Minutes approved on 17 February 2011

Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

ANNUAL WORKSHOP

MEETING MINUTES

05 and 06 January 2011
Stuenkel Conference Center
Floyd Medical Center
304 Turner McCall Boulevard
Rome, Georgia 30165

DAY ONE: 05 January 2011

STAFF PERFORANCE REVIEWS

Staff Performance reviews scheduled from 1:00 p.m. to 2:30 p.m. on 05 January 2011 was closed to the public under O.C.G.A. Section 50-14-3(6)

05 January 2011

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Bill Moore Dr. Leon Haley Kurt Stuenkel Linda Cole, RN Kelli Vaughn, RN Rich Bias Ben Hinson	Dr. Joe Sam Robinson (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
Regina Medeiros	MCG Health
Debra Kitchens	MCCG
Dr. Pat O'Neal	SOEMS
Dr. Danlin Luo	SOEMS
Jill Mabley	SOEMS
Renee Morgan	SOEMS
Gordon Jones	GER
Tanya Simpson	Doctors Hospital
Scott Maxwell	Doctors Hospital
Lee Oliver	MCCG

WELCOME AND INTRODUCTIONS

Dr. Dennis Ashley, Chair, welcomed all present and thanked Mr. Kurt Stuenkel for hosting the workshop at the Floyd Medical Center. Mr. Alex Sponseller confirmed quorum status. *(Copy of signed affidavit attached)*

Presentation: Doctors Hospital Augusta, Georgia

Dr. Dennis Ashley introduced Mr. Scott Maxwell with the firm of Matthews and Maxwell, Inc., whom represents the Burn Center and Doctors Hospital. Doctors Hospital is interested in becoming a part of the Georgia Trauma Network. Mr. Maxwell introduced Mr. Terence van Arkel, VP and CFO of Doctors Hospital and Ms. Tanya Simpson, Assistant VP for Burn Services. At the end of the presentation there will be a time of questions and answers. Mr. Terence van Arkel began with a power point presentation and was followed by Ms. Tanya Simpson. (*copy attached of power point presentation*)

Discussion

Ms. Linda Cole asked for clarification regarding the total number of burn patients indicated in their presentation, "Did they meet the trauma registry criteria or just burn registry criteria?" Mr. van Arkel responded these patients meet the burn registry criteria.

Mr. Rich Bias again questioned which population is being discussed? "With regard to the volumes that were referenced, is that all burn patients, is that all burn registry patients and to what extent the subset of trauma ICD registry designation vs. burn"? Ms. Simpson responded that they believe that burns are trauma and that all burn patients that are admitted go into the burn registry regardless of the extent of their injuries. Doctors Hospital does not use ISS because it is not a predictor of mortality in the burn patient. They have a scoring system in place called the BOW System, which is their mortality predictor. Mr. Rich Bias stated that when it comes down to money, our funding is tied to patients that are in the trauma registry. Burn registry will not qualify them unless they also fall into the subset associated with the trauma registry. Ms. Simpson states they have a burn registry is Digital Innovations it is the same thing as trauma; it is an arm of the trauma registry. Ms. Simpson stated they do not submit to the State Trauma registry but do submit to the American Burn Association.

Ms. Simpson states that if Georgia is making a world-class trauma network, the Burn Center feels they play a significant role in that. She states that they want to be equals, however, they do not treat primary trauma. The Burn Center average length of stay is .76 per percent burn, which comes down to about 6-7 days. The majority of burns are between 1-10 percent with seventeen (17) percent of volume being 70-100 percent burns.

Ms. Renee Morgan clarified that they do not include burn patients in the trauma registry typically because those burn patients are transferred out. The patient may be listed as a transfer and what may happen is an occasional burn patient may get in the trauma registry because they did not meet specific criteria to get them transferred to a burn center and they had other injuries related to trauma that ended them in there. If a patient shows up as a primary burn injury, they will go directly to the burn center without being listed in the trauma registry.

Ms. Renee Morgan noted that the College of Surgeons defined this many years ago to break out the burn patients because of the fact that there are so many mitigating factors that took place with burn patients that did not take place with the trauma patients. It is a component of the trauma system and not in the primary registry because it is such a unique injury and the length of stay is longer.

Mr. Kurt Stuenkel stated that we, as the Trauma Commission, have a good sense of what it costs to run a trauma center and the loss that they can occur. What we have talked about is that we do not have a good sense of that as it pertains to a burn center. Doctors Hospital is investor-owned and expanding and one has to assume that they are doing well financially. He questioned, "Would Doctors Hospital be willing to share what their operating margin is on the Burn Center, and if it is profitable, then why should funding come from the Trauma Commission?" Mr. van Arkel replied that he did not have that information with him but he would be willing to share any information that a trauma center is required to share to the Commission. Mr. van Arkel states whether profitable or not, they feel that they should be eligible through the Trauma Commission to participate.

Mr. Stuenkel replied that there are investor-owned facilities that are funded through the Trauma Commission and this is not a prejudice view through this question. "As a Commission, should we be subsidizing something that is already doing pretty well"?

Ms. Linda Cole questioned, "Do they have to pay on-call coverage costs to get the specialists?" Mr. Rich Bias questioned, "Are there different medical staff criteria for the on-call staff for the Burn Center and Doctors Hospital?" Mr. van Arkel replied, "No, they cover for the Burn Center as well as Doctor's Hospital."

Ms. Kelli Vaughn replied, "When it comes to funding, SB60 says a trauma center and there is a definition for trauma center and trauma patient defined as state trauma registry, so if this is something they are thinking about pursuing, they would have to participate in the State Trauma Registry and their patients would have to meet the same criteria."

Ms. Linda Cole stated in SB60 it refers to trauma center and does not refer to burn center and that doesn't mean we don't want to support it; it is how do we do it within SB60? Mr. van Arkel responded that the requirements of being a regular trauma center you are not required to treat burn patients but only a transfer system to a burn center, if that requirement was not in place or didn't exist, those patients would most likely be in a trauma center today.

Mr. van Arkel would like the Burn Center to be part of the network and feels the ticket in there is meeting the requirements of the National Burn Center which are strict requirements and he feels it should allow them to enter the network. In regard to the other levels of the trauma center, Mr. van Arkel feels the Burn Center essentially meets the requirements of a Level 2 trauma center.

Ms. Renee Morgan stated we accept designation from the College of Surgeons and they do have to meet a lot of the same components and if you read the chapter in the Burn Center book it explains how they are a component to the system. To ideally match them to the trauma center criteria, the College has set the distinction of how those burn centers are separated and we follow the College of Surgeons guidelines.

Ms. Linda Cole referenced a letter from Mr. Alex Sponseller to the Trauma Commission dated December 29, 2010, regarding the question of whether or not burn centers are eligible for funds from the Georgia Trauma Care Network Commission. (*Letter is attached as part of these minutes)*

Ms. Linda Cole further stated that she is getting "hung up" on the statement that, "for uncompensated care funding, the GTCNC laws also require that the "trauma patient" is registered "on the State Trauma Registry or the National Trauma Registry of the American College of Surgeons."

Ms. Renee Morgan stated that both the Trauma Registry and the Burn Registry are housed with the American College of Surgeons. For the burn it is specified to the burn care but the College of Surgeons mirror it with the designation process or verification process that they do for trauma centers. You have to go through the exact same process for verification that trauma centers have. The College of Surgeons

decided years ago to break this out because the burns were so unique and they needed their own registry.

Mr. Bill Moore responded, "Either DCH needs to designate this as a trauma center or SB60 needs to be modified. One of these two things has to occur but we can't move on this until something is done with SB60".

Mr. Alex Sponseller agrees with this statement and says that under the Trauma Commission Statute for an institution to receive funding, it has to be a designated trauma center and to get uncompensated care the patient has to be on one of those two registries, either the National Registry or the State Registry. So the bottom line is you have to be a designated trauma center to receive funding. There are really three options to approach this:

1. For DCH to tweak their policy to allow a burn center to be designated as a trauma center and if they meet that criteria then they could apply just like anybody else; but if they were different criteria in that policy it could be a problem if the burn center is exempted from that and the trauma centers are not. The commission is also authorized to provide funding for the start-up cost if they meet the criteria. So the number one question is, "are they a designated trauma center?"

Mr. Rich Bias questioned, "Given the statement Mr. Sponseller just made, they are operating under a single license, a single medical staff, and if they did that wouldn't Doctors Hospital as a whole have to be a trauma center. How can the Burn Center apply as a trauma center?"

Mr. Sponseller responded that statement is correct; Doctors Hospital would have to apply as a whole. The way the statute is written now, that is what they would have to do. The General Assembly can also change the Trauma Commission Statute to state trauma center or burn center.

2. There is a regulation, which authorizes DCH to designate a trauma center, Regulation 290-5-30.04. This regulation doesn't really say that much and there is a possibility that DCH could change the regulation to include a burn center but that also raises a lot of problems too. This would be up to the Board of Community Health if they wanted to do that.

3. The Statute could be changed to include a subsection stating a designated trauma center and certified burn center. The way it is written now you would have to go through the designated process for trauma centers, Levels 1, 2, 3, or 4. In the Commission Statute, there is two sub-sections that deal with funding to institutions directly and that would be readiness costs for trauma centers and uncompensated care for trauma centers and they both require that you be a designated trauma center. So if you are not a designated trauma center, level 1-4, you cannot get funding as the statute is written now.

Dr. Ashley refers to the second option of the DCH rule change and questions, "has this been done before and how would the wording look?" Mr. Sponseller responds that it is a possibility to change the rule but that would need to be voted on by the Board of Community Health and there could be problems with change in policy because if it is not uniform for all the other trauma centers, there could be disputes.

Dr. Pat O'Neal responded that we need to remember the position of DCH on anything related to the trauma system is to essentially be a conduit for the wishes of the Trauma Commission in terms of rule formation. You have the authority to make your own rules but it is easier to go through DCH. DCH does not want to create rules that are going to be in conflict with what the Trauma Commission thinks is best for the system. So, if you tell me you want the rules changed to accommodate the burn centers, we can do that, we can take it to the board. DCH will not create rules that they think might be in conflict with the wishes of the Trauma Commission when it pertains to the trauma system.

Mr. Alex Sponseller stated that without changing the Statute you have to try to change the regulation to reflect exactly what is said in the Statute. The Statute says you have to be a designated trauma center, level 1,2,3, or 4, so you would somehow change the regulation to say burn centers meets this criteria then it is considered to be a trauma center. The way the statute is written now, only designated trauma centers can get funding.

Ms. Linda Cole stated that she felt the cleanest thing to do, if we wanted to move forward, is to take option three and change the Statute.

Mr. Alex Sponseller responded you cannot change a regulation to enlarge a scope of a statute or provide exemptions from certain things, so for any change, you would have to be very careful with.

Dr. Pat O'Neal agrees that the cleanest thing would be to change the statute and also from the standpoint of ongoing system development, rather than changing the statute just to reflect burn centers, he feels we need to be broad, and general. He suggested consideration be given to changing the statute to reflect, specialty care centers as approved by the Trauma Commission. This would give the Commission the option to identify in rule what specialty care centers the Commission would choose to reimburse.

There being no further discussion, Dr. Dennis Ashley, thanked Mr. Terence van Arkel and Ms. Tanya Simpson for their presentation and expressed that he was supportive of them. The question remains as to how to get them in the system. In relation to the Statute, he feels their hands are tied until a change has been made. This meeting was a vital first step in getting the Burn Center on line.

Dr. Ashley recognized Dr. Pat O'Neal. Dr. O'Neal will be leaving due to an emergency. He introduced the newest addition to the Section of Emergency Preparedness and Response within Public Health, Dr. Danlin Luo. Dr. Luo will be able to provide the type of analysis of data as we move forward with system improvement. Dr. Luo, as a doctorate level trauma epidemiologist, can assist the Trauma Commission with statistics and analyses in a way that will permit system development and improvement to be data-driven. She is funded under the Emergency Preparedness and Response grant from the CDC. He encouraged each one to welcome her to our group and to contact her as data analysis needs are identified. Dr. O'Neal has asked her to begin looking at the numbers of trauma patients going out of state and vice versa. Dr. O'Neal announced that he would be stretched for a while, as he will be acting as Interim State Health Officer until a permanent person has been selected.

Presentation: SAAB North America, Inc.

Dr. Dennis Ashley introduced Mr. Scott Sherrill with GTRI. Mr. Scott Sherrill stated he has Mr. Willie Palmer with Georgia Tech Purchasing participating via tele-conference who will be monitoring. There will be a presentation to the Trauma Commission of the vendor and product recommended by the evaluation committee for the TCC RFP. It is based on the combined technical and costs scores of the vendors and a notice of intent to award has been issued to the apparently successful offeror. It is real unusual for a public demonstration of a solution offered in a RFP to be made, but arrangements have been made to do it in this case. The evaluation process is confidential until the notice of intent to award has been posted. What is being presented today is a demonstration, not an evaluation, and only those serving on the evaluation committee had input in the evaluation itself and each member had to commit to following the appropriate state guidelines relative to confidentially and integrity of their review. Arrangements have been made for the commission to see this. Mr. Sherrill makes it clear that the evaluation and the negotiation at this point are complete. The vendor has made its' best and final offer. We will have the opportunity to see the recommended product and will have an opportunity to ask questions regarding the product. The commission cannot require changes to either the solution or the price. The commission will

then have an opportunity to make a decision as to whether or not to move forward. If the commission votes to move forward, an agreement will be executed subject to some administrative concerns and getting approval of the appropriate state agencies. It is noted that during this presentation, only members of the commission will be allowed to ask questions. Mr. Sherrill then introduced Mr. Michael Hoglund and Mr. Ron Sinek with SAAB North America, Inc.

Mr. Hoglund and Mr. Sinek provided a power point presentation regarding the product**.** *(Copy of power point attached)*

Discussion

Ms. Linda Cole commented that as we develop this we need to work with GHA and the database that they have developed in that the hospitals don't want to enter information twice. Mr. Sherrill responded that it does require cooperation on both ends and that they plan to do this.

Mr. Bill Moore made reference to the slide that stated, "Adding modifications could result in less than satisfactory operations". Mr. Sinek responded that they would deliver a complete and tested system. If some other factor is required later, they are advising caution when adding more fields to the database and to really consider utilizing a software developer to oversee it to make sure it is tested properly when done.

Ms. Linda Cole questioned as to the timeline to implement this. Mr. Scott Sherrill responded, "Assuming today if the commission wanted to move forward, there is one administrative issue that we are currently facing and hope to resolve quickly. Given that we need to reduce the agreement to an actual contract within 30 days and a proposed 3-4 month implementation by SAAB. Approval from the Commission is needed for work to begin."

Mr. Rich Bias questioned, "Should there be leakage into the next fiscal year, because the contract is in place, would we be able to encumber the funds and not hit next year's budget". Mr. Jim Pettyjohn responded that the contract can be amended and extended and the funds would be available to the end of that amended contract. We would be using FY11 dollars.

Mr. Bill Moore asked how this came in with comparison to our budget. Mr. Sherrill stated it did fit within the budget.

Dr. Ashley questioned, "How long the support would be as far as implementation getting started, and how will that affect our staff, how long will SAAB be available and how long will support be provided?" Mr. Sinek stated that the training period is brief and that TCC operators and administrators are trained onsite first. In the RFP, there is additional training for hospitals. Level 1 support can handle support via phone 24/7. Mr. Sherrill also stated that for the five years that have been quoted support would be 24/7 via phone.

Mr. Bill Moore questioned about references on the company. Mr. Sherrill responded that all references were in Sweden where they have been in use for seven years. We are very comfortable with this and feel there is a lot of strength in dealing with a larger company committed to open standards that would let us work with third party tools that were available to us.

MOTION GTCNC 2011-01-01:

I make the motion to that we move forward to complete this and use this product to set up the TCC.

MOTION BY:	**Mr. Rich Bias**
SECOND:	**Ms. Linda Cole**
ACTION:	The motion ***PASSED*** with no objections, nor abstentions.

Dr. Ashley thanked SAAB for their presentation and stated he looked forward to working with them.

Day One adjourned at 4:55 p.m.

DAY TWO: 06 January 2011

CALL TO ORDER

Dr. Dennis Ashley welcomed everyone and introduced Mr. Greg Bishop. Mr. Bishop presented a handout regarding objectives/strategies for discussion and planning with discussion regarding strategic plan development**.** *(Copy of handout attached)*

Follow-up to discussion included: According to the budget the Commission needs to figure out their priorities. We need to restructure the priorities in the most effective fashion to present to the legislature. Then use that as a tool for a head start on funding. We will condense it into three strategies, and ten objectives, to make sure we have a good idea where we want to go over the next 5 years. It will be called the 2011 Strategic Plan.

