Minutes approved 11 August 2011

MEETING MINUTES

Thursday, 19 May 2011

Scheduled: 10:00 am until 1:00 pm
Atlanta Medical Center
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 10:12 a.m.

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

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
Scott Sherrill	GTRI
Regina Medeiros	GHSU
Lawanna Mercer-Cobb	SOEMS/T – Region 6
Renee Morgan	OEMS/T
Lee Oliver	MCCG
Rana Bayakly	DPH
Danlin Luo	DPH
Kathy Sego	ARMC
Elaine Frantz	Memorial
Blake Thompson	Wilkes County EMS
Gigi Goble	GPT
Amanda Cook	CHOA
Kim Brown	Hamilton Medical Center
Laura Garlow	Wellstar Kenneston

Mickey Moore	OEMS
Tanya Simpson	Doctors Hospital
Greg Pereira	CHOA
Fran Lewis	Grady
Scott Maxwell	M & M
Josh Mazkey	GAEMS
John Walraven	GA Governmental /Affairs, LLC
Russ McGee	Region 5 OEMS/T
Patricia Mayne	Wellstar Kennestone
Adam Bomar	Wellstar Kennestone
Ethan James	GA Hospital Association
Brandi D. Holton	Phoebe Putney Memorial
Rochella Moon	Atlanta Medical Center
Gina Solomon	Gwinnett Medical Center
Dr. Romeo Massoud	Gwinnett Medical Center
Hunter Kellett	Senate Budget Office
Karen Pope	GER-Global Emergency Resource
Jamila Pope	CHOA
Keith Wages	OEMS

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT

Dr. Dennis Ashley welcomed all present. There was a confirmation of Commission members attending; Ben Hinson will be here in a minute. Mr. Jim Pettyjohn confirmed quorum status. Dr. Joe Sam Robinson and Kelly Vaughn were confirmed as attending via teleconference.

Dr. Ashley states we had our second Trauma Medical Directors Conference Call on May 9, 2011. As part of the performance based payments we are trying to pull all of the trauma centers Medical Directors together. We had great attendance, almost every body from all the trauma centers Medical Directors were on the call. It looks like everyone is completing their check boxes for the performance-based payments according to the contracts. More importantly it was a chance for the Medical Directors to actually talk. We are going to continue to meet, probably on an every other month bases or more frequently if we need to. Out of this meeting came the idea that we should try to have a meeting to reinvigorate the Georgia Committee on Trauma which is through the American College of Surgeons, and have all the trauma centers, trauma directors have a yearly trauma meeting. There are a lot of things that can happen from that. We could possibly meet with the trauma coordinators and have a session with them. This is really a good chance for the trauma centers to clinically pull together and work out their issues or identify issues that need to be addressed. These issues will also be brought to the Commission, which will also give the Commission a way of sending information back to the Trauma Medical Directors. We also discussed the TQIP of which you have heard a presentation before from Dr. Avery Nathens on the Trauma Quality Improvement Project. That was presented to the Medical Directors and they are all on board with that, and would like to participate. Later on in our agenda I will be bringing that up for further discussion at the appropriate time.

We have two new Commission members that were appointed by the Governor, the two new members are Dr. Robert Cowles and Dr. Fred Mullins. They will be taking over when the current Commission member's terms end September 30. They will be replacing Rich Bias and Kelly Vaughn. We will have a formal seating ceremony in November when the Commission meets. In November they will be officially seated but their terms will actually start October 1, 2011.

FT 2012 Budget Review

Ms. Linda Cole states there are some items that she would just like to review so that the Commission can think about them and determine what more information we need before we can vote. There are also some items that need to be voted on today, and those items are located on the handout and are highlighted in green. Ms. Cole states that she will start with the estimated budget of around 20 million. There is 2.5 million that is for a grant

that is very specialized and not part of the general operations budget that has been taken out for discussion today. So you can see from that the breakdown from the 17 million for Commission operations, Communications Center development, and OEMS/T. We will go through specifics on those items as we move through the budget. What is left is the 14 million to be divided between EMS and the trauma centers, of which the subcommittees will be working out the details on that.

Ms. Cole states that there are three areas in the budget that will need to be voted on today, and they are highlighted in green. We will go through all three and do a vote at the end.

COMMISSION OPERATIONS

The first item highlighted in green that will need a vote today is Commission Operations. Ms. Cole states that Commission operations include the Executive Director budget, which is neutral from last year. It also includes a budget Procurement Officer, of which we had talked about adding last year. At that time the Commission made the decision not to add a Procurement Officer because of such a decrease in funds. Ms. Cole states that as more and more activities are coming up we need this position filled so we can focus on the merited of contracts that the Commission is doing, and some of the day-to-day detail of making sure that people are compliant. This would relieve the Executive Director to take care of the bigger visionary and other things that need to be looked at. Ms. Cole asks Mr. Pettyjohn if there is anything he would like to add to that.

Mr. Jim Pettyjohn states that the Communications Center is going to be opening up and there will have to be a lot of education, training, and selling involved with that. The Procurement Officer position is planned to be located at 2 Peachtree 16 floor.

Ms. Cole states that the Office Coordinator, Executive Assistant is a rollover from last year, no increase there. The Commission per Diems, of which there are six members that have completed forms. We anticipate six meetings next year, so we estimated that. The rest of the dollars are for general operations such as the Conference Call account, the GTCNC web site, printing, office materials, and the Atlanta office for the Procurement Officer.

Mr. Bill Moore wants to know in budgeting for the Procurement Officer located at office at 2 Peach Street, if they will be dedicated to the Trauma Commissions business?

Mr. Jim Pettyjohn states that yes this will be a Commissions staff position.

Mr. Moore was just wondering if it is a full-time position there will be other needs for that person, and wants to know if we could consider sharing that, although he doubts the State has any money to help pay for that.

Mr. Pettyjohn states that the Procurement officer would be very busy.

Mr. Moore states that a portion of Mr. Pettyjohn's job is a full time job for somebody else.

Mr. Pettyjohn states that is correct, if it is to be done right. There are also so many other things to be done. The Communications Center up and running, region 5 & 6 and then region 9 are going to be coming on board with the RTAC developments. We are hopefully going to have a better liaison and working relationship with the office of EMS and Trauma. Mr. Pettyjohn states that he has not been to any trauma centers and he would need to visit some of the out of state trauma centers to start working those issues.

Mr. Moore states that he has know doubt that there is plenty of work for Mr. Pettyjohn to do. He was just wondering if the Procurement Officer was a full time position.

Mr. Pettyjohn states that yes the Procurement Officer will be a full-time position.

Ms. Cole states that basically to be honest Mr. Pettyjohn has been a Procurement Officer to a great extent. If we take our eye off the detail of the contracts we all have seen what has happened in the years past where it

was a year to get a contract through. It still takes constant vigilance to move these contracts through the state system.

Mr. Pettyjohn states that July 1 the Commission will be attached to its third mother ship in its short life, the first being DHR, the second DCH, and third DPH. It is Mr. Pettyjohn's advise to the Commission that they have internal staff that can make these transitions less cumbersome, and able to keep the work moving forward. Mr. Pettyjohn thinks the Procurement Officer would help the Commission do that.

Ms. Linda Cole states that she understands where Mr. Moore is coming from, it is not just another staff member, its more dollars, kind of off the top. Ms. Cole states that Mr. Pettyjohn had to convince her that a Procurement Officer was needed, because she does agree that the leanest most efficient staff you have the better off you are.

Dr. Dennis Ashley states that he thinks that the Commission is the leanest agency there is. Dr. Ashley thinks with the amount of work that we are doing, that we have all rolled up our sleeves and showed that effort. Dr. Ashley states that the Commission as gotten to the point, that we now have many things on the table. The Commission has made many advances, and has many deliverables on all these contracts that need to be overseen. Dr. Ashley states that we need to push to increase Mr. Pettyjohn's position into being a leader, and help and assist him to move forward. Dr. Ashley states that the Commission has been very good stewards of the taxpayer's dollars, and done more with less. If we are really going to have a statewide system then we need to have our Executive Director be more of a visionary and out making that happen. Dr. Ashley has been traveling around visiting hospitals with the Regional Trauma Advisory Counsel, which includes himself as a Trauma Surgeon, Lee Oliver, region 5 EMS Counsel Chair, Debra Kitchens as the lead, and Ms. Krystal Smith, RTAC Coordinator. We are on the road a lot, and have been to 4 or 5 hospitals. Mr. Rich Bias's group has been to 8 or 9 hospitals. I think we have maxed out everything we can do, and we need to let Mr. Pettyjohn do what he needs to do as Executive Director.

Mr. Pettyjohn states that the new Department of Public Health will have 2 attached agencies. The Commission and the Brain Trauma Commission. The Brain Trauma Commission has an annual budget of 1.5 – 2 million dollars. They have 5 full time employees. The Commission has one full time employee, plus a temp.

Dr. Ashley states that he thinks the Commission is well under that.

Mr. Moore's only question was whether when we broke this function up that is full time, since it is going to be based at 2 Peachtree, would they be grabbing this employee to do some of their work? And if that was going to happen could we share in that.

Mr. Pettyjohn states that the Commission would monitor that.

Mr. Ben Hinson states that when he looked at this purely from a financial standpoint he pushed back as well, and relayed that to Mr. Pettyjohn. Mr. Hinson states but if he looked at it as if it was his own business, that the money spent on hiring a Procurement officer would be well returned, to enable Mr. Pettyjohn to have his full attention on the contracts, and other such important matters. Mr. Hinson states that he is in full support of hiring a Procurement Officer.

TRAUMA COMMUNICATIONS CENTER BUDGET

Ms. Linda Cole states that the Commission is hoping that this facility will be opening this summer. The Commission has made great progress with the software. We are interviewing for the Trauma Center Communications Center Coordinator. There were several applicants, of which four interviews have taken place. We think that a selection will be made in the next few days.

There is also an EMS and Hospital Educator on the budget. The most important aspect of making the Communications Center successful is going to be communication and education, understanding the role, and how this center interacts with EMS, and the hospitals. The Commission anticipates that until the center is at least totally up and running that we will need someone to actually play that role of educator liaison. In the

years to come Ms. Cole does not know if that position would be ongoing. Ms. Cole states that in the initial start-up there will be many questions, misperceptions, and misinformation, that we will need somebody full time on educating. In the budget there is also Communications Center Operators, that's for 9 FTE'S for double coverage. The other is capital expenditure for the monitors. Under operations is Verizon airtime, and that is to continue out the contract so that those that have the AVLS'S will continue to have air coverage through the end of the year. The dollars would run out on the contract we have now at the end of June 2011.

Ms. Cole states that it would be the same thing for the support agreement with In Motion for the AVLS. The $2,300 is one log-in per agency and many agencies need more than one log-in, actually 2 so this would increase that. Ms. Cole asks if she is stating that correctly?

Mr. Pettyjohn states that actually there are 2 that come with the package, and we needed to have more than 2 so we negotiated and got 5 log-ins for $180.00 per agency per year.

Mr. Ben Hinson states that it is crucial as the buy in happens with In Motion, the more people in the agency that can see it, and use the tool, the easier the jobs above this will be. It becomes a dynamic part of what they are doing.

Ms. Cole goes over the building lease for GPSTC (Georgia Public Safety Training Center). The budget for telephone and Internet access we have estimated because we have not had those bills in the past. There will be no licensing fees until 2013. There will need to be some enhancements with SAAB, and we will see that as we work through, so we estimated for that. Plus other office operations, cell phones, and telephones. We built in a $150,000 contingency because this is the first year running this, to cover anything that we may have forgotten.

Mr. Rich Bias states that he has a problem with the level of staffing on this component of the budget for the coming year. I have no question about this level of staffing when it is fully deployed, when everything is up and running and we have all the regions online. If I were building this budget I would of gone to 5 maybe 6 full time equivalent rather than the 9, for the Communications Center Operators to give you some back up on vacation and holidays. I would look for the Communications Center Coordinator to assume the responsibility for the education, and communication role as well, since we are talking about only 3 regions right now.

