Minutes approved 17 March 2011

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 17 February 2011

Scheduled: 10:00 am until 1:00 pm
Atlanta Medical Center
Health Pavilion-Letton Auditorium
320 Parkway Drive NE Atlanta, GA 30312

CALL TO ORDER

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

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Linda Cole, RN Ben Hinson Dr. Leon Haley Bill Moore Rich Bias Kelli Vaughn, RN (via tele-conference) Dr. Joe Sam Robinson	Mr. Kurt Stuenkel

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Office Coordinator	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Alex Sponseller	Assistant Attorney General
Scott Sherrill (via tele-conference)	GTRI
Regina Medeiros	MCG Health
Gigi Goble	GPT
Lawanna Mercer-Cobb	SOEMS/T – Region 6
Kim Brown	Hamilton Medical Center
Marie Probst	OEMS/T
Patricia Mayne	Wellstar Kennestone
Russ McGee	Region 5 OEMS/T
Debra Kitchens	MCCG
Renee Morgan	OEMS/T
Lee Oliver	MCCG
Elaine Frantz	Memorial
Keith Wages	OEMS
David Bean	EMS Consulting Services
Jill Mabley	OEMS

Adam Bomar	Kennestone
Carie Summers	Georgia Hospital Association
Rana Bayakly	DPH /Chronic Disease
Pat O'Neil	DCH
Danlin Luo	CHD
Jim Sargent	Tenet Health
Michelle Putnam	Healthstat
Courtney Terwilliger	GAEMS
Barry Renz	GMC

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT

Dr. Dennis Ashley welcomed all present. Confirmation of Commission Members attending and Ms. Kelli Vaughn participated by conference call. Thanking Mr. Bill Moore of Atlanta Medical Center for allowing the Commission to use his facility.

Last month we did not have a Commission meeting but a Workshop that took place in Rome Georgia, that Mr. Kurt Steunkel was nice enough to host, and those minutes have been posted, and there are copies as well. We looked at our strategic plan and reprioritized and discussed accomplishments. A new plan is in edit form now, and when that is available we will put that on the GTCNC Website. We took an $11 million cut in our budget for this fiscal year, that's 53%, and that's for this year that will end June 30 2011. We will be discussing that as we move through this meeting, and what it means.

APPROVAL OF THE MINUTES OF THE 18 NOVEMBER 2010 & 5 & 6 JANUARY 2011 MEETING

The draft minutes of the 18 November 2010 Georgia Trauma Commission and the 5 & 6 January Workshop 2011 meeting were distributed to the Commission prior to the meeting via electronic means and are also available to meeting attendees in printed form.

Mr. Jim Pettyjohn stated unless the Commission disapproves he would like to go more paperless. He stated that during the week of the Commission meeting all documents that we have to present during the Commission meeting we put them on the GTCNC Web Page for people to review and copy as desired. I will bring hard copies for the Commission's use.

Mr. Jim Pettyjohn mentions that the first hour of the first day of the January 2011 Workshop was closed for staff performance review, according to open records allowances it was a closed meeting, the affidavit that was signed by the presiding officer Dr. Dennis Ashley is also within the minutes, it was notarized according to the Attorney Generals directions.

MOTION GTCNC 2011-02-01:
I move that the minutes of the 18 November 2010 Georgia Trauma Care Commission and 5&6 January Workshop 2011 meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Dr. Leon Haley**

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

ADMINISTRATIVE REPORT REVIEW

Mr. Pettyjohn summarized the Administrative Report *(Administrative report as well as all approved minutes will be posted to www.gtcnc.org.)*

We have a special presentation today on the Trauma Quality Improvement Program by Dr. Avery Nathens, a physician with the American College of Surgeons and Melanie Neal who is the National Trauma Data Base Manager as well as the TQIP manager. Within the Admin Report is the latetest on the TQIP Program, and also available is the Bio of Melanie Neal and Dr. Avery Nathens. Included in the report is our most recent Super-Speeder Revenue, and that will show that we are on target to receive the funding that was budgeted by the governor for FY 2011. A copy of the invite from the Andrew Young School of Health Policy to injury prevention and injury control researchers and folks around the state to a Commission sponsored one and half day seminar on systems thinking involving injury prevention in a effort to develop a Dynamic Systems Model. You will also see a letter from Dr. Gage Oshner, of which Elaine Frantz will be talking about later in the agenda. Included are pages from the Governor's budget book for FY 2011 and revenues expected from driver's services, and it will show that the Super Speeder Bill in 2010 only generated a little over 2 million dollars and it is projected to provide 10.5 million for the entire FY 2011. Office of Planning and Budget as well as the House Appropriation Subcommittee has the understanding that the Commissions budget, as we know it now and in the next few years will be tied to the actual revenue stream of the Super Speeder Bill. The Emergency Preparness and Trauma System Improvement Program were cut and there is a change that regards the Commission. The Commission is now directed to add to our grants and contracts and to all trauma centers, the requirement that trauma centers provide registry data to the Office of EMS. So that must now be included in our contracts. Because we are decreasing funds for the hospitals in 2011 we will have to amend our contract in place with each of the hospitals. The Commissions budget is printed in detail, and also the budget documents.

FY 2011 BUDGET REPORT

Ms. Linda Cole goes over the 2011 budget report. We have 53% less than we thought which is 10.5 million dollars. From the 10.5 million there was two errors from the 2011 that occurred where the dollars did not get paid out of the FY 2010 budget so had to be paid out of 2011 budget. This gives us a base to start at of about 8.8 million. There is the 3% to OEMS and Trauma Commission operations, the Communication Center System Development and what is available to stakeholders. In detail the Office of EMS and Trauma Allocation had a considerable decrease. Their 3% of actual base will be approximately $264,000. From those dollars Dr. Pat O'Neal hopes to fund several positions, and we will let him determine how to spend those dollars with the exception of a request that the $12,000 remain for region 5 & 6 regional directors travel. As we develop region 5 & 6 and the Trauma Communications Center we think we will really need their assistance and availability to travel. Commission operations auditing services were cut almost in half, rather than $100,000, it is now $51,000, and we are proposing not to move forward with the Procurement Officer. The Commission per diem we cut the number of meetings, and many of the Commissioners have not moved forward with receiving their per diem. Some travel funds had to be added back in, as it had been left out. We cut the contingency planning from $100,000 to $25,000. So that leaves a new total for Commission Operations of $314,000, about $170,000 less than originally. *(Attached FY 2011 Amended Budget)*

The next discussion is on the Trauma Communications Center and the proposed cuts. On hardware we are not far enough along to be able to cut anything with any certainty. The staff was trimmed down to $ 96,000. We knew what the rent would be with Georgia Public Safety Training Center (GPSTC) so we were able to put in a real number there, which decreased it. A considerable amount was cut from the contingency fund, $100,000. The total for the Trauma Communications Center is down to 1.4 million dollars, which is about a $300,000 cut.

Mr. Ben Hinson comments that he thinks we could get all the benefits of the Communications Center from the first 3 months of operation if we just staffed the center 9-5, five days a week. It would give the day staff a chance to learn the system and iron out the challenges and work to improve them. At night

and on the weekends it would be the same as it is now, which is working. At night you do not have your senior staff. At night they might just be sitting there waiting for the phone ring, when you have not quite figured out how to do everything. I think that might save us some money and give us a better product, while we are learning the system.

Ms. Linda Cole is concerned that most traumas do not occur 9-5 Monday through Friday. Most traumas occur in the evenings and on weekends. "My biggest concern is for the EMS to remember to call." If they are not doing something different consistently, versus remembering to do something different a percentage of the time could be challenging. Also I think we would not get the good usage that we need. When we look at the cost the staffing cost is less than a $100,000 on a budget of 1.4 million. Ms. Cole added, "I would hate to cut pennies to save some dollars and potentially sacrifice this not working well by not being consistently there."

Mr. Ben Hinson states if the Commission thinks we need to go 24/7 on it, he is not going to fight it. He just wanted to make that point thinking it could be a place where we could save some money. Since it is under a $100,000 on the whole thing, it is not worth the discussion.

Mr. Rich Bias wants to know if the line for communications software includes all the expenses that were identified in the successful bid. Is there a licensing fee, or maintenance fee in the initial acquisition that is not necessarily in the software one? Is everything included?

Mr. Scott Sherrill states that there is not for the first year. There is a licensing fee for ongoing years. There are some other expenses related, antennas, generators, things of that nature that have been explicitly called out as not included into the RFD. Mr. Scott Sherrill states the winning bidder was in the high five figures from going in on the licensing and technical support, so below $100,000 on an annual basis.

Ms. Linda Cole states that it also includes not just support to the TCC but also support for the hospitals that are communicating back and forth to the TCC.

Mr. Bill Moore wants to know if no more than 2/3 of this revised budget is in the hardware capital expenditure, and if that has to be spent by June 30th of this year

Ms. Linda Cole states that is absolutely possible.

Mr. Jim Pettyjohn states that the contract can also be amended to go further and also carry those funds as well.

Mr. Ben Hinson states that we need to remember that in the past there was $600,000 we thought we could spend, that went away suddenly.

Ms. Linda Cole's next discussion is on the System Development Access, Trauma System Regionalization, and those are the grants to region 5 & 6, to begin the Trauma Center Readiness Groups. Georgia Tech for assistance in the communication center setup was cut about $20,000. Bishop & Associates for the work that he has done for us, primarily for the Workshop last month and in developing the Economic Surveys. Membership in the Trauma Center Association of America. The $ 50,000 for the Telemedicine, Teletrauma Grant Award we have already done, $50,000 for Broselow, and that project is moving along very nicely, we were not able to cut much there so right at $459,000. We continue the same split at the dollars that were left over after funding the more fixed costs and other costs with 20% split for EMS, 80% for the hospitals and the physicians combined.

Mr. Rich Bias asked the chairman if he might express a concern. From the perspective from at least one trauma center what has occurred is a hardline cost shifting related to the registry expense. We had ongoing support for years for the trauma registry and it has been a requirement to even get into the game. We require it for those who are getting grants or anticipating grants. That $377,000 should be

added on top of the readiness component. Because we are just absorbing it, along with the trauma centers, it is not being distributed proportionately. He would like consideration with the FY2012 budget, of literally adding the registry expense as a hardline on top, not simply writing it in as a requirement for performance.

Mr. Jim Pettyjohn states and that would be $377,000 is for six months, so if you want to fund it for the entire 2012 that would be about $750,000.

Mr. Rich Bias states that this is total cost shifting it is literally reducing whatever the hospitals end up getting through readiness.

Mr. Jim Pettyjohn says that he would like to work with the OEMST as we prepare the 2012 budget to get the actual numbers on how much the registry does cost, and bring that to the Commission. It maybe more or it may be less. We might have to decide. But we will work on that.

Mr. Rich Bias states that is not even readiness it is just getting in the game.

Mr. Ben Hinson states that basically what that means is that part of it comes out of EMS, and part of it comes out of hospital. I just do not want to say that I agree with that.

Mr. Rich Bias states that the alternative that he would go for is we have to play the proportional split game. Would be to go from the top down with the distribution of whatever that figure is.

Mr. Ben Hinson states that he does not disagree, but would like to have a full debate on that at a later date. No change now.

Mr. Jim Pettyjohn would like to discuss the hospitals distribution. We have received the draft of the trauma center audit, and there will be a presentation on March 17. There is an opportunity for the for the Commission to a Subcommittee recommendation to revisit the uncompensated care dollars distribution for the trauma centers, so those numbers could change.

Dr. Leon Haley agrees that the Subcommisson needs to review the audit, and think about what those recommendations are.

Mr. Jim Pettyjohn states that the total uncompensated dollar amount to hospitals is not going to change, but the individual dollar amount to the hospitals might change.

Dr. Dennis Ashley states that the Subcommittee will work on that between now and the next meeting. And we will finalize that at the next meeting.

Mr. Rich Bias asked the question whether or not it is possible to have the contracts written that allows the EMS figure to flex based on the decision of the Commission without having a dollar amount.

Mr. Pettyjohn states that he was told that we have to have fixed dollar amounts to do the contracts. After today we will have the readiness amount determined. I will have to amend all 17 contracts for just the readiness. And then on the 17 of March when the uncompensated care amounts are determined he will then again have to amend all 17 contracts to accommodate the new uncompensated care amounts.

Rich Bias wants to clarify that there is a huge difference between amending an executed contract and holding them up for rewriting, which has been occurring so far. And you are saying they will be executed to allow everything but uncompensated care, will there be another amendment that would be the finalization of uncompensated care?

Mr. Jim Pettyjohn says no, they are executed with the old numbers before the 53% cut. Today we are going to have new numbers for readiness. So the executed contracts in place now will have to be amended.

Mr. Rich Bias states so when that amendment is done we can start readiness and not wait until an amendment occurs from uncompensated care.

Mr. Jim Pettyjohn agreed.

MOTION GTCNC 2011-02- 02:
I move that the Georgia Trauma Care Network Commission adopt the budget as currently presented to reflect the Governors revised recommendations to the Commission.

MOTION **Mr. Bill Moore**
SECOND BY: **Ms. Linda Cole**

DISCUSSION: Mr. Jim Pettyjohn needs direction that he is to move forward with amending these Contracts as of today, so we can start working on the readiness knowing that there might be another amendment after March.

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

SUBCOMMITTEE REPORTS

EMS Subcommittee on Trauma – Mr. Ben Hinson reported. (*(08 February EMS subcommittee meeting – draft minutes attached to Admin report)*. There were 12 -15 members present, so it is still a very dynamic and vibrant group, a lot of good work. We had a presentation from Dr. Jim Broselow on his system and how it will be applied in the EMS world. There was conversation about the AVLS Program. The Trauma Commission funded the first phase of the AVLS Program. We are buying about 200 units to put in ambulances that are going to region 5 & 6 and the pilot program. There was some hope that GEMA could reach back with the federal funding they had and purchase the ones that the Trauma Commission had already done thus making some money available to EMS. More importantly putting the entire system under one program. It was found out right before the EMS meeting on February 8, that GEMA could not do that. So the Trauma Commission will be faced with funding the ongoing airtime cost for the 300 units that were already purchased. We were planning on paying for 1,350 units from now on, so we only have 200 saved so that's actually a win. Several motions came up dealing with equipment that is being bought through the Trauma Equipment List Grant Program. We came up with a very solid list of equipment to go on ambulances. You cannot purchase anything that was required on the ambulance, but you could buy additional equipment specifically for trauma patients. We have expanded the list, because other people had good reason to buy certain things. Rather than approving an acceptation we decided we would simply expand the list. So if one person could buy it anybody else that needed it could buy it in the future. So one of the motions at the last Subcommittee meeting was a motion to ask the Commission to allow the Subcommittee on EMS to expand the equipment list as needed.

MOTION GTCNC 2011-02-03:
I move that the Georgia Trauma Care Network Commission allow the EMS Subcommittee to Expand the equipment list as needed, for equipment purchase through the EMS Grant Program.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Mr. Rich Bias**

DISCUSSION:

Dr. Dennis Ashley states that if he understands the motion correctly that would be the EMS Subcommittee that approves it.

Mr. Ben Hinson states that they will not approve all requests for additional equipment without a very robust hearing, and it was felt to have to bring that request to the Georgia Trauma Commission every meeting was not a good use of time.

Mr. Rich Bias thinks that the minutes come forth and that the action taken would be monitored and if the Commission had any concern at any point going forward it could review the process. I think it makes a lot of sense.

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

Mr. Ben Hinson states that Treutlen County EMS which runs a BLS service down in South Georgia, qualified for an ambulance grant and they bought a very small van type ambulance with their grant and had some money left over. Due to changes that the FCC is going through all of the radios in their EMS system will soon be outdated and unusable. They presented this to the EMS Subcommittee asking be allowed only on specific approval to use the excess money from their grant to buy radios to go in the new ambulance an into their old ambulance so they can communicate following the FCC changes. The EMS Subcommittee did move to allow the Treutlen County EMS to use the excess funds over the cost of their ambulances to replace radios in their fleets. So that comes as a motion with a second from the Subcommittee.

Mr. Jim Pettyjohn states that it is about $4900.00. The action will result as an amendment to that grant and there will be certain processes and thresholds in order to move that forward. But it is entirely possible that it could be done.

Dr. Joe Sam Robinson asks if there is any precedence to doing this, or legal emcompasses to allow people to just change their grants.

Mr. Alex Sponseller reply's that the Statute states that as long as the EMS readiness costs fall into that category the Commission can make a specific vote to spend that money for that reason.

Mr. Ben Hinson states that this does not set a precedent that everybody can do this. This action is for this awardee and for this grant only. If someone has a unique situation and they bring it to the EMS Subcommittee they will discuss it and then it has to go to the Trauma Commission each time.

MOTION GTCNC 2011-02-04
I move Treutlen County EMS be allowed to use the left over FY 2010 grant money to purchase radios as requested.

MOTION BY: **Mr. Bill Moore**
APPOVED BY: **Rich Bias**

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

Uncompensated Care for EMS – Mr. Ben Hinson states that the Commission approved last meeting to adopt the Medicare fee schedule so everyone will have the same fee schedule. The total amount of money will not pay everyone but at least will give you the numbers to put in the formula. The Commission also agreed that rural services should get a bonus on their mileage rate, just like they do in the Medicare process. It has been determined that we will simply go by the county where the patient was picked up to determine if it was a rural call or not. We have a listing of county's called the Georgia Medicare Rural Hospital Flexibility Emergency Medical Services Grant Program, which is found in the EMS Subcommittee Report. Basically Medicare has already determined what counties are rural or not. So we would move to adopt that listing, for the 50% bonus payment on mileage for patients transported under the Uncompensated Care Program.

