Minutes approved 15 March 2012

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

ANNUAL WORKSHOP
MEETING MINUTES

Thursday – Friday, January 26 & 27, 2012

Day One Scheduled: 08:00 am until 05:00 pm

Stuenkel Conference Center
Floyd Medical Center
304 Turner McCall Boulevard
Rome, Georgia 30165

DAY ONE: 26 January 2012

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

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Administration	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
John Cannady, TCC Coordinator	Georgia Trauma Care Network Commission
Michelle Martin, TCC Operations Assistant	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Alex Sponseller	Assistant Attorney General
Lawanna Mercer-Cobb	GPT
Gina Solomon	Hamilton Medical Center
Keith Wages	OEMS
Russ McGee	Region 5 OEMS/T
Renee Morgan	OEMS/T
Lee Oliver	MCCG
Laura Garlow	Wellstar Kennestone Hospital
Fran Lewis	Grady
Pat O'Neal	DPH/OEMS/T
Susan Bennett	JMS Burn Centers, Inc.
Lee Oliver	MCG
Courtney Terwilliger	GAEMS

Quorum established
Dr. Dennis Ashley established quorum.

Staff Performance Review

Ms. Linda Cole stated that she has completed the evaluation on Mr. Jim Pettyjohn and it was sent out to the Commission members for comments. Ms. Cole has received those comments back and will hand them over to Dr. Ashley. Dr. Ashley will set up and appointment with Mr. Pettyjohn to discuss the evaluation personally.

Dr. Ashley asks that Mr. Jim Pettyjohn and Ms. Lauren Noethen step out of the room so the Commission members can discuss the comments that were received by Ms. Cole.

MOTION GTCNC 2012-01-01:
I move that the open meeting of the Georgia Trauma Commission be closed to the public for the scheduled Staff Performance Review.

MOTION BY: **Dr. Fred Mullins**
SECOND BY: **Dr. Robert Cowles**

The open meeting of the Georgia Trauma Commission was closed to the public at 8:15 a.m., pursuant to the provisions of Chapter 14 of Title 50 of the Official Code of Georgia Annotated *(Chapter 14 of Title 50 of the Official Code of Georgia attached to the meeting minutes)*.

MOTION GTCNC 2012-01-02:
I move that the closed meeting of the Georgia Trauma Commission be opened to the public.

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

The closed meeting of the Georgia Trauma Commission was opened to the public at 9:05 a.m.

CALL TO ORDER

Dr. Dennis Ashley, Chair, called the scheduled Annual Workshop meeting of the Georgia Trauma Care Network Commission to order at 9:35.

Dr. Ashley stated that just to be official the Commission meeting is back in open session now. We were closed this morning for the staff evaluations. We will now move into the Strategic Planning part of the meeting.

WELCOME, INTRODUCTIONS AND CHAIRMAN'S REPORT
Dr. Dennis Ashley thanks Mr. Kurt Stuenkel for allowing the Commission to use his facility.

Dr. Dennis Ashley introduces Ms. Carol Pierce who is a Public Health Consultant. Dr. Ashley stated that last year the Commission did Strategic Planning and this year we are going to facilitate so that the Commission can have an organized discussion and come up with goals. We are going to discuss where we are now and what goals are reasonable. Dr. Ashley turns the meeting over to Ms. Carol Pierce who will guide us through this discussion.

Strategic Planning

Ms. Carol Pierce stated that she is a nurse by background and has spent about ten years in the private sector working with the healthcare system in New Mexico as a Clinician in the urgent care field, another decade working in public health, another decade helping organizations realize their visions and what they want to accomplish. Ms. Pierce stated that she is a neutral facilitator that is here to help move things forward and she has a passion for public health, in prevention and with helping populations in states have the healthiest people they can. Ms. Pierce thanks everyone for the opportunity to create a robust conversation and stated that at the end of the day what she wants to accomplish is to advance the vision for a comprehensive trauma system in Georgia. *(A COMPREHENSIVE TRAUMA SYSTEM FOR GEORGIA 2011-14 Strategic Plan Summary included in the Annual Workshop binder)* and *(The State of Trauma: Chairman's' Annual Report January 2012 Public Service for Georgians February 2009 included in the Annual Workshop binder.)*

Ms. Pierce stated that based on the feedback she received from folks that reviewed the Summary document, *(SUMMARY ACCOMPLISHMENTS AND GAPS UPDATE AMERICAN COLLEGE OF SURGEONS TRAUMA SYSTEM CONSULTATION RECOMMENDATIONS FOR GEORGIA: January 2009 & Our Emerging Vision: A new Public Service for Georgians February 2009 included in the Annual Workshop binder)* and given what the ACS says in terms of what are priorities are to move a system forward, Ms. Pierce picked ten priority areas to discuss today. From the **Trauma System Assessment** (**1**) Indicators as a Tool for System Assessment. From **Trauma System Policy Development** (**2**) Statutory Authority and Administrative Rules**,** (**3**) System Leadership, (**4**) Lead Agency and Human Resources Within the Lead Agency, (**5**) Trauma System Plan, and (**6**) Financing. From **Trauma System Assurance** (**7**) Emergency Medical Services, (**8**) Definitive Care Facilities, (**9**) System-Wide Evaluation and Quality Assurance (**10**) Research. Ms. Pierce stated that those that were left off were not left off because they were not important, or shouldn't be included, but we had to start somewhere. Ms. Pierce also recommended, **Proposed Criteria for Actions**, (**1**) Does the action support role clarification among trauma system leaders and organizations?, (**2**) Does the action promote collaboration and partnership?, (**3**) Does the action promote optimal outcomes for the seriously injured?, (**4**) Does the action provide evidence for a return on investment.

Dr. Ashley stated that if he understanding the process correctly this will be the rules of engagement and the scorecard as we discuss each item. Then we will assign each point of discussion some kind of quality based on the four scoring systems.

Ms. Pierce describes the process she is proposing for the discussion: **1.** Ms. Pierce will pause for a few minutes to give folks a chance to review the information contained in each priority area 1-10, **2.** Pause and give people a chance to review the successes, **3.** Give folks a chance to ask for clarification about the gaps and recommendations, **4.** Add other gaps and recommendations. **5.** Recommend an action using the criteria, which goes back to Dr. Dennis Ashley's clarification.

Ms. Pierce stated that she would write up this meeting and work with Mr. Pettyjohn to make sure that everything is captured. Ms. Pierce will be presenting the results to the Commission at the March meeting.

Dr. Ashley stated that the meeting today was just the beginning. He has learned from previous experiences that things can get pushed to the side. This presentation will be put into a message format where it can be reviewed. We will then start assigning projects and moving forward.

Next meeting: Tomorrow January 27, 2012 at 10:00 am

Meeting Adjourned: 5:50 pm

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

ANNUAL WORKSHOP
MEETING MINUTES

Thursday – Friday, January 26 & 27, 2012

Day Two Scheduled 08:00 am until 4:00 pm
Stuenkel Conference Center
Floyd Medical Center
304 Turner McCall Boulevard
Rome, Georgia 30165

DAY TW0: 27 January 2012

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

STAFF MEMBERS SIGNING IN	REPRESENTING
Jim Pettyjohn, Executive Director	Georgia Trauma Care Network Commission
Lauren Noethen, Administration	Georgia Trauma Care Network Commission
Judy Geiger, Business Operations Officer	Georgia Trauma Care Network Commission
John Cannady, TCC Coordinator	Georgia Trauma Care Network Commission
Michelle Martin, TCC Operations Assistant	Georgia Trauma Care Network Commission

OTHERS SIGNING IN	REPRESENTING
Laura Garlow	Wellstar Kennestone Hospital
Fran Lewis	Grady
Rana Bayakley	GDPH
Linda Capewell	GDPH
Danlin Luo	GDPH
Jim Sargent	North Fulton Hospital
Scott Sherrill	GTRI
Scott Maxwell	Doctors Hospital

Quorum established
Dr. Dennis Ashley establishes quorum.

APPROVAL OF THE MINUTES OF THE 17 November 2011 MEETING

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

MOTION GTCNC 2012-01-01:
I move that the minutes of the 17 November 2011 meeting of the Georgia Trauma Care Network Commission distributed and presented here today to be approved.

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

DISCUSSION: None

Motion has been copied below:

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

FY 2012 Budget Discussion

Ms. Judy Geiger goes over the Georgia Trauma Commission Proposed FY 2012 Amended Budget document. *(Proposed FY 2012 Amended Budget pages 52-64 included in the Workshop binder)*. Ms. Geiger started with page 52 the Trauma General Fund Allocations, which is an overview of the Commissions budget from day one. The Commission started off with 20 million. In the original legislation there was 2.5 million ARRA funding (American Recovery and Reinvestment Act) and we discovered we could not use that and it was immediately removed from the budget. That left us with 17.6 million. In August the governor requested that each state agency propose a 2% reduction, which was $353,000. That left us with 17.3 million. In January the governor came out with his proposed amended 2012 budget and instead of giving us a 2% cut, he directly tied our budget to revenue collections, which reduced our budget by 1.7 million, which amounts to about a 10% cut. The Trauma Commission had already approved the August 2% reductions, so we went from that and did a hard budget review, of which the whole staff participated in. We took expenditures from 12/31 and projected out what we expected to spend for the next six months, until June 30th, which is the end of the state fiscal year. We added those two amounts together and that became the new proposed budget.