Ms. Cole states that she hears Mr. Bias' questions and that she asked a lot of those same questions herself. Ms. Cole states that she thinks the need for double coverage is anytime you have one person there they are going to need to use the bathroom and also grab something to eat. It is challenging to do anything because the center is not co-located with somebody that can at least just answer the phone while you are gone. The people that are going to be utilizing the center are going to look for the phone to always be answered. If you have left for any reason you are leaving it unmanned. Ms. Cole does not think it reasonable that you will ever have a place that one person can be there by themselves and it is going to run properly. That is the reason we have built in the double coverage.

Mr. Ben Hinson states that he thinks you have to overspend to start with, and he thinks that this budget does that. If we were to start off and people call and no body is there it is a problem. Mr. Hinson thinks that down the road as we get this system more and more automated the need for double coverage will drop some. If we co-located in the future, we could cut that cost in more than half by simply putting the center somewhere with another operator. I think all those things being considered lets start with this for the learning curb.

Mr. Bias wants to know what they going to do with the down time when there are no calls coming in. Which could possibly happen for an entire shift.

Ms. Cole states that she does not think we are far enough down the road to tell you what they are going to do, but she thinks there will be a lot to do with working with the RTACS, and knowing the regional trauma advisory plans. Ms. Cole thinks we could find them things to do, and would be concerned leaving anyone there by himself or herself because it is a fairly isolated spot. If you will recall we tried to find a place that we could co-locate, and we could not find that.

Mr. Jim Pettyjohn states to Mr. Bias that we will monitor everything, and come back with a report to the Commission each time the Commission meets. These employees will be part-time to start, and will not be State employees. On utilization you are free to come down and look. We will have policies and procedures, and performance evaluations. We are looking for a Communication Center Coordinator that has some kind of experience in this kind of field.

Mr. Bias last comment is that this is a chunk of change out of limited budget, and he has concerns about the priorities.

Mr. Cole agrees, but she does not want to short change us, and have a hospital call or EMS call and no body there to answer the phone. Ms. Cole does not think that it would take but a couple of calls and they would loose confidence. We are certainly working to garner confidence to begin with.

Dr. Leon Haley states that he thinks it can be done both ways. That the budget can be approved to allocate for that level of staffing, but as you hire the Coordinator, you can put that person responsible for trying to allocate the actual staffing and what it should look like. We may be able to determine that we do not need double coverage 24/7 coming out of the gate, but what you do not want to do is say we do not need it, and than have to come back and do a budget ramification 6 months from now. So you can allocate the dollars but you may want to staff it single coverage to begin with to see what our volume is, and to see where we are at, and then if you need more people you have already allocated for that.

Mr. Rich Bias wants to know where we left off about the possibility of the Coordinator handling the educator opportunities?

Ms. Cole states that when she looks at everything that has got to happen to get this center up and going, her perception is that Coordinators be very focused on the Center, managing the people, determining how much staff we need to have, and is the center running well. Ms. Cole does not see the Coordinator having a lot of time to do education, at least in the beginning, other than education of the center.

Mr. Rich Bias suggests that one of the values of having the Coordinator having the added responsibility of educator is that it gets him or her out of the silo. Mr. Bias believes the center will function better if the Coordinator has a good connection with the community.

Ms. Cole states that her concern is that whenever she has opened anything new there is a need to be there fulltime, at least in the beginning, because people are going to have questions because it is new. If you are in Valdosta doing an education she thinks that would make it very challenging.

Dr. Dennis Ashley states that he has an understanding of the EMS, and Hospital educator position. The more he spoke with EMS, and the hospitals, it is amazed him how he had to repeat the same information over and over. What we are doing here with this pilot project is monumental. Actually in making this happen there are going to be a lot of bumps in the road. The EMS, and hospital educator is one of the most key positions, and they need to be out moving around the state. In each region we have a lot of EMS services, paramedics, and hospital ER's. There are just a lot of people to talk to in order to make this happen. Dr. Ashley states that you cannot just send an email, because people do not hear that. Once this program actually starts, the first few calls you have coming in are probably going to be done the wrong way. If we are gong to succeed we have to make sure we are going to invest in education. It is a very key position.

Mr. Rich Bias states that he sees a broader purpose for this position that he would want completed. He is concerned about the potential for this position bumping up against what the various RTAC'S are doing. The responsibility of RTAC is getting out there and communicating directly to the EMS services, and hospitals in their region, and acting as a collective. The responsibility of the RTACS is ongoing performance, improvement and quality. Much of this is going to be fed by data from the Communications Center. I would like to formally request that this position have a significant portion of it be coordination among and between the RTAC's. Mr. Bias states that for him that is more important in terms of our regional picture here and our system picture than the one to one communication here with individual agencies. That is the piece that can pull together the work that we are trying to do with regions 5, 6, and 9, and then the other regions will come on.

Ms. Cole states that she agrees with that.

Mr. Hinson has some questions about the 150,000 dollars contingency that is over 10%. He thinks that that if there is a contingency perhaps the Commission at least needs to be advised on what that is. We need to put it in the budget, but the expenditures need to come back to the Commission.

Ms. Cole thinks that is a great idea. Anytime we touch the contingency that we give a report on what those contingency dollars are.

Mr. Bill Moore wants to know if this budget assumes that this will be up and running by July 1?

Ms. Cole states yes. That she thinks we should be up and running right about that time.

Mr. Moore asks if we would be able to hire all these positions by that time.

Mr. Pettyjohn states that we would have a Coordinator starting hopefully July 1 or very shortly after that. We will take our first call in September, but we have a lot of staffing meeting to do.

Ms. Cole states that we will need to do a lot of training. They will need to understand regional trauma plans for the 2 regions. We may not have some of the staffing on till August or September, most in August.

Mr. Moore wants to know if we will need the 2 operators by then?

Ms. Cole states that if we take the first call in September we will need to bring them on in August to be trained.

System Development, Access and Accountability

Ms. Cole continues on with the next two green items. The first item is the accounting firm Gifford Hilegass & Ingwersen, which is the same group we used last year. We would like to continue the audit services that they have preformed. If you recall we did the ISS Process Review for the Level I Trauma Centers and we would like to add some of the Level 2's this year. It will be the busiest and highest volume level 2's. We would like to also have them look at the uncompensated care for EMS and how the hospitals are doing the trauma position.

We also would like to allocate funds for Bishop & Associate's to help us evaluate burn care, similar to the way they did with trauma care. So we can look at what is the true cost, and what is the loss on burn care, so we can compare that to a trauma center.

Mr. Bill Moore states that these are estimates, but haven't the accounting fees doubled?

Mr. Pettyjohn states that is correct. We have added additional procedures this time. We are going to be adding four more centers to the ISS Process Review. There is also a piece for the EMS Uncompensated Care based on last years program that is going to require a lot of communications back and forth. Gifford Hilegass & Ingwersen will be at the Commission meeting in July to go over their contract before it is signed, and to present what they are going to be doing. It would be good to have this generally approved so we could keep writing those contracts. Bishop & Associates will also be at the Commission meeting in July.

Office of EMS and Trauma Allocation

Ms. Cole states that this is the last green area of the budget, the 2.8 % allocated to OEMS/T. We are just allocating the dollars and not exactly what they are spent on.

Mr. Pettyjohn states that this dollar amount was actually prescribed by the Governors office in Planning the budget, as well as the amount of money we can use for operations. This was in the Governors budget bill.

Ms. Cole states that the Commission needs to have a motion to approve the green sections of the budget that she has gone over.

Mr. Bill Moore wants to know that with the technology we have available does the Commission feel that we have exhausted all telecommunications options available to the Communications Center. Possibly calls could be rolled over to somebody else so that call would not be missed?

Ms. Cole states that she would not say that we have exhausted all options, and is not totally apposed to saying we could approve less than this. The problem is she does not know where all the challenges are going to be. Ms. Cole states the Commission has found it is easier to take the dollars and reapply them, than come back to the stakeholders and say we are taking away. Ms. Cole's suggestion is that the Commission votes on this budget as it is, and then in November we comes back with a report from the Trauma Center Coordinator. If he or she determines that we do not need that extra coverage than we can reapply those dollars to the stakeholders.

Mr. Pettyjohn's states that we could do a whole budget review in November of all areas, the cash flow, and spreadsheet. We could then reassign the funds wherever they need to be.

Ms. Cole suggests that the Commission approves this budget; knowing there will be a pending November review.

Mr. Rich Bias has two questions, but they are not about the green areas of the budget. The first is to get clarification from Mr. Pettyjohn on what is the extra million that makes it 17.6.

Mr. Pettyjohn states that the 16.6 million is what the Governor allowed us based on projections for the Super Speeder. The Senate came back and added 2.5 million dollars more to the State funds for the Commission. When the appropriations bill went into conference committee the resulting was those 2.5 million additional funds were cut down to 1 million. That 1 million is additional state funding.

Mr. Rich Bias asks if that is different than the 2.5 million in question.

Mr. Pettyjohn states that is correct. In the Senate there was 2.5 million from the HIE funding, plus 2.5 million additional from state funds.

Mr. Rich Bias second questions has to do with minutes from the March meeting that reflect the administrative report which quoted Mr. Bias as asking that the Commission be sure to consider that the Trauma Registry support was deleted in the amount of $754,000 to all the trauma centers. That is in affect a hard line reduction. The way this budget is structured it has just disappeared completely. Mr. Bias would request consideration that that $754,000 is on top of the stakeholder amount and added back in either to the Readiness on top of the 80% or to a different section of the budget. That is a concrete almost million dollars of reduction in support that the trauma centers have been receiving, and in affect is reducing the 80% in the readiness today. Mr. Bias states that he is bringing this up now because we are looking at pieces that come together like in a puzzle. Once there is a commitment to the green there is no opportunity to move those things around.

Dr. Ashley states that million dollars was put into the budget by the senate to be a matching fund for a federal grant. The way he understands it, is we get this million dollars whether or not the grant comes through.

Mr. Rich Bias states that the million is already distributed in this proposed budget. The 3 quarters of a million of lost support is not being considered in this proposed budget.

Dr. Ashley states that if you took that million and set it aside and put $754,000 to the hospitals, which would be about 75% that would cover $754,000 that you are talking about. Then the other 25% could go to EMS. So you could start the budget minus 1 million dollars, but basically if you put the million dollars in the budget to start with it is still going to be about a 75/25 split. I think we are going to end up with that million dollars unmarked for anything, and it would subsidize what you are talking about.

Mr. Rich Bias states that given the fact that the million dollars is already distributed across this budget up front, from his perspective it is not subsidizing anything, and that is three quarters of a million that is being forgotten.

Ms. Linda Cole wants to know if Mr. Bias is stating that he would like to see a line item before available for stakeholder distribution, that would be $754,000 for registry allocation.

Mr. Bias replies, "yes that is correct, because that would be necessary to affectively address the fact that it was totally removed". Given the fact that every trauma center has to have a registry, they do not have a choice in this.

Mr. Ben Hinson asks if those three quarters of million dollars were in our budget the last several years?

Mr. Rich Bias states that it was in our State budget and the Governor wiped it out in January. It has always been in the State budget, for OAEMS in support of the Registry.

Mr. Pettyjohn states that the breakdown of what that money went to is on Page 9 of the Administrative Report.

Mr. Ben Hinson wants to know if Mr. Bias basically saying is that, that is another three quarters of a million dollars the Governor took away from trauma, that we need to make the trauma centers hold before we begin to do the distribution.

Mr. Rich Bias states that is correct.

MOTION GTCNC 2011-05-01:
I make a motion that the Commission considers placing $754.000 of the FY 2012 State funds available for Commission to offset the deletion of those funds from the Trauma Registry.

MOTION BY: Rich Bias
SECOND BY: Bill Moore

DISCUSSION: Ms. Linda Cole's only concern is if we are not prepared to do that today than we cannot vote on the budget .The Commission does not meet until July, so we will not have the budget ready to go on July 1.

Mr. Pettyjohn asks if the Commission could possibly meet in June to consider the budget for this one single issue via teleconference. The Commission could do a lot of back and forth through emails and send out several drafts over the next couple weeks.

Mr. Bias states that yes we could have a single-issue conference call on that part of the budget.