MOTION GTCNC 2011-02-05:
I move that the Georgia Trauma Commission adopt the Georgia Medicare Rural Hospital Flexibility Emergency Medical Services Grant Program list to determine which Counties are rural or not for the 50% bonus payment on mileage for patients transported under the EMS Uncompensated Care Program.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **No second needed as motion came from subcommittee.**

DISCUSSION: Mr. Rich Bias states that the list is so long it is almost the entire state.

Mr. Ben Hinson states that there are 50 counties that do not qualify, that may speak to some of the challenges we have.

Dr. Joe Sam Robinson states there are 109 counties that are rural counties and 50 that are urban. He also asks Mr. Ben Hinson that in adopting this list is it, a simplication arrangement.

Mr. Ben Hinson states that the Commission had already determined we would make these payments based on the county that the transport originated in, but we did not have a specific list, and someone found this list that Medicare had already adopted and we think it is just the best way to go. Its objective and so we do not get involved who is and who is not qualified. We use the Federal Government list and we are done. It is a very clean way to go.

Dr. Joe Sam Robinson states that it begs the question how to distribute resources to the other underserved areas of the state, so we just have to think about that in the future.

Mr. Alex Sponseller states that for the grants the state statues define rural a county with a population of less than 35,000, according to the U.S. census of 1990 and any future census. Excluding military basis.

Mr. Jim Pettyjohn just wants to be clear that we are not using that definition, but we are using the list mentioned.

Mr. Alex Sponseller says correct.

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

MOTION GTCNC 2011-02-06:
The EMS Subcommittiee moves to change the allocation of the $96,440.91 Trauma Care related equipment dollars, and put $46,764.36 into the Vehicle Equipment Replacement Grants, and the remaining $49,676.55 into the First Responder Training.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **No second needed as motion came from subcommittee.**

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

PERFORMANCE BASED PAYMENTS PROGRAM Ms. Kelli Vaughn stated that the Readiness Subcommittee met last week via conference call to talk about their performance based payment component of the contract for the trauma centers. In the current contract there were 4 deliverables. The one that was discussed was the Diversion Webinar and Summit. With the time constraints that we are down to and the amendments that are coming with the new contract we discussed what needed to happen with the diversion component of this, and come up with a definition for diversion. The thought is we are going to work through the trauma coordinators and do possibly a six-month auditing tool to see how many patients are affected or how many hours' trauma centers are affected, as a pilot project to see what's out there. A good definition to start with for trauma diversion, is anything that prevents the transfer or transport of a trauma patient from the field or emergency department to a designated trauma center. From there we worked with the coordinators and track for 6 months different things that may prevent patients from coming into trauma centers.

Mr. Joe Sam Robinson asks about the way that the law in our nation defines diversion. Is this not a federal concept? In other words a hospital has to take a trauma patient unless it demarcates itself as being on diversion. We are getting into some legal issues are we not as to what diversion is?

Mr. Rich Bias states that Mr. Joe Sam Robinson is absolutely correct in a very broad sense. But it is limited from emergency room to emergency room. Once the patient is admitted it is not under EMTALA anymore. So it is only if it is coming from an emergency room request. And in response to that general expectation one of the reasons that Kelli had a challenge in getting any similarity of diversion policy of various organizations was because each of us has come up with a different methodology for responding to it. The issue is that there are many possibilities for diversion that do not have anything to do with trauma. We have seven different levels of diversion in our policy and only the last one prevents trauma from coming in.

Dr. Joe Sam Robinson states that this is a huge issue in the state of Georgia right now, the amount of diversion that is going on. I see it every day in my practice where hospitals will not take patients who are sick. This is a very important study.

Dr. Dennis Ashley asked Ms. Kelli Vaughn if she is bringing a motion or just updating us on the Subcommittee, what is the next step.

Ms. Kelli Vaughn states that she is just updating us now. She will be going to the Coordinators meeting in March and she will have something more formal in March.

Mr. Rich Bias asks do we need anything at this point for it to be reflected in the Readiness Performance Component of the contract?

Mr. Jim Pettyjohn replies that we do. We need it now.

Ms. Kelli Vaughn asks Mr. Jim Pettyjohn what he recommends.

Mr. Jim Pettyjohn states that this will be new content in the contract via the amendment and it needs to come from the Commission, and we need to approve a motion for that to happen.

MOTION GTCNC 2011-02-07:
Ms. Kelli Vaughn makes a motion: I move that the current Trauma Center contract Performance Based Payments section be amended in the following way: Remove the Diversion webinar and summit. Initiate a Pilot project with the Trauma Centers to include monthly reports from Trauma Centers tracking trauma diversion based on the following definition "anything that prevents the transfer/ transport of a trauma patient from the field or an Emergency department to a designated trauma center"

MOTION BY: **Rich Bias**
SECOND BY: **Linda Cole**

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

TRAUMA COMMUNICATIONS CENTER REPORT

Mr. Scott Sherrill reports that SAAB the apparent winning vender for the RFP made a presentation to the Commission and the Commission recommended that we go forward with the purchase of that product from them. The issue was that the apparent losing vendor in the RFP has filed a protest with the Assistant Commissioner of the OAS. Last week the Assistant Commissioner denied that protest and the apparent losing vendor has now filed a protest with the Commissioner of the OAS, which we hope to have resolved shortly. And in addition to that we are continuing to work on infrastructure issues relative to those sorts of things like getting policies and procedures in place. We will try to be ready to go just as quickly as this hurdle gets removed. We are dealing with the process as defined by the laws of the State of Georgia.

Mr. Bill Moore asks if there is a certain time restraint as to when the OAS has to rule on this?

Mr. Scott Sherrill states that there are recommended time frames, and thinks very shortly they will be having an additional meeting about this. This should be quicker than the initial protest was, but I do not think that there is an absolute limit imposed upon the OAS.

Mr. Bill Moore states that the Commission will just have to monitor it because that would affect our ability to spend that money.

Mr. Jim Pettyjohn spoke with Office of Planning and Budget, and the critical hire process for our Trauma Communications Center Coordinator is to be called Lead Coordinator Position as a State Employee, was approved yesterday morning. We hope to have that position posted next week. That position will post for 30 days, and we will advertise it blindly. And hopefully that person will be on board and working out of our Forsyth Georgia GPT office space soon.

Mr. Ben Hinson asks if that money is already at GTRI or do we run the risk of it being recouped if we do not spend it by 30 June 2011.

Mr. Jim Pettyjohn states that money is encumbered in the contract. It is attached to a contract that is executed and they are already invoicing from. When money was taken from the Commission before it had not been encumbered.

TRAUMA QUALITY IMPROVEMENT PROGRAM (TQIP)

Dr. Dennis Ashley introduces Dr. Avery Nathens the Division Head in General Surgery and Director of Trauma at St Michaels Hospital in Toronto Canada, and a Professor of Surgery at the University of Toronto, a practicing trauma surgeon and Epidemiologist with a focus on Trauma System Design. *(Dr. Avery Nathen's Bio attached to Admin report and PowerPoint Presentation attached to these minutes)*

Dr. Avery Nathens speaks on what TQIP has to offer us as a State and as individual centers. This is a program that allows you to get a good sense of how you perform, and what your outcomes are like compared to other trauma centers. What TQIP is not; it is not public reporting. The reports come back to individual centers or your Trauma Commission. We do this by providing you information in the form of reports on a quarterly basis. Our goal is to improve the care of trauma patients across all centers from low to high performing centers. We work within your existing infrastructure. The data that we collect is based on the NTD, which insures everybody is collecting the same data in the same way, focusing on outcomes, understanding how you care for your patients. Our objective is to raise the quality of care for all trauma patients in all trauma centers. We provide lots of education and training to make sure the data quality is good, and to make sure you know how to use the reports that we give you, and make the best of those reports. The goal is to also make sure you interact with other centers to learn from each other. We are risk adjusted bench marking which means we acknowledge the fact that every trauma center sees different types of patients. The subsets that we have are blunt multisystem trauma, penetrating trunked injury, and blunt single system. We present the data in the form of a "caterpillar graph." Every center is represented on the X-axis, on the Y-axis is the observed to expected mortality ratio. We also have a length of stay model, including other aspects. For instance a patient that is difficult to place. We also present excess length of stay. Which is anything defined as 20% more than the number of days they should be in the hospital. *(TQIP one-pager providing program overview attached to admin report)*

DISCUSSION: Mr. Ben Hinson asks if the length of stay is tied to the severity of injury as well.

Mr. Avery Nathens states that we bring it all in. We bring in other things that might impact getting that patient out of the hospital.

Mr. Ben Hinson asks if the data obtained from Georgia is prepared in such a way that it is easily comparable to national data in your entire database. Did you put Georgia through the same rigors you have the others?

Mr. Avery Nathens states that it has been put through the same analysis, but we do not know if the data quality is the same as the other TQIP centers, because they have not gone through the education and training to go along with that.

Dr. Joe Sam Robinson asked whether the data is Canadian data.

Dr. Avery Nathens states that it is all ACS data.

The cost is depending on the version used is as much as $100,000, with the nurse extractor. TQIP is $9000.00, which includes registrar training and education, in person online and webinars, and web conferences with the Trauma Medical Directors. Also we visit the centers to validate the data. The cost also includes the analysis online report generation, and annual meeting and registration.

Dr. Joe Sam Robinson asks about the economic resources of the individual centers. In Canada the centers' resources are pretty much spread equally. In the U.S. this is not so. If a center has very poor

patients that hospital would not have the same dollars to work with. Is the actual amount of resources of that particular hospital taken into consideration? One of the things that really confronts the American Health Care System is the amount of cost. Does this report include the expenses the individual hospital might incur?

Dr. Avery Nathan replies that all you can do with the data if you are an underfunded center and your performance is below average is argue that perhaps you need additional funding. We have found that centers have not had to hire additional registrar's to do this. The only potential additional costs are related to your vendor as some have been charging a little bit of a premium for their software.

Mr. Ben Hinson asks whether this data ever gets us to the point of truly comparing the outcomes in a trauma center verses a non-trauma center? Is there anyway we can use this data to improve the care in the non-designated trauma centers?

Dr. Avery Nathan replies that we really do not know from this what the non-designated centers are doing. In terms of improving the care of the non-designated centers, this does not fall into that unfortunately.

Mr. Bill Moore asked if the TQIP centers have been able to improve the mortality rates, has that bar been raised?

Mr. Avery Nathens replies that we are probably going to be looking at that towards the end of next year. We had 23 centers the first year, and 65 the second, so we have not had a lot of overlap from year to year. We are going to have enough centers over the next year to do that.

Dr. Dennis Ashley asks if there is an annual meeting to share data? Is that what the annual meeting is for TQIP, and will there be lectures on what works, as opposed to just having to do it ourselves.

Mr. Avery Nathens replies that the plan for this years meeting is to have large sessions where we have a 100 speakers, where we have some of the most important findings, and small group sessions.

Mr. Ben Hinson asks Dr. Dennis Ashley what he is asking of the Commission?

Dr. Dennis Ashley replies that he would like to see the Commission adopt this for the whole State of Georgia with the 2012 budget. We will be talking about that at the next meeting. I wanted the whole Commission to hear the presentation and get your thoughts.

Mr. Ben Hinson states that we cannot move to adopt this right now till we get our budget numbers, but he would move that we at least take a vote and get a sense of the Commission as to whether or not we think this is somewhere we need to go. We will work the details out as we go.

MOTION GTCNC 2011-02-08:
I make the motion to move forward to adopting the TQIP Program as the budget allows within the next few weeks.

MOTION BY: **Mr. Ben Hinson**
SECOND BY: **Dr. Joe Sam Robinson**

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

DCH Division of Emergency Preparedness and Response: Ms. Renee Morgan reports that since the last meeting they had two facilities seeking designation or upgrade. They were Lower Oconee as a level 4, that's in Glenwood Georgia. The other process was the upgrade for ANC to a level 1, and that is still ongoing. There are currently 18 designated trauma centers. That is 4 level 1's, 10 level 2's, 1 level 3, and 3 level 4's. There are a couple of centers that are non-designated but have purchased the registry, and are going through their training an installation process. So by the end of the month we will have two more participating in the registry.

Dr. Pat O'Neal reports that SOEMS/T has not filled 2 of the 4.5 positions previously approved by the GTCNC. With the additional budget reduction, SOEMS/T will not be able to move forward in filling the Trauma Nurse Coordinator position or the EMS Educator position. Dr. O'Neal mentioned that the Emergency Preparedness and Response Section has applied to CDC for a Preventive Medicine Resident to work with the Section for a year. In the application we were asked to outline 5 potential projects for the PM resident. One of those projects would require that the resident evaluate our earlier projection of an Optimal Trauma System for GA having 30 designated trauma centers strategically located throughout the state. The challenge for the resident would be to use the evaluation to determine the probability of GA being able to reduce its trauma death rate to drop to, or below, the national average traumatic death rate for the United States. We hope within the next week to have an announcement of which one of possibly 8 residents we will get. That person will start the first of August and be with us for one year. We also are continuing to do a better job of cleaning the data that is coming out of the Trauma Registry thanks to Dr. Danlin Luo. We are working with the Registrars at the trauma centers to provide greater consistency in the data that is input into the registry.

Dr. Pat O'Neil mentions that with us today is Ms. Rana Bayakly who at some point would like to offer to the Commission the opportunity to look at how she separates out the rural counties, from the metropolitan, and suburban counties. Ms. Rana Bayakly manages the cancer registry, and because she has dealt with this for some period of time she has come up with a pretty good system that she could share with the Commission.

Mr. Jim Pettyjohn states that we will have the trauma registry, trauma epidemiologist presentation at the March 17th Commission meeting.

LAW REPORT: Mr. Alex Sponseller reminds the Commission about filing conflict of interest affidavit.

OLD BUSINESS: None reported.

NEW BUSINESS:

Region 9 Regionalization Activities- Ms. Elaine Frantz read a prepared statement, which summarizes the activities that we have undertaken since June. On behalf of region 9 Dr.Gage Ochsner who is the Chief of Trauma Services of Memorial Universal Medical Center and the Regional EMS I am submitting a formal request for the Trauma Commissions consideration and subsequent approval for inclusion of Region 9 as the third region to actively develop and pilot RTAC. Since assuming my role in June Dr. Gage Ochsner and I have developed a comprehensive strategic plan for Trauma Services at Memorial. Of parallel importance is the development of Regional Trauma Advisory Council, consisting of all levels of EMS providers, hospitals and key stakeholders in Region 9. Dr. Gage Ochsner, the Trauma Surgery Team, and I began by traversing the region. Which consists of 24 counties in Georgia, and four in South Carolina. Initially to perform a swat analysis of referring hospitals using defined criteria. Our goals were to determine trauma needs in terms of trauma delivery, system needs, and regional integration. Most importantly performance improvement needs. So to reintroduce the RTAC concept so as to solicit impute for the development of a basis for RTAC blueprint in region 9. Having visited 15 of

the 19 hospitals in the region we concluded that there is a tremendous passion and willingness to come on board with regard to participation of all aspects of RTAC region 9. EMS needs would be of tremendous importance and critical to the success of RTAC. (*Attached letter of request from Dr. Gage Ochsner is included in the admin report and the prepared statement from Ms. Elaine Frantz is included with these minutes.)*

Mr. Rich Bias is not exactly clear on what the request means. I have no concern about endorsing the work you are doing or in supporting it. I just do not know about what it means to say yes. One of the elements that are probably essential in what's happening with the pilots of 5 & 6 is AVLS distribution, which has not occurred in Region 9. So how can that be synced in so that the pilot can coordinate with the communications center?

Dr. Dennis Ashley states that at some point we have set up a pilot project for 5 & 6, we made investment in hardware and financial. At some point after the two pilots we had planned to bring on other regions. At that point when we do decide we are ready to bring on anther region, of which we are not today, we will need commit resources to do that. So it is my understanding that they want to be considered or approved to be the next region to come on.

Ms. Elaine Frantz agrees to Dr. Dennis Ashley's explanation of what she is asking for. And states we are not going to stop, we are going to continue doing the work we are doing now. Yes with regards to resources they are not available and we understand that.

Rich Bias, states that they are asking for our endorsement, but that's beyond what they are doing. There is a difference between a RTAC and communications center pilot. What I hear you doing is working hard to forge ahead with RTAC, and I am really comfortable saying five thumbs up to endorsing and approving that. It's just the other part is more of a practical consideration and a budgetary consideration.

Mr. Ben Hinson states that there is something that is going to come up quicker. We may not have the resources to put into Region 9 right now I understand that. If we approve this request today that might impact how GEMA determines who gets the next AVLS units. They are not bound by what the Commission says but they work very hard to corporate with what our initiatives are. My question is with this motion is that where the Trauma Commission wants the next AVLS units to go?

Dr. Dennis Ashley makes the point that we have a rural region, we have a trauma center in that region. And we have a region that is already organized and out forming an RTAC, which we didn't have to invest in. I know of no other region that is that advanced. So with all those factors lined up, why would we not pick Region 9 to go online next? I am comfortable with all the data presented there is no other reason that I could think of to not go forward.

Mr. Rich Bias states that he is comfortable going forward on RTAC including the elements that the current to pilots are deliverable requirements, because that is necessary for the planning process, and to feed it in. I am not comfortable with a motion that suggests there is a prioritize commitment for resources. If the plan that came out of the RTAC ended up with all the AVLS's going up in the top half of that region that's not meeting our concern.

Dr. Dennis Ashley replies, that on that section we are not getting in to the grass here, you have to remember our white paper the final RTAC decision whatever they come up with flows through the Commission. So you are not relinquishing control here that they are the next group to come online, outside the Commission. Whatever region comes online has to fall in line with white paper, as this is just a motion to be considered for the next region to come on inline with what the Commission is doing.

Mr. Alex Sponseller thinks that if we are going to have a motion make it more specific than what is in the letter.

MOTION GTCNC 2011-02-09:
I make the motion that the Trauma Commission actively support and approve EMS Region 9's continuation of efforts with the Regional Trauma Advisory Council (RTAC) development. With the addendum that no funds are being committed for this effort, but that the Commission is acknowledging the good work.

MOTION BY: **Dr. Joe Sam Robinson**
SECOND BY: **Mr. Rich Bias**

DISCUSSION:
Not further discussion.

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

PROPOSED AMENDMENT TO SB 60 : Mr. Josh Mackey states: Currently the Commission for uncompensated care can only reimburse EMS services if they transport a patient directly to a designated trauma center. The difference with this and the change we are trying to make is that we would expand it to anybody that is a trauma patient. According to State Code a trauma patient is defined as somebody that is listed on the Georgia or National Trauma Registry. There have been instances where a patient is transported to a non-designated center inside or outside the State that participates in one of the registries, but the current code puts limitations on reimbursement. So all we are doing with this bill is providing the Commission the opportunity to do that if they choose to do so. *(Attached copy of draft Senate Bill 76, Mr. Mackey presented, is included wit these minutes)*

Mr. Ben Hinson asks am I understanding that there will be patients carried to hospitals inside Georgia that go on the trauma registry that are not to designated trauma centers.

Mr. Josh Mackey replies that yes, it is his understanding that there are hospitals in Georgia that participate in the Trauma Registry that are not designated centers. If a service takes them to a non-designated center that participates in that registry in State, and if the Commission allowed it they could be reimbursed for uncompensated care.

Dr. Dennis Ashley states that there are no hospitals that participate in the registry that is not designated.

Ms. Kelli Vaughn replies, "think about those centers that have to collect data for several months, before they go through the designation process".

Dr. Dennis Ashley replies, " but that hospital in the process of being designated, it is not a stand alone out of the blue saying I am going to collect trauma data center."

Ms. Renee Moran states that a hospital has the right to participate in the register without ever becoming a designated trauma center.

Mr. Ben Hinson states that the intent of the EMS Subcommittee was to be able to pay ambulance services if they carried someone to a designated trauma center outside the State of Georgia, and they were uncompensated. We wanted them to get paid. I did not understand that there were hospitals in Georgia that patients could be on the registry that were not designated centers. However I think if we support this bill, and it is passed, we could still limit our payment to patients to designated centers in the State, or designated centers outside the State. Passage of this law would allow us to do what we intend to do; it would not require us to do it.

Mr. Josh Mackey agrees that this is just giving you the choice to do that, it is not require for you to do it. It is not required that you even provide uncompensated care to EMS, it is just if you have this program and you want to reimburse them for that purpose than you can. This is just allowing the Commission and the EMS Subcommittee to make a recommendation to do it and actually be able to carry it out.

Mr. Jim Pettyjohn asks Mr. Josh Mackey if that patient were eventually transferred to a trauma center that EMS service would become eligible to receive funding for its uncompensated care?

Mr. Josh Mackey states that yes it could. You could make that argument now.

Mr. Jim Pettyjohn states that we do make that argument now. We did it last year and it is in our plan to do it this year.

Mr. Rich Bias states this process will not make it any easier with that because it is still going to require a trauma registry search. The EMS service is going to have to initiate the registry search anyway. I am a little mixed up about intent. I did think it was the conversation that Ben alluding to, and not the business of expanding reimbursement to patients taken to non-designated centers.

Mr. Josh Mackey states that he did not necessarily think that was our intent, but that is something that can take place if you choose to do it. I think that is something that should be discussed on the table. It can take place because by definition a trauma patient is anybody that is on the Georgia or National Registry. But again it is going to be up to you. You could put that limitation saying that they have to be transported to a designated center at some point.

Mr. Bill Moore asks if he is right in that this bill does not require us to do anything we are not doing now but gives us the flexibility if we so choose to, is that accurate?

Dr. Dennis Ashley replies that we could do the same thing now with the bill we already have. I think it is deleting one line here that really does sort of confuse things. I am in support of the intent but what I thought was coming out of the EMS Subcommittee, but if there are hospitals now that can just go out and put patients on the registry and not come into the trauma system, this is a back door loophole.

Dr. Dennis Ashley states that would it not be easier instead of deleting transported to a designated trauma center just saying what you are trying to do. State provided to trauma patients transported to designate trauma centers in Georgia or surrounding states.

Mr. Rich Bias states that the definition of designated trauma centers is the issue there.

Mr. Josh Mackey agrees we would have to change that definition in Georgia code, to do that. I personably would feel less comfortable going to legislature and trying to change the definition of things.

Mr. Ben Hinson states that the intent is to pay for uncompensated patients transported to designated trauma centers in Georgia, which are by code defined as Trauma Centers recognized by DCH. It is also to identify trauma centers in surrounding States. So couldn't we add simply the language of centers identified by the Trauma Commission in surrounding States for the purpose of this code section? It gets to what we are trying to do, it does not muddy the water with trauma centers trying to get in that are in Georgia that are in the registry but not all the way in and it lets us specifically choose which ones we will pay for.

Mr. Alex Sponseller states that you would really have to be specific in defining what you are saying. My point is that if you are going to go to the trouble of going to the legislature you should amend Subsection 7A, which is the uncompensated care today.

Mr. Josh Mackey states that is something he would be willing to discuss with you and legislative counsel. More discussion is better.

Mr. Rich Bias states that he would prefer to go with the direction that Mr. Ben Hinson suggested and might be going so far as to say trauma centers identified in adjacent states identified by the Trauma Commission. I think that OEMS and DCH work very closely to assure, as this has gone forward that the direction that they have been taking in designation and rule making has been consistent with the direction the Trauma Commission wants to go. So if there not going to be doing the designation it would seen that it would be appropriate for the Commission to specifically identify, and not just have it open end. What I am supportive of is what was discussed at the Subcommittee, which was to support those folks who are on the border of Georgia.

Dr. Dennis Ashley thinks that is reasonable, that if you just want to add to that line, saying adjacent States that provide trauma care as designated by the Commission.

Mr. Josh Mackey states that he would be willing to go to Legislative Counsel and see what there thought and interpretations are on that. I will go to the Legislative Counsel next week and get back with Mr. Jim Pettyjohn and Mr. Alex Sponseller.

NEXT MEETING AND ADJOURN:

17-March-2011 in Macon, Mr. Jim Pettyjohn to post announcement to Commission's website: www.gtcnc.org

Meeting Adjourned: 1:00 p.m.

Minutes crafted by Lauren Noethen

Trauma Quality Improvement Program (TQIP)

Avery B. Nathens, MD, PhD, FACS
ACS Committee on Trauma

What is the ACS Trauma Quality Improvement Program ?

* TQIP is designed to measure trauma center performance using process & outcomes measures
* What does TQIP provide?
  * Low performing centers: “dashboard warning light”
  * Average centers: “are we as good as we could be”
  * High performing centers: “best in class”
    * Identifies innovators, who share their best practices
* What TQIP is not: Public reporting

ACS tqip® TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Principles

* Improve the quality of care of trauma patients
* Confidential reports – results are not publicly released
* Uses existing trauma center staff and data collection infrastructure
* Based on NTDB data collection and the new National Trauma Data Standard (NTDS) with specific enhancements
* Focus on outcomes & understanding processes
* Objective: To raise the performance of all trauma centers to a higher level

ACS tqip® TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Components

* Standardized data collection
* Education and training
  * Assist centers in interpreting and using their own results
* Risk adjusted benchmarking
* Online customizable reports
* Identification and sharing of best practices
* Targeted process measures
* Ongoing performance monitoring

ACS tqip® TRAUMA QUALITY IMPROVEMENT PROGRAM

Lessons Learned

* Wide variation across centers
* High performers in one area may be average or below in other areas
  * Expertise varies across centers – most centers have some opportunities for improvement
* Data quality is critically important

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Mortality "Spread" Across Centers

	Risk of death as a function of outlier status			
	All patients	Blunt multisystem	Penetrating	Single system
Low outlier	Reference	Reference		Reference
Average	1.6 (1.4-2.0)	2.1 (1.5-3.0)		2.6 (1.9-3.8)
High outlier	3.3 (2.6-4.2)	5.0 (3.3-7.5)		5.9 (3.9-8.9)

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Reports for 2011

* Annual report
  * All patients
* Traumatic Brain Injury
* Hemorrhagic Shock
* Elderly Patients

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Subsets

* The ACS TQIP reports on all incidents that meet the inclusion criteria and on three distinct subsets of severely injured patients derived from this population.
* Each subset represents different challenges to trauma centers
* Directs resources to areas of greatest concern – more efficient

ACS tqip® TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Subsets

* Subset 1- Blunt multisystem injury
  * e.g car crash victim
* Subset 2 – Penetrating truncal injury
  * E.g. Gunshot wound or stab wound
* Subset 3
  * Blunt single system injury
    * e.g. many falls, some assaults, etc

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Predicting Outcomes

* Patient characteristics and injury severity differ across trauma centers
* Differences affect the risk profile of patients at one center compared to another
* Crude mortality comparisons are not valid
* Statistical models estimate the predicted outcomes based on experiences of all centers

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

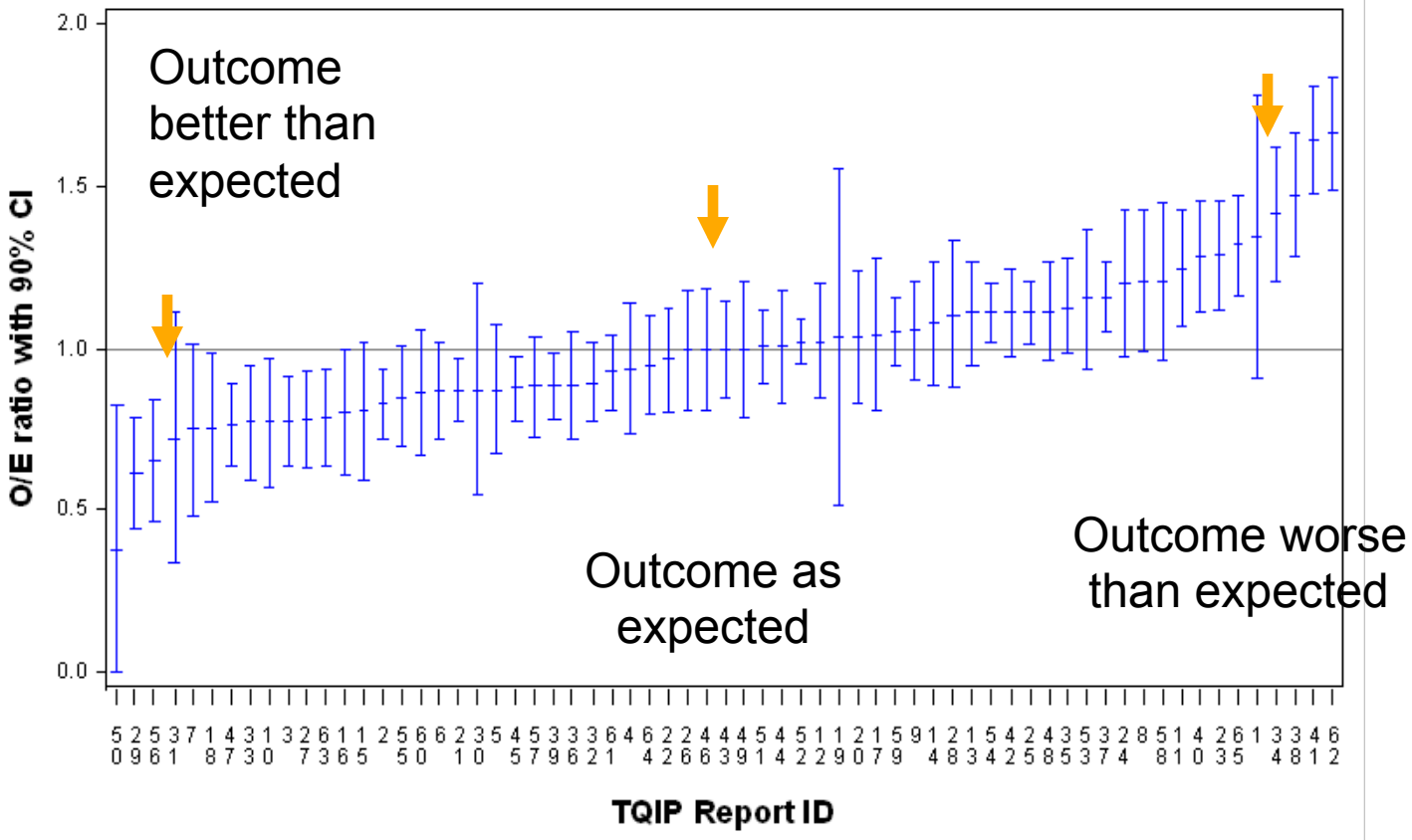
Data Elements in Mortality Model

* Initial GCS motor score in ED
* Initial systolic BP in ED
* Initial pulse rate in ED
* Mechanism of injury
* Number of Co-morbidities
* Transfer status
* Age
* Gender
* Head injury severity (AIS)
* Neck injury severity (AIS)
* Chest injury severity (AIS)
* Abdominal injury severity (AIS)
* Lower extremity injury severity (AIS)
* Spine injury severity (AIS)
* Single Worst Injury (SWI)

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Mortality

Mortality: All patients including those classified as DOA or died in the ED



ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Data Elements in LOS Model

* Initial GCS motor score in ED
* Initial systolic BP in ED
* Initial pulse rate in ED
* Mechanism of injury
* Number of Co-morbidities
* Complications
* Transfer status
* Age
* Payment type
* Gender
* Head injury severity (AIS)
* Neck injury (AIS)
* Chest injury severity (AIS)
* Abdominal injury severity (AIS)
* Lower extremity injury severity (AIS)
* Spine injury severity (AIS)

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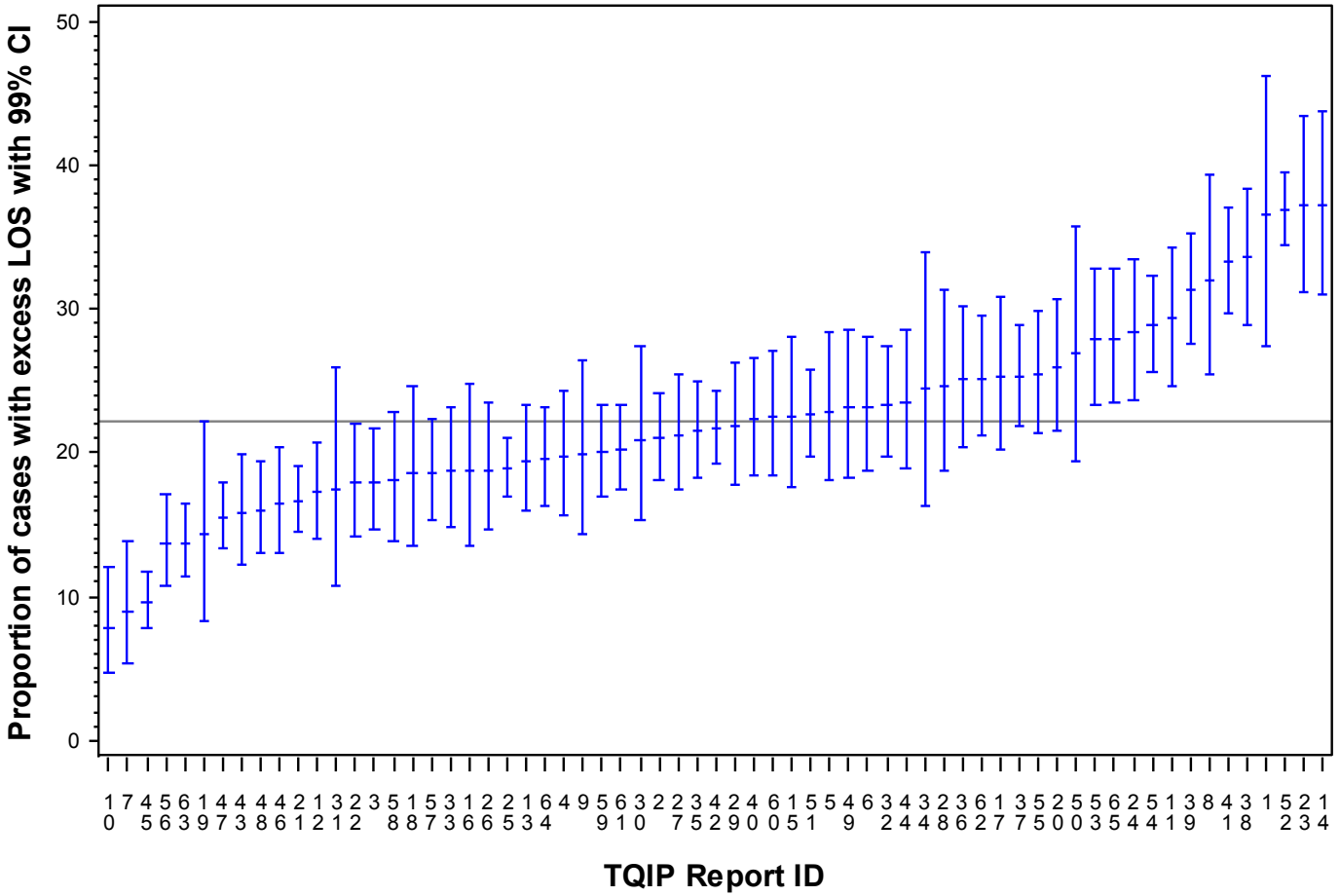
Length of Stay



ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Time to Death

Table 4. Elderly Patients, Excluding Those with ED Disposition of Died					
	Total Deaths	**Mortality (percent)**	**Mean time to death (days)**	**Median time to death (days)**	**Proportion of all deaths with time to death>30days**
All centers	1451	9.9	7.1	4	2.6
TQIP ID					
1	5	18.5	7.8	6	0
2	24	7.1	5.5	2.5	4.2
3	18	9	5.3	3	0
4	22	11.1	5	2.5	0
5	17	11.6	10.7	4	11.8
6	20	17.7	4.4	3	0
7	8	6.4	4.8	4	0
8	17	18.3	17.9	5	17.6
9	3	10.3	3.7	5	0
10	9	6.3	3.7	2	0

Processes of Care

* Traumatic Brain Injury:
  * National guidelines support intracranial pressure monitoring for severe brain injury
  * Compliance generally poor
  * Monitor timeliness and compliance with guidelines
* Venous Thromboembolism Prophylaxis
  * Guidelines support specific approaches to prophylaxis
  * Tremendous variation in practices across centers
  * Provides opportunity to evaluate your practice compared to national norms

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TQIP Results: Georgia

* There were 5,071 cases from 14 Georgia hospitals.

Trauma Level	N (%)
I	4 (28.6%)
II	9 (64.3%)
IV	1 (7.1%)

* Two hospitals with less than 10 records were excluded from the analysis.

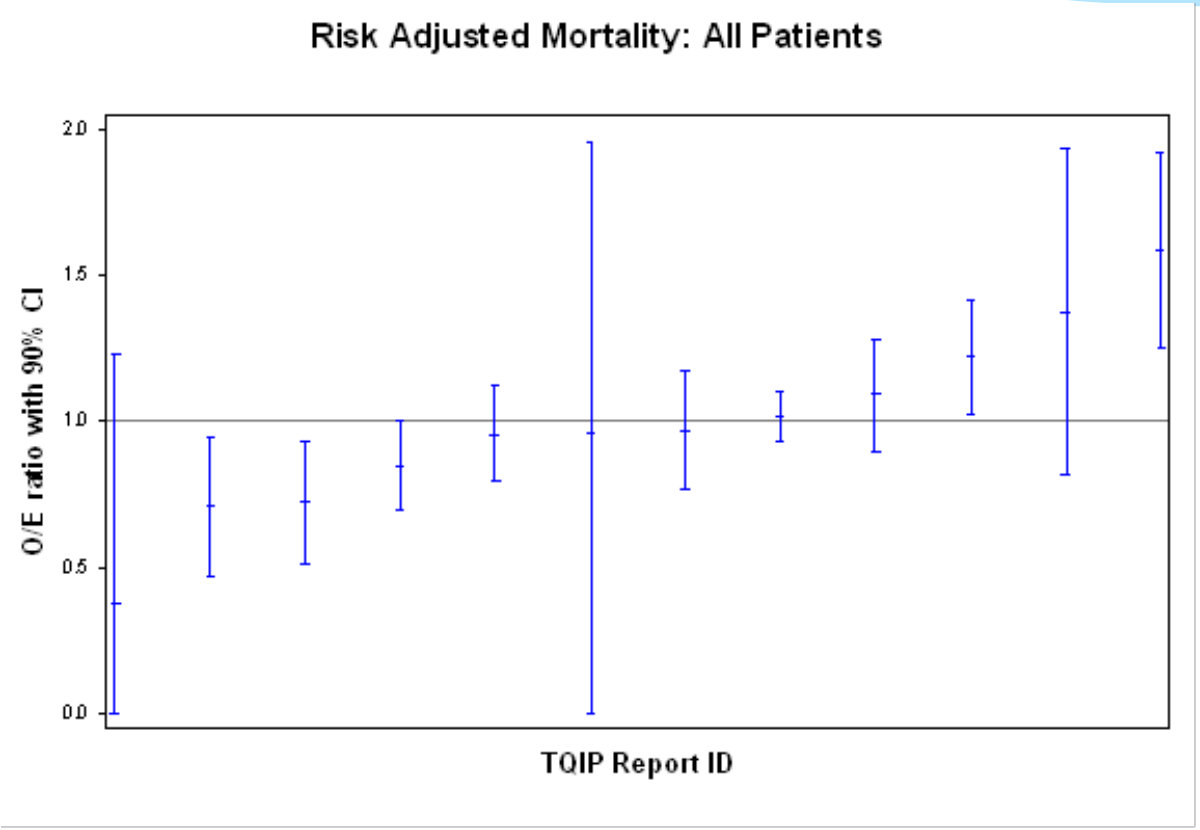
ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Results for Georgia

* Final analysis has 12 hospitals and 5,058 trauma cases.
* Mortality rate for this population was 8.4%

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Georgia: All Patients



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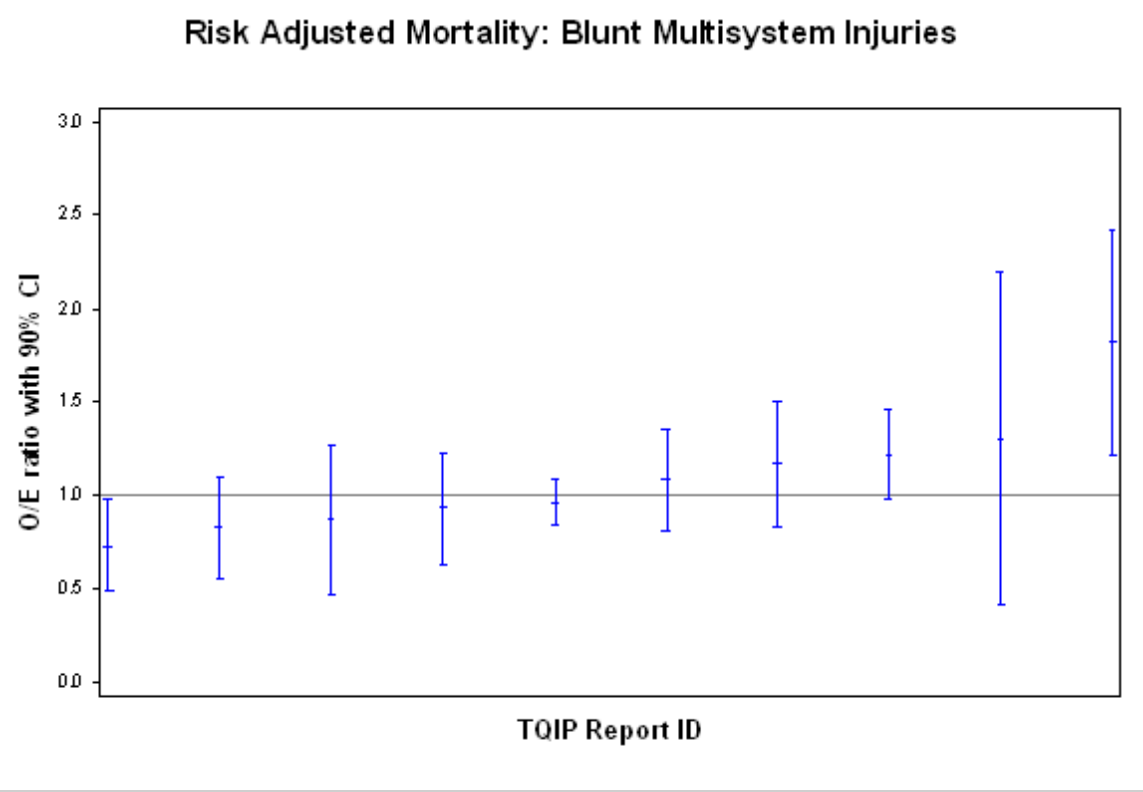
Georgia: Blunt Multisystem Injuries



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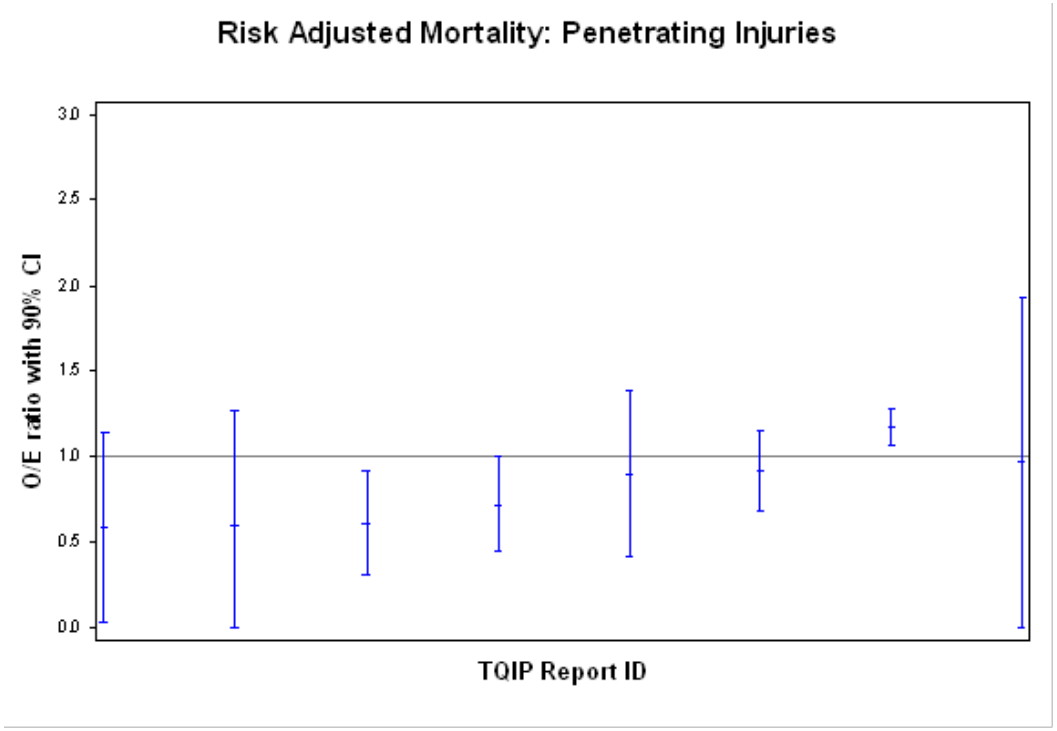
Georgia: Penetrating Injuries



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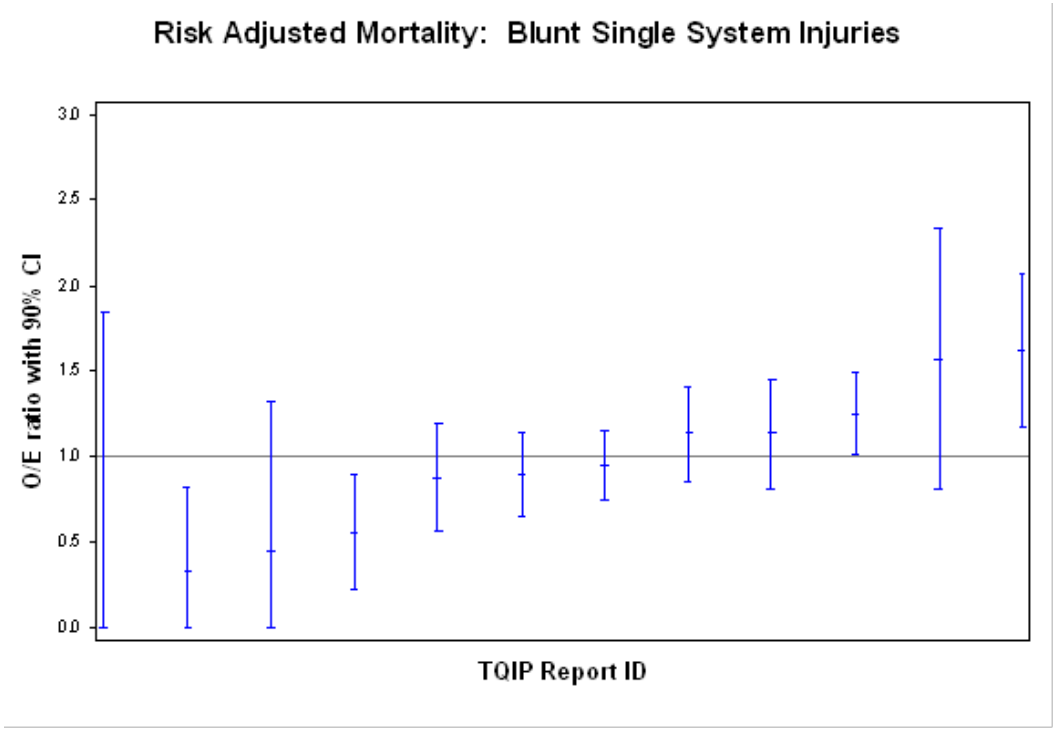
Georgia: Blunt Single System Injuries



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Using TQIP Results

* If you identify performance gaps
  * Consider the report as a dashboard warning light
  * Review cases from that subgroup closely for quality of care issues
  * Are there data quality issues?
* Is your center one with excellent performance in one or more areas?
  * Tell us what you are doing
  * You might be an unwitting innovator

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

TQIP Benefits

* Provides valid inter hospitals comparisons
  * Good idea of where you are and where you need to improve
* Fosters a community for sharing best practices
* Includes ongoing communications among participants to discuss changing practices as result of TQIP reports
* Offers educational opportunities finely tuned to needs of registrars and based on real data quality concerns

ACS tqip® TRAUMA QUALITY IMPROVEMENT PROGRAM

The value proposition… the costs

* $9,000.00 annual fee
  * Registrar training & education
    * In person, online, webinars
    * Trauma medical directors web conferences
  * External validation of data
  * Statistical analyses, report generation
    * Online tool
  * Annual meeting & registration
  * Site visits

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…the benefits

* Identification of opportunities to prevent one additional case of VAP
  * Cocanour, Surg Infect, 2005: $52,000
  * Warren, Crit Care Med, 2003: $11,897
  * Safdar, Crit Care Med, 2005: $10,019
* "QI revenue"
* ….Much of the cost has been leveraged through NTDB infrastructure

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

Thank you!

For more information:

Email: tqip@facs.org

Website: www.acstqip.org

ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

RTAC Presentation: February 17, 2011

- Thank you - Mr. Pettyjohn, members of the Trauma Commission and guests for afforded me the opportunity to speak with you today.

- Behalf of Reg IX, Dr. Ochsner, Chief of Trauma, and regional EMS, I am submitting a formal request for the Trauma Commissions' consideration and subsequent approval for inclusion of Reg IX as the 3rd region to actively develop and pilot a RTAC.

- Since assuming my role as Dir, Tr Svc, Dr. Ochsner and I have developed a comprehensive strategic plan for Tr Svc at Memorial. Of paramount importance was the development of a RTAC, consisting of all levels of EMS providers, hospital and other key stakeholders in Region IX.

- Dr. Ochsner, other trauma surgeons, and I began by traversing the Region, consisting of 24 counties and 4 in South Carolina, initially to perform a SWOT analysis of referring hospitals.

    - Using defined criteria, our goals were to determine trauma needs in terms of trauma delivery, system needs and regional integration.
    - So too, we introduced the RTAC concept so as to solicit input for the development of a framework for an RTAC blueprint.
    - Having visited 15 of the 19 hospitals in the region, we concluded that there is tremendous passion and willingness to come on board with regard to participation in all aspects of a RTAC.

- Furthermore, Dr. Ochsner and I determined that active involvement in Reg IX EMS activities in addition to solicitation of the region's EMS needs would be critical to the success of a Regional Council.

    - At the most recent SE Ga EMS Council Meeting, I discussed RTAC with not only the council members, but also the Reg IX EMS Prog Dir, Shirley Stallings, in order to solicit input. Permit me to underscore the resounding positive response to the RTAC pilot program discussion. Next week, Tim Genest, Council Chair and I are meeting in order to discuss various items, first and foremost is RTAC.

- In summary, as the only Level I Trauma Center in Southeast Ga and EMS region IX, Memorial has initiated the planning process for RTAC. We are hereby requesting your approval of our proposal to continue our plans and activities which ultimately lead to the establishment of a RTAC.

Thank you.

Senate Bill 76

By: Senators Mullis of the 53rd, Rogers of the 21st, Goggans of the 7th, Unterman of the 45th, Stoner of the 6th and others

A BILL TO BE ENTITLED

AN ACT

To amend Code Section 31-11-102 of the Official Code of Georgia Annotated, relating to the duties and responsibilities of the Georgia Trauma Care Network Commission, so as to revise certain provisions relating to uncompensated trauma care provided by emergency medical services; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Code Section 31-11-102 of the Official Code of Georgia Annotated, relating to the duties and responsibilities of the Georgia Trauma Care Network Commission, is amended by revising paragraph (2) as follows:

"(2) For the first two fiscal years in which funds are appropriated to the commission for distribution, to distribute such funds in the following areas with the priority for distribution to be set by majority vote of the commission:

(A) Physician uncompensated trauma care services provided in designated trauma centers;

(B) Emergency medical service uncompensated trauma care services provided to trauma patients ~~transported to designated trauma centers~~;

(C) Uncompensated trauma care services of designated trauma centers;

(D) Trauma care readiness costs for designated or certified trauma care service providers; and

(E) Trauma care service start-up costs for providers seeking a trauma care designation or certification.

The commission shall adopt a formula that prioritizes the distribution of state appropriated funds that may be implemented during the third state fiscal year in which funds are appropriated to the commission for distribution. Such formula shall be evaluated and modified, if needed, every two years thereafter;"

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.