Minutes approved 15 November 2012

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 16 August 2012

Scheduled: 10:00 am until 2:00 pm
Mid Georgia Ambulance Training Center
252 Holt Avenue
Macon, Georgia 31201

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Linda Cole, RN Dr. Leon Haley Dr. Robert Cowles Dr. Fred Mullins Kurt Stuenkel Elaine Frantz, RN (via conference line) Ben Hinson Bill Moore (via conference line)	

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
John Cannady, TCC Coordinator	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Renee Morgan	OEMS/T
Kelly Nadeau	DPG/EPR
Karl Gorrell	Doctors Hospital Augusta
Heyward Wells	Doctors Hospital
Karen Waters	Georgia Hospital Association
Emily Denis	Georgia Department of Audits
Matt Taylor	Georgia Department of Audits
Regina Medeiros	GHSU
Fran Lewis	Grady
Jeff Nicholas	Grady/Emory
Dean Rice	Image Trend
David Zaiman	Image Trend
David Bean	EMS Consulting
Greg Bishop	Bishop & Associates
Kim Brown	Hamilton Medical Center
Marie Probst	OEMS/T
Lee Oliver	MCCG
Randy Clayton	GOHS

Julie Tanner	DHOA
Barbara Fiebiger	Doctors Hospital Augusta
Debra Kitchens	MCCG
Scott Maxwell	M&M Inc.
Lawanna Mercer-Cobb	Region 6 EMS
Jo Roland	Archbold Memorial
Gina Solomon	Gwinnett Medical Center
Liz Atkins	CHOA
Janet Schwalbe	Gwinnett Medical Center
Pat O'Neal	DPH
Sam MacFie	Coliseum Hospital
Greg Pereira	CHOA
Rochella Moon	AMC
Karen Johnson	CHOA
Courtney Terwilliger	GAEMS Emanuel County EMS
Russ McGee	Region 5 OEMS/T

CALL TO ORDER AND QUORUM ESTABLISHED

Dr. Dennis Ashley confirmed that Ms. Elaine Frantz and Mr. Bill Moore were on the conference line and Quorum was established. The meeting was called to order at 10:05.

CHAIRMAN'S REPORT

Dr. Ashley stated that Region 1 would be holding their RTAC meeting tomorrow and he was very excited and proud of their efforts so far. The Commission offers their support as they organize their region.

Dr. Ashley stated that through the legislation from last year the Commission has the opportunity to report to the Senate in the House Appropriations Committees this coming year and fully remit what we are doing at the Commission level to our legislators. We have not had that opportunity before, which has made it hard for us to get information out.

Dr. Ashley stated Dr. Pat O'Neal and he have known each other for a long time and they have worked in various roles throughout the state regarding trauma. They have also worked closely together over the last few years since the Commission has been formed. With everything that they both are involved with they have had a lot of things to keep their eyes on, which can sometimes makes it difficult to move forward. Over the last few months Dr. O'Neal and he have had some meetings to reenergize themselves. They went over where they have been, where they are going, and where they need to go. They want to make sure that all entities are moving forward for the betterment of the patient and to promote trauma care.

Dr. O'Neal stated that there have been frictions between the regulatory side of trauma and the trauma system development side and our endeavor is to overcome those frictions and get things back on track. Dr. Ashley and he agree that they share the same vision of how the trauma system can be optimized in Georgia and their goal is to continue to focus on that vision. They have also agreed that when they disagree that it will be done in a professional way and with respect for each other. Dr. O'Neal represents the regulatory side and Dr. Ashley represents the trauma system development side and that type of relationship is going to be key to seeing the trauma system move forward and succeed. We are facing the toughest economic times that we have ever faced and much of what the Commission has depended upon to energize moving forward has been funding and that is going to be shrinking. We have to think of other ways that we can develop this system in the face of lessening governmental funds, and there are many things that we can do to make this system move forward, but the key thing is we are asking all the stakeholders to keep their focus on the optimal trauma system and what it needs to be and be respectful when there are differences, and to work through those differences so that we end up with the best thing we can for the folks here in Georgia. That is Dr. Ashley and Dr. O'Neal's pledge to each other, to the Commission, and all of the stakeholders. They are also asking that the stakeholders join them in that pledge.

APPROVAL OF THE MINUTES OF THE 18 MAY 2012 MEETING

MOTION GTCNC 2012-08- 01:
I move that the minutes of the 18 May meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Dr. Dennis Ashley**
SECOND BY: **Dr. Leon Haley**

DISCUSSION: Ms. Elaine Frantz stated that a couple of corrections needed to be made. Mr. Jim Pettyjohn and Ms. Lauren Noethen noted those edits and the minutes will be revised to reflect those changes.

Motion has been copied below:

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

ADMINISTRATIVE REPORT AND AGENDA REVIEW

Mr. Jim Pettyjohn stated that the Administrative Report was posted to the Commissions website three days ago and wanted to know if anybody had any questions or comments on the report.

Mr. Ben Hinson stated that the Administrative Report is so huge he would like to be informed ahead of time of any hot topics so that he can understand them.

Mr. Pettyjohn stated that the Administrative Report has evolved where it is basically a handout supported to the discussion during the Commission meeting. The only exception would be documentation of emails he has had with the Commission between the last meeting and today. In this case it would be the HB 160 funding for FY 2012, but every other handout is supported to the presentation today.

SPECIAL EXAMINATION-SCOPING DOCUMENT UPDATE

Mr. Pettyjohn stated that that Commission is subject to a special examination proposed by the House of Appropriations Committee. Mr. Matt Taylor and Ms. Emily Denis who are from the Office of Audits and Accounts are here today to go over the plan for that special examination *(Special Examination Plan-Overview Document attached to the Admin. Report)*.

Mr. Taylor stated he is the audit manager and Ms. Emily Denis is the principal managing analyst and team leader on this project. Ms. Denis will be working on this project every day. This report has to be done by the end of this year. In November they will have a draft report prepared which will be sent to Mr. Jim Pettyjohn. He will have a couple of weeks to review the report. It is a confidential report. After it has been reviewed the Commission will need to provide a written response. That response will be incorporated into the initial report.

Mr. Taylor stated that they do not have contact with legislators during the course of the examination so he cannot provide a whole lot of insight as to why the Appropriations Committee are asking these questions. Early on this year you will have a chance to present your activities to the House Appropriations and since that has not consistently happened in the past, is most likely the reason for these questions.

GEORGIA PATIENT TRACKING SYSTEM

Dr. Pat O'Neal stated in emergency events they need to be able to track not only the patients that need to be transported, but also what those patients take with them such as wheelchairs and walkers. What they are going to talk about today is a system to be able to do that. Dr. O'Neal stated that Ms. Kelly Nadeau is going talk about the

Federal Government and the series of capabilities that the Department of Public Health is responsible for in all states and territories, both on the hospital preparedness side, public health side, and the emergency management side.

Ms. Kelly Nadeau stated that over the past year the federal government has come out with two documents that are critical. One is the Public Health Capabilities, and the other is the Healthcare Capabilities document. *(Links to Capabilities documents:*

Public Health Preparedness Capabilities
http://www.cdc.gov/phpr/capabilities/DSLR_capabilities_July.pdf

Healthcare Preparedness Capabilities:
http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf

Ms. Nadeau stated that over the next five years the goal is that all of our communities be better prepared together. For the healthcare community that means coordinating all of the plans that are already out there so that they work more closely together *(PowerPoint Georgia Patient Tracking System attached to the meeting minutes).*

Ms. Nadeau introduces Ms. Karen Waters from GHA who will talk about the current project where we are and where we are going.

Ms. Karen Waters stated they have been directly involved in the process that has been developed in this grant. This process has involved the hospitals and Public Health coming together. The meetings have been open and if people expressed an interest in being a part of it they were automatically added to an Information Distribution List. It was really unusual for GHA at that time because previously we only distributed information directly to the CEO's of the hospitals. It is exciting to roll this system out using the same process we have in the past, involving both EMS, and in this case the hospitals to make sure we structure it in a way that will meet their needs and address their concerns. This project will rollout along the coastal region in preparation for an evacuation in case of a hurricane or some other event. It will then be rolled out to the rest of the state. Public Health and the hospitals will have access to the information on the website, such as where the patients are going. We are going to initially ask for a few data points that EMS enters. A handheld will be provided to the EMS services. They will be able to use this devise to scan a bar code that is applied to the patient. This bar code will not have any patient identification on it. They will enter what time they leave the scene and a triage level, red, yellow, or green. That information will be communicated to the hospital and they will know that someone is coming. When they leave the scene they will scan the barcode and when they arrive at the hospital they will scan it again so that it enters those times for the EMS providers into the system. The hospital will have access to a website where they will have the ability to see when the patient will be arriving. This system is being devised so that only EMS and hospitals are seeing the day-to-day patient tracking.

Ms. Waters stated that when an event occurs such as a nursing home needing evacuation or a hospital, that information will be translated into an event on the website and other individuals for example, Public Health will be allowed to see that information and assist in the evacuation, otherwise on a day to day basis only EMS and the hospital will be able to access that website. EMS will only be able to see their information and hospitals will only be able to see the information if that patient is coming to them. If that patient changes on route to someplace else the information will automatically change and the previous hospital will no longer be able to see that information on the screen.

Ms. Nadeau stated that they are going to first see how this works with the five counties on the coast. They will get their recommendations before moving it to other counties. There are several other states that are using it for events, but not day-to-day events. We know that in five years we have to be able to do it for events, but as part of the practice and training this is where we are going to start.

Ms. Linda Coles asked whether this system would eventually intergrade with GEMSIS.

Ms. Nadeau stated if this system works and it had the feed into PCR's it would populate those patient care reports that EMS was doing from a handheld directly into that PCR. That would cut down the amount of work that the medic

would have to do on route to the hospital, because that information would be complete. We are a long way from that point right now.

Ms. Coles asked when the system would be rolled out.

Ms. Nadeau stated they are planning to roll it out in September.

Dr. Leon Haley asked how they will know if the system is working.

Ms. Nadeau stated they will be looking at medics reports to see how easy it is to use and whether the hospital is having better visibility of the patient arriving and in what time frame.

Ms. Coles asked wanted to know if there had been discussion about eventually intergrading it with the Trauma Communications Center.

Ms. Nadeau stated there had been discussion and the only piece that they recognized as being helpful was the bed status or availability status.

IMAGE TREND: HOSPITAL DASHBOARD

Mr. Dean Rice stated that the hospital dashboard is a way to get information directly from a PCR into the hospital system faster and more efficiently. Mr. Rice introduces Mr. David Zaiman who is his director and will be presenting the Hospital Dashboard *(Image Trend handout attached to Admin. Report)*.

Mr. Zaiman stated that Image Trend is the vendor for GEMSIS. The Hospital Dashboard is a view into GEMSIS. Based on your hospital you can see trauma and non-trauma patients that have been transported to your hospital. This provides the opportunity throughout the state for one central repository for hospitals access patient information and enables you to see the original 911 transport along with the transport in between from hospital to hospital. You can look at that data in PDF or print it and depending on how quickly the service sends their data to GEMSIS you could have recent activity displayed on a board in the ER. This display would have no patient identifiable information on it, just the patient's age and symptoms while on route to the ER. Ambulance services would have options to submit real-time with Image Trend or any of the other NEMSIS compliant EPCR systems. Image Trend will provide the ability to automatically export data. One example is EMS charts, the services can submit their runs to the state every hour, so instead of doing a bulk submission they can pretty much do it real-time.

Mr. Hinson stated it would be an advantage to the TCC if they could access this data to get the run times rather then getting it from GEMSIS or calling the EMS services.