Ms. Linda Cole agrees that would be better.

Dr. Ashley states that if you are going to form the motion in that way could there be a compromise on the dollar amount. What if the Commission could only come up with $6000.00, would you accept that, or is $754,000 a hardcore number?

Mr. Bias states that he would accept whatever the Commission feels is appropriate to do.

Dr. Ashley wants to know if the Commission accepts an amendment to the motion to not reflect a definite dollar amount.

MOTION GTCNC 2011-05-02:
I make a motion to amend the motion to state that the Commission considers placing $754.000 or has much as possible of the FY 2012 State Funds available for Commission to offset the deletion of those funds from the Trauma Registry.

MOTION BY: Rich Bias
SECOND BY: Bill Moore

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

Dr. Ashley asks Ms. Cole if the Commission can now vote on the green part of the budget.

Ms. Cole states that we cannot vote on the green part of the budget because that is where the dollars will come from to make the $754.000. Ms. Cole states we will have to do the special call meeting in June.

Mr. Pettyjohn states that he will have something for Commission to review over the weekend. If we settle on something through emails in the next week or so, we can set up a conference call and advertise it in 48 hours and move forward with it.

Dr. Dennis Ashley discusses bringing a motion that Trauma Quality Improvement Program (TQIP) be one of the performance based payment sections of the contracts. Then if we list that the cost would be $9000.00 per center, this would be the level I's, and Level 2's minus the CHOA, because there is not a pediatric version of this yet. There would be a $1000.00 year service agreement. So the cost would be $10,000 per center with a one time up front cost of $3,500.00, so about $13,000. The whole package would be $162,000. This would bring our whole state on, and we would be the first state to do this.

MOTION GTCNC 2011-05-03:
I make a motion to the Commission that TQIP be one of the performance based payment sections of the contacts.

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

DISCUSSION: Ms. Kelly Vaughn states that GCTE (Georgia Committee on Trauma Excellence) talked about that extensively yesterday and realized that we were moving in that direction. There was some concern about the state owning the license or the hospital individually owning the license, and how that is all going to work out. Ms. Vaughn wants to know if Dr. Ashley just wants to wait and let that issue be addressed at subcommittee level.

Dr. Ashley states replied, " Yes that will be addressed there".

Mr. Bill Moore asks Dr. Ashley what his motion is, to allocate that money now?

Dr. Ashley states that there is a start date of July 1, for working with the National Committee. We need to let them know that we are actually going to be in there to do this, to get us in the game before we wait a whole year.

Mr. Moore asks if Dr. Ashley where that $162.000 would come from.

Dr. Ashley states that it would be part of the Performance Based payments. We would be earmarking $10,000 per hospital in your Readiness cost for you to be involved with TQIP.

Dr. Leon Haley asks Dr. Ashley if he is putting the ownership on the Commission to allocate dollars for that or the individual hospitals as part of the condition of Readiness to have that?

Dr. Ashley replied, "Yes it would come out of their Readiness".

Regina Medeiros wants to make everyone aware that there is a set time-line for TQIP that we cannot begin data collection until sometime in January. So if we build TQIP into paid performance and readiness it needs to reflect appropriately the time-line in which we would be able to participate and adhere to the downloads.

Dr. Ashley states that Regina is absolutely right. We will not have data right up front because it takes a while to get online. That is why if we do not do our part up front we are two years down the road before we actually have any data.

Ms. Medeiros wants to be able to allocate that some of those funds could be used for people to attend the mandatory training in Chicago.

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

APPROVAL OF THE MINUTES OF THE 17 MARCH 2011 MEETING

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

MOTION GTCNC 2011-05-04:
I move that the minutes of the 17 March 2011 meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

MOTION BY: **Mr. Leon Haley**
SECOND BY **Ms. Kelly Vaughn**

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

ADMINISTRATIVE REPORT REVIEW

Mr. Jim Pettyjohn goes over the Administrative Report.

Governor Deal appoints two new Georgia Trauma Commission members

Mr. Pettyjohn states that there is a press release from Governor Deal announcing the appointment of the two new Commission Members, which were posted to the GTCNC website yesterday morning at 7 a.m. (*Press release attached to Administrative Report)*.

09 May 2011 Medical Director Conference Call
(Minutes attached to Administrative report)

Georgia Trauma Registry TQIP Module Roadmap, Digital Innovations, Inc.

Mr. Pettyjohn states that there was conversation about Digital Innovations, which is the software vendor for the Trauma Centers registry. They have provided some documents on their roadmap to participating with TQIP, and the cost of that. We will be referring to those documents when we go the Subcommittee on Trauma, to consider and discuss how that is going to reside in the contracts.
(Documents attached to Administrative Report)

FY 2011 OEMS/T Trauma Registry Contract: $754,000 Funding Cut 50% in FY 2011 and 100% in FY2012

Mr. Pettyjohn states that in keeping with Mr. Rich Bias request of last Commission meeting that the Commission considers the $754,000 that was cut from the OEMS/T budget, the distribution of that was attached to the Administrative Report. *(Documents attached to Administrative Report)*

Letter of Appreciation from Doctor's Hospital, Augusta, Georgia

We received a letter of appreciation from Doctor's Hospital for our support of them moving forward with House Bill 307. We have Mr. John Walraven who is here with us today to speak to us on that process, and give us some information pertaining to that Bill. *(Letter attached to Administrative Report)*

HB 160 Revenues Report: Through 30 April 2011

This is the Super Speeder Bill and the revenues we generated from that. *(Report attached to Administrative Report)*

Pages from FY 2012 Final Conference Committee Budget

Supportive to the budget conversation Mr. Pettyjohn has added two pages from the Conference Committee budget that the Governor signed. *(Documents attached to Administrative Report)*

Criteria for Federal Grant Sub-awards: State Health Information Exchange Cooperative Agreement Program

This is from the Stimulus Funding Grant, a Federal grant. We met with Ruth Carr who is the person within the Department of Community Health who is responsible for the Georgia piece of that Federal grant. Ms. Carr gave us a heads up on the work that the Commission is doing around the Communications Center. Ms. Carr stated that it does not fit within the very stringent criteria that the Federal Government is looking for in their sub grant awards approval for the HIE funding. Mr. Pettyjohn states that we are expecting a letter from the director of the Governors office of Planning and Budget giving us further direction on that 2.5 million and our opportunity to issue a sub grant for that. After speaking with Ruth Carr it does not look like we are going to be able to access those dollars. *(Documents attached to Administrative Report)*

Trauma Associates of Georgia Education Grant request

There was a grant for a little over $50,000, for education. One of the courses was for the AAAM, which is supportive to the trauma coordinators and registrars learning best practices in determining ISS scores. It was a recommendation from the audit firm that all the trauma coordinators and registrars have the same frame of reference when they the chart for the ISS score determination. That grant request for those trainings addresses that as well.

Ms. Regina Medeiros states that TAG historically has been providing an annual conference for all health care providers throughout the state. It has not been cost prohibitive for us to attend, so we switched gear to doing educational courses TNTC and ANTC for rural hospitals.

Ms. Rochella Moon states that to this point we have done three TNTC courses educating approximately 60 people.

Ms. Regina Medeiros states that they use the profits from the conferences to do that, but are running out of funds. We feel that it is important to continue education, especially as we are evolving our regional protocol in our trauma systems statewide. So we are coming too the Trauma Commission to request some funding to help us continue these educational courses. The new courses that we want to add are The Rural Trauma Team Development Course, which has been hugely successful in other parts of the country. We have put in a specific number of courses that we hope to achieve over the year, and the number of people we would like to educate. *(Course specifics attached to Administrative Report)*

Mr. Ben Hinson wants to know if Regina has attempted to get grants from other sources?

Ms. Medeiros states that there have been some attempts to get some funding, but they were unsuccessful.

Mr. Hinson wants to know if when the Commission gets ready to consider this in the budget if Ms. Medeiros could send him a list of the grants that have been applied for, listing whom you asked, when you asked, and what they said.

Ms. Medeiros stated she would supply that.

Bishop & Associates FY 2012 proposal
(Documents attached to Administrative Report)

Draft FY 2012 Trauma Commission budget

This is the budget we went over today. *(Document attached to meeting minutes)*

FY 2011 EMS Vehicle Equipment Replacement Grants Program Award Recommendations

The results of the Top 9 awardees will be discussed later on in the Agenda. *(Document attached to the meeting minutes.)*

TRAUMA COMMUNICATIONS CENTER UPDATE

Mr. Scott Sherrill states that the Commission has had a fair amount of activity this month. We had the kick-off for the TCC Implementation the very first of this month in which SAAB sent representatives from Washington, DC, and Stockholm, Demark to show different parts of their system. We have been doing ongoing reviews online of the software prototypes, which is enabling us to look at the system as it is being developed and give feedback on that development. In addition to that we have been trying to initiate the liaison that we need to be doing more of with other participating members of the community. That will be an integral part of the success of the TCC. Yesterday we met with representatives of the hospital trauma centers who will be using this system. We have scheduled meetings with EMS as well, and will be having those in just a couple of weeks. We are also in the process of making some basic upgrades to the facility itself. Work is being done to get the system in place with a projected opening of September 1, 2011.

Mr. Jim Pettyjohn states as Mr. Sherrill mentioned there are EMS Subcommittee meetings. They will be held in June and July, and we will be devoting a significant amount of meeting time to take some EMS comments and questions. We will be explaining the process, as we know it going forward, and will be working with region 5 & 6 directors to bring some EMS clinical folks from their regions to both those meetings to give us a reality check.

HB 307 UPDATE AND INFORMATION

Mr. John Walraven states that all they were looking to do was to figure out a way to bring burn patients into the trauma network, in a more precise and specific way then was currently being done under the four tier trauma network. While thinking about how to amend HB 307 as it is reduced to accomplish the goal we found a lot of unattended consequences in the way it was drafted. Through input from the Commission and other folks, we came out with a substitute version in the House that basically just put the word burn before the word trauma. We found that the two major burn units in Georgia both saw at least 300 inpatients in a calendar year, including the proliferation burn units throughout the state. Given that burn treatment is such an expensive means of medical care, of healing and follow-up treatment, 300 was decided to be a good number. Most importantly for the medical community was defining what exactally is a trauma burn patient. Factors were brought in from the International Classification of Diseases. These factors were developed based on criteria of American Burn Association, and would guide patients to the trauma registry where they had partial thickness burns of at least 10%. Such as burns on their face, hands, genital, or major joints, third degree burn for any major group, and a chemical burn or inhalation burn. Rather than trying to figure out whether a burn trauma patient would fit into a burn trauma facility at levels, 1, 2, 3, or 4, we decided that burn would be a designation and of itself. That is

when we learned that to incentivize medical facilities to cover trauma care, some benefits were given to those trauma care centers with the burn CON (Certificate of Need). So we put in a blanket prohibition on any healthcare facility that is a trauma burn center getting in or around the CON requirements. We also updated the discharge and the trauma service codes to get ready for the ten split. Mr. Walraven states that beyond that, that is all the Bill did.

FY 2011 VEHICLE EQUIPMENT REPLACEMENT GRANT AWARDS

Mr. Bill Moore states that he is reporting in the absence of Mr. Kurt Stuenkel, Chair of this Committee. It is the recommendation from EMS Vehicle Equipment Replacement Scoring Subcommittee that the Trauma Commission approve the following nine applications for the fiscal year 2011 Ambulance Replacement Grant Awards of $72,500 each. The criterion that was established by the EMS Subcommittee was the criteria that were used for the scoring of these nine awardees. *(FY 2011 top nine-awardee list attached to the meeting minutes)*

Dr. Dennis Ashley asks if the criteria for this award process can be stated to the Commission to refresh our memories.

Mr. Jim Pettyjohn states that working through the EMS Subcommittee we established a process. There was an evaluation committee that was put in place that was made up of Lauren Noethen, Executive Assistant, Keith Wages, the Director of the Office of EMS, and myself. We posted the application on the GTCNC Website. We received applications for about 30 days, with a cut-off date of midnight April 1. After receiving the applications Ms. Noethen opened up and reviewed the applications. About 30% of the applications had missing or questionable information, or the information was not clear. We called all those applicants and received clarity on that information. We then proceeded to rank order those applications. We realized that we needed to ensure that vehicles that were used for this year were not vehicles that were used and awarded replacement grants in the FY 2009. In order to do that we went through each contract from 2009, and found three that mistakenly submitted the ambulance once again. We then personally spoke with the leader of all those three agencies, and it was found to be an over sight. They were all aware that they were removed from competition.

Mr. Ben Hinson asks whether or not those three agencies were given the opportunity to change those applications?

Mr. Pettyjohn states that no, the application window had shut.

We then took the applications to Atlanta and met with Mr. Keith Wages and systematically went through all top 15 applications, reviewed the process, and justified our scoring with Mr. Wages. At which time Mr. Wages approved our process. We then made a recommendation to the Subcommittee for the top 9 awardees.

Dr. Dennis Ashley asks a question pertaining to the FY 2011 EMS Vehicle Equipment Replacement Grant Award Draft List. Dr. Ashley wants to know in one column it says Award in 2009, and then in the other column it says cleared, what does that mean.

Mr. Pettyjohn states that it asked the question whether or not that organization received an award in 2009, and cleared means we have checked the Vin # on the application in 2011 against the Vin # that was awarded in 2009. If they were cleared, than it is a yes.

Mr. Hinson wants to clarify that Heartland EMS is the provider in Wilkinson County, and whether Wilkinson County has a separate license that this award is going too?

Mr. Keith Wages states he is checking that right now.

Mr. Pettyjohn states the vote will be delayed until later in the meeting when the answer to Mr. Hinson's question is obtained.

Dr. Ashley states that the Commission will move forward and address this later in the meeting.

PRESENTATION: TRAUMA REGISTRY DATA GEORGIA 2004-2009, FIRST LOOK

Dr. Rana Bayakly who is with the Georgia Division of Public Health, and a Chronic Disease Chief Epidemiologist makes this presentation. Dr. Bayakly's division includes the Epidemiologist for the Trauma Registry. Dr. Bayakly thanks Dr. Danlin Luo who is the Epidemiologist that did the analysis on this presentation. *(PowerPoint presentation attached to the meeting minutes)*

PRESENTATION: TRANSFORMING THE TRAUMA SYSTEM RESULTS OF CHOT MEMBERSHIP ACTIVITES FY 2011

Mr. Pettyjohn states that the Trauma Commission joined CHOT last year and Dr. Eva Lee is going to give an update on the activities that the Commission sponsored over the last fiscal year.

Dr. Lee states that the Commission is actually a member of the National Science Foundation and the Center for Health Organization Transformation. This is quite unique because instead of just looking at one hospital the Commission is looking at the Statewide Trauma Network. Dr. Lee states that there are a lot of exciting things that can be done with that information, and she is going to give you some results of that study today. *(PowerPoint presentation attached to the meeting minutes)*

EMS SUBCOMMITTEE OF TRAUMA

Mr. Ben Hinson states that almost the entirety of the EMS Subcommittee meeting in May was Dr. Lee's presentation like you heard today. The EMS Subcommittee looked at it and was fascinated with the possibilities. After the presentation there was some pretty robust conversation via email, but the EMS Subcommittee did not come to a position on it. There was no one saying it was absolutely wrong, but there was no one saying we are absolutely recommending it at this point in time. Mr. Hinson states so that is the work we are trying to do. At the next EMS Subcommittee meeting in June this subject will be one of our main topics of discussion as to whether or not we recommend moving forward with this. We will bring that to the next Trauma Commission meeting in July. Mr. Hinson states that personally he thinks that this type system is fundamentally required in order to get to a fact based, outcome based, system design, and he is very encouraged by something like this if not this.

Dr. Dennis Ashley states that he would like to bring to the attention of the Commission a subject concerning Medicaid. Apparently there is a regulation with Medicaid as far as getting patients out the door. To give an example of this we have patients that are quadriplegic it is obvious they are not going to get better, and they are unfunded. When we start the process for discharge the nurses on the team tell me that you are going to have to babysit these patients for three months because that is how long it takes to work through the process. We know this patient needs to go to a nursing home, if they cannot be cared for at home, but the nursing homes will not take them until they get their Medicaid number. There is apparently an arbitrary rule that it has to be four or five weeks before there can be an interview with the patient represented, and the family. Once that happens then it is a wait game. What Dr. Ashley would like to do is to work with the backing of the Commission and with Mr. Pettyjohn to draft a letter to ask for some support in alleviating some of the barriers of time. Dr. Ashley asks Dr. Pat O' Neil who that letter would be sent too.

Dr. O'Neil suggests that the letter be sent to Commissioner David Cooke, and a copy to Dr. Jerry Dubberly who is the Director of Medicaid.

Dr. Ashley wants to know if that is ok with the Commission if we start down that road, this would also help the trauma centers get their numbers quicker, so we could move these patient's to the appropriate facility.

Mr. Rich Bias thinks that is a good idea. He thinks that everyone would welcome a solution to this problem.

Dr. Ashley states then we will start down that process, and if there is other things that we can do like that, and they are not financial, please bring it to the Commission's attention.

Mr. Pettyjohn's states that since we are going to lose quorum because two of the Commission members need to leave early, we need to vote on the EMS Vehicle Grant Awards. Mr. Pettyjohn states that it has been confirmed that Wilkinson County has a 911-zone certificate. Mr. Pettyjohn apologizes for not having this information earlier. There is a limit of one grant per 911 zone, and two grant awards for applying or operating organization with those two awards going to different 911 zones has been established for the program. Also a 911 zone cannot receive an award in two consecutive grant program years. One grant program year must pass before the 911 zone is again eligible to receive an award. There was also a limit of three awards to any 911 zone in a ten year period established. The FY 2009 grant program was year one, this is year three. All top nine met all these requirements.

MOTION GTCNC 2011-05-05:
I make motion that the Trauma Commission approves the EMS Scoring Subcommittee's top 9 applications for the FY 2011 EMS Vehicle Equipment Replacement Grant Awards.

MOTION BY:	**Mr. Ben Hinson**
SECOND BY	**Dr. Leon Haley**

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

Mr. Jim Pettyjohn states that he will post the top 9 awardees of the FY 2011 EMS Vehicle Equipment Replacement Grant Awards to the GTCNC website for one week for any protests, then move forward with the grants.

GEORGIA COMMITTEE ON TRAUMA EXCELLENCE

Ms. Kelly Vaughn states that Ms. Regina Medeiros spoke about the education that the Trauma Coordinators are proposing for funding. Ms. Vaughn presented the information on TQIP and how that is moving along. Mr. Scott Sherrill came to the meeting and gave a report on the Trauma Communications Center, and how that is moving forward. Ms. Vaughn plans on having Mr. Sherrill return in July with a full presentation, as the meeting has grown with many new members to the program.

Mr. Ben Hinson mentions that the EMS uncompensated form is to be posted soon.

DCH OEMS, OFFICE OF TRAUMA AND PUBLIC HEALTH

Mr. Pat O'Neal states that as July 1, 2011 we will become a Department of Public Health instead of a division of public health, which is good news. The bad new is that we received notice yesterday that the Governor has asked that we cut 186 positions from public health, however we have more than that number of vacancies, so we will be cutting vacancies.

LAW REPORT None

Old business: None

New business: Mr. Pettyjohn states that the Trauma Commission will be meeting in a couple of weeks via teleconference to discuss the FY 2012 budget to be approved.

NEXT MEETING Not discussed.

MEEETING ADJOURNED: Hearing no call for additional business or concerns for the Commission to address, Dr. Ashley declared the meeting adjourned at 1:09 PM.

Minutes crafted by Lauren Noethen

Georgia Trauma Commission FY 2012		
General Trauma Fund Allocations		
ESTIMATED Budget Version # 4: 15 May 2011		**DRAFT**
Approved by General Assembly (State and Federal Funds)	**$ 20,156,896**	
Federal Funds ARRA HIE Grant (sub award)*		**($2,500,000)**
FY 2012 State Funds Available for Commission	**$ 17,656,896**	
Commission Operations		**$ 444,897**
Trauma Communications Center		**$ 1,141,245**
System Development, Access & Accountability		**$ 689,030**
State OEMS/T Allocation		**$ 499,707**
Total	**$ 2,774,879**	
Available for Stakeholder Distribution	**$ 14,882,017**	
EMS Distribution @ 20% of available funding		**$ 2,976,403**
Trauma Centers/Physicians Distribution @ 80% of available funding		**$ 11,905,614**
	Remaining:	$ -

*Ruth A. Carr, Senior Deputy General Counsel and State Health Information Technology Coordinator, Georgia Department of Community Health stated her belief the federal Office of National Coordinator (ONC) would not approve a sub grant agreement to utilized the American Recovery and Reinvestment Act (ARRA) Health Information Exchange (HIE) federal dollars for the Trauma Communications Center.

As per OPB directions (Paula Brown 11 May 2011 email) re Operations and OEMST budgets plus the additional $1M is added for a total of $17,656,896:

	FY11 Base	**Gov Rec Reduction**	**Gov FY12 Budget Rec**
OEMS/T Allocation	667,230	(167,523)	499,707
Commission Operations	494,330	(49,433)	444,897
All Other Functions	21,079,440	(5,367,148)	15,712,292
Total State Funds	22,241,000	(5,584,104)	16,656,896

Georgia Trauma Commission FY 2012

Commission Operations

ESTIMATED Budget Version # 4: 15 May 2011 **DRAFT**

Staff			Salary	Benefits	Travel	
Executive Director	$ 162,834		$ 104,000	$ 41,834	$ 17,000	Rising Fawn-based
Budget/Procurement Officer*	$ 86,535		$ 60,000	$ 24,135	$ 2,400	Atlanta-based
Office Coordinator/Executive Assistant	$ 63,796		$ 43,000	$ 17,296	$ 3,500	Rising Fawn-based
Commission Members Per Diem	$ 3,780		6 members for 6 meetings at $105.00 each (ESTIMATE)			
Operations						
Conference call account	$ 6,000		Premier Global: $500.00 per month (Includes: Commission, EMS and GCTE conference calls) ESTIMATE			
Website service and support	$ 2,500		Hosting and design support (ESTIMATE)			
Printing/Supplies	$ 5,500		FedEx Office and Office Depot: Meetings and Office (ESTIMATE)			
Atlanta Office set-up	$ 3,500		Computer, monitor, fax/scanner/printer and supplies			
Telephone/ Internet	$ 4,200		Trenton Telephone: Commission Office (ESTIMATE)			
Electrical	$ 2,000		Georgia Power: Commission Office (ESTIMATE)			
Shipping	$ 2,500		FedEx (ESTIMATE)			
Staff Cell Telephones	$ 4,000		Estimate for three cellphones (~$110.00/month/per telephone)			
Contingency funding	$ 97,752		Unexpected costs			
Total:	**$ 444,897**					

*Dedicated budget and procurement support, will provide time for Ex. Dir. to provide direction and oversight of Commission's mission, duties, responsibilities, goals and strategic plan implementation.

Areas in Green need to be approved before end of FY 2011 (30 June 2011)

As per OPB directions (Paula Brown 11 May 2011 email) re Operations and OEMST Budgets plus the additional $1M is added for a total of $17,656,896:

	FY11 Base	**Gov Rec Reduction**	**Gov FY12 Budget Rec**
OEMS/T Allocation	667,230	(167,523)	499,707
Commission Operations	494,330	(49,433)	444,897
All Other Functions	21,079,440	(5,367,148)	15,712,292
Total State Funds	22,241,000	(5,584,104)	16,656,896

Georgia Trauma Commission FY 2012 Budget

Trauma Communications Center Operations

ESTIMATED Budget Version # 4: 15 May 2011 **DRAFT**

Staff			Salary	Benefits	Travel	
Communications Center Coordinator	$ 114,910		$ 71,250	$ 28,660	$ 15,000	Forsyth-based
EMS and Hospital Educator	$ 104,135		$ 60,000	$ 24,135	$ 20,000	Atlanta-based
Communications Center Operators	$ 504,000		9 FTE ($56,000 per) double coverage 24/7			
Capital Expenditures						
Hospital CPUs and monitors	$ 32,000		32 at $1000 per (see below)			
Operations						
AVLS (200 AVLS Unit in Regions 5 and 6)						
Verizon Airtime @ $42/month/unit EMS Regions 5 and 6	$ 50,400		Current contract with GTRI covers airtime thru 31 December 2011 (Amount shown for 6 month ESTIMATE)			
In Motion Service Support Agreement @ $12.50/month/unit	$ 30,000		Currently paid thru 30 June 2011 (12 month ESTIMATE)			
5 oMM logins per agency @ $180/agency	$ 2,300		Currently paid thru 31 December 2011 (6 month ESTIMATE)			
Building Lease and Utilities	$ 13,500		Rent and Utilities per year at GPSTC			
Telephone and Internet Access	$ 25,000		ESTIMATES			
SAAB Software licensing fees	$ -		SAAB (yearly) No licensing fees until FY 2013			
SAAB Software Enhancements	$ 100,000		Estimates			
TCC "office" operations and staff cell telephones	$ 15,000		Estimates			
Contingency	$ 150,000		Unforeseen expenses			
Total:	**$ 1,141,245**					

EMS and Hospital Educator: New OEMST position paid by Commission to provide EMS and Hospitals education and training re TCC and trauma system development . This funding of this position will not be from the 3% OEMST allocation and job duties and performance will be assured via detailed contract deliverables which will include matrix reporting to State EMS Director and Commission Executive Director or TCC Coordinator.

Capital Expenditures: 30 CPUs provided via SAAB contract. 18 will go to trauma centers with 12 remaining. Total required for EMS region 5, 6 and 9 is 44 or 32 CPU and monitor purchases required in FY 2012.

Areas in Green need to be approved before end of FY 2011 (30 June 2011)

Georgia Trauma Commission FY 2011 Budget			
System Development, Access and Accountability			
ESTIMATED Budget Version # 4: 15 May 2011			**DRAFT**
Development and Access			
Trauma System Regionalization Activities	$ 225,000		Trauma System Regionalization Activities in EMS Region 9, 5 and 6. $75K each. Initial funding for EMS Region 9 (Memorial Health) and second year funding for EMS Regions 5 and 6 (MCCG and MCG)
Georgia Tech Research Institute	$ 100,000		TCC and AVLS integration technical assistance and support: 01January 2012 - 30 June 2012 (Current contract extended to 31 December 2011) ESTIMATE
National Foundation for Trauma Care	$ 1,500		Annual membership
Center for Health Organization Transformation	$ 50,000		CHOT annual membership
Georgia Committee for Trauma Excellence	$ 52,530		TNCC courses x 3, RTTD courses x 3 and AAAM course
Accountability			
Gifford Hillegass & Ingwersen	$ 110,000		Audit and Accounting Services: ISS process review for 8 trauma centers; CY 2009 Uncomp Claims audit; FY 2011 EMS Uncomp program (claims) audit; Trauma Physician funding process review with recommendations on best practices; CY 2010 financial survey (collaborate with B+A); and, accounting review services (ESTIMATE)
Bishop + Associates	$ 100,000		Technical Services: Evaluate burn care support and financial needs, Assist CY 2010 TC Financial Survey, Reevaluate TC and physician funding methodologies to include burn centers for FY 2013 (ESTIMATE)
Additional contracts and costs	$ 50,000		For additional contracts, accommodating budget short fall and or unforeseen and increased costs or other contingencies.
Total	**$ 689,030**		

Georgia Trauma Commission FY 2012			
EMS Allocation			
ESTIMATED Budget Version # 4: 15 May 2011			**DRAFT**
Available EMS Budget @ 20% of available fudns for stakeholders	$ 2,976,403		
Stakeholder meeting support	$ 3,500		Staffing and minutes development
Remaining :	**$ 2,972,903**		

GEORGIA TRAUMA CARE NETWORK COMMISSION FY 2012 BUDGET
TRAUMA CENTER/PHYSICIAN ALLOCATION

ESTIMATED Budget Version # 4: 15 May 2011 **DRAFT**

	Amount	
New Trauma Center Startup Grants[1]	**0**	
Trauma Center Readiness Payments[3]	4,166,965	70%
Performance Based Payment[4]	1,785,842	**30%**
Sub Total Readiness Payments	5,952,807	100%
Uninsured Patient Care Payments[5]	5,952,807	
Total Trauma Center Allocation[6]	**11,905,614**	

Hospital/Physician Fund Division[7]	75% Hospital	25% Physician	Total
Trauma Center Readiness Payments	$4,464,605	$1,488,202	$5,952,807
Uninsured Patient Care Payments	$5,022,458	$1,674,153	$5,952,807
Total	**$9,487,063**	**$3,162,354**	**$11,905,614**
New Trauma Centers Startup Grants			$0
Total			**$11,905,614**

Notes:

[1]Grant program to foster the development of new trauma centers in regions of Georgia with the greatest need.

[3]Trauma Center readiness payments are described on page 2.

[4]A performance based payment (PBP) program will reward trauma centers that meet defined standards. For 2011, 30% of trauma center funding will be set aside for PBP.

[5]Uninsured trauma patient care payments are described on page 3.

[6]Amount allocated to Trauma Centers by the GTCNC.

[7]Payments for readiness and uninsured patient care received by Trauma Centers are to be proportionally distributed between the hospital and physicians on a 75%/25% basis.

Green numbers are dynamic

GEORGIA TRAUMA CARE NETWORK COMMISSION FY 2012 BUDGET
TRAUMA CENTER READINESS & PAY FOR PERFORMANCE PAYMENTS

ESTIMATED Budget Version # 4: 15 May 2011

Trauma Center	Funding Level	% of Fund	Readiness Payments[1]	Potential P4P Payments[2]	Total Readiness Payments
Level IV Morgan	5%	0.49%	22,860.39	9,797.31	32,657.70
Level IV Taylor	5%	0.49%	22,860.39	9,797.31	32,657.70
Level IV Lower Oconee	5%	0.49%	22,860.39	9,797.31	32,657.70
Level III Walton	10%	0.98%	45,720.78	19,594.62	65,315.40
Level II	60%				
Athens	60%	5.85%	274,324.68	117,567.72	391,892.40
Archbold	60%	5.85%	274,324.68	117,567.72	391,892.40
Atlanta	60%	5.85%	274,324.68	117,567.72	391,892.40
Columbus	60%	5.85%	274,324.68	117,567.72	391,892.40
Floyd	60%	5.85%	274,324.68	117,567.72	391,892.40
Gwinett	60%	5.85%	274,324.68	117,567.72	391,892.40
Hamilton	60%	5.85%	274,324.68	117,567.72	391,892.40
North Fulton	60%	5.85%	274,324.68	117,567.72	391,892.40
Egleston	60%	5.85%	274,324.68	117,567.72	391,892.40
Scottish Rite	60%	5.85%	274,324.68	117,567.72	391,892.40
Level I	100%				
Grady	100%	9.76%	457,207.80	195,946.20	653,154.00
MCCG	100%	9.76%	457,207.80	195,946.20	653,154.00
MCG	100%	9.76%	457,207.80	195,946.20	653,154.00
Memorial	100%	9.76%	457,207.80	195,946.20	653,154.00
Totals	**1025%**	100.00%	4,686,379.95	2,008,448.55	6,694,828.50

Notes:

Level II trauma center received 60% of the payments for Level I trauma centers. Level III trauma centers receive 10% and Level IV trauma centers receive 5%.

[2]Pay for performance (P4P) payments, if fully earned, will be distributed to trauma centers based upon the readiness payment formula.

Red numbers are dynamic

CY 2008 Data. CY 2009 data will drive FY 2012 funding

GEORGIA TRAUMA CARE NETWORK COMMISSION FY 2011 BUDGET
TRAUMA CENTER UNINSURED PATIENT CARE PAYMENTS

ESTIMATED Budget Version # 4: 15 May 2011 **DRAFT**

	Self Pay Patients Meeting SB 60 Requirements[1] in CY 2008					Cost Norm Based Allocation of Funds[2]			
Trauma Center	ISS 0-8	ISS 9-15	ISS 16-24	ISS >24	Total	Severity Adjusted Cost Norms	Total Based Upon Cost Norms	Allocation Based On % of Norm Cost Total	
Leve I IV Morgan									
Level IV Taylor									
Level IV Lower Oconee									
Level III Walton	4	2			6	$6,987	$41,924	0.11%	$7,614.16
Level II									
Athens									
Archbold	27	21	5	5	58	$10,846	$629,052	1.71%	$114,247.30
Atlanta	143	110	47	21	321	$13,327	$4,277,961	11.61%	$776,955.63
Columbus	9	18	9	0	36	$11,437	$411,741	1.12%	$74,779.66
Floyd	25	25	5	1	56	$9,365	$524,450	1.42%	$95,249.67
Gwinett	36	41	21	9	107	$12,475	$1,334,811	3.62%	$242,425.99
Hamilton	12	9	2	1	24	$9,594	$230,253	0.62%	$41,818.14
North Fulton	33	21	22	10	86	$13,535	$1,164,021	3.16%	$211,407.41
Egleston	38	11	5	1	55	$9,832	$540,780	1.47%	$98,215.50
Scottish Rite	47	12	1	1	61	$6,988	$426,256	1.16%	$77,415.85
Level I									
Grady	468	395	122	65	1,050	$12,889	$13,533,553	36.71%	$2,457,939.69
MCCG	83	59	32	11	185	$13,433	$2,485,128	6.74%	$451,344.50
MCG	93	127	50	21	291	$14,588	$4,245,058	11.52%	$770,979.84
Memorial	66	111	96	71	344	$20,399	$7,017,111	19.04%	$1,274,435.15
Total LI/LII	**1080**	**960**	**417**	**217**	**2,674**		**$36,862,099**	**100.00%**	**$6,694,828.50**

Patient Treatment Cost Norms[3]		
ISS	**Community**	**Academic**
0-8	$5,267	$6,373
9-15	$10,428	$12,618
16-24	$19,626	$23,747
>24	$33,945	$41,073

Notes:

[1]Trauma Centers report number of uninsured trauma patients meeting SB 60 requirements by Injury Severity Score (ISS) category.

[2]Allocation is based upon the number and severity of patients meeting SB 60 requirements times cost norms. This derives a percent of total costs which is then applied to the total amount available.

[3]To develop a fair and consistent approach to estimating costs, national trauma center patient treatment cost norms by injury severity were used, for both community and academic hospitals.

CY 2008 Data. CY 2009 data will drive FY 2012 funding

ESTIMATED Budget Version # 4: 15 May 2011 **DRAFT**

Trauma Center	Readiness Payment	Potential P4P Payments[2]	Total Readiness Payments	Uninsured Patient Payment	Total	%
Leve l IV Morgan	$22,860	$9,797	$32,657.70		$32,658	0.2%
Level IV Taylor	$22,860	$9,797	$32,657.70		$32,658	0.2%
Level IV Lower Oconee	$22,860	$9,797	$32,657.70		$32,658	0.2%
Level III Walton	$45,721	$19,595	$65,315.40	?	$65,315	0.5%
Level II						
Athens	$274,325	$117,568	$391,892.40	?	$391,892	2.9%
Archbold	$274,325	$117,568	$391,892.40	$114,247.30	$506,140	3.8%
Atlanta	$274,325	$117,568	$391,892.40	$776,955.63	$1,168,848	8.7%
Columbus	$274,325	$117,568	$391,892.40	$74,779.66	$466,672	3.5%
Floyd	$274,325	$117,568	$391,892.40	$95,249.67	$487,142	3.6%
Gwinett	$274,325	$117,568	$391,892.40	$242,425.99	$634,318	4.7%
Hamilton	$274,325	$117,568	$391,892.40	$41,818.14	$433,711	3.2%
North Fulton	$274,325	$117,568	$391,892.40	$211,407.41	$603,300	4.5%
Egleston	$274,325	$117,568	$391,892.40	$98,215.50	$490,108	3.7%
Scottish Rite	$274,325	$117,568	$391,892.40	$77,415.85	$469,308	3.5%
Level I						
Grady	$457,208	$195,946	$653,154.00	$2,457,939.69	$3,111,094	23.2%
MCCG	$457,208	$195,946	$653,154.00	$451,344.50	$1,104,499	8.3%
MCG	$457,208	$195,946	$653,154.00	$770,979.84	$1,424,134	10.6%
Memorial	$457,208	$195,946	$653,154.00	$1,274,435.15	$1,927,589	14.4%
Total	**4,686,380**	**2,008,449**	**$6,694,828.50**	**$6,687,214.34**	**13,382,043**	**100.0%**

CY 2008 Data. CY 2009 data will drive FY 2012 funding

Georgia Trauma Commission FY 2012								
Office of EMS and Trauma Allocation								
ESTIMATED Budget Version # 4: 15 May 2011								**DRAFT**
Total Available for OEMS/T	**$ 499,707**	(3% of $17,656,896 = $527,707)						
Remaining:	**$ 499,707**							

As per OPB directions (Paula Brown 11 May 2011 email) re Operations and OEMST Funding plus the additional $1M is added for a total of $17,656,896:

	FY11 Base	Gov Rec Reduction	Gov FY12 Budget Rec
OEMS/T Allocation	667,230	(167,523)	499,707
Commission Operations	494,330	(49,433)	444,897
All Other Functions	21,079,440	(5,367,148)	15,712,292
Total State Funds	22,241,000	(5,584,104)	16,656,896

FY 2011 EMS Vehicle Equipment Replacemet Grant Award

DRAFT

Award Number	Organization	Zone/County	Score	Award in 2009?	Cleared?	DISQ Score
1	HEARTLAND EMS INC	Bleckley	205.56	yes	yes	
2	LUMPKIN COUNTY BOARD COMMISSIONERS	Lumpkin	186.14	no	yes	
3	WILKINSON COUNTY AMB. SER.	Wilkinson	177.96	yes	yes	
4	MCDUFFIE COUNTY EMS	McDuffie	176.72	no	yes	
5	WILKES COUNTY EMS	Wilkes	176.38	yes	yes	
6	EMANUEL CITY BOARD COMMISSIONERS	Emanuel	174.94	yes	yes	
7	HANCOCK COUNTY BOARD COMMISSIONERS	Hancock	172.12	yes	yes	
8	CANDLER COUNTY EMS	Candler	170.58	yes	yes	
9	PHOEBE WORTH MEDICAL CTR EMS	Worth	170.54	yes	yes	
10	SCREVEN COUNTY EMS	Screven	167.81	yes	yes	
11	ALMA BACON COUNTY AMB. SER.	Bacon	167.30	yes	yes	
12	TERRELL COUNTY EMS	Terrell	163.28	yes	yes	
13	BRANTLEY COUNTY EMS	Brantley	161.60	yes	yes	
14	WHITE COUNTY EMS	White	159.21	no		
15	CRISP CO. EMS	Crisp	158.75	yes	Yes	
16	DODGE COUNTY	Dodge	158.14	yes	yes	
17	IRWIN COUNTY EMS	Irwin	157.87	yes	yes	
18	GORDON COUNTY EMS	Gordon	153.69	no	yes	
19	DOOLY COUNTY EMS	Dooly	153.55	no	yes	
20	AMBUCARE, INC. #1	Haralson	153.05	no	yes	
21	GLYNN COUNTY	Glynn	151.97	no	yes	
22	JENKINS COUNTY EMS	Jenkins	148.18	yes	yes	
23	APPLING HEALTHCARE SYSTEM	Appling	147.81	yes	yes	
24	COMMISSIONER OF ROADS & REVENUE DAWSON CO.	Dawson	147.65	no	yes	
25	ATKINSON COUNTY EMS	Atkinson	145.00	yes	yes	
26	TOOMBS/MONTGOMERY EMS DBA	Montgomery	143.74	yes	yes	
27	MADISON COUNTY EMS	Madison	142.29	no	yes	
28	MITCHELL COUNTY EMS	Mitchell	140.85	yes	yes	
29	BEN HILL COUNTY EMS	Ben Hill	140.77	no	yes	
30	RABUN CO. EMS	Rabun	140.64	yes	yes	
31	WARREN COUNTY EMS	Warren	138.05	yes	yes	
32	SEMINOLE COUNTY EMS	Seminole	137.91	yes	yes	
33	OGLETHORPE COUNTY EMS	Oglethorpe	137.89	yes	yes	

34	Effingham County EMS	Effingham	135.95	no	yes	
35	Tift County EMS	Tift	135.85	no		
36	LINCOLN CO. BOARD COMMISSIONERS	Lincoln	135.68	yes	yes	
37	CLARK AMBULANCE SER.	Paulding	133.15	no	yes	
38	Washington County EMS	Washington	131.75	no	yes	
39	PUTNAM COUNTY EMS	Putnam	131.05	no	yes	
40	TAYLOR COUNTY EMS	Taylor	130.09	yes	yes	
41	CHARLTON COUNTY EMS	Charlton	128.68	yes	yes	
42	MCINTOSH COUNTY EMS	McIntosh	127.88	no	yes	
43	Ware County EMS	Ware	126.80	yes	yes	
44	ELBERT CO. EMS	Elbert	125.85	no	yes	
45	Colquitt County Board of Commissioners	Colquitt	125.25	no	yes	
46	BERRIEN COUNTY AMBULANCE SERVICE	Berrien	122.95	yes	yes	
47	STEPHENS COUNTY EMS	Stephens	122.78	no	yes	
48	AMBUCARE, INC. #3	Haralson	122.35	no	yes	
49	COWETA COUNTY EMS	Coweta	120.79	yes	yes	
50	AMBUCARE, INC. #2	Haralson	120.35	no	yes	
51	CHEROKEE COUNTY FIRE AND EMERGENCY SERVICES	Cherokee	118.86	no	yes	
52	Barrow County EMS	Barrow	118.60	no	yes	
53	HABERSHAM CO. EMS	Habersham	117.21	no	yes	
54	GRADY CO. EMS	Grady	115.16	no	yes	
55	MONROE CO EMS	Monroe	114.36	no	yes	
56	LAURENS COUNTY BOARD COMMISSIONERS	Laurens	113.15	no	yes	
57	WALTON COUNTY EMS	Walton	110.02	no	yes	
58	DOUGLAS CO. FIRE & EMER. SER.	Douglas	105.39	no	yes	
59	THOMAS CO. EMER. MED. SER.	Thomas	102.70	no	yes	
60	BARTOW CO. GOVERNMENT	Bartow	94.32	no	yes	
61	SPALDING REGIONAL MEDICAL CTR	Spalding	93.89	no	yes	
62	DOUGHERTY COUNTY EMS	Dougherty	83.40	no	yes	
63	WEST POINT FIRE DEPT.	Troup	79.52	no	yes	
64	FAYETTE COUNTY FIRE AND EMERGENCY SERVICES	Fayette	77.89	no	yes	
65	CLAYTON COUNTY FIRE & EMERGENCY SERVICES	Clayton	46.29	no	yes	
66	GRADY HEALTH SYSTEM AMB. SER.	Fulton	32.80	no	yes	
67	TATTNALL COUNTY EMS	Tattnall	0.00	yes	DISQ	148.54
68	WILCOX CO. BOARD COMMISSIONERS	Wilcox	0.00	yes	DISQ	177.98
69	PIERCE COUNTY EMS	Pierce	0.00	yes	DISQ	174.20

Georgia Trauma Registry Data, 2004-2009

First

Presentation to
Georgia Trauma Care Network Commission
May 19, 2011

Prepared by Rana Bayakly and Danlin Luo

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 2011

FY 2011

- Continuity of Operations Preparedness
- Customer Service
- Emergency Preparedness
- Financial & Program Integrity
- Health Care Consumerism
- Health Improvement
- Health Care Transformation
- Public Health
- Workforce Development

Georgia Trauma Registry

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

Analytical File

- Original File had 87,026 Observations (1997-2010)
- Records were removed from final analytical file for the following reasons:
  - Duplicate records (Hosp, MR, Injdate, ED arrival date, DOB and discharge date)
  - Records with "Complete Status" coded as "N", or "blank"
  - Records where Hospital Number was "0000000000"
  - Demo record

Editing Process

- Remove Records where DOB and Date of Hospital Admission were the same
- Remove Records where DOB was after the Date of Hospital Admission

• Recode records of patients who were admitted to the ER, with “0” hour for length of stay and discharge status is coded dead
  - Recode to Dead on Arrival (DOA)

Trauma Cases By Year

Avg:11,501

Major Hosp Dropped

Hospital Added

Data Standard/
Software issues

Incomp YR

Number of Observations

Year	Cases
2002	591
2003	9670
2004	10686
2005	11946
2006	12898
2007	11916
2008	10546
2009	11016
2010	4552

Trauma cases as reported by the16 designated trauma centers in Georgia

Georgia Roadway Fatalities & Fatality Rates (Per 100 Million Vehicle Miles Traveled)

Total Fatalities
Total Rate

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total Rate	1.72	1.74	1.76	1.69	1.63	1.52	1.47	1.53	1.41	1.47	1.44	1.52	1.49	1.46	1.37

2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0

1.80
1.70
1.60
1.50
1.40
1.30
1.20
1.10
1.00

Trauma Cases by Hospital, 2009

Number of Cases

Hospital	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Cases	2597	1531	1405	1022	908	762	679	525	372	314	285	278	147	133	40	18

Level I

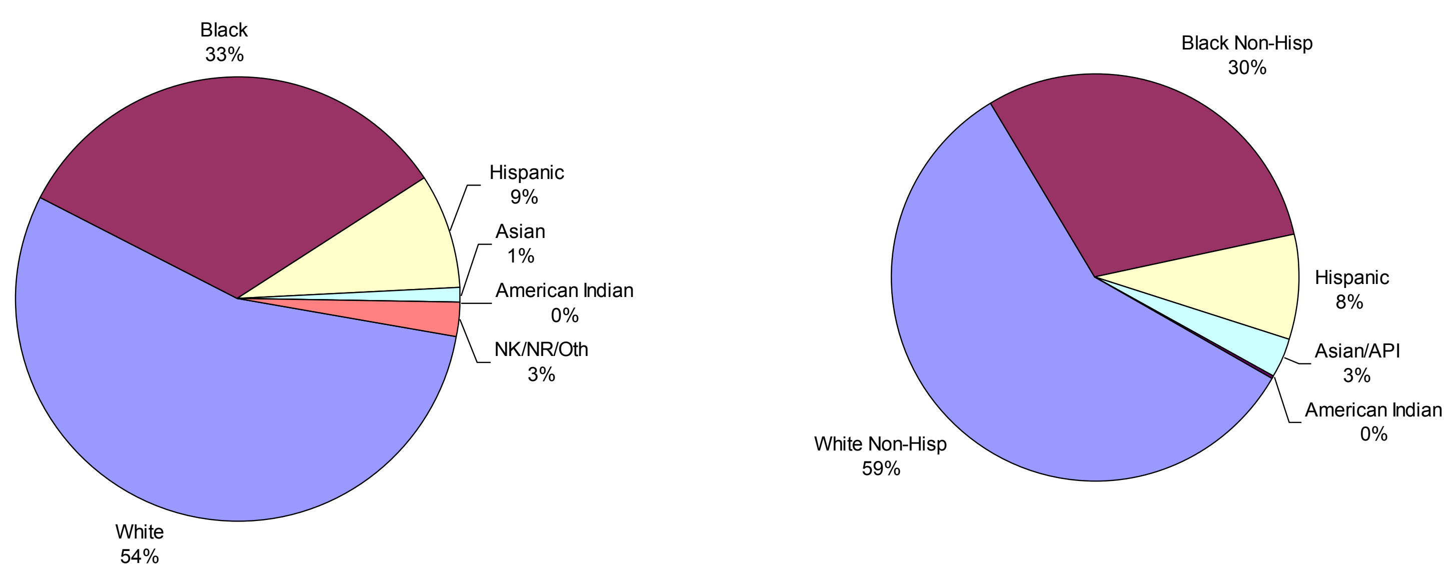
Level II

Level III

Level IV

Trauma cases as reported by the16 designated trauma centers in Georgia

Trauma Cases by Race, 2004-2009



Trauma cases as reported by the16 designated trauma centers in Georgia

2004-2009 INCIDENTS BY AGE AND GENDER

INCIDENTS

1400
1200
1000
800
600
400
200
0

1 5 9 13 17 21 25 29 33 37 41 45 49 53 57 61 65 69 73 77 81 85

AGE

FEMALE MALE

Trauma cases as reported by the16 designated trauma centers in Georgia

Trauma Cases by Age-Group, 2004-2009

Frequency

12000
10000
8000
6000
4000
2000
0

<1 | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | 85+ | NK/NR

Figure 9: Motor Vehicle Fatalities by Age

250
200
150
100
50
0

<5 | 5-9 | 10-15 | 16-20 | 21-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | >74 | Unknown

Figure 9 Source: 2009 Georgia Motor Vehicle Fatality Report Preliminary Report Draft , May 12, 2010 Accessed May 10, 2011

Trauma cases as reported by the16 designated trauma centers in Georgia

Trauma Death by Age-Group, 2004-2009

Frequency

900
800
700
600
500
400
300
200
100
0

<1 | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | 85+ | NK/NR

Trauma cases as reported by the16 designated trauma centers in Georgia

Case Fatality Rate by Sex and Age-group, 2004-2009

All Female Male

Fatality Rate Per 100

25
20
15
10
5
0

<1 1-4 5-9 10-14 15-19 20-24 25-34 35-44 45-54 55-64 65-74 75-84 85+

Age Group

Trauma cases as reported by the16 designated trauma centers in Georgia

2004-2009 INCIDENTS BY AGE AND RACE

INCIDENTS

800
700
600
500
400
300
200
100
0

1 6 11 16 21 26 31 36 41 46 51 56 61 66 71 76 81 86

AGE

Black
Hispanic
White

Trauma cases as reported by the16 designated trauma centers in Georgia

2004-2009 CASE FATALITY RATE BY RACE AND GENDER

CASE FATALITY RATE %

12.00
10.00
8.00
6.00
4.00
2.00
0.00

White
Black
Hispanic
Asian
American Indian
NK/NR

FEMALE
MALE

RACE AND GENDER

Trauma cases as reported by the16 designated trauma centers in Georgia

MECHANISM	All Males	%	White	%	Rank	Black	%	Rank	Hisp	%	Rank
MOTOR VEHICLE TRAFFIC	20303	43.0	11356	47.2	1	6443	38.5	1	1817	37.9	1
FALL	9934	21.1	5907	24.6	2	2357	14.1	3	1267	26.4	2
FIREARM	5075	10.8	1028	4.3	5	3472	20.7	2	423	8.8	3
STRUCK BY, AGAINST	3499	7.4	1402	5.8	4	1584	9.5	4	381	7.9	4
CUT/PIERCE	2225	4.7	605	2.5	6	1181	7.0	5	377	7.9	4
TRANSPORT, OTHER	**2149**	**4.6**	**1748**	**7.3**	**3**	**298**	**1.8**		**64**	**1.3**	
UNSPECIFIED	1011	2.1	335	1.4		555	3.3	6	104	2.2	6
PEDAL CYCLIST, OTHER	752	1.6	437	1.8		213	1.3		65	1.4	
MACHINERY	**702**	**1.5**	**357**	**1.5**		**177**	**1.1**		**149**	**3.1**	**5**
OTHER SPECIFIED & CLASSIFIABLE	690	1.5	334	1.4		231	1.4		91	1.9	
NATURAL/ENVIRONMENTAL	294	0.6	221	0.9		46	0.3		22	0.5	
OTHER SPECIFIED, NOT ELSEWHERE CLASSIFIABLE	213	0.5	105	0.4		82	0.5		21	0.4	
PEDESTRIAN, OTHER	161	0.3	81	0.3		63	0.4		12	0.3	
OVEREXERTION	71	0.2	48	0.2		19	0.1		2	0.0	
FIRE/BURN	45	0.1	29	0.1		12	0.1		4	0.1	
SUFFOCATION	40	0.1	27	0.1		10	0.1		1	0.0	
DROWNING/SUBMERSION	16	0.0	11	0.0		4	0.0		0	0.0	
POISONING	9	0.0	4	0.0		5	0.0		0	0.0	
TOTAL	47189	100.0	24,035	100.0		16,752	100.0		4800	100.0	

Trauma cases as reported by the16 designated trauma centers in Georgia

Georgia Department of Community Health

Table Summary, Males

- Overall Motor Vehicle, Falls, and Firearem contribute to 75% of all trauma cases reported to the Trauma registry among males.
  - 76% among white males
  - 73% among black males
  - 73% among hispanic males

MECHANISM	All Female	%	White	%	Rank	Black	%	Rank	Hisp	%	Rank
MOTOR VEHICLE TRAFFIC	11481	53.0	6810	50.1	1	3693	59.4	1	549	50.7	1
FALL	6472	29.9	4681	34.4	2	1212	19.5	2	326	30.1	2
TRANSPORT, OTHER	891	4.1	779	5.7	3	69	1.1	8	18	1.7	8
STRUCK BY, AGAINST	680	3.1	338	2.5	4	272	4.4	4	38	3.5	3
FIREARM	611	2.8	192	1.4	5	371	6.0	3	31	2.9	5
CUT/PIERCE	**389**	**1.8**	**124**		**0.9**	**224**	**3.6**	**5**	**24**		**2.2**
UNSPECIFIED	234	1.1	99		0.7	110		1.8	16		1.5
PEDAL CYCLIST, OTHER	236	1.1	144		1.1	57		0.9	21		1.9
OTHER SPECIFIED & CLASSIFIABLE	**241**	**1.1**	**113**		**0.8**	**86**		**1.4**	**33**	**3.0**	**4**
NATURAL/ENVIRONMENTAL	219	1.0	164		1.2	37		0.6	6		0.6
MACHINERY	69	0.3	32		0.2	20		0.3	12		1.1
PEDESTRIAN, OTHER	65	0.3	44		0.3	17		0.3	1		0.1
OVEREXERTION	35	0.2	25		0.2	5		0.1	2		0.2
FIRE/BURN	23	0.1	8		0.1	10		0.2	4		0.4
SUFFOCATION	6	0.0	1		0.0	1		0.0	1		0.1
DROWNING/SUBMERSION	5	0.0	4		0.0	0		0.0	0		0.0
POISONING	2	0.0	2		0.0	0		0.0	0		0.0
TOTAL	21659	100.0	13,597		100.0	6,214		100.0	1082		100.0

Trauma cases as reported by the16 designated trauma centers in Georgia

Table Summary, Females

- Overall Motor Vehicle, Falls, and Other Transport contribute to 87% of all trauma cases reported to the Trauma registry among females.
  - 90% among white females
  - 80% among black females
  - 83% among hispanic females

2004-2009 FATALITY RATE BY MECHANISM AND GENDER

FATALITY RATE %

25.00
20.00
15.00
10.00
5.00
0.00

MOTOR VEHICLE TRAFFIC
FALL
FIREARM
STRUCK BY, AGAINST
TRANSPORT, OTHER
CUT/PIERCE

MECHANISM

FEMALE MALE

Trauma cases as reported by the16 designated trauma centers in Georgia

Leading Causes of Trauma by Age-group, 2004-2009

Number of Trauma Cases Reported

7000
6000
5000
4000
3000
2000
1000
0

Fall
Motor Vehicle
Other Transport

<1 1-4 5-9 10-14 15-19 20-24 25-34 35-44 45-54 55-64 65-74 75-84 >=85 NK/NR

Figure 9: Motor Vehicle Fatalities by Age

250
200
150
100
50
0

<5 5-9 10-15 16-20 21-24 25-34 35-44 45-54 55-64 65-74 >74 Unknown

Figure 9 Source: 2009 Georgia Motor Vehicle Fatality Report Preliminary Report Draft , May 12, 2010 Accessed May 10, 2011

Trauma cases as reported by the16 designated trauma centers in Georgia

Leading Causes of Trauma by Age-group, 2004-2009

Number of Trauma Cases Reported

1800
1600
1400
1200
1000
800
600
400
200
0

<1 | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75-84 | >=85 | NK/NR

Fire Arm
Cut/Pierce
Struckby/Against

Trauma cases as reported by the16 designated trauma centers in Georgia

Future Enhancement

- County level analysis
- Safety
  - Location, seat belt use, helmet use etc..
- Linkages
  - EMS
    - Street Address where injury occurred
  - Georgia Violent Death Reporting System
    - Learn about circumstances of the intentional injury
    - Add demographic information
- Hospital Discharge Analysis
- Investigating GA cases going out of state

Georgia Trauma Registry

Questions

Division 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

Optimal Care Delivery
Transforming the Trauma System

Eva K. Lee, PhD
Director, Center for Operations Research in Medicine and HealthCare
Co-Director, NSF I/UCRC Center for Health Organization Transformation
Senior Health Systems Professor, US Department of Veterans Affairs
Professor, Industrial & Systems Engineering, Georgia Institute of Technology

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Outline of Presentation

- Introduction
- Project purpose/goals
- List of Year 1 milestones
- Year 2 proposed work
- Concluding remarks

Transforming Care Delivery

Some projects we have carried out

- Practice variance reduction
- ED optimal clinical and patient workflow
- Systems advances and critical care transformation
- Advancing public health, medical preparedness and emergency response
- **Transforming the trauma care system**

Transforming the Trauma System

Trauma and EMS Systems

US Trauma Centers (TCs)

- Hospitals with ability to **immediately** care for severely injured patients. Requirements:
  - Resources
  - Equipment
  - Specialized personnel
- Four tier classification (I – IV)
  - Level I – provides the highest level of trauma care
  - Level IV – can provide preliminary care and transport the patient to a higher level trauma center as needed
  - All trauma centers and hospitals at every level are vital components of the trauma system.

Trauma and EMS Systems

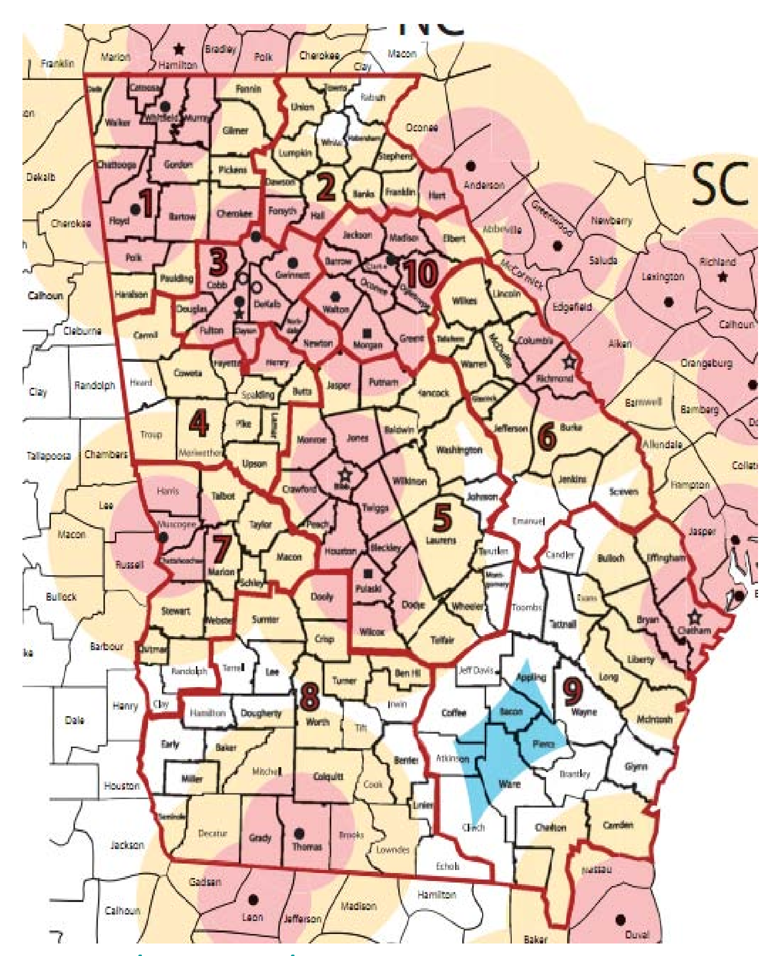
- CDC-supported research shows a 25% reduction in deaths for severely injured patients who receive care at a Level I trauma center rather than at a non-trauma center.
- Rapid transportation of trauma patients to the most suitable hospital for treatment is critical to reduce the risk of mortality and permanent injuries.
- Georgia has 17 trauma centers. (4 Level I, 10 Level II, 1 Level III and 2 Level IV)

Source: http://www.cdc.gov/traumacare/access_trauma.html

EMS System in Georgia

Statewide EMS System in Georgia

- Georgia has 10 EMS Regions.
- Georgia Department of Community Health Emergency Medical Services (EMS) Trauma Section
  - Regional planning, expansion and improvement of each Region
  - Region-wide medical control of EMS system.
  - Integrated EMS Information System



Source: http://ems.ga.gov/.http://www.georgiatraumacommission.org/uploads/2011GATraumaMapsm1.pdf

EMS System in Georgia

- EMS firm has its own territory for serving patients.
- An ambulance cannot serve patients in other territories if the patient calls to 911.
- Patient may call an ambulance from another territory's EMS provider.
- Ambulances are split into teams by quadrant. Their positions are fixed.
- Ambulance in quadrant where incident occurred is dispatched (even if there is a closer ambulance in a different quadrant)
- Allows each team to learn its quadrant

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EMS System in Georgia

- Patient chooses desired hospital
- If patient's choice of hospital is not within reasonable distance, EMT determines hospital
- If patient is unable to choose, EMT makes choice based on patient's medical condition and/or:
  - (1) Trauma related emergency
  - (2) Resources at the local and surrounding facilities
  - (3) Geographic location of the various facilities
  - (4) Ambulance service resources
  - (5) Obligation to provide emergency services in the assigned ambulance zone
  - (6) Availability of mutual aid

Limitations and Opportunities

Challenges

- Poor EMS coordination across county lines
- Closest ambulance to incident not always dispatched
- Can prove to be costly
  - Traveling farther distances
  - Not going to optimal hospital/trauma center
- Lack of interstate communication and transportation

Opportunities

- Explore different operating modes to improve quality of service
- Develop best use of grants from GTCNC:
  - EMS vehicle replacement; trauma care supplies; first responder training programs; Regional pilot projects;..

What modes? How to invest?

Best Practice EMS Models

- Using 'mobile' telemedicine in ambulances.(e.g. Cincinnati Children's Hospital Medical Center)
- Building trauma communication system (e.g. Alabama trauma communications system helps to reduce trauma death rates by 12%)
- Trauma center destination recommendation (e.g. Kansas City EMS arranges the ambulance diversions)
- Regionalization strategy
- **Systems approach: information-decision support**

Source: http://www.marc.org/emergency/pdfs/diversionplan.pdf
http://www.georgiatraumacommission.org/uploads/Deveopment_of_a_Statewide_Trauma_System.pdf

Strategic EMS Funding Plan

- Local trauma advisors at each Region identify needs.
- $10.5 million allocated to trauma in FY2011
- Grants to EMS providers to replace equipment, etc.
- *With limited financial resource, how should policy makers determine what investment is the best?*
- Allocate resources such that facility/equipment utilization and patient outcome will be maximized, and that the process is fair.

Source: http://www.georgiatraumacommission.org/uploads/167205162State_of_Georgia_Budget_FY2012.pdf

Project Focus and Objectives

Advance Georgia trauma response system through

- Systems analysis of the statewide performance
- Decision engines that allow for
    - Analysis of portfolio of investment/expansions that best serve the Regional and statewide needs
    - Cost-effectiveness analysis of statewide response that equalizes TC utilization and optimizes patient outcome.
- Empower GTCNC and GA State/Local leaders to make better decisions/investment for statewide advances
- Provide objective information to local decision makers
- Facilitate integration of intra- and inter-state communication system (operational, strategic, and policy).

Technological Advances

I. Service-Investment Analyzer: analysis of portfolio of investment that best serve the State & Regional needs

- Can accept multiple Regional proposals for input
  - e.g. Facility upgrade, equipment, labor, training, injury prevention program,…
- Determine the best combination of upgrades and/or investment that maximize the *overall statewide and Regional* response and treatment outcome.

Empower leaders to determine best investment of their limited financial resources for optimal return

Technological Advances

II. System Simulator: cost-effectiveness analysis of statewide development that equalizes trauma care utilization and optimizes patient outcome.

- ***Systems approach:*** Can simulate yearly trauma cases and subsequent response across the entire state
- One goal: determine strategies that maximize Regional/State coverage and optimize outcome
- Some features: Determine and analyze
  - Comparison of methods for emergency responder allocation
  - methods to pre-position and assign emergency vehicles
  - utilization of each trauma centers
  - needs of patients (ensure level 1 trauma center not overwhelmed with patients that can be handled by other facilities)
  - Proactive injury-prevention programs

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Two Decision Scenarios

- Case 1: Use of service-investment analyzer
  - Show how policy makers can make objective investment out of a set of Regional requests:
    - A site upgrade to a trauma center
    - An injury preventive plan
    - Upgrade of equipment, addition of a new ambulance, etc
- Case 2: Use of system simulator
  - Contrast the results from current system versus system with new investment
  - Contrast results when ambulances can cross county lines and pre-position (outside current sites)

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Service-Investment Analyzer

- ***Input:*** Trauma cases across counties; all hospitals and EMS providers are involved; a trauma patient can only be sent to a center of equivalent level.
- ***Investment of services***: Request facility (new/upgrade), equipment, labor, injury preventive programs etc.
- ***Objectives:*** Choose a set of new services (along with existing ones) that maximize acceptable response performance, minimize transportation time, and minimize injury incidents.
- ***Systems analysis:*** Multiple stochastic scenarios are performed.
- ***Modeling to recommend the best utilization of resources***

Results are then fed into the System Simulator for overall statewide performance analysis

Hospitals Upgrade to Trauma Centers

- : Potential TC's
- : Existing Level I TC
- : Existing Level II TC
- : Existing Level III TC
- : Existing Level IV TC
- : Existing Pediatric TC

- Some potential sites are relatively close to existing trauma centers.
- 3 potential sites are located at southwestern part of the state.

Trauma System Simulator

Allows for systems modeling and large-scale simulation for comparative analysis (current practice versus alternative strategies)

- ***Input:*** responder allocation scheme, methods for assigning emergency vehicles, capacity and utilization of each trauma center, methods for assigning hospitals, real-time traffic conditions, etc.
- ***Output:*** Various outcome metrics, including distributions for response and wait times, ambulance utilization, facility utilization, *quality of outcome*, ...
- ***Systems analysis:*** can simulate rapidly for an entire year (or multiple years) of trauma incidents, allows decision makers to observe year-long performance and response patterns.
- ***Identify best statewide strategies:*** Tradeoffs and best methods for emergency responder allocation, emergency vehicles assignment, TC assignment, resource sharing, etc.

Empower leaders to determine the best strategies for trauma care practice (transforming organizational practice)

Results

Systems	Average (Max) time spent /patient before arrival to hospital	Average Ambulance service time / incident	Comments
Current System	77 minutes 101 minutes	132 minutes	
Change: Upgrade 1 hospital to TC II, add an ambulance to a TC.	-5.5% -8.3%	-7.6%	Have different effect, depending on where these investments are made.
Change: Remove county restrictions, pre-position ambulances (instead of current practice)	-11.2% -16.1%	-17.3%	Strategic change, minimal investment on resources

Illustrates three simple metrics, need guidance in terms of performance metrics

Year 1 Deliverables

- Study of current Georgia EMS and trauma system
- Evaluation of statewide trauma care strategic plans of several states (identify best practice).
- Systems modeling and development of decision engines
  - Service-investment analyzer
  - System simulator
- Comparison of multiple scenarios

What the system can do now

- Service-investment analyzer
  - Can be used to advise policy makers on investment for objective and system-wide selection (macro and economic decision analysis)
- System simulator
  - Allow evaluation of statewide trauma care strategic plans
  - Can benefit from next phase data collection

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Service-Investment Analyzer

- Not all hospitals have the commitment, capacity and equipment to become a trauma center.
- *Use recommendations from Regional advisors' plans as input.*
- Current analysis assigns patients to only equivalent level trauma center. A different setting can be experimented.

Objective goal-driven systems approach for policy making and resource investment

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Trauma System Simulator

- Incorporate detail Georgia trauma Injury data (through the leadership and collaboration with the Injury Epidemiology Section at GA Department of Community Health Division of Public Health). *Urban vs Rural*
- Incorporate real-time utilization and capacities of each trauma site (through the leadership of GTCNC and the on-going design of the trauma/EMS communication system by SAAB).
- Identify injury–prevention programs for trauma incidents

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Year 2 Proposed Work

- Work with GTCNC leaders to review Regional recommendations and perform analysis of cost-effective and return on investment. (The system is ready now for such analysis)
- Work with Injury Epidemiology Section at GA Department of Community Health Division of Public Health to incorporate detail data on injury cases.
- Work with GTCNC on incorporating communications center within our system model analysis (our system can accept real-time information from hospitals for decision analysis)

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Concluding Remarks

- Systems modeling and simulation analysis of the statewide trauma care is critical for *measuring, optimizing, and transforming the systems performance.*
- *Dynamic* decision engines can allow for objective
  - Analysis of service investment that best serve the Regional and statewide needs
  - Cost-effectiveness analysis of statewide response that equalizes TC utilization and optimizes patient outcome.
- GTCNC and GA State/Local Department leaders can make better financial and policy decisions for statewide advances

Questions?

THANK YOU

Evaluation of statewide trauma care strategic plans states

State	Training	Equipment	Medical Direction	Legislation	State Funding
Connecticut	Courses developed and approved by state. Certification, testing, and instruction through state	State inspects vehicles and equipment	State Medical Director advises Medical Directors in hospitals	Governs EMS organizations, provides direction on grants, sets up state trauma system	State funded $1.2 M in 2006, grants of approx. $8.4 M
Delaware	ALS training though Community Colleges & BLS training through State Fire School	State Fire Prevention Commission oversees BLS equipment & apparatus. State EMS Office does same for ALS	Each ALS agency is assigned a Medical Director by the State	Set up as part of Health & Social Service but EMS Oversight Council makes recommendations to Safety & Homeland Security	State provided in excess of $30 M to EMS care in 2005
Maryland	State has 21 certified providers of ALS education, 3 BLS, and 15 for refresher programs.	State inspects and licenses commercial ambulances. No one inspects fire service EMS vehicles	Each region has appointed a Medical Director. Online medical direction is available 24/7	1993 Maryland EMS Law shaped existing structure; has been modified over the years to improve EMS delivery	State provided $10.8 M
Ohio	State certifies instructors and handles accreditation of training facilities. Also oversees state, local, and private firefighter and instructor programs	State provides standards for apparatus and equipment; localities are responsible for compliance	State Medical Director works with Regional Physicians Advisory Board to develop protocols and minimum standards	State Administrative Code 4765 defines purpose, scope, and organization of the agency	State funds $3.2 M, Federal funds $5.9 M. Other grants $9.3 M. Seatbelt fines $5 M
Virginia	State accredits training programs. Training available through state, regional councils, & private entities	All vehicles providing EMS are certified by State	Each EMS agency is responsible for hiring a Medical Director.	EMS is a part of Health Department, as is Emergency Preparedness & Response; separate from Fire Programs	State OEMS received $2.5 M in FY2007, each of 11 regional councils unequally divided $2.9 based on services provided.
New Jersey	State accredits training programs. Training available through various organizations. ALS training at four community colleges	All ALS and licensed BLS vehicles are certified by the state. Equipment for ALS specified in regulations.	Commissioner of Health is responsible for EMS. No specific state EMS medical director. ALS programs and licensed BLS programs have medical directors	State Legislation and Regulations govern administrative and operational regulations	State receives funding from Treasury, UASI and other federal monies. Funding for BLS training from traffic citations (indirect)