Ms. Geiger stated that under Commission Operations budget on page 53 you will see that the employer's share of health insurance increased from 27.63% to 34% effective January 1st and that is basically why the budget increased in this case, because we have to cover salaries and fringe benefits. The Department of Community Health negotiates the rates in the State Benefit Plan and every state agency ends up getting hit with this.

Ms. Geiger stated page 54 is Trauma Communications Center Operations, the Commission was able to take a considerable amount more out of that budget. There were some things that were paid through contracts that were extended through June 30th. GTRI had enough funding to carry them through FY 2012, and that helped us a great deal.

Ms. Geiger stated page 55, is System Development, Access and Accountability at the beginning of the year we had projected spending an additional $100,000, but they have enough money left over from their FY 2011 funding, and that was a huge savings. We do not project any additional costs on contracts in that budget, so we took that amount out.

Mr. Ben Hinson wanted to know if money was left over because the cost of the ambulances was lower than anticipated?

Ms. Geiger stated it is because they had not completed all the deliverables in the contract, and the $100,000 was an estimate at the beginning of the year as to what their needs would be.

Mr. Jim Pettyjohn stated that in August we did not have the strong leadership at the TCC that we have now and it was anticipated that we might need to lean on GTRI for some additional work. We do not need to do that now. Mr. Scott Sherrill continues to work with us based on funding from the FY 2011 contract, of which we were able to extend and so we should be fine throughout the remainder of the year.

Ms. Geiger moves onto EMS Allocations page 56. Ms. Geiger stated that the EMS Subcommittee would still need to review their total budget and come up with the line items and approve them. We basically took the August budget and gave you a handout that was not included in the book, to show you a comparison of where we started in the August 2011 Approved budget and then where we ended up, and the changes in the January proposed *(Comparison of Approved August Budget with 2% Reduction & Proposed January Budget EMS attached to the minutes)*.

Mr. Bill Moore wants to know if we have allotted the EMS Vehicle Replacement dollars yet and if that money must be spent by June 30th.

Mr. Pettyjohn stated that we have to award the grants by June 30, 2012. The application process took place and was closed December 2011. The Scoring Committee, which includes Mr. Keith Wages, Lauren Noethen and myself, will meet and do the final scoring. The subcommittee chair will submit recommendations to the full Trauma Commission for consideration during the March 15, 2012 Trauma Commission meeting.

Ms. Geiger moves onto Office of EMS and Trauma Allocations page 57, and stated that we do not recommend any additional cuts other than the 2%, which still puts them at the 3% mandate of the budget.

Mr. Hinson makes a clarification that the mandate is 2%, and it is funded up to 3%.

Ms. Geiger moves onto Trauma Center Physician Allocation page 58, which shows the 20%, and 80% split on the stakeholders funding. This shows the breakout of the 75% that goes to the hospitals, and the 25% that goes to the physicians, in both readiness payments and uninsured patient care payments.

Ms. Geiger stated that on page 59 you will find the Trauma Center Readiness and Performance Based Payments for each of the Trauma Centers, and page 60 reflects the adjusted numbers from the audit that GHI did.

Mr. Pettyjohn stated that the red numbers on page 60 in the ISS buckets reflect the results of the audit.

Ms. Geiger stated that on page 61 is the Trauma Fund Trauma Center Allocations for Readiness, Performance Based and Uninsured Patient payments, and the breakdown of what each center receives. On Page 62 you will find the Trauma Registry Fund, and the details behind that. Then page 63 kind of summarizes everything. The total for each center in the right hand column is the amended contract amounts for each of the centers. Ms. Geiger stated that it is important to note that we did not cut any of the regionalization funding's that go to the pilot program. Ms. Geiger stated that page 64 is basically the details of the deliverables for each of the trauma center's contracts. Where you see the X that is a deliverable in the contract.

Mr. Moore wants to know what regionalization funding's are.

Mr. Pettyjohn explains what the Regionalization funding's are that go to the pilot program, stating that last year in 2011 MCG, and MCCG both received $75,000 in their Readiness and Uncompensated Care contract which was a carved out deliverable for them to do work with their EMS regions to develop the RTAC. This

year they received $20,000 dollars a piece in sustainment funding. Also this year EMS region 9 through Savannah received $75,000 dollars for that as well. That $75,000, and 20/20 remained uncut.

Ms. Cole stated that even though there was a 10% cut because of the cuts that were made in Operations, there was only a 5% cut to the stakeholders.

Ms. Geiger stated that was made possible by realized savings in other budget categories.

Ms. Geiger explains the AVLS process stating that the rollout in the equipment of AVLS is handled through GTRI and GEMA and FEMA funding. Right now GTRI is also paying for the airtime for those devices. When we started evaluating taking on the charges that GTRI was paying TCC as far as phone lines, and computer lines, we decided to bring that all in house. When we did that we also wanted to evaluate what costs there would be in taking on the AVLS airtime charges, verses what the cost would be to continue the contract with GTRI. We found that GTRI charges 13.6% overhead on those airtime charges, so it would be an effective savings to bring that in house and pay those bills directly instead of going through the contract. Our contract was extended until June 31, but we have already transferred those accounts and payed the first bill starting in January. We will continue to pay those AVLS charges through June. That was already included in our 2012 budget from the very beginning, so it is no additional dollars. The budget was estimated at $50, 000, and it is going to cost us $51,000. So we are covered for 2012.

Mr. Pettyjohn stated that we are going to submit next years budget depending on what the Commission decides to do on paying AVLS, to bring this totally in house. It is just a matter of paying the air fees as well as well as the In Motion service contract and having telephone access to providers who have questions. Unless there are additional funds found somewhere else to buy additional units we think we can handle this part without any additional staff. We could realize these savings by not contracting with GTRI, just to pay air card time.

Mr. Hinson stated when the system was being built they needed their help to manage it. Now that we are stable and GEMA and FEMA is funding the additional units and we are just paying for the maintenance, he thinks it can be brought in house. If in the next budget we find out there is no more FEMA or GEMA money and we want to buy some more units, we may have to revisit someone helping us to do the install and rollout. Right now I think it will be a savings in this part of our budget.

Ms. Geiger stated that page 125 is a projection for future years if every ambulance in Georgia receives an AVLS unit this would be the yearly cost of airtime. It is a comparison of effective savings of almost $100,000 by bringing that billing in house and paying the bills directly instead of going through contract.

Mr. Pettyjohn stated that if this budget were approved he would need to go back and start amending contracts with the hospitals.

Ms. Cole wants to know if it will be on the amended budget and not the AVLS budget.

Mr. Pettyjohn stated not on the AVLS, that the Commission would go back to that at the March Commission meeting when we start talking about 2013 funding.

MOTION GTCNC 2012-01-02:
I make the motion to approve the budget as presented.

MOTION BY: **Ms. Linda Cole**
SECOND BY: **Ms. Elaine Frantz**

DISCUSSION: None

Motion has been copied below:

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

EMS Subcommittee Update and Discussion

Mr. Ben Hinson stated that the EMS Subcommittee met on January 4th in Atlanta. GAEMS is doing an outstanding job of getting first responder classes accomplished across the state, but we realized that not as many people signed up for the class as we had allocated dollars for. The discussion was to redirect some of that money to start an education course provided by Georgia Southern that teaches people specific extrications and also to fund some positions in EMS leadership training. The money was redirected there. This was done on January, 04 2012 and then we learned about the governor's additional cuts on January, 10, 2012 and that is about another $192,000 dollars out of our bucket. Mr. Hinson asks that the Commission would allow the EMS Subcommittee to use the budget that is allocated to EMS to basically accomplish what the EMS Subcommittee asks for, which is to help with the class at Georgia Southern. The extrication school would allow us the flexibility to figure out how to make the amount of money we have now work to do that. Mr. Hinson stated that as soon as the EMS Subcommittee meets again we would be able to move forward.

Dr. Robert Cowles wants to know if we have metrics that show that First Responders really help.

Mr. Hinson stated that he does not have absolute metrics, but he can tell you antidotal that they make a huge difference in very rural counties. GAEMS actually contracts with the people to do the course, they are pretty stringent and we are not wasting money.

Dr. Cowles stated that his experience is the opposite that the First Responders slow everything up dramatically. They take to long to access the situation. Dr. Cowles stated that before the Commission spends an incredible amount of money on First Responders class's metrics need to be attached to show if we are getting our moneys worth.

