



ADMINISTRATIVE REPORT

March 2010

March Treasurer's Report:

Attached.

Trauma Commission Procurements, Grants and Contracts Update

March update report attached.

Grady Health System Report and Request

Request for No-Cost Extension of FY 2009 Trauma Center Capital Equipment Grant: Request and supportive documentation attached.

Georgia Readiness Costs Determination UPDATE Report

Preliminary report: Greg Bishop will present.

Performance Based Payments Program Report

Recommendations to the full Commission: Greg Bishop will present.

Georgia Trauma Care Network Commission

Treasurer's Report

February 28, 2010

Encumbered Balance

Beginning Balance \$ 23,000,000.00

	Actually Spent YTD	Encumbered & Not Spent YTD
Expenditures:		
Classic Party Rental	\$ 405.50	
National Trauma Foundation Care		
Membership Dues	1,500.00	
Bishop & Associates	110,850.00	135,100.00
* Bishop & Associates		245,950.00
Floyd Healthcare MGMT		534,036.00
Fulton Dekalb Hospital Authority		4,210,054.00
Tenet Health System GB INC		1,016,942.00
* Tenet Health System GB INC		517,018.00
Childrens Healthcare of Atlanta		515,814.00
Gwinnett Hospital System INC		839,959.00
John D Archibold Memorial Hospital		565,373.00
Hamilton Medical Center		502,450.00
Medical College of Georgia		1,373,328.00
The Medical Center of Central Georgia		1,126,371.00
North Fulton Medical Center		612,115.00
Morgan Memorial Hospital		27,000.00
The Medical Center, Inc		557,544.00
Memorial Health University		1,782,598.00
Monroe HMA, Inc.		27,000.00
Total	<u>\$ 112,755.50</u>	<u>\$ 14,588,652.00</u>
Total Encumbered		\$ 14,701,407.50
Ending Available Balance, February 28, 2010, FY 2010		<u><u>\$ 8,298,592.50</u></u>

* Potential Error

Georgia Trauma Care Network Commission
Treasurer's Report
February 28, 2010

	Fund Balance	
Beginning Balance		\$ 13,168,892.38
Revenues:	\$1,916,666.66	
Total Revenues		\$1,916,666.66
Expenditures:		0.00
Total Expenditures		<u>0.00</u>
Ending Balance, February 28, 2010		<u><u>\$ 15,085,559.04</u></u>

Trauma Commission FY 2010 Budget Procurements, Grants and Contracts Update Worksheet					
Budget Item	GTCNC FY 2010 Approved Budgeted Amount	Status	Jim Pettyjohn 14 February 2010	Curtis Chronister 5 March 2010	Jim Pettyjohn 15 March 2010
Center for Healthcare Organization Transformation Membership	\$ 50,000	Pending		Awaiting clarification from GTRC as to what information they will want to collect in order to ensure data collected is not proprietary in nature or in violation of HIPPA. Once received, the Contract Authorization Request (CAR) will be sent to budget then on to contracts for processing.	
EMS Vehicle Equipment Replacement Grants Program	\$ 2,125,000	Pending	Application and instructions complete...to have been posted to www.gtnc.org on 15 February. Hold on posting per Dana Greer (12 Feb) until DCH grants P&P addressed. C. Chronister to detail specifics.	Pending post to DCH website. Expected to be post by 18 March 2010.	Finalizing Grant Documents. Proposed posting 18 March.
GAEMS sole source/ sole brand Contract for first responder training and trauma-related equipment for 911 zone ambulances.	\$ 676,900	Pending		CAR will be sent to budget then to contracts for processing on Monday, 15 March 2010.	
GPT matching funds Grant	\$ 200,000	Pending		Awaiting sole source/brand justification from Telemed. Once received, DCH will process and post to website.	
New Trauma Center Startup Grants	\$ 1,000,000	Pending	On 12 February per Dana Greer, hold on verbal communications (Q&A) with applicants, all questions for potential applicants to be in writing and grants program must be approved by DCH. C. Chronister to detail specifics.	Pending post to DCH website. Expected to be post by 18 March 2010.	Finalizing Grant Documents. Proposed posting 18 March.
OEMS/IT 3% Allocation	\$ 655,000	Pending		NO CHANGE. Positions not yet requested: Trauma Nurse, IT Position, and PT EMS Med Director (A determination needs to be made as to how much money will not be spent that was allocated for these positions based on the time when these positions will actually be filled. These funds will then be redirected to the uncompensated trauma care fund or as the Trauma Commission directs.)	
Regional EMS Agreement	\$ 100,000 for FY 2010 and 5 \$100,000 awards for FY 2011	Pending	Awaiting AG's Office opinion as to most appropriate entity for Commission to contract with (District Health Office??) Alex Sponseller to report during 18 Feb Commission meeting.	NO CHANGE - WILL CONTINUE TO WORK. I am working to see what alternatives exist to get this moving forward. One possibility is to develop a grant for each of the Regions, fund the 5 for this year, then have them invoice through the Trauma Commission for signature then back to DCH for payment. This can be accomplished by assigning a vendor number to those identified as members of the Regional Committees.	
Web-based Registry Support	\$ 49,550	Pending		Renee Morgan is recommending the TC re-allocate these funds.	
Website Design	\$15,000 (Reduced to \$4,995)	Pending		Request for purchase sent to OIT for their review and approval.	
Communications Center Lead Position	\$ 100,000	Human Resources	Revised update on this position to be provided by C. Chronister.	Request pending Dr. Edwards signature.	Job Description posted to www.gtnc.org with f/u instructions to contact K. Dixon
Broselow and Lutin System	\$ 200,000	Contract		CAR being sent to budget then to contracts for processing.	