Mr. Zaiman stated that it is set up as a permission of what the state wants to offer, and those permissions are available and are not an objective of the Hospital Dashboard. Currently if GEMSIS wants to give those permissions out to run reports on data, those permissions can be set up. Image Trend would be more then happy to work with GEMSIS to set those permissions up, and that could be done today without purchasing the Hospital Dashboard.

Dr. Ashley wanted to know who owns GEMSIS and is in charge of that state entity.

Mr. Zaiman stated that the Office of EMS owns GEMSIS. They contract with Image Trend and it is hosted on our servers in Minneapolis and replicated in Chicago.

Dr. Ashley wanted to know if GEMSIS is really Image Trend.

Mr. Zaiman stated that GEMSIS is their product and is a brand of the Image Trend state bridge. It is our product name. In Wisconsin it is called Wards, in Minnesota it is called Minstar. We have 26 states that currently use the Image Trend state bridge for statewide data collection.

Dr. Ashley wanted to know what the difference is between the technology we already have now and Image Trend.

Mr. Zaiman stated that this product gives you a better view into grabbing just the individual EPCR's instead of the aggregate data.

Dr. Ashley stated that the Commission does not want to fund something that they would not be able to get permissions to. If we decided to fund this product how would we get permissions?

Mr. Zaiman stated that when you are talking about global security the Office of EMS, or whoever is administrating it has the options to set up numerous different permission levels. This basically depends on what the person is allowed to see or do. Whether it is from a state perspective, a Trauma Commission perspective, regional, at the service level, or a billing company. Those are all individual set permissions the GEMSIS staff can do on their own. It is not some special programing by Image Trend, but we are there to make sure those permissions get set up.

Mr. Kurt Stuenkel made comments as to what the Commission has in their developmental cue. The TCC is up and operating, our regional trauma plans are in process which involve EMS counsels and EMS providers, and hospitals are working out their individual plans and integration into the TCC, and the new Georgia Patient Tracking System is yet to be deployed. Now we potentially have the Hospital Dashboard. Mr. Stuenkel wants to know how much can we digest at one time.

Mr. Hinson stated that this is the database for the Office of EMS and Trauma. He is proposing that we allow hospitals to look at that and it will not require any more effort from providers, or anybody else. He thinks it would be a fairly small cost to get it started. The cost would be about $40,000-$50,000 to get it started and about $10,000 a year to keep it going.

Dr. Leon Haley thinks that this product has lots of capabilities, and actually well beyond the trauma patient population, but he is not sure that the Trauma Commission should fund it. Reason one is the developmental timeline and two the Commission's tight budget that is shrinking.

Ms. Elaine Frantz asked if currently there was a way to access aggregate and individual patient data at the hospital other than through Image Trend.

Mr. Zaiman stated the only hospital view of patients that have been transported by a service to their hospital is the view through GEMSIS.

Ms. Cole stated that if we wanted an aggregate report we do have ways to do that now.

Mr. Zaiman stated that was correct.

BURN CENTER UNCOMPENSATED CARE REPORT

Mr. Greg Bishop stated that the urgent issue is finalizing the Burn Assessment and the crosswalk for burn center uncompensated care reimbursement *(Georgia Burn Center Uncompensated Care Reimbursement PowerPoint attached to the meeting minutes)*.

Dr. Leon Haley stated Mr. Bishop had presented the Burn Center Uncompensated Care Report to the Hospital Physician Subcommittee via conference call and they agreed with Mr. Bishop's recommendations and are bringing this forward for final Commission approval.

Dr. Ashley stated that Dr. Haley is the Chair of this subcommittee and a second to the motion will not be required.

MOTION GTCNC 2012-08-02:
I make the motion to approve the Burn Center Uncompensated Care Report.

MOTION BY: **Dr. Leon Haley**

DISCUSSION: None

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

GEORGIA TRAUMA FOUNDATION PROPOSAL

Mr. Greg Bishop stated that the formation of a Trauma Foundation had been discussed at the January Workshop. Mr. Bishop has been asked to put together a plan to develop this concept in Georgia *(Georgia Trauma Foundation Concept and Planning PowerPoint attached to the meeting minutes)*.

Mr. Bishop stated the cost to develop this plan would be $40,000. To actually put it together and make it work would be an additional 120,000.

Mr. Stuenkel wanted to know what kind of return Texas got on their investment.

Mr. Bishop stated Texas found that it basically brought all of their pieces together outside of their Commission.

Dr. Haley wanted to know what Texas is managing as far as a foundation in terms of their funds.

Mr. Bishop stated that he does not know, but he could look into that more as part of the process.

MOTION GTCNC 2012-08- 03:
I make the motion to form a subcommittee with key stakeholders to look at this plan closely, specifically to see what the Trauma Foundation would look like and then make recommendations at the next Commission meeting.

MOTION BY: **Ms. Elaine Frantz**
SECOND BY: **Dr. Robert Cowles**

DISCUSSION: Dr. Fred Mullins agreed to this approach.

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

Dr. Ashley appointed Dr. Fred Mullins as Chair of the Georgia Foundation Subcommittee. Ms. Elaine Frantz and Dr. Robert Cowles were also appointed. Dr. Ashley asked Mr. Greg Bishop to be a part of it as well and stated that the Commission would have a thorough discussion and vote at the next meeting.

GEORGIA TRAUMA SYSTEM PERFORMANCE TOOL PROPOSAL

Mr. Greg Bishop stated that every state has hospital discharge data sets for every patient discharged from a hospital and if you add an ISS score to that data set you have a tool to look at trauma system performance because you can tell what that hospital is doing with respect to trauma system severity. *(Georgia Trauma System Performance Tool Concept & Development attached to the meeting minutes)*.

Mr. Bishop stated that the previous ISS methods for statewide hospital discharge data sets had not been updated since 1995 and were obsolete. The Georgia Trauma System is positioned to be the first that employs updated technology into measuring its performance.

MOTION GTCNC 2012-08-04:
I move to make the motion to approve the Georgia Trauma System Performance tool contingent upon GHA attorneys approving the availability of the hospital discharge data.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Mr. Kurt Stuenkel**

DISCUSSION: Dr. O'Neal stated that we would probably need to get clarification from the attorneys at GHA on the availability of that discharge database for research purposes.

Mr. Hinson stated that we should take that into consideration in the motion.

Mr. Stuenkel asked whether one of the potential outcomes of this tool is to give us more refined model that will ultimately enable us to better allocate our funds to needed areas.

Mr. Bishop stated that you would have data to look at where the needs are, payer mixed data, and a fairly rich data set showing what is going on with non-trauma centers.

Mr. Bishop stated that he has worked with GHA and they have given him this information for several years, but it would be a good idea to receive their permission.

Ms. Frantz wanted to know if it would interface with OEMS/T and the data that we have now and if there were any testimonials in terms of usage, or if it was the first in the United States.

Mr. Bishop stated that Ms. Ellen MacKenzie of John Hopkins was very involved with this and had actually developed an ICD-9 map in 1990 with Digital Solutions. Then in 2004 a group got together to look at data and their number one recommendation was to take the ICD-9 map and update from 1995, but that never occurred. This is the first time that will happen and we are pretty comfortable with the DI (Digital Solutions) rules engine in terms of being that sophisticated data tool and ideally it would be a non-proprietary tool that would be used by everybody, but that option is not available at this time.

Ms. Frantz asked what the annual cost to maintain this tool would be.

Mr. Bishop replied that the cost the cost of the entire project would be $22,500 and stated that Digital Solutions would like to develop a module that would allow anybody to do it as many times as they want to and that would cost from $2,000-$3,000. If that module were developed it would be given to Georgia as part of this project. The basic rules engine is about $1000.00 to actually run the data and the other work associated with it.

Ms. Cole asked how long it would take to run the data and expect to see information.

Mr. Bishop stated about one month to just run the data and then to start looking at the various applications would take more time.

Ms. Frantz wanted to know who would be handling the operation year to year.

Mr. Bishop stated if a module is used, Georgia would have the module, and since it is a collaborative project the Commission and OEMS/T would both own it.

Ms. Marie Probst wanted to know if the appropriate people are talking about the ICD-10 codes and how those will be converted.

Mr. Bishop stated that they are in the process of updating it for ICD9-10. It is not available yet, but that would be the next step to make it a more powerful tool.

Motion has been copied below:

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

CY 2010 TRAUMA CENTERS UNCOMPENSATED CARE CLAIMS AUDIT REPORT

Mr. Paul Lundy stated that he has been working with the Trauma Commission for a couple of years helping Mr. Pettyjohn and his team audit the claims that are submitted by the various trauma centers. Ms. Jessica Story is a senior in his office and has managed this from the beginning. Mr. Lundy stated that they are going to summarize the draft report today *(GTCNC Validation of Uncompensated Care Claim Data Agreed Upon Procedures Year Ending December 31, 2010 draft attached to the meeting minutes)*.

Mr. Pettyjohn stated that each trauma center received the final report of the numbers that were scrubbed and knew the numbers that were going to be put in this report and had the opportunity to comment.

Ms. Story stated that there was a new claim issue concerning patients that had indemnity insurance or supplemental insurance and had received a certain dollar amount per day for the length of their stay in the hospital. That money was never really intended for anyone other then the patient. They consulted with Mr. Pettyjohn and asked him to correspond with the Attorney General for clarification as to whether that claim was an exception or was eligible. The Attorney General reported the claim to be an exception.

Mr. Lundy stated the fact that that money existed at all made that claim an exception.

Ms. Linda Cole stated that the hospital had billed the patient appropriately, but the patient chose not to pay.

Mr. Pettyjohn stated we have Senate Bill 60 that was passed in 2007, and in May of 2010 the Commission clarified some of these rulings in a role meeting with Mr. Alex Sponseller and those motions have been taken out of the minutes and supplied as clarification to the trauma centers. In January of this year there was additional clarification that claims sold to a collection agency were now exception as well. We have a list of criteria that is developing and we are moving forward with that.

MOTION GTCNC 2012-08-05:
I move to make the motion to accept the CY 2010 Trauma Centers Uncompensated Care Claims Audit Report.

MOTION BY: **Mr. Kurt Stuenkel**
SECOND BY: **Ms. Linda Cole**

DISCUSSION: None

Motion has been copied below:

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

Mr. Kurt Stuenkel stated that we have just gone through an audit of a very complex system that the Commission has had in place for three or more years. We also have a very complex and less uniform system for compensation of physicians for uncompensated calls. He thinks that we should entertain alternative uses for that money rather then go through the complex allocation method that each hospital has had to introduce in order to try and reimburse the physicians for uncompensated care. The dollars should still go to physicians that are in the business of delivering trauma care, but we need a better methodology. One option would be if you were paying trauma call you can use that money to help in the administration of the trauma call patient. There may be some other options, but he thinks simplicity would be a blessing.

Mr. Hinson wanted to know how to move forward with Mr. Stuenkel's suggestion.

Dr. Ashley stated that the Trauma Center and Physicians Funding Subcommittee could review this and come back with suggestions.

Mr. Pettyjohn stated that we can move the uncompensated care claims quickly to the trauma centers if the budget

Is approved. If the Commission agrees we can ask the trauma centers to hold off on distributing the physicians dollars until you vote in November on the Subcommittees findings on a better or a different use for physician uncompensated care distribution.

Dr. Mullins wanted to know if the physicians had already gone through the process.

Dr. Haley stated that they had and we are now looking at next year.

Mr. Pettyjohn wanted clarification as to whether this would be an FY2014 distribution.

Dr. Haley stated that it would be an FY 2014 distribution.