06 January 2011

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Dr. Dennis Ashley Bill Moore Dr. Leon Haley Kurt Stuenkel Linda Cole, RN Kelli Vaughn, RN Rich Bias Ben Hinson	Dr. Joe Sam Robinson

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
Lawanna Mercer-Cobb	Region 6 EMS
Russ McGee	Region 5 EMS
Jill Mabley	SOEMS
Courtney Terwillinger	GAEMS
Regina Medeiros	MCG
Lee Oliver	MCCG
Karen Waters	GHI
Elaine Frantz, RN	Memorial

Subcommittees' Reports and Updates

Mr. Ben Hinson reported on the EMS Sub-Committee with the following:

The EMS Sub-committee met and discussed uncompensated care and working on how the Medicare piece is working. Mr. Keith Wages is representing the EMS Sub-Committee on the Vehicle Grant and is working with Mr. Jim Pettyjohn on this. There are some action items that need to be brought before the commission:

1. Through the In-Motion AVLS system each provider gets two log-in seats, so two people in the organization can be looking at their data at anytime. We have been able to negotiate with In Motion to upgrade that to five log-ins seats for each provider. In-Motion is giving us a cost of about 20% of the normal cost if we buy it for the whole system and that would be a total of $4,800.00. We would like the commission to take action to re-budget $4800.00 as it does not change our top number; it just moves some money inside the AVLS program to pay for additional login seats.

MOTION GTCNC 2011-01-01:

I make the motion that the Commission re-budget $4,800.00 within the AVLS budget to purchase additional log-ins seats from In-Motion for a total of five log-ins per provider.

MOTION BY:	**Mr. Ben Hinson**
SECOND:	**Mr. Rich Bias**
ACTION:	The motion ***PASSED*** with no objections, nor abstentions.

2. At the end of December we were notified that, while GEMA through federal grants, are taking up the payments on the AVLS program, they would not be starting January 1, 2011, so the air time and the final installs that we have on the equipment that was bought could possibly be interrupted. We could wake up February 1 and they could have turned the system off. We need to reallocate funds to pay for the air time for the currently installed AVLS system in the amount of $71,923.19 to carry us to the point where GEMA funding through the federal grant will pick up. Mr. Pettyjohn clarified we had a contract with GTRI that was to have ended at the end of this past calendar year. When it was realized this gap might exist, we scrambled and were able to extend this contract from December 31 through the end of this FY June 30, 2011. The money that we need to put in there will be FY11 funds and how are we going to identify those funds? The money will come from the EMS budget. Mr. Hinson stated we need to make those payments now and we will reallocate some of the 2011 funds in the next subcommittee meeting.

MOTION GTCNC 2011-01-02:

I make the motion that the Commission re-budgets $71,923.19 to pay for air-time and final installations of AVLS equipment with funds coming from FY2011 budget and that the sub-committee will reallocate some of the 2011 funds at the next sub-committee meeting.

MOTION BY:	**Mr. Ben Hinson**
SECOND:	**not needed as this is a recommendation from the sub-committee**

ACTION: The motion ***PASSED*** with no objections, nor abstentions.

3. Mr. Hinson reported that as the trauma equipment grants have gone across the state, there have been requests for variances so services can purchase items that are not on the list. The sub-committee decided rather than grant variances, just to add those items to the list, so whoever needs it later can get it. A part of this is to add washing machines to the trauma equipment list. The washing machine is to sanitize equipment that is reusable and a machine is needed that meets all the standards of OSHA. We are asking to include a washing machine to sanitize the trauma equipment and a chest decompression needle to the equipment list.

MOTION GTCNC 2011-01-03:

I make the motion that the Commission includes on the list of trauma equipment that can be purchased, the addition of a commercial washing machine and a chest decompression needle.

MOTION BY: **Ben Hinson**
SECOND: **not needed as this is a recommendation from the sub-committee**
ACTION: The motion ***PASSED*** with no objections, nor abstentions.

Mr. Hinson further reported that the sub-committee has a request from a county that has been able to purchase a vehicle for $4,000.00 less than what our grant was and they want to use that money to equip the ambulance. This will be taken to the EMS sub-committee before it is brought to the Commission.

OLD BUSINESS

None.

NEW BUSINESS

The next meeting will be February 17, 2011, in Atlanta with place to be announced at a later date. It was decided that meetings will go to an every other month meeting schedule on odd months with the exception of when the legislation is in session and meetings will then be monthly.

Meeting adjourned 2:30 p.m.

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 5th day of JANUARY, 2011, 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

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 11 day of January, 2011.

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

Sworn to and subscribed
before me this 11 day
of January, 2011.

Notary Public
My Commission Expires: March 10, 2014

(Notary Seal Here)

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Terence van Arkel, VP/ Chief Financial Officer
Tanya Simpson, RN, MS - Assistant Vice President
Doctors Hospital

HCA®
Hospital Corporation of America®

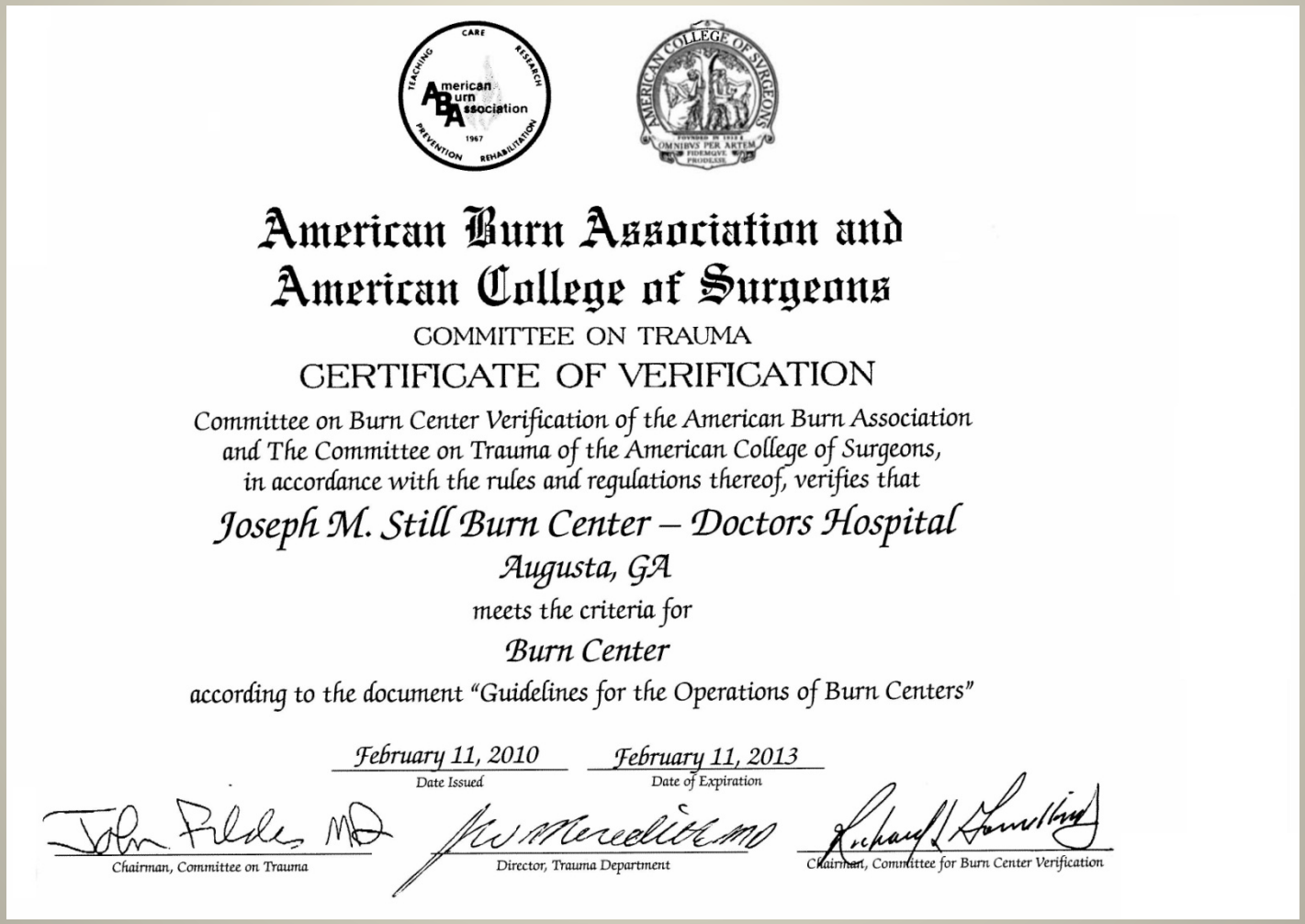
DOCTORS HOSPITAL
Joseph M. Still Burn Center

Objectives

- Why Burn Centers should be part of a "World Class" State-wide Trauma System.
- Educate trauma commission on the operational facts and attributes of the Joseph M. Still Burn Center at Doctors Hospital- Augusta, Georgia.

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital Burn Unit Verified by the ABA/ACS Validating our compliance with the Standards of Care 2/11/2010



American Burn Association and
American College of Surgeons

COMMITTEE ON TRAUMA

CERTIFICATE OF VERIFICATION

Committee on Burn Center Verification of the American Burn Association and The Committee on Trauma of the American College of Surgeons, in accordance with the rules and regulations thereof, verifies that

Joseph M. Still Burn Center – Doctors Hospital
Augusta, GA

meets the criteria for

Burn Center

according to the document "Guidelines for the Operations of Burn Centers"

February 11, 2010 — Date Issued
February 11, 2013 — Date of Expiration

Chairman, Committee on Trauma
Director, Trauma Department
Chairman, Committee for Burn Center Verification

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Why Include the Burn Center in the Network?

- Doctors Hospital Burn Center cares for 68% of all burn patients in the state.
- Research has proven patient outcomes are better when treated in a specialized burn center. Carter, J.E, Neff, L.P, Holmes, J.H. Adherence to Burn Center Referral Criteria: Are Patients Appropriately Being Referred?, Burn Care and Research 2010; 31: 26-30.
- Trauma designation standards do not require that a designated facility treat burn patients, only that there is a "transfer agreement" with a hospital with a burn center.
- Burn Center currently receives 3 patient transfers a week from trauma centers around the state (Level I – Level IV).
- Currently, Burn Center removes the burden of treating burn patients from other Trauma centers without access to reimbursement for uncompensated care patients or readiness costs.
- Burn center has the resources in place to meet Level II criteria, per designation standards, as they relate to the care of burn trauma patients.
- Currently meet designation requirements : quality programs, research, peer review, outreach education and prevention and physician/staff educational requirements. (Crosswalk hand out provided).
- **Doctors Hospital is the only hospital in the state with a trauma service line that is verified by the American College of Surgeons.**

DOCTORS HOSPITAL
Joseph M. Still Burn Center

National Burn Statistics

- 2.4 million burn injuries occur per year
- 650,000 seek medical treatment
- 75,000 are hospitalized
- 20,000 have burns > 25% TBSA
- 8,000 – 12,000 will die from burn injury

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Burn Center Facts
National Statistics

- There are 125 Burn Centers in the United States
- Average Burn Center in US size is 15 beds
- From 1998-2008, there were 127,016 burn patients treated in Burn Centers nationally.
- 71% of burn patients are male
- Mean age for all cases is 32 years old
- Most common etiologies of burns are flame burns in adults and scald burns in children
- Pneumonia is the most frequent complication of a burn injury

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Georgia Statistics

- 89 fire deaths in 2009
- 25 of these fire deaths were children - 28%
- In 2008 there were 1,410 burn injuries that occurred in Georgia, serious enough to require hospitalization in a Burn Center

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Mechanism of Burn Injury

- Fire/Flame: 40%
- Scald: 30%
- Contact with hot object: 8%
- Electrical: 4%
- Chemical: 3%
- Other: 15%

American Burn Association 2008 National Burn Repository Data

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital Joseph M. Still Burn Center Statistics

- Founded in 1978, by Dr. Joseph M. Still, we have served burn victims throughout the Southeastern US for over 30 years.
- Largest Burn Center in the country with 70 designated burn beds, treating 3,000 in- patients annually.
- Treat 12,000 patients annually in our Wound and Burn Outpatient Clinic.
- Average Daily Census of 45 over last two years (76% Occupancy).
- Provide quality patient care to all we serve regardless of funding

Fall 2008 Vol. 3

INSIDE:
The Past Present and Future of Burn Care Page 3
Educating the Public about Burns Page 7
Caring for Burn Patients' Families Page 8

SPECIAL 30TH ANNIVERSARY EDITION

Burn Care Commentary is a publication of the Joseph M. Still Burn Center at Doctors Hospital in Augusta, Georgia.

If you have questions, comments or suggestions for future topics, please contact Tanya Simpson, RN, MS, Assistant Vice President of Burn Services at 706.651.6399.

Beth Fritz, Public Relations Coordinator can be contacted at 706.364.6400.

For patient referrals, contact R. Fred Mullins, MD, Medical Director of Joseph M. Still Burn Center at 1.877.863.9595

Burn Care Commentary

A Publication for Healthcare Professionals provided by the Joseph M. Still Burn Center

Joseph M. Still Burn Center Celebrates 30 Years!

Dr. Joseph M. Still, Jr. as he appeared when the Burn Center was established in 1978. Through Dr. Still's vision, compassion and determination, his dream was realized. At the time of his death in 2006, the Joseph M. Still Burn Center had become one of the world's leading burn treatment facilities. His memory lives on as the Burn Center continues to expand and advance in its fourth decade.

To many it seems like just yesterday when Dr. Joseph M. Still presented his vision for a multi-disciplinary, world-class burn center to the administration of Doctors Hospital. With the support of local and corporate administrations and the idea that every patient would receive the highest quality of care, regardless of his or her ability to pay, the Joseph M. Still Burn Center opened in 1978 with one bed, two physicians, Drs. Joseph Still and Butch Garrison, and one nurse, Sue Nevil, who later became Mrs. Joseph Still.

As the Burn Center's level of knowledge and expertise and its reputation for compassionate, excellent care grew, the unit soon expanded to 10 beds and in 1985 opened the self-contained facility of 25 beds. In 2005 the Burn Center opened a 34 bed step-down unit for a total of 59 beds.

Along with the rapid growth came significant changes in the way burn care was and is provided. While medical and technological advances inspired much of this change, Dr. Still and his staff pioneered several new procedures, including early excision and the use of cultured epithelial autografts.

According to Dr. Carlos Blanco, a world-renowned expert in burn care, physicians did not learn how to treat burn patients until the early 1920's. "It used to be that a patient with a 20-30% surface area burn would die. They would go into shock and die. Once physicians began replacing fluids, patients would do better," he said.

While burn patients' chance of survival improved, the outlook for a severely burned patient was still bleak in the 1950's and 60's. According to Blanco, a person with a 45% surface area burn had a 50% chance of survival in 1967, and that patient remained in the hospital for approximately 45 days, one day for every percentage of surface area burned.

Currently, the national survival rate for all burns is 95%. And while more burn patients are surviving, their quality of life has also improved. Patients experience far fewer scars and deformities and report greater ease of returning to home, work or school.

(Continued on Back cover, see "Celebrating 30")

DOCTORS HOSPITAL
Joseph M. Still Burn Center
josephmstillburncenter.com

DOCTORS HOSPITAL
Joseph M. Still Burn Center

State Burn Market Share Data

	2007		2008		2009	
Facility	Cases	Market Share	Cases	Market Share	Cases	Market Share
Doctors Hospital of Augusta	1,064	66.71%	1,114	70.20%	1,059	68.50%
	1,064	**66.71%**	**1,114**	**70.20%**	**1,059**	**68.50%**
Grady Memorial Hosp/Grady Health System	343	21.50%	296	18.65%	354	22.90%
Memorial Health University Medical Center	15	0.94%	17	1.07%	10	0.65%
Southeast Georgia Health System, Brunswick Campus	10	0.63%	10	0.63%	7	0.45%
South Georgia Medical Center	6	0.38%	9	0.57%	4	0.26%
Hamilton Medical Center, Inc.	5	0.31%	7	0.44%	4	0.26%
Washington County Regional Medical Center	7	0.44%	8	0.50%	-	0.00%
John D. Archbold Memorial Hospital	4	0.25%	3	0.19%	6	0.39%
Childrens Healthcare of Atlanta At Egleston	5	0.31%	4	0.25%	4	0.26%
Henry Medical Center, Inc.	7	0.44%	5	0.32%	-	0.00%
Floyd Medical Center	4	0.25%	3	0.19%	4	0.26%
	406	**25.45%**	**362**	**22.81%**	**393**	**25.42%**
	125	7.84%	111	6.99%	94	6.08%
	1,595	**100.00%**	**1,587**	**100.00%**	**1,546**	**100.00%**

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital of Augusta
Burn Inpatient Admission Payer Mix – Ga Residents
Jan 2010 – Nov 2010

Facility		
Payor Group	**Total Cases**	**Total % of Total**
BCBS	83	7.84%
Commercial	12	1.13%
Managed Care	98	9.25%
Medicaid	125	11.80%
Medicaid Mgd Care	205	19.36%
Medicare	145	13.69%
Medicare Mgd Care	4	0.38%
Other	4	0.38%
Other Govt	30	2.83%
Self Pay/Charity	242	22.85%
Workers Comp	111	10.48%
Grand Total	**1,059**	**100.00%**

Georgia Trauma Centers - Excludes DHA Burn Patients Trauma Payer Mix (Georgia Residents Only)

Trauma Inpatients*		
Payor Group	Total Cases	Total % Down
BCBS	534	5.73%
Commercial	1,020	10.95%
Managed Care	1,241	13.32%
Medicaid	538	5.78%
Medicaid Mgd Care	297	3.19%
Medicare	2,434	26.13%
Medicare Mgd Care	224	2.40%
Other	814	8.74%
Other Govt	246	2.64%
Self Pay/Charity	1,712	18.38%
Workers Comp	255	2.74%
Grand Total	**9,315**	**100.00%**

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Burn Transfers to Doctors Hospital Burn Center from Designated Trauma facilities in Georgia
Jul 01, 2009 – Jun 30, 2010

Level I

• Medical College of Georgia	20
• Medical Center of Central Georgia	29
• Memorial Health, Savannah	28
1 year Total	77

Level II

• Archibald Memorial	8
• Athens Regional	22
• Medical Center – Columbus	15
• Floyd Medical Center	18
• Gwinnet Medical Center	4
• Hamilton Medical Center	15
• North Fulton Regional	4
Total	86

Level IV

• Morgan Memorial	6

Grand Total of 169 patients transferred to the Joseph M. Burn Center from designated trauma centers in one year.

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital Quality Indicators Better than National Averages

- Survival Rate
- Length of Stay
- Infection Rates

  Bloodstream Infections

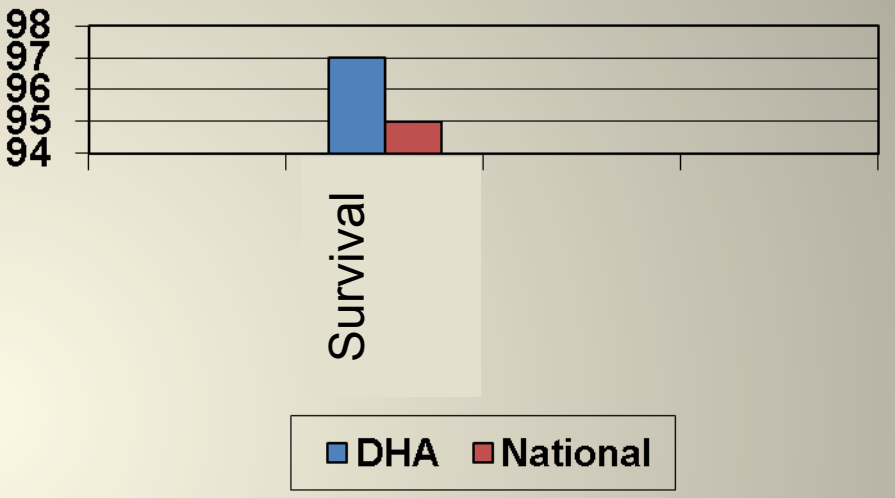
  Urinary Tract Infections

  Ventilator Associated Pneumonia

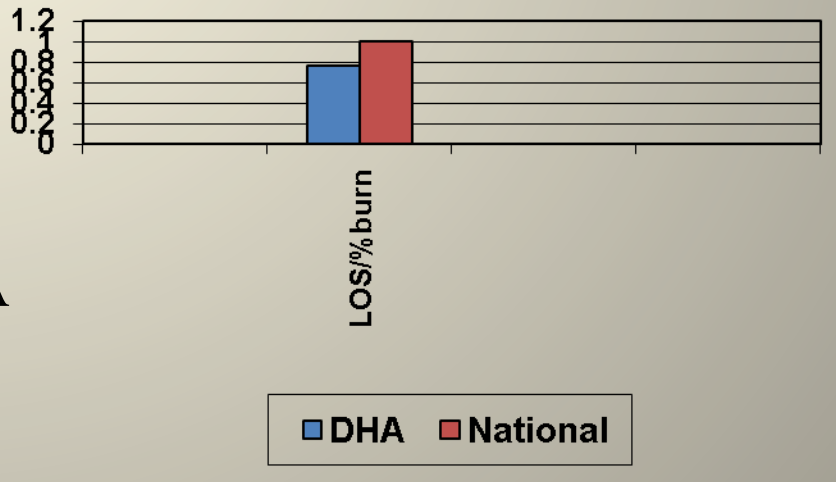
DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital Burn Center Indicators

- **Survival Rate DHA: 97%**
- **Survival Rate National: 95%**



- **LOS DHA: 0.76 days/%TBSA**
  (TBSA-total burn surface area)
- **LOS National: 1.0 day/%TBSA**



DOCTORS HOSPITAL
Joseph M. Still Burn Center

Doctors Hospital Burn Services
Dedicated Human Resources

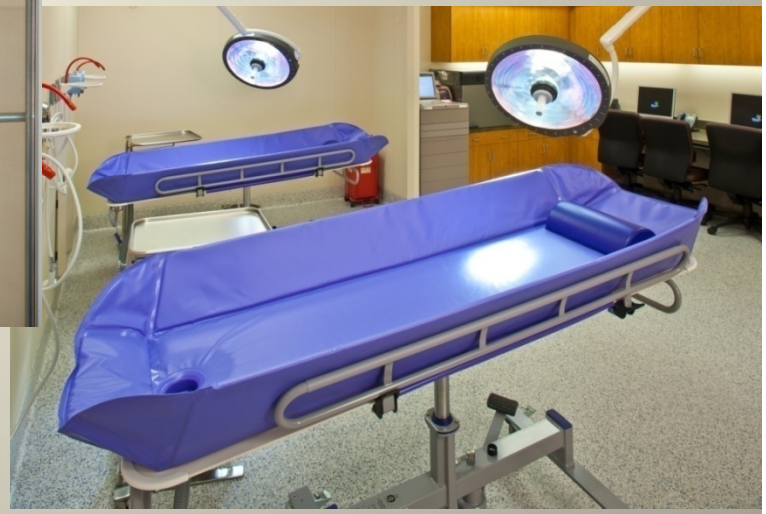
- **5 Full-time Burn Surgeons and 2 Part-time surgeons**
- **17 Mid Level Practitioners (Nurse Practitioners and Physician Assistants)**
- **24 hour Burn dedicated Adult Intensivists and Pediatric Intensivists**
- **2 Burn Educators**
  - Provide ongoing staff competency education
  - Provide certifications in ACLS, ABLS, & PALS for all Burn staff
- **2 Full-time Social Workers and 4 Full-time Case Managers dedicated to Burn Services**
- **18 Physical and Occupational Therapists dedicated to Burn Services**
- **Full-time, dedicated Clinical Pharmacist for the BICU**
- **Full-time Child Life Specialist for Burn Services**
- **> 185 Burn Nurses**
  - 26% Nursing staff > 10 years burn experience
  - Burn Fellowship Program to train new nurses in burn care and burn critical care
- **Burn specialty OR teams and anesthesia**
- **35 Burn Technicians with burn specific training**
- **Full-time Data Coordinator (TRACS) – Burn Registry**

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Commitment to Ongoing State of the Art Technology and Care renovation and expansion to include:

- New 20 bed private room burn ICU designed to meet the special needs of a major burn trauma patient . All rooms are temperature controlled, have new cardiac monitors, beds with specialty mattresses to reduce pressure and Infection Control and prevention stations. 70 Beds Dedicated to Burn Services.
- New Advanced Wound and Burn Outpatient Clinic includes 16 treatment rooms and 4 fully monitored procedure rooms
- Burn Center ambulance entrance
- 2 bay receiving/admission room
- Burn Pre-op suite
- 4 Burn operating suites
- Staff lounge and EMS workroom
- Inpatient family waiting room
- Outpatient waiting room and registration

DOCTORS HOSPITAL
Joseph M. Still Burn Center



DOCTORS HOSPITAL
Joseph M. Still Burn Center

Complexity of Care

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Equipment/Special Needs for Burn Trauma Patients at Doctors Hospital

Specialized equipment available to care for the critically injured burn patient includes:

- Ventilators – multiple type for various modes of ventilation
- Multiple IV Pumps (i.e.. 20 infusions)
- Rapid Infusers
- Cardiac/Hemodynamic Monitoring
- Dialysis (Hemodialysis and CRRT)
- Nutritional (Duodenal Tube Feedings)
- Low air loss specialty surface
- Warmers (body and fluid)
- Thermo-regulated rooms
- Whirlpool/Hydrotherapy
- Dermatomes/Meshers/Bovies
- Traction Devices
- Isolation capability
- Hyperbaric Chambers

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Complexity of Equipment

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Commitment to Follow-up Care
Advanced Wound and Burn Clinic at Doctors Hospital

- 20 bed outpatient facility opened in Jan 2010
- Comfortable waiting facilities and private registration areas
- State of the art monitoring equipment, hydrotherapy, and hyperbaric treatment alternatives
- Dedicated, wound care certified staff including PT/OT therapists.
- Lymphedema management
- Easy access to burn outpatient services

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Commitment to Families

Partnering with the Southeastern Firefighters Burn Foundation allows us to care for families under stress by:

- Providing on campus housing at the Shirley Badke Retreat – capacity of 50 family members
- Coordinating local churches and civic organizations to bring daily meals to the waiting room
- Sponsors educational sessions and support groups for families while their love one is hospitalized

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Commitment to Research
Joseph M. Still Research Foundation

The Research Program allows us to provide cutting edge technology. Typically 8 -12 research studies are in progress at all times.

- Burn dressings/topicals
- Anti-infective agents
- ARDS drugs
- Anti-fungal agents
- Medical Devices
- Physician CEO Carlos Blanco

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Commitment to Burn Outreach Education and Prevention

Medical Education

- JMS Burn Symposium annually
- Emergency Burn Care Lectures to nursing schools, EDs, EMS
- ABLS Courses (Conduct 6-12 annually)
- Burn Care Commentary produced bi-annually and mailed to 20,000 ED and Trauma physicians throughout the Southeast

Community Prevention Education

- Burnie mascot Safety Program for pre-school and school-age children
- Health Fair Burn Prevention Displays

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Success Based on:
Experience and Resource Availability

- Proven Quality Outcomes
- 32 years experience and dedication to Burn care
- Streamlined referral process. ED physicians will speak immediately and directly to burn surgeon for transfer and emergent care guidance
- Rapid transport from ED or the "scene" to the Burn Center
- On-campus capability to house family members at the Shirley Badke retreat
- State of the art equipment and treatment options
- Fully integrated multi-disciplinary team

DOCTORS HOSPITAL
Joseph M. Still Burn Center

ABA Referral Criteria

A burn unit may treat adults or children or both. Burn injuries that should be referred to a burn unit include the following:

1. Partial thickness burns greater than 10% total body surface area (TBSA).

2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Third-degree burns in any age group.

4. Electrical burns, including lightning injury.

5. Chemical burns

6. Inhalation burns

7. Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality.

8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in situations and should be in concert with the regional medical control plan and triage protocols.

9. Burned children in hospitals without qualified personnel or equipment for the care of children.

10. Burn injury in patients who will require special social, emotional or long-term rehabilitative intervention.

Excerpted from Guidelines for the Operations of Burn Units (pp. 55-62), Resources for Optimal Care of the Injured Patient: 1999, Committee on Trauma, American College of Surgeons.

DOCTORS HOSPITAL
Joseph M. Still Burn Center

Questions ??

Department of Law
State of Georgia

THURBERT E. BAKER
ATTORNEY GENERAL

40 CAPITOL SQUARE SW
ATLANTA, GA 30334-1300

29 December 2010

Facsimile: (478) 633-6195

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

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

RE: Burn Center Eligibility For Commission Funds

Dear Dr. Ashley and Commission Members:

You have asked for a response to inquiries from Mr. Terence van Arkel, Vice-President and CFO of Doctors Hospital, of which the Joseph M. Still Burn Center ("JMSBC") is a part. By letter dated December 14, 2010, Mr. van Arkel asks whether burn centers are eligible for funds from the Georgia Trauma Care Network Commission ("GTCNC") and requests advice on how current law would permit burn centers to receive funding. The responses to the specific questions raised in the December 14, 2010 letter are provided below:

1. *Do the GTCNC laws allow the Department of Community Health to designate a burn center such as JMSBC so as to be eligible to receive funding from the GTCNC?*

Yes, so long as a burn center falls under the definition of "trauma center" and is so designated as a trauma center by the Department of Community Health ("DCH"). As you know, the GTCNC laws authorize funding to designated trauma centers, physicians who treat trauma patients in designated trauma centers, and EMS providers treating trauma patients. O.C.G.A. § 31-11-102(3)-(7). The main types of funding to these recipients include funds to reimburse for uncompensated trauma patient care, funds for readiness costs, funds for start-up costs for new trauma centers, and funds for trauma transportation. *Id.* § 31-11-102(3)-(8). To receive funding for uncompensated patient care and readiness costs, a hospital or healthcare institution must be a designated "trauma center." *Id.* § 31-11-102(3), (4). "Trauma center" is defined as "a facility designated by [DCH] as a Level I, II, III, or IV trauma center." *Id.* § 31-11-100(1). Additionally, for uncompensated care funding, the GTCNC laws also require that the "trauma patient" is registered "on the State Trauma Registry or the National Trauma Registry of the American College of Surgeons." *Id.* § 31-11-100(2).

DCH designates trauma centers through the Office of EMS pursuant to DCH Rule 290-5-30-.04.[1] Generally, trauma centers are designated based on a recommendation from a Regional EMS Council where the candidate institution is located. DCH Rule 290-5-30-.03(3). The Office of EMS defines the policy and process for designation and "has the authority to review, enforce and recommend removal of trauma center designation for trauma centers." DCH Rule 290-5-30-.04.

It is my understanding that neither Doctors Hospital nor JMSBC has been designated as a trauma center by DCH. To receive uncompensated care and readiness cost funding from the GTCNC as an institution, either Doctors Hospital or JMSBC must first be designated as "trauma center" by DCH. O.C.G.A. §§ 31-11-100(1); 31-11-102(3),(4); DCH Rule 290-5-30-.04. However, although Doctors Hospital and JMSBC cannot currently receive funding for uncompensated care and readiness costs, these institutions may receive GTCNC funding for trauma center start-up costs if eligible and approved by the GTCNC. O.C.G.A. § 31-11-102(6).

---

[1] DCH Rule 290-5-30-.04 provides:

> **(1) Applicability.**
>
> (a) This section shall not prevent any hospital or medical facility from providing medical care to any trauma patient.
>
> (b) No hospital or medical facility shall hold itself out or advertise to be a designated trauma center without first meeting the requirements of these rules.
>
> **(2) Designation.**
>
> (a) The OEMS shall define in policy the process for trauma center designation and redesignation.
>
> (b) The OEMS has the authority to review, enforce and recommend removal of trauma center designation for trauma centers failing to comply with applicable statutes, Rules and Regulations and department policy.
>
> (c) Designation will be for a period of three (3) years.
>
> (d) Each designated trauma center will be subject to periodic review.

2. *Was the intent of the GTCNC laws to include burn center patients in the benefits of the trauma system, including funding and reimbursement for uncompensated patient care and readiness cost funds?*

Yes, if the burn patient was treated at a designated trauma center and the burn patients fell within the definition of "trauma patient" under GTCNC laws. For the reasons set forth in response to question no. 1, only institutions designated as trauma centers may receive funding for readiness and uncompensated care costs. O.C.G.A. §§ 31-11-100(1); 31-11-102(3),(4). Further, for uncompensated care costs, only services to those patients falling under the definition of "trauma patient" may be reimbursed.[2] *Id.* §§ 31-11-100(2); 31-11-102(4). Hence, if a burn patient was treated in a designated trauma center and that patient was registered as a trauma patient under applicable law, then the GTCNC laws authorize the GTCNC to approve readiness and uncompensated care costs funding for that institution.

3. *If burn centers did not exist and burn injuries were handled in trauma centers, would burn injuries be excluded from GTCNC funds?*

No, so long as the burn injuries were treated at a designated trauma center and the patient fell under the definition of "trauma patient." O.C.G.A. §§ 31-11-100(1), (2); 31-11-102(3),(4). For the reasons set forth in responses to questions nos. 1 and 2, if a burn patient was treated in a designated trauma center and that patient was registered as a "trauma patient" under applicable law, then the GTCNC laws authorize the GTCNC to approve readiness and uncompensated care costs funding for that institution.

4. *To enter the trauma network, should burn centers seek admission through Regional EMS Councils or seek admission through the GTCNC directly?*

Pursuant to DCH Rules, applicant institutions for trauma center designation are recommended by Regional EMS Councils to the Office of EMS and DCH for designation approval. DCH Rules 290-5-30-.03; 290-5-30-.04. Under current law, the GTCNC does not designate trauma centers,

---

[2] Both readiness costs and uncompensated care costs have additional requirements for reimbursement which will not be discussed in detail here. For readiness costs reimbursement, the GTCNC must be the payor of last resort, all other resources must be exhausted, and the GTCNC funds "must be used to meet a verified need that assists the trauma center to maintain a trauma center designation." O.C.G.A. § 31-11-102(3)(A)-(C). Similarly, for uncompensated care costs, the GTCNC must be the payor of last resort, the funds must be used for "designated trauma patients," and reimbursement must be on a fee basis which cannot exceed the average rate under the State Health Benefit Plan. O.C.G.A. § 31-11-102(A)-(E).

but may provide start-up funding for institutions to enter the system as new designated trauma centers. O.C.G.A. § 31-11-102(6).

5. *Because the National Trauma Registry, American College of Surgeons ("ACS") also has a burn specific registry and ICD-9 codes for burn injuries designated as trauma codes by ACS, would burn patients fit the definition of "trauma patient" so as to receive funding under the GTCNC laws?*

Probably yes, but a hospital or healthcare institution receiving GTCNC funds must also be designated as a trauma center. O.C.G.A. §§ 31-11-100(1), (2); 31-11-102(3),(4). If a burn patient is registered "on the State Trauma Registry or the National Trauma Registry of the American College of Surgeons," then the GTCNC is authorized to provide funding if all other criteria are met. *Id.* § 31-11-100(2). However, if a hospital or healthcare institution applying for funding is not a designated trauma center, then the GTCNC is not authorized to provide readiness costs or uncompensated care costs funding to that institution. *Id.* §§ 31-11-100(1); 31-11-102(3),(4).

I hope this letter is responsive to your inquiry.

Yours very truly,

Alex F. Sponseller
Assistant Attorney General

cc: Commission Members
Jim Pettyjohn, Administrator

Document No. 611021

DOCTORS HOSPITAL

3651 Wheeler Road
Augusta, Georgia 30909
(706) 651-3232

www.doctors-hospital.net

December 14, 2010

Dr. Dennis Ashley, Chairman
Georgia Trauma Care Network Commission

Dear Dr. Ashley:

This letter is to request that Doctors Hospital of Augusta, home of the Joseph M. Still Burn Center which treats approximately 70% of the burn patients who reside in the state of Georgia, be permitted to make a presentation to the Georgia Trauma Care Network Commission (GTCNC) at your January 5 & 6, 2011 workshop. As you know, the Burn Center is actively working to become a full and equal partner in the Georgia Trauma Care Network. However, at several meetings of the Commission, questions have arisen about the necessary prerequisites for a Hospital to receive burn trauma designation, as well as the correct procedure to be followed. It is our desire to reach a conclusion collaboratively on these issues, and we hope we could do so during the Commission's workshop session scheduled in January 2011.

We also request clarification of some of the terms, definitions, restrictions and authorities existing in current Official Code of Georgia 31-11 *et seq.* which govern the creation and operation of the GTCNC. (SB 60, 2007)

To wit:

Does language in the above mentioned statute governing the work of the GTCNC (or any other statute) allow for the Department of Community Health to designate a "Burn Center" in such a way that it would be eligible under law to receive funding from the GTCNC should the Commission elect to distribute such?

Was the intent of SB 60 to include burn trauma patients in the benefits of the trauma system, including funding and reimbursement from the uncompensated patient and readiness cost funds? Or, exclude them? If burn centers did not exist and burn care was being handled today in the existing Designated Trauma Centers, would burns be excluded from the benefits provided by the Commission?

As burn centers draw patients from across the state and receive transfers from most designated trauma centers regardless of their location, should the burn center go through a regional EMS

council for entrance into the network or should such request go directly through the Commission?

Since the National Trauma Registry, American College of Surgeons (NTRACS) also has a burn specific registry www.dicorp.com, and burn ICD -9 codes for burn (940 – 949) are designated as trauma codes by the ACS, would burn patients fit the definition of "trauma patient" in the Official Code of Georgia?

If everyone has a clear understanding of the statute's parameters during discussions at the January workshop, it would certainly facilitate a resolution to this issue in a timely manner.

Thank you for your consideration.

Sincerely,

Terence van Arkel
VP/Chief Financial Officer

Georgia Trauma Communications Center

Presentation to Georgia Trauma Commission

Michael Höglund and Ron Sinek
January 5, 2011

A HISTORY OF HIGH TECHNOLOGY

1941

First B17 delivered

1948

Tunnan – first flight

1979

First RBS15 contract

1990

First laser simulator BT46

1993

First Gripen delivered

2002

First contract for NLAW

2005

Contract for Neuron

2006

Saab 2000 ERIEYE™ AEW&C

2008

Gripen Demo – first flight

1937 Saab is founded

1990 Saab Automobile independent company

2000 Saab acquires Celsius

2005 Saab acquires Grintek

2006 Saab acquires EMW

1646

Bofors Järnbruk is founded

1894

Alfred Nobel acquire Bofors

1948

First order for Carl-Gustaf

1998

StriC in operation

1950–

Development of fighter radar

1970–

Development of GIRAFFE

1980–

Development of ARTHUR

1990–

Sea GIRAFFE AMB is launched

VISION

It’s a human right to feel safe

Since Saab was started, we have striven to keep society and people safe. It is a basic human need to feel safe and, as we see it, a human right. Through systems and solutions that increase security, we can make this possible.

NORTH AMERICAN PRESENCE

1 **Saab North America Inc.**
Washington DC

2 Saab Barracuda USA LLC
Lillington, North Carolina

3 Saab Training USA LLC
Orlando, Florida

4 Saab Support and Services LLC
Sterling, Virginia

Saab Aircraft Leasing
Sterling, Virginia

5 **Saab Technologies Canada Inc.**
Headquarters in Ottawa

6 Saab Microwave
Halifax, Canada

SAAB

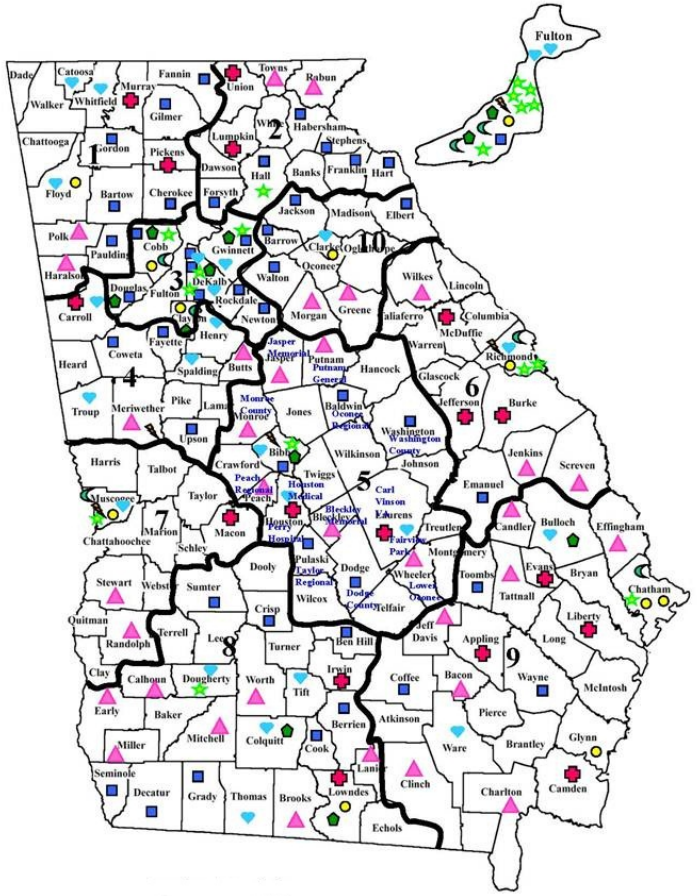
OVERVIEW

- Proposed system is Americanized version of Saab's Paratus system in use throughout much of Sweden
  - TCC operator interface based on existing Paratus framework
  - Integration of Tacticall, Saab's widely-used communications bridge product
  - Tailoring to meet Georgia Trauma Commission's requirements

Paratus means "Ready!" in Latin, as in the US Coast Guard's motto:
Semper Paratus

OVERVIEW

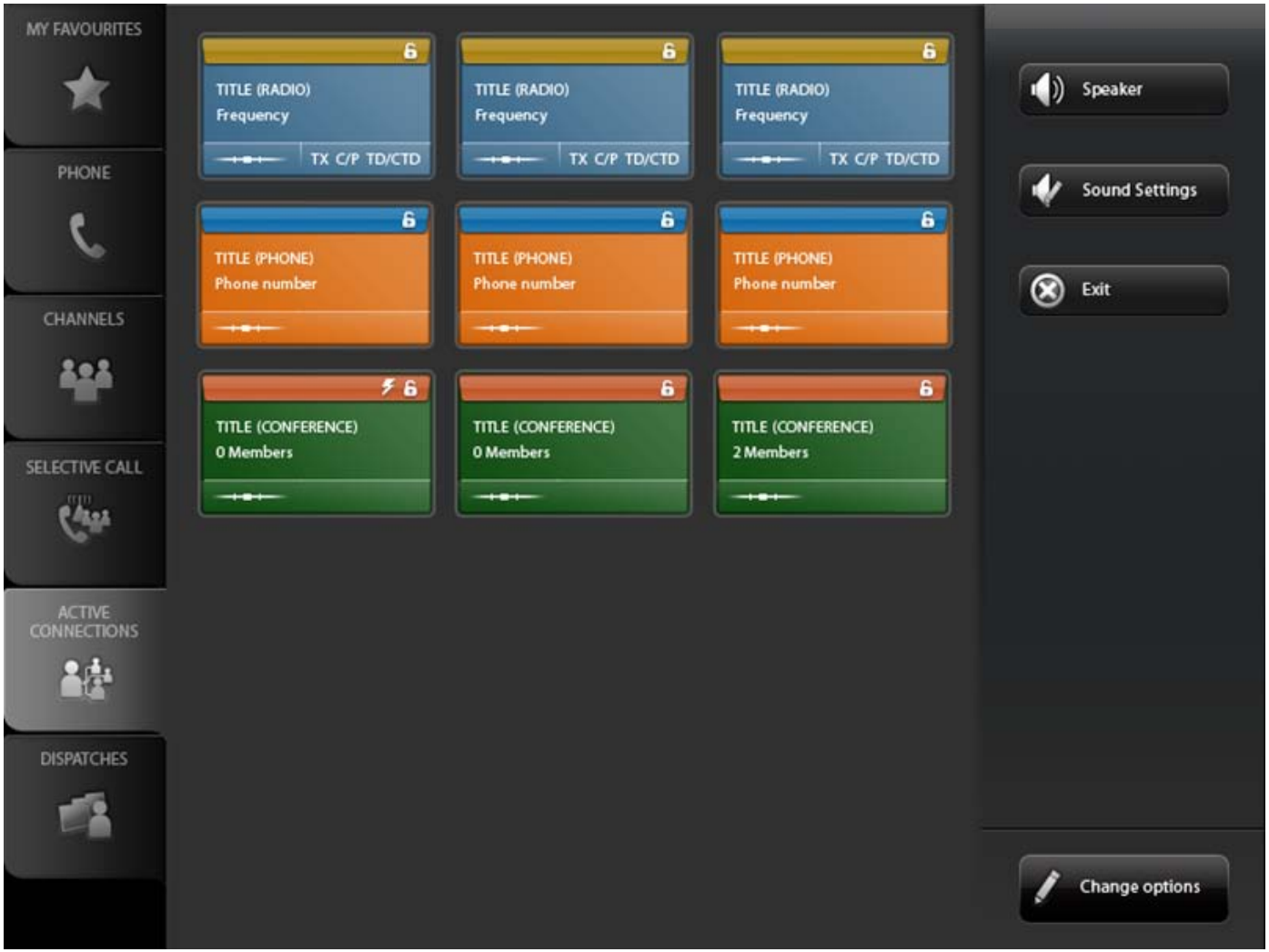
- System is 100% web-based
  - IE8 is the recommended and supported browser, and is the ONLY software required on the client system.
  - Redundant servers will meet the State's needs now and into the future
  - Microsoft SQL Server industry standard database
    - Supports a wealth of reporting and data interchange tools



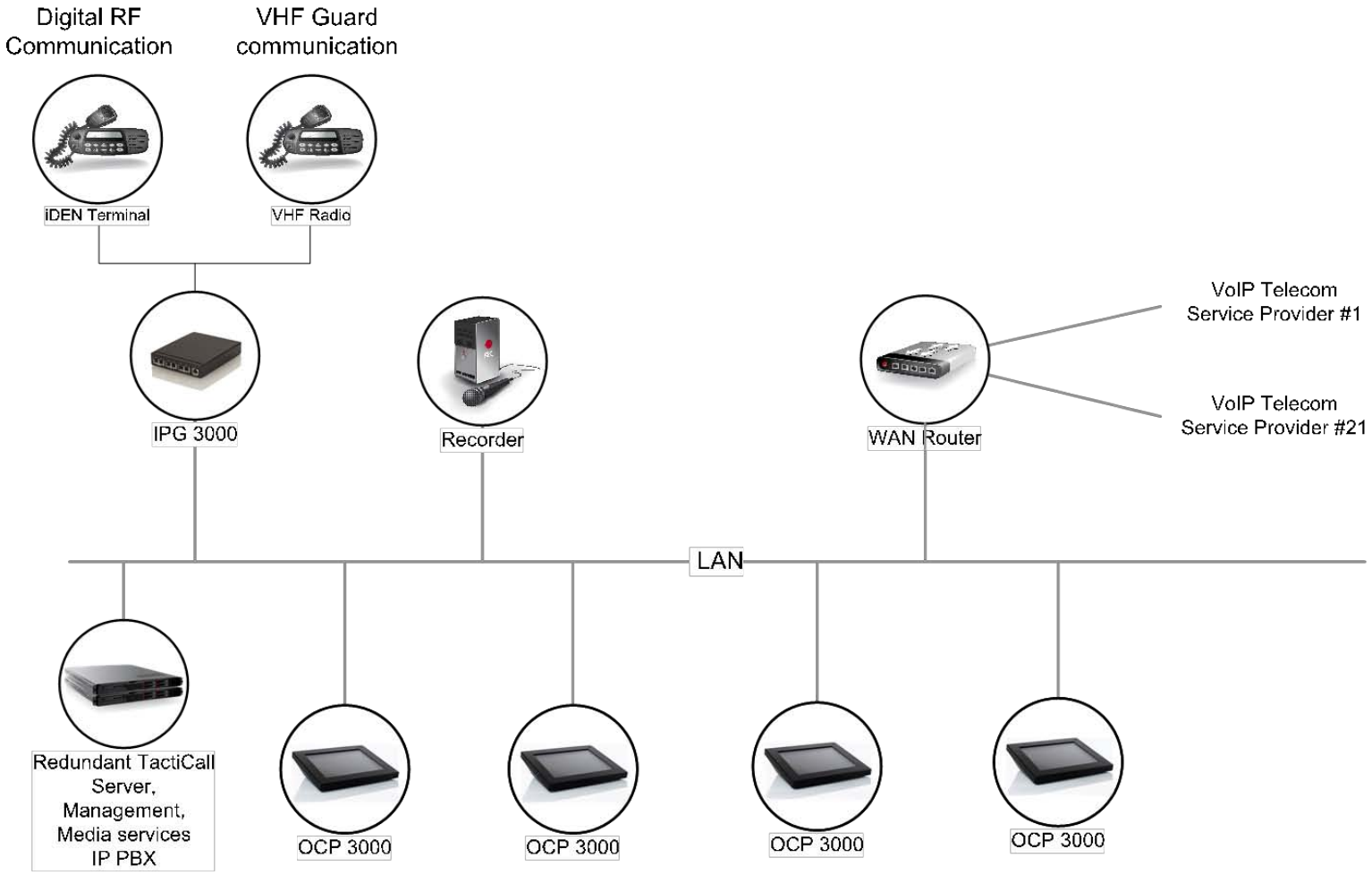
COMMUNICATIONS EQUIPMENT

- Tacticall
  - Saab's commercially available IP-based communications bridge
  - Widely used in civilian and military applications
  - Simple & elegant user interface (touchscreen)
    - Eliminates need for any other communication gear at operator's console
  - Allows complete flexibility of patching, e.g., radio to phone, etc.
  - We will integrate specified radios and POTS & IP telephony
    - Motorola i365 & CM3000 (or others if Georgia prefers)
  - Recording will be on dedicated server

COMMUNICATIONS EQUIPMENT



COMMUNICATIONS EQUIPMENT



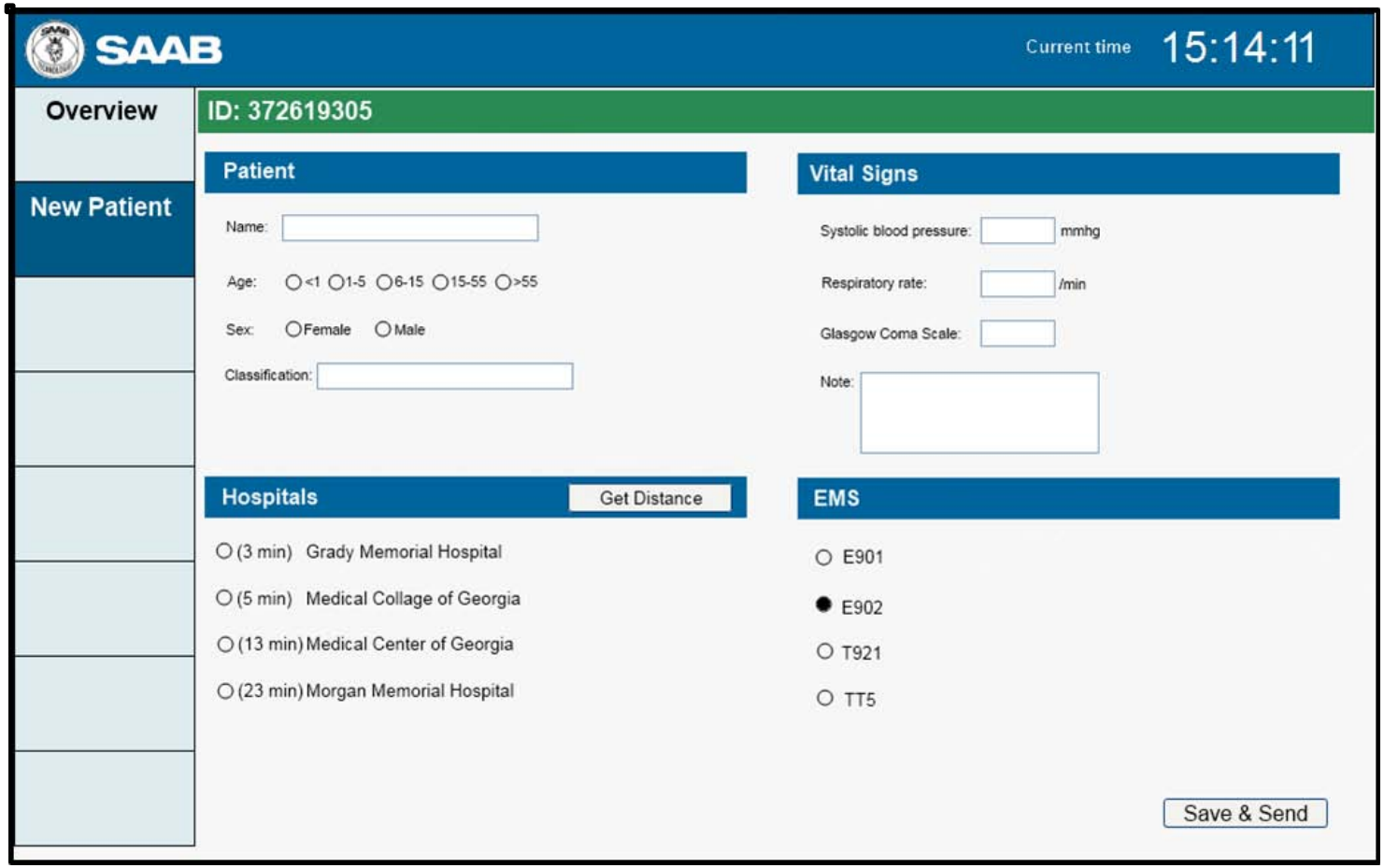
HARDWARE/EQUIPMENT

- Main “horsepower”: Two completely redundant Dell PowerEdge R710 Servers
  - 12 Intel Xeon cores each (24 cores in normal operations)
  - Virtualization supports
    - Web server
    - SQL Server
    - Tacticall
- High reliability Dell Equalogic SAN
- Dell Optiplex operator workstations (3-monitor setup)
- *Unlimited hospital licenses for state of Georgia included.*

SYNCHRONIZED COMMUNICATIONS

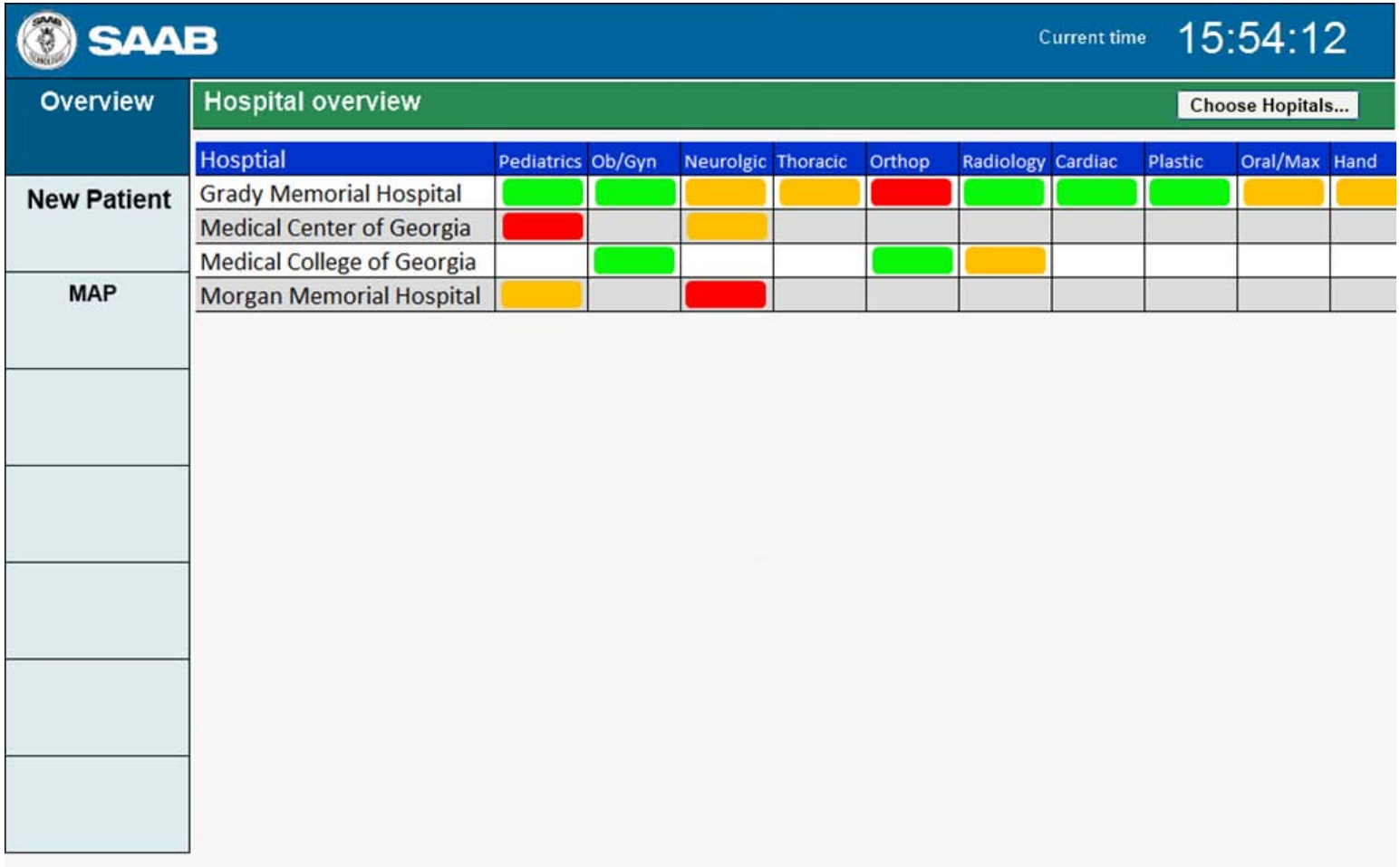
- Voice data is recorded with timestamp
- Tacticall logs (with timestamp) all operator actions (answer call, patch call, etc.)
- Paratus logs all operator actions (with timestamp)
- Common timestamp allows exact synchronization when reviewing historical incident

PATIENT INFORMATION / RECOMMENDED TRANSPORT



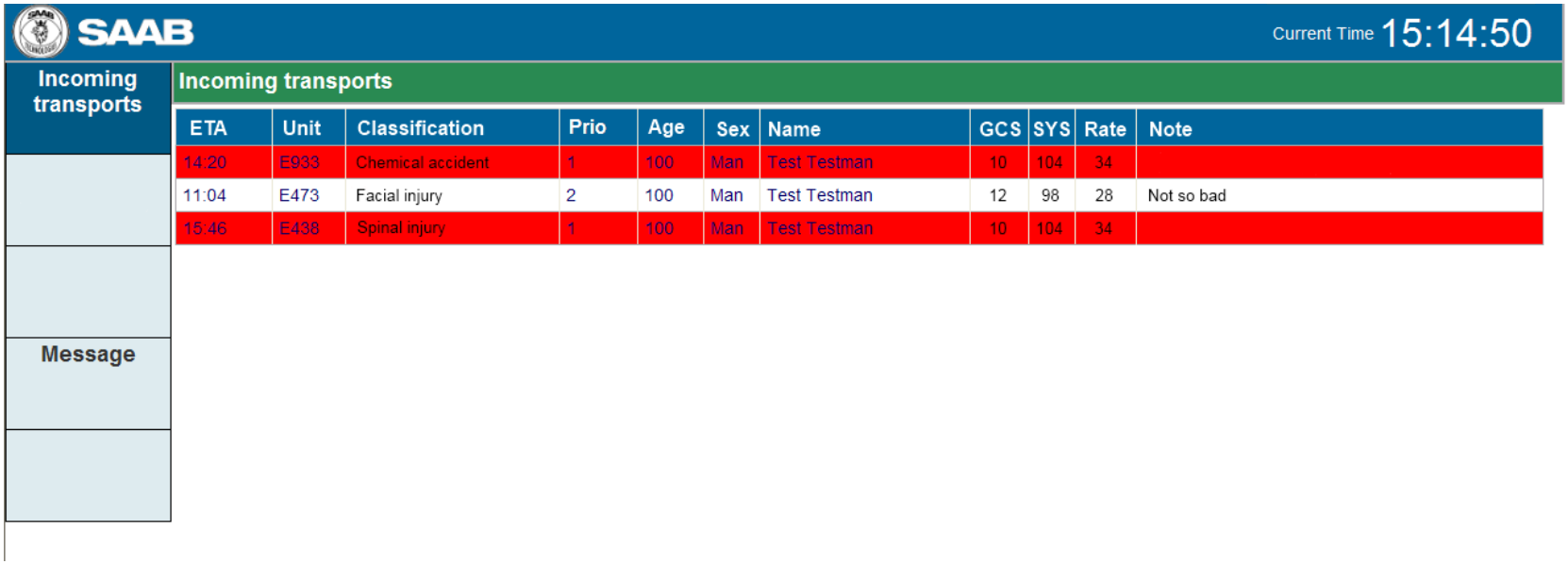
Note. Adapted view from the Swedish system. State of Georgia will review during design/customization.

RESOURCE AVAILABILITY DISPLAY



Note. Adapted view from the Swedish system. State of Georgia will review during design/customization.

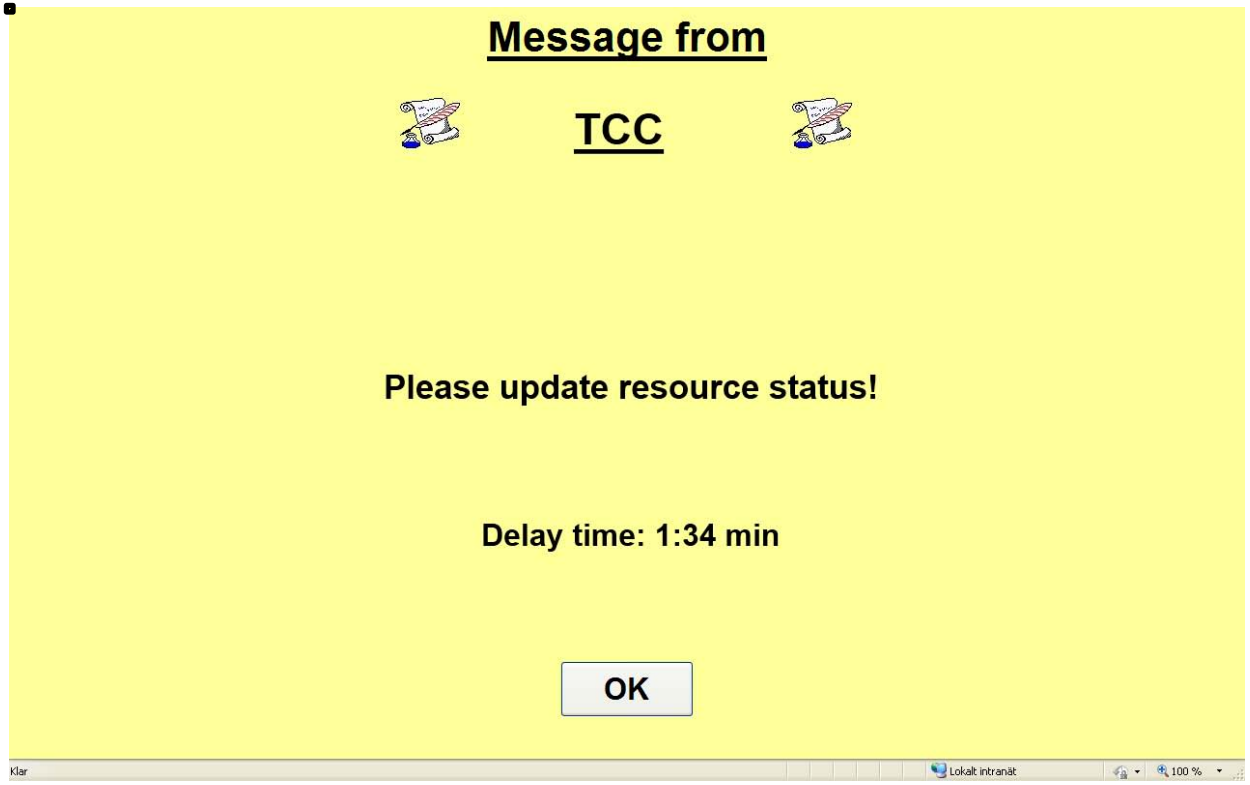
HOSPITAL VIEW



ETA	Unit	Classification	Prio	Age	Sex	Name	GCS	SYS	Rate	Note
14:20	E933	Chemical accident	1	100	Man	Test Testman	10	104	34	
11:04	E473	Facial injury	2	100	Man	Test Testman	12	98	28	Not so bad
15:46	E438	Spinal injury	1	100	Man	Test Testman	10	104	34	

Note. Adapted view from the Swedish system. State of Georgia will review during design/customization.

HOW HOSPITALS ARE PROMPTED



Note. Adapted view from the Swedish system. State of Georgia will review during design/customization.

RECEIVING HOSPITAL RECOMMENDATION

- Automated routing or system-generated recommendations are not included in this proposal, but can be adopted in future deliveries based on Paratus systems currently in use in Sweden

IMPLEMENTATION AND TRAINING

- Servers built & configured in Sterling VA (Dulles Airport)
  - Saab Support & Services (also provides logistics to Saab aircraft)
- Saab team will install system at TCC and conduct training on Paratus and Tacticall
  - Combination of TCC user and administrator training
- Hospital installation is truly minimal
  - Any Windows PC with IE8
    - Download from Microsoft if not already installed
  - Recommend hospitals control/manage their own IT
    - Active Directory-based logins, etc.
- Hospital Training
  - Requirement for training on Paratus is also minimal; support will be via phone, essentially talking users through the menus.

PRINTED MATERIAL

- User's Guides
  - Basic system operation
  - Hospital and TCC guides
- Trainee Guide
  - Material to support training
- Administrator's guide
  - More technical information to support the administration of the system

CONTINUITY OF OPERATIONS

- Hardware is high reliability/redundancy/availability
  - Hot-swappable hardware
  - Ability to operate in degraded mode (one server)
  - RAID drive array (redundant storage) with dual power supplies
- Software can run on any server for reconstituted capability in alternate location (e.g., hosted site)
  - Paratus software
  - SQL Server
- Operators can access capability from any PC
  - Alternate State facility with radios
  - Home phone & PC
  - Etc.

SCALABILITY AND OPERATORS

- 24 Xeon cores can do a lot of serving…
- SQL Server (virtually no limit on transactions)
- Number of operators is only practical limiting factor
  - System can handle significantly more operator stations
  - Frequency of trauma events drives number of operators
  - Number of operators should reflect State's need to accommodate simultaneous calls.
- Licensing as proposed sufficient for statewide use

We believe this system as delivered for the pilot will be more than adequate to handle the entire state, both software and hardware (including licenses)

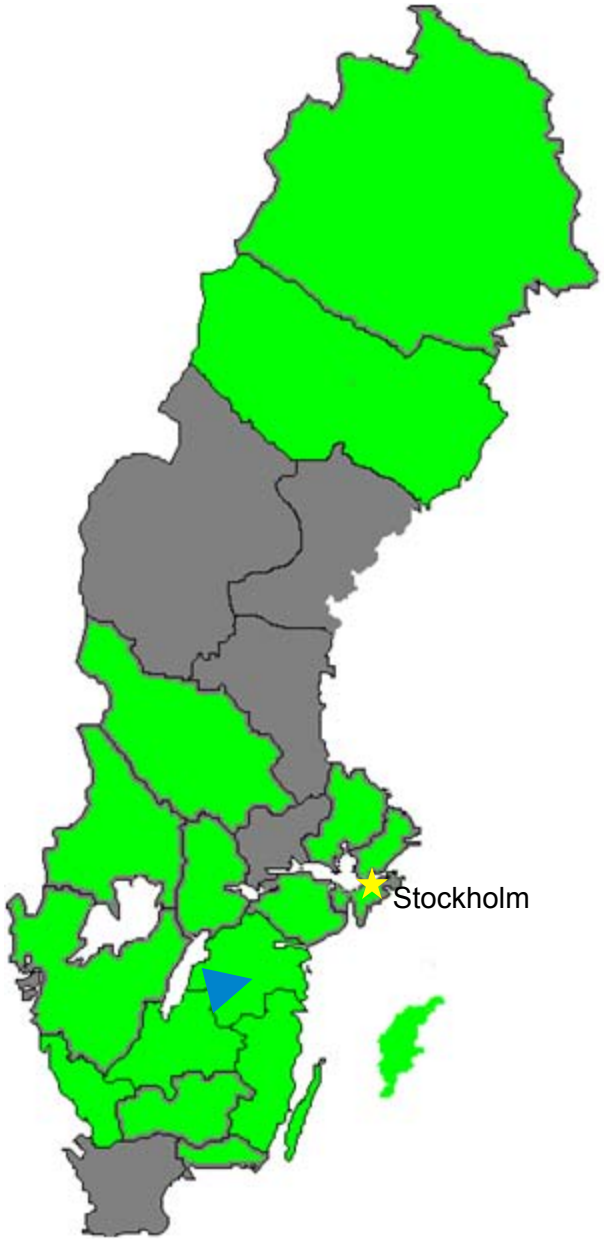
HIPAA/NEMSIS/NIEM

- HIPAA
  - System protects data at rest (firewall & encryption)
  - System protects data in motion (encryption)
  - No data remains on client after logout
  - Self-certified that Paratus complies
  - HIPAA has no requirement for 3rd party certification
    - Nor Government oversight of self-certified certifiers…
  - User training on HIPAA is key to compliance
    - We assume all personnel using the system will have been trained by their employers on HIPAA-compliant conduct
- NEMSIS/NIEM
  - Paratus is flexible; most fields are not hard coded
  - Most of the terms/data field labels used in the system for the TCC will be customized as directed by GTC or will be in accordance with NEMSIS
- Saab is a member of HL7 consortium
- Paratus designed in keeping with tenets of HL7
  - Data interchange is supported via open interfaces (e.g., directly into/out of SQL Server)
  - Data translation into a variety of interchange standards can be easily supported

Saab is committed to open standards

PAST EXPERIENCE

- Country of Sweden
  - Over three times the area of Georgia
  - About the same population
- Paratus system widely deployed
  - >1,000,000 ambulance “call outs” a year
  - 200,000 trauma cases a year
  - 24/7/365
- Paratus fully supports Prehospital Trauma Life Support (PHTLS) methodology
- Reference provided is one of these counties (Östergötaland)
  - Home of *Center for Teaching & Research in Disaster Medicine and Traumatology*



WARRANTY/SUPPORT

- One year warranty provided by Saab on all systems
  - Four years additional maintenance provided in quote
  - Dell extended factory warranty on all Dell H/W (NBD)
- Support structure:
  - Level 1 support from Saab in Sterling, VA
    - 24x7x365 phone support (human on the line)
  - When issues are escalated to Level 2 or Level 3
    - Hardware: will be maintained from Sterling office
      - On-site at TCC whenever necessary to address problems
    - Software: will be maintained & problems addressed from Sweden
      - Remote S/W maintenance is the standard for this type of system
      - On-site at TCC whenever necessary to address problems
  - Critical errors (Level 3) will receive immediate attention

REPORTING CAPABILITY

- SQL Server Reporting Services
  - 30 preformatted Paratus report formats included; more can be added by customer administrator
  - Numerous other COTS tools on the market to work with the most common database server on the planet
  - Manual queries using SQL

Created 2010-11-11 17:02 by PERFORMIT00\paratus

Response time

From date:	2008-01-01	**To date:**	2008-01-31	**Time interval:**	15 min	**Show unsigned:**	No
Zones:	Finspång, Kisa, Linköping, Mjölby, Motala, Norrköping, Valdermarsvik, Åtvidaberg, Ödeshög						
Priorities:	1						

Num of transports in time interval (min.) of response time, priority 1 assignments, and first unit on scene

Station\Time interval (min)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	30	45	60	All
Finspång	0	1	5	5	9	5	5	1	3	0	1	0	1	0	2	1	3	2	1	3	4	0	1	54
Percent(%)	0	2	11	20	37	46	56	57	63	63	65	65	67	67	70	72	78	81	83	89	96,30	96,30	98,15	100%
Kisa	0	4	3	2	1	0	0	0	1	0	0	0	1	1	0	0	0	1	0	0	1	1	0	17
Percent(%)	0	24	41	53	59	59	59	59	65	65	65	65	71	76	76	76	76	82	82	82	88,24	94,12	94,12	100%
Linköping	14	18	37	48	61	40	40	26	14	10	10	13	6	8	5	2	0	4	3	1	8	1	0	379
Percent(%)	4	9	19	32	48	58	69	76	79	82	85	88	90	92	93	94	94	95	96	96	97,89	98,15	98,15	100%
Mjölby	2	10	13	9	8	2	5	11	2	5	2	3	3	4	1	0	1	1	0	1	2	0	0	91
Percent(%)	4	15	30	40	48	51	56	68	70	76	78	81	85	89	90	90	91	92	92	93	95,60	95,60	95,60	100%
Motala	5	12	19	16	15	6	3	3	3	10	7	7	5	6	4	3	0	0	3	3	5	1	0	139
Percent(%)	4	12	26	37	48	53	55	57	59	66	71	76	80	84	87	89	89	89	91	94	97,12	97,84	97,84	100%
Norrköping	9	12	35	42	54	69	35	25	9	6	4	9	9	7	11	6	3	4	2	1	7	1	0	370
Percent(%)	3	6	16	27	42	60	70	76	79	81	82	84	86	88	91	93	94	95	95	96	97,57	97,84	97,84	100%
Valdermarsvik	1	1	3	4	0	1	1	0	0	1	2	0	1	0	1	0	3	0	2	1	6	5	0	34
Percent(%)	3	6	15	26	26	29	32	32	32	35	41	41	44	44	47	47	56	56	62	65	82,35	97,06	97,06	100%
Åtvidaberg	0	1	3	1	4	4	2	1	2	0	1	4	2	0	1	0	0	0	1	1	4	0	0	33
Percent(%)	0	3	12	15	27	39	45	48	55	55	58	70	76	76	79	79	79	79	82	85	96,97	96,97	96,97	100%
Ödeshög	1	0	1	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Percent(%)	20	20	40	60	60	60	60	80	80	100	100	100	100	100	100	100	100	100	100	100	100,0	100,0	100,0	100%
Average percent(%)	3	9	19	31	44	56	64	70	73	76	78	81	84	86	88	89	90	91	93	93	96,79	97,59	97,68	100%

ENHANCEMENTS AND ADDITIONS

- Paratus is in continuous development in support of large installed base with many customers
  - Enhancements to baseline software are included with maintenance
- Specific enhancements as requested by Georgia
  - Some database changes may be made by customer (e.g., field label changes)
  - Underlying software changes require Saab's involvement at our normal S/W development rates
- More significant changes by Georgia (e.g., adding a field for co-morbidity factors) could result in less satisfactory user experience
  - Saab involvement recommended to ensure usability and reliability is maintained
  - Saab applies standard S/W process for changes to ensure quality results

ADDING HOSPITALS

- No licensing required!
- Hospital has or gets a PC with IE8
- TCC Admin adds a hospital to the database
- TCC Admin creates & provides hospital users with Paratus login usernames, passwords and the user's guide
- TCC personnel talk hospital personnel through logins and info entry screens

INFORMATION EXCHANGE

- Paratus has an open SQL Server database with virtually unlimited support for information/data exchange, e.g.:
  - Web services
  - XML or delimited files
  - Windows sockets
  - Etc.
- Paratus currently is applied in many applications where its data is displayed or used in other applications such as dispatch, billing, medical, etc.

OTHER PARATUS FAMILY PRODUCTS

Paratus for Emergency Response

Paratus Commander

Paratus Pocket Translator

Paratus Map

Paratus Information System

Paratus Mobile System

Paratus TIB

Paratus Pocket Navigation

Paratus Sync

SAAB

SAABGROUP.COM

FIVE YEAR GEORGIA TRAUMA SYSTEM STRATEGIC PLAN OUTLINE

The objectives of the 2009-2014 plan, with short term objectives in bold, are as follows:

1. **Obtain Permanent Trauma System Funding**
2. **Maintain & Expand Georgia's Trauma Centers Focusing On South Georgia**
3. **Strengthen Emergency Medical Services Focusing On Rural Regions**
4. **Develop Statewide Trauma Transfer System**
5. Pilot/Build Trauma Telemedicine System
6. Enhance Pediatric Trauma Subsystem
7. Strengthen Physician Support For Trauma Care In Rural Georgia
8. Expand System To Rehabilitation, Burn Care & Interstate Transfers
9. Assist In Initiatives To Reduce Traumatic Injury
10. Integrate Trauma System With Disaster/Terror Preparedness
11. Expand System To Acute Emergency Care Needs
12. Develop Trauma System Regionalization In Georgia
13. Continue Developing Trauma System Policy/Stakeholder Structure
14. **Build Trauma System Infrastructure Under Department of Health**
15. **Establish Mechanisms To Assure Exceptional Accountability**

1. OBTAIN PERMANENT FUNDING

Without a permanent funding mechanism, trauma system development cannot proceed and it will be impossible to recruit any new trauma centers into the Georgia trauma system.

2. MAINTAIN & EXPAND GEORGIA'S TRAUMA CENTERS FOCUSING ON S. GEORGIA

The initial 2008 funding has stabilized and strengthened Georgia's remaining 13 Level I & II trauma centers. They received $36 million to help with the added costs they incur due to their trauma center status, and passed on another $12 million to their trauma medical staff. A grant program of $4.2 million also supported additions of critical equipment purchases at the state's trauma centers.

The Commission surveyed these trauma centers to establish a baseline for measuring progress in strengthening Georgia's trauma centers and performance of them. For example, the average score for the challenge Level II trauma centers faced in maintaining support of major trauma specialties in 2007 was 3.2 (on 1-4 scale with 4 indicating extreme problem). In 2008 this had declined to 2.8, providing an early indication of the impact of the state's financial support.

Key measures of trauma center performance will be established to uniformly monitor defined quality indicators. These indicators may include:

- Number of hours of "diversion" (i.e., denying access to injured patients)
- Quality of trauma care assessments conducted monthly at each trauma center
- Regional and statewide quality of trauma care reviews
- Trauma center designation reviews conducted by the Office of EMS/Trauma to assure adherence to trauma center requirements

By 2014, based upon this plan and national trends, we anticipate the state's trauma centers will have taken on added responsibilities in acute emergency care, including regional transfer system management and a broader role in emergency surgery.
The Commission has conducted discussions with hospitals that have the potential for becoming designated as Level II and Level III trauma centers, with a focus on South Georgia where the need is greatest. These discussions indicate that 4 to 6 Level II and Level III trauma centers may be developed between 2009 and 2011 under the following conditions:

1. New trauma centers would receive sustainable funding at the level trauma centers received in 2008. (They are being asked to make a long term commitment.)
2. A statewide trauma transfer system that facilitates the flow of trauma patients requiring a higher level of care to trauma centers, and when appropriate with low severity patients, requires they remain in their local hospital for care.
3. The startup of several trauma centers to assure a new trauma center is not overburdened with volume due to pent up demand in its greater region.

The key initial measure of performance for them to obtain funding is whether they can meet stringent trauma center requirements. Thereafter, the trauma centers' performance would be measured with the same system used for all Georgia trauma centers.

3. STRENGTHEN EMERGENCY MEDICAL SERVICES FOCUSING ON RURAL REGIONS

Due to obvious needs among Georgia's many and varied Emergency Medical Services programs, the integral relationship between EMS and trauma care, and best practices in other states, the Commission has taken on significant responsibility for strengthening EMS. This should grow over time into a fully integrated EMS/Trauma initiative that assures high quality emergency care for all, regardless of the type of injury or illness they present.

Readiness Support

To assure that EMS is prepared to meet the needs of trauma center patients, it is necessary to support EMS readiness for all emergency cases. The most cost-effective alternative to help do so is to transfer trauma funds to Medicaid to use, coupled with federal matching funds, to raise Medicaid reimbursement for all EMS Medicaid-eligible transports. There should be a guarantee that EMS reimbursement would not then be cut, essentially wasting the trauma funds.

GPS & Automatic Vehicle Locator System

This system will continue to be developed in conjunction with the statewide trauma transfer system and disaster and preparedness systems in Georgia. No state trauma funds are being requested in 2009-10.

Advocacy On Behalf of EMS

EMS in Georgia is a fragmented and under-resourced system, and since it is essential to an effective trauma system, the Commission has advocated for its needs and will continue to do so. This includes the implementation of the recommendations of the Senate Study Committee on EMS Recruitment, Retention, and Training in Georgia.

Incentivize Consolidation of EMS Districts

As a system EMS is hindered by its fragmentation between the state's high number of small county jurisdictions. As is happening in other states, Georgia must move towards a regionalized structure for EMS system design to serve the most patients in the most effective and efficient manner. Many rural EMS organizations in Georgia should be combined to create regional EMS districts, geography, and patient flow patterns.

These larger EMS districts would provide more stability to EMS employees, enhanced opportunities for training, and the overall challenges of recruitment and retention would be lessened. In addition, fewer ambulances would be needed around the clock due to more efficient use of scarce ambulance resources. The capability for equipment replacement would be enhanced again due to better use of resources. The bottom line would be to provide faster response times with personnel that provide a higher quality of care. This can be accomplished through a regional EMS/trauma infrastructure offering economic incentives based on performance improvement.

Air Medical Transport Imbalance

There are apparently more than enough air medical helicopters in north Georgia and none southwest of Macon. This imbalance presents problems in terms of the timely transport of critically injured patients. Georgia is beginning to regulate air medical providers, and to optimize the role of air transport within the emerging Georgia Trauma System, a coordinated approach by air medical providers to assure full coverage of Georgia should be implemented. The first step would be a collaborative planning process that engages both EMS and air medical transport companies in determination of solutions.

EMS Resources Targeted At Specific Regions' Needs

2008 funding included a capital grants program for EMS to purchase new ambulances that should be continued. These grants will be targeted based upon need, with priority given to EMS programs serving regions with long transport times to trauma centers.

4. DEVELOP STATEWIDE TRAUMA TRANSFER SYSTEM

Serious injuries in Georgia often trigger a time consuming search for a trauma center that has room to accept new patients for treatment, and they may not end up at the appropriate hospital. A transfer control/communications center that coordinates trauma patient triage, transfer and transport can be built to streamline the process and assure that injured patients quickly get to where they need to go. It can redirect patients throughout the state should one or more facilities become saturated, and will also serve to keep patients with minor injuries in their own community for care at less cost. It can also support patient stabilization and definitive care in local emergency departments and community hospitals.

The regionalized system built around lead trauma centers throughout Mississippi and in other state systems will be used as the working model for Georgia. This state's four Level I trauma centers would take on this responsibility and lead the process for collaboratively determining patient transfer protocols among all hospitals within their regions. This system will be integrated statewide and with EMS regions and all hospitals, and also use state-of-the-art technology statewide to optimize efficiency.

System development will start with system planning and the organization of a collaborative process within each region. The Commission requests support for planning and adding appropriate infrastructure to pursue regionalization. Federal funding will be pursued as well for future development.

It is important to recognize that this system will coordinate/enhance the operational relationships between trauma centers, EMS regions, EMS providers, and all acute care hospitals, which will in turn open up added opportunities to optimize emergency care beyond trauma care. This Transfer Control/Communication System will also be developed in conjunction with a con-current initiative led by the Georgia Hospital Association to mitigate and resolve the broader emergency department diversion problem.

5. PILOT/BUILD TRAUMA TELEMEDICINE SYSTEM

Telemedicine is a decade old concept to bring the doctor remotely to the patient, and the time has come for its use to support trauma specialty care in rural Georgia. While the need for telemedicine has escalated, barriers to its effective use such as cost, technology, reimbursement, liability, and physician participation have lessened, but continue to exist. Best practice models for the use of telemedicine in trauma care have been developed in other states. In Georgia, there is experience in using telemedicine (e.g., Center for Tele-Health at the Medical College of Georgia) as well as a developing statewide infrastructure to support it (e.g., Georgia Partnership for Tele-Health, Inc.) that may be used in collaboration with the Georgia Trauma System to pilot and develop trauma telemedicine.

In trauma care, telemedicine would bring specialty surgeon expertise to rural hospitals to help direct treatment when unstable patients cannot be transported. In addition, it also serves to help determine whether low severity patients can remain in their own community for treatment at their local hospital which is more cost effective and convenient for injured patients and their families.

The shortage of pediatric neurosurgeons provides an excellent opportunity to pilot trauma telemedicine. Instead of transporting a child with a suspected head injury to a pediatric trauma center, the child could be evaluated remotely at the local community hospital by a neurosurgeon based at the pediatric trauma center.

Telemedicine promises to enhance and expedite care of children with serious injuries, and ultimately adults, and also benefits rural trauma care providers who are in short supply, as well as urban surgical specialists.

A $500,000 USDA federal grant for telemedicine support to rural areas will be pursued in collaboration with the Georgia Partnership for Tele-Health, Inc. The grant award will support equipment purchases to launch two pilot programs in rural trauma telemedicine. Additional support for technical assistance in the development of a successful rural trauma telemedicine initiative for Georgia will be needed.

6. ENHANCE PEDIATRIC TRAUMA SUB-SYSTEM

Georgia enjoys an exceptionally strong array of pediatric trauma centers that are well located to care for seriously injured children under age 15. They account for 12% of trauma center patients and require a different system than adults due to their specialized needs. The pediatric trauma facilities are collaborating on a model trauma sub-system plan for pediatrics that includes:

- A statewide pediatric patient transfer system that functions as part of the overall system.
- The provisions of pediatric emergency care training and equipment for EMS.
- Development of physician extender roles specific to pediatric trauma centers.
- Maintenance of surge capacity to children regarding disaster/terror events.
- Support for prevention of childhood injury in collaboration with other organizations.
- Telemedicine program development to enable local hospitals to effectively evaluate possible head injuries in children.
- Expansion of the pediatric trauma care system to pediatric emergency care.

The components of this pediatric trauma sub-system will be fully integrated with the overall Georgia Trauma System, and the transfer system and telemedicine components will actually be piloted within this pediatric trauma sub-system.

The result will be the nation's state-of-the-art model for delivering high quality care to children who are seriously injured, as well as those needing emergency surgery due to causes other than injury.

7. STRENGTHEN PHYSICIAN SUPPORT FOR TRAUMA CARE IN RURAL GEORGIA

The essential challenge facing Georgia is strengthening trauma medical staff support in the face of a nationwide trend of declining numbers of surgical specialists interested in trauma care. The following strategies to both expand and leverage scarce trauma physician resources will be pursued:

- Develop corps of trauma physician "extenders", perhaps including nurse practitioners, physician assistants, registered nurse first assists, and/or trauma nurse specialists.
- Expand trauma surgeon training and retraining to augment the supply of trauma surgical specialists in rural Georgia.
- Maintain Georgia's strong liability protection for trauma physicians.
- Facilitate fair compensation of trauma physicians in terms of their emergent response (like we pay plumbers) and the sacrifices they make in taking trauma call.
- Manage trauma patient flow with an effective transfer system.
- Develop community call systems for high demand, low supply trauma specialties (hand, eye, etc.) to engage as many surgeons as possible in trauma and emergency call.
- Use of telemedicine to leverage scarce trauma physician resources and enable effective evaluation of patients re: necessity of transfer to a higher level of care.
- Technical assistance on best practices for building sustainable trauma hospital-based practices for trauma physicians.

For 2009-10, collaborative planning with a variety of partners will be conducted, including the Level I trauma centers and their medical school partners, nursing schools, the Georgia Board for Physician Workforce, and the Medical Association of Georgia.

8. EXPAND SYSTEM TO REHABILITATION, BURN CARE & INTERSTATE TRANSFERS

These will be important steps as the Georgia trauma system matures:

Uninsured Access to Rehabilitation

Georgia's trauma centers report transferring Medicaid/uninsured patients to rehabilitation facilities is generally impossible since such care is not funded. This requires the trauma centers to keep such patients in expensive acute care settings, which adds unnecessary costs and inappropriately fills scarce hospital beds. The patients, who tend to recover and become productive citizens, would be better off in the lower cost rehab facility. Approaches to resolving this dilemma can require creativity and collaboration rather than funding.

Burn Centers

Georgia's two burn centers, located at Grady Memorial Hospital and Doctors Hospital of Augusta, provide burn care to patients in a multi-state region. An assessment of their capabilities in relation to Georgia's long-term needs will be appropriate in the future, and they should be integrated into the trauma transfer/control system.

Stability of Interstate Trauma Transfers

Some regions in Georgia rely on trauma centers located in adjacent states due to proximity (e.g., Tennessee, Florida), and the stability of these resources are essential to a stable Georgia Trauma System. For example, Erlanger Medical Center in Chattanooga, Tennessee treats a substantial amount of the major trauma patients treated by all Georgia trauma centers. In addition, four Georgia trauma centers - Memorial Health University Medical Center in Savannah, John D. Archbold Memorial Hospital in Thomasville, Medical College of Georgia in Augusta, and Medical Center-Columbus - serve patients from neighboring states. Regional and interstate collaboration is materializing on such issues and this will need to be addressed. In the short run, such transfers will need to be incorporated into the transfer control system.

In 2009-10, the Commission will conduct basic planning on these issues.

9. ASSIST IN INITIATIVES TO REDUCE TRAUMATIC INJURY

Fire departments are a great example of a public service that broadened its mission to provide a higher value to the public by working to prevent fires rather than just extinguish them. Trauma center personnel, driven by the carnage they witness, are uniquely motivated and credible for work on preventing injury, but are rarely given resources to do the job.

Each trauma center can serve as a "Community Focal Point on Injury", which incorporates the following functions:

1. Identify injury causes in the community that are subject to intervention.
2. Define solutions that have proven effective in similar circumstances.
3. Focus media attention and community resources on the specific cause of injury.
4. Foster and coordinate the development of interventions.
5. Evaluate the effectiveness of specific prevention programs.

The Georgia Trauma System can use this same approach statewide in a collaborative role that assists established injury prevention organizations. In 2009-10 the Commission will ask members of the Trauma Advisory Council to form a committee to identify and assess feasible opportunities for injury prevention as the best means of reducing the tremendous costs of serious injury. Advocacy for a federally funded Injury Prevention Center will also be conducted.

10. INTEGRATE TRAUMA SYSTEM WITH DISASTER/TERROR PREPAREDNESS

Trauma care is already integrated with disaster and terror preparedness in Georgia. Trauma centers need to be able to amass resources needed to respond to mass casualties by scaling up their everyday operations. Ongoing relationships with EMS and other hospitals result in rapid patient triage and treatment decisions in community crises of all types.

Because Level I trauma centers have larger capacities, unique staffing, and enhanced training programs, they are often the logical base (in collaboration with regional EMS and homeland defense personnel) to coordinate hospital response to terror and disaster events. This has proven to be the case in North Carolina, Texas and Oklahoma where strong regional trauma systems have been built, and is emerging as a strong trend in other states.

As the regionalized Georgia trauma system materializes, its infrastructure will enhance trauma care's involvement in local, regional, and state disaster preparedness planning. The emerging transfer control/communication system may prove to be a major asset to Georgia's disaster/terror preparedness sector due to its potential to efficiently monitor and route emergency medical transports to acute care facilities throughout the state and greater region.

In 2009-2010, the Commission will collaborate with the Georgia Hospital Association and the Georgia Emergency Management Agency (GEMA) on how the trauma system can best enhance disaster/terror preparedness in Georgia.

11. EXPAND SYSTEM TO ACUTE EMERGENCY CARE NEEDS

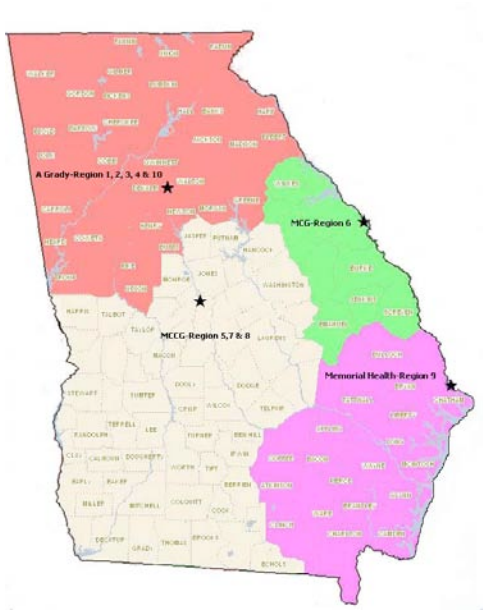
A major benefit from constructing a robust, statewide trauma care infrastructure and system is that it can be expanded to address broader emergency care service issues. This enables a highly cost-effective approach to strengthening the entire problematic emergency care safety net. This is already being accomplished in some respects. Assuring adequate coverage for surgery, neurosurgery, orthopedic surgery, etc. for care of trauma patients also assures the same specialties will be available to care for non-trauma patients requiring their services.

An expansion to other time sensitive emergency health care issues such as strokes and heart attacks is feasible since they require the same systems approach and components required for trauma care. Before progress can be made in this regard, the trauma system must be substantially complete.

While this expansion to supporting broader emergency care functions promises to be an important return on the state's investment in trauma care, in 2009-2010 the Commission will focus on building the core trauma system.

12. DEVELOP TRAUMA SYSTEM REGIONALIZATION IN GEORGIA

Key lessons from other states in building a strong and effective infrastructure to support trauma and emergency care include:



- Build a statewide system that incorporates all local and regional stakeholders and integrate them into a regionalized network.
- Define regions by patient referral patterns to enable participants within traditional catchment areas to work together with the major referral hospital.
- Provide technical assistance and basic operational funding to help regional groups organize.
- Build it for the long term and make it expandable to emergency care and related functions.
- Foster a grassroots network that generates statewide public support.

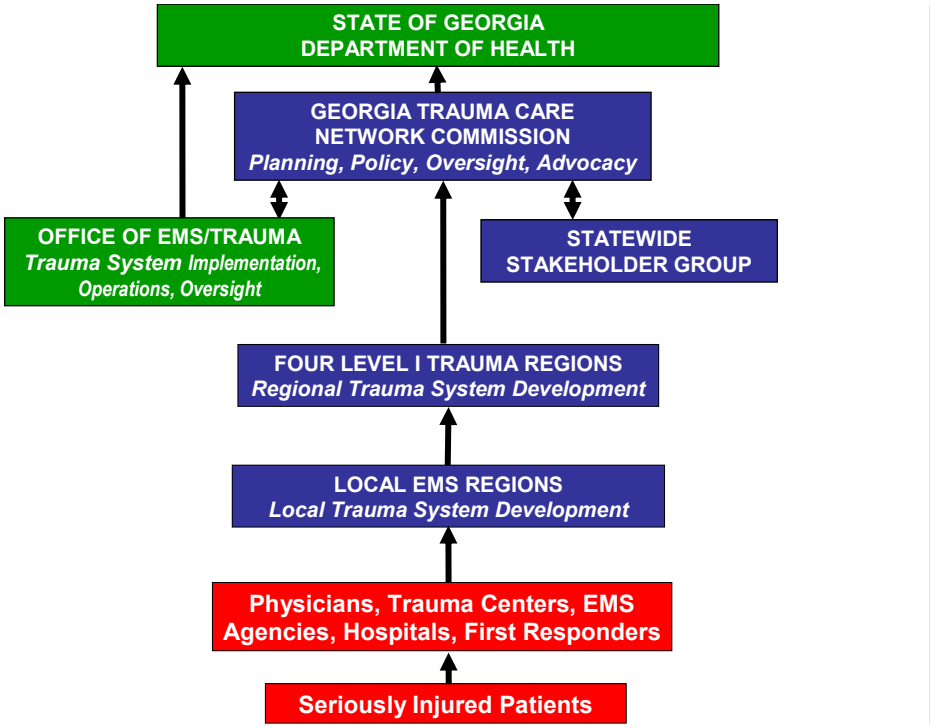
Georgia already has 10 established EMS regions which provide a base to build upon for development of trauma regions.

As Georgia considers regionalizing its trauma system, the first step is to define trauma regions. Presently, Georgia has four well positioned Level I trauma centers. If they were to serve as a focal point for trauma regions that incorporate existing EMS regions, the map above provides an example of how trauma regions could be designed. In the event that additional regional trauma centers develop, it is important to note that the determination of trauma regions may be dynamic to accommodate changes in trauma center resources and trauma patient flow patterns.

13. CONTINUE DEVELOPING TRAUMA SYSTEM POLICY/STAKEHOLDER STRUCTURE

Georgia enjoys strong leadership for trauma and EMS, and has established a successful Trauma Commission, composed of key stakeholders to guide the development of the Georgia Trauma System. The next step will be to extend this developing structure to the Level I trauma regions described above and to incorporate local EMS regions. The following chart outlines the emerging policy development structure for Georgia:

TRAUMA SYSTEM POLICY DEVELOPMENT STRUCTURE



In essence, local and regional trauma stakeholder groups will provide input to the Commission based upon trauma patient and provider experiences and needs. The Commission will formulate policy, which will be implemented by the Office of EMS/Trauma. A statewide stakeholder group will be formed by the Commission with broad representation from Governor/Lt. Governor, Speaker of the House, State Legislature, Georgia Hospital Association, Georgia Association of EMS, Medical Association of Georgia, the business community, media, etc. to provide input and support the work of the Commission.

The Commission will regularly reach out to stakeholders for input, including EMS agencies, trauma centers, local hospitals, County government, injury prevention partners, community groups, local legislators, burn care, air medical transport and other interested and participating stakeholders.

This coalescing of collaborative leadership locally, regionally and statewide, will strengthen the Commission's ability to quickly move this conceptual plan to reality throughout Georgia. In turn, this structure will reinforce the Commission's role of planning, policymaking, oversight and advocacy.

14. BUILD TRAUMA SYSTEM INFRASTRUCTURE UNDER DEPARTMENT OF HEALTH

The Commission asked for a thorough, expert, "warts and all" review of Georgia's trauma system by the American College of Surgeon's Trauma System Consultation program, which occurred on January 4-7, 2009. While their findings were not surprising, they underscored the fact that critical components of the Georgia Trauma System infrastructure are either missing or largely unsupported. They include:

- Establishment by State statute of the trauma system lead agency's authority and provision for promulgation of clear system regulation and rules.
- Comprehensive trauma system plan defines the system, its subsystems and structure, and establishes procedures and standards for implementation, monitoring and system performance improvement, and is supported by promulgated rules and regulations.
- Staffing for the State of Georgia to build and operate trauma and EMS systems.

These critical needs are addressed in detail by the ACS Trauma System Consultation report. In order to build an effective state trauma system, an effective and fully-staffed Office of EMS & Trauma under the Department of Health will be essential.

15. ESTABLISH MECHANISMS TO ASSURE EXCEPTIONAL ACCOUNTABILITY

Aggressive assessments of quality of care and system performance are core strengths of the field of trauma care in part because it was founded based upon such assessments. State-of-the-art performance improvement standards and accountability measures will be included in the Georgia trauma system, such as the following:

- Time trauma centers are on diversion and deny access to injured patients
- Percent of state's trauma patients (by severity) who reach trauma centers
- Time of EMS transport from call to scene, and from scene to trauma center
- The "preventable" death rate for each trauma center and overall system
- Severity-adjusted trauma center length of stay/costs compared to national/state norms
- Reductions in injuries targeted by injury prevention measures

In 2009-10 the Commission will develop a performance improvement and accountability system to assure optimum performance by all trauma system components.

In addition to the accountability system described above, the Trauma Commission will arrange a follow on visit from the American College of Surgeons Trauma Systems Review program in three years. A return visit will assess Georgia's progress on implementing recommendations made by the ACS during the course of its site visit in January 2009.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
1. Obtain Permanent Trauma System Funding, as without a permanent funding mechanism, trauma system development cannot proceed and it will be impossible to recruit any new trauma centers into the Georgia trauma system.						
2. Maintain and Expand Georgia's Trauma Centers, Focusing On South Georgia, to achieve access to a Level I, II, or III trauma center within one hour for all Georgians by 2012, and maintain such access for three decades.						
A. Maintain Georgia's remaining 13 Level I & II trauma centers, to prevent further closures, and strengthen them so they can meet state standards and increase their capacity for delivering trauma care.	The 2008 funding has stabilized Georgia's trauma centers. Due to a poor cost structure with substantial readiness and uninsured patient care costs, long term funding will be required.	Governor, Lt. Governor, Speaker of the House, State Legislature, trauma centers, EMS, other trauma care stakeholders, business community, philanthropic groups, etc.	Funding provided last year cut trauma center losses by about half and stabilized them. This level of funding will need to be sustained over the long term.	Reduction in trauma mortality rates, number of trauma centers, time on "diversion", s, and regular reviews to assure GA receives highest level of performance based on national trauma center norms.	Refine formula for distribution of funding to trauma centers. Refine trauma center economic reporting. Report on impacts of trauma center funding.	Similar funding levels as 2008 that are permanent and sustainable.
B. Expand number of trauma centers in Georgia, focusing on developing new LII/III trauma centers in South Georgia along I-75, while seeking additional trauma center capacity in the greater Atlanta region and in other rural regions where such need exists.	Add 4-6 Level II & III trauma centers over 2009-11 in Georgia. Additional trauma centers will be developed in 2011-14 to assure Georgia adequate capacity for the decades ahead.	Commission takes lead in working with hospitals that have significant volumes of trauma patients to consider trauma center designation.	This will require an extension of funding to new trauma centers for start up/dev. costs. Physician buy-in is critical; funding to support physician recruitment, call panels, will also be required.	To obtain funding, hospitals must meet stringent trauma center requirements. Thereafter, new trauma centers' performance would be measured as above.	Continue to recruit new trauma centers, focused in the South. Obtain sustainable funding for trauma centers. Add 4-6 trauma centers in Georgia.	Funding for the start-up of new Level II and III trauma centers will be required.
C. Maintain/enhance trauma center review process conducted by Office of EMS/Trauma, and supplemented by transparent economic reporting, to foster high level of trauma center performance.	Office of EMS/Trauma needs immediate staffing to conduct effective reviews, and this staffing needs to be maintained over the long term.	Office of EMS/Trauma takes lead with support from the Commission on economic reporting.	No funding impacts on Commission, but state funding for Office of EMS/Trauma is essential.	Trauma center performance. Strength of trauma center review program re: national norms.	Support EMS/Trauma funding. Develop best practice economic reporting.	Incorporated in Office of EMS/Trauma annual budget.
D. Develop EMS/air medical transport solutions for areas in which trauma center proximity is a challenge to effective trauma care.	After EMS is strengthened in 2009-10 and new trauma centers will be added, gap areas will be identified and filled.	Commission takes lead in balancing EMS/air resources with trauma center proximity.	No new funds are needed; existing funding can be targeted at gap areas.	Reduced transport times to trauma centers. Reduced trauma mortality.	Focus on strengthening ground and air coverage of Georgia in 2009-10	Incorporated in Commission planning budget.
3. Strengthen Emergency Medical Services Focusing on Rural Regions, to fully develop an integrated, statewide EMS/Trauma system that assures high quality emergency care for all, regardless of their type of injury or illness, by 2014.						

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
A. Support EMS readiness for all emergency care with a focus on increasing Medicaid reimbursement for all EMS Medicaid-eligible transports, including a capital grants program for EMS to purchase new ambulances based upon need.	The initial plan of involving a Medicaid match may not be effective over the long term, so other means to increase EMS Medicaid payments may be needed. Timeframe is 2009-10.	Commission takes lead in advocating for EMS funding for readiness.	Significant state funding will be required to support EMS readiness whether it comes through the Commission or directly from the state.	EMS ground transport times from scene to trauma center. Increased stability and training of EMS workforce.	Assist in funding EMS readiness costs. Advocate for increased EMS Medicaid reimbursement.	Significant state funding will be required to support EMS readiness whether it comes through the Commission or directly from the state.
B. Build GPS Automatic Vehicle Locator System in conjunction with the trauma transfer system and disaster and preparedness systems in the state.	Timeframe is 2009-11 for full development and integration into trauma and preparedness.	EMS, new transfer system, Georgia Tech, GEMA and GHA.	Additional funding to come from homeland defense sector.	Functional, effective system. Efficient use of EMS ground and air resources	Define plan for full development and integration with transfer system.	Additional funding to come from homeland defense sector.
C. Advocate on behalf of EMS in Georgia, a fragmented and under-resourced system that is essential to an effective trauma system.	Timeframe is continuous with focus on short term improvements in Medicaid payments to EMS and funding for Office of EMS/Trauma.	Commission takes lead and coordinates with GAEMS.	None for Commission although increased state funding to EMS is needed.	Robust statewide EMS system.	Promote EMS Medicaid funding and implementation of Senate Study Committee on EMS recommendations.	Increased state funding for EMS is needed.
D. Facilitate Consolidation of EMS Districts into a regionalized structure with many rural EMS organizations combining to create more efficient and effective regional EMS districts.	This is a 5 year objective that will be pursued incrementally with EMS regions as effective strategies emerge and funding is available.	EMS districts are partners; Commission takes lead with Office of EMS/Trauma.	Funding will be required to help local districts consolidate.	Consolidation that occurs. EMS system efficiency.	Form Commission workgroup to address all EMS related issues. Prepare plan for implementation	Funding will be required to help local districts consolidate.
E. Optimize air transport within emerging Georgia Trauma System with a coordinated approach by air medical providers to assure full coverage of the state.	Timeframe is 2010-12.	Commission will work with Office of EMS/Trauma, EMS and air medical providers.	None. The consolidation of air providers indicates the air franchise is profitable.	Air medical service in South Georgia. Decrease in number of low severity patients transported by air.	Form Commission workgroup Conduct collaborative planning with EMS and air providers.	Funding will be required to help local districts consolidate.
4. Develop Statewide Trauma Transfer System: The trauma transfer system will move seriously injured patients quickly to the best facility for their care, and will be organized at the four Level I trauma centers and CHoA. The statewide trauma transfer system will be fully implemented by June 2010.						
A. Develop a detailed operational plan for the development of a statewide Trauma Transfer System that utilizes state of the art technology for GA.	This will be done incrementally as other objectives are addressed and will be completed with common technology component by 12/09.	GTCNC Transfer System Workgroup, Level I/CHOA transfer centers, technology resources.	Long term funding will be needed, but costs are limited because centers are being added to existing hospital-based transfer centers.	Complete operational plan. Reduced transport times for patients needing trauma care. Reduce unneeded transfers. Trust established in region.	Develop Commission workgroup Prepare common technology plan Prepare operational plan	Funding for technical and operational planning for development of the system.
B. Develop regional trauma triage and transfer protocols for GA in a collaborative fashion that functions as the first step in organizing Level I trauma regions.	CHOA is already proceeding and Level I outreach will begin as soon as personnel are available. Basic protocol template should be in place by 12/09.	Trauma Centers, other hospitals, EMS, and EMS regions, workgroup.	Development funding with 4 Outreach Coordinators and common technology.	Completion of collaboratively developed and enforceable regional protocols.	Form sub-workgroup with input from key stakeholders to develop protocol template based upon Mississippi and other models.	Funding for 4 Outreach Coordinators at Level I's.
C. Implement Statewide Pediatric Transfer System for Georgia that integrates with Level I regional transfer centers.	This is already underway in Georgia in an initiative led by CHOA in strong collaboration with other pediatric providers. Target due date is 12/09.	Pediatric Subcommittee; LI's in Macon, Savannah, and Augusta.	Development funding with 1 Outreach Coordinator and common technology.	Statewide system operational. Reduced transport times for patients needing trauma care. Reduce inappropriate transfers.	Pediatric Workgroup will oversee implementation. Coordination with adult trauma transfer system in development.	Funding for 1 Outreach Coordinator at CHoA.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
D. Implement state-wide Trauma Transfer System for Georgia that coordinates trauma patient triage, transfer and transport to streamline the process.	Target date for this high priority objective is implementation of functional transfer system by 12/09, with full operations being achieved by 6/10.	All of the above plus GHA Subcommittee on ED Diversion and Office of EMS/Trauma.	Operational funding with 5 Outreach Coordinators will be needed along with funding for common technology support.	System operational in 4 trauma regions anchored at Level I TC's in GA. Measures identified above.	Assign workgroup tasks including responsibility for implementation. Tasks referenced above.	Funding for common technology
5. Pilot/Build Trauma Telemedicine System: To bring specialty surgeon expertise to rural hospitals to help direct treatment when unstable patients cannot be transported, as well as help determine whether low severity patients can remain in their own community for treatment.						
A. Establish tele-trauma pilot projects at 1-2 Level I trauma centers for adults and CHoA for children in collaboration with rural hospitals and partners.	Telemedicine system is already developing in Georgia, and Tele-Trauma will be added, first on a pilot basis that will be operational by 6/10.	GTCNC Transfer System Workgroup, GA Partnership for Telehealth; MCG Telemedicine Dept., rural hospitals.	Federal grants will help buy equipment & health insurer payment will be sought for consults. Some planning & operational funding needed.	Do pilot programs attract physician participation and satisfaction? Can pilot programs be replicated statewide?	Support GPT in app. for USDA grant. Develop & evaluate pilot programs. Prepare plan for statewide system with outside experts.	Matching funds for a $500,000 USDA telemedicine grant applied for by GPT. Planning and development funding.
B. Implement statewide rural tele-trauma program for Georgia once pilot programs have proven successful.	Gradual implementation over two years will result in statewide system by 6/12.	Continue to partner with above and new partners identified in initiative.	System to be part of transfer /communication system, so incremental costs only.	System anchored at Level I TC's in GA is operational. Improved patient care.	Initial planning of statewide system.	None.
6. Enhance Pediatric Trauma Subsystem: To assure optimum care for seriously injured children in Georgia, fully utilizing Georgia's expansive pediatric trauma resources, by June 2010.						
A. Implement pediatric education and equipment requirements for EMS for Georgia to optimize prehospital care of children.	This is currently being pursued and will be fully implemented by 12/10.	GA EMS, Office of EMS/Trauma, and GTCNC Peds Subcommittee.	Funding from existing EMS resources.	Improved prehospital pediatric trauma outcomes. Improved scores on EMS retraining for pediatrics.	Oversight by Pediatric Workgroup.	None.
B.Continue planning/strengthening pediatric trauma system with transfer system, physician extenders, injury prevention, telemedicine, etc.	Continue planning and incremental implementation of peds trauma system. System complete by 2014.	GTCNC Peds Subcommittee, above partners, others as identified.	Funding implications beyond planning to be determined.	Improved pediatric trauma outcomes.	Pediatric Workgroup to continue planning and defining steps for implementation.	Incorporated in planning budget.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
7. Strengthen Physician Support for Trauma Care in Rural Georgia: This task will address the essential challenge of strengthening trauma medical staff support in the face of declining numbers of surgical specialists interested in trauma care.						
A. Pursue strategies to expand and leverage scarce trauma physician resources.	For 2009-10, collaborative planning will be conducted, with implementation of strategies to be conducted in 2010-13, and ongoing leadership, planning and support provided by Commission.	Commission will lead with Level I trauma centers, medical and nursing schools, Georgia Board for Physician Workforce, and Medical Association of Georgia.	Major funding will come from existing sources for clinical education. Planning will be needed and perhaps added support for education.	Metrics to measure trauma centers ability to obtain needed staff are being developed and will be used as a basis for planning and measuring success.	Form Commission workgroup to lead initiative. Collaboratively develop strategic plan for strengthening trauma physician resources by 2014. Identify surgeons available for trauma care in GA	Incorporated in Commission planning budget.
8. Expand System to Rehabilitation, Burn Care & Interstate Transfers: Establish rehabilitation and burn centers as active participants in Georgia's trauma system, resulting in coordinated post-acute and burn care for trauma victims.						
A. Assess trauma system needs re: rehabilitation, burn care and interstate transfers, and address them. This will initially address access issues, and ultimately address strategies to optimize patient care.	These issues will be addressed with collaborative planning in 2010-11 with implementation of strategies to be conducted in 2012-14.	Collaborative partners will include rehabilitation centers, burn centers, out-of-state trauma centers, and others identified in planning.	Funding implication can be substantial, although other states provide little support for these sectors.	Patient access to care. Reduction of days Medicaid/uninsured patients are in trauma centers rather than rehabilitation facilities.	Integrate interstate transfer issue in transfer system planning. Develop plan for addressing these issues by 2014.	Incorporated in Commission planning budget.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
9. Assist in Initiatives to Reduce Traumatic Injury: Have a state trauma system that is an active partner in a statewide coordinated system for reducing injury-related morbidity and mortality.						
A. Develop a strategic plan in collaboration with trauma system participants and injury prevention organizations to effectively reduce traumatic injury.	For 2009-10, collaborative planning will be conducted, with implementation of strategies to be conducted in 2010-13, and ongoing leadership, planning and support provided by Commission.	Collaborative partners will include trauma system stakeholders and injury prevention organizations identified in planning.	Major funding will be from existing sources for injury prevention. Planning support will be needed .	Integration of trauma system into Georgia's injury prevention sector. Significant reduction in injury.	Form Commission workgroup to lead initiative. Collaboratively develop strategic plan for significantly reducing injury by 2014.	Incorporated in Commission planning budget.
10. Integrate Trauma System with Disaster/Terror Preparedness: Assure optimum use of and support of the Georgia Trauma System by agencies charged with disaster and terror preparedness responsibilities.						
A. Develop a strategic plan in collaboration with trauma system participants and disaster/terror preparedness organizations to assure optimum integration between trauma and preparedness organizations.	Planning will be conducted during 2009-10 on the best way to enhance preparedness with evolving trauma system.	Partners will include GEMA, GHA, Office of EMS/Trauma, and federal agency partners.	Major funding will be from existing sources for terror and disaster preparedness. Planning support will be needed .	Integration of trauma system into Georgia's disaster and preparedness sector.	Work with GEMA to initially define p	Incorporated in Commission planning budget.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
11. Expand System to Acute Emergency Care Needs: Other time sensitive emergencies such as stroke and STEMI can utilize the same "systems" approach and infrastructure that is being developed for trauma care.						
A. Assess trauma system opportunities in expanding to support broader emergency care needs in Georgia. This will initially address access issues, and ultimately address strategies to optimize patient care.	In 2010-11, collaborative planning will be conducted, with strategies being incrementally implemented by 2014.	Collaborative partners will include trauma system stakeholders, hospitals and EMS.	To be determined, but envisioned costs would be constrained to added load on transfer system.	Does trauma system contribute to care of other emergency patients.	None	Incorporated in Commission planning budget.
12. Develop Trauma System Regionalization in Georgia: Establish regional trauma system structure for Georgia that integrates with established EMS regions to build a strong statewide infrastructure to support trauma and emergency care.						
A. Develop statewide Trauma Transfer System to enhance regional relationships and trust as first step in building Level I trauma regions.	The transfer system will be complete by 6/10: during this time each region will achieve a critical mass of trust to effectively organize for the long term.	Level I trauma centers, other designated trauma centers, other hospitals, EMS regions, EMS, Office of EMS/Trauma.	No funding implications; see Transfer Center. Office of EMS/Trauma will support trauma region operations.	Stakeholder collaboration. Build effective network. Define trauma region maps.	Define common network organization. Define regions by patient referral patterns.	Incorporated in Trauma Transfer System.
B. Build and operationalize Level I Trauma Regions that integrate with EMS regions and ultimately serve all emergency care needs in GA.	The actual formation of the regional structure comes next, and they are anticipated to be operational in 2010.	Same as above.	Each Trauma Region will need administrative and some operational support.	Build functional organization. Ability to develop solutions to regional problems.	Planning and organization of regions.	Incorporated in planning budget or Office of EMS/Trauma.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
13. Continue Developing Trauma System Policy/Stakeholder Structure: To coalesce collaborative leadership locally, regionally, and statewide to strengthen the Commission's capability for planning, policymaking, oversight and advocacy on behalf of the Georgia Trauma System.						
A. Engage stakeholders in promoting/refining Commission's strategic plan, advocating for funding, and building statewide Trauma Transfer System.	Currently underway and to achieve a critical mass of collaboration and trust by 6/09.	Broad based trauma/EMS stakeholders from all sectors led by GTCNC.	Minor funding implications.	Participation in planning and advocacy.	Develop informal network to connect with all parties. GTCNC needs to support trauma funding.	Incorporated in administrative and planning budgets.
B. Establish Advisory Council to the GTCNC composed of broad stakeholder representation.	To be completed by 6/09.	GTCNC and stakeholders.	Minor funding implications.	Approval of GTCNC By-laws. Effective stakeholder group.	Develop GTCNC Advisory Council. Energize by engaging participation.	Incorporated in administrative budget.
C. Define and establish relationships between Trauma Regions, EMS Regions, and GTCNC.	Conducted with Office of EMS/Trauma and completed by 12/09.	GTCNC and Office of EMS/Trauma.	Minor funding implications; needs full funding for Office of EMS/Trauma.	Formal stakeholder structure. Approval of GTCNC By-laws.	Work closely with Office of EMS/Trauma to assure an effective structure.	Incorporated in administrative budget.
14. Build Trauma System Infrastructure Under Department of Health*: In order to build a strong state trauma system, an effective Commission and a fully staffed Office of EMS & Trauma will be essential to develop, support, regulate and monitor it. (*It is presumed that the Office of EMS/Trauma will be transitioned to the Georgia Dept. of Health)						
A. The Georgia Trauma Care Network Commission will provide overall direction to trauma system planning, policymaking, oversight, and advocacy.	Ongoing; this is the core mission for the GTCNC.	GTCNC leadership with full stakeholder participation at local, regional and state levels.	Annual funding to support the planning and administrative function of the GTCNC is necessary.	Workable strategic plan. Adequate system funding. Functional statewide stakeholder network.	Develop GTCNC rules and By-laws. Conduct broad trauma system planning and development activities. Build stakeholder organization.	Planning budget incorporates a variety of objectives, and administrative support needs funding.
B. The Office of EMS/Trauma is designated as the lead agency with broad responsibility for the development, operations, monitoring of the trauma system based upon the policies established by the GTCNC.	Ongoing; this is the core mission for the Office of EMS/Trauma.	Governor's Office, House, Senate, Lt. Governor's Office, Office of EMS/Trauma and GTCNC.	Funding to fully staff the Office of EMS/Trauma is essential.	Adequate funding for staff. Promulgation of Trauma System rules and regs. Maintain/enhance oversight capabilities.	Recruit staff for trauma system support. Review ACS recommendations with GTCNC and implement as appropriate.	In state budget.

STRATEGY/OBJECTIVES	TIMEFRAME	LEAD AGENCY/ PARTNER'S)	FUNDING IMPLICATIONS	MEASURES OF SUCCESS	FY 2009-2010 TASKS	FY 2009-2010 FUNDING
C. Work with Office of EMS/Trauma to prepare statewide trauma system plan and promulgate necessary rules and regulations to support it.	Updated trauma system plan will be prepared by 12/2009 and current proposed rules and regulations will be revised as needed and promulgated by 6/2010.	GTCNC, Office of EMS/Trauma, trauma centers, and EMS.	Funding to fully staff the Office of EMS/Trauma is essential.	Comprehensive statewide trauma system plan supported by promulgated trauma system rules & regulations.	Research other states' trauma system plans for best practices and work with stakeholders to define local, regional and state-wide trauma system plans.	Incorporated into GTCNC planning budget and Office of EMS/Trauma staffing budgets.
D. Seek adequate levels of permanent and recurring funding for all components of Georgia's trauma system including trauma centers, trauma physicians, EMS, regional trauma agencies, Office of EMS/Trauma and GTCNC.	Commitment by close of current GA Legislative session.	Governor's Office, Senate, Lt. Governor's Office, Speaker of the House, House, GTCNC and all trauma stakeholders.	Adequate levels of permanent, dedicated, and sustainable funding is required to maintain the existing "network" and to develop a true trauma system for GA.	Revisions to SB60 enacted. Legislated trauma funding for GA that is adequate and sustainable.	Build model trauma system for Georgia that attracts public support and funding. Organize stakeholders effectively.	Refer to overall Commission budget.
15. Establish Mechanisms to Assure Exceptional Accountability: State-of-the-art performance improvement standards, accountability measures, and oversight will be built into the Georgia trauma system.						
A. Enhance current Office of EMS/Trauma statewide review of trauma system performance.	This will be complete by 12/2009.	GTCNC, Office of EMS/Trauma, designated Trauma Centers, EMS, all stakeholders.	Minor impacts for GTCNC; Office of EMS/Trauma must be fully staffed.	Promulgation of Trauma Rules & Regulation. Model accountability system.	Review ACS recommendations and implement as appropriate. Define state-of-art accountability system for GA Trauma System.	Incorporated in planning budget and Office of EMS/Trauma Budget.