Trauma Commission FY 2010 Budget Procurements, Grants and Contracts Update Worksheet					
Budget Item	GTCNC FY 2010 Approved Budgeted Amount	Status	Jim Pettyjohn 14 February 2010	Curtis Chronister 5 March 2010	Jim Pettyjohn 15 March 2010
Trauma Centers and Physician Funding Contract (readiness and uncompensated care)	\$ 14,153,600	Contract		The following contracts are with Dr. Medows waiting for her signature. Once signed, these contracts will go back to procurement for return to the respective hospitals. Once received, the hospitals can then begin to bill and invoice. CHOA - Eggleston; CHOA - Scottish Rite; Floyd Medical Center; Grady Health System; Archbold Memorial Hospital; Walton Regional Medical System; Morgan County Hospital Authority	
MCG Health Inc. contract for FY 2010 EMS Uncompensated Care Reimbursement Program		Contract		Seeking input from procurement on how to expedite this request.	
Federal Stimulus Funding Solicitation	no funds	Pending	C. Chronister to investigate status. Original email request with required documents sent to R. Morgan on 23 October forwarded to C. Chronister.		Not Completed. C. Chronister requested to locate FRI and provide update.
Commission Travel/Per diem	\$ 10,000	Pending		Renee is the POC for this item.	15 March: R. Morgan continues to work to complete process. Members not receiving stipends
<p>Complete - Business related to item closed Procurement - In procurement process or pending decision from DCH Procurement to begin process Contract - In contract approval process, which could include a legal decision, drafting of contract or approval process of final contract Human Resources - In HR process for approval Pending - None of the above or tabled or pending a decision from other than DCH Procurement, DCH Contracts or DCH Human Resources.</p>					

FY 2010 Completed				
B+A Amendment and Commission administrator combined	\$ 245,970	Complete		
Conference Call Account	\$ 7,200	Complete		
Administrative Assistant	\$ 50,000	Complete		Carol Dixon accepted the position and will begin work on 9 March 2010.
Trauma Center Association of America a/k/a National Foundation for Trauma Care	\$ 1,500	Complete		

FY 2011 Procurements, Grants and Contracts				
Budget Item	Budgeted Amount	Status	Jim Pettyjohn 14 February 2010	Curtis Chronister 26 February 2010
Professional services contract for J. Pettyjohn as Commission administrator FY 2011 Contract (01 July 2010 - 30 June 2011)	\$ 138,000	Pending	Notified C. Chronister and Dana Greer to work directly with Dr. Ashley and or Commission member representatives on this contract.	UPDATE: Will send contract request to DCH procurement NLT 17 March 2010.
Communications Center Software	up to 1,000,000			This will need to be drafted into a contract with GTRI for FY 2011. Drafting of this contract should begin no later than 26 March 2010.

Note: on 25 February, DCH agreed to add Dr. Ashley as a signatory on all Trauma Commission Contracts



Fran Lewis, RN, MN
Trauma Program Manager
80 Jesse Hill Jr. Drive S.E.
Atlanta, GA 30303

March 8, 2010

Georgia Trauma Care Network Commission
c/o Dennis Ashley, MD, Chairperson
Trauma Services
MCCG
777 Hemlock Street
MSC 103
Macon, GA 31201

Dear Members of the Trauma Commission:

Grady Memorial Hospital would like to thank you for the funding that was made available in the form of the Capital Grant (DHR Contract # 427-93-0909-1249-99) in 2009. Though we are moving forward with the three (3) projects as planned, our Project Manager has predicted that there might possibly be a small amount of money remaining in one of the projects upon its completion. We are asking that if this is the case, that it be possible to place that amount of money into one of the other two projects.

Again, we thank you for making these advancements in trauma care at Grady possible. If you have questions, you may contact me at 404-616-4584

Sincerely

Fran H. Lewis, RN, MN
Trauma Program Manager



Calvin Thomas IV
Senior Vice President Operations
80 Jesse Hill Jr. Drive S.E.
Atlanta, GA 30303

March 8, 2010

Georgia Trauma Care Network Commission
c/o Dennis Ashley, MD, Chairman
MCCG
Trauma Services
777 Hemlock Street
MSC 103
Macon, GA 31201

Dear Members of the Trauma Commission:

On behalf of the Grady Memorial Hospital and its Board of Directors, I would like to thank you for funding the Capital Grant that we received in 2009. Due to unforeseen construction delays and new regulatory compliance standards that must be followed, these three (3) projects will not be completed by the original completion date. As a result, all of the money will not be encumbered by March 31st, 2010 as stipulated by the contract.

We therefore request a no-cost extension of the contract (DHR Contract # 427-93-0909-1249-99 for \$2,600,000.00). We feel that we will have all three projects completed by this time and look forward to caring for the trauma patients of our area in a much more efficient manner.

All of the necessary pre-construction documents, including a Certificate of Need have been procured. Accompanying this letter you will find the proposed construction plan developed by the Grady Project Manager. If you have questions concerning our projects, please do not hesitate to call me at 404-616-4886.

Thank you again for the funding and we look forward to working with you in the future.

Sincerely,

Calvin Thomas IV
Senior Vice President of Operations

INTEROFFICE MEMORANDUM

To: **Fran Lewis**
Trauma Program Manager – Grady health System

From: **George Smith**
Architectural Project Manager / Facilities Development

Subject: **STATE TRAUMA FUND SCHEDULE**

Date: 1/22/2010

cc: Craig Tindall, Senior Vice-President, Operations and Facilities;
Mark Mack, Director, Facilities Development (Interim);
File

Following is a narrative supplementing/expanding the attached schedule.

1. TRAUMA CENTER EXPANSION - \$1,000,000

- a. Supplemented by Marcus Funds – next installment due November, 2010;
- b. Requires relocation of Anatomic Pathology Offices, Histology Lab, and Main Outpatient Pharmacy;
 - i. Pharmacy project is a separate effort, phased with other Pharmacy initiatives – slated for completion late April, 2010;
 - ii. Pathology and Histology included in overall project;
- c. A/E team engaged and working on design for both the Pathology/Histology relocation and the Trauma Center Expansion;
- d. Project anticipated to coordinate with cash flow, with State funds completing design, construction of Pathology and Histology relocation spaces, and abatement of project area on Ground Floor, C-wing, in anticipation of demolition and construction/completion of the project;

2. 7-D CONNECTOR & WAITING ROOMS - \$1,000,000

- a. Construction documents due mid-February;
- b. Engineering effort proved to be more complex than anticipated, leading to prolonged design phase;

