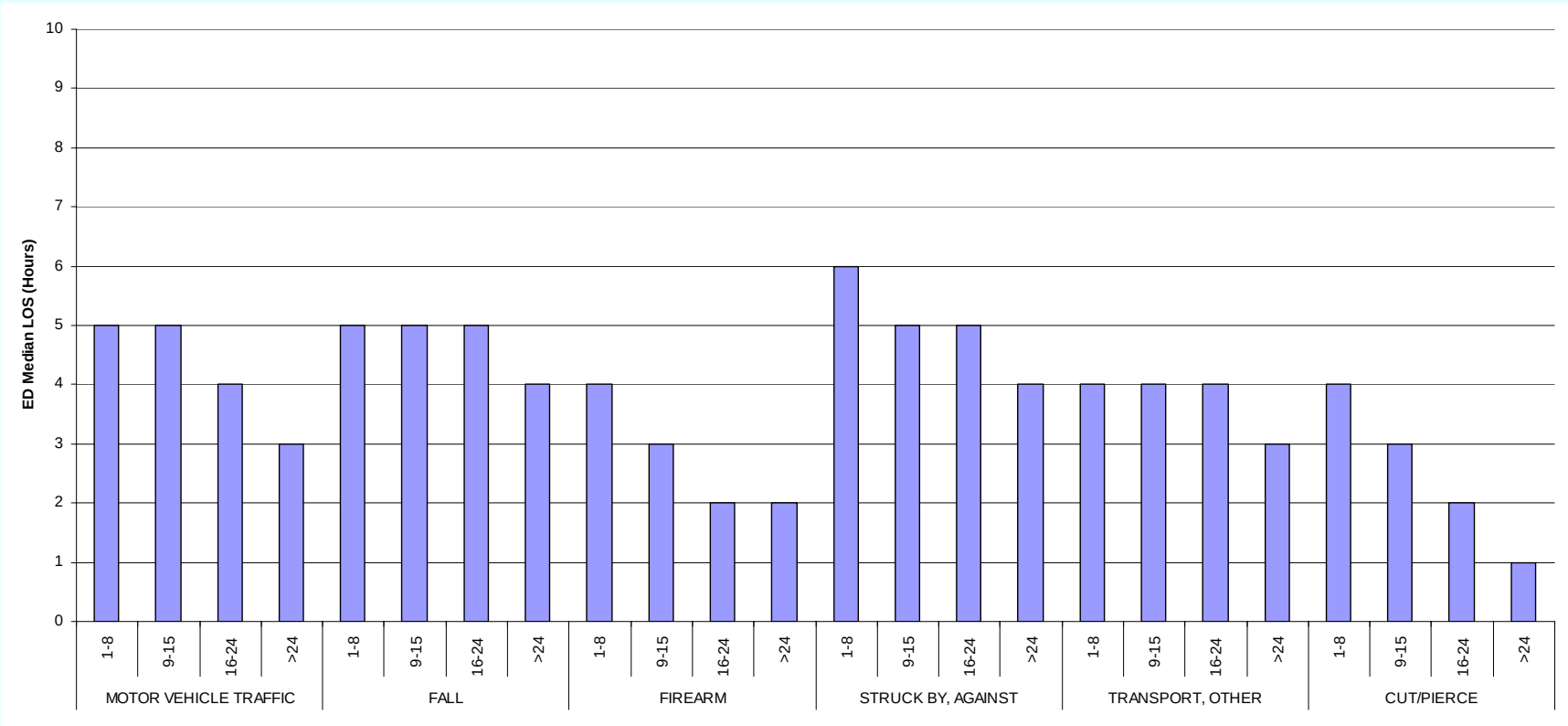
GA Trauma Registry Central Site

ED Length of Stay by Mechanism



Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

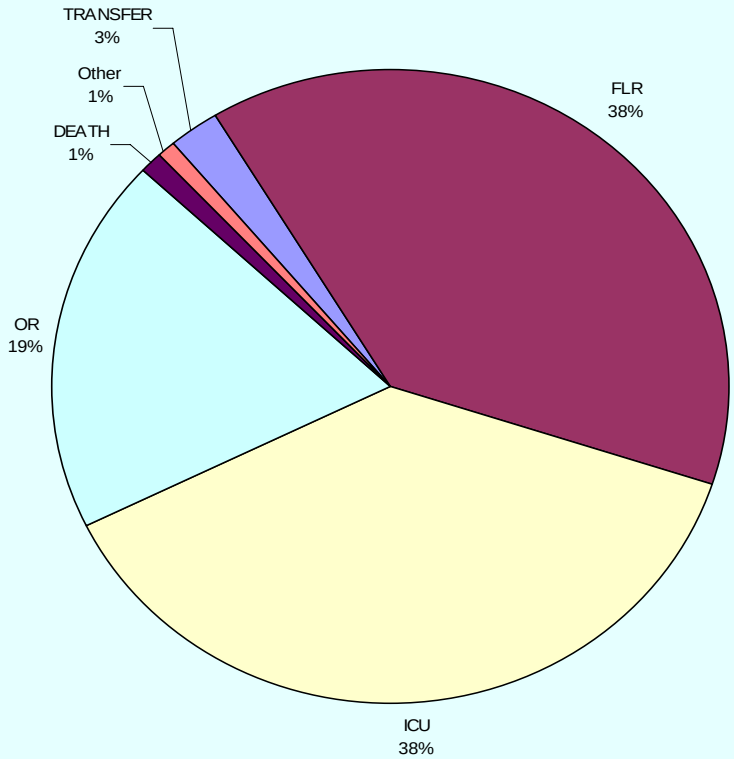
ED LOS by Mechanism and Severity



Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

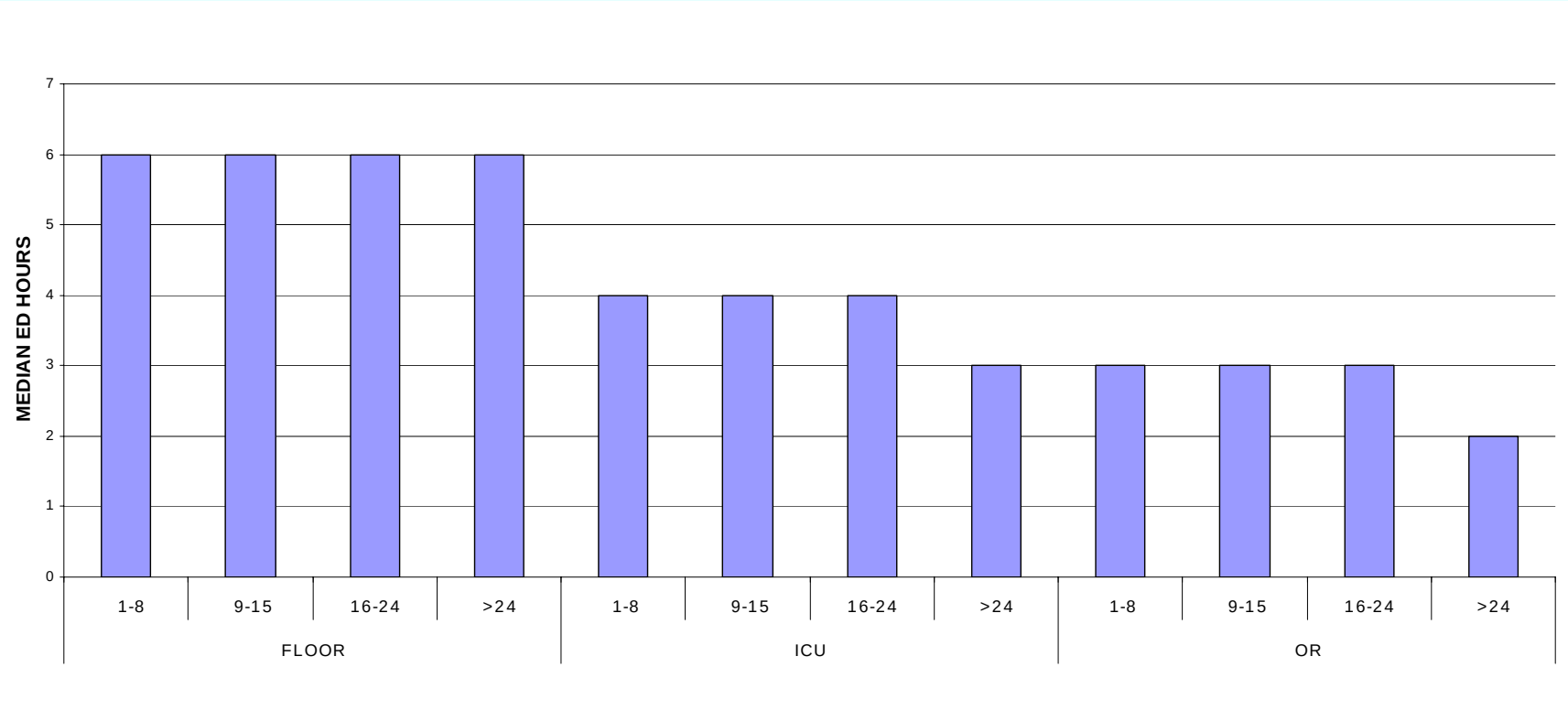
GA Trauma Registry Central Site

ED Disposition



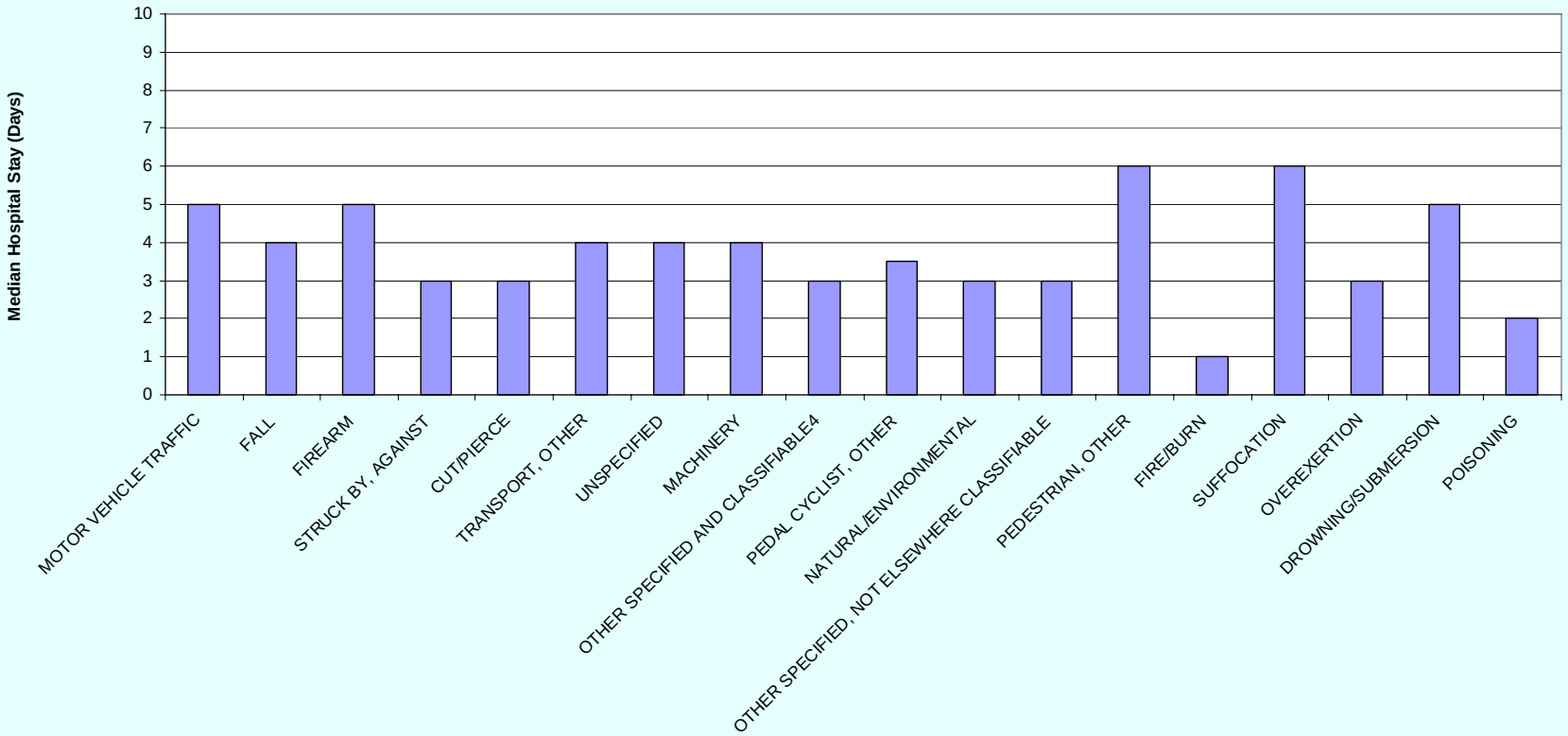
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

ED LOS by Severity and Disposition



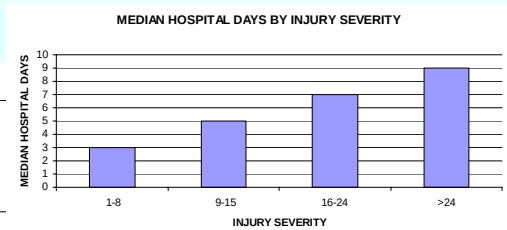
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at Hospital by Mechanism



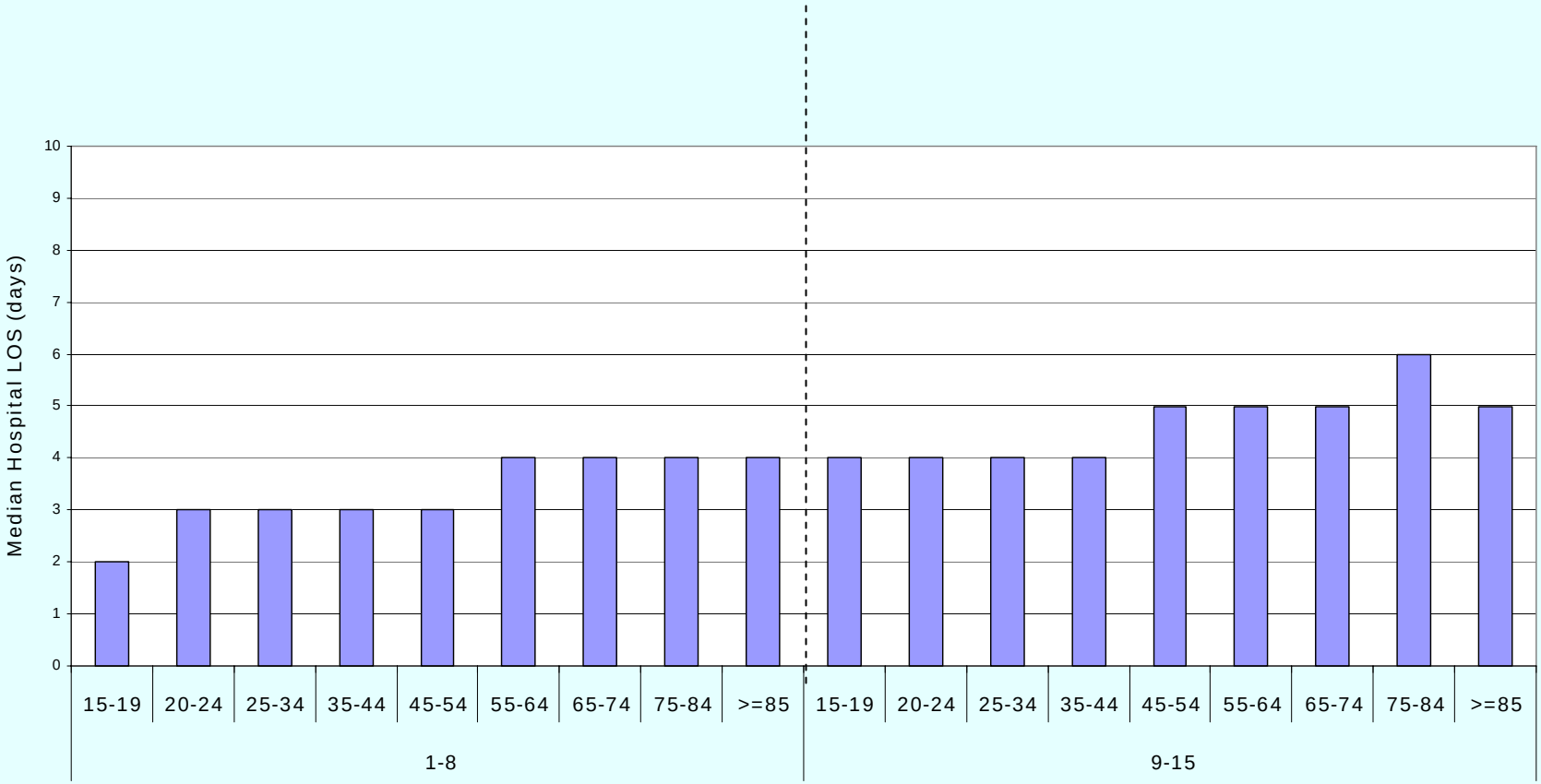
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at Hospital for the Top 6 Mechanism and Severity



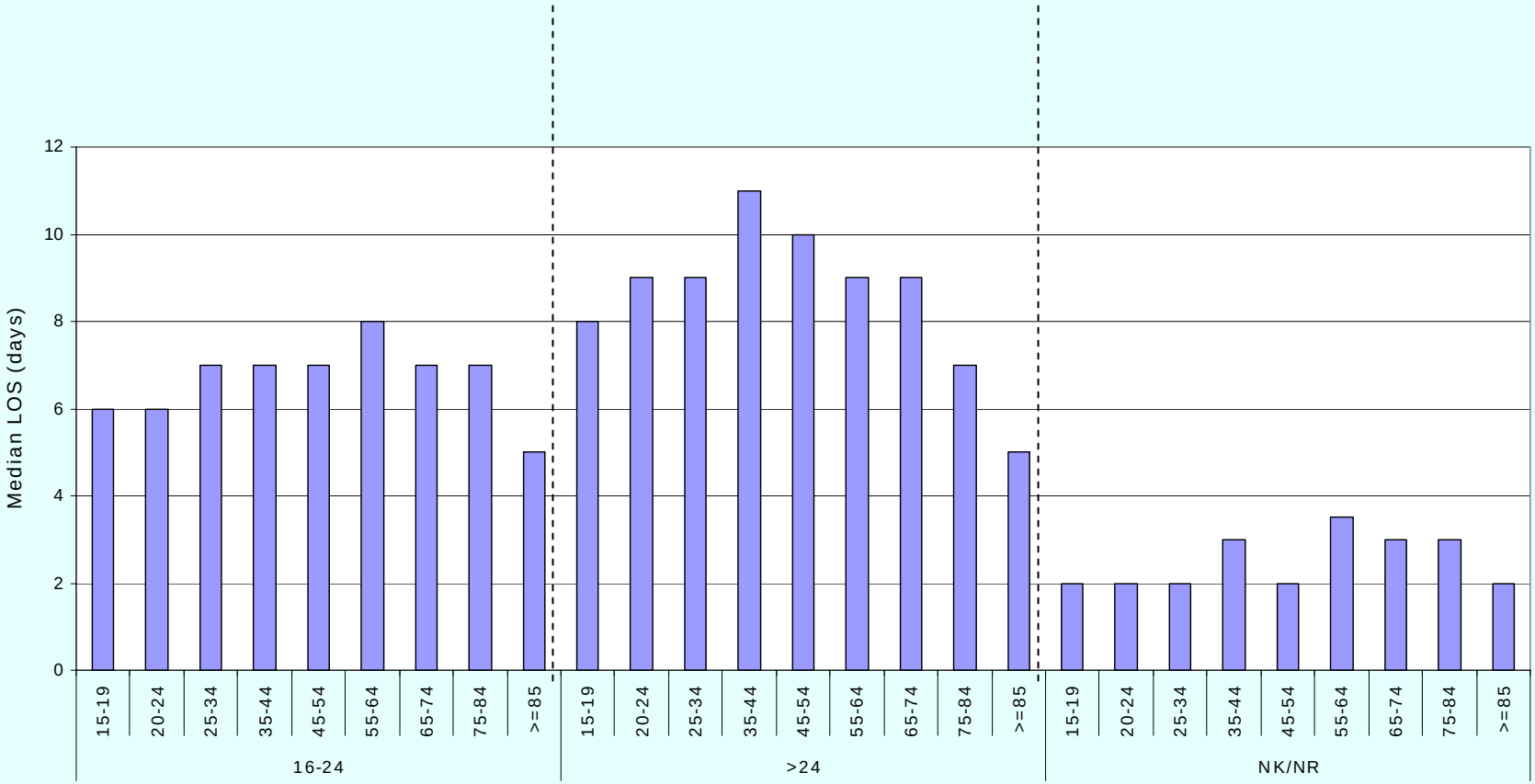
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at Hospital by Age Group and Severity



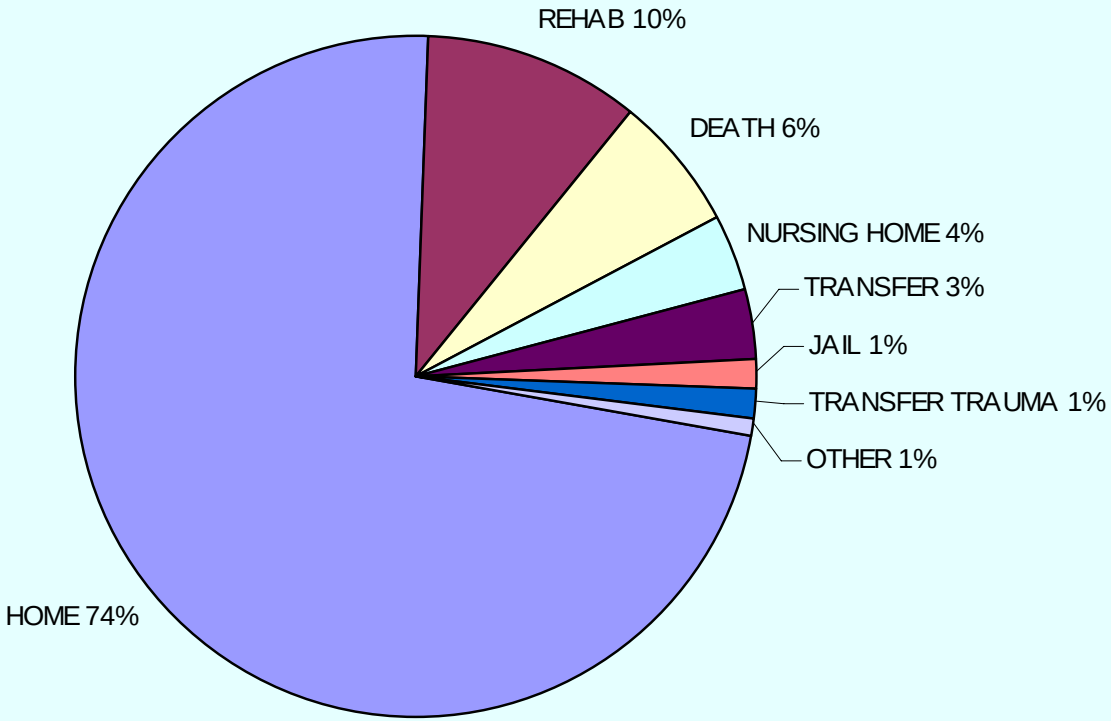
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at Hospital by Age Group and Severity



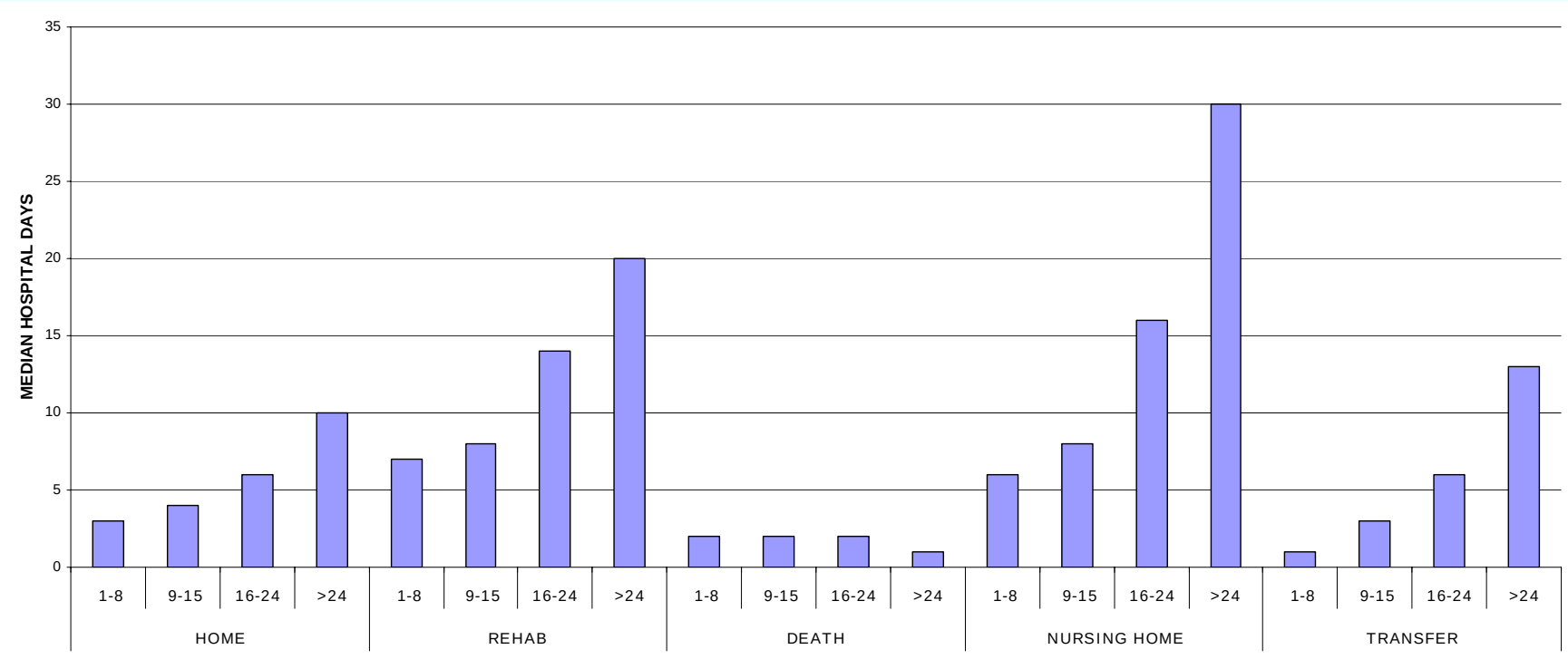
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Hospital Disposition



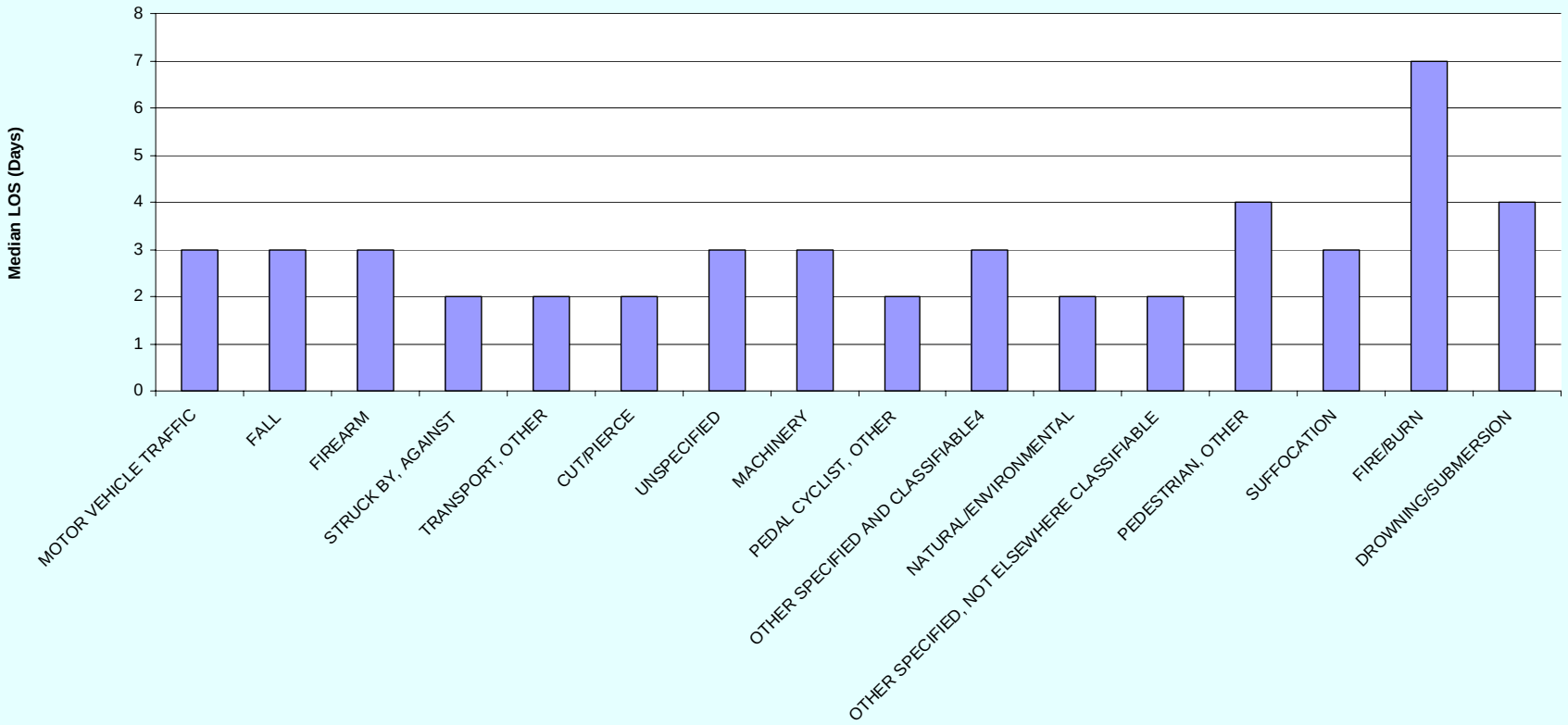
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at Hospital by Severity and Disposition



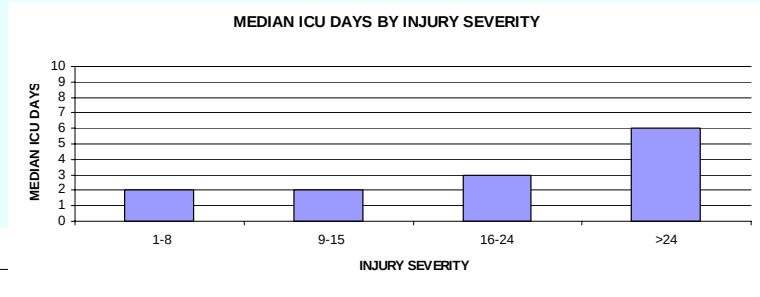
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

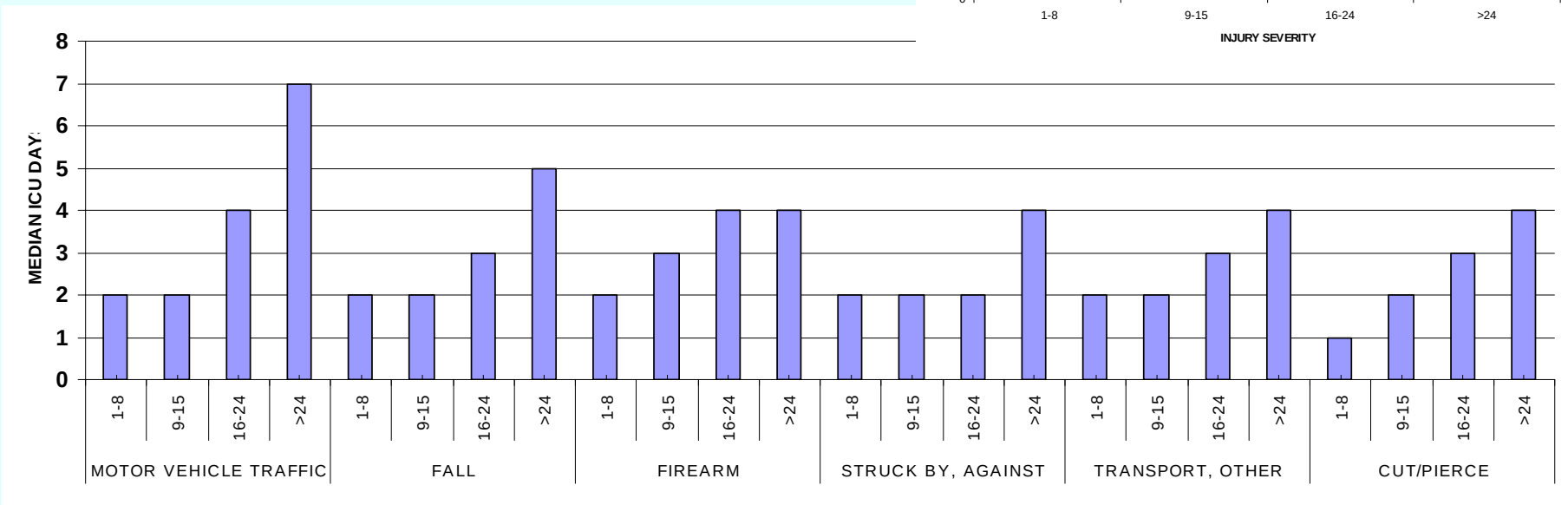
Median LOS at ICU by Mechanism



Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

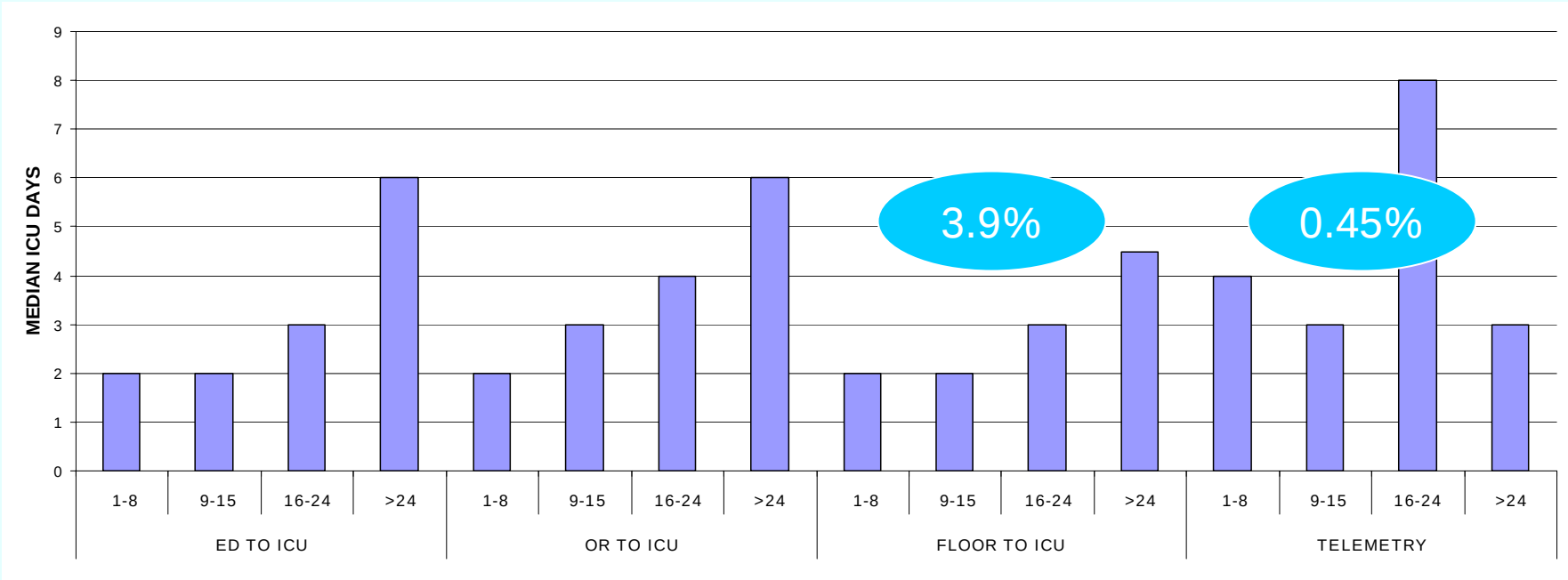
Median LOS at ICU by Mechanism and Severity





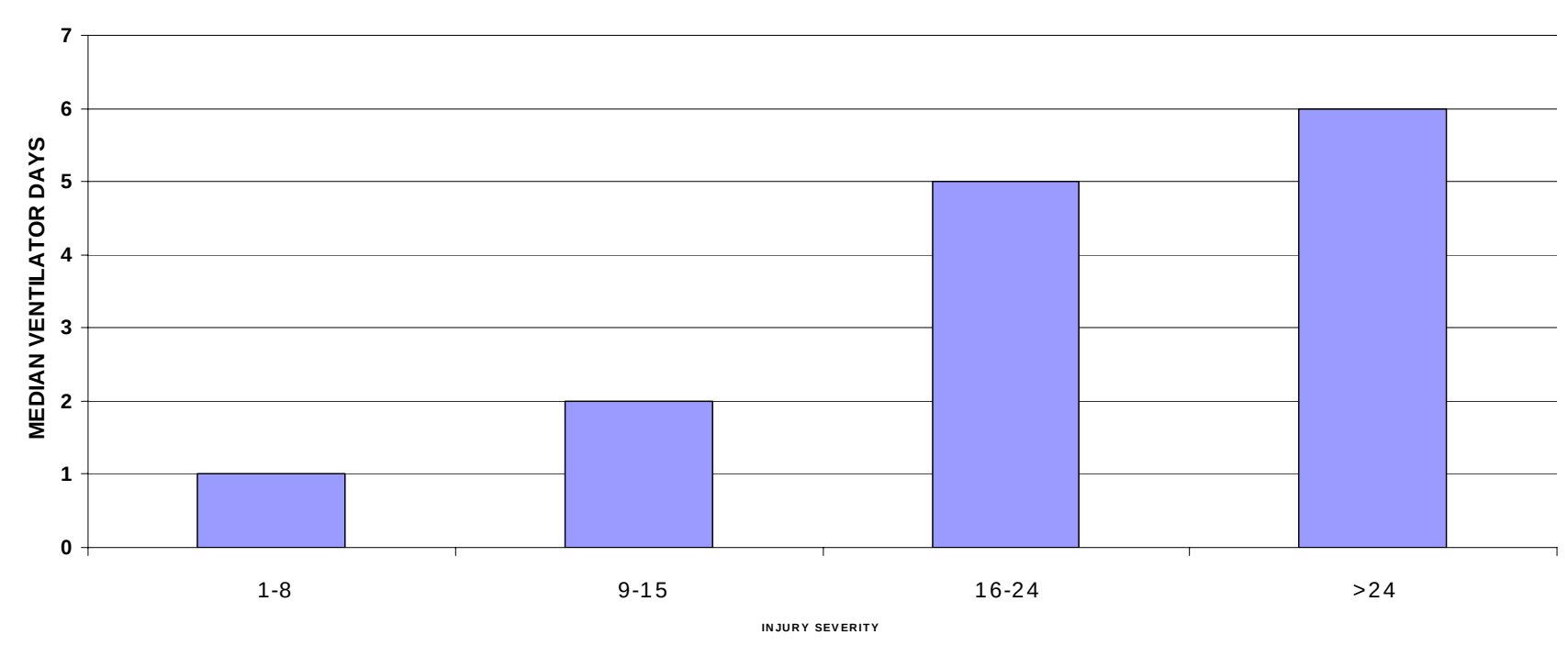
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS at ICU by Severity After Transfer from Another Hospital Unit



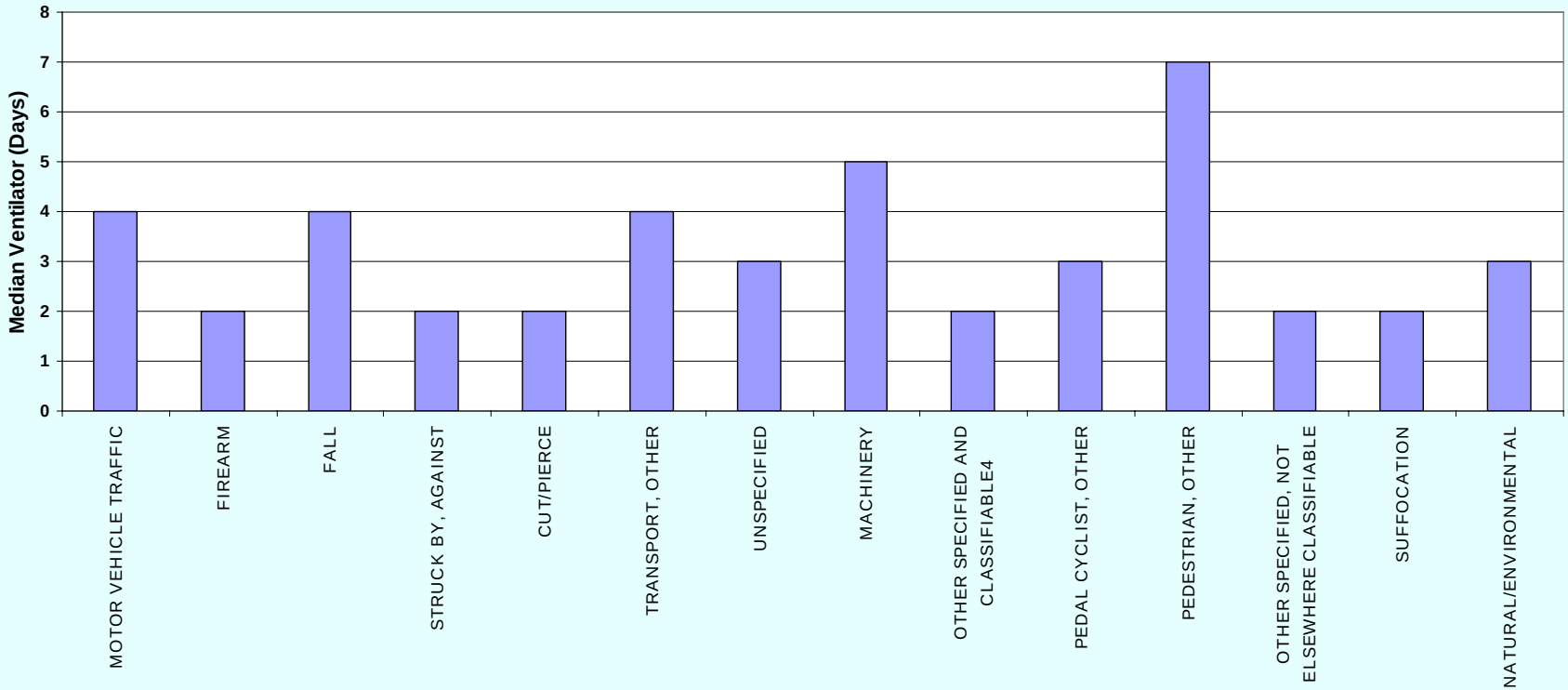
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS on Ventilator by Severity



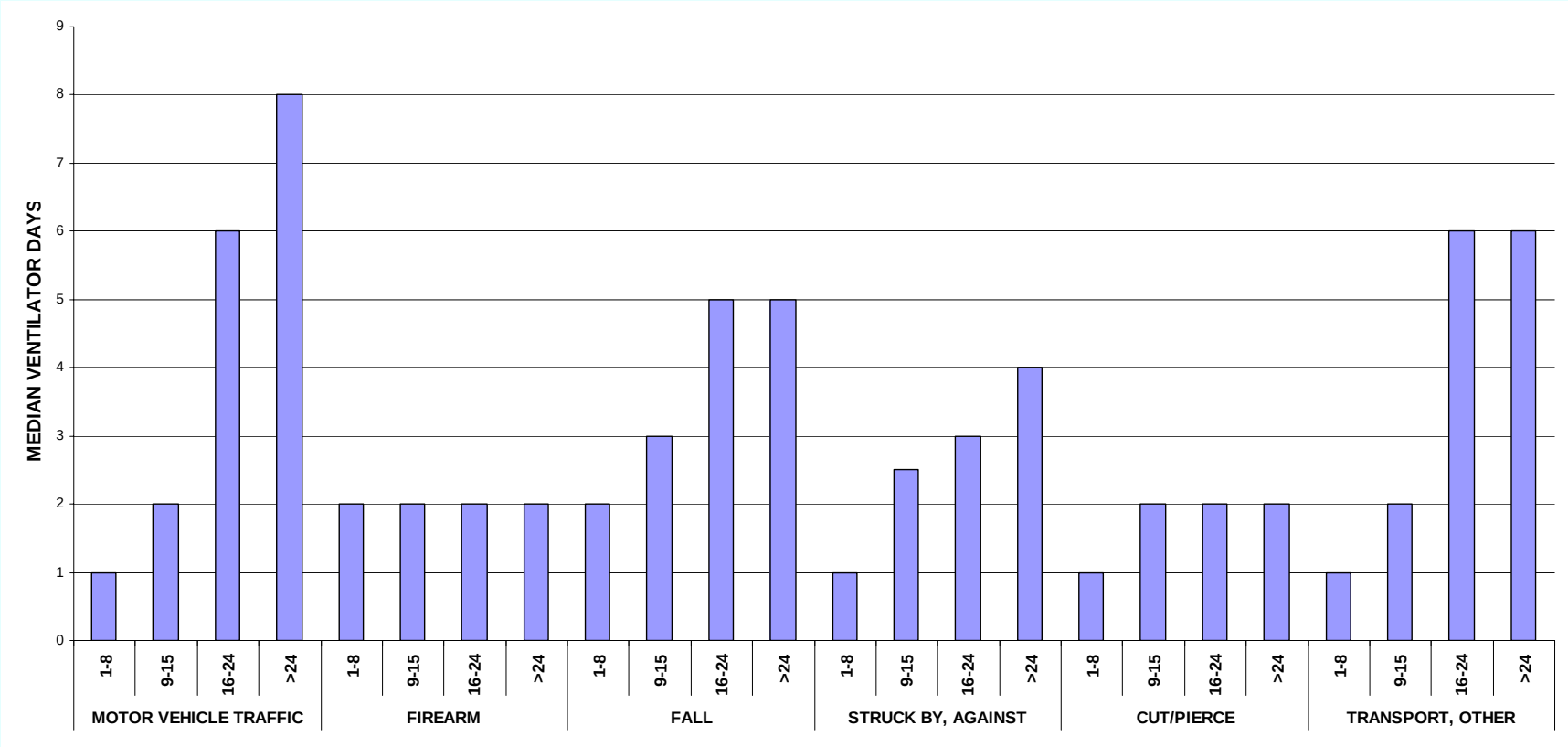
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS on Ventilator by Mechanism



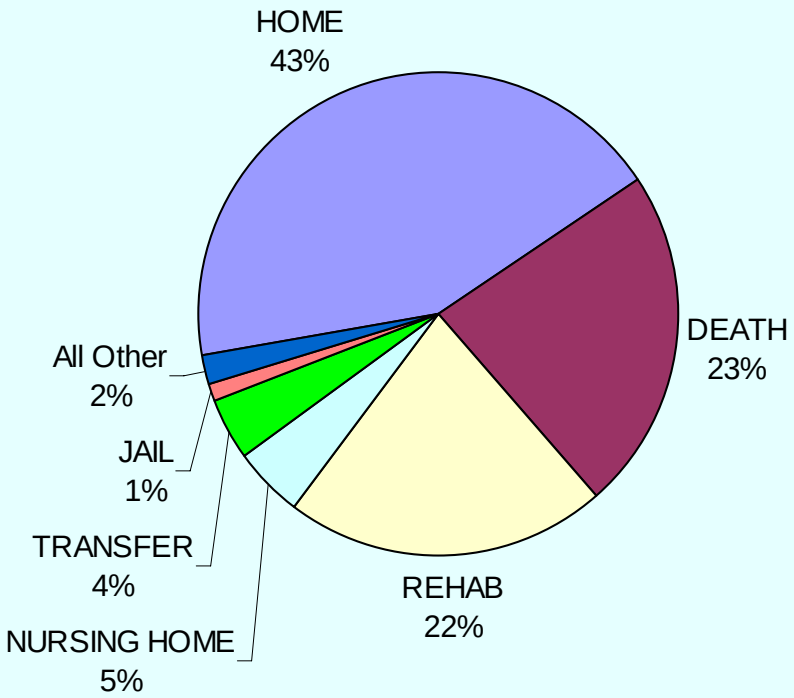
Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

Median LOS on Ventilator by Mechanism and Severity

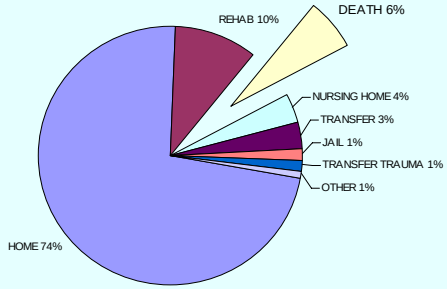


Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

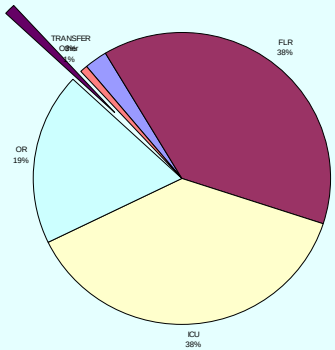
Ventilator Disposition



Hosp Disp



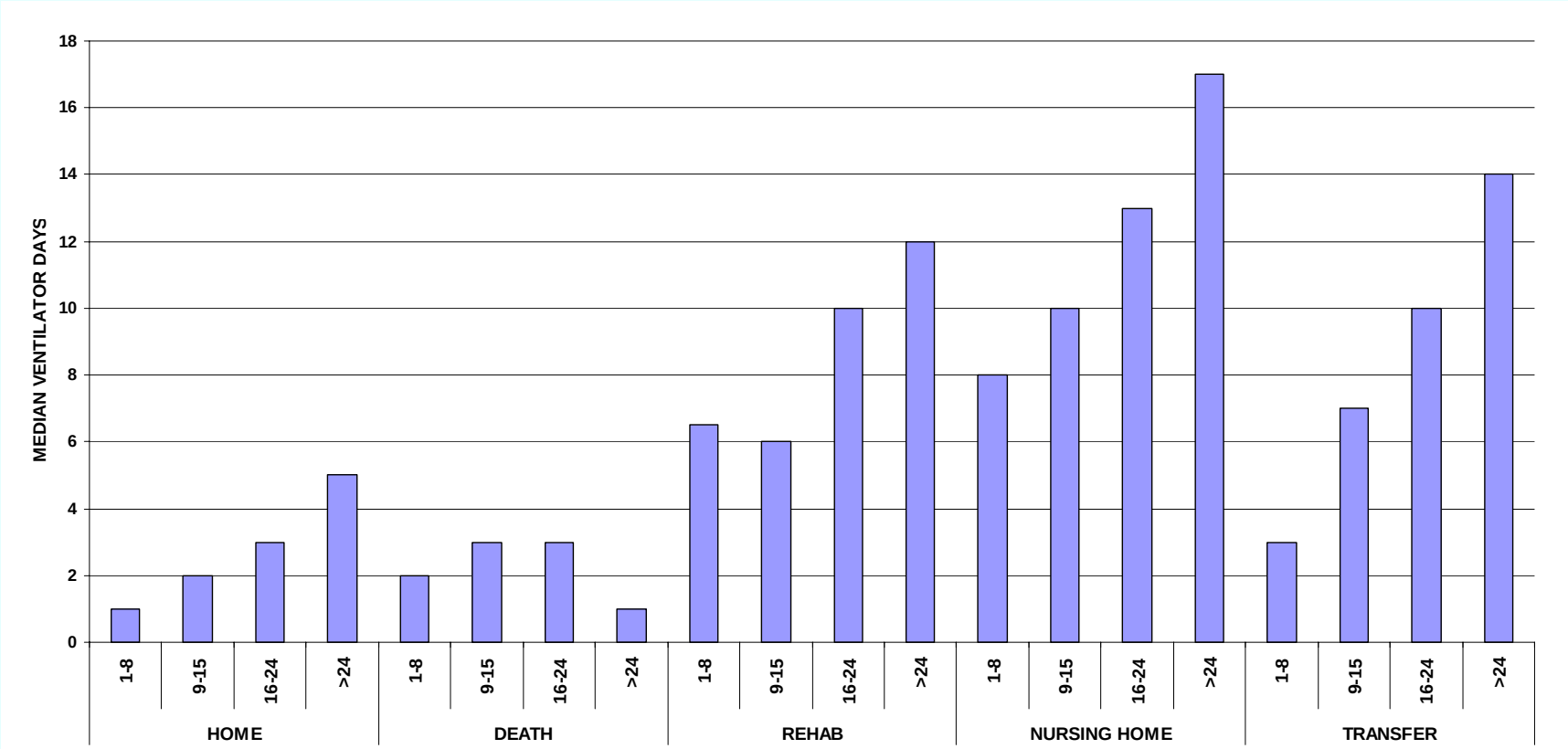
ED Disp



Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

GA Trauma Registry Central Site

Median LOS on Ventilator by Severity and Disposition



Source: Georgia Trauma Registry 2004-2009, Age 15+, As of Dec 28, 2010

THANK YOU

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