Mr. Hinson stated that several times in the past year we have talked about the hospital turning in uncompensated claims and actually selling those claims to the Trauma Commission. He knows that the law does not allow that right now, but he thinks we should investigate that possibility. We could transfer those hard to collect claims over to an organization that the Trauma Commission contracts with and let those people try to collect with the force of the state insurance commissioner.

Mr. Alex Sponseller stated that we addressed selling claims several years ago and it was concluded that we could not do that. He would have to locate the letter that clarified that.

Mr. Hinson stated it had been made very clear that we could not do that, but he would like the Commission to revisit the selling of uncompensated claims, and if the law could be changed to allow that to happen.

MOTION GTCNC 2012-08-06:
I move to make the motion for the Trauma Center and Physicians Funding Subcommittee to review and discuss the selling of uncompensated care claims and the legislative changes that would need to be made in order to do that.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Mr. Kurt Stuenkel**

DISCUSSION: Dr. Ashley stated that he thinks it is worth investigating.

Mr. Hinson stated that maybe we could visit with the auditors and after the claims have been reviewed they could inform us as to whether there is uncollected money out there.

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

FY 2012 FINAL EXPENDITURE & AFY 2013 BUDGET

Ms. Judy Geiger stated that the Commission will return $8,413.00 to the State Treasury and had spent 99.95% of there FY 2012 budget. The $8,413.00 that lapsed were dollars not spent out of the Commission Operations budget and the TCC budget and that was due to the variables in the budget with utility bills etc. and not knowing what the bills would amount to at the end of the month. All of the other budget categories were spent at 100% *(Final FY 2012 Expenditure Report attached to the Admin. Report pages 19-24)*.

Ms. Geiger stated that the Governor has sent out a letter to all state agencies, and executive directors asking for a proposed 3% reduction in the budgets. Ms. Geiger stated that the reductions are 3% across the board for each budget category. In the proposed budget realignment we moved $5,000 from the Commission Operations Contingency to the System Development and Access & Accountability Budget. In the negotiation of contracts it was determined that an increase of $5,000 was needed. The 3% that is coming out of the Commission Operations

budget is coming out of the Contingency budget. Ms. Geiger stated that they would like to propose that in the System Development Access & Accountability Budget with the $5,000 realignment that we do not actually take cuts from that budget and instead take 50% of that reduction from the Commission Operations Contingency and the other 50% from the TCC Contingency Funds to absorb the reduction in System Development Access & Accountability Budget *(FY 2013 approved Budget with AFY 2013 3% reduction draft budget attached to the Admin. Report pages 25-36)*.

Mr. Pettyjohn went over the Total Trauma Centers & Physician Allocation budget area and stated that that out of the five $50K grants one had already been determined. They are also talking with Athens and the trauma centers in EMS region 10, 8 and 9 and want to work with those trauma centers to begin the regionalization activities in their EMS regions so they can hopefully receive the other four $50,000 grants. *(Total Trauma Centers & Physicians Allocations page 36 of the Admin. Report)*.

Mr. Pettyjohn refers to the Budget Area of Gifford, Hillegass & Ingwersen contract amount of $20,000 and stated that the actual cost was $80,000 but the Commission was able to realize cost savings in FY 2012 and put that into GH&I's existing contract covering all but $20,000 of the work they are doing in FY 2013. This is just an example of Ms. Judy Geiger's good financial management of your budget to insure that we do not lapse dollars back and not use them *(System Development, Access and Accountability page 28 of the Admin. Report)*.

Mr. Pettyjohn stated that the work with Ms. Carol Pierce of Public Health Consultants was funded with the FY 2013 budget based on cost savings. Ms. Carol Pierce has contacted many of you because we are in the process of writing up the report for the Pilot Project, which will be brought to the January Workshop as a final draft report.

MOTION GTCNC 2012-08-07:
I move to make the motion to approve the AFY 2013 Budget as presented.

MOTION BY: **Mr. Kurt Stuenkel**
SECOND BY: **Dr. Fred Mullins**

DISCUSSION: None

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

DPH OFFICE OF EMS AND TRAUMA UPDATE

Dr. O'Neal reported that the Office of EMS which is part of Public Health is struggling with the request for a 3% cut for all state agencies. The Office of EMS is already cut to the bone and he does not see how any further cuts can be taken there. Dr. O'Neal does not think the Commissioner will push for that, but we will be losing a lot of personnel in Public Health some of which may have supporting roles for EMS. We have to find 5.6 million dollars to cut. Fortunately 70% of our budget is federal, but unfortunately we have to have state match, and state match is what may have to be eliminated in the 5.6 million dollar cut. The final budget recommendations are due August 23rd when we meet with the district health director. Then it will be submitted to OPB on September 4th, and we will make you aware at the next meeting as to whether there is any impact on EMS.

Dr. O'Neal recognizes Ms. Lawanna Mercer-Cobb who is retiring from EMS and has been one of their most important and loyal folks for many years. Ms. Mercer-Cobb is the Region 6 EMS program director, a nurse by background, as well as a medic, and has contributed immensely to the program. We are very sorry to see her retire but wish her the best.

Dr. O'Neal stated that with the difficulties that everyone is going to be facing with funding he hopes that the Commission will look favorably into the idea of forming a foundation. Looking back at SB 60 he thinks that there was every intention on the part of legislators that the Commission would try to find funding from every possible

source and a foundation is one good way to do that. It would be good to include a stakeholder group that goes well beyond OEMS/T and the Commission. Dr. O'Neal passed out a list he put together of possible stakeholders the Commission might consider as an advisory group that could conceivably be part of the foundation and could come forward with not only recommendations on how we can make our system better, but help us figure out where the funding would come from to make this system move forward *(Listing of suggested state multi-disciplinary committee members attached to the meeting minutes)*.

Dr. Ashley stated that Dr. O'Neal makes a good point and the Commission had discussed this at the Retreat in Rome, GA in January, and he is in favor of forming a trauma foundation and the list of suggested committee members is a good list.

MOTION GTCNC 2012-08-08:
I make the motion that the Commission looks into forming a Trauma Foundation and to come up with more specifics as to how to do that for our next Commission meeting.

MOTION BY: **Dr. Dennis Ashley**
SECOND BY: **Ms. Linda Cole**

DISCUSSION: Mr. Bill Hinson thinks the idea of getting more people involved is great, but he does not think we should give people the credentials or credibility to be the place that ideas should go to before they come to the Commission. He does not want to officially form a committee where people are going to advise us, but building a group to support the Commission and help disseminate information would be great.

Ms. Linda Cole stated it would be important to determine what the committees objectives, purpose, and roles are. A clear definition of their role would deter any tension or stepping on toes. Forming a Trauma Foundation is a great idea and she wholeheartedly supports it, because trauma is huge and the more support we can give to it throughout the state the better.

Dr. Leon Haley is in support of it also, but thinks the foundation subgroup that was formed should walk hand and hand in developing the Trauma Foundation.

Mr. Benson wants to know if this group is formed and they make a recommendation to us and the Commission does not go along with it where does that put us.

Dr. Ashley stated that he respects Mr. Hinson's opinions and he has made some good points, but the Commission has matured. We have done a lot of good work, but we need to go beyond the regional level to the state level and in order to do that you have to have all those people that are on the list. The Commission is set up to make decisions and to be accountable and we have to take our responsibility seriously, but it never hurts to get help and ask for opinions. Dr. Ashley thinks we need a larger group of stakeholders because there is a lot of talent that needs to be rolled into one body that is moving forward and with some structure and guidance we can do that. Dr. Ashley stated that if we gave stakeholders an idea to research and they came up with something the Commission did not want to do, the Commission would have to listen to all parties involved, analyze all the data, talk to legislators, know the budget, and put all those variables together and make the final decision.

ACTION: Approved the motion ***PASSED*** with no objections, Mr. Ben Hinson abstained
(Approved minutes will be posted to www.gtcnc.org)

Dr. Ashley asked Dr. O'Neal to work with Dr. Fred Mullins, and the Georgia Foundation Subcommittee and report back to the Commission.

TCC UPDATE
Mr. John Cannady reported that as of two days ago the TCC had taken in a total of 438 trauma patient calls from EMS and or hospitals and 15 of those calls were hospital to hospital transfers with the vast majority still coming from on the scene.

Mr. Cannady stated that there was a question at the last Commission meeting relating to patient destination. Of those 438 patients 51 went to a non-designated trauma center. That is an increase of 29 patients since the last meeting. Two of those did not meet TSEC criteria. The vast majority of patients that did not go to a designated trauma center did not meet the TSEC criteria as adopted by the Commission. Of the two that did meet TSEC criteria one patient was expired and taken to the closest available facility and the other was a medic discretion taken to the closest available facility. About 40 of the total calls have come outside of the pilot project regions of 5 & 6.

Mr. Cannady stated that the TCC Advisory Board was formed and they had their first meeting in June of this year, with members from the Commission and members from the approved active RTAC's. The next meeting is scheduled for September 12th. The role of the Board is to provide advice and counsel to the TCC as we continue with regionalization on how to incorporate those various RTAC plans into the TCC operation. They will also provide counsel on budgeting, staffing, and improvements to the TCC as well.

Mr. Hinson commented that the EMS Subcommittee is concerned that the TCC Advisory Board has board members that are not even on their local RTAC's. It was the EMS Subcommittees understanding that the Advisory Board was set up to simply talk with Mr. Cannady about how they could interface better with field medics to make the process work better. They never envisioned the TCC Advisory Board would be working on differences between RTAC's, and working on policies and budget etc. The EMS Subcommittee wants a group of field managers to work with Mr. Cannady to advise on how the system is working and leave policy decisions at the Commission level.

Ms. Linda Cole stated that her perception of the TCC Advisory Board was that it was not a policy creating committee. Ms. Cole strongly agrees with Mr. Hinson that we need clear objectives and criteria established to avoid conflicts. If Mr. Cannady feels that he needs direction, she wants to insure that we give him the support and direction that he needs, but with clear directions on who should be on that committee to give advice.

Mr. Hinson requested that we clarify objectives for the TCC Advisory Board and maybe reappoint people to be on this board.

Dr. Ashley expressed that maybe Board is the wrong name and it should be called a group. His interpretation of what this Board or Committee was trying to do was to decide who should be on it to help. We should change the name and establish some goals and bring that back before the Commission.

Mr. Hinson asked that the TCC Advisory Board's objectives and criteria be defined and written out.

Dr. Ashley asked Ms. Cole to work with Mr. Pettyjohn and Mr. Cannady to make that definition and bring it back to the next Commission meeting.

EMS SUBCOMMITTEE ON TRAUMA

Mr. Hinson reported that the first motion of the EMS Subcommittee was a request that the Trauma Commission require all RTAC's to be connected to their respected regional councils.

Mr. Hinson stated First Responder Grant applications and vehicle grant applications criteria is the same as in the past and the Subcommittee voted to pass both of those and is asking the Commission to approve that vote so they can move forward with the distribution of training grant funds and emergency vehicle equipment grant funds. The funding for those amounts is covered in the budget and has already been discussed.

MOTION GTCNC 2012-08-09:

I make the motion that if the Commission were to approve the Vehicle Equipment Replacement Program to distribute funds for that using the same scoring criteria as last year.

MOTION BY: **Mr. Ben Hinson**

DISCUSSION: Dr. Ashley stated that a second to the motion was not required because it came from the Chair.

Dr. Robert Cowles asked Mr. Hinson if the EMS Subcommittee had discussed results and benefits of providing new ambulances to various services.