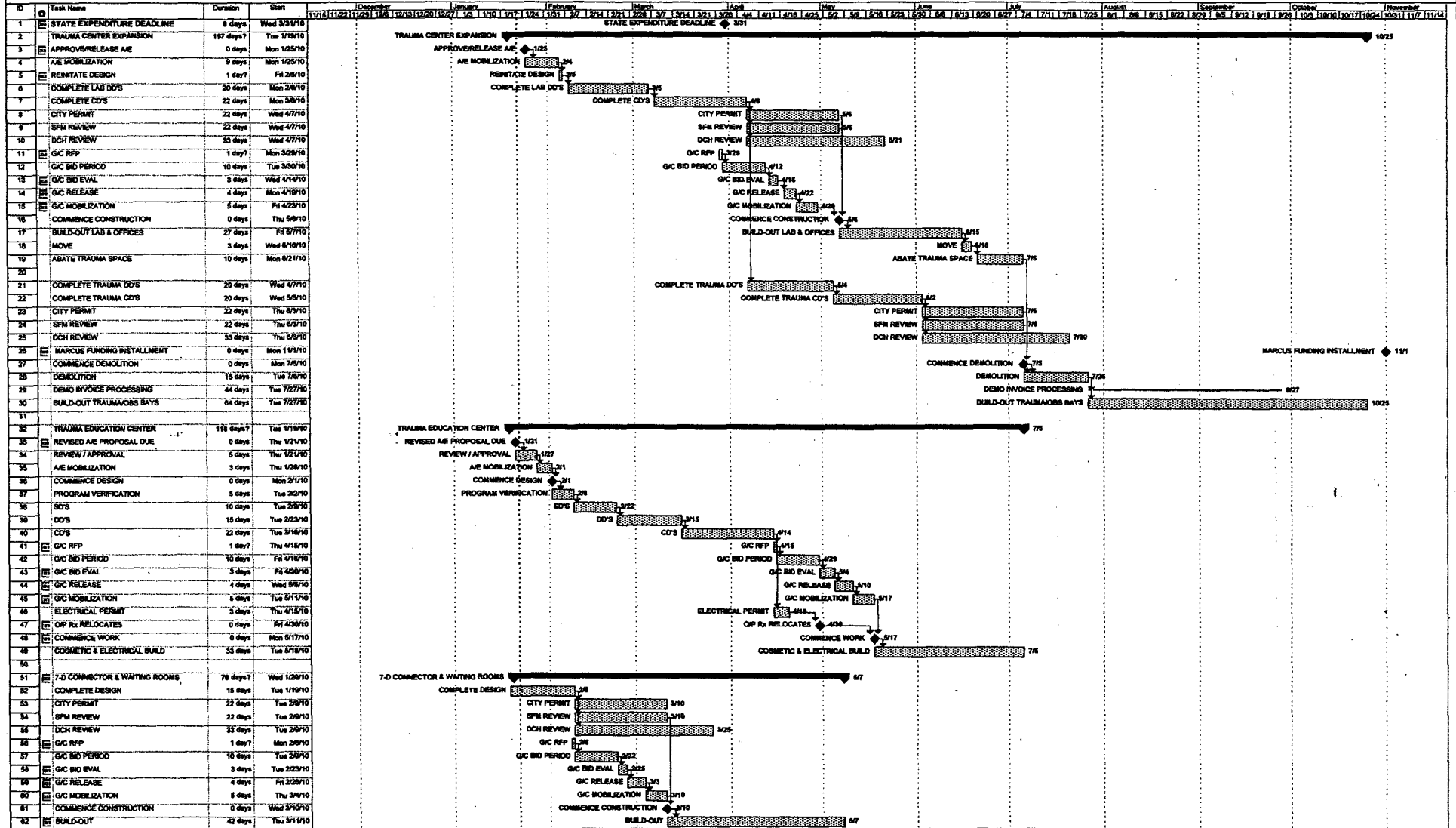
3. TRAUMA EDUCATION CENTER - \$600,000

- a. Requires relocation of Main Outpatient Pharmacy as the Auditorium currently functions as Pharmacy Waiting Room;
- b. Pharmacy project is a separately funded effort slated for completion late April, 2010;
- c. Revised design team proposal under review with anticipated release early February;

Please let me know if I can provide any additional information.

FACILITIES DEVELOPMENT
(V): 404-616-3228
(F): 404-616-3355
(e): gcsmith@gmh.edu

STATE TRAUMA FUND PROJECTS
(TRAUMA CENTER EXPANSION / TRAUMA EDUCATION CENTER / ICU CONNECTOR & WAITING ROOMS)



Project: STATE TRAUMA PROJECTS
 Date: Fri 1/22/10

Task: Milestone Rolled Up Task External Task Group By Summary

Progress: Summary Rolled Up Milestone Split Project Summary Deadline

GTCNC CY 2008 READINESS COST SURVEY RESULTS SUMMARY
March 18, 2010

PROJECT DESCRIPTION & GOAL

The goal is to produce a rigorous and transparent methodology to measure the financial requirements for maintaining Georgia's trauma centers. This will provide accurate and credible data to the State Legislature regarding the costs of trauma care. This project also has national implications.

Trauma patient treatment costs are relatively well defined by standardized hospital cost-accounting systems coupled with an established methodology that enables severity adjusted comparisons of such costs among trauma centers. The costs required by trauma center regulations to maintain essential infrastructure and capacity to provide emergent services on a 24/7 basis are not well defined. These are non-patient care costs the hospital would not have to pay if it were not a trauma center. They are described as trauma center readiness costs.

The GTCNC's Trauma Care Economic Subcommittee developed a new methodology to assess such costs, based upon previous trauma center readiness cost surveys in Georgia and Florida, and using the American College of Surgeon's standards for trauma centers¹ (which Georgia has adopted). Financial and program managers from all Georgia trauma centers then participated in two meetings to review and refine the methodology – a webinar held in conjunction with the Georgia Hospital Association, and a Readiness Cost Summit, a face-to-face meeting held in Atlanta.

The survey instrument, with instructions based upon the Committee's methodology and results of meetings with trauma centers, was then prepared and then distributed. All trauma centers then completed the surveys based upon calendar year 2008 costs. This report summarizes the results and implications.

READINESS COST SURVEY RESULTS

The summarized results of the survey are as follows:

Readiness Cost Category	LI Total	LI Average	L2 Total	L2 Average	New, LIII & LIV	Georgia Totals
Administrative	2,431,530	607,883	3,339,644	371,072	221,522	\$5,992,696
Medical Staff	18,003,208	4,500,802	12,836,008	1,426,223	1,198,120	\$32,037,336
In House OR	1,744,231	436,058	2,284,553	253,839	405,646	\$4,434,430
Education/Outreach	222,518	55,630	1,437,046	159,672	115,599	\$1,775,163
Georgia Totals	\$22,401,487	\$5,600,372	\$19,897,251	\$2,210,806	\$1,940,887	\$44,239,625

¹ ACS Resource for Optimal Care of the Injured Patient: 1999 and ACS Re-verification documentation.

A more detailed summary of results is attached. The CY 2008 results total \$44.2 million, compared to \$46.3 million in CY 2007, and \$44.0 million in CY 2006. These surveys used a broader definition of readiness costs, but took a less rigorous approach (see attached).

While a full comparison between 2008 results with 2006/2007 is not possible due to different cost categories, a few comparisons are possible. For example, in-house OR costs totaled \$4.4 million in CY 2008, versus \$5.8 million in both CY 2006 and 2007. This was due to a more rigorous definition of the costs a trauma center should include.

Another comparison can be made regarding trauma center costs for maintaining medical staff support, which were \$22.4 million in CY 2006, \$25.1 million CY 2007, and \$32.0 million in CY 2008. The increase in 2008 reflects in part the funding the GTCNC provided to trauma centers for this purpose in 2008.

Survey Instrument

The survey instrument is attached, and it includes the guidelines for determining trauma center readiness costs that were developed by the Committee and vetted by the trauma center representatives. This new methodology is expected to attract the attention of other states as they address their trauma centers' costs.

POTENTIAL DEFICIENCIES

Due to very poor financial performance in previous years, most of Georgia's trauma centers have not been able to maintain full support for their programs. This survey provides evidence of this in the following areas:

Readiness Cost Category	Georgia Totals	Outliers	Average w/o Outliers	No Cost
Education & Outreach				
Injury Prevention	\$1,030,620	2	\$7,414	7
Community Outreach	\$263,492	1	\$246	11
Professional Outreach	\$35,170	1	\$1,474	7
Outlying Hosp. Education	\$520		\$37	14
Administrative				
Trauma Program Manager	\$1,132,730		\$78,556	
Outreach Coordinator	\$194,556	2	\$5,046	8
Injury Prevention Coordinator	\$85,558	1	\$598	12

The table shows the average expenditure by trauma centers when 1-2 outliers (who spend substantial amounts) are removed. It also shows the number of trauma centers that report no costs in the category.

Injury prevention and outreach activities, required by trauma center regulations, clearly received very little support in CY 2008. The amount for the Trauma Program Manager position (or Trauma Administrative Director or Trauma Coordinator), the key management position in a trauma center, includes benefits, which if removed, leaves a salary of \$62,845 compared to a CY 2007 national trauma center average of \$82,164². This indicates an increased investment in trauma center management may be appropriate, perhaps combined with training (this survey process turned into a statewide seminar on trauma center finance for the trauma program managers).

Use in Performance Based Payment

This annual GTCNC readiness cost survey can be considered a support mechanism for the proposed performance based payment program being considered by the GTCNC in that it discerns whether a trauma center is actually allocating resources to functions required by Georgia trauma center standards such as outreach, education, injury prevention, registrars, etc. This information can be added to the review process as a means of rewarding trauma centers for providing appropriate support to such functions.

² From the National Foundation for Trauma Care's Trauma Center and ED Staff Survey – December 2007

GTCNC CY 2008 Readiness Cost Survey Results Summary

18-Mar-10

	LI Total	LI Average	L2 Total	L2 Average	New, LIII & LIV	Georgia Totals
Administrative						
Senior Administrative Support	169,440	42,360	650,028	72,225	24,800	844,268
Trauma Program Manager	353,438	88,360	667,792	74,199	111,500	1,132,730
State/Regional Participation	1,917	479	10,195	1,133	500	12,612
Trauma Center Staff Support						
Outreach Coord.	12,704	3,176	181,852	20,206		194,556
Case Mngt/DC Plng	698,941	174,735	575,143	63,905	10,825	1,284,909
Injury Prev. Coord.	80,558	20,140	5,000	556		85,558
Research/PI Coord.	160,020	40,005	4,316	480		164,336
Trauma Registrar	339,161	84,790	334,532	37,170	19,233	692,926
Secretarial Staff	191,101	47,775	99,833	11,093		290,934
Trauma Med Director	186,041	46,510	340,731	37,859	20,664	547,436
Part. In S/R Activities	9,575	2,394	1,000	111		10,575
ED Medical Director	77,305	19,326	206,877	22,986	25,000	309,182
ICU Surgical Director	66,594	16,649	158,909	17,657		225,503
Orthopedic Liaison	51,100	12,775	22,680	2,520		73,780
Neurosurgeon Liaison	26,020	6,505	54,360	6,040		80,380
Registry Hard/Software	7,615	1,904	26,396	2,933	9,000	43,011
Subtotal-Administrative	2,431,530	607,883	3,339,644	371,072	221,522	5,992,696
Clinical - Medical Staff						
Trauma Medical Staff Compensation						
Trauma Surgery	4,258,276	1,064,569	4,136,134	459,570	108,729	8,503,139
Subtotal-Clinical Med Staff	18,003,208	4,500,802	12,836,008	1,426,223	1,198,120	32,037,336
In House OR Availability Education & Outreach	1,744,231	436,058	2,284,553	253,839	405,646	4,434,430
Injury Prevention	14,400	3,600	940,508	104,501	75,712	1,030,620
Community Outreach	795	199	262,697	29,189		263,492
Prof. Outreach	18,694	4,674	12,876	1,431	3,600	35,170
Outlying Hosp. Educ.	520	130				520
16 Hours Trauma CME						
Trauma Med. Dir.	8,224	2,056	4,562	507		12,786
Trauma Prog. Mgr.	4,790	1,198	7,036	782	1,800	13,626
ED Trauma Liaison	5,480	1,370	5,899	655	2,200	13,579
Neurosurgical Liaison	3,853	963	2,445	272		6,298
Orthopedic Liaison	1,750	438	13,040	1,449		14,790
Trauma Education-Hospital Staff						
ED	73,138	18,285	94,811	10,535	32,287	200,236
ICU	69,198	17,300	89,897	9,989		159,095
Surgery	21,676	5,419	3,275	364		24,951
Subtotal-Educ/Outreach	222,518	55,630	1,437,046	159,672	115,599	1,775,163
Georgia Totals	22,401,487	5,600,372	19,897,251	2,210,806	1,940,887	44,239,625

2007 Trauma Center Readiness Costs

Readiness Cost	Level I TC	GA Avg.	Level II	GA Avg.	LI/II Total
Total Medical Staff	\$12,922,170	\$3,230,543	\$12,173,618	\$1,352,624	\$25,095,788
24 Hour OR Staffing	\$2,530,000	\$632,500	\$3,279,800	\$364,422	\$5,809,800
Higher Staffing Levels	\$510,000	\$127,500	\$619,393	\$68,821	\$1,129,393
Transportation	\$1,756,000	\$439,000	\$250,000	\$27,778	\$2,006,000
Support Services	\$657,495	\$164,374	\$464,564	\$51,618	\$1,122,059
Injury Prevention	\$78,500	\$19,625	\$1,074,770	\$119,419	\$1,153,270
Training	\$220,000	\$55,000	\$488,456	\$54,273	\$708,456
Administration	\$2,400,000	\$600,000	\$3,627,949	\$403,105	\$6,027,949
Physician Extenders	\$737,000	\$184,250	\$121,744	\$13,527	\$858,744
Verification Process	\$3,800	\$950	\$21,250	\$2,361	\$25,050
Trauma Equip	\$50,000	\$12,500	\$354,782	\$39,420	\$404,782
Other Costs*	Included Above		1,943,149\$	\$215,905	\$1,943,149
Total	\$21,864,965	\$5,466,242	\$24,419,475	\$2,713,275	\$46,284,440

Source: 2008 project conducted by Bishop+Associates for the Healthcare Georgia Foundation

2006 Trauma Center Readiness Costs

Readiness Cost	Level I TC	GA Avg.	Level II	GA Avg.	LI/II Total
Total Medical Staff	\$12,017,488	\$3,004,372	\$10,343,929	\$1,063,557	\$22,361,417
24 Hour OR Staffing	\$2,665,000	\$666,250	\$3,177,955	\$338,631	\$5,842,955
Higher Staffing Levels	\$510,000	\$127,500	\$665,404	\$54,983	\$1,175,404
Transportation	\$1,756,000	\$439,000	\$325,008	\$43,334	\$2,081,008
Support Services	\$674,201	\$168,550	\$405,406	\$33,411	\$1,079,607
Injury Prevention	\$77,775	\$19,444	\$408,021	\$23,292	\$485,796
Training	\$218,440	\$54,610	\$454,195	\$34,796	\$672,635
Administration	\$1,817,534	\$454,384	\$3,680,934	\$330,791	\$5,498,468
Physician Extenders	\$733,259	\$183,315	\$235,160	\$18,021	\$968,419
Verification Process	\$3,300	\$825	\$34,250	\$1,100	\$37,550
Trauma Equip	\$335,000	\$83,750	\$517,838	\$37,934	\$852,838
Other Costs*	Included Above		\$3,007,126	\$245,395	\$3,007,126
Total	\$20,807,997	\$5,201,999	\$23,255,227	\$2,225,245	\$44,063,224

Source: 2009 project conducted by Bishop+Associates for the Georgia Trauma Care Network Commission

CY 2008 GEORGIA TRAUMA CENTER READINESS COSTS BY DESIGNATION LEVEL
Georgia Trauma Care Network Commission

January 25, 2010

To Georgia Trauma Centers,

Attached is the 2008 Readiness Cost Survey that resulted from the December Webinar and recent January Summit on readiness costs. It covers calendar year 2008. The due date is February 5, 2010.

Please immediately acknowledge that you have received this survey by replying to the email from Ann@traumacare.com.

Phase 2 of this survey – requested financial information – will be sent separately to avoid confusion.

If you have questions, please email them to Ann@traumacare.com. We will circulate answers to all trauma centers.

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

Please provide the following information:

Trauma Center _____ Level _____
Name of person who completed this Survey: _____
Phone Number: _____
Email Address: _____

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

_____ CFO

LINE ITEM/	LEVEL		SURVEY INSTRUCTIONS	AMOUNT
	I	II III IV		
Criteria Deemed Essential For Level In ACS Gold Book ADMINISTRATIVE			Do Not Respond To Item If Your Trauma Center Level Is This Color As It Is Not Essential For Your Level*	Use Actual Costs in 2008
Senior Administrator Support			% of time focused on trauma by main senior administrator involved in trauma X salary and benefits	
Trauma Program Manager (TPM)			Salary & benefits X % of time on trauma (if position has other duties in low volume trauma centers).	
Participation in state and regional activities (e.g., EMS Council)			Trauma Program Manager travel costs to meetings	
Trauma Center Staff Support			<ul style="list-style-type: none"> If any of the following positions generate reimbursement or are supported by grants, use net hospital costs X time spent on trauma to calculate their costs. If position employed by trauma program, or if employed by another department which focuses trauma responsibility on few staff, use salary and benefits less revenue and grant support for costs. If employed by another department which spreads trauma responsibility among most staff, use portion of trauma patient admissions of total admissions X department salary costs. 	
Outreach Coordinator			* E.g., Level III/IV trauma centers should skip this as not required Salary & benefits X % of time on trauma	
Case Mgmt, Discharge Planning			Salary & benefits X % of time on trauma. If support is provided by personnel from a hospital case management department, use trauma discharges/total discharges X department salary costs.	
Injury Prevention Coordinator			Salary & benefits (less grant support) X % of time on trauma.	
Research/PI Coordinator			Salary & benefits (less grant support) X % of time on trauma.	
Trauma Registrar			Salaries & benefits X % of time on trauma – Limit of 1 registrar per 500 – 1000 patients.	
Secretarial Staff			Salaries & benefits X % of time on trauma.	

Trauma Medical Director				Board-certified surgeon with specialty interest in trauma care. Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions only.	
Participation in state and regional activities (e.g., EMS Council)				Trauma Medical Director travel costs to meetings.	
ED Medical Director				Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions.	
ICU Surgical Director				Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center administrative functions.	
Orthopedic Liaison				Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center admin functions. Must participate actively with trauma service with documented CME and PI.	
Neurosurgeon Liaison				Administrative stipend if contracted, or if employed, salary & benefits X % of time spent on trauma center admin functions. Must participate actively with trauma service with documented CME and PI.	
Registry Hardware and Software				Costs for registry hardware, software and maintenance fees.	

CLINICAL – MEDICAL STAFF

Trauma Medical Staff Compensation

Do not include amounts paid for administrative duties.

Includes the costs of maintaining trauma physician support for your trauma center other than the costs of admin functions addressed above.

- If you pay specialty a stipend exclusively for trauma call, enter the full amount.
- If you pay a stipend to a specialty that is for both trauma and ED call, estimate the portion attributable to trauma care.
- If you employ your physicians, determine net cost (salary + benefits – pro fee reimbursement) and estimate portion attributable to trauma.
- If you are supported by a faculty practice arrangement, take portion of trauma admissions to overall admissions and apply to overall hospital subsidy provided to faculty practice structures.

Or

Total number of physicians by specialty and apply AAMC salary database (at 50% of range) for SE region, add estimated benefits, subtract estimate salary support from pro fee reimbursement, and then apply portion of trauma admissions to overall admissions to arrive at net cost for specialty support.

- Do not include amounts specifically paid to trauma physicians for care of uninsured trauma patients in the amounts for each specialty; you will be asked for a total amount of such pay at the end of this section.

Trauma Surgery			See above.
Orthopedics			See above.
Neurosurgery			See above.
Anesthesia			Estimate portion of hospital net cost for anesthesia (including CRNA's) that is attributable to trauma.
Hand			See above.
Microvascular			Include only if hospital pays for support and then only portion attributable to trauma.
Cardiac			Include only if hospital pays for support and then only portion attributable to trauma.
OB/ GYN			Include only if hospital pays for support and then only portion attributable to trauma.
Ophthalmic			Include only if hospital pays for support and then only portion attributable to trauma.
Oral/ Maxillofacial			See above

ENT/ Plastics				See above.	
Critical Care Medicine				See above	
Radiology				Estimate portion of hospital net cost for radiology that is attributable to trauma.	
Thoracic				Include only if hospital pays for support and then only portion attributable to trauma.	
Surgical Resident Support				This applies to surgical residency only. There are two options: Take residency costs and subtract federal funding and apply portion attributable to trauma, or take residents' hourly salary + benefits for time on trauma rotation, and subtract federal funding for this time.	
Payment for uninsured trauma patient care for all specialties				If you paid your trauma medical staff (those listed above) specifically for uninsured trauma patient care in 2008 (with hospital and/or state trauma funds), enter the total amount for all specialties on this line.	
<u>IN HOUSE OR AVAILABILITY</u>				Level I hospitals require in-house 24 hour availability and some Level IIs maintain this as well.	
				<ul style="list-style-type: none"> If you maintain a dedicated OR that remains open, staffed and is used exclusively for trauma, please estimate net costs (less reimbursement) below. If you maintain 24 hour in-house OR availability but do not maintain a dedicated OR that remains open and staffed exclusively for trauma, provide your costs for an RN and OR tech for PM and night shift for 7 days a week. 	
Costs Of In House OR Availability					

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

PERFORMANCE BASED PAYMENT FOR GEORGIA'S TRAUMA CENTERS
Georgia Trauma Care Network Commission (GTCNC)
March 1, 2010

Performance based payment (PBP) is an evolving concept in health care that is gaining traction as a means of improving quality and reducing costs by financially incentivizing providers to do so. Its application in trauma care is very limited, although it has strong potential in terms of quality and costs, particularly in states that fund trauma centers.

A few states have implemented individual components of PBP for trauma centers. New Mexico, Oklahoma and Georgia have used national severity adjusted patient treatment cost norms as a basis for payment. Arkansas is implementing payment for data submission as a precursor to payment based upon clinical outcomes. In a broader context, the designation process itself provides an attractive, long term business franchise to hospitals that meet designation criteria. Another example of performance based payment is Mississippi's "pay or play" approach in which hospitals that do not serve as trauma centers help fund those that do.

Georgia is poised to take the lead nationally in trauma care PBP, due to the funding the GTCNC has secured from the state legislature and its commitment to use these funds in the most cost-effective manner possible. This document describes six PBP concepts that can be applied in Georgia, along with recommendations for implementation.

PBP concepts that can be considered in Georgia are as follows:

- I. Trauma System Participation & Reporting**
- II. Fostering Trauma Care Cost Effectiveness**
- III. Assuring Trauma Center Access**

- IV. Maintaining Georgia Trauma Center Standards**
- V. Optimizing Trauma Care Clinical Outcomes**

Each concept is described along with an outline of the following:

- Implementation Requirements
- Standards & Performance Measures
- Time Frame & Costs

This document will enable the GTCNC to select and shape the components of the PBP program it ultimately adopts. The items in *italics* are factors that the GTCNC needs to determine and can adjust periodically as the trauma system evolves.

FY 2011 GTNC TRAUMA CENTER READINESS AND PERFORMANCE BASED PAYMENT BUDGET

In FY 2011, 20% of readiness payments have been initially assigned to PBP (this proposal suggests this be raised to 30%). This document proposes the criteria for which these payments will be made in FY 2011.

Georgia Trauma Commission FY 2011 \$23 Million Budget Trauma Center Readiness and Performance Based Payments (PBP)							
Trauma Center	Readiness Payments ¹	Potential PBP ²	Total Readiness Payments	New Trauma Centers	Readiness Payments ¹	PBP ²	Total Readiness Payments
Archbold	\$349,809	\$87,452	\$437,261	Athens Level II	\$349,809	\$87,452	\$437,261
Atlanta	\$349,809	\$87,452	\$437,261	Walton Level III	\$174,904	\$43,726	\$218,630
Columbus	\$349,809	\$87,452	\$437,261				
Floyd	\$349,809	\$87,452	\$437,261	New Trauma Centers	\$524,713	\$131,178	\$655,891
Gwinnett	\$349,809	\$87,452	\$437,261	Existing Trauma Centers	\$5,480,336	\$1,370,084	\$6,850,421
Hamilton	\$349,809	\$87,452	\$437,261	All Trauma Centers	\$6,005,049	\$1,501,262	\$7,506,312
North Fulton	\$349,809	\$87,452	\$437,261				
Egleston	\$349,809	\$87,452	\$437,261				
Scottish Rite	\$349,809	\$87,452	\$437,261				
Level II Totals	\$3,148,278	\$787,070	\$3,935,348				
Percent	57.4%	57.4%	57.4%				
Grady	\$583,015	\$145,754	\$728,768				
MCCG	\$583,015	\$145,754	\$728,768				
MCG	\$583,015	\$145,754	\$728,768				
Memorial	\$583,015	\$145,754	\$728,768				
Level I Totals	\$2,332,058	\$583,015	\$2,915,073				
Percent	42.6%	42.6%	42.6%				
Existing Trauma Center Totals	\$5,480,336	\$1,370,084	\$6,850,421				

DRAFT

TOTAL OF ANNUAL PBP PAYMENT PERCENTAGES BY PBP CONCEPT

This table summarizes the suggestions for the percent of readiness payments to be tied to each PBP concept over the next five years.

PBP% of Total Trauma Center Readiness Funds

PBP Concept	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1. Participation & Reporting	20%	10%			
2. Cost Effectiveness	<i>Implemented</i>				
3. Assuring Access		20%	20%	20%	20%
4 Trauma Center Standards	10%	10%	10%	10%	10%
5. Clinical Outcomes		10%	20%	20%	20%
Total	30%	50%	50%	50%	50%

I. TRAUMA SYSTEM PARTICIPATION & REPORTING

Description

A critical requirement for trauma system development is participation by providers. The objective of this PBP component is to reward the necessary participation of trauma centers in the following:

- Participation in Georgia trauma system development, meetings and activities.
This includes meetings such as the readiness cost Webinar and summit, other meetings developed by the GTCNC, and regional activities related to the development of the Georgia trauma communication system.
- Provision of accurate and timely data requested by GTCNC or OEMS/T; e.g., trauma center surveys, data on use of trauma funds, etc. This includes timely responses to annual surveys conducted by the GTCNC, and information requests, and trauma center site reviews conducted by OEMS/T.

Implementation: Requires defined standards for participation with “earned point” values, and tracking system like a teacher’s grading system.

Timeframe: This should be considered the first step in PBP and the timeframe for implementation is 2010 and on. New standards can be defined annually or quarterly.

Suggested Initial Standards: For FY 2011, 20% of Trauma Center Readiness payments would be at risk due to lack of participation, defined as not present at meetings/webinars, or not completing survey/registry within time required (e.g., 50% point loss for being late). See attached for suggested required activities and performance criteria.

Future Standards: Can be expanded to include clinical data submission to the National Trauma Data Bank to enable PBP on clinical outcomes, activities such as a statewide injury prevention initiative, etc.

Costs: GTCNC and/or OEMS/T personnel time to set standards, track each trauma center’s participation in required trauma system activities (e.g., sign in sheet for meetings), and tabulate resulting payments.

Example: See attached. Due to a survey that was returned late, this Level II trauma center would receive 95% (\$83,079) of its FY 2011 PBP potential payments of \$87,452, or alternatively would lose 5% (\$4,373).

TRAUMA SYSTEM PARTICIPATION AND REPORTING MEASUREMENT

This table provides a format for defining required trauma center activities and performance criteria, and measuring and tracking their performance in a manner that clearly and fairly determines their payment.

The required activities and performance criteria are examples drawn from FY 2010, which can be updated quarterly. The point value is the weight assigned to the activity, and points earned add up to produce an earned rate which is applied to this trauma center's full readiness allocation (it receives 95% of the 20% that was at risk).

FY 2009 Required Activities (Example) - Performance Criteria	Point Value	Points Earned	Comments Re: Participation
<i>Participation In Readiness Cost Webinar - Hospital Represented On Webinar Call</i>	10	10	Participated re: webinar call in list
<i>Participation In Readiness Cost Summit - Hospital Represented On Webinar Call</i>	10	10	Participated re: meeting attendance list
<i>Complete Readiness Cost Survey By 2/5 - Survey Returned 5 pts.; Returned by 2/8 5 pts.</i>	10	10	Survey returned by 2/8
<i>Complete Financial Survey By 2/30 - Survey Returned 5 pts.; Returned by 3/2 5 pts.</i>	10	5	Survey returned after 3/2; -5 points
<i>Participation in Communication System Develop - Develop hospital protocol for accepting transfer</i>	20	20	Developed hospital protocol for accepting transfers
<i>Maintenance of Up-To-Date Trauma Registry - Data submission 60 days after end of quarter</i>	10	10	Trauma registry data submitted on time
<i>Other - Performance Criteria</i>	20	20	Yes
<i>Other - Performance Criteria</i>	10	10	Yes
Total Earned Rate	100	95 95%	

Once points have been tabulated, each trauma center should be given 2 weeks to provide information that supports any claim they may have to a higher level of participation.

II. FOSTERING TRAUMA CARE COST EFFECTIVENESS

Description

Cost-effectiveness in the acute care setting has been promoted with the use of an all-inclusive case rate such as the Medicare diagnostic related group (DRG) system, which means the less in costs, the more in profit. This is an alternative to paying on a fee-for-service basis in which the more in costs, the more in profit.

In trauma center funding by states, usually for uninsured trauma patient care, the initial approach was to pay based upon reported costs; those with higher costs received more in payment. This changed first in New Mexico, and then Oklahoma and Georgia, whom adopted a severity adjusted case rate methodology based upon patient injury severity scores (ISS) to distribute state trauma funds. Their motivation was this methodology's simplicity and immunity to gaming on costs.

Trauma Cost Norms Used As Basis For Fund Allocation

Trauma center patient treatment cost norms by ISS category were developed for both community and academic hospitals by the National Foundation for Trauma Care, which collected patient treatment cost data from over 100 trauma centers. The norms for each ISS category are contained in the table on the right.

ISS	Community	Academic
0-8	\$5,267	\$6,373
9-15	\$10,428	\$12,618
16-24	\$19,626	\$23,747
>24	\$33,945	\$41,073

A survey of Georgia Level I and II trauma centers was conducted to determine the volume and severity of uninsured patients who met SB 60 requirements. The cost norms were multiplied times the number of patients in each ISS category and then added to produce expected patient treatment costs for each trauma center. Their proportion of total patient treatment costs for all trauma centers was then applied to the fund to determine their payment.

An Example

In the FY 2010 distribution of uninsured trauma patient care funds (see next page), Archbold Memorial Hospital has 29 ISS 0-8 self pay trauma patients. They are multiplied times the community hospital cost norm of \$5,267 to arrive at \$152,743. This is repeated for other ISS categories to arrive at the total cost of \$706,417, which is 1.3% of the total for all trauma centers of \$52.9 million. Archbold was then allocated 1.3% of uninsured trauma patient care funds. While only covering 13% of costs limits its impact, this approach also eliminates the gaming that other states that reimburse trauma centers based upon costs experience (e.g., Texas).

Injury Severity Score	Vol	X Community Cost Norm	= Total
0-8	29	\$5,267	\$152,743
9-15	24	\$10,428	\$250,272
16-24	12	\$19,626	\$235,512
>24	2	\$33,945	\$67,890
Total	67		\$706,417

FY 2010 GTCNC TRAUMA CENTER UNINSURED PATIENT CARE BUDGET

In FY 2009 and 2010, trauma center payments for uninsured patient care were based upon this methodology.

FY 2010 GTCNC Uninsured Patient Care Budget

Trauma Center	Self Pay Trauma Patients Meeting SB 60 Requirements ¹					Cost Norm Based Allocation of Funds ²		
	ISS 0-8	ISS 9-15	ISS 16-24	ISS >24	Total	Total Based Upon Cost Norms	Allocation Based On % of Total Norm Costs	
Archbold	29	24	12	2	67	\$706,417	1.3%	\$89,395
Atlanta	122	108	38	30	298	\$4,274,826	8.1%	\$540,964
Columbus	15	14	11	6	46	\$644,553	1.2%	\$81,566
Floyd	13	21	7	1	42	\$458,786	0.9%	\$58,058
Gwinnett	38	90	28	35	191	\$2,876,269	5.4%	\$363,981
Hamilton	8	9	2	1	20	\$209,185	0.4%	\$26,472
North Fulton	27	38	17	6	88	\$1,075,785	2.0%	\$136,137
Egleston	9	9	3	2	23	\$324,306	0.6%	\$41,040
Scottish Rite	6	15	3	2	26	\$314,790	0.6%	\$39,836
Level II Totals	267	328	121	85	801	\$10,884,917	20.6%	\$1,377,447
Grady	556	551	292	233	1,632	\$27,000,039	51.0%	\$3,416,757
MCCG	55	68	34	15	172	\$2,632,032	5.0%	\$333,074
MCG	96	78	67	34	275	\$4,583,543	8.7%	\$580,031
Memorial	91	137	104	74	406	\$7,817,699	14.8%	\$989,301
Level I Totals	798	834	497	356	2,485	\$42,033,313	79.4%	\$5,319,163
Total LI/LII	1,065	1,162	618	441	3,286	\$52,918,230	100%	\$ 6,696,610

Developing Cost Norms for Georgia

A next step will be to develop trauma center cost norms that reflect the realities of Georgia. The 2010 financial survey will collect trauma center patient treatment cost data by ISS category, and will serve as a starting point for defining norms. In addition, trauma center length of stay (LOS) data, for the entire LOS as well as the ICU LOS, is also collected and can be compared to norms for Georgia and the U.S. (This can be done through the National Trauma Data Bank as well).

III. ASSURING TRAUMA CENTER ACCESS

Description

Trauma centers need to go to extraordinary lengths to maintain their availability for the treatment of the seriously injured in their region, as failure to do so means longer transport times and risks for patients. This PBP concept will reward them for minimizing:

- Time on diversion to trauma patient transports or transfers-in due to lack of readiness capacity or capabilities “essential” to designation standards (e.g., no ICU beds).
- Transfers out due to lack of readiness capacity or capabilities “essential” to designation standards (e.g., no neurosurgeon available for a Level II).

Trauma centers should not be penalized for diverting or transferring out additional patients when their resources are tied up treating multiple trauma patients. In addition, the proposed communication system should regulate the flow of trauma patients with regard to each trauma center’s capacity.

Implementation: This will require the statewide implementation of the proposed communication system which will require all trauma centers to report their status in real time. It will also require defined standards for authorized closures by trauma centers due to multi-trauma incidents, as well as an allowable amount of time on diversion.

Timeframe: This should be considered for implementation in FY 2012 once the communication system is operational.

Suggested Standards: 20% of Trauma Center Readiness pay would be at risk due to excessive time on unauthorized diversion. Suggested authorized closure standards for larger Level I & II trauma center is *2 or more trauma patients arriving within a 3 hour timeframe, and 5 or more trauma patients arriving within 24 hours.* (These can be differentiated by trauma center/level/volume, etc.) The allowable threshold for full payment would be *10% time on diversion* for each period plus time for authorized closures. For each *added 1% of diversion time, the trauma center would lose 2% of PBP funds.*

Costs: Once the communication system is operational, trauma center closure data, including cause, should be readily available. Added costs would be for GTCNC and/or OEMS/T personnel time to track and vet each trauma center’s closures, and tabulate resulting payments.

Example: This Level II trauma center would receive 90% of its potential PBP payments (i.e., lose 10%) because its diversion rate was 5% over the limit of 10%. (See attached.)

ASSURING TRAUMA CENTER ACCESS MEASUREