Minutes approved 19 May 2011

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

MEETING MINUTES

Thursday, 17 March 2011

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

CALL TO ORDER

Dr. Dennis Ashley, Chair, called the scheduled monthly meeting of the Georgia Trauma Care Network Commission to order at 10:09 a.m.

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

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	GTRI
Regina Medeiros	MCG Health
Lawanna Mercer-Cobb	SOEMS/T – Region 6
Marie Probst	OEMS/T
Renee Morgan	OEMS/T
Bambi Bruce	WRMC
Lee Oliver	MCCG
Janet Schwalbe	GMC
Rana Bayakly	DPH/Chronic Disease
Danlin Luo	DCH
Keith Wages	OEMS
Kelly Nadeau	DCH/OPH/SEPR
Kevin Bloye	Georgia Hospital Association
Mickey Moore	OEMST
Kathy Sego	ARMC

R. David Bean	EMS Consulting Services
Elaine Frantz	Memorial
Blake Thompson	Wilkes County EMS

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT

Dr. Dennis Ashley welcomed all present. There was a confirmation of Commission members attending. Attorney General Alex Sponseller will be here at some point during the meeting. Mr. Jim Pettyjohn confirmed quorum status.

Dr. Ashley states we had our first Trauma Medical Directors Conference Call on March 14, 2011. This went very well and was rather historic in the event that we have never had any infrastructure where all the trauma center medical directors had any kind of consistent communication with each other at one time. Some of our goals are to work with the Chair of the American College of Surgeons Georgia Committee on Trauma. They have a Committee on Trauma for each State and there is a State Chair that serves a term. Dr. Chris Dente who is a Trauma Surgeon at Grady is the Chair this year. If you have an interest and want to be on that Committee you can email Dr. Dente and let him know. Our goal is to pull the Commission and our Georgia chapter of the ACS Committee on Trauma together and allow them to develop some infrastructure throughout the State. One way to do that is to have conference calls with the Trauma Centers' medical directors. The second way is to have annual meetings, where all the trauma directors and coordinators are together and use that for education as well as exchange of ideas. *(Trauma Medical directors' meeting minutes are include in the March administrative report.)*

APPROVAL OF THE MINUTES OF THE 17 February 2011 MEETING

The draft minutes of the 17 February 2011 meeting were distributed to the Commission prior to the meeting via electronic means.

MOTION GTCNC 2011-03-01:
I move that the minutes of the 17 February meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

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

ADMINISTRATIVE REPORT REVIEW

FY2011 Commission Staffing Update: As of March 01, 2011 Mr. Jim Pettyjohn became a State Employee. The Trauma Communications Center Coordinator position posted on the States website, and so far 10 applications have been received. That position closes on April 8, 2011. The Commission will have a committee review those candidates and hopefully have someone hired within a month or so after the review. The Office Coordinator Position continues as temporary employee, and the plan is to move this position to state employee during FY 2012.

Mr. Jim Pettyjohn states that at the February 17th Commission Meeting he mentioned that in order to cut down on cost that we would begin posting the documents for each meeting on the Georgia Trauma Network Commission Website. The Administrative report and the Commission's most recent expense versus cash flow report were posted yesterday morning. We did, in transition, make thirty copies available for the public today. Mr. Pettyjohn states that he wants to encourage everyone to go to the

website at *www.gtcnc.org* and sign up to receive emails. Every time something is posted to the Commission's website you will receive an email the next morning.

The FY2010 EMS Vehicle Equipment Replacement Grants Program -There was 29 awards, 10 were paid with FY 2011 dollars, and 19 were paid with FY 2010 dollars. Of all the 29 awards we have received all but 5 work plans/budgets, and invoices.

The FY2011 Vehicle Equipment Replacement Grants Program- The grant application process was posted March 1, 2011, and the application period closes April 1, 2011. So far we have received 13 applications. There will be 9 awarded at $72,500 a piece. We will have an evaluation committee that will include the Office of EMS Director, Keith Wages, Jim Pettyjohn, and Lauren Noethen. They will get together and score the submissions. The score will then be submitted to the Grant Subcommittee of the Commission who will approve and hopefully announce those chosen at the May Commission Meeting.

FY2011 OEMS/T Trauma Registry Contract Funding Distribution- Mr. Rich Bias had asked at the last Commission meeting that when you fund the trauma centers in 2012 that you would consider the $754,000 for trauma registry support that were taken from OEMST. These dollars were the sole-provided registry funding last year. What you see in this report is a breakdown of what that money was used for. Ms. Marie Probst will be going over that at todays meeting. *(Spreadsheet included in admin report)*

Medical Director Conference Call minutes- Mr. Pettyjohn had some feedback from some of the Medical Directors; Office Coordinators, stating that they would like to be included in the invitations that are sent out to the Medical Directors, as it would be helpful in setting the Medical Directors schedules. Mr. Pettyjohn thinks that can be accommodated. *(Minutes included in admin report)*

Mr. Bill Hinson understands that this is a conference call with the Medical Directors of designated trauma centers and wants to know if it would be beneficial if Medical Directors from non-designated Hospitals were allowed to be included in the conference call. Mr. Hinson feels by allowing them to listen in it would knock down some of those walls and bring a better understanding of the work that we do, and how closely it relates to what they do.

Dr. Dennis Ashley states that is a fine idea, and mentions that we actually had a surgeon from an interested hospital listen in on the first Medical Director Conference Call.

FY Commission budget adjusted for accounting error - In February the Commission passed a budget that Mr. Pettyjohn put together that resulted from the 53% budget cut that we received from the Governors FY 2011 amended budget. Mr. Pettyjohn states that in his work to do that budget he made an error, and double counted a $153.000 deduction. Those dollars were split 80/20 with $30,000 coming from EMS and the other $123,000 from the trauma centers. The document included in the admin report reflect the accurate budget for FY 2011. *(Included in admin. report)*

Proposed revised FY 2011 Trauma Centers and Physicians funding distribution changes based on trauma center uncompensated care claims audit- We will hear from Ms. Evelyn Poulas who is with the accounting firm Gifford, Hillegass & Ingwersen, that performed the procedures for the trauma centers audits for the calendar year 2008. *(Included in Admin. report)*

Senate Bill 76 as passed by Senate – This Bill concerns the Georgia Trauma Care's provisions relating to uncompensated trauma care provided by emergency medical services. Dr. Dennis Ashley confirms that this Bill did pass the Senate and is in the House now.

Mr. Ben Hinson states that Mr. Josh Mackey worked hard to address some of the concerns the Commission had on this Bill. One of those issues was to allow us to pay ambulance services for carrying people to out of state hospitals. Now the Commission has the authority to pay that and figure out exactly how they qualify.

Dr. Pat O'Neil states that the thing that concerns him is that this Bill took away the ability for the Commission to pay for a service that transports a trauma patient to a non-trauma center in Georgia, for stabilization, who then ultimately ends up at a designated trauma center and on the registry. Now there is no provision for the Commission to be able to pay for that initial transport.

Ms. Regina Medeiros states that provision was in the original plan. And an EMS services has always been able to apply for and receive funding for the initial transport from scenes to a non-designated hospital, provided that those patients ultimately ended up in the registry.

Mr. Ben Hinson states that the way he reads Senate Bill 76 he thinks the Commission would still have the authority to pay for patients who end up at a designated trauma center whether it is in state or out of state all the same way.

Dr. Pat O'Neil would like Mr. Alex Sponseller to take a close look at the Bill to be sure that this does not preclude what was previously allowed.

Mr. Hinson states, that right now if an ambulance picks a patient up and takes them to a local hospital that is not a designated trauma center and then subsequently that service or another service takes them to a designated trauma center both legs of the trip are eligible to be paid if the calim is uncompensated, that was the intent of this Bill. If a patient ends up at an out of state designated trauma center that the EMS service would be reimbursed the same way. Dr. O'Neil's point is that he is not sure whether the Commission would treat both instances equally. The question to be answered is does the new language limit the Commissions ability to pay for patients that end up out of state?

Dr. Dennis Ashley states the only thing he sees that has changed is the one line, which is on lines 17 & 18, underlined. So they added the line that states: <u>and to trauma patients transported to out-of-state hospitals as approved by the Commission</u>. Dr. Ashley does not see that one line changing anything because it has the word "and" in it. So if Dr. O'Neil's point is valid then what we are doing now is incorrect, because nothing else in the whole Bill has changed. Dr. Ashley's interpretation of the bill, which is currently SB 60, is that if a patient is transported to a non-trauma hospital and then transported to a trauma center and ends up on the registry, then this patient is by definition a trauma patient. The Commission would allow EMS to be enumerated for that first leg. We have taken the interpretation that is a trauma registry patient eventually. Dr. Ashley thinks that is the appropriate thing to do, and is what we should do, and want to do. I think we might need a clarification on our interpretation of SB 60.

Mr. Alex Sponseller thinks that we are amending this one part, which is for the first two fiscal years, and we are past that. What really needs to be amended is subsection 7C, which is the general rule that applies to uncompensated care of diversion of EMS services. They should add language to subsection 7C to say for the period after the first two fiscal years this is the rule to.

Mr. Pettyjohn states that we did remark on that point to Mr. Josh Mackey at the last Commission meeting. Mr. Pettyjohn asks if there had been follow-up done with Mr. Mackey on subsection 7C.

Mr. Sponseller stated that he aware of any follow-up.

Dr. Ashley asked Mr. Courtney Terwilliger (GAEMS) if he would speak with Mr. Josh Mackey about amending subsection 7C. Mr. Mackey is a lobbyist working for GAEMS.

Mr. Jim Pettyjohn addresses Mr. Hinson's point about using that leg of the patient transport where the patient does not go directly to the designated trauma center but was on route to the center after he went to a community hospital. Mr. Pettyjohn thought we had covered that at a previous meeting and it was discussed with Mr. Sponseller in the room and determined it was ok. As long as ultimately the patient wound up in the registry.

Dr. Ashley directs Mr. Ben Hinson to retract his request of Mr. Sponseller to clarify the new language in SB60.

Mr. Ben Hinson retracts is request.

Mr. Pettyjohn thinks that the Commission needs to develop a policy and procedure book. For example: How we define 10% of self-pay. These issues should be documented with a point of reference to the minutes.

Dr. Ashley agrees, and thinks it is a very good point. With our staff and Mr. Sponseller maybe we could get that done.

HB 307 as passed by House Committee on Health and Human Services – This is the Burn Center Trauma Bill. Mr. Pettyjohn states that Mr. John Walraven now leading the fight for HB 307. Mr. Walraven was unable to attend today, but would like very much to attend the next Commission meeting in May. This Bill passed 165/2. (*Attached to Admin. Report Mr. John Walraven's H.B. 307 Bill and history of the 307 Substitute Summary)*

Dr. Ashley states that the first Bill that passed had a lot of deletions in it that needed clarification. This Bill gives you two basic reasons, for the Bill. One is to define what a burn center is, the other is to define the burn patient. The one problem Dr. Ashley has with this Bill is the definition of Burn Trauma Center. Which is a facility that has been designated by the Department of Community Health as a burn center that admits at least 300 patients annually. Dr. Ashley states that we really do not need numbers in a bill, because if we had to change the number by one, it would have to go all the way back through the House, and the Senate. Dr. Ashley states that this is an error in HB 307, and numbers belong in rules and regulations.

Dr. Joe Sam Robinson states that maybe they are trying to dramatically limit who can participate as a burn center.

Dr. Leon Haley states that there are already restrictions in place. The first part of the language states that it will be designated by DCH. Which means you have already restricted whom that group is going to be. Dr. Haley agrees with Dr. Ashley there is not a need to put a specific number of patients in the Bill.

Mr. Ben Hinson agrees policy wise it is not good to have a number in the Bill, but thinks there will be times we wish there was. Mr. Hinson's biggest concern is that we have to be sure when the Burn Center seeks funding from the Commission that suddenly we are not required to fund uncompensated care from all over the Southeastern United States. The uncompensated care numbers from Burn Centers could be off the roof.

Ms. Linda Cole asks if we currently provide coverage to out of state patients that are included in the uncompensated care numbers?

Ms. Regina Medeiros states yes we do.

Dr. Ashley asks Mr. Sponseller does this Bill still give us the ability to look at the needs of the trauma system and allow the Commission to integrate Burn Centers into it with a funding mechanism, because we do have limited funds.

Mr. Sponseller states that the Commission should be able to allocate funds and make a formula out of that. There should be ways you could tweak it so somebody is not getting a windfall of funds.

Dr. Ashley feels that we need to look and sub define the burn patient in rules and regulations as to what patients we are going to consider eligible. We do not have to decide today but I think it is work for this Commission to do.

Mr. Ben Hinson states that on line 39 pages 2 of the Burn Center Bill it talks about what uncompensated care means to a trauma patient as defined by the Commission. Mr. Hinson thinks that wording allows us to tighten the definition.

Mr. Sponseller states that line 39 is the definition of uncompensated and that might just be limited to what uncompensated means. It seems to me that the way the language is written here that even if this passes, the Burn Center could not come in immediately for funding unless they were designated by DCH.

Mr. Ben Hinson asks if this legislation empowers DCH to designate Burn Centers?

Dr. Pat O'Neil replies yes, but they have not done it yet. Several months ago Dr. O'Neil presented a proposed rule to the Commission that would be presented to DCH for the designation process on Burn Centers. The Commission did not move with it because of the concerns about whether our not there needed to be a change in legislation before we did that. Dr. O'Neil states that DCH is going to do what the Commission wants related to the Burn Centers. We are not going to step out and make the decision to do designation unless the Commission supports the concept of the Burn Center being an inclusive part of the system.

Mr. Kurt Stuenkel wants to know if there is an economic crisis in burn centers. Mr. Stuenkel thinks that is a question for the Commission to think about as we consider funding these burn centers. We should ask for data.

Mr. Jim Pettyjohn states that the Commission could do a means test formula for funding.

Mr. Alex Sponseller replies, " That is entirely possible".

Dr. Haley states that there are two questions that need to be addressed, one is do we want to take the number out of the Bill? The secondary question is do we as a Commission want to make a recommendation that burn centers be designated by DCH?

Dr. Pat O'Neil would recommend taking the number out of the Bill and putting it in the rules and regulations.

Mr. Hinson agrees on taking the number out and asks if that is the direction of the Chair. Mr. Hinson with the direction of the Commission would be glad to get in touch with people on the Senate side working this Bill, and ask them to take that number out. Mr. Hinson states that it does not imply we are committing DCH to designate trauma centers. If DCH does not designate trauma centers none of this matters. Mr. Hinson thinks getting the number out now would give us more flexibility, if that were the direction of the Chair.

Dr. Dennis Ashley states that he is ok with that.

Mr. Jim Pettyjohn wants to know if a motion and a vote is needed.

Mr. Ben Hinson thinks that the Commission can just go on the consensus and direction of the Chair.

Dr. Dennis Ashley agrees that it is not at the level of a motion to vote.

Trauma Communications Center – Mr. Scott Sherrill states that as members of the Commission are aware we have issued an RFP for the hardware and software associated with the trauma communications center. In the fall of this year the evaluation committee recommended that we go with SAAB North America. SAAB made a presentation to the Committee in January at which time the Commission also recommended that we go forward with that purchase. The purchase has been delayed because a losing vendor protested the initial intent to award. They lost their protest. They then appealed that protest to the Commissioner of DOAS. This week they lost that appeal as well. There are no administrative protests remaining. At this point in time there is a contract from the Commission through GTRI on SAAB's desk.

This contract is on schedule to be looked at on Friday March 5. We should have an executed contract from SAAB very quickly. Mr. Sherrill anticipates that we will have a kick off meeting for planning and implementing the TCC very soon.

Dr. Ashley wants to know once SAAB signs the contract what is the next step?

Mr. Scott Sherrill states that SAAB was required to submit a project plan with their RFP that basically showed what to expect from day one after the contract is signed. Mr. Sherrill did not specifically review that information, but he believes it was a 3-4 month time frame. We will have a system actually installed right at the end of the FY2011. Mr. Sherrill states he is not quite sure how much time it will take to do the training and tweaking. He hopes to be open and running this summer before school starts back up.

Dr. Ashley wants to know when there will be a location that we can walk into?

Mr. Scott Sherrill states that the location exists today. We are actually paying for it. The system is located at GPSTC. The basic computers that will be used for the TCC software are a part of this contract. Not included in the contract are some antennas, generators, and a few PC'S for general office functions. Mr. Sherrill expects to see those items being physically present probably in the May/June time frame.

Dr. Dennis Ashley wants to know who will over see the coordination of this project, and is it under Mr. Sherrill's jurisdiction, or obligation.

Mr. Scott Sherrill states that it was not originally, but until the Commission gets a TCC lead it will be. Mr. Sherrill relays that he definitely will be coordinating with SAAB, but as soon as we get the TCC person hired, that person will be taking the lead. During that interim time I will be working closely with Mr. Jim Pettyjohn.

Dr. Dennis Ashley wants to know if we need to purchase a computer is there some big State fiasco we have to go through. Do we have to get 10 bids in order to do this?

Mr. Scott Sherrill states that there would not be a bid process. Mr. Sherrill will get with Mr. Pettyjohn on the specific details as to whether you have to buy a computer via the State contract that provides for standard configurations, prices and things of that nature.

Mr. Jim Pettyjohn states that everything we need is going to be through a State contract.

Mr. Scott Sherrill states that typically if the item is under $5,000 we can use the P-card. Some of the other equipment such as generators may be a little less standard, but I think we will be able to work them in such a way that they do not require going through the RP process.

Ms. Linda Cole asks Mr. Scott Sherrill if he can do a time line for the Commission to show us when these different activities will occur?

Mr. Scott Sherrill replies that he would be able to do that in a week or two. He would like to be sure that the time line he presents to the Commission is consistent with SAAB'S.

Mr. Jim Pettyjohn adds that one of the deliverables from GTRI to the Commission in their contract is an implementation plan that's been fitful getting done, but now that things our moving forward could be part of that deliverable.

Ms. Linda Cole states that it sounds good.

Update: Developing a Strategy Model for Georgia Injury Prevention – Ms. Rachel Ferencik from Georgia State University, Health Policy Center gave a Power Point Presentation consisting of A Project Plan Overview, and several slides.

Mr. Ben Hinson thinks that what they are doing is absolutely fascinating the way the modeling works. Mr. Hinson is excited about the injury prevention, but he is thinking more about how we can begin to model system designs changes all across Georgia in our trauma system. To find out the changes we make and what the impact will be.

Dr. Dennis Ashley states that this study is very impressive, and wants to know if the purpose of this modeling is to change the variables and ultimately show the lives that have been saved by making changes to the dashboard.

Ms. Rachel Ferencik states that yes that is what we are trying to show, and we will have a dashboard. It has not yet been determined exactly what variables will be on the model that depends on available, usable data. For example you could perhaps have a little dial that says currently law enforcement for super speeding is at a certain percentage. What if you could turn that dial and increase that by some amount, what impact might that have on injury, 10 or 20 years down the road.

Dr. Dennis Ashley wants to know if you would take that data and use it for example to say that we know that at so many miles an hour the death rate is this and if we decrease the miles per hour for the population in Georgia the death rate would go down this much, does that work?

Ms. Rachel Ferencik states that yes that works; a lot of it is based on probability. There are calculations in the model that allow us to see how that will impact injury maybe by population, or region of the state. Some of this is going to have to unfold as we move forward. We will have subject matter experts working on finding usable data. Of course we will have to make assumptions in some areas when we do not have complete data.

Dr. Joe Sam Robinson wants to know if there are other states that are doing this.

Ms. Rachel Ferencik does not know if there has been one on trauma or injury. There are models that have been done in a variety of other public health areas, such as childhood obesity, diabetes, and heart disease.

Dr. Joe Sam Robinson wants to know if the deaths in Georgia have a number pertaining to the deaths of those involved in care accidents.

Ms. Rachel Ferencik states that she is hoping the subject experts will be able to help us figure out what that number is.

Dr. Ashley wants to know if Ms. Ferencik has any areas of expertise that need to be filled.

Ms. Ferencik states she does not at this point. I am in close conversation with Mr. Pettyjohn and as this study unfolds and we find out that we really need another source of data I am confident that he can help direct me to that data. We also have a lot of strong support from DCH, The Center for Disease Control.

Trauma Center Audit Report – Mr. Jim Pettyjohn introduces Evelyn Poulas Senior Auditor with Gifford, Hillegass & Ingwersen a contracted audit firm. The Commission has been working closely with Ms. Poulas on the goal to validate the Uncompensated Care Case Data that was contained in the CY2008 Bishop & Associates survey. *(Report in Blue binder handout)*

Mr. Jim Pettyjohn asks if Ms. Poulas has overall recommendations on the findings on the ISS determination process at the level 1-trauma centers?

Ms. Poulas states that Ms. Mary Hobel a Registered Healthcare Information Technician and Certified Coding Specialist was contracted by GH&I to test the ISS scoring by Trauma Centers. One of Ms. Hobel's recommendations were that the Registrars should continue communicating with one another regularly and work on some of the items that were not consistent. Ms. Hobel also noted that duel monitors were helpful. There was a variation in the level of knowledge related to the coding specifics. It was felt that

there were cases where some additional training might really benefit in getting a consistent product among the registrars, employees and the system as a whole. To make sure that the trauma centers are using all injuries and not using the drop down box, of which NTRAC (trauma registry software) was a big one. Because apparently that gives you a different score then if you use the AIS coding guidelines and book.

Mr. Ben Hinson looking at the audit report notices that false negatives were never checked. In other words the center did not put somebody on the registrar that should have been on it. Mr. Hinson wants it to be in the record that while the numbers might show that more was billed than should have been, he would like it noted that perhaps it is because we never looked to see if there were some they should of billed but did not. In this time of insurance Medicare/Medicaid fraud every time there is an audit and they say you should not of billed us for this, we need to note there is probably some that should have been billed for that were missed. Mr. Hinson would like comment to be noted in the audit notes that you did not check for false negatives, and asks if that is a reasonable request.

Ms. Poulas agrees to include that in the audit notes.

Dr. Ashley thinks that is an excellent point.

Mr. Hinson wants to know if the audit was static from the date that the registrars submitted the information, or if they had received a subsequent payment that put them over the 10% threshold. Did you count the latter payment that they would not? Was it neither known or knowable at the time they submitted their request?

Ms. Poulas states that we cut it per payments received as of the date that the survey went out which was February 9, 2010.

Mr. Alex Sponseller goes over the Uncompensated Care definition revisions- These revisions pertain to Part 3 of the Audit report page 8, A-G. and are gone over in detail by Mr. Sponseller in a Letter dated 15 March 2011. This letter was sent to Dr. Dennis Ashley and the Commission Members. (*Mr. Alex Sponseller's letter attached to the minutes)*

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.

Mr. Ben Hinson wants to know if we are on solid ground with the 10% rule legally?

Mr. Alex Sponseller states that yes we are. We had concluded that any payment by the patient themselves would not disqualify a claim from reimbursement. And the Commission also had stated that there is a 10% rule. If the patient pays over 10% it is almost like they are paying most of the claim themselves, so they will not be reimbursed. If it is less than 10% they will.

Dr. Dennis Ashley wants to know is it 10% more or is it less than 10%, and if somebody pays exactly 10% where do they fall.

Ms. Linda Cole states that it is less than 10% for the patient to qualify for reimbursement.

Ms. Evelyn Poulas has questions concerning insurance settlements. Mr. Sponsellers letter states that if it is related to medical coverage than it would be excluded. Ms. Poulas does not know if the hospitals are always aware of medical coverage. If it is a lawyer that is fighting a case is it always against the insurance company? If the lawyer pays the hospital would that be considered a patient payment or is that considered under the other rule any settlement or judgment resulting from such coverage.

Mr. Alex Sponseller states that he thinks we are talking about judgments and settlements that's relating to for instance, your auto insurance. Say you get into an auto accident, and you get a judgment against somebody who hit you. Their auto insurance will pay that judgment.

Ms. Evelyn Poulas wants to know can that mean any settlement payment?

A Mr. Alex Sponseller state yes as long as it is related to insurance coverage. The key word is coverage.

Mr. Ben Hinson states that payment would not have the 10% threshold. So if you received a minimum insurance payment from the person who hit you, insurance company it would not be considered an uncompensated claim right?

Mr. Sponseller states that is correct.

Dr. Dennis Ashley wants to know if the hospitals donate 3% of their revenues for charity?

Mr. Kurt Stuenkel replies that it is not donated the hospital just writes it off. In other words 3% of the adjusted gross revenue.

Dr. Dennis Ashley wants to know what if your net revenue is $100,000?

Mr. Kurt Stuenkel replies then you have to do $3000.00 for free.

Mr. Alex Sponseller wants to know how the Commission wants to address the 3% charity requirement.

Mr. Kurt Stuenkel states his initial response would be that the 3% is a requirement, but that 3% does not represent a payment.

Ms. Linda Cole wants to know if you got compensation through the Trauma Commission would those patients have to come out of the charity care bucket?

Mr. Kurt Stuenkel states that it would show up on your income tax statement as other revenue. So yes you would have to still meet the 3% somewhere. This 3% is like a bubble because it is going to go up, it is going to be there, or else the hospital is not going to be compliant with their CON commitment. Regardless of what the Trauma Commission pays.

MOTION GTCNC 2011-03-02:
I move that the Commission make a motion that in cases where financial counselors at the Trauma Center determined that the patients qualified for charity program offered by the hospital and whereby the account was written off and further attempts to collect were not made, these claims are deemed qualifying under Trauma Commission uncompensated care definition.

MOTION BY: Ben Hinson
SECOND BY: Leon Haley
DISCUSSION: none

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

B) Cases where patients were victims of a crime and the Trauma Center received a small payment less than 10% from a third party charity.

MOTION GTCNC 2011-03-03:
I Move that the Commission makes a motion that in 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, these claims are deemed qualifying under Trauma Commission Uncompensated care definition.

MOTION BY: Dr. Leon Haley
SECOND BY: Dr. Joe Sam Robinson

DISCUSSION: Dr. Ashley wants to know if there is a stipulation of 10% on that or none at all.

Mr. Ben Hinson states that would be a separate motion. We vote this first and then deal with the overall 10%.

Mr. Jim Pettyjohn states that the 10% is already in this.

Mr. Ben Hinson states that he is just saying for these cases 10% are good.

Dr. Dennis Ashley states that was my question. Do we want a 10% threshold in B or do we just want to say the victims of crime are not disqualified. How specific do we want to be?

Mr. Ben Hinson states that he would like for it to be 10% across the board, unless it is a payment excluded by statue. There are some statutory payments that we cannot consider uncompensated, but anything else if it is under 10% it can be considered uncompensated.

Dr. Dennis Ashley wants to know if the commission should put the 10% in as our threshold to be consistent, or should we pass this as is without the 10%, and then just say at the end in another motion, for any other payer with less than 10% as our threshold. Dr. Ashley feels that might get complicated as to which payer's are we talking about. Or would it be better to have a 10% in each of these motions we are going to make.

Mr. Sponseller states doing the 10% for each motion makes more sense.

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

C) Cases where patients were undocumented Aliens and the Trauma Center received a small payment (less than 10%)from a third party charity.

Ms. Linda Cole states that the Commission should stay consistent with 10%.

Mr. Joe Sam Robinson wants to know if the State is doing something on some new law about undocumented aliens?

Mr. Alex Sponseller states that he is not aware of that.

MOTION GTCNC 2011-03-04:
I move that the Commission makes a motion that in 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, these claims are deemed qualifying under Trauma Commission uncompensated care definition.

MOTION BY: Mr. Leon Haley
SECOND BY: Ms. Linda Cole
DISCUSSION: None

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

D) Cases where a patient expired and the Trauma Center did not attempt to collect.

Mr. Jim Pettyjohn wants to know what the story is on this one.

Ms. Evelyn Poulas states that some of the cases that she reviewed when they handed off the collection notice to a third party companies they never noted to the third party company whether they expired or not. In some cases she saw some hospitals absolutely trying to collect. Some hospitals said out of respect they did not attempt to collect.

Dr. Dennis Ashley states that is a good policy from a humanistic, ethical standpoint. I do not think it should necessarily be the Commission's responsibility to pay that claim if the hospital chooses not to send a bill because of their particular moral, ethical response.

Mr. Kurt Stuenkel states that Floyd Medical Center sends the bill, so I think it is a choice by the organization.

Ms. Linda Cole states that Children's Hospital does not bill, it is just to sensitive a time, but Ms. Cole is fine with the way it is written. It does not happen that frequently.

Mr. Alex Sponseller asks Ms. Cole would these children be covered under some other program?

Ms. Linda Cole states most but not all. We will bill the insurance company, Medicaid, or Blue Cross. If the family of the child is not insured we will not send a bill. There is so many if's. If the child is in the hospital for a long time typically you can get them on Medicaid. If the child is basically DOA in the ED we all know it is a rigorous process to get the child on Medicaid after the fact. It is usually a very painful time for the child's parents, so typically we would not send a bill.

Mr. Kurt Stuenkel thinks payer of last resort if the hospital chooses not to pursue payment then they should not be reimbursed through this mechanism.

Mr. Leon Haley states the Commission already has this right that is what OCGA states that there must be documented attempts of the Trauma Care Services of trying to collect payment.

MOTION GTCNC 2011-03-05:
I move that the Commission make a motion that in cases where the patient expired and the Trauma Center did not attempt to collect, these claims are deemed not qualifying under Trauma Commission uncompensated care definition.

MOTION BY: Mr. Kurt Stuenkel
SECOND BY: Ms. Linda Cole
DISCUSSION: None

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

E) Cases where patients received settlements directly but did not pay the trauma Center after repeated collection attempts.

Mr. Ben Hinson states that if the patient's insurance pays the patient rather than the hospital then that patient cannot be an uncompensated patient.

Mr. Alex Sponseller states yes that would disqualify the patient

Mr. Joe Sam Robinson states that there are legal ways for the hospital to extract those dollars. It would appear to me that it is the job of the hospital to do that.

Mr. Kurt Stuenkel states but what if the hospital try's to collect, the patient looses is lawsuit or declares bankruptcy. Would the Commission be able to go back then and include it in the list?

Mr. Alex Sponseller replies that it seems to him that the way the statue is written the first is to mandate that there is no coverage at all, or judgments or anything, and then that there were documented attempts for collections and nothing could be collected, then money could be obtained from the fund.

Mr. Kurt Stuenkel states that maybe if the hospital has a documented trail of trying to collect the money filing suit, etc., then a judgment is made as to whether it is on the list or not. Rather than just saying we are not going to allow any of these cases. That would be my recommendation.

Ms. Evelyn Poulas states that the way they audit is by looking at what is in the patient's hospital notes, which are not necessarily all that detailed. So it would be in the grey area for auditability to decide cases individually.

Mr. Ben Hinson wants to know what the Commission wants to do on this statue right now exclude this case on the advise of counsel?

Mr. Dennis Ashley states that Mr. Sponseller has done that in his letter, so I think we need to exclude this on the advise of counsel.

MOTION GTCNC 2011-03-06:
I move that the Commission makes a motion that in cases where the patient receives a settlement directly but did not pay the Trauma Center after repeated collection attempts, these claims are deemed not qualifying under Trauma Commission uncompensated care definition.

MOTION BY: Mr. Ben Hinson
SECOND BY: Ms. Linda Cole
DISCUSSION: None

ACTION: The motion ***PASSES*** with no objections.
(*Approved minutes will be posted to www.gtcnc.org)*

F) Cases where there was a reciprocal agreement with another party for exchange of services and the trauma center did not attempt further collection procedures.

Ms. Evelyn Poulas states that this is specific to Grady. If there is a city of Atlanta employee injured on the job or a prisoner that is treated at Grady, the hospital does not charge the city of Atlanta. In return

according to the CFO of Grady, the hospital receives a certain amount of free water. The CFO'S point was that it is not one for one. They might get 1.4 million dollars water but probably give about 6 million dollars in care.

Mr. Ben Hinson states that it is not applied specifically to an account so it is somewhat like the Dish payment right?

Dr. Leon Haley states that is right, that it is a generic amount of money for a generic amount of water.

Dr. Dennis Ashley states that they are receiving water for their services so I think this is a straightforward disqualification. This is considered a barter system.

MOTION GTCNC 2011-03-07:
I move that the Commission makes a motion that in cases where there was reciprocal agreement with another party for exchange of services and the Trauma Center did not attempt further collection procedures, that these claims are deemed not qualifying under Trauma Commission uncompensated care definition.

MOTION BY:	Mr. Leon Haley
SECOND BY:	Ms. Linda Cole
DISCUSSION:	None
ACTION:	The motion ***PASSES*** with no objections. *(Approved minutes will be posted to www.gtcnc.org.)*

G) Cases where insurance could not be verified.

Ms. Evelyn Poulas states that this is a case where the patient states that they have medical insurance, but they never provided any information to the hospitals so the hospital could file a claim against that medical insurance.

Dr. Dennis Ashley states that it just seems like there needs to be another line in the hospital data bank that says no insurance provided so the hospital can close the account.

Mr. Alex Sponseller states that they are eligible as long as it has been verified that there is not coverage at all and there are documented attempts to collect payment.

MOTION GTCNC 2011-03-08:
I move that the Commission makes a motion that in cases where insurance could not be verified, these Claims are deemed qualifying under Trauma Commission uncompensated care definition.

MOTION BY:	Mr. Leon Haley
SECOND BY:	Mr. Ben Hinson
DISCUSSION:	None
ACTION:	The motion ***PASSES*** **with** no objections. *(Approved minutes will be posted to www.gtcnc.org.)*

MOTION GTCNC 2011-03-09:
I move that the Commission makes a motion that what the Commission decided today needs to be written up as the Commission's policy going forward.

MOTION BY:	Mr. Ben Hinson
SECOND BY:	Ms. Linda Cole
DISCUSSION:	None

ACTION: The motion ***PASSES*** **with** no objections.
(Approved minutes will be posted to www.gtcnc.org.)

Mr. Jim Pettyjohn states that we need to get the clarification to Bishop & Associates to send out the financial survey from calendar year 2009 data, which will inform the uncompensated care budget for the hospitals for 2012. Mr. Pettyjohn states that based on what we have decided today I would like to direction that I can go ahead and send out the survey.

Mr. Dennis Ashley states that Mr. Pettyjohn can go ahead and send out the survey.

MOTION GTCNC 2011-03-10:
I move that the Commission makes a motion that under finding number one that the survey data for the above listed centers which is in your document be amended, reflect the changes outlined in the total number of cases by ISS from the list provided to GH&I be considered as complete CY 2008 for the Trauma Centers.

MOTION BY: Dr. Leon Haley
SECOND BY: Ms. Linda Cole
DISCUSSION: None

ACTION: The motion ***PASSES*** **with** no objections.
(Approved minutes will be posted to www.gtcnc.org.)

MOTION GTCNC 2011-03-11:
I move that the Commission makes a motion that provides the CY 2000 uncompensated care list to exclude all cases for patients with a greater than 10% payment.

MOTION BY: Dr. Leon Haley
SECOND BY: Ms. Linda Cole
DISCUSSION: None

ACTION: The motion ***PASSES*** **with** no objections.
(Approved minutes will be posted to www.gtcnc.org.)

PROPOSED REVISED FY 2011 TRAUMA CENTERS AND PHYSICIANS FUNDING DISTRIBUTION CHANGES BASED ON TRAUMA CENTER UNCOMPENSATED CARE CLAIMS AUDIT- Mr. Jim Pettyjohn states that based on recommendations 1 & 2 there is a new distribution of the uncompensated care claims and the dollars associated with those claims for calendar year 2008, which informed fiscal year 2011 funding this current fiscal year. *(Budget document attached to admin. report)*

Mr. Kurt Stuenkel asks Mr. Pettyjohn what the definition of regionalization is.

Mr. Jim Pettyjohn states that regionalization is the $75,000 too MCCG, and MCG to work within their communities to develop The Regional Trauma Advisory Counsels.

Dr. Dennis Ashley adds that is was money for the RTAC coordination, or the two pilots.

MOTION GTCNC 2011-03-12:
I move that the Commission make a motion to adopt this budget.

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

DISCUSSION: Ms. Elaine Frantz understands that the Commission's subcommittee accepted audit recommendations number 1 & 2, based upon the ISS errors. Ms. Frantz wants to know would the uncompensated care that was received from a third party payment and the adjustments made ultimately affect the differences on the ISS because of the error on data submitted in 2010 from CY 2008 data?

Mr. Jim Pettyjohn states that yes these new numbers resulted from 1 & 2.

Ms. Elaine Frantz states that there may be a letter to the Commission from Memorial stating what did occur relevant to items 1 & 2. Ms. Frantz states that following discovery of the significant errors in the original ISS submission to Mr. Bishop, the errors were immediately corrected during the audit. It was determined that NISS numbers were submitted rather than ISS. With that being said, this certainly would have made a difference in the bottom line. In addition it was 100% perfection when Ms. Mary Hobel came out from GH&I. It was 100% identical scoring ISS to ISS. Does that bare any relevance, or weight on the ultimate decisions?

Mr. Jim Pettyjohn states that it is his understanding that the NISS by ISS categories are not the same as the ISS to ISS categories. When we put Memorial's ISS numbers into the formula for determining uncompensated care funding distributions it changed the distributions to the Centers.

Mr. Ben Hinson states his understanding is that if Memorial had used the ISS score to begin with instead of the NISS the result would have been exactly what the amended budget is, is that what you are asking?

Ms. Elaine Frantz states that yes that is what she was trying to confirm. In consideration of that information, there are no other concerns and the issue seems resolved.

ACTION: The motion ***PASSES*** **with** no objections.
(Approved minutes will be posted to www.gtcnc.org.)

FY 2011 COMMISSION BUDGET ADJUSTED FOR ACCOUNTING ERROR- *(Budget document attached to admin. report)*

MOTION GTCNC 2011-03-13:
I move that the Commission make a motion to approve the FY 2011 amended budget based on the $153,000 accounting error as new distribution.

MOTION BY: Mr. Ben Hinson
SECOND BY: Ms. Linda Cole
DISCUSSION: None

ACTION: The motion ***PASSES*** with no objections.
(Approved minutes will be posted to www.gtcnc.org.)

Mr. Kurt Stuenkel wants to know if the $284,000 and the $988,000 on EMS Uncompensated is that associated with MCG?

Mr. Jim Pettyjohn states that yes MCG, as they did last year, is administrating EMS Uncompensated Care Program. Ms. Regina Medeiros works with all the state EMS services sending in their uncompensated care claims. Ms. Medeiros works to validate that list and ensure everything is correct according to the

deliverable that is in their contract, of which was previously approved by the Commission. Then Ms. Medeiros dispenses that money out.

Mr. Kurt Stuenkel states so the money gets parked there, but that money does not go to MCG?

Mr. Jim Pettyjohn replies that it is a straight pass through, with a 5% admin.

FY 2011 OEMS/TRAUMA REGISTRY CONTRACT: FUNDING DISTRIBUTION- *(Budget doc. Attached to Admin. report)*

Ms. Renee Morgan states that at the last Commission meeting in February we presented some general information about the Trauma Registry, what we collect, how we collect, and what is the basis for it. Since then we got together with Mr. Jim Pettyjohn and discussed presenting a 3-4 part series on the Registry. One of the things that we want to make perfectly clear is that the Registry follows the guidelines of the American College of Surgeons. We use the criteria that ACS sets forth for us to collect. Any changes that take place to the data dictionary's, any changes that are considered at our office are worked out previously with the trauma coordinators and the trauma registrars. With that said Ms. Rene Morgan turns the meeting over to Ms. Marie Probst who will present a power point presentation which includes: DCH Mission, DCH Initiatives FY 2009 and 2010, Georgia Trauma Registry's purpose, and a Registry Preview which includes, Criteria, Data Abstraction, ICD9 and AIS Codes, ISS, and Data Validation. (Registrar *Power point presentation attached to the minutes)*

Ms. Marie Probst when going over the data that is entered on the financial screen, by the registrar, mentions that the entry for payer source, secondary payer source and work related injury that is suppose to be entered those fields are not completed 100% of the time. Some hospitals have refused to provide us with that information. It is basically up to the hospital administration to send that information to us.

Mr. Ben Hinson wants to know concerning the financial screen is that information the hospital would provide to the registrar?

Ms. Marie Probst states that not necessarily. The face sheet would be in the patient's chart, and the registrar would abstract the information from the face sheet.

Mr. Ben Hinson wants to know whether it is a retroactive thing where you can go back to the business office after the fact and ask them how did you really get paid.

Ms. Marie Probst states no, due to the volume in the Trauma Registry and the other hats that registrars wear, they are not going to go back and look in the billing system.

Mr. Ben Hinson was just wondering if there was a way that could take place. The Trauma Commission is giving the hospital money based on this data. If the Trauma Commission could make a rule where the hospital business office 12 months after the patient has been discharged, has to let the Commission or Registrar know that information. Mr. Hinson thinks that information would help the Trauma Commission when they are figuring out the uncompensated care. Mr. Hinson wants to know why ask for the financial information at the start, because like we saw in the audit today, day one may not have anything to do with whether the hospital got paid or not.

Ms. Regina Medeiros states that historically the registrar had not submitted that data because there is not a way to validate that what was on the hospital face sheet was accurate. It is very hard based on volume to follow-up on this information.

Ms. Renee Morgan states that the key focus for this data is for performance not specifically for financial. After one year the hospital record on a patient is completely closed out to the registrar.

Mr. Ben Hinson states that for the Commissions financial purposes this registrar would not really be helpful, since there is no payment until one year latter.

Ms. Renee Morgan states that the Commission is better if they go directly to the financial division of the hospital rather than through the registry.

Ms. Marie Probst states that there is a breakdown of the $754,000 distribution of funds to the Trauma Registry on page three of the Administrative Report. There is also information on New Designated Trauma Centers to be included in the FY 2112, Non-designated Trauma Registry Participants and Annual NTRACS expenses.

Ms. Renee Morgan states that they notified the Trauma Care Coordinators and the Registrars that the funds for the third and forth quarters have been retracted and we will be sending the centers an amended contract to reflect that money being retracted. There is money still in there for first and second quarter, if they have not received those payments yet. We will then go forward with new contracts or agreements. We will still have to have a contract of some sort because of the designation process. They will still be in agreement to send us downloads. The only changes are in the funding.

Mr. Ben Hinson wants to know other than the volume of patients that the Trauma Centers see is there any difference in cost as related to the level of centers for the registry.

Ms. Renee Morgan states that it is the same price. The volume is the resource, because you have to have more registrars if you have more patients.

Mr. Jim Pettyjohn wants to know what they are going to focus on for the next Commission meeting.

Ms. Marie Probst states they will focus on the downloads.

EMS SUBCOMMITTE OF TRAUMA-. Mr. Ben Hinson states he would like to begin the EMS grant award process earlier in the year.

Mr. Jim Pettyjohn thinks that would be great. We could post the application July 1, and then amend it depending on the actual budget approved for the awards.

Mr. Ben Hinson states that right now we have a 30-day window for grantees, and a lot of these county commissions cannot approve things within that time frame. We want to give people 60 days to go to the commissioners and get them to sign off on the paperwork.

Mr. Hinson states the EMS Subcommittee will not meet again until May.

Mr. Pettyjohn states that at the EMS Subcommittee meeting in May, lets have a discussion on next years EMS grant criteria, so we can post it as soon as July 1, comes around.

Mr. Hinson states that is fine with him.

DCH OEMS, OFFICE OF TRAUMA AND PUBLIC HEALTH- Ms. Renee Morgan states the Public Health Bill for us to move out, passed the Senate, but there is no money to establish a new organization.

Mr. Keith Wage's states that yes that Bill came out of the House and it is in the Senate, and if it gets to the floor of the Senate, it is going to pass with flying colors.

Mr. Jim Pettyjohn states this is the Bill that assigns the Trauma Commission to the Department of Public Health.

Mr. Keith Wages states that there is no language change in the Bill. It is the Language that has been in the code since the 1940's. It is just changing Community to Public. All the things Public Health has always done as a division it will do as a Department. There will be no additional powers.

Mr. Hinson wants to know if the department will have it's own board and budget?

Mr. Keith Wages answers yes. There were technical modifications that the department made to make sure that both departments would have appropriate authority when separated.

Old business: None

New business: None

NEXT MEETING Will be on Thursday, May 19, 2011 in Atlanta

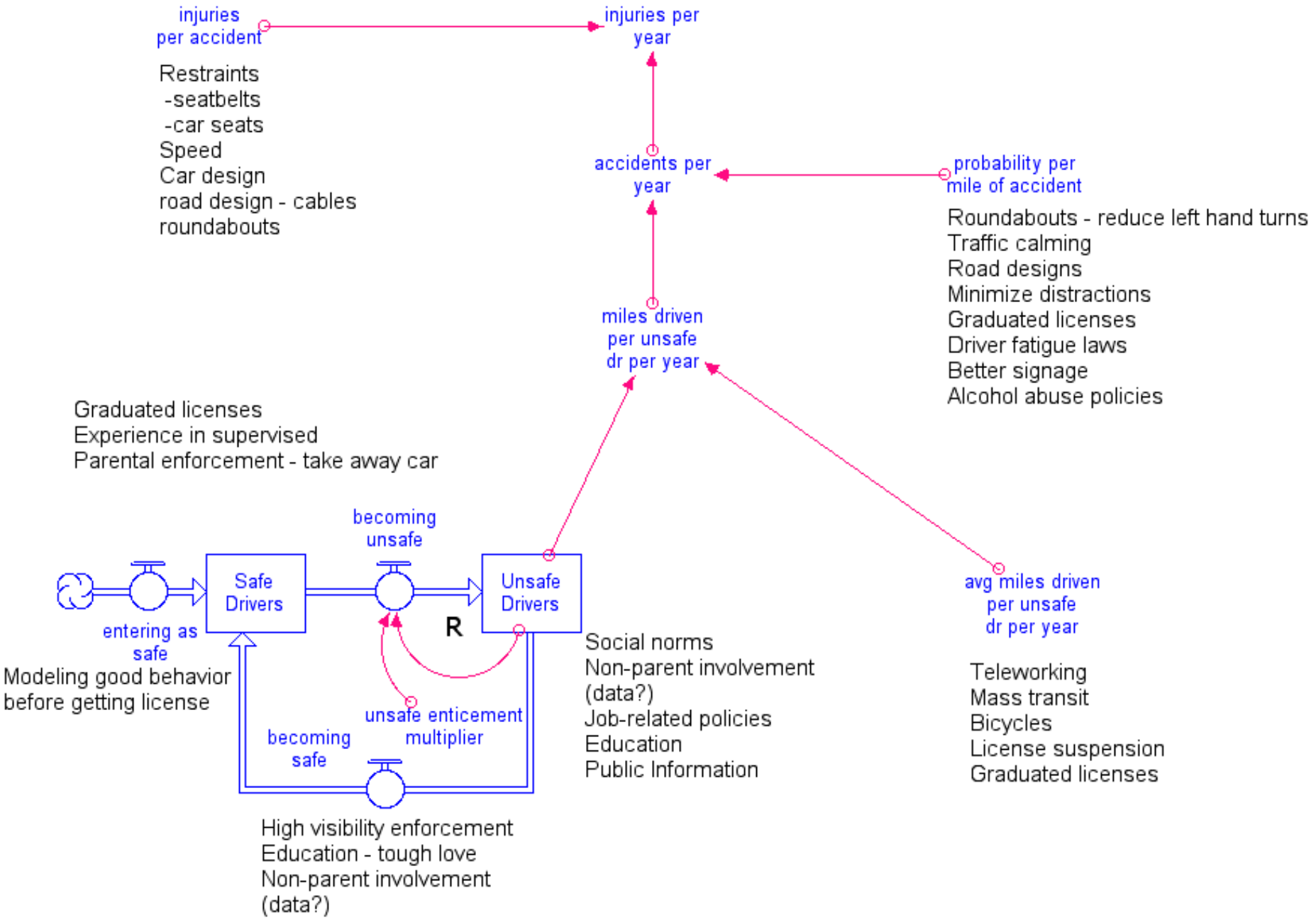
Meeting Adjourned: 02:10 p.m.

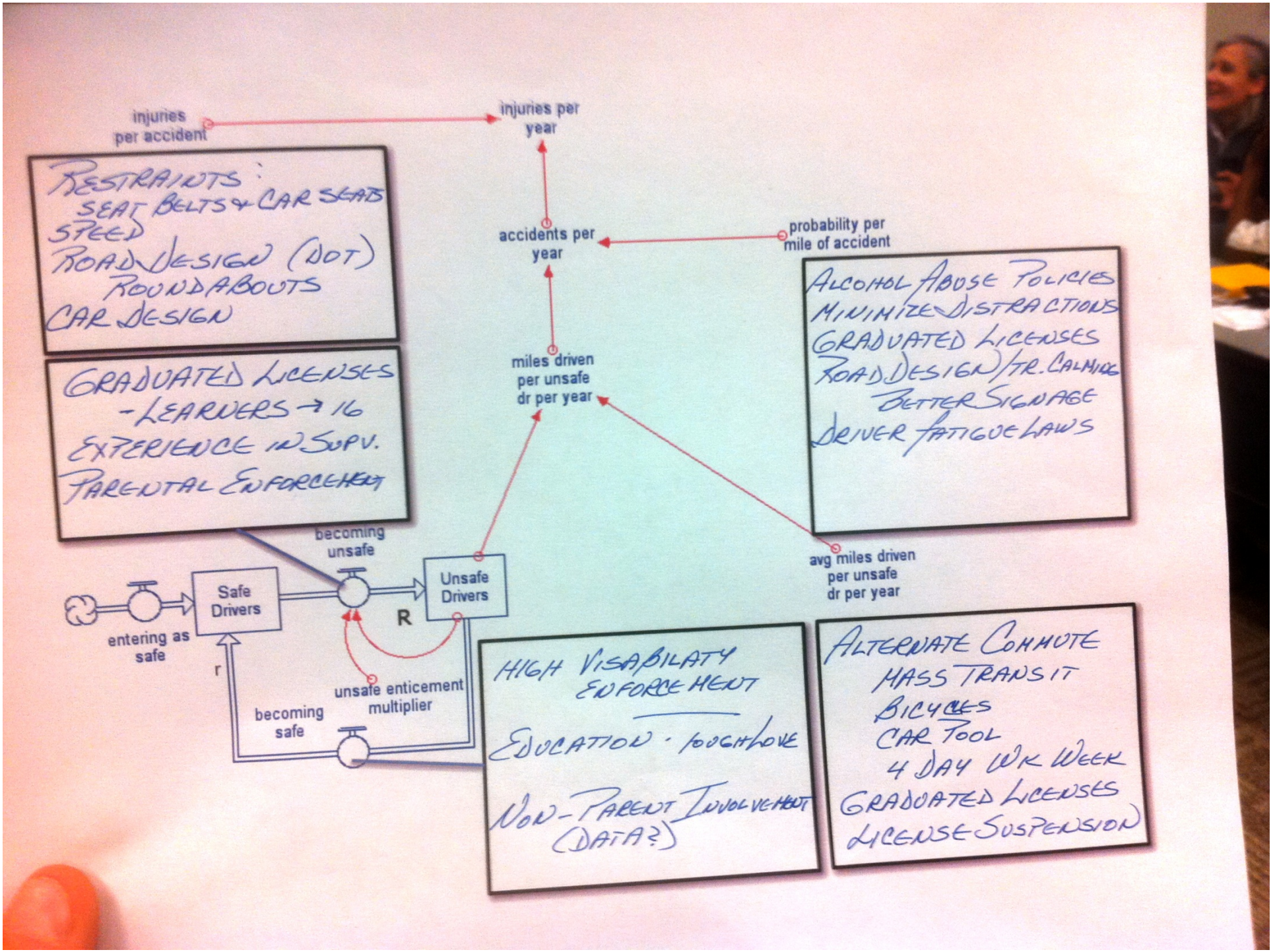
Minutes crafted by Lauren Noethen

Georgia Injury Prevention System Dynamics Model

Georgia Injury Prevention
System Dynamics Modeling Team

Randy Clayton, Governor's Office of Highway Safety
Linda Cole, RN, MBA, Children's Healthcare of Atlanta
Lisa Dawson, Department of Community Health
Rachel Ferencik, Georgia Health Policy Center
Elaine Frantz, RN, BSN, MA, Memorial University Medical Center
David Guthrie, MPA, Centers for Disease Control and Prevention
Ben Hinson, Mid Georgia Ambulance
Chris Jones, Ph.D., Centers for Disease Control and Prevention
Sherika Kimbrough, Grady Health System
Debra Kitchens, MCCG
Beverly Losman, Safe Kids of Georgia, Children's Healthcare of Atlanta
Terri Miller, Safe Kids of Georgia, Children's Healthcare of Atlanta
Jill Mobley, MD, Department of Community Health
Rochella Mood, Atlanta Medical Center
Renee Morgan, Department of Community Health
Greg Pereira, RN, Children's Healthcare of Atlanta
Jim Pettyjohn, GA Trauma Care Network Commission
Tanya Simpson, Doctors Hospital
L. Shakiyla Smith, MPH, Emory University School of Medicine


injuries per accident
injuries per year
Restraints
-seatbelts
-car seats
Speed
Car design
road design - cables
roundabouts
accidents per year
probability per mile of accident
Roundabouts - reduce left hand turns
Traffic calming
Road designs
Minimize distractions
Graduated licenses
Driver fatigue laws
Better signage
Alcohol abuse policies
miles driven per unsafe dr per year
Graduated licenses
Experience in supervised
Parental enforcement - take away car
becoming unsafe
Safe Drivers
Unsafe Drivers
R
entering as safe
Modeling good behavior before getting license
unsafe enticement multiplier
becoming safe
Social norms
Non-parent involvement (data?)
Job-related policies
Education
Public Information
avg miles driven per unsafe dr per year
Teleworking
Mass transit
Bicycles
License suspension
Graduated licenses
High visibility enforcement
Education - tough love
Non-parent involvement (data?)


injuries per accident
injuries per year
RESTRAINTS:
SEAT BELTS & CAR SEATS
SPEED
ROAD DESIGN (DOT)
ROUNDABOUTS
CAR DESIGN
accidents per year
probability per mile of accident
ALCOHOL ABUSE POLICIES
MINIMIZE DISTRACTIONS
GRADUATED LICENSES
ROAD DESIGN/TR. CALMING
BETTER SIGNAGE
DRIVER FATIGUE LAWS
GRADUATED LICENSES
- LEARNERS → 16
EXPERIENCE W SUPV.
PARENTAL ENFORCEMENT
miles driven per unsafe dr per year
becoming unsafe
Safe Drivers
Unsafe Drivers
R
entering as safe
r
unsafe enticement multiplier
becoming safe
avg miles driven per unsafe dr per year
HIGH VISABILATY ENFORCEMENT
EDUCATION · TOUGH LOVE
NON-PARENT INVOLVEMENT (DATA?)
ALTERNATE COMMUTE
MASS TRANSIT
BICYCLES
CAR TOOL
4 DAY WK WEEK
GRADUATED LICENSES
LICENSE SUSPENSION

Project Plan

Overview

- Assemble steering team (including SMEs)
- Refine/modify the system map
- Identify and organize data
- Develop prototype model
- Review with steering team and other stakeholders
- Refine/modify the model
- Develop supporting materials to facilitate model use for different stakeholders

~1 month

2-3 months

1-2 months

Georgia
Trauma Registry

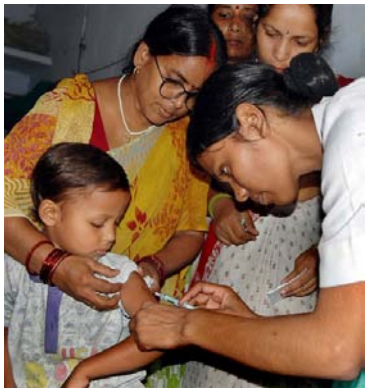
Presentation to
Georgia Trauma Care Network Commission
March 17, 2011

Section of Emergency Preparedness and Response
Office of EMS and Trauma

Georgia Department of Community Health

DCH Mission

ACCESS



Access
to affordable, quality health care in our communities

RESPONSIBLE

Responsible
health planning and use of health care resources

HEALTHY

Healthy
behaviors and improved health outcomes

DCH Initiatives
FY 2009 and FY 2010

FY 2009

- Medicaid Transformation
- Health Care Consumerism
- Financial & Program Integrity
- Health Improvement
- Solutions for the Uninsured
- Workforce Development
- PeachCare for Kids™ Program Stability
- Customer Service

FY 2010

- Medicaid Transformation
- Health Care Consumerism
- Financial & Program Integrity
- Health Improvement
- Workforce Development
- Customer Service
- Emergency Preparedness

Georgia Trauma Registry

PURPOSE

A well designed trauma registry assists health care providers, policymakers and community organizations in establishing a coordinated approach to trauma care and injury prevention. Trauma registries are scalable and can provide important information at the local, State and national levels.

The following are some uses for trauma system data:

- **Evaluate and improve the timeliness, appropriateness and quality of patient care;**
- **Provide a mechanism for comparing patient outcomes across service areas, provider groups, etc.;**
- **Identify excessively hazardous environments (e.g., specific auto intersections);**
- **Prioritize and evaluate public health interventions relating to injury prevention;**
- **Identify injury trends by geographic location, hospital length of stay, etc.;**
- **Provide data for clinical benchmarking, process improvement, and patient safety; &**
- **Provide the capability to monitor trauma system trends.**

Georgia Trauma Registry

REGISTRY PREVIEW

Criteria

Data Abstraction

ICD9 and AIS Codes

ISS

Data Validation

Georgia Trauma Registry

CRITERIA

• **Any patient with ICD-9-CM diagnosis code between 800.00 – 959.9.**
Excluding patients with codes of 905 –909 (late effects of injury), 910-924 (blisters, contusions, abrasions and insect bites), 930-939 (foreign bodies) and patients who are >65 years of age who are admitted with isolated hip fractures that are the result of a same-level fall.

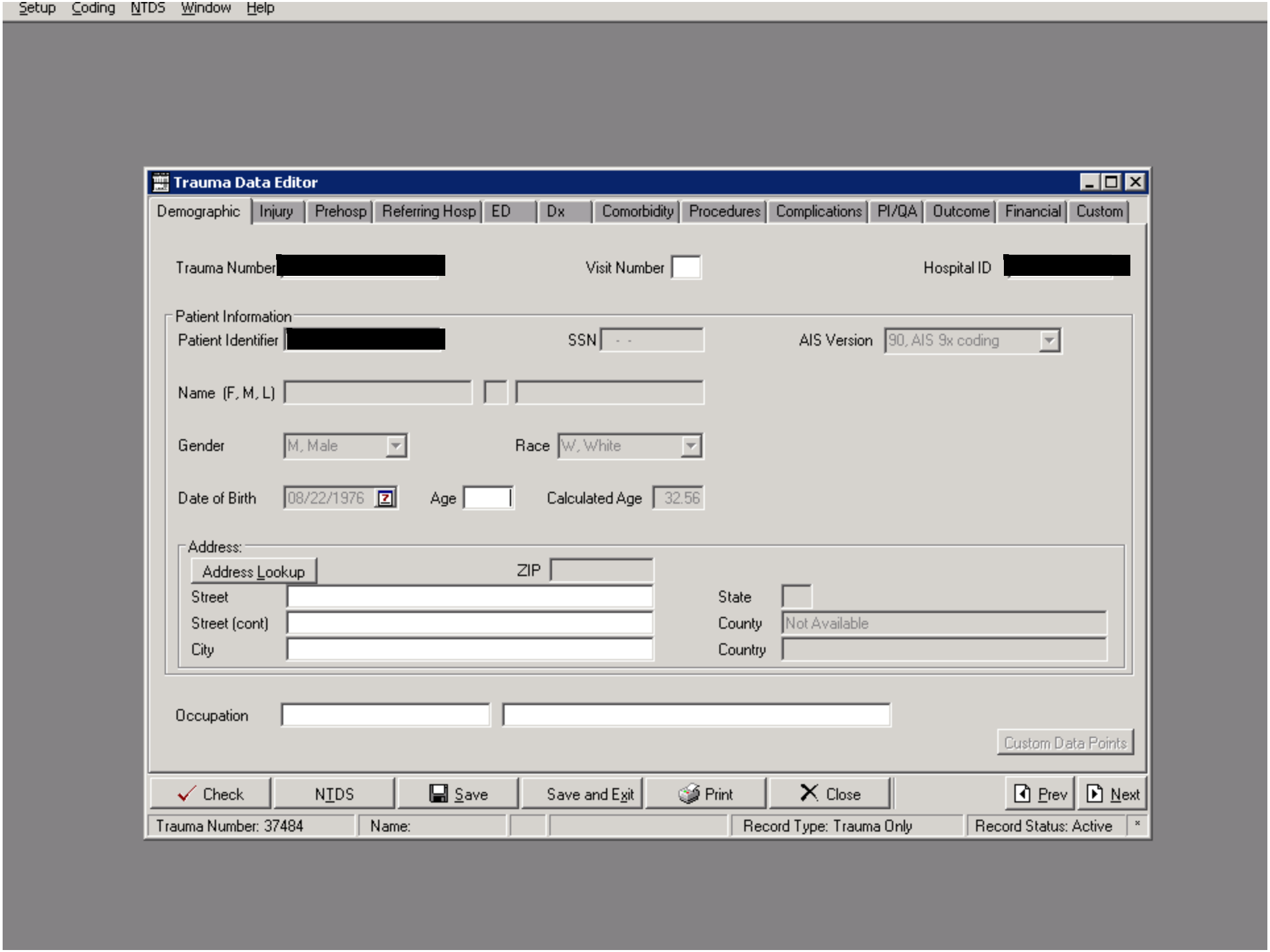
AND

- admitted for at least 48 hours

OR

- transferred to or from another facility
- died, regardless of length of stay
- admitted to the ICU, regardless of length of stay
- DOAs
- unscheduled readmissions, associated with the trauma, within 72 hours of discharge from the first visit.

Adopted June 26, 2002 from the American College of Surgeons,
Resources for Optimal Care of the Injured Patient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Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
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Patient Information
Patient Identifier [redacted]
SSN - -
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Race W, White
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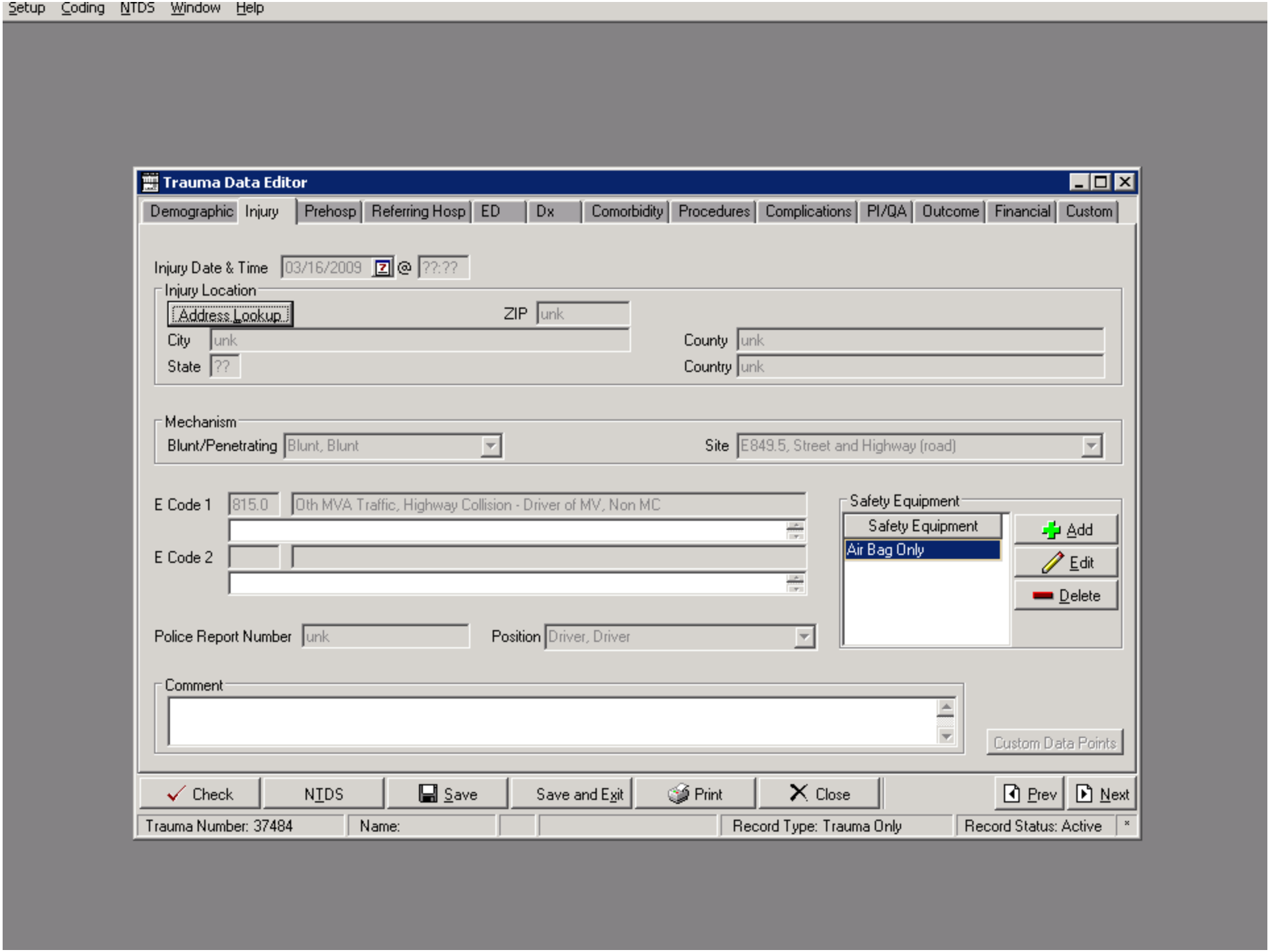
Record Status: Active


Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
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Injury Location
Address Lookup
ZIP unk
City unk
County unk
State ??
Country unk
Mechanism
Blunt/Penetrating Blunt, Blunt
Site E849.5, Street and Highway (road)
E Code 1 815.0 0th MVA Traffic, Highway Collision - Driver of MV, Non MC
E Code 2
Police Report Number unk
Position Driver, Driver
Safety Equipment
Safety Equipment
Air Bag Only
Add
Edit
Delete
Comment
Custom Data Points
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Name:
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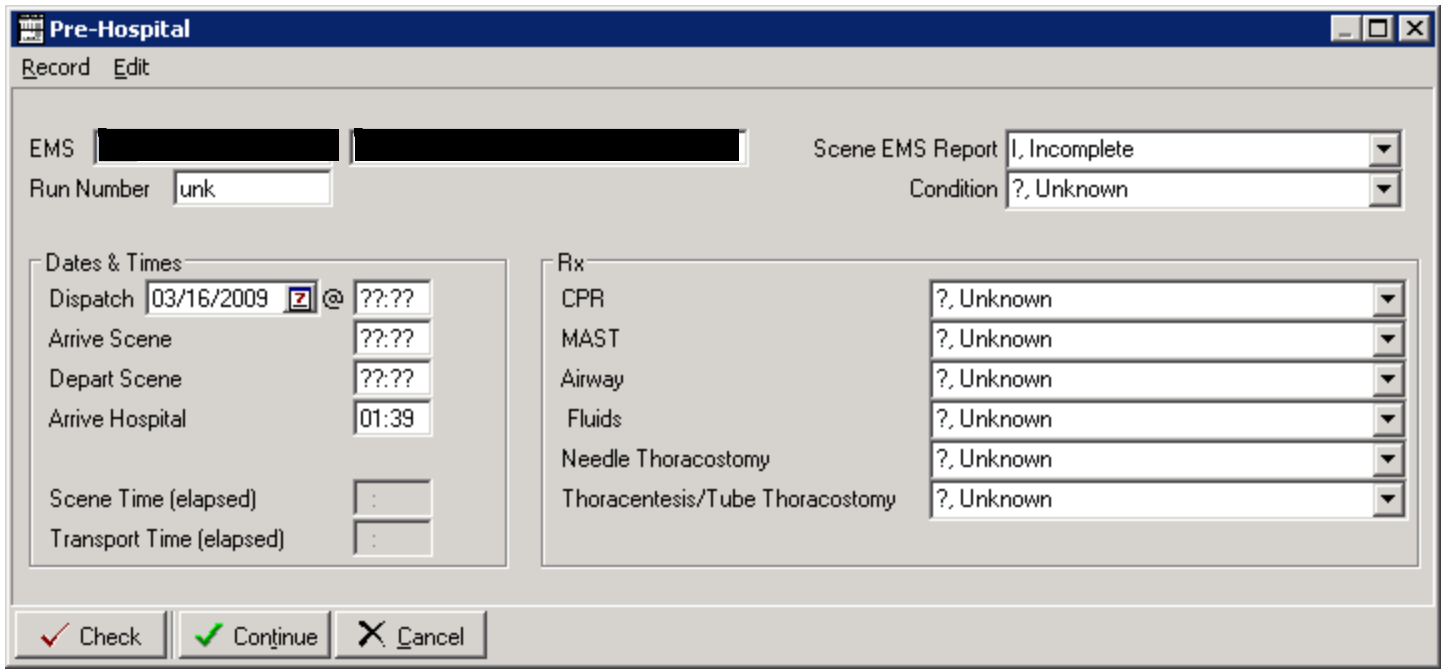
Record Status: Active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Condition
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Dates & Times
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@
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Arrive Scene
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Depart Scene
??:??
Arrive Hospital
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Scene Time (elapsed)
Transport Time (elapsed)
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CPR
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MAST
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Airway
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Fluids
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Needle Thoracostomy
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Thoracentesis/Tube Thoracostomy
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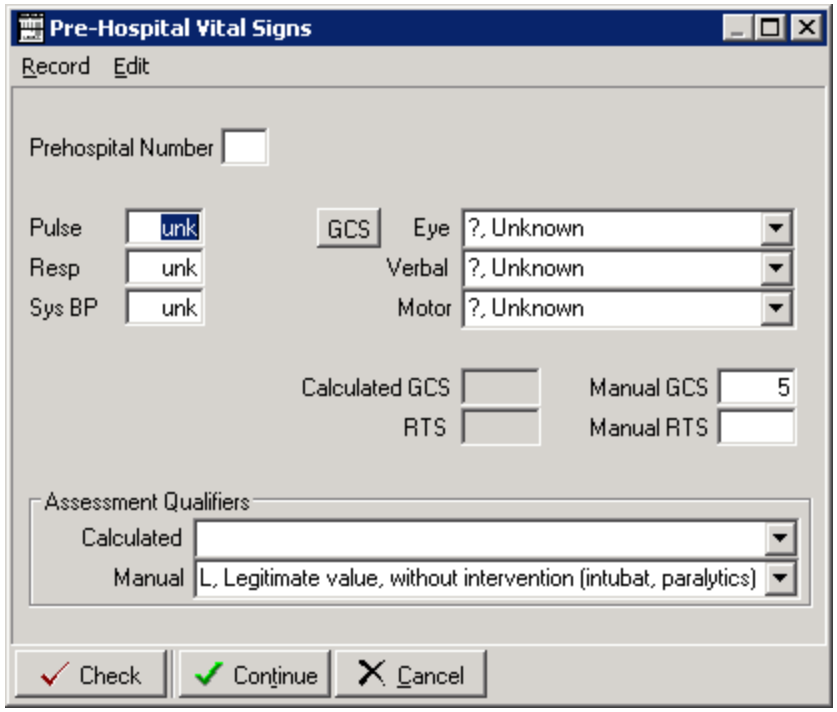
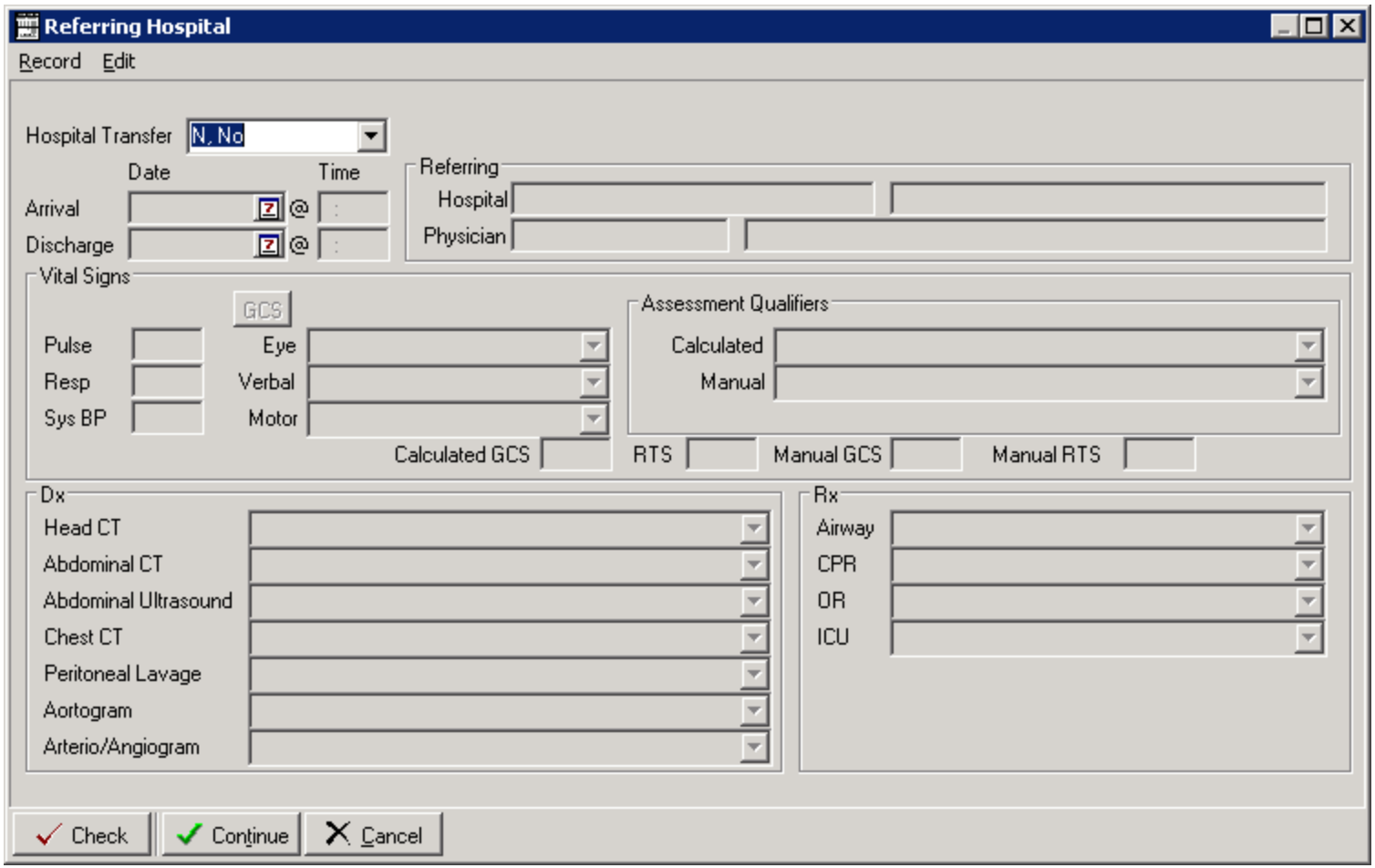
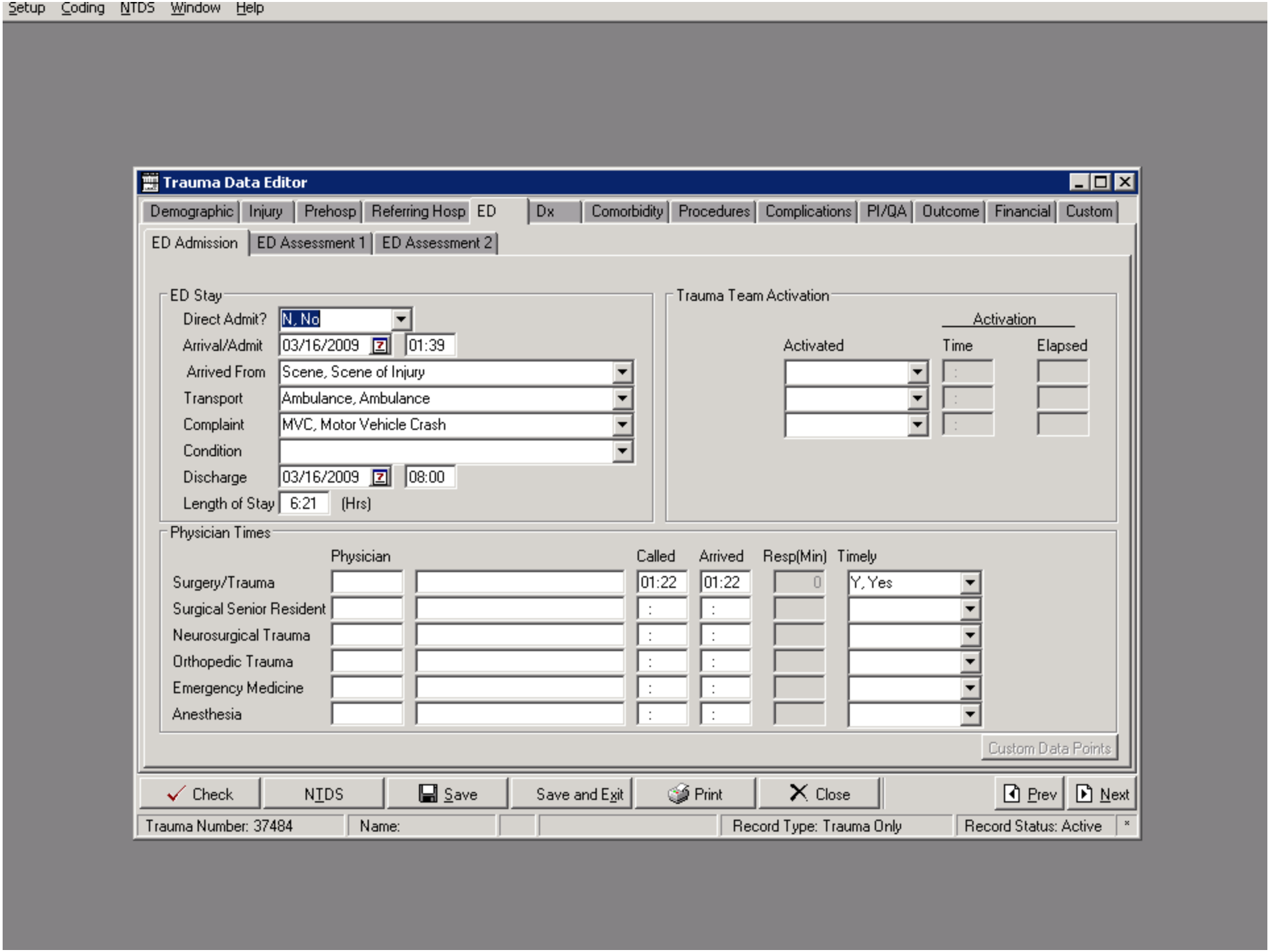
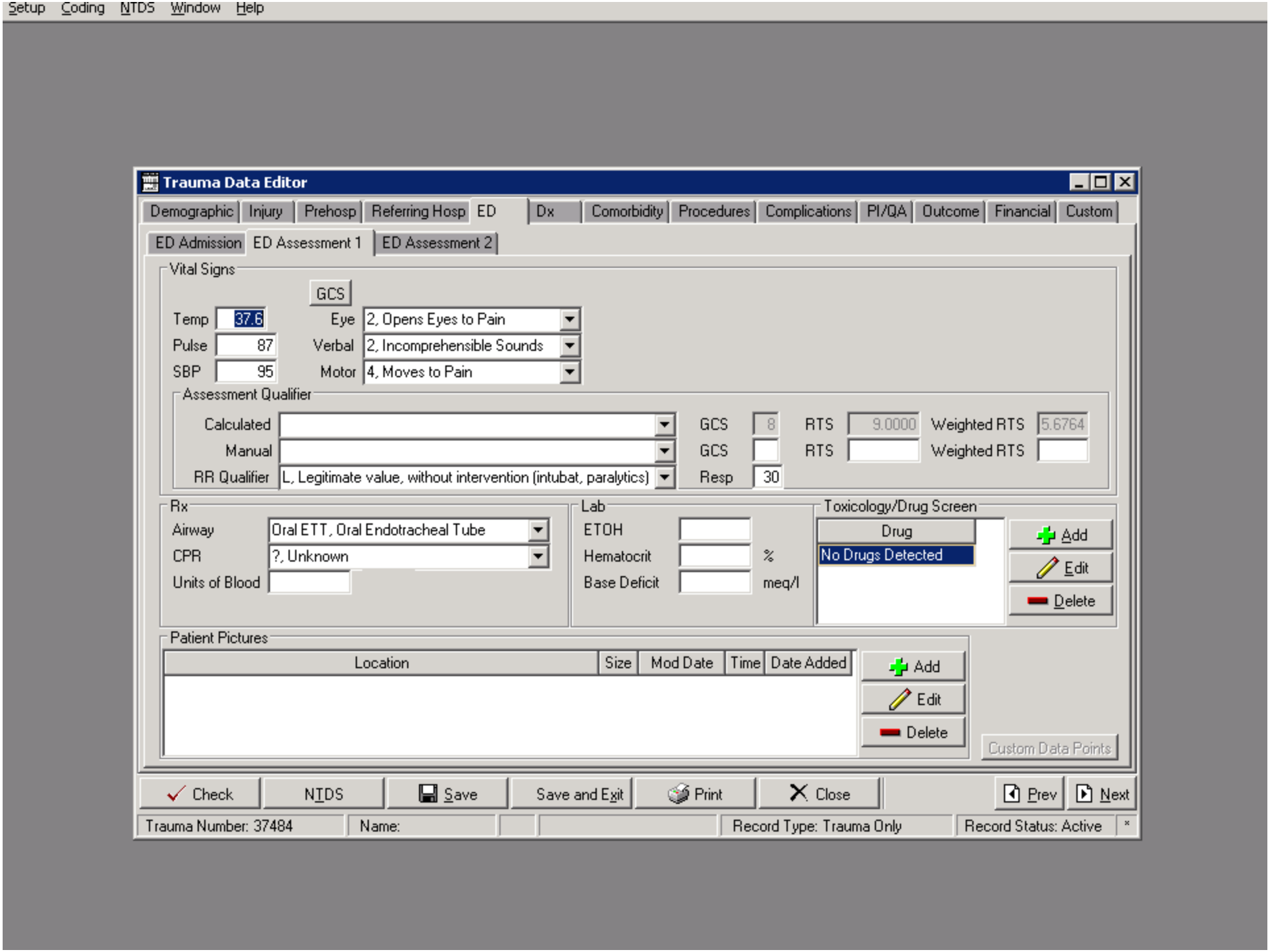
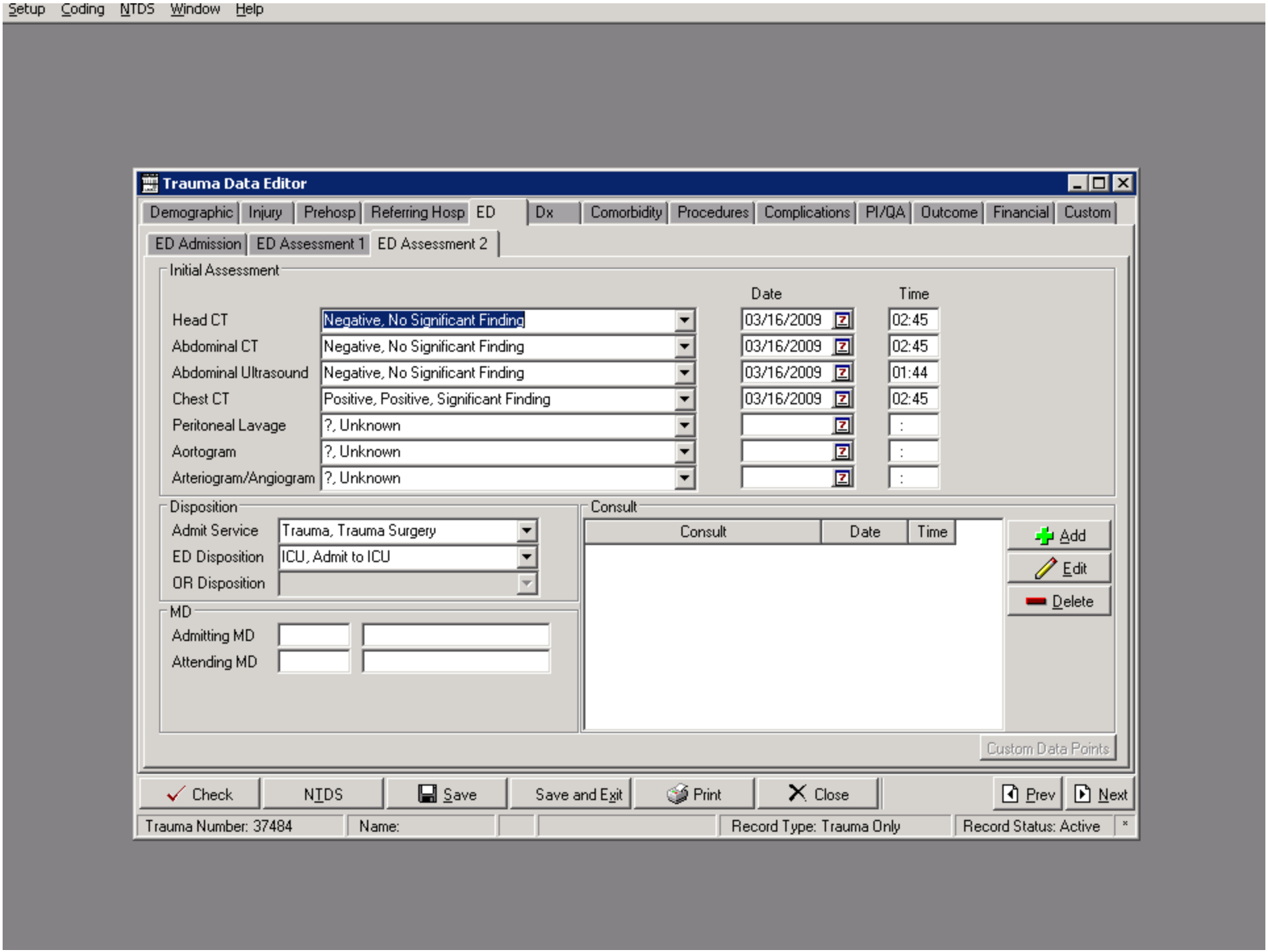
Continue
Cancel

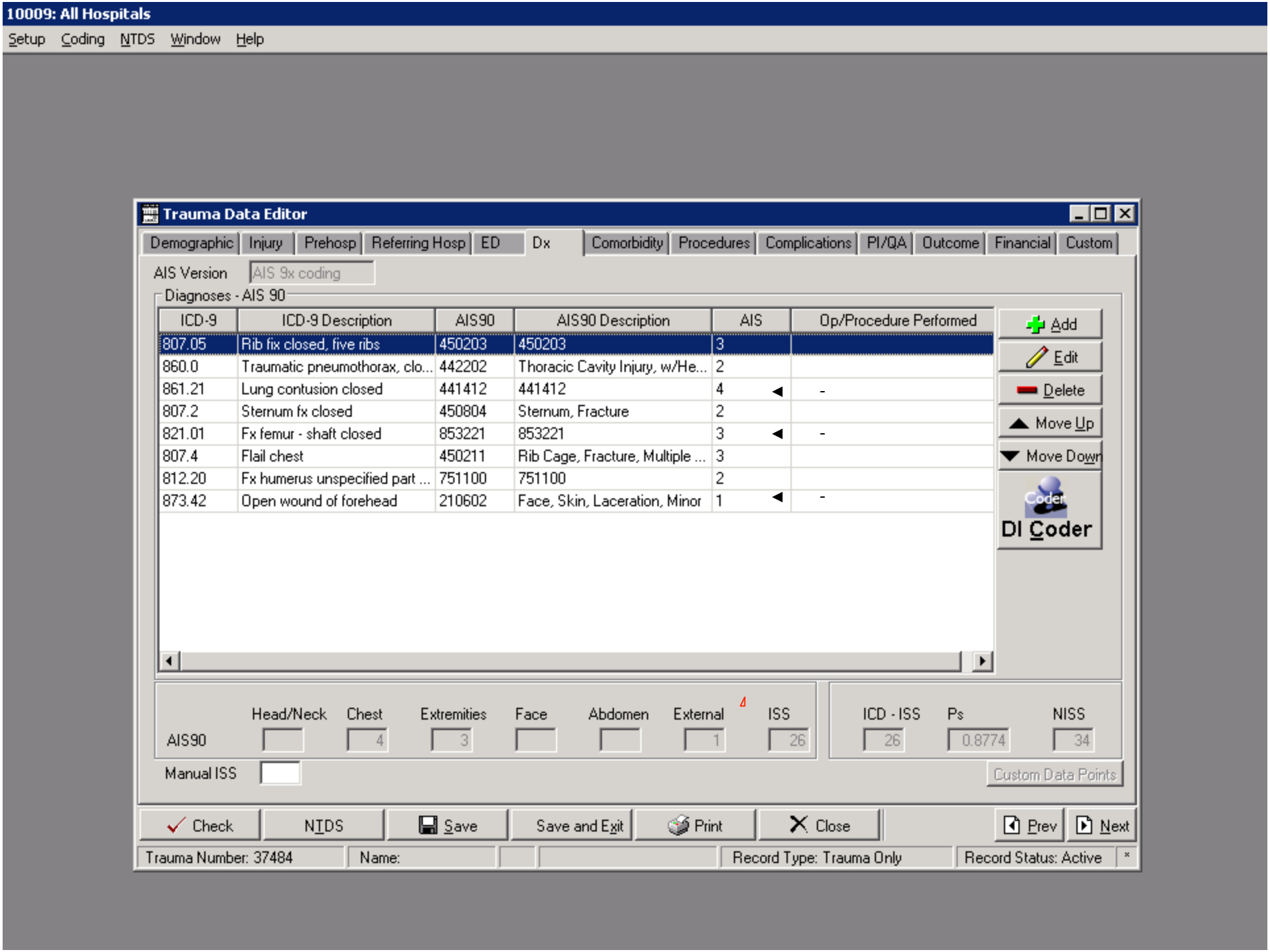

Pre-Hospital Vital Signs
Record
Edit
Prehospital Number
Pulse
unk
Resp
unk
Sys BP
unk
GCS
Eye
?, Unknown
Verbal
?, Unknown
Motor
?, Unknown
Calculated GCS
RTS
Manual GCS
5
Manual RTS
Assessment Qualifiers
Calculated
Manual
L, Legitimate value, without intervention (intubat, paralytics)
Check
Continue
Cancel

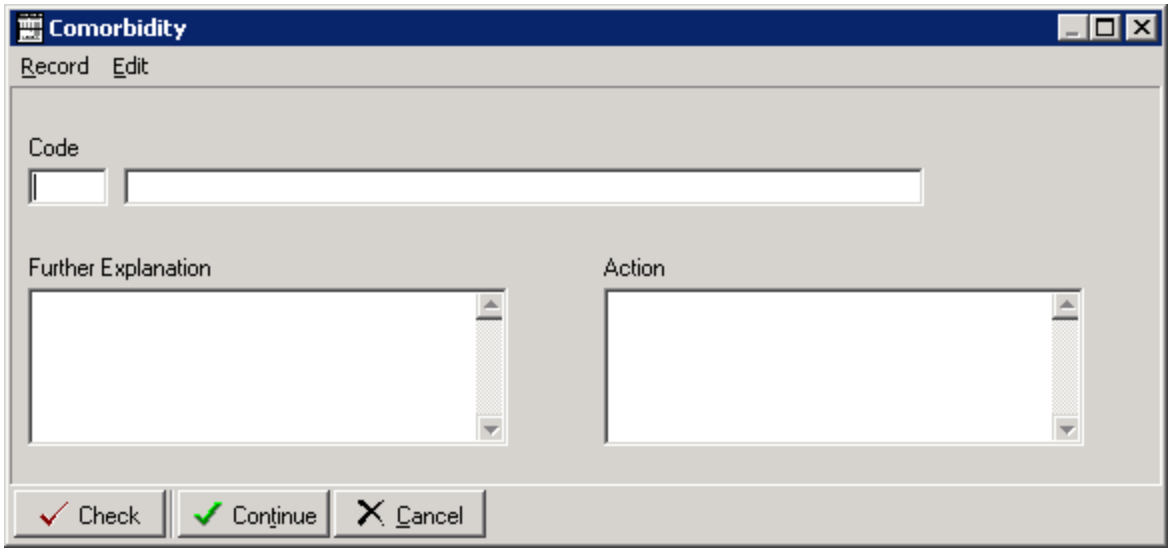

Referring Hospital
Record
Edit
Hospital Transfer
N, No
Date
Time
Arrival
Discharge
@
@
Referring
Hospital
Physician
Vital Signs
GCS
Pulse
Resp
Sys BP
Eye
Verbal
Motor
Calculated GCS
Assessment Qualifiers
Calculated
Manual
RTS
Manual GCS
Manual RTS
Dx
Head CT
Abdominal CT
Abdominal Ultrasound
Chest CT
Peritoneal Lavage
Aortogram
Arterio/Angiogram
Rx
Airway
CPR
OR
ICU
Check
Continue
Cancel

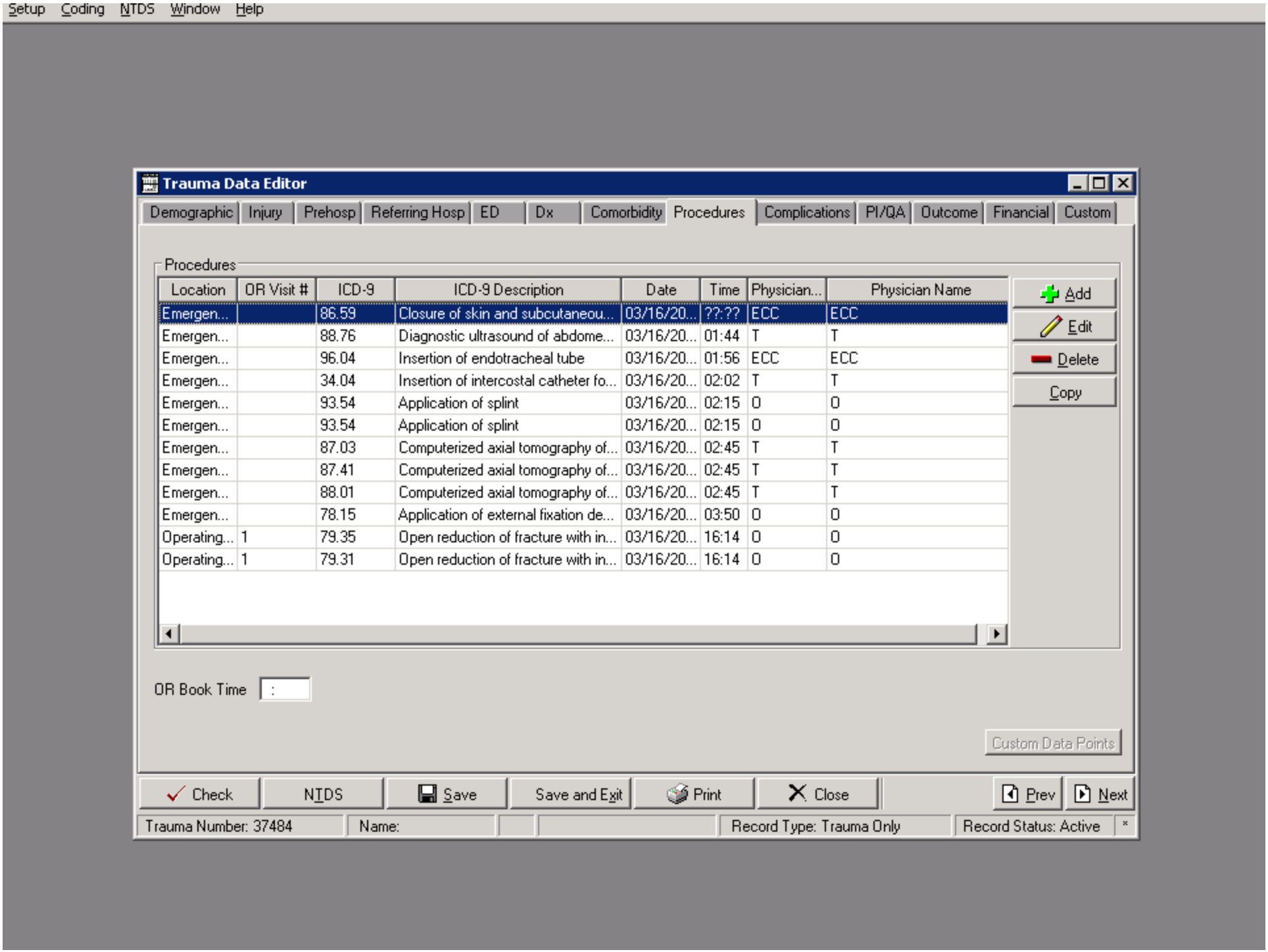

Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
ED Admission ED Assessment 1 ED Assessment 2
ED Stay
Direct Admit? N, No
Arrival/Admit 03/16/2009 01:39
Arrived From Scene, Scene of Injury
Transport Ambulance, Ambulance
Complaint MVC, Motor Vehicle Crash
Condition
Discharge 03/16/2009 08:00
Length of Stay 6:21 (Hrs)
Trauma Team Activation
Activation
Activated
Time
Elapsed
Physician Times
Physician
Called
Arrived
Resp(Min)
Timely
Surgery/Trauma 01:22 01:22 0 Y, Yes
Surgical Senior Resident
Neurosurgical Trauma
Orthopedic Trauma
Emergency Medicine
Anesthesia
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484
Name:
Record Type: Trauma Only
Record Status: Active

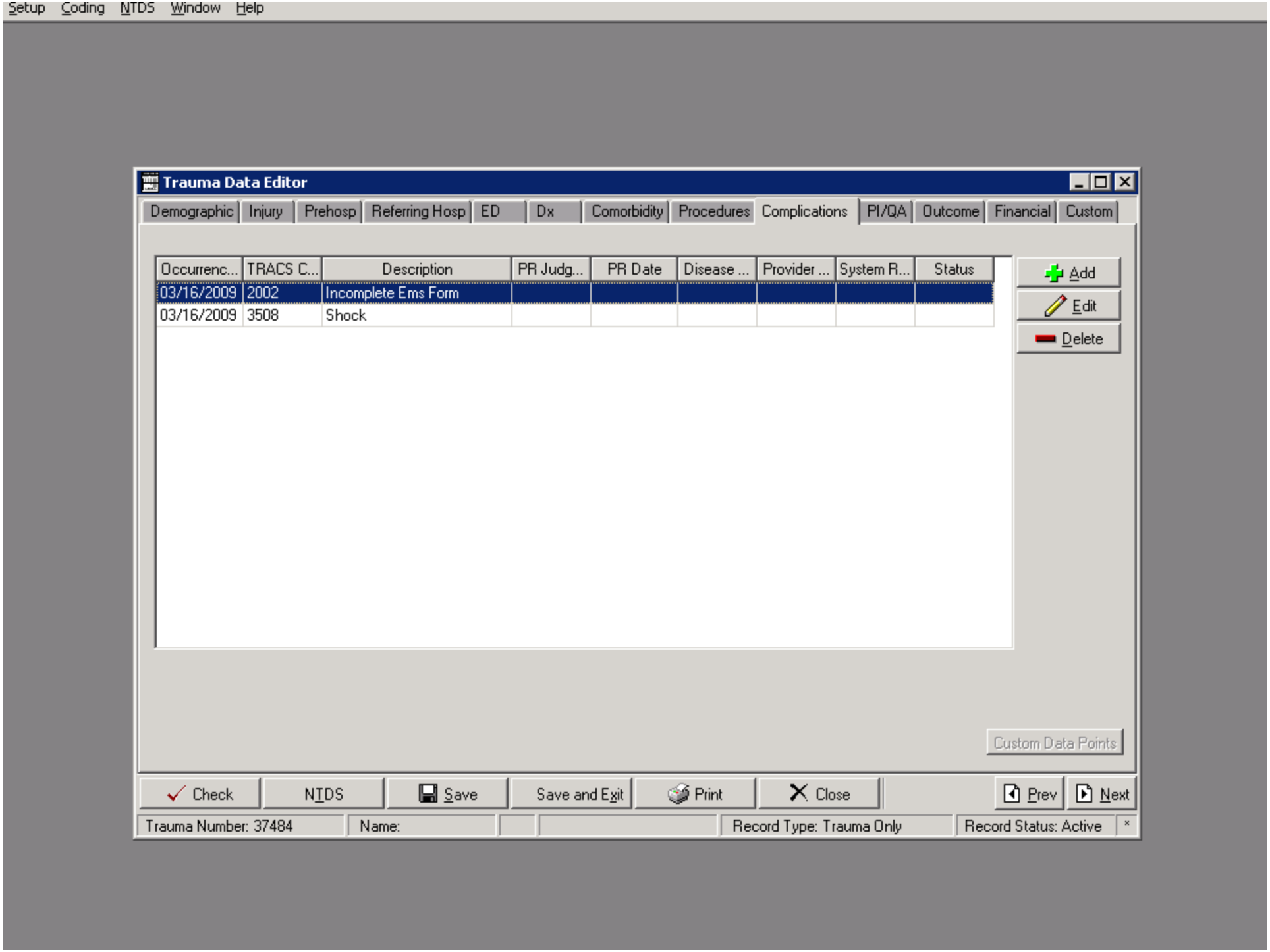

Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
ED Admission ED Assessment 1 ED Assessment 2
Vital Signs
GCS
Temp 37.6
Pulse 87
SBP 95
Eye 2, Opens Eyes to Pain
Verbal 2, Incomprehensible Sounds
Motor 4, Moves to Pain
Assessment Qualifier
Calculated
GCS 8
RTS 9.0000
Weighted RTS 5.6764
Manual
GCS
RTS
Weighted RTS
RR Qualifier L, Legitimate value, without intervention (intubat, paralytics)
Resp 30
Rx
Airway Oral ETT, Oral Endotracheal Tube
CPR ?, Unknown
Units of Blood
Lab
ETOH
Hematocrit %
Base Deficit meq/l
Toxicology/Drug Screen
Drug
No Drugs Detected
Add
Edit
Delete
Patient Pictures
Location Size Mod Date Time Date Added
Add
Edit
Delete
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484
Name:
Record Type: Trauma Only
Record Status: Active

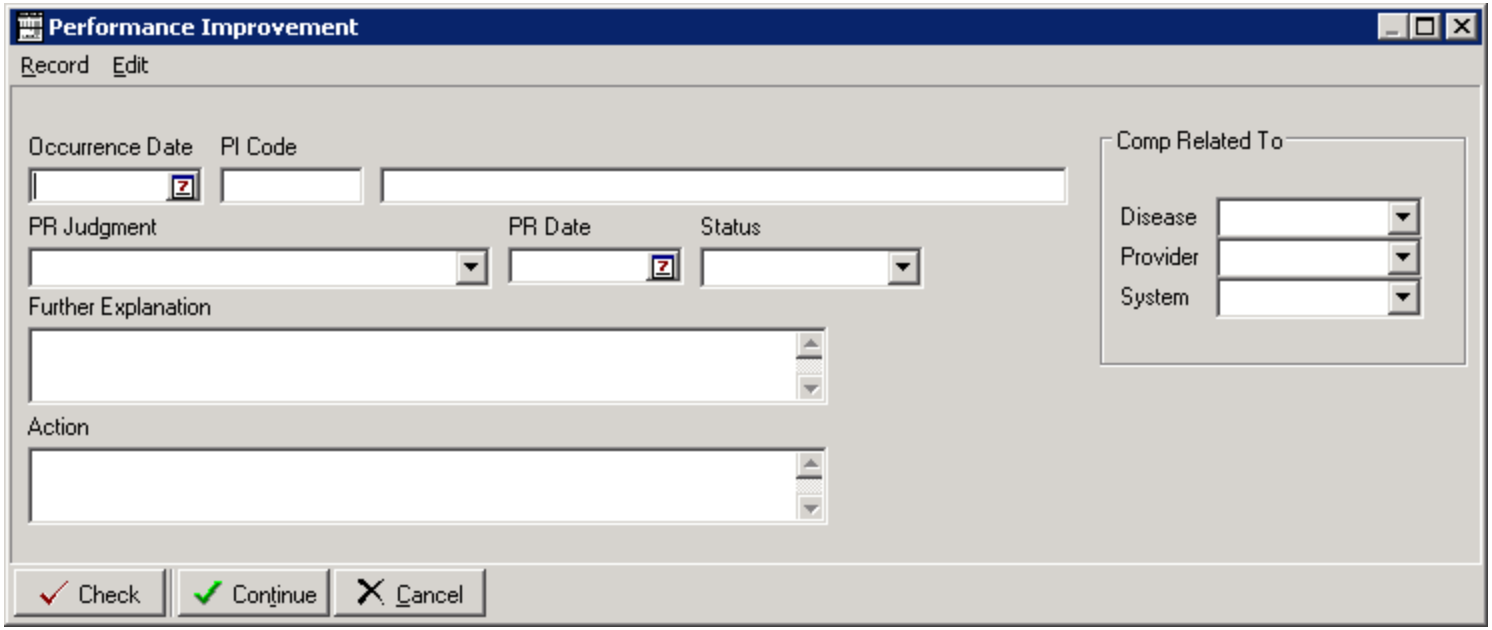

Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
ED Admission ED Assessment 1 ED Assessment 2
Initial Assessment
Date
Time
Head CT
Negative, No Significant Finding
03/16/2009
02:45
Abdominal CT
Negative, No Significant Finding
03/16/2009
02:45
Abdominal Ultrasound
Negative, No Significant Finding
03/16/2009
01:44
Chest CT
Positive, Positive, Significant Finding
03/16/2009
02:45
Peritoneal Lavage
?, Unknown
Aortogram
?, Unknown
Arteriogram/Angiogram
?, Unknown
Disposition
Admit Service
Trauma, Trauma Surgery
ED Disposition
ICU, Admit to ICU
OR Disposition
MD
Admitting MD
Attending MD
Consult
Consult
Date
Time
Add
Edit
Delete
Custom Data Points
Check
NTDS
Save
Save and Exit
Print
Close
Prev
Next
Trauma Number: 37484
Name:
Record Type: Trauma Only
Record Status: Active

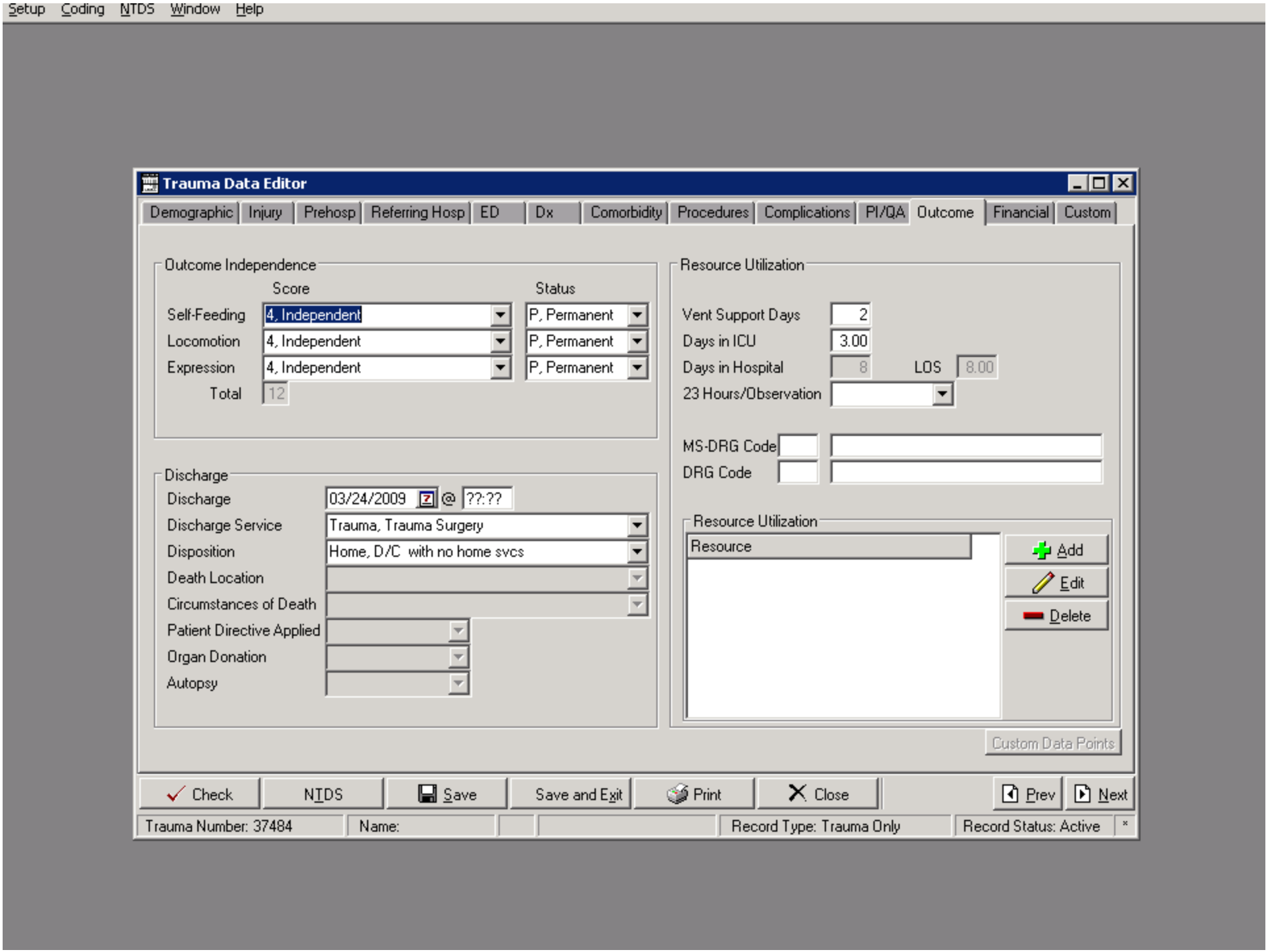

10009: All Hospitals
Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
AIS Version AIS 9x coding
Diagnoses - AIS 90
ICD-9 ICD-9 Description AIS90 AIS90 Description AIS Op/Procedure Performed
807.05 Rib fix closed, five ribs 450203 450203 3
860.0 Traumatic pneumothorax, clo... 442202 Thoracic Cavity Injury, w/He... 2
861.21 Lung contusion closed 441412 441412 4 -
807.2 Sternum fx closed 450804 Sternum, Fracture 2
821.01 Fx femur - shaft closed 853221 853221 3 -
807.4 Flail chest 450211 Rib Cage, Fracture, Multiple ... 3
812.20 Fx humerus unspecified part ... 751100 751100 2
873.42 Open wound of forehead 210602 Face, Skin, Laceration, Minor 1 -
Add
Edit
Delete
Move Up
Move Down
DI Coder
Head/Neck Chest Extremities Face Abdomen External ISS
AIS90 4 3 1 26
ICD - ISS Ps NISS
26 0.8774 34
Manual ISS
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484 Name: Record Type: Trauma Only Record Status: Active

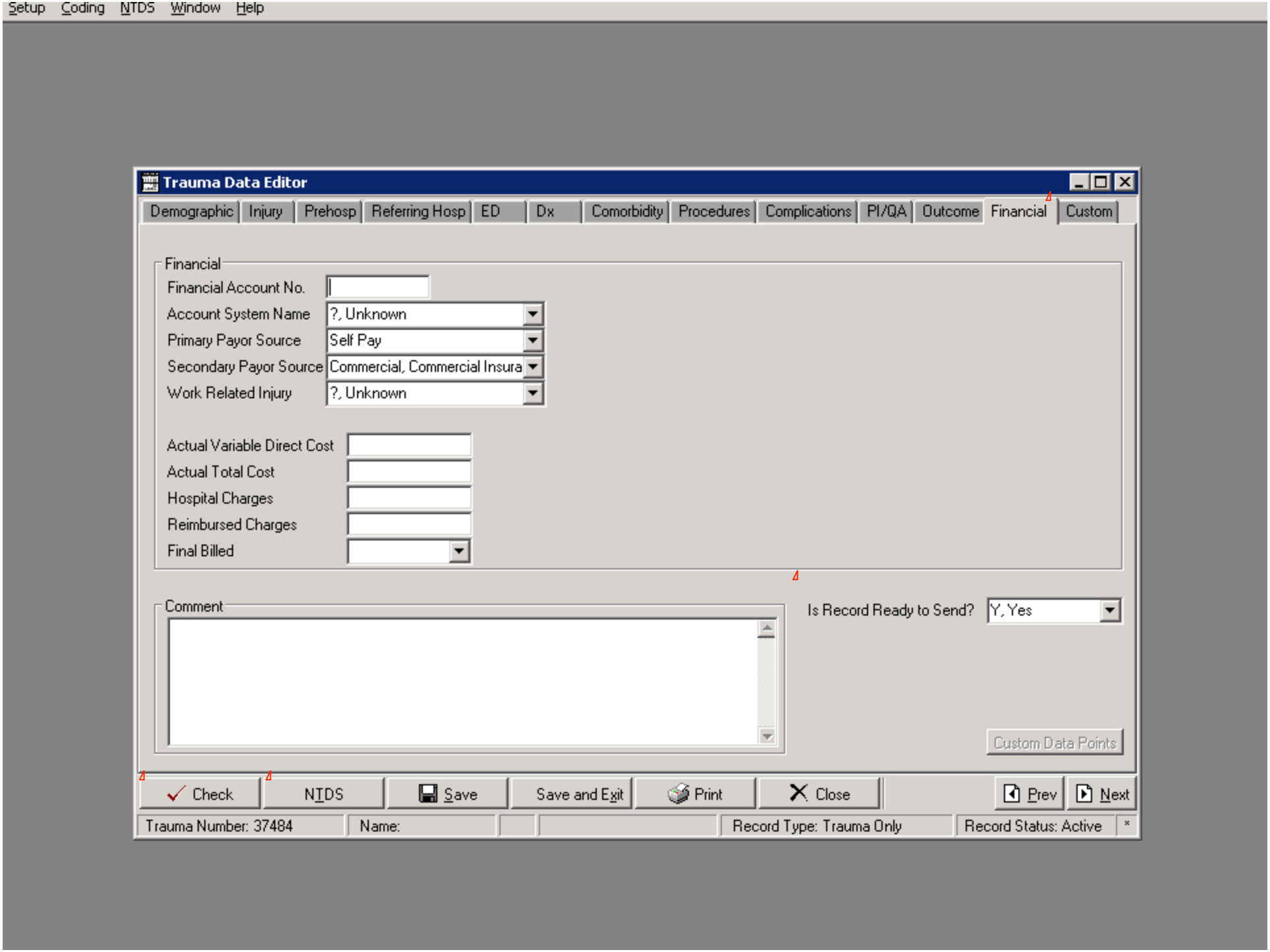

Comorbidity
Record
Edit
Code
Further Explanation
Action
Check
Continue
Cancel

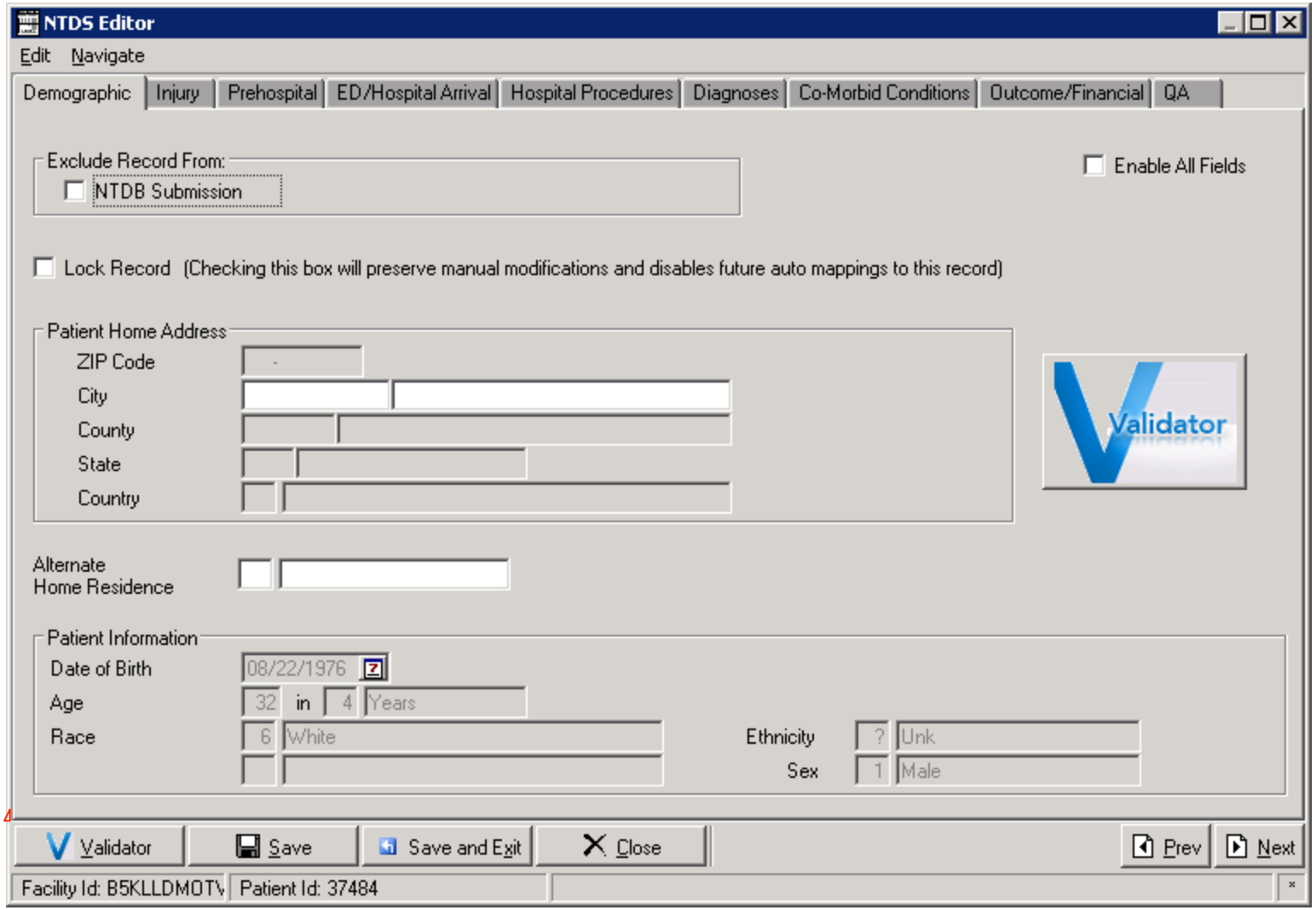

Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
Procedures
Location | OR Visit # | ICD-9 | ICD-9 Description | Date | Time | Physician... | Physician Name
Emergen... | | 86.59 | Closure of skin and subcutaneou... | 03/16/20... | ??:?? | ECC | ECC
Emergen... | | 88.76 | Diagnostic ultrasound of abdome... | 03/16/20... | 01:44 | T | T
Emergen... | | 96.04 | Insertion of endotracheal tube | 03/16/20... | 01:56 | ECC | ECC
Emergen... | | 34.04 | Insertion of intercostal catheter fo... | 03/16/20... | 02:02 | T | T
Emergen... | | 93.54 | Application of splint | 03/16/20... | 02:15 | O | O
Emergen... | | 93.54 | Application of splint | 03/16/20... | 02:15 | O | O
Emergen... | | 87.03 | Computerized axial tomography of... | 03/16/20... | 02:45 | T | T
Emergen... | | 87.41 | Computerized axial tomography of... | 03/16/20... | 02:45 | T | T
Emergen... | | 88.01 | Computerized axial tomography of... | 03/16/20... | 02:45 | T | T
Emergen... | | 78.15 | Application of external fixation de... | 03/16/20... | 03:50 | O | O
Operating... | 1 | 79.35 | Open reduction of fracture with in... | 03/16/20... | 16:14 | O | O
Operating... | 1 | 79.31 | Open reduction of fracture with in... | 03/16/20... | 16:14 | O | O
Add
Edit
Delete
Copy
OR Book Time :
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484 Name: Record Type: Trauma Only Record Status: Active

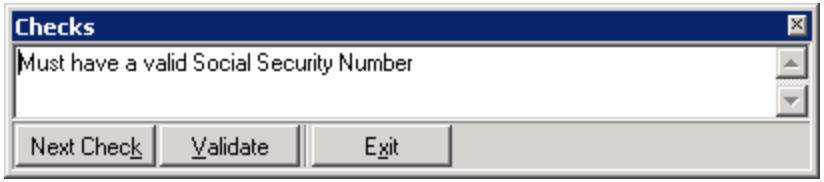

Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
Occurrenc... TRACS C... Description PR Judg... PR Date Disease ... Provider ... System R... Status
03/16/2009 2002 Incomplete Ems Form
03/16/2009 3508 Shock
Add
Edit
Delete
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484
Name:
Record Type: Trauma Only
Record Status: Active


Performance Improvement
Record
Edit
Occurrence Date
PI Code
Comp Related To
Disease
Provider
System
PR Judgment
PR Date
Status
Further Explanation
Action
Check
Continue
Cancel


Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
Outcome Independence
Score
Status
Self-Feeding
4, Independent
P, Permanent
Locomotion
4, Independent
P, Permanent
Expression
4, Independent
P, Permanent
Total
12
Discharge
Discharge
03/24/2009
@
??:??
Discharge Service
Trauma, Trauma Surgery
Disposition
Home, D/C with no home svcs
Death Location
Circumstances of Death
Patient Directive Applied
Organ Donation
Autopsy
Resource Utilization
Vent Support Days
2
Days in ICU
3.00
Days in Hospital
8
LOS
8.00
23 Hours/Observation
MS-DRG Code
DRG Code
Resource Utilization
Resource
Add
Edit
Delete
Custom Data Points
Check
NTDS
Save
Save and Exit
Print
Close
Prev
Next
Trauma Number: 37484
Name:
Record Type: Trauma Only
Record Status: Active


Setup Coding NTDS Window Help
Trauma Data Editor
Demographic Injury Prehosp Referring Hosp ED Dx Comorbidity Procedures Complications PI/QA Outcome Financial Custom
Financial
Financial Account No.
Account System Name ?, Unknown
Primary Payor Source Self Pay
Secondary Payor Source Commercial, Commercial Insura
Work Related Injury ?, Unknown
Actual Variable Direct Cost
Actual Total Cost
Hospital Charges
Reimbursed Charges
Final Billed
Comment
Is Record Ready to Send? Y, Yes
Custom Data Points
Check NTDS Save Save and Exit Print Close Prev Next
Trauma Number: 37484 Name: Record Type: Trauma Only Record Status: Active


NTDS Editor
Edit
Navigate
Demographic
Injury
Prehospital
ED/Hospital Arrival
Hospital Procedures
Diagnoses
Co-Morbid Conditions
Outcome/Financial
QA
Exclude Record From:
NTDB Submission
Enable All Fields
Lock Record (Checking this box will preserve manual modifications and disables future auto mappings to this record)
Patient Home Address
ZIP Code
City
County
State
Country
Validator
Alternate
Home Residence
Patient Information
Date of Birth
08/22/1976
Age
32
in
4
Years
Race
6
White
Ethnicity
?
Unk
Sex
1
Male
Validator
Save
Save and Exit
Close
Prev
Next
Facility Id: B5KLLDMOTV
Patient Id: 37484



RECORD STATUS

“CLOSED” or “ACTIVE”

Georgia Trauma Registry

DOWNLOADS

1st Quarter – June 10
January 1, 20XX – March 31, 20XX

2nd Quarter – September 10
January 1, 20XX – June 30, 20XX

3rd Quarter – December 10
January 1, 20XX – September 30, 20XX

4th Quarter – March 10

January 1, 20XX – December 31, 20XX

WORK TO DO

Evaluate Data Field Options

Trauma Dash Boards

TQIP – Trauma Quality Improvement Program

Georgia Trauma Registry

SUMMARY

The purpose of the trauma registry is to collect and analyze trauma system data to:

✓ evaluate the delivery of adult and pediatric trauma care,

✓develop injury prevention strategies for all ages, and

✓provide resources for research and education.

Georgia Trauma Registry

FUTURE SERIES TOPICS

May
Download Process

July
Data Analysis

September
Data Linkage

Georgia Trauma Registry

QUESTIONS

Division of Public Health
Section of Emergency
Preparedness and Response
Office of EMS/Trauma
40 Pryor Street SW, 4th Floor
Atlanta, Georgia 30303
Office: 404-463-5440
Fax: 404-463-5393

Department of Law
State of Georgia

SAMUEL S. OLENS
ATTORNEY GENERAL

40 CAPITOL SQUARE SW
ATLANTA, GA 30334-1300

15 March 2011

Facsimile: (478) 633-6195

Dennis W. Ashley, M.D.
Chairman
Georgia Trauma Care Network Commission
777 Hemlock Street
Hospital Box #103
Macon, Georgia 31201

Direct Dial:
404.651.7675
Facsimile:
404.656.0677
Email:
asponseller
@law.ga.gov

RE: Audit Questions for Uncompensated Care Reimbursement for Trauma Centers

Dear Dr. Ashley and Commission Members:

You have asked for advice on questions which arose from a recent audit of the Georgia Trauma Care Network Commission's ("GTCNC") uncompensated care reimbursement program for Trauma Centers. The auditor identified several claims submitted by Trauma Centers which may not be authorized for reimbursement under the GTCNC statutes. As shown below, almost all of the auditor's questions can be answered through an interpretation of what "uncompensated" means under the GTCNC laws.

As you know, the GTCNC statutes require that any reimbursement to Trauma Centers for uncompensated care must satisfy criteria that: (1) the trauma fund is a payor of last resort; (2) the reimbursement be for services provided to designated trauma patients; (3) the reimbursement be for services based on trauma service codes; (4) the reimbursement for trauma care costs must be on a fee schedule or grant basis; and (5) the trauma center must submit a semiannual report documenting and verifying the use of such funds. O.C.G.A. § 31-11-102(4).

"Uncompensated" is defined in the GTCNC statutes as "care provided by a designated trauma center . . . to a trauma patient" who: (A) has no medical insurance, including federal Medicare Part B coverage; (B) is not eligible for medical assistance coverage; (C) has no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage; and (D) has not paid for the trauma care provided by the trauma provider after documented attempts by the trauma care services provider to collect payment. O.C.G.A. § 31-11-100(4).

Specifically, I read subparagraph (A) to mean that the patient does not have either private health insurance, or any Medicare coverage. Most patients enrolled in Medicare Part B are already enrolled in Medicare Part A because they are eligible under the Social Security Act or pay voluntary premiums. *See, e.g.*, 42 U.S.C.A. §§ 1395c; 1395i-2. Further, patients who are

enrolled in Medicare Parts C (Medicare Advantage) and D (Prescription Drugs) must also first be eligible for Medicare Part B. *See, e.g.*, 42 U.S.C.A. §§ 1395w-101 to 1395w-152; 42 C.F.R. § 417.420. Hence, it is my view that the GTCNC statutes require that the trauma patient not be covered by private insurance or Medicare programs.

I also read "medical assistance coverage" in subparagraph (B) to mean that the patient is not eligible for any Medicaid program in the State, including PeachCare for Kids, Georgia Families, and the Long Term Care program. *See, e.g.*, O.C.G.A. §§ 49-4-140 to 49-4-157. For example, "medical assistance" is defined in the Georgia Medical Assistance Act as "payment to a provider of a part or all of the cost of certain items of medical . . . service rendered by the provider to a recipient of medical assistance, provided such items are rendered and received in accordance with . . . [federal Medicaid laws]." O.C.G.A. § 49-4-141(5). Hence, I read subparagraph (B) of Code Section 31-11-100(4) to mean that the patient is not covered through Medicaid programs.

I further read subparagraph (C) to mean that the patient also does not have "medical coverage for trauma care" through third party payors that are not private or government health insurers. This would include coverage provided through workers' compensation or automobile insurance providers and any judgments or settlements resulting from such coverage. However, I also read this subparagraph to mean that any payment from a third-party payor must not involve "medical coverage for trauma care" because "coverage" is defined as the "[i]nclusion of a risk under an insurance policy; the risks within the scope of an insurance policy." BLACK'S LAW DICTIONARY (7th ed.). Hence, partial payments from third parties that do not involve or arise from "medical coverage" would not disqualify a claim for reimbursement from the GTCNC.

In a previous letter to the GTCNC, this Office also concluded that partial payments made directly from uninsured patients would not disqualify reimbursement for uncompensated services. *See* Letter dated April 22, 2008 (attached). The GTCNC accordingly adopted a policy whereby claims arising from patients making payments of less than 10% of their total trauma care service bill would be eligible for uncompensated care reimbursement.

With these rules in mind, I will address the following audit questions:

1. *Cases where the Trauma Center determined that the patients qualified for the Trauma Center's charity program and the accounts were immediately written off.*

It is my understanding that most Trauma Centers operate charity programs which assist in payment for indigent patients with no insurance. It is also my understanding that these programs operate using various criteria and procedures specific to each institution. In the specific question presented above, it is my view that these claims would not qualify for reimbursement because

there were admittedly no "documented attempts by the trauma care services provider to collect payment." O.C.G.A. § 31-11-100(4)(D).

However, another question arises as to whether a Trauma Center would be eligible for reimbursement if it made documented collection attempts and then moved the claim to its charity program after an uninsured patient did not make payment. Although the definition of "uncompensated" in the GTCNC laws does not appear to disqualify claims from reimbursement because these payments do not arise from any form of health insurance or "medical coverage," the GTCNC should also be mindful that claims for treating uninsured patients may also be reimbursed through State aid for indigent patients such as the Indigent Care Trust Fund, *see, e.g.*, O.C.G.A. §§ 31-8-1 to 31-8-46; 31-8-150 to 31-8-160, and hospitals are required to devote at least 3% of their annual adjusted gross revenue for indigent and charity care to retain their Certificates of Need. *See* DCH Regulation 111-2-2-.20(2)(f)2.

Because the GTCNC is designated as a "payor of last resort," O.C.G.A. § 31-11-102(4), the GTCNC should adopt appropriate policies which ensure that it does not pay claims which may have been paid by other entities, whether charitable or State-funded.

2. *Cases where the patients were victims of a crime and the Trauma Center received small payments (less than 10%) from a third party.*

It is my understanding that some medical expenses of patients are paid by a third party payor such as the State making payments under the Crime Victim Compensation Act, O.C.G.A. §§ 17-15-1 to 17-15-14. Pursuant to this Act, crime victims may be compensated by the Crime Victims Compensation Board for the victim's "cost of medical care . . . , and any other emergency expenses incurred by the victim." O.C.G.A. § 17-5-5(c)(2). Victim compensation for medical expenses is capped at $15,000. O.C.G.A. § 17-15-8(c)(2).

It is my view that partial payments would not disqualify a claim for reimbursement from the GTCNC because the payment is not on behalf of a private or government health insurer (either Medicare or Medicaid), and does not constitute "medical coverage for trauma care" or a judgment arising from such coverage. O.C.G.A. § 31-11-100(4). Hence, payments from the Crime Victims Compensation Board, particularly those payments which are under 10%, would not disqualify a claim for reimbursement from the GTCNC. However, as noted in response to Question #1, since the GTCNC is a "payor of last resort," the GTCNC should adopt appropriate policies which ensure that it does not pay claims which may be paid by other State programs.

3. *Cases where the patients were undocumented aliens and the Trauma Center received small payments (less than 10%) from a third party charity.*

For the same reasons set forth in response to Question #2, it is my view that these payments would also not disqualify reimbursement from the GTCNC because the payment is not on behalf of a private or government health insurer (either Medicare or Medicaid), and does not constitute "medical coverage for trauma care." O.C.G.A. § 31-11-100(4). However, because the GTCNC is designated as a "payor of last resort," O.C.G.A. § 31-11-102(4), the GTCNC should adopt appropriate policies which ensure that it does not pay claims which may have been paid by other entities.

4. *Cases where the patient died and the Trauma Center did not attempt to collect payment.*

For the same reasons set forth in response to Question #1, it is my view that these claims would not qualify for reimbursement because there were no "documented attempts by the trauma care services provider to collect payment." O.C.G.A. § 31-11-100(4)(D).

5. *Cases where the patients received settlements directly, but did not pay the Trauma Center after repeated collection attempts by the Trauma Center.*

It is my understanding that some patients are reimbursed directly for trauma medical expenses via a judgment or settlement but do not pay the Trauma Center for the expenses incurred. It is my view that these claims would not be reimbursable so long as the settlement or judgment received derived from "medical coverage for trauma care." O.C.G.A. § 31-11-100(4)(C). This is so because the requirements of Code Section 31-11-100(4) mandate that the patient not have any coverage at all *and* the Trauma Center make documented collection attempts. Hence, the failure to collect does not make an eligible reimbursable claim if the patient has some form of "coverage" or judgments resulting from coverage.

6. *Cases where the Trauma Center had a reciprocal agreement with another party for exchange of services and the Trauma Center did not attempt further collection procedures for certain patients.*

It is my understanding that Grady Memorial Hospital has an arrangement with the City of Atlanta wherein Grady does not charge for medical services provided to city employees injured on the job and for inmates injured at the City Jail. In return, the City does not charge Grady for water usage. It is my view that these claims would not qualify for reimbursement for several reasons. First, both the city employees and the inmates could be covered through workers' compensation or some other form of private or government health insurance. O.C.G.A. § 31-11-

100(4)(A)-(C). Second, Grady admittedly does receive payment for patient treatment in the form of debt-forgiveness in not paying the City for water usage. *Id.* Third, Grady also admittedly did not attempt collection. O.C.G.A. § 31-11-100(4)(D). Accordingly, it is my view that a Trauma Center would not be eligible for reimbursement in these circumstances.

7. Cases where insurance could not be verified for the patients.

It is my understanding that some patients treated at Trauma Centers claim that they have health insurance when in fact they do not have coverage. It is my view that these claims are eligible for reimbursement as long as the patient had no other "medical coverage for trauma care" and the Trauma Center made "documented attempts . . . to collect payment." O.C.G.A. § 31-11-100(4)(D).

I hope this letter is responsive to your inquiry.

Yours very truly,

Alex F. Sponseller
Assistant Attorney General

cc: Commission Members
Jim Pettyjohn, Administrator

Document No. 618799