Mr. Hinson stated that it had been brought up but they had been unable to find a way to get results and that is why he is pleased that the audit group has been charged with answering those questions. They are planning to meet with GH&I to help develop the questions.

Dr. Ashley asked Mr. Hinson what his personal opinion was on ambulances and the Commissions role in funding them. Should it be a four or five year plan or should we stop providing them.

Mr. Hinson replied that he did not think we should stop providing ambulances.

Ms. Cole stated that that there needs to be a vision within the EMS Committee. The vision should define what resources are required to accomplish that vision, and then very year we need to chip away at to reaching that vision.

ACTION: Approved the motion ***PASSED*** with Dr. Robert Cowles and Ms. Elaine Frantz apposing and no abstentions. *(Approved minutes will be posted to www.gtcnc.org)*

MOTION GTCNC 2012-08-10:
I make the motion to approve the First Responder grant application as written.

MOTION BY: **Mr. Ben Hinson**

DISCUSSION: None

ACTION: Approved the motion ***PASSED*** with Dr. Robert Cowles apposing and no absentations. *(Approved minutes will be posted to www.gtcnc.org)*

MOTION GTCNC 2012-08-11:
I move that the Commission in conjunction with RTAC's investigate the development of a trauma care training program that is mandatory in all hospital emergency departments in Georgia.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Mr. Kurt Stuenkel**

DISCUSSION: Ms. Cole wanted to know if that training would include physicians, and nurses.

Mr. Hinson stated that it would include the whole deal, and the trauma team approach that Dr. Ashley has been involved with called Advanced Trauma Life Support (ATLS). He wants to insure that when a patient arrives at a trauma center from a rural hospital that the rural hospital provided the care that was necessary before they were transported. Mr. Hinson stated that he wants the Commission to investigate providing that course to every ER and eventually he wants the Trauma Commission to fund that training. Mr. Hinson believes that if we provided training in every hospital, trauma care would radically improve, and we would be reaching way beyond the designated trauma centers.

Dr. Ashley stated that there is a course called Advanced Trauma Life Support (ATLS) of which Mr. Hinson was referring to, but there is a new course available now called Rural Trauma Development Course. A team goes to a rural hospital and identifies those hospitals resources. It is a course on getting hospitals to talk about what they have as resources and how to use those resources to take care of a really bad trauma patient. Dr. Ashley stated that Ms. Debra Kitchens and Dr. Regina Medeiros and he have been teaching that course around the state, but they are limited based on the staff, and time available to do it. Dr. Ashley thinks that it would be a good course to do

throughout the state. He is not sure we would have the authority to mandate it, but maybe the Commission could provide some funding to help those hospitals.

Mr. Kurt Stuenkel stated one of the reasons we put together RTAC's was to do a review of how patients get transferred and he agrees that the hospital ED's need to be part of that because they are a source of transfer not just in the field but in the hospital as well. We need to put this into the RTAC system development.

Dr. Regina Medeiros made the comment that the RTAC's are already doing what Mr. Hinson is asking. They have developed a survey tool that is being sent out to every emergency room physician, ER nurse, every medic in their region, and every trauma surgeon, getting a listing of various certifications, finding out who had ATLS, etc.; and who holds currant certifications. We are gathering all that data and looking at gaps and focusing the education efforts on those gaps to bring up the education level of everyone. Dr. Medeiros does not think it is realistic to have a base mandatory course that everybody can take. They are already surveying and doing it at the RTAC level and thinks it would be redundant to do it at the state level.

Mr. Hinson stated that he appreciated Dr. Medeiros comment, but just because someone is doing it does not mean that that we should not worry about it.

Motion has been copied below:

ACTION: APPROVED the motion ***PASSED*** with Dr. Leon Haley and Ms. Elaine Frantz apposed and no abstentions. *(Approved minutes will be posted to www.gtcnc.org)*

GEORGIA COMMITTEE FOR TRAUMA EXCELLENCE

Dr. Regina Medeiros goes over the recommendations made by GCTE to the Georgia Trauma Care Network Commission for consideration and action *(Recommendations attached to the Administrative report page 42)*.

Dr. Ashley asked Dr. Medeiros if these recommendations needed action today.

Dr. Medeiros replied that she would like the recommendations taken back to the Medical Director group to find out if they would need to make a final vote on them. In terms of the data elements they have already approved those. We have added a couple back and spoke to Dr. Gage Oschner about those and explained that we added those data elements back in to support EMS Uncompensated Care. We request that you follow-up with the State Office to make sure that GTCE's recommendations will not have an impact on what they do at the state level, and then we can work with them to create a policy for a minimum data-set for the 24 hours as well as the elements.

Dr. Ashley stated that the Trauma Medical Directors have a conference call scheduled for Monday and he asked Dr. Medeiros to attend that call and present the recommendations.

Dr. Ashley asked Ms. Marie Probst where we stand with the State Office on these recommendations.

Ms. Probst stated that they have been in discussions with GTCE about the data element list. The impact of the change from 48 hours to 24 will not affect the state database, but it will affect the smaller facilities. We have a large enough volume that it will increase their volume. That will be the only impact that she can see regarding that change. Eliminating data elements will ultimately be Dr. O'Neal's decision. Ms. Probst can appreciate the committees on both sides and the medical directors making their recommendations and Dr. O'Neal will take those recommendations into consideration and make a decision.

LAW REPORT

Mr. Alex Sponseller stated that there has been confusion regarding TCC HIPAA compliance. Mr. Sponseller emphasized that the TCC has always intended to comply with all the security rules of HIPAA and privacy rules. They have been working on policies for their staff and for their existing system to secure the system from any

breakthroughs from outside sources. The HIPAA rules are lengthily with the Administrative Safeguards, Physical Safeguards, Technical Safeguards and documentation requirements. The most important is the Risk Analysis and Risk Management and that requires someone to come in and look at the system and perform tests on it to see if someone could break into it or put a virus in it. That is critical for compliance and Mr. Sponseller would advise that the Commission get someone to come to the TCC and test the system and verify that it is protected. The system is already encrypted and is password protected and the staff has prepared policies. Mr. Sponseller stated that the hospitals that are worried about sending their information to the TCC should sign a Business Associate Agreement and the Commission should agree to sign what the hospital proposes.

Mr. Pettyjohn stated that GTRI did a Risk Assessment based on their knowledge of the software and the information regarding HIPAA. Mr. Pettyjohn stated he would like an independent firm to come in and do a Risk assessment, and he would like one of the stakeholders to recommend someone.

Dr. Ashley requested that someone do the Risk Assessment as soon as possible.

Mr. Pettyjohn stated that he would make sure that the Risk Assessment is done.

Dr. Ashley wanted to know how the TCC's work on security policies was coming along.

Mr. Pettyjohn responded that the TCC has security privacy policies developed and in place and we are moving forward to make sure everyone understands that we are compliant and respectful.

NEW BUSINESS: None

NEXT MEETING Thursday, 15 November 2012 in Augusta

MEETING ADJOURNED: Dr. Ashley declared the meeting adjourned at 2:33 pm.

Minutes crafted by Lauren Noethen

GEORGIA BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

Greg Bishop

Bishop+Associates

August 16, 2012

GEORGIA BURN CENTER ASSESSMENT

PROJECT COMPONENTS

- Economic Assessment of Georgia's Burn Centers
- Formula For Burn Center Readiness Cost Payment
- Crosswalk for Burn Center Uncompensated Care Reimbursement

CROSSWALK FOR BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

TRAUMA CENTER FORMULA

Trauma Center Cost Norms					
ISS	Community	Academic	Vol	X Norm	= Total
0-8	$5,267	$6,373	90	$6,373	$573,576
9-15	$10,428	$12,618	45	$12,618	$567,805
16-24	$19,626	$23,747	83	$23,747	$1,971,039
>24	$33,945	$41,073	24	$41,073	$985,763
			242	**$16,935**	**$4,098,183**

CROSSWALK FOR BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

BURN CENTER FORMULA

2009 Trauma Center Survey			
Severity Group	**Pats**	**Days**	**ALOS**
ISS 0-8	4,412	19,538	4.4
ISS 9-14	4,352	29,132	6.7
ISS 16-24	1,690	21,122	12.5
ISS >24	865	14,050	16.2
Total	**11,319**	**83,842**	**7.4**

2010 Burn Center Survey			
Severity Group	**Pats**	**Days**	**ALOS**
% TBSA 0-5%	559	1,804	3.2
% TBSA 6-10%	349	1,624	4.7
% TBSA 11-20%	204	1,423	7.0
% TBSA 21-30%	47	840	17.9
% TBSA >30%	53	1,446	27.3
Electrical burn	38	421	11.1
Smoke inhalation	19	146	7.7
Total	**1,269**	**7,704**	**6.1**

CROSSWALK FOR BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

BURN CENTER FORMULA

Severity Group	Burn Criteria	Trauma Criteria	BC ALOS	TC ALOS	BC Pat %	TC Pat %
Basic	TBSA 0-5% 6-10%	ISS 0-8	3.8	4.4	71.6%	39.0%
Moderate	Smoke, TBSA 11-20%	ISS 9-14	7.0	6.7	17.6%	38.4%
Major	Electrical Burn	ISS 16-24	11.1	12.5	3.0%	14.9%
Severe	TBSA 21-30% 30+%	ISS >24	22.9	16.2	7.9%	7.6%
		Average	**6.1**	**7.4**	**100.0%**	**100.0%**

BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

IMPLEMENTATION

Burn centers will be eligible for funding once state certified and the annual survey period occurs.

Doctors Hospital was certified as a burn center on July 7, 2011, and will be eligible for funding for SB 60 patients treated in the balance of 2011 (in FY 2014).

Grady Memorial Hospital's burn center was certified on May 25, 2012 and will be eligible for the balance of 2012 in the FY 2015 budget.

BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

PATIENT INCLUSION CRITERIA

- A minimum 48 hour length of stay upon admission unless the patient was transferred or died.
- Patients must meet SB 60 requirements.
- Due to burn centers' multi-state service areas, only patients from Georgia will be included.
- Eligible burn patients must have a principal ICD-9 code indicating a burn diagnosis and at least one injury or complication based upon ABA criteria.

BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

BURN CENTER REPORTING

The burn centers will be required to respond promptly to requests for financial, operational and performance information.

The burn centers will submit annually the basic report required by the National Burn Repository, containing patient demographic, clinical, hospital resource use and cause of injury information on each burn patient.

BURN CENTER UNCOMPENSATED CARE REIMBURSEMENT

BURN CENTER IMPACT ON TRAUMA FUND

- Burn centers will receive 50% of Level I trauma center readiness funding; as a result, they will receive 7.8% of overall readiness funds
- In FY 2016, burn centers would receive 9.5% of uncompensated care funds.
- Burn centers would receive 8.6% of the combined readiness and uncompensated care funds.
- Burn care physicians will receive 25% of readiness and uncompensated care payments.

QUESTIONS

GEORGIA TRAUMA FOUNDATION
Concept & Planning

GEORGIA TRAUMA FOUNDATION

CONCEPT

The Georgia Trauma System is an essential public service.

Developing public support, leveraging system resources with additional funding, and building needed infrastructure to carry out the “Framework” and strategic plan is necessary to fulfill its mission.

Trauma foundations have developed in a variety of states to support trauma system objectives.

GEORGIA TRAUMA FOUNDATION

A MODEL

Perhaps the best model for Georgia is the Texas EMS Trauma & Acute Care Foundation, a 501(c) (3) nonprofit organization formed in 2006 with broad stakeholder support.

It provides operational support for the trauma system with Divisions in EMS, Pediatric, Injury Prevention, RTACs, Disaster, Professional Education & Trauma.

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DIVISIONS

Acute Care

The Acute Care Division's strategic priority is to further develop the Stroke and Cardiac Systems in Texas. This will be done by enhancing and improving patient care, evolving system... more

EMS

The TETAF EMS Division supports EMS and the role of EMS in the trauma and acute care systems of Texas through advocacy, education, resources and legislative initiatives utilizing strategic goals and... more

Injury Prevention

The TETAF Injury Prevention Division focuses on injury prevention education, injury prevention resources, advancement of injury prevention and safety at the RAC and state level... more

Pediatric

The TETAF Pediatric Division is leading efforts to enhance and evolve pediatric emergency and trauma care in Texas. Chaired by Lori Vinson, Trauma Services Director, Children's... more

Professional Education

RAC and Disaster

Trauma

GEORGIA TRAUMA FOUNDATION

POTENTIAL FUNCTIONS

Cost-effective infrastructure for some of the following:

Engage Georgians In Supporting Trauma System

- State-of-the-art communication strategies with stakeholders and policymakers
- Public education on trauma care and trauma system development
- Organize referendum to create permanent/ adequate trauma system funding

GEORGIA TRAUMA FOUNDATION

POTENTIAL FUNCTIONS

Augment Trauma System Resources With Grants And Fundraising

- Develop expertise in grant development for trauma and EMS
- Organize collaborative grants/projects among stakeholders
- Support full collection of Super Speeder law revenues
- Develop a Georgia trauma research capability

GEORGIA TRAUMA FOUNDATION

POTENTIAL FUNCTIONS

Provide Structure To Support Trauma System Development And Operations

- Provide support services to Regional Trauma Advisory Committees (SHDDS)
- Support trauma center outreach, education and injury prevention initiatives
- Support for robust Performance Based Payment
- Support development of Level IV trauma centers

GEORGIA TRAUMA FOUNDATION

POTENTIAL FUNCTIONS

Develop Stakeholder Services/Opportunities

- Organize statewide trauma conference
- Conduct professional education for providers
- Develop/offer trauma center support services

The GTF should enjoy the enthusiastic participation of a broad range of stakeholders constructively addressing trauma system challenges.

GEORGIA TRAUMA FOUNDATION

Region Support

Technical Assistance
Common Web System
Common Services
MGMT Education

Education & Advocacy

Public Education
Social Marketing
CE/CME Programs
Advocacy

Trauma System Support

Grants/Fundraising
System Research
Rural Development
Operational support

GEORGIA TRAUMA FOUNDATION

PLANNING PROJECT

Develop Initial GTF Plan

- Input From Potential GTF Participants
- Define Organizational Structure
- Outline Alternate Functions
- Outline Financial Plan & Sources of Support
- Develop Implementation/Organizing Plan

Timeframe: 120 days

Project Costs: $40,000

QUESTIONS?

GEORGIA TRAUMA SYSTEM PERFORMANCE TOOL
Concept & Development

TRAUMA SYSTEM PERFORMANCE TOOL

BACKGROUND & CONCEPT

Statewide hospital discharge data sets (SHDDS), combined with an updated software algorithm that assigns injury severity scores (ISS), promise to be a powerful, cost-effective tool for assessing state trauma system performance.

The previous ISS algorithm for SHDDS had not been updated Since 1995 and was obsolete.

The Georgia Trauma System is positioned to be the first that employs this updated technology in measuring its performance.

TRAUMA SYSTEM PERFORMANCE TOOL

SHDDS DATA ELEMENTS

- Treating hospital
- ICD-9 diagnosis codes
- Mechanism of injury
- Procedure codes
- Length of stay
- Age, sex
- Payer class
- Charges
- Type of admission
- Patient source (ED, transfers)
- Patient disposition
- Zip code of residence/County

Adding an ISS score enables severity-based analysis of the state's injury patients, including the identification of injury patients meeting trauma center triage criteria.

TRAUMA SYSTEM PERFORMANCE TOOL

DEVELOPMENT OF TOOL

- B+A has used SHDDS extensively for 2 decades in trauma center and system projects.
- Digital Solutions (DI) developed a trauma registry that uses AIS 2005 (update 2008) to calculate AIS/ISS.
- B+A initially tested this tool for validity on one state's SHDDS with trauma center ISS data.
- Definitive validity testing will be conducted in Georgia as part of this project.
- Application in Georgia will be conducted as a research project to enable national reporting.

TRAUMA SYSTEM PERFORMANCE TOOL

POTENTIAL USES IN GEORGIA

This will enable the determination of the volume and severity of trauma patients being treated at non-trauma hospitals. Additional applications may include:

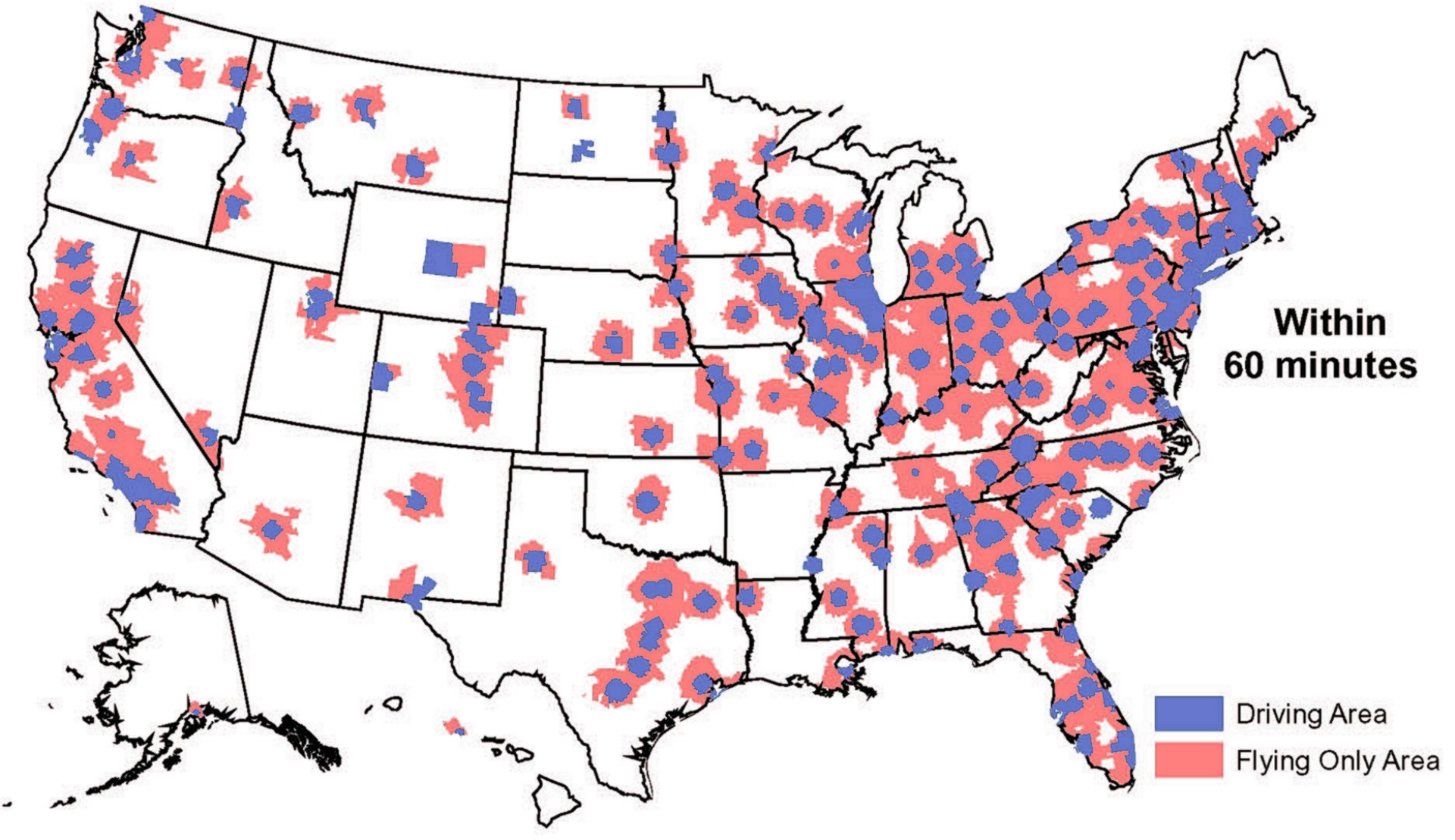
- Assessment of subset injury populations (pediatric, burn)
- Determine impact of new trauma centers on existing centers
- Economic profiling of a potential new trauma center
- Evaluation of ISS scoring by trauma centers
- Comparison of care quality in trauma/non-trauma centers
- Trauma Resource Allocation Model Ambulances/Hospitals

The ISS scored data set also can be provided to OEMS/T to support endeavors in trauma epidemiology.

EXAMPLE OF SHDDS USE

Patient Volume, Severity & Fully Allocated Care Costs					
Injury Severity Score	**# of Pts**	**% Pts**	**Per Day**	**ALOS**	**Patients Costs**
0-8 Basic	300	40%	**$3,000**	3.12	$2,810,808
9-14 Moderate	238	32%	$3,030	5.53	$3,981,202
15-24 Major	142	19%	$3,240	9.23	$4,243,548
24+ Severe	69	9%	$3,840	13.29	$3,536,628
Total	**749**	**100%**	**$3,252**	**5.98**	**$14,572,186**

TRAUMA RESOURCE ALLOCATION MODEL FOR AMBULANCES & HOSPITALS (TRAMAH)



TRAUMA SYSTEM PERFORMANCE TOOL

WORK PLAN FOR GEORGIA

I. **Form Project Task Force**
   GTCNC, OEMS/T, RTACS, GHA, Dennis Ashley, MD, Chair
II. **Calculate ISS Score For Georgia SHDDS**
III. **Identify Likely Trauma Center Patients In Georgia SHDDS**
IV. **Provide OEMS/T With Scored SHDDS**
V. **Review Results With Project Task Force**
VI. **Assess Georgia Trauma System Performance**
VII. **Report Results**

Timeframe: 120 days.

Project Costs: $22,500.

QUESTIONS

Patient Tracking Project

Background

- Contracted by the Department of Public Health
- Funding from the Health and Human Services, ASPR Healthcare Preparedness Program Grant

Georgia Hospital Association
Research & Education Foundation

April 10, 2009 – Augusta Tornado

- 120 residents of Amara Nursing Home were evacuated to area hospitals

Georgia Hospital Association
Research & Education Foundation

February 2010 – Earthquake Response

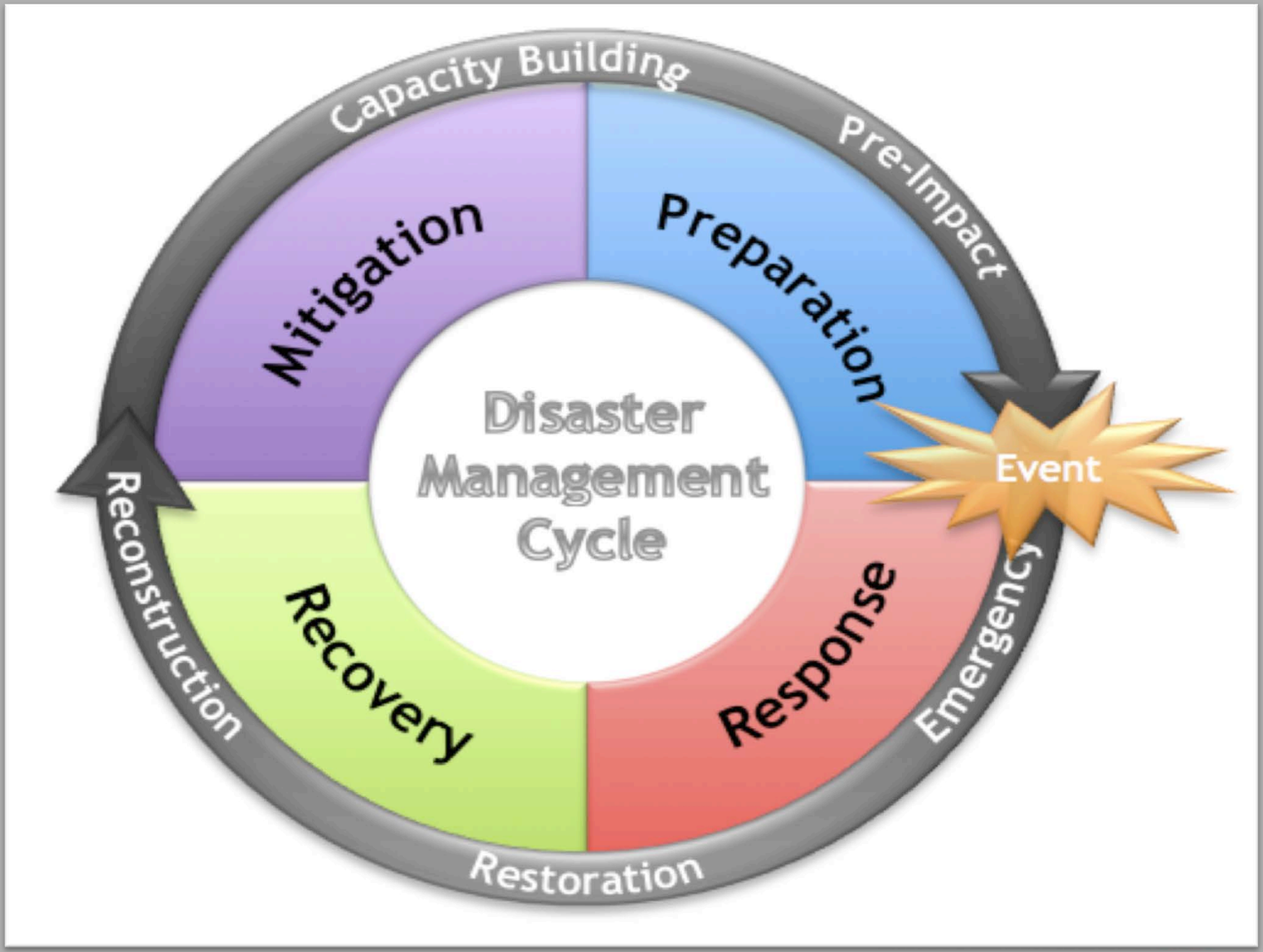
- 51 patients airlifted from Haiti to Georgia hospitals during a 30-day NDMS activation

Georgia Hospital Association
Research & Education Foundation

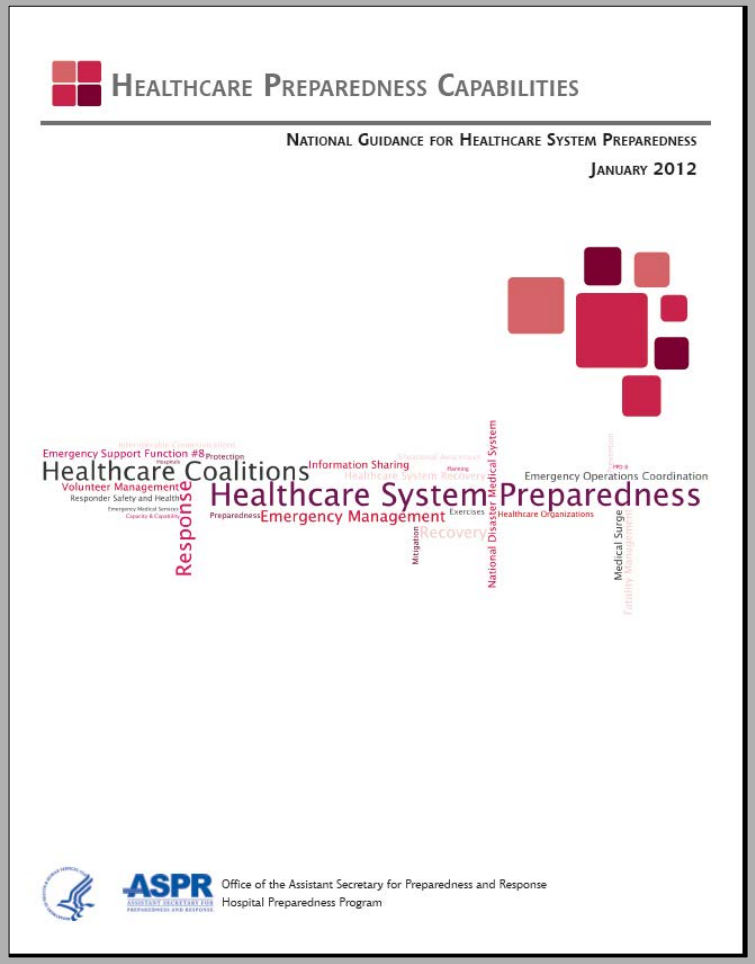
March 24, 2011 - Partial Roof Collapse

- 110 residents were evacuated from an assisted living center

Georgia Hospital Association
Research & Education Foundation


Capacity Building
Pre-Impact
Mitigation
Preparation
Disaster Management Cycle
Event
Reconstruction
Recovery
Response
Emergency
Restoration

Healthcare Preparedness Capabilities



Georgia Hospital Association
Research & Education Foundation

Capability 6: Information Sharing

- P6. Patient tracking
  - The State and Healthcare Coalitions, in coordination with EMS, healthcare organizations, and emergency management, develop, refine, and sustain a process to track patients and/or have access to an electronic patient tracking system during an incident.

Georgia Hospital Association
Research & Education Foundation

Capability 6: Information Sharing

- Identify system users that have the appropriate authority/access permissions for electronic systems
- Access relevant and available aggregate patient tracking data from EMS and healthcare organizations (e.g., number of patients requiring receiving facilities, requiring transfer services)
- Integrate the aggregate patient tracking data into the local, state and/or Federal incident common operating picture

Georgia Hospital Association
Research & Education Foundation

Capability 6: Information Sharing

- Adhere to mandatory patient confidentiality regulations

- Integrate with the Federal patient tracking system of record (Joint Patient Assessment and Tracking System (JPATS) used by the National Medical System (NDMS) patient movement system)

Georgia Hospital Association
Research & Education Foundation

GHA

Georgia Hospital Association
Research & Education Foundation

GHA

Georgia Hospital Association
Research & Education Foundation

GEORGIA TRAUMA CARE NETWORK COMMISSION

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

AGREED UPON PROCEDURES

For the Year Ending December 31, 2010

GH&I Gifford Hillegass & Ingwersen, LLP
CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

GEORGIA TRAUMA CARE NETWORK COMMISSION

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GH&I Gifford Hillegass & Ingwersen, LLP
CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS

INDEPENDENT ACCOUNTANTS' REPORT

To the Georgia Trauma
Care Network Commission

We have performed the procedures enumerated on Attachments A and A-1, which were agreed to by you, solely to assist you with respect to the validation of uncompensated care claim data for the year ending December 31, 2010. The Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers' (as listed on Attachment A) management are responsible for the uncompensated care claim data submitted for these procedures. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Georgia Trauma Care Network Commission. Consequently, we make no representation regarding the sufficiency of the procedures described on Attachments A and A-1, either for the purpose for which this report has been requested, or for any other purpose.

Our findings, documentation and recommendations for the procedures outlined in Attachments A and A-1 are outlined in Attachments B, B-1, and B-2, to this report.

We were not engaged to, and did not, conduct an audit or examination, the objective of which would be the expression of an opinion on the uncompensated care claim data. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers and is not intended to be and should not be used by anyone other than these specified parties.

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ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

Georgia-designated Trauma Centers:

- Atlanta Medical Center (AMC) – Atlanta
- Grady Memorial Hospital (Grady) – Atlanta
- Medical Center of Central Georgia, Inc. (MCCG) – Macon
- GA Health Sciences Medical Center (GHS) – Augusta
- Memorial Health University Medical Center (Memorial) – Savannah
- Athens Regional Medical Center (Athens)– Athens
- Floyd Medical Center (Floyd) – Rome
- Gwinnett Medical Center (Gwinnett) – Lawrenceville
- Hamilton Medical Center (Hamilton) – Dalton
- John D. Archbold Memorial Hospital (Archbold) – Thomasville
- Medical Center-Columbus (Columbus) – Columbus
- North Fulton Regional Hospital (North Fulton) – Roswell
- Clearview Regional Medical Center (Clearview) – Monroe
- Childrens Healthcare of Atlanta at Egleston (Egleston) – Atlanta
- Childrens Healthcare of Atlanta at Scottish Rite (Scottish Rite) – Atlanta
- Morgan Memorial Hospital (Morgan) – Madison
- Taylor Regional Hospital (Taylor) – Hawkinsville

Procedures:

The following are the agreed-upon procedures that Gifford, Hillegass & Ingwersen, LLP (GH&I) was engaged to perform related to the Georgia-designated Trauma Centers (Trauma Centers) listed above.

1. GH&I will assist the Georgia Trauma Care Network Commission (GTCNC) in the development of the uncompensated care claims survey instrument for the year ending December 31, 2010 (CY2010). GH&I will deliver the survey instrument to all Trauma Centers that were designated for all or part of CY2010 as listed above.

2. GH&I will collect the CY2010 uncompensated care claims survey instruments and detailed listings of uncompensated care claims submitted by each Trauma Center during the period that Trauma Center was designated in CY2010.

3. GH&I will consider each Trauma Center listed above and will recommend to the GTCNC sample sizes for detailed testing of the uncompensated care claims that were submitted. Factors that will be considered in determining the sample for detailed testing are listed below:

a. GH&I will evaluate the quantity and trending of the historical error rate for uncompensated care claims based on the test results of GH&I procedures in prior years.
b. GH&I will consider the consistency or variances noted in the number of claims that each Trauma Center has submitted in the current year compared with prior years.
c. GH&I will consider the volume of claims submitted by each Trauma Center.
d. GH&I will consider the types of errors that were identified during GH&I's first year of testing (CY2008 data) and evaluate whether the Trauma Center had the same types of errors in GH&I's CY2009 testing. We will also consider the types of errors that were identified during CY2008 and CY2009 testing and determine if these errors where addressed by the Assistant Attorney General's letter to Dr. Ashley dated March 15, 2011.
e. GH&I will exclude only one or two Level I Trauma Centers from our testing each year. GH&I will not exclude any Level I Trauma Center from testing for more than one consecutive year.
f. For Level II, III and IV Trauma Centers, GH&I may propose excluding a Trauma Center from testing for two consecutive years, but in the third year GH&I will include the Trauma Center in the sample for testing.
g. GH&I will structure the sample selection to achieve a testing average of 55%-65% of the physical locations and 70%-80% of the total claims population for the year.
h. GH&I will also exercise professional judgment in determining the proposed sample of Trauma Center locations for testing in consultation with Jim Pettyjohn, Executive Director of GTCNC. Mr. Pettyjohn will approve the final sample selection.

4. For each Trauma Center selected for testing as outlined in procedure # 3 above, GH&I will select a sample of the uncompensated care claims for testing as follows:

a. For Trauma Centers with less than 25 claims, GH&I will test 5 claims;
b. For Trauma Centers with between 25 and 50 claims, GH&I will test 10 claims;
c. For Trauma Centers with between 50 and 150 claims, GH&I will test 20 claims; and,
d. For Trauma Centers with greater than 150 claims, GH&I will test 40 claims.

5. For each claim selected in procedure #4 above, GH&I will view (on site at the Trauma Center location) the electronic billing record (EBR) or documents comparable to the EBR to determine that as of March 31, 2012 each claim selected in our sample met the criteria for consideration as an uncompensated care claim. The criteria for consideration as an uncompensated care claim are as follows:

a. The EBR documents that the patient had no medical insurance, including Medicare Part B coverage;
b. The EBR documents the patient was not eligible for medical assistance coverage;

c. The EBR documents that the patient had no medical coverage for trauma care through workers' compensation insurance, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage;
d. The EBR documents that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments;
e. The EBR documents that there were no third party payments received.

6. For each claim selected in our sample (as defined above), GH&I will determine that the Trauma Center has documented attempts at collection using the documentation that is available at each Trauma Center.

7. GH&I will verify that the ISS (Injury Severity Score) assigned to each claim selected in our sample (as defined above) matches the ISS for that patient in NTRACS (trauma registry software) used by all Trauma Centers.

8. GH&I will consider the additional clarifications approved by the GTCNC listed below:

A. Claims deemed qualified under the GTCNC 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.

B. Claims deemed NOT qualified under the GTCNC 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.

GH&I

ATTACHMENT A-1

ADDITIONAL PROCEDURES PERFORMED

GH&I discussed the findings summarized in Attachment B and presented in detail in Attachment B-1 from the execution of our agreed-upon procedures as described in Attachment A with the Executive Director for the Georgia Trauma Care Network Commission. As a result of this discussion, GH&I was engaged to perform the following additional procedures:

1. Provide each Trauma Center with the findings from our agreed-upon procedures as described in Attachment A. See the information that was provided to each Trauma Center in Attachment B-2.

2. Request revised lists of uncompensated care claims from the following Trauma Centers:

   - MCCG
   - Memorial
   - Grady
   - Columbus

   These revised lists should be duplicates of the original list provided to GH&I minus any claims that were identified in our agreed-upon procedures (AUP) to be in error (re: Attachment B Findings A through G in our report).

3. Compare the revised lists received above against the original lists received to ensure that errors GH&I noted in the AUP were eliminated (along with any other claims that the hospitals identified as erroneous) and that there are no new claims added to the list.

4. Revise GH&I AUP report to report the updated uncompensated care claims for each Trauma Center. Results are presented in Attachment B-2.

5. Present our draft report at Georgia Trauma Care Network Commission meeting on August 16, 2012 in Macon, Georgia.

6. Make any additional revisions to our draft report as requested by the Commission.

GH&I performed only the procedures outlined in Attachments A and A-1 and did not perform any additional procedures. We did not perform any procedures to evaluate if there were trauma patient claims that should have been reported by the Trauma Centers as uncompensated care claims and were not.

GH&I

ATTACHMENT B

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

FINDINGS SUMMARY:
We have accumulated our findings from our agreed-upon procedures that are outlined in Attachment A. They are outlined below along with our recommendations which have been considered and acted upon as deemed appropriate (See Attachment A-1). Additional information for each finding can be found in the detailed reports by location. (See Attachment B-1)

1. Finding: We noted claims at the following Trauma Centers where we concluded that the documentation did not meet the criteria for an uncompensated care claim due to:

   A. Patient had insurance including Medicare Part B coverage
      - Grady
      - Memorial
      - Archbold
      - Columbus

   Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where patients had insurance including Medicare Part B coverage.

   B. Patient was eligible for medical assistance coverage
      - Columbus
      - North Fulton

   Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where patients were eligible for medical assistance coverage.

   C. Patient had medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
      - Grady
      - MCCG
      - GHS
      - Memorial
      - Athens
      - Floyd
      - Columbus

Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where patients had 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. Payment by patient greater than 10%
   - Morgan

Recommendation: We recommend the GTCNC consider requesting that this Trauma Center revise its CY2010 uncompensated care claim list to exclude all claims where patients paid greater than 10% of the total charges.

E. Receipt of a third party payment
   - Grady
   - MCCG
   - Memorial
   - Athens
   - Columbus
   - Clearview

Recommendation: We recommend that the GTCNC consider requesting these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where third party payments were received.

F. No collection attempts were made by the Trauma Center.
   - Grady
   - Columbus

Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where there were no collection attempts made.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: ARCHBOLD

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with between 50 and 150 claims, we will test 20.
Archbold reported 66 claims, therefore we selected a sample of 20 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Medrec #	Trauma #	Admit Date	ISS	a	b	c	d	e	f	1	Comments
1	442165	2316	04/07/2010	9	X	P	P	P	P	P	P	The patient had an Aflac insurance supplemental policy. The patient received a payment but did not pay the hospital.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: COLUMBUS

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with more than 150 claims, we will test 40.
Columbus reported 182 claims, therefore we selected a sample of 40.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	ACCT ID	Registry #	ISS	a	b	c	d	e	f	1	Comments
1	713575017	7656	4	X	P	P	P	X	X	P	Patient had insurance and the hospital received a payment of $645 from Blue Cross Blue Shield. The hospital applied a $8,119.66 contractual adjustment for PPO discount.
2	713020048	7261	6	P	X	X	P	X	P	P	The patient was approved for Alabama Medicaid. The hospital received two payments on this account. The hospital received $1,000 from an attorney and $3,152 from Alabama Medicaid.
3	713520765	7603	9	P	P	X	P	X	P	P	The hospital received $2,000 from an attorney.
4	712906866	7287	12	X	P	P	P	P	X	P	The patient had Tricare insurance. The hospital received a Tricare payment of $5,681.
5	713577641	7660	13	P	X	P	P	X	X	P	The patient was approved for GA Medicaid. The hospital received a payment of $18,299.48 from GA Medicaid.
6	713363554	7499	14	P	P	P	P	P	X	P	The patient was a Columbus inmate. The hospital has a contract with the state to treat prisoners. There were no collection attempts due to the contract with the state.
7	713686186	7741	14	P	P	X	P	X	P	P	The hospital received a $2,000 payment from an attorney.
8	713357119	7487	17	X	P	P	P	X	X	P	The patient had Blue Cross Blue Shield (BCBS) insurance. The hospital received a payment of $16,850 from BCBS.
9	713089563	7315	22	P	X	P	P	P	X	P	The patient had Medicaid but the hospital did not get authorization to process the Medicaid. The hospital did not receive any payments from Medicaid since the hospital did not get the proper authorization.
10	713219582	7410	50	P	X	P	P	X	X	P	The patient was approved from Alabama Medicaid. The hospital received a payment of $16,610.72 from Alabama Medicaid.

Tickmark Explanations:

P Step performed without exception
X Step performed with exception, see explanation to right

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: FLOYD

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with between 25 and 50 claims, we will test 10.
Floyd Medical Center reported 31 claims, therefore we selected a sample of 10 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

- **a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- **b** The EBR shows the patient was not eligible for medical assistance coverage.
- **c** The EBR shows that the patient had 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** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- **e** The EBR shows that there were no third party payments received.
- **f** The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

- **1** We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Medical Record No	Admit Date	Registry No	ISS	a	b	c	d	e	f	1	Comments
1	F0000961077	8/15/2010	2711	8	P	P	X	P	P	P	P	The hospital's attorney found through his own research that the patient was awarded and received $5,000 from auto insurance medical pay. The hospital did not receive any payments from the patient.

Tickmark Explanations:

- **P** Step performed without exception
- **X** Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GRADY

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.
Grady reported 676 claims, therefore we selected a sample of 40 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Acct No	Medical Record No	Admit Date	ISS	a	b	c	d	e	f	1	Comments
1	457304301	20545795	8-Apr-10	14	P	P	X	P	X	P	P	The patient received a settlement of $850,000. The total charges from the hospital were $23,065.15. The hospital received a payment of $22,921.15 on this account.
2	461232134	20572887	10-Oct-10	14	X	P	P	P	P	P	P	The patient had BCBS insurance. The hospital wrote off the account to "untimely write-off" because insurance was not filed on time.
3	456444371	4255833	2-Mar-10	25	P	P	P	P	P	X	P	Patient was a prisoner of the city of Atlanta. The hospital has a contract with the city to treat prisoners. There were no collection attempts due to the contract with the city.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MCCG

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.
MCCG reported 270 claims, therefore we selected a sample of 40
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.

b The EBR shows the patient was not eligible for medical assistance coverage.

c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

e The EBR shows that there were no third party payments received.

f The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Medical Record No.	AMIT DATE	Registry No	ISS SCORE	a	b	c	d	e	f	1	Comments
1	98628077-0358	24-Dec-10	20230	4	P	P	X	P	X	P	P	The hospital received victim of crime payments on 2/7/11 and on 3/18/11 of $7,500 each.
2	98200178-0079	20-Mar-10	18907	5	P	P	X	P	X	P	P	The hospital received a victim of crime payment on 5/24/10 of $13,193.50.
3	98598351-0037	6-Feb-10	18740	10	P	P	X	P	X	P	P	The hospital received victim of crime payments on 4/5/10 and on 6/10/10 of $7,500 each.
4	98119892-0252	9-Sep-10	19762	17	P	P	X	P	X	P	P	The hospital received a check from Ken Nugent on 2/2/11 for $10,000 as a result of a settlement.
5	98595013-0001	1-Jan-10	18603	41	P	P	X	P	X	P	P	The hospital received victim of crime payments on 3/11/10 and 6/24/10 for $7,500 each.

Tickmark Explanations:

P Step performed without exception

X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GHS

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.
GHS reported 232 claims, therefore we selected a sample of 40 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	MRN	Admit Date	ISS	a	b	c	d	e	f	1	Comments
1	9036710	10/7/10	11	P	P	X	P	P	P	P	Patient received a settlement of $25,000. The attorney requested a discount based on the settlement and the hospital accepted the attorney's request but the hospital never received a payment.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MEMORIAL

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.
Memorial Health reported 272 claims, therefore we selected a sample of 40 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, For each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	PATIENT ID	ADMIT DATE	ISS	a	b	c	d	e	f	1	Comments
1	1010700017	4/17/2010	1	P	P	X	P	X	P	P	The hospital received a victim of crime payment of $11,239 on 8/20/10 that was greater than 10% of the patient's total charges.
2	1012200263	5/2/2010	4	P	P	P	P	X	P	P	The patient account was sold to a collection agency.
3	1009900925	4/9/2010	4	P	P	P	P	X	P	P	The patient account was sold to a collection agency.
4	3000007061	5/23/2010	13	X	P	P	P	P	P	P	The patient had a supplemental indemnity plan insurance that paid the patient $200/day up to $1,000. The hospital, however, never received a payment from the patient or the insurance provider.
5	1015400540	6/3/2010	14	X	P	P	P	P	P	P	The patient had BCBS medical insurance. A payment from BCBS was received on May 2, 2012 for $5,500 on total charges of $37,867.87. While the payment was received after the cut-off date of March 31, 2012, it is not eligible due to the patient having insurance when admitted.
6	1005200036	2/21/2010	19	P	P	P	P	X	P	P	The patient account was sold to a collection agency.
7	3000007702	1/4/2010	59	P	P	X	P	X	P	P	The patient received a settlement of $25,000. The hospital asked the attorney to pay $10,000 of the amount awarded. The attorney's office countered with $5,000. The hospital countered with $7,500 and the attorney accepted. The hospital received a payment of $7,500 on 12/8/10 from Progressive Insurance. Total hospital charges were $291,000.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: ATHENS

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with 50-150 claims, we will select 20.
Athens reported 91 claims, therefore we selected a sample of 20 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Trauma No	Account No	Admit Date	ISS	a	b	c	d	e	f	1	Comments
1	2055	5393332	9/14/10	9	P	P	X	P	X	P	P	The hospital received a payment of $621 from the patient's medical pay auto insurance.
2	2141	5448523	12/26/10	13	P	P	X	P	P	P	P	The patient was eligible for bodily injury coverage through auto insurance. There was $25,000 available for all of her bills. The insurance company wants the entire amount to be written off and the hospital has countered but no settlement has been reached.

Tickmark Explanations:

P Step performed without exception
X Step performed with exception, see comments to the right for more information.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: NORTH FULTON

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with between 50 and 150 claims, we will test 20.
North Fulton reported 73 claims, therefore we selected a sample of 20 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Registry No	Patient Account Number	Admit Date	Injury Severity Code	a	b	c	d	e	f	1	Comments
1	4416	18805978	2010/07/02	10	P	X	P	P	P	P	P	Patient was eligible and approved for Medicaid coverage. No payments were received as of 5/8/12.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: CLEARVIEW

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with less than 25 claims, we will test 5.
Clearview reported 17 claims, therefore we selected a sample of 5 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	Medical Record No	Record No	Admit Date	ISS	a	b	c	d	e	f	1	Comments
1	2280275	718	17-May-10	1	P	P	P	P	X	P	P	The hospital sold the account to a collection agency.
2	2307060	891	15-Dec-10	4	P	P	P	P	X	P	P	The hospital sold the account to a collection agency.
3	2298652	840	10-Oct-10	5	P	P	P	P	X	P	P	The hospital sold the account to a collection agency.
4	2266077	635	28-Jan-10	13	P	P	P	P	X	P	P	The hospital sold the account to a collection agency.
5	2275880	690	14-Apr-10	17	P	P	P	P	X	P	P	The hospital sold the account to a collection agency.

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

Results: The results of our testing of the sample of 5 claims indicated there was an issue with criteria e. All 5 of the claims in our sample were sold to a collection agency. We tested the remaining 12 claims specifically for criteria e to determine if these accounts were also sold to a collection agency. Based on this additional testing, we determined that all 17 claims that were originally submitted by Clearview were sold to a collection agency and, therefore, were not eligible as uncompensated care claims. We did not request Clearview to resubmit their list since we determined that all claims were ineligible.

GH&I

ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MORGAN

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with less than 25 claims, we will test 5.
Morgan reported 6 claims, therefore we selected a sample of 5 for testing.
For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b The EBR shows the patient was not eligible for medical assistance coverage.
c The EBR shows that the patient had 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 The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
e The EBR shows that there were no third party payments received.
f The hospital has documented attempts at collection via documentation available at the hospital.
Additionally, for each claim selected we determined the following:
1 We verified that the ISS reported is the same as that listed in the hospital's trauma registry software.

	TRAUMA REGISTRY NO.	MEDICAL RECORD NO.	DATE OF ADMISSION	ISS	a	b	c	d	e	f	1	Comments
1	83	279832	10/17/2010	4	P	P	P	X	P	P	P	The patient made payments that are more than 10% of the total patient charges. Total charges were $1,352 and the patient paid $345 for a total of 26%.

Tickmark Explanations:

P Step performed without exception
X Exception noted see comment for explanation

GH&I

ATTACHMENT B-2

SUMMARY FINDINGS BY LOCATION

Locations Tested With Claims Resubmitted

		ISS Category						
		0-4	5-8	9	10-15	16-24	>24	Total
Grady	Per Original Survey	228	66	117	116	80	69	676
	Per AUP	227	66	117	114	80	69	673
	Difference 1	(1)	-	-	(2)	-	-	(3)
	Per Revised List	204	62	105	99	66	59	595
	Difference 2	(24)	(4)	(12)	(17)	(14)	(10)	(81)
MCCG	Per Original Survey	66	47	28	59	41	29	270
	Per AUP	65	46	28	58	40	28	265
	Difference 1	(1)	(1)	-	(1)	(1)	(1)	(5)
	Per Revised List	42	35	20	52	34	15	198
	Difference 2	(24)	(12)	(8)	(7)	(7)	(14)	(72)
Memorial	Per Original Survey	60	48	41	55	49	19	272
	Per AUP	57	48	41	53	48	18	265
	Difference 1	(3)	-	-	(2)	(1)	(1)	(7)
	Per Revised List	51	43	40	54	44	20	252
	Difference 2	(9)	(5)	(1)	(1)	(5)	1	(20)
Columbus	Per Original Survey	36	27	34	41	34	10	182
	Per AUP	35	26	33	37	32	9	172
	Difference 1	(1)	(1)	(1)	(4)	(2)	(1)	(10)
	Per Revised List	27	23	28	26	28	8	140
	Difference 2	(9)	(4)	(6)	(15)	(6)	(2)	(42)
Total	Per Original Survey	390	188	220	271	204	127	1,400
	Per AUP	384	186	219	262	200	124	1,375
	Difference 1	(6)	(2)	(1)	(9)	(4)	(3)	(25)
	Per Revised List	324	163	193	231	172	102	1,185
	Difference 2	(66)	(25)	(27)	(40)	(32)	(25)	(215)

Difference 1: ineligible claims determined by GH&I

Difference 2: ineligible claims determined by GH&I plus ineligible claims determined by center during resubmission process

GH&I

ATTACHMENT B-2

SUMMARY FINDINGS BY LOCATION—Continued

Locations Tested Without Resubmission

		ISS Category						
		0-4	5-8	9	10-15	16-24	>24	Total
GHS	Per Original Survey	44	44	38	53	40	13	232
	Per AUP	44	44	38	52	40	13	231
	Difference 1	-	-	-	(1)	-	-	(1)
	Total claims per AUP	44	44	38	52	40	13	231
Athens	Per Original Survey	23	5	18	22	17	6	91
	Per AUP	23	5	17	21	17	6	89
	Difference 1	-	-	(1)	(1)	-	-	(2)
	Total claims per AUP	23	5	17	21	17	6	89
Floyd	Per Original Survey	8	4	6	5	4	4	31
	Per AUP	8	3	6	5	4	4	30
	Difference 1	-	(1)	-	-	-	-	(1)
	Total claims per AUP	8	3	6	5	4	4	30
Archbold	Per Original Survey	20	15	6	12	9	4	66
	Per AUP	20	15	5	12	9	4	65
	Difference 1	-	-	(1)	-	-	-	(1)
	Total claims per AUP	20	15	5	12	9	4	65

		ISS Category						
		0-4	5-8	9	10-15	16-24	>24	Total
North Fulton	Per Original Survey	13	10	17	16	11	6	73
	Per AUP	13	10	17	15	11	6	72
	Difference 1	-	-	-	(1)	-	-	(1)
	Total claims per AUP	13	10	17	15	11	6	72
Morgan	Per Original Survey	5	-	-	-	-	1	6
	Per AUP	4	-	-	-	-	1	5
	Difference 1	(1)	-	-	-	-	-	(1)
	Total claims per AUP	4	-	-	-	-	1	5
Clearview	Per Original Survey	8	2	1	4	2	-	17
	Per AUP	-	-	-	-	-	-	-
	Difference 1	(8)	(2)	(1)	(4)	(2)	-	(17)
	Total claims per AUP	-	-	-	-	-	-	-
Total	Per Original Survey	121	80	86	112	83	34	516
	Per AUP	112	77	83	105	81	34	492
	Difference 1	(9)	(3)	(3)	(7)	(2)	-	(24)
	Total claims per AUP	112	77	83	105	81	34	492

Difference 1: ineligible claims determined by GH&I

GH&I

ATTACHMENT B-2

SUMMARY FINDINGS BY LOCATION—Continued

Locations Not Tested

		ISS Category						
		0-4	5-8	9	10-15	16-24	>24	Total
AMC	Per Original Survey	129	60	48	53	41	21	352
Gwinnett	Per Original Survey	48	18	36	22	20	13	157
Hamilton	Per Original Survey	8	2	7	4	3	-	24
Egleston	Per Original Survey	19	-	6	2	5	-	32
Scottish Rite	Per Original Survey	29	-	2	1	1	1	34
Taylor	Per Original Survey	3	-	-	-	-	-	3
Total		236	80	99	82	70	35	602

Summary

	ISS Category						
	0-4	5-8	9	10-15	16-24	>24	Total
Total Claims Per Original Survey	747	348	405	465	357	196	2,518
Claims Not tested	236	80	99	82	70	35	602
Total Claims Tested	511	268	306	383	287	161	1,916
Claims Subject to Testing	68%	77%	76%	82%	80%	82%	76%
Totals Per AUP	496	263	302	367	281	158	1,867
Difference 1	(15)	(5)	(4)	(16)	(6)	(3)	(49)
Per Revised List	324	163	193	231	172	102	1,185
Per AUP Without Resubmission	112	77	83	105	81	34	492
Total After Revised List and AUP	436	240	276	336	253	136	1,677
Difference 2	(75)	(28)	(30)	(47)	(34)	(25)	(239)
Total Claims	672	320	375	418	323	171	2,279

Difference 1: ineligible claims determined by GH&I
Difference 2: ineligible claims determined by GH&I plus ineligible claims determined by center during resubmission process

GH&I

ATTACHMENT B-2

SUMMARY FINDINGS BY LOCATION—Continued

Trauma Center	ISS Category 0-8	9-15	16-24	>24	Total
Level IV					
Morgan Memorial Hospital	4	-	-	1	5
Level III					
Taylor Regional Hospital	3	-	-	-	3
Clearview Regional Medical Center	-	-	-	-	-
Level II					
Athens Regional Medical Center	28	38	17	6	89
John D. Archbold Memorial Hospital	35	17	9	4	65
Medical Center-Columbus	50	54	28	8	140
Floyd Medical Center	11	11	4	4	30
Gwinnett Medical Center	66	58	20	13	157
Hamilton Medical Center	10	11	3	-	24
North Fulton Regional Hospital	23	32	11	6	72
Childrens Healthcare of Atlanta at Scottish Rite	29	3	1	1	34
Level I					
Atlanta Medical Center	189	101	41	21	352
Childrens Healthcare of Atlanta at Egleston	19	8	5	-	32
Grady Memorial Hospital	266	204	66	59	595
Medical Center of Central Georgia, Inc.	77	72	34	15	198
GA Health Sciences Medical Center	88	90	40	13	231
Memorial Health University Medical Center	94	94	44	20	252
	992	793	323	171	2,279

CONCLUSION:

We appreciate the opportunity to be of service to you. This report summarizes the results of our engagement. If you have any questions, please let us know.

Very truly yours,

GIFFORD, HILLEGASS & INGWERSEN, LLP

The state multi-disciplinary committee made up of not only physicians, but also members of the EMS, nursing, public health, and Regional staff, numerous professional organizations and affiliated groups. Member should include but not limited to……

Trauma Coordinators, Surgeons and ER Physicians from designated trauma centers

Regional Health District Directors

Regional EMS Medical Directors

Regional EMS Program Directors

EMS Directors and service Medical Directors

Hospital administration and medical staff from non-designated facilities

Air Medical Services

Emergency Medical Services for Children

Office of Rural Health

Amer. Red Cross

Association of County Commissioners

Traumatic Brain Injury Trust

Gov. Office of Hwy Safety

Public Health

Georgia Emergency Management Agency

Injury Prevention

Georgia Hospital Association

Burn Centers

Rehabilitation

Consumer advocates