Mr. Bill Moore wants to know if the First Responders pass some sort of test and is there competency checklists.

Mr. Hinson stated that there is evidence that we have trained them properly and we are following national standards. He thinks Dr. Cowles is asking is if there are metrics that prove that care improves.

Mr. Hinson stated the EMS Subcommittee would work to get that budget done and report back at the March meeting. We may have to move forward with getting those contracts done, but we will stay within our budget.

Trauma Center Audit Report and Discussion GH&I

Mr. Pettyjohn introduces Jessica Story and Paul Lundy who are with Gifford, Hillegass & Ingwersen the Commissions audit firm here for the second year to report on the procedures they performed for us. Mr. Paul Lundy stated that he is passing out their report, which is still in draft form and he will walk the Commission through the findings from their work. *(GH&I Uncompensated Care audits draft report included in the Workshop binder page 70-114)*

Mr. Pettyjohn mentions that the draft report was provided to the Commission and was posted to the Trauma Commission website on Tuesday.

Mr. Lundy stated that the were engaged last year for the first time to go out and perform procedures at each of the trauma centers looking specifically at uncompensated claims being submitted for reimbursement and making sure that those claims met the criteria of Senate Bill 60. Mr. Lundy stated that most of the work contains a sampling of the claims. We started with the list that is first compiled by the trauma centers and then submitted to Bishop & Associates, the Commissions consulting firm. Then based on that initial data that they submitted we selected samples.

We also were making sure the claims had been properly bedded, properly documented and the results of our work indicated it was an appropriate claim. When you look at all this information that is what the first round of our procedures were focused on. Mr. Lundy stated that they did find some exceptions and they are identified in our report. Based on those exceptions and working with Mr. Pettyjohn and his group, we got back to each of the trauma centers and asked the ones that had exceptions to go back through their material again, look at it and submit a new list of numbers. We have summarized some of those results in our report. Mr. Lundy stated that they also went through the claims to verify the ISS score that was assigned to it. Based on that work we documented that all together and that was the first round of results. We reviewed that information with Mr. Pettyjohn and then based on that we sent the information back to the trauma centers.

Ms. Jessica Story stated in summary of their findings all the criteria that did not qualify was listed out and they bullet pointed the specific trauma centers who had an exception with that criteria. The criteria with the most widespread exception range was that the patient did have medical coverage, either through Workman's Compensation, automobile insurance or some other third party, including a settlement or judgment.

Ms. Story stated that the second way we summarized this information was by individual ISS scores. We began with the original data that was submitted to us, and then we performed our procedures and worked from that data. Those were the cases that they identified that did meet the criteria. The difference number one is the exceptions that we found in our test work. After we performed our test work we came back with additional procedures and asked the trauma centers to go through their lists and scrub their original data to see if there were any other exceptions. The revised list is the information that the trauma centers provided back to them in that second round of testing. The difference two is the combination of the results from their test work and also the results from the trauma centers rescrubbing their data.

Mr. Lundy stated that another situation that they encountered this year was whether or not the trauma center had received any sort of reimbursements. There was a hospital that was actually selling their receivables that they were unable to collect and they were getting paid. So under the letter of the law they were paid something for this claim and so we treated it as an exception. From a business perspective that is probably a wise decision for them to actually try to sell and get something out of the receivables, but it immediately disqualifies them.

Mr. Hinson wants to know if the payments for the uncompensated care were made prior to the audit being done.

Mr. Pettyjohn stated that the hospitals have not been paid. The budget you approved this morning had those numbers factored in.

Mr. Lundy stated they performed a new procedure this year. They were engaged to gain an understanding of the process that each trauma center goes through for funding physicians with their portion of Readiness and Uncompensated Care dollars. Based on that process, and our documentation, we have a couple of recommendations. For the Readiness we recommend that those locations continue that process that they already have implemented. As far as funding physicians for uncompensated care we would recommend the trauma centers analyze the list of trauma patients before sending the list to the individual physicians as outlined in the Commissions contract, which is taken from Senate Bill 60. There is one criterion the physicians should scrub themselves and that is if they receive a patient payment of 10% or more, because that could be different from the physicians side verses the hospital side.

Dr. Ashley wants to know what scrubbing the list means.

Mr. Lundy stated they narrow down the list of trauma registry patients to only those that meet the definition for uncompensated care.

Dr. Cowles stated that it is critical that we readdress the ten-dollar car tag fee to increase funding to the Commission.

Ms. Frantz wants to know what the next step would be to get Amendment #2 which provided for a $10.00 car tag fee back on the ballot in November.

Ms. Cole's concern is if the tag fee went back to the legislature and we got it back on the ballot the Commission would be no better off than we were before. We need to get the coalitions together, because we do not want to fail twice.

Dr. Cowles agrees with Ms. Cole and stated that the Commission needs time to get the legislatures lined up get everybody onboard, get the right PR groups together, and spokespeople.

Dr. Ashley agrees and thinks that we need to start a coalition now, and then start working on reintroducing Amendment #2 back to the legislature.

Mr. Lundy stated that they met with the EMS Subcommittee earlier this month and presented their report to on procedures that were performed this year explicitly on the EMS service companies that were receiving funding from the FY 2010 EMS Uncompensated Care Program (CY 2008 claims). We interviewed 20 of the 44 EMS companies. Our goal was to understand the general process and procedures that they go through submitting their claims. We did not test individual claims, we were interviewing and understanding the process and documenting that. From that work our recommendations were: 1. EMS companies standardize the process of submitting claims for uncompensated care funding and that all EMS service companies have a written policy and follow that policy so that each case is handled in a consistent manner, 2. that they all develop written standardized policies concerning collection procedures and 3. that all locations consider implementing a second review before the list is submitted to the Commission.

MOTION GTCNC 2012-01-03:
I move to accept the Gifford, Hillegass & Ingwersen Audit report in draft form.

MOTION BY: **Dr. Leon Haley**

SECOND BY: **Mr. Bill Moore**

DISCUSSION: None

Motion has been copied below:

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

Burn Center Report and Georgia Trauma Foundation Concepts

Mr. Greg Bishop stated that he is going to be talking about the Burn Center Assessment (*Georgia Burn Center Assessment January 27, 2012 PowerPoint attached to the meeting minutes)*. The core goal was to do an objective economic assessment of the burn centers and compare that to the economic assessment that we did with the trauma centers, so we can to define burn centers relative need for state funding. Mr. Bishop stated that Doctors Hospital in Augusta is a very good addition to the system in Georgia. They are the

largest burn center in the country and have been around for 30 years. They have a major initiative in terms of outreach, education and prevention. Grady Memorial Hospital is the other burn center and is in Atlanta. They have a very strong program as well and are strengthening over time. Mr. Greg Bishop stated that the bottom line is that we have the burn centers, their report of the percent of those numbers in terms of their total costs and them we have that compared with per patient to the trauma centers. Mr. Bishop stated that if you look at the various comparisons and their revenue and take out the total cost, the burn centers show a 28% surplus and the trauma centers show a 16% loss. Mr. Bishop stated that clearly the burn centers were profitable in 2009 and the trauma centers were not. The difference here is that the trauma centers have substantially more in terms of readiness costs, which is 17% of there total cost verses 7% for the burn centers. The other issue is that on the revenue the burn centers get 28% surplus on those costs and the trauma centers are losing 16% on the revenue right from the get go. Mr. Bishop stated that he would take the Medicaid and the Medicare surplus for the burn centers at 13-15% and just call it a wash, if you look at the overall payer mix. Which leaves us the difference being the reimbursement on the insured patient, which the burn centers do very well on compared to the trauma centers.

Dr. Dennis Ashley wants to know what Mr. Bishop means when he says that Medicare, and Medicaid are awash.

Mr. Bishop stated that going back to the payer mix discussion, because the burn centers have 9% fewer insured patients and more Medicare and Medicaid funded patients and because Medicare and Medicaid pays them at a higher rate on the same dollar of costs, it is somewhat comparable. The point he was trying to make is that the payer mix does not make a big difference. The big difference is the readiness costs and the amount of revenue the burn centers are receiving on the insured patient.

Ms. Elaine Frantz wants to know what the comparison at first collection rate is in general when comparing Level 1 and Level 2 to burn centers?

Mr. Bishop stated that we never deal with collection rates anymore because the charges are so out of whack. We do a cost recovery rate. The differences between the two are trauma centers are around 140% cost on the insured patient and burn centers are above 200%.

Mr. Bill Moore wants to know how you can estimate the patient treatment cost?

Mr. Bishop stated that patient treatment costs are the fully allocated costs that they report to us and that is both direct and indirect. Mr. Bishop stated that because of the cost center issue we took the readiness costs out of the patient treatment costs because we felt they were double counted. We also looked at the trauma center costs in that regard. There are some trauma centers reporting fairly high costs that indicate that they have cost centers and are including that overhead. So we reduced the patient treatment costs for the trauma centers by 25% of that 44 million. We took 11 million out of the trauma center patient treatment cost so we could have an apple-to-apple comparison.

Dr. Fred Mullins asks Mr. Leon Haley how Grady determines a burn patient and if they put them into the trauma category.

Dr. Leon Haley stated that they would go into the trauma registry if they have a significant traumatic injury, but if they are just a straight burn then that is a separate entry.

Ms. Fran Lewis stated that if they have any traumatic injury than they go into the trauma registry.

Dr. Fred Mullins stated that large portions of burns have traumatic injuries.

Mr. Bishop stated that when they first started this process they separated the Grady Burn from the trauma, not necessarily the patients that were injured and needed the trauma center themselves. We made it a point to not include them.

Dr. Ashley wants to know if there is a list that Commission can look at that shows funding of burn centers by the states.

Mr. Bishop replied, "Any state that funds their trauma centers where the burn center is part of the center then those are typically included in the allocations of funding by that state." The independent burn centers are typically not in terms of that application. Mr. Bishop stated that he would be happy to provide Dr. Ashley a list of burn centers funding by states.

Mr. Bishop stated that his report would be going to the Committee next where issues will be addressed and then brought back to the Commission at some point.

Dr. Haley stated that it would go to the Trauma Center and Physician Funding Subcommittee so they can review Mr. Bishop's conclusions and then it will come back to the Trauma Commission to make a full recommendation as to how the Commission will fund the burn centers.

Mr. Bill Moore wants to know, since Mr. Bishop mentioned that the burn centers have been effective in lobbing and getting sort of add-on or enhanced Medicaid payments, if he is able to identify what that enhanced portion is.

Mr. Bishop stated that it is 13% from the same dollar of costs. We ask how much cost did you have with Medicaid patients and how much revenue. Then we compare that cost recovery rate. The burn centers receives 13% more on Medicaid revenue over the cost to that of trauma centers.

Dr. Mullins asked, "So for every dollar they get an extra 13%?

Mr. Bishop replied, " Yes, for every dollar of patient cost they get an extra 13%".

Dr. Ashley stated that there was legislation to give trauma centers an increase or percentage on Medicaid, in other words if you are a trauma center you would receive a percentage more than a non-trauma center. That legislation fell through, but needs to be revisited.

Dr. Mullins stated that burn patient's absorb a tremendous amount of resources. A burn patient can be in the hospital for weeks and sometimes months. There is no funding of those patients 99 out of 100 times, but they have to be taken care of.

Mr. Bishop stated that this survey has been done annually over the last four years and as we continue we will continue to address that issue.

Ms. Rana Bayakly wants to know where Mr. Bishop obtained the figure of 11,000-trauma center burn cases. Did he get that number from the hospital discharge or did he survey the trauma centers asking them how many burn cases they had.

Mr. Bishop stated that he did not ask the trauma centers how many burn patients they had, we asked them how many trauma center patients they had. We survey that and they report that to us. This information is in the trauma registry and it is coming from there and that is how we get the 11,000 for trauma centers and we ask the burn centers the same thing.

Dr. Mullins asks, "Is that 11,000 burn patients?"

Mr. Bishop replies, "No, that is 1,200 burn patients."

Ms. Bayakly replies, "I understand now, there are 11,000 trauma patients."

Mr. Bishop was also asked to look at the issue of Trauma Foundations and he has included that in his PowerPoint presentation. Mr. Bishop also included a list of items from the GTCNC Strategic Plan that consists of functions that could contribute to or be carried out by a Trauma Foundation. The basic approach would be

to define what the Commissions needs are. It would be a contractual relationship between the Commission and a Trauma Foundation in terms of doing things for the Commission on an annual contract basis. Mr. Bishop mentions that Dr. Ashley went to Arkansas where they are developing a new Trauma Foundation and asks Dr. Ashley if he has any insights on that.

Dr. Dennis Ashley stated that it is very similar in a sense that they have a Trauma Foundation with their own board and their Commission puts money into that. They can also approve other money from corporations or private citizens and that is tax deductible. The money is used for education and research. They report back to the Commission from what their strategic plan was for the year of the Commission. Education was one big issue where the Commission would decide what educational courses they wanted to keep or change and it is the Foundations job to set up the web site with those courses so that students can register online. They have their plan and will be very organized once it is instituted.

Dr. Mullins stated that Joseph M. Still Burn Center has a Burn Foundation and in it they have over 300 publications and post a meeting every quarter where people from all over the world commune and talk about burn care. It presents at every national and international meeting on burn care and really ties everything together.

State Vision on Trauma System in Georgia

Dr. Pat O'Neal stated there is a need for more outreach and involvement of the larger group of stakeholders in the community. We urged looking at some of the existing coalitions and giving consideration to joining those instead of creating new ones. Dr. O'Neal stated that the greatest advocates for trauma system in the state of Georgia are those individuals with the Trauma Coordinator group. Dr. O'Neal believes that the Commission would be well advised to establish a much more integral relationship with that group to assist in getting into the coalition business a more definitively. Dr. O'Neal stated that each of the Commission members have fulltime jobs and may not have time to participate in coalitions, but the trauma coordinators do have the opportunity to participate. We have 14 Regional Coordinating Hospitals throughout the state and many of them are trauma centers. Each of the Regional Coordinating Hospitals has an existing coalition and it is the very same membership that is needed to advance the trauma system.

Dr. Ashley asks, "What is a Regional Coordinating Hospital?"

Dr. O'Neal replied, "In response to a request from Public Health the Georgia Hospital Association did a fantastic job of organizing hospitals into 14 regions through-out the state with each of the regions having a Regional Coordinating Hospital surrounded by several satellite hospitals." There are mutual aid agreements that facilitate the hospitals supporting each other during disasters and crises. This network of hospitals has functioned exceedingly well. Each of the Regional Coordinating Hospitals has a coalition of members, which assist in emergency/disaster planning. It would be helpful for the Trauma Coordinators to join the coalitions at their closest Regional Coordinating Hospital, which in many cases is in their own trauma center. Dr. O'Neal thinks that the Trauma Commission could do a really good job of jumping into the coalition approach real quickly with the help of the Trauma Coordinators and that would get the dialogue out there to the community. In terms of getting funding Dr. O'Neal thinks there is little chance that we will get any additional funding this year from the legislature, but that does not mean that we shouldn't start to get the message out. It is going to be a 1-½ year process at least to get to where we need to be with the public and the legislature to obtain the necessary funding. That coalition piece needs to start right away and this is just one place that it can be done. Dr. O'Neal stated that the data piece is also critical. We need to be able to go to the legislature and show them the numbers. We need to be able to show that we have improved outcomes for trauma care in Georgia. For the metrics Dr. O'Neal stated that he should not stop with the interval from injury to acceptance because there are too many ways to fake that. He would go from the time of the injury until the patient arrives at definitive care. Dr. O'Neal stated that he had asked his associate Dr. Linda Capewell from the CDC to look at trauma data in the hospital discharge database and she will be addressing that shortly with the Commission.

Hospital Discharge Data/Trauma Data Set

Dr. Linda Capewell, VMD, MPH, CDC Preventive Medicine Fellow presents a PowerPoint on the evaluation of the Trauma System in Georgia *(Copes of this PowerPoint are available by Ms. Rana Bayakly email address arbayakly@dhr.state.ga.us)*. Dr. Capewell stated her outline is the methodology direction she took to abstract common data from the Georgia Hospital discharge database of 2009. Her first step was to identify those areas in need of trauma care coverage and place new trauma centers in those needed areas. Dr. Capewell also will be comparing the differences in outcome between patients in a non-designated trauma center verses designated.

Dr. Ashley stated that he thinks he understands what Dr. Capewell is doing but he needs to see the bottom line. Dr. Ashley thinks that the two groups are not comparable based on ISS scores and asks Mr. Bishop if there is a way to take the data base and the discharge data and assign an ISS score so that you can see if the two groups that you are talking about are exactly the same.

Mr. Greg Bishop stated that there is, but it is not exact.

Dr. Ashley stated that as you go through this analysis it is key that you put in ISS scoring for patients when comparing trauma center to non-trauma center patients.

Mr. Moore stated especially when you start comparing mortalities.

Dr. Ashley stated if you base your study just on taking out some ICD-9 codes, the groups might be totally asymmetrical. The ISS score is very sophisticated and gives you a way of knowing just how sick a patient is, through computer software and multiple papers where it well written out. Dr. Ashley is not saying that it is easy. He thinks that Dr. Capewell is off to a good start, but as we walk down this road with outcomes the Commission we will have to ask those questions.

Ms. Bayakly stated that they would follow up on that idea and see if they can do the ISS scores.

Dr. Capewell stated that her next steps would be to compare outcomes between those two groups and to give a representation of how many patients are going to the different hospitals. This will be in her next presentation.

Dr. Ashley stated that if he understanding Dr. Capewell's study correctly, it is about transporting patients and showing that the further a patient is away from a trauma center the worse the outcome. That study is all good, but when you are comparing directly a trauma center verses a non-trauma center based on the methodology that he has seen today and the way you are doing it, there is no scientific validity compared to what is in the literature. Dr. Ashley stated that if we are going to go down that route to answer that one question, for example, does a ruptured spleen in a non-trauma center have the same survival as a ruptured spleen in a trauma center, that there is a way to do that, it is very expensive, labor intensive and it has already been proven at a national level. Do we want to invest that much time into a question that has already been answered, and if we do it better be done the right way. Dr. Ashley believes that is separate to the question that Dr. Capewell is answering, but is just focused on that one question and wants to make sure we do not go down the wrong path.

Planned Trauma Data Use During CY 2012

Ms. Rana Bayakly, stated that their goals for the 2012 calendar year are related to the ACS Consultation Visit Report from 2009 and the research project that the Commission is currently involved with, also the Trauma Data Enhancement which we will be starting soon and some of the activity we are doing with the data use for injury control and prevention programs. To just concentrate on the research projects we are going to be presenting the data at the Admission Trauma Society in April 12-13 in Savannah and if you are there please drop by. We are doing training with the Emory Center for Injury Control and how to use various injury data

sets, including the trauma registry data. This way we can encourage academic research. From the presentation we did in September, we came up with two projects and the author on those two projects is Dr. Anitha Mathews, who is funded from the Emory Center for Injury Control for Pediatric Research. This project is titled Analysis of Children Traffic Motor Vehicle Collision Outcomes Based On Designation and Distance in Demographics. Dr. Matthew is also applying for the other project, which concentrates on adults. The purpose of engaging in these types of research is to enhance our data, such as adding the address of the injury and the time between the transportation from injury to definitive care. We will be able to do some of the outcome that the Commission has expressed interest in looking at. We will also be starting a pilot sometime in February linking the emergency EMS database with the trauma registry database. We have picked a couple of hospitals to work with. If we are successful with those two hospitals then we can learn from that and expand it to the rest of the trauma centers. Ms. Bayakly stated that she has been working with injury control and the prevention program of the state and she will be participating in the Advisory Committee and hopefully will be able to present the data that will be useful.

Trauma Communications Center Update

Mr. John Cannady stated that the TCC began staffing 24/7 on December 19th in order to allow for additional training and shift acclimation. In addition, we wanted to be sure that the hospitals became familiar and comfortable with updating their status on a 24/7 basis. We made ourselves available to receive calls on 1/1/12. Regions 5 and 6 have decided to "phase in" their training and utilization of the TCC with the Region 5 deadline to complete training by 1/31 and the Region 6 deadline by 3/1. We have taken four calls to date. We have and will continue to perform review and PI on these calls to find areas of strengths and weaknesses. We recognize that the TCC is there to provide a service to EMS and hospitals. We have used this service-based approach as we move forward and will continue to keep high levels of service as a top priority. We rely on feedback from EMS and hospital providers in order to ensure that we are providing the highest level of service possible. As we recognize the importance of coalition building and working with all stakeholders I want to point out the work of the RTAC's in bringing all the various stakeholders together. With the cooperation of Russ and Lawanna from OEMS, I feel that both Region 5 and Region 6 have done a great job of garnering cooperation throughout each region.

Mr. Cannady thanks Mr. Scott Sherrill for his assistance and hard work with the TCC as well Mr. Kirk Pennywitt for his work with the AVLS program and GTVC at the TCC.

AVLS Update

Mr. Kirk Pennywitt stated that he is going to be presenting a review of the Automatic Vehicle Location System program and all the numbers and figures he will be giving you are up to date as of two days ago *(PowerPoint presentation Georgia EMS AVLS Program Update 27 January 2012 attached to the meeting minutes)*. Mr. Pennywitt stated that they publish a quarterly newsletter, and newsletter number 4 was just approved yesterday *(Onboard Newsletter number 4 January 2012 attached to the meeting minutes)*.

Ms. Linda Cole asks, " What UASI stands for " ? *(UASI area ambulances mentioned on slide 20 of the PowerPoint attached to the minutes)*.

Mr. Pennywitt replies, "UASI stands for Urban Area Security Initiative." There are certain cities within the Unites States that are designated as potentially high-risk terrorist targets. Atlanta is one of those areas and so it gets special federal dollars for security initiatives that are related to their uniqueness.

Ms. Cole wants to know if Atlanta is the only city within Georgia that is UASI.

Mr. Penneywitt stated that Metro Atlanta is the only city in Georgia, including 6 counties in that area.

Mr. Penneywitt stated that the Georgia EMS AVLS Program is the only program in the Unites States to tie so many individual EMS agencies into a single integrated system. There are other systems in the country that are actually larger and have more vehicles, such as LA Metro, all of their buses, taxi cabs, fire and police have units in their vehicles and that is more than 750, but they are all under the jurisdiction of a single

agency. Mr. Pennywitt stated that ours are under the jurisdiction of 85 agencies and so there is no other program that has such a disparate collection of different agencies unified in a single system.

eBroselow Discussion

Mr. Peter Lazar presents a PowerPoint presentation on the Artemis Initiative that we have done with the Georgia Trauma Commission in the state of Georgia *(eBroselow Georgia Artemis Initiative PowerPoint attached to the meeting minutes)*. This is a system to prevent dosing errors particularly in children and acute situations. This is built on Dr. Jim Broselows and Lutins work over the last decade and also the pediatric pharmacy adversary group which is a which is a 700 member non-profit group based in Memphis Tennessee. Together they have created this library of approved standardized dosing which really had not been created before. Tools were also created as a way to administer the drugs in a way that prevents errors.

Mr. Lazar stated that there were some speed bumps and we found that there needed to be a few structural adjustments on how we do things and they all have to do with the slowness of how long it takes to implement. Mr. Lazar is convinced that it is not inherit in the Artemis itself, because they have rolled out to even larger sets of hospitals. One of the challenges that they have had is that it was set up as a one year contract and hospitals were not sure about future payments and how much they would it be, if they would be tied into it and whether the cost would be absorbent in the future. The proposed solution is to make the next version of this contract multi-year, so the hospital would know what expectations were for at least five years. There also is not really a formal structure and so the potential solution was to put this under a Trauma Subcommittee and actually have eBroselow representation and provide a report at least four times a year. We also found that the institutions were completely swamped with there meaningful use EMR rollouts and the solutions to that is naturally that is going to flush out and more people will be available to do other things. Mr. Lazer stated that eBroselow is introducing some additional exciting features *(eBroselow Phase 2-Additional Features slide 5 Artemis Initiative PowerPoint attached to the meeting minutes)*. eBroselow's proposal on how they will do this*(eBroselow Phase 2-Proposal slide 6 Artemis Initiative PowerPoint attached to the meeting minutes)*.

Dr. Fred Mullins wants to know if the $3,750 is per year?

Mr. Lazar stated that it is per hospital per year for years 2-5.

Ms. Elaine Frantz wants to know if that $3,750 is per hospital regardless of the size, or if that is an average

Mr. Lazar replied that it is an average, they can come back, make it flexible and change it around.

Dr. Ashley wants to know if Georgia is the first state to do the EMS application.

Mr. Lazar replied that Georgia was the first state, but Colorado did something similar.

Ms. Elaine Frantz wants to know if the adult dosing is available now.

Mr. Lazar replied that they have it in a test environment and they will show it to the Commission in their PowerPoint presentation today.

Ms. Frantz wants to know if there is ability in the system to customize it.

Mr. Lazar replied that there is.

Dr. Broselow stated that they are willing to take on the liability and there is nothing in the system that says use this has a guide, it is just really up to you, we are just giving you background. We are willing to stand behind our standards. We never say it is the only way to do it, but we do say it is a good way to do it.

Ms. Linda Cole stated at Children's they had been utilizing the Ibex documentation record in the ED for years and had always documented live, we did not have paper in the trauma room, or resuscitation room. We made the move to EPIC July 13th of last year. Because our documentation was taking so much longer on EPIC in the trauma room and resuscitation rooms we had to go back to paper, which was very painful. Ms. Cole stated that Children's is looking at using eBroselow to be their documentation tool in the Trauma room and resuscitation room.

Dr. Broselow stated that they are very interested as a company in trying to fill that niche and are trying to develop something that works like paper, but is better and faster. We want the information up front and in real time so you have the information that you need. Our goal is to look at the system over the next year or two and add some ability to do standard orders off it, at least trauma orders like chest x-ray, blood and cross match. This would give you the option to do acute care off of something like a touch screen and enter the orders.

Ms. Cole stated that we started off this year with the 50 hospitals and we received feedbacks that the hospitals liked the product, but there was concern they would put time and energy into implementation for only a year of usage. Part of that is they do not understand or have not experienced what this system can do for them and the value it brings, or they would probably purchase it. I would like to propose we agree to a five-year agreement. The next fiscal year would be paid out of dollars we have already allocated and we would commit to funding the Broselow system for the remaining 4 years. Next year would be basically what we have already paid to get us through the next fiscal year and we would commit to paying for those 50 hospitals for the next four years. What we would really like to do over those five years is gather data. Submission of data would be one of the rules of participation to have the system funded through the Trauma Commission. The data would be utilized to determine if it has made a difference in those hospitals, has care improved and have we decreased medication errors. Ms. Cole is hoping Ms. Elaine Frantz, Ms. Debra Kitchens and Regina Medeiros will help with this study. Ms. Kitchens had already started some pre-implementation surveys in anticipation of this taking place. In addition by working with the Children's Miracle Network, Children's is facilitating the installation in 16 hospitals in the North Georgia area. The same rules of participation regarding data collection are being utilized. Ms. Cole stated that we really do not have to make this decision until the Commission creates their next budget. Even though no dollars need be designated in the Commissions next budget we are making the agreement that we will fund it for the following five years.

Mr. Bill Moore wants to know how many hospitals is it in now.

Ms. Cole stated that we are getting ready to put it into 50 hospitals. Right now it is in Children's and all the Level 1's and Level 2 trauma centers.

Dr. Broselow wants to point out that what was bought initially was just for kids and did not include adults, scanning, or recording applications and the price we are giving now per hospital per year is less than you paid originally. eBroselow's goal is to keep adding features, not price. What we want to do is keep adding value and be successful as a company because everybody uses it. We want this to become the standard way to get very rapid information for medications.

Ms. Cole stated EMS would be another area to continue to work with and develop.

Dr. Broselow stated there is a raw opportunity to study that within Georgia. We have already obtained a connection with EMS and they downloaded our basic apps. The idea that we would develop a pre-hospital system and this would be the first geographical area where we have put it all together from critical care, to basic transport, to flight nurses to tertiary care.

Ms. Cole stated that today was just for information only. When the Commission meets in March and we start talking about the budget we will review this again.

Dr. Broselow stated that they have worked with Hospital Corporation of America, starting with 52 of their hospitals and are now expanding it to four other divisions. There are many hospitals there in all different

circumstances that have used eBroselow for almost two years. That may be a way that the Commission could get some additional information on users.

Commission Subcommittees Discussion

Mr. Pettyjohn stated that the current GTCNC Subcommittees list is on pages 148-150 of the Workshop binder. This document was prepared to reflect those committees past and currant. As you can see there were several over the last 3-4 years. Dr. Leon Haley's Trauma Center and Physician Funding Subcommittee is still active. The Trauma Center Capital Grants Subcommittee has morphed into the EMS Vehicle Replacement Grant Subcommittee, which is the staff working with Mr. Keith Wages from the Office of EMS. They review the applications and come up with a list and recommendations for awards. Then based on the number of dollars available that subcommittee makes a recommendation to the full subcommittee to award that number of grants. Then there is the Government Affaires Subcommittee that Mr. Ben Hinson led, it had some activity prior to Amendment #2.

Dr. Ashley recommends that Ms. Linda Cole, Dr. Leon Haley, Mr. Pettyjohn and he take another look at this subcommittee list and come up with a new list of committees that are needed. Then open it up to the Commission and find out who is interested in being on those committees. He would also like to get together with Mr. John Cannady and compile some information that they gathered from attending the Arkansas meeting and present it to the Commission at the March meeting. He thinks they had some good infrastructure in forming their trauma foundation.

Ms. Linda Cole stated that the Committee that she thinks the Commission really needs is the Coalition Foundation Subcommittee.

Mr. Pettyjohn asks Dr. Ashley to remember, as Dr. O' Neal mentioned, the trauma coordinators as a coalition. We should remain close to them and recognize them as an official subcommittee of the Commission.

Dr. Ashley stated that he thought we had incorporated the trauma coordinators into the Commission because they are a standard subcommittee with a direct access to the Commission's recommendations. Dr. Ashley believes the coordinators are tied into Commission just about at the highest level they can be and he agrees the coordinators need to be there and they are.

Ms. Elaine Frantz stated that she believes Dr. Ashley will be seeing a positive change in the GTCE based on what happened at the last meeting. They are actually providing some focus and guidance and their alignment of bylaws are very close in alignment to the Trauma Commission as a subcommittee.

Dr. Ashley stated there are several committees that need to be maintained that have non-commission members on them, as outreach and focus and they are Georgia Committee on Trauma Excellence, the Trauma Medical Directors Subcommittee, of which he is the Chair and the EMS Subcommittee on Trauma. We are reaching out and we do have the arms going out there to touch all stakeholders, which is what we need to be doing.

2012 Commission Meeting Schedule and Workshop Wrap-Up

Mr. Jim Pettyjohn stated that through various conversations with Commission members we came up with the idea of a schedule for 2012, and 2013*(Proposed Trauma Commission meeting schedule for 2012 into 2013 included in Workshop binder)*. Mr. Pettyjohn's feels that this would give the Commission presence across the state and the opportunity for folks and other stakeholders to attend and see the Trauma Commission's work.

Dr. Ashley sees two issues here, change our meeting schedule from every other month to a semi-quarterly schedule and rotating the meetings to include Savannah and Augusta Georgia.

Ms. Cole thinks that if we get the subcommittees formed and functioning, the new meeting schedule makes sense, but if we do not and the Commission goes three months without a meeting we might lose

momentum. If we do decide to travel to Savannah and Augusta we need to reach out to those constituents in that RTAC and let them know about that meeting.

Mr. Bill Moore thinks that we should at least try having the meetings somewhere besides Atlanta and Macon. He has never been to Savannah and recommends having the Savannah meeting on a Friday to allow time for travel.

Dr. Ashley stated that moving the Savannah meeting from a Thursday to a Friday is fine with him.

Mr. Pettyjohn stated the Savannah Commission meeting will be on Friday, May 18th and all meetings will be from 10-1 pm.

Old business: None

New business:
Mr. Bill Moore stated that AMC did a Trauma Symposium, it was a lot of work and the attendance was good, but he feels that it could be better if it was a combined effort with the trauma centers in the town where it all falls together. Mr. Moore wants to know if the Trauma Commission would like to organize a statewide Trauma Symposium. We have a lot talented physicians and EMS personnel and we could do something great and hopefully get better attendance. It would be a lot of work to organize, but he wants the Commission members to think about it.

Dr. Ashley stated that he has been conferring with Dr. Chris Dente the Georgia COT Chair from Grady about having a Committee on Trauma. We used to have one but it fell by the wayside. Dr. Ashley stated that his goal is bring the trauma coordinators and medical directors from all the trauma centers together and have a meeting once a year and make that meeting a requirement as part of the Performance Based payment, in other words one of the deliverables. Dr. Ashley thinks that we need to push for that at the Commission level. This would really get our trauma centers all together, plus provide education. Dr. Dente has actually been working on doing that and was planning to try and hold the first joint meeting in 2013 to include, EMS trauma coordinators and the medical directors.

NEXT MEETING: March 15, 2012 Atlanta, Georgia

Meeting Adjourned: 2:20

Minutes crafted by Lauren Noethen

County of Floyd
State of Georgia

AFFIDAVIT OF PRESIDING OFFICER

Personally appeared before the undersigned officer, duly authorized to administer oaths, Dennis W. Ashley, M.D., Chairman of the Georgia Trauma Care Network Commission, who, after being sworn, deposes and states under oath the following:

1. THAT affiant is the duly appointed Chair, is over the age of eighteen years, and has personal knowledge of the facts contained in this Affidavit.

2. THAT this Affidavit is given as required by that portion of the Georgia Open Meetings Act (O.C.G.A. § 50-14-1, *et seq.*) codified at O.C.G.A. § 50-14-4(b).

3. THAT the Board met in an open meeting, as required by O.C.G.A. § 50-14-1(b), on the 26 day of January, 2012, and during the course of that meeting it became necessary for the Board to close the meeting to the public pursuant to the provisions of Chapter 14 of Title 50 of the Official Code of Georgia Annotated.

4. THAT affiant presided over the closed portion of the meeting of the Board.

5. THAT, as reflected in the minutes of the open meeting to which this Affidavit is attached, upon a majority vote of a quorum of members of the Board present for the meeting, the meeting of the Board was closed for the specific reason set out in the minutes, the specific exception to the Open Meetings Act being O.C.G.A. § 50-14-3(6).

6. THAT during the portion of the meeting of the Board which was closed to the public no public matter, official business, or policy was discussed or presented, no official action was taken, and no recommendations on any public matter, official business or policy were formulated, presented or discussed **EXCEPT** as such discussion, presentation, recommendation or action related to the specific

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exceptions to the Open Meetings Act for which the meeting was closed to the public, as set out in Paragraph 5 of this Affidavit.

FURTHER AFFIANT sayeth not, this 10 day of February, 2012.

DENNIS W. ASHLEY, M.D.
CHAIRMAN, GEORGIA TRAUMA CARE
NETWORK COMMISSION

Sworn to and subscribed
before me this 10 day
of February, 2012.

Notary Public
My Commission Expires: March 10, 2014

(Notary Seal Here)

Georgia Trauma Commission FY 2012

EMS Allocation

11 August 2011 APPROVED

Available EMS Budget @ 20% of available funds for stakeholders: Reflects Governor-directed 2% budget reduction		$ 2,914,407		
Staffing and Meeting Support		$ 3,500		Staffing and minutes development
Available for distribution	$ 2,910,907			Available for distribution
% Distribution from FY 2010 funding	%			
EMS Uncompensated Care	26.30%	$ 765,569		
EMS Vehicle Equipment Replacement Grants	41.32%	$ 1,202,787		#17 Awards at $70,752 a piece
First Responder Training Grants	8.90%	$ 259,071		
Trauma Care Related Equipment	13.76%	$ 400,541		
EMT- B Courses	4.86%	$ 141,470		
PHTLS/ITLS	4.86%	$ 141,470		
Total	100.00%			
Remaining :		$ (0)		

Georgia Trauma Commission FY 2012

EMS Allocation

Amended 2012 January Proposed

Available EMS Budget @ 20% of available funds for stakeholders:		$ 2,722,217	Amount Change from Aug. Approved to Jan. Proposed (192,191)	
Staffing and Meeting Support		$ 3,500	$ -	Staffing and minutes development
Available for distribution	$ 2,718,717			Available for distribution
% Distribution from FY 2010 funding	%			
EMS Uncompensated Care	26.30%	$ 715,022	$ (50,547)	
EMS Vehicle Equipment Replacement Grants	41.32%	$ 1,123,374	$ (79,413)	#15 Awards at $74,891.60 a piece SUGGESTED
First Responder Training Grants	8.90%	$ 241,966	$ (17,105)	
Trauma Care Related Equipment	13.76%	$ 374,095	$ (26,446)	
EMT- B Courses	4.86%	$ 132,130	$ (9,340)	
PHTLS/ITLS	4.86%	$ 132,130	$ (9,340)	
Total	100.00%			
Remaining :		$ -		

GEORGIA BURN CENTER ASSESSMENT
January 27, 2012

Greg Bishop, MBA

Bishop+Associates

GEORGIA BURN CENTER ASSESSMENT

PROJECT GOALS

The core goal: An objective economic assessment of Georgia's burn centers to compare with that of Georgia's trauma centers to define burn centers' relative need for state funding.

Georgia's burn centers - Grady Memorial and Doctor's Hospitals - fully participated in the process.

JMS
JOSEPH M. STILL BURN CENTERS, INC.

Leading the Way in Burn Care with Innovative Treatments and Research

find us on facebook

R. Fred Mullins, MD
Medical Director, President

Zaheed Hassan, MD
Hermann Orlet, MD
Claus Brandigi, MD

Welcome to Joseph M. Still Burn Centers, Inc.

Directions to JMS Burn Center

house of angels

"It seems like everybody there is working these miracles. If I would not have been there, I don't think I would have survived. Everybody seemed to bring it all together and make my recovery successful and I think it is just

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ER average wait time | 10 MIN AS OF 1/24 2:00 AM

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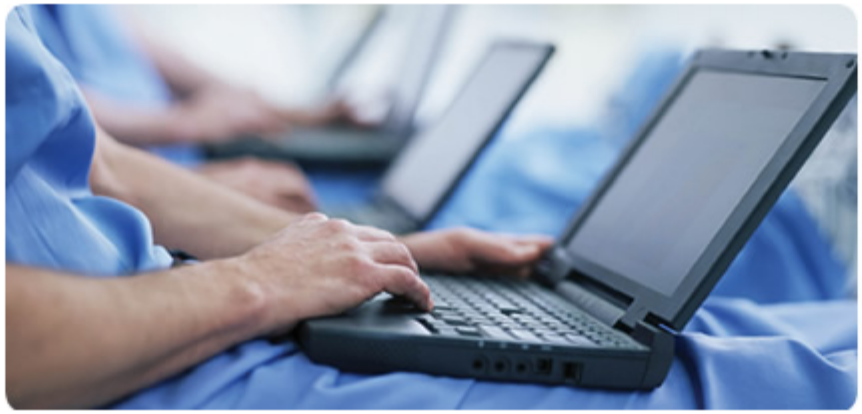

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In the Community

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Events & Classes | Recent News

Ready and Able (3 of 3 sessions)
Jan 24
Suite 310, Medical Office Building One, 3623 J. Dewey Gray Circle (Doctors Hospital Campus).

Minimizing Joint Pain: Non-Surgical and Surgical Treatments
Jan 26
Cumberland Village, 3335 Wise Creek Lane, Aiken SC 29801

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GradyHealth We appreciate u @VMedDream Grady is the strong beating heart of vibrant ATL.I'm honored & thrilled every time I step foot in that hospital

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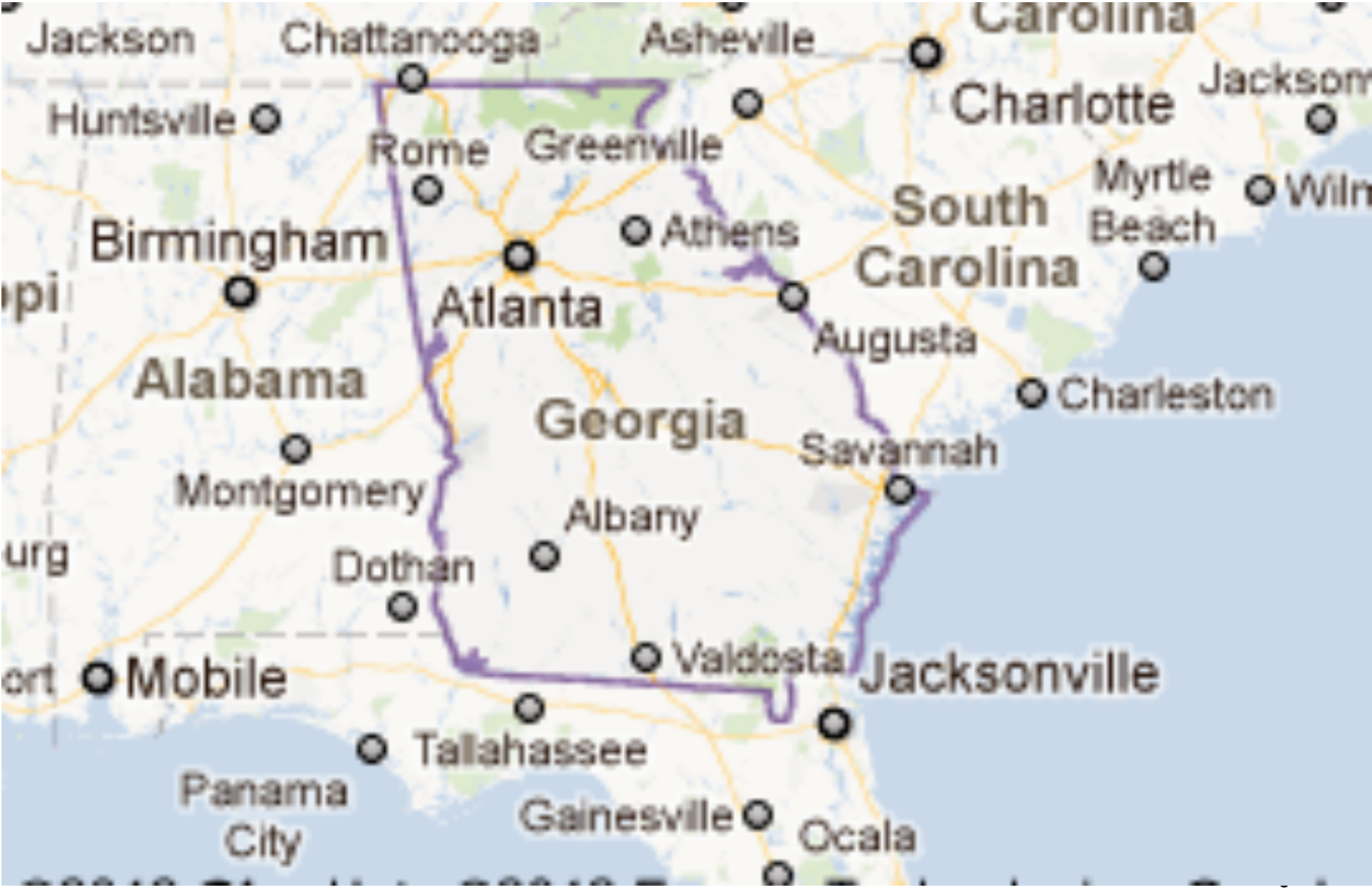
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GEORGIA BURN CENTER ASSESSMENT

PROJECT COMPONENTS

- An economic survey based upon trauma center surveys and modified in collaboration with the burn centers
- Research on burn center economics, including with the American Burn Association
- Assessment of Georgia's hospital inpatient discharge data set
- An assessment of support provided to burn centers by other states
- Development of economic performance norms

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

September 2, 2011 (5th Draft)

To Georgia Burn Centers,

This survey replicates the trauma center financial surveys conducted for four years to benchmark their financial performance and identify uninsured patients eligible for funding. It covers calendar year 2009 and the due date is September 25, 2011.

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

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

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

Please provide the following information:

Burn Center: _____

Name of person who completed this Survey: _____

Phone Number: _____

Email Address: _____

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

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

_____ CFO

SECTION 1 – BURN REGISTRY AND PATIENT COST INFORMATION

A. Volume & Severity of Burn Patients Meeting Following Criteria:

Please identify patients meeting the following criteria:

1. Injured in Georgia
2. ICD-9 diagnosis code of 940.0 to 949.5
3. Were admitted to the hospital during the 12 months of 2009 and dad a length-of-stay of at least 2 days, or:
   - Were transferred in from another hospital and admitted, or died after admission (regardless of length of stay).

Please sort patients by following Total Burn Surface Area (TBSA) categories, or if TBSA does not apply, place in other categories indicated below:

TBSA Category	# of Patients	Total Costs*	Total Hospital Days	Total ICU Days**
% TBSA 0 – 5				
% TBSA 6-10				
% TBSA 11 – 20				
% TBSA 21-30				
% TBSA >30				
Electrical burn only				
Smoke inhalation only				
Totals				

*Total costs are fully allocated patient treatment costs

** Include in total hospital days

Burn Admissions < 2 Day LOS
Please indicate number of burn patients who were admitted but discharged in less than 2 days and were not included in table: _____.

B. Subset Of Patients In Table Above Who Were Put On A Ventilator

In the table below, please provide information on the patients included in the table who required a ventilator.

TBSA Category	# of Patients	Total Costs*	Total Hospital Days	Total ICU Days**	Ventilator Days
% TBSA 0 – 5					
% TBSA 6-10					
% TBSA 11 – 20					
% TBSA 21-30					
% TBSA >30					
Electrical burn only					
Smoke inhalation only					
Totals					

READINESS/PREPAREDNESS COSTS

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

CLINICAL – MEDICAL STAFF **Burn Medical Staff Compensation** Do not include amounts paid for administrative duties.	Includes the costs of maintaining burn physician support for your burn center other than the costs of admin functions addressed above. • If you pay specialty a stipend exclusively for burn call, enter the full amount. • If you pay a stipend to a specialty that is for both burn and ED call, estimate the portion attributable to burn care. • If you employ your physicians, determine net cost (salary + benefits – pro fee reimbursement) and estimate portion attributable to burn. • If you are supported by a faculty practice arrangement, take portion of burn admissions to overall admissions and apply to overall hospital subsidy provided to faculty practice structures, Or Total number of physicians by specialty and apply AAMC salary database (at 50% of range) for SE region, add estimated benefits, subtract estimate salary support from pro fee reimbursement, and then apply portion of burn admissions to overall admissions to arrive at net cost for specialty support. • Do not include amounts specifically paid to burn physicians for care of uninsured burn patients in the amounts for each specialty; you will be asked for a total amount of such pay at the end of this section.	
Surgery	See above.	
Orthopedics	See above.	
Neurosurgery	See above.	
Anesthesia	Estimate portion of hospital net cost for anesthesia that is attributable to burn.	
Radiology	Estimate portion of hospital net cost for radiology attributable to burn care.	
Plastic surgery	See above.	
Otolaryngology	See above.	
Ophthalmology	See above.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty_____.	
Other Required Specialty	See above, name specialty_____.	
Surgical Resident Support	This applies to surgical residency only. There are two options: Take residency costs and subtract federal funding and apply portion attributable to burn care, or take residents' hourly salary + benefits for time on burn care rotation, and subtract federal funding for this time.	

EDUCATION & OUTREACH	Includes costs for travel, courses, training, supplies and materials for activities specific to burn. This does not include personnel costs, which should have been included in the Administrative Section.	
Injury prevention	Must be specific to burn.	
Community outreach	This includes public education.	
Professional outreach	This includes offering ATLS courses and providing burn clinical education to EMS and hospital staff in your region.	
Outlying hospital education	This addresses the unique responsibilities of Level I burn centers in supporting outlying hospitals.	
Required Burn CME	Includes costs for courses and travel for up to 16 hours of burn CMEs only for personnel below:	
Burn Medical Director		
Burn Program Manager		
ED Burn Liaison		
Education – burn related for hospital staff	Includes cost of courses plus salary costs for educational time.	
Emergency Department		
Intensive Care unit		
Surgery		

SECTION 5 - BURN CENTER COST CENTER

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

Administrative	
Clinical - Medical staff	
Education & Outreach	
Total	

Please indicate total number of burn patients admitted to your Burn Center in CY 2009 _____. This includes patients from outside of Georgia.

VOLUME, COSTS, DAYS AND ALOS BY SEVERITY

Total Burn Surface Area	Patients	Patient Care Costs	Ave LOS	Cost Per Patient	Cost Per Day
% TBSA 0-5	559	4,976,838	3.2	8,903	2,759
% TBSA 6-10	349	5,024,630	4.7	14,397	3,094
% TBSA 11-20	204	4,449,198	7.0	21,810	3,127
% TBSA 21-30	47	2,928,184	17.9	62,302	3,486
% TBSA >30	53	10,138,802	27.3	191,298	7,012
Electrical burn	38	1,700,226	11.1	44,743	4,039
Smoke inhalation	19	574,424	7.7	30,233	3,934
Totals/Average	**1,269**	**$29,792,302**	**6.1**	**$23,477**	**$3,867**
Trauma Centers	11,319	$232,594,192	7.4	$20,549	$2,774

BURN CENTER PAYER MIX

Payer Type	# of Patients	Patient Costs	Burn Center Payer Mix	Payer Mix
Commercial	390	$9,073,707	30.5%	39.2%
Medicare	182	$5,710,107	19.2%	13.5%
Medicaid	381	$8,436,048	28.3%	19.4%
Self Pay	286	$4,866,420	16.3%	18.7%
Other	30	$1,706,020	5.7%	9.1%
Totals	**1269**	**$29,792,302**	**100%**	**100%**

READINESS/PREPAREDNESS COSTS

Readiness Cost Category	Burn Center Total	Burn Center Average	Trauma Center Average
Administrative	1,175,831	587,916	443,936
Clinical - Medical Staff	911,431	455,716	2,372,247
In-House OR	na	na	309,906
Education & Outreach	132,947	66,474	127,659
Total Readiness Costs	**$2,220,209**	**$1,110,105**	**$3,253,749**

Joseph M. Still Burn Centers spent $964,058 in 2009 for burn prevention, outreach and provider education, with about 50% of these initiatives in Georgia.

REVENUE & FINANCIAL VIABILITY

2009 Financial Performance	Burn Centers	%	Per Pat	Trauma Centers	%	Per Pat
Patient Care Revenue	**$38,074,209**	**128%**	**$30,003**	**$223,277,762**	**84%**	**$19,726**
Patient Treatment Costs	$27,572,093	93%	$21,727	$221,521,285	83%	$19,571
Readiness Costs	$2,220,209	7%	$1,750	$44,291,628	17%	$3,913
Total Costs	**$29,792,302**	**100%**	**$23,477**	**$265,812,913**	**100%**	**$23,484**
Surplus/Loss	**$8,281,907**	**28%**	**$6,526**	**-$42,535,151**	**-16%**	**-$3,758**

Uninsured Burn Patient Care

Georgia's burn centers reported 263 patients meeting SB 60 and state contractual requirements. This would add about 10% to the 2,674 such patients reported by Georgia's trauma centers in 2009.

STATEWIDE HOSPITAL DISCHARGE DATA

An analysis of 2011 data on burn inpatients indicated:

- Verified data supplied by Georgia burn centers
- 90% of burn patients in Georgia reach burn centers
- Few serious burn injuries are admitted to other hospitals

Access to burn care in Georgia is excellent.

STATE FUNDING OF BURN CENTERS

An assessment of other state's practices indicated:

•If a burn center is part of a trauma center, burn patients are often considered trauma patients for funding purposes.

•Funding of burn centers that operate independently of trauma centers occurs through a variety of means; e.g., a small direct allotment in Washington and participation in county uninsured emergency patient care funds in California.

- In Mississippi, 5% of state trauma funds go to burn centers.

Burn centers' funding initiatives focused on Medicare and Medicaid payment rates and they have been effective as evidenced by the 13-15% premium they receive over trauma centers.

While limited, there is precedent for state funding of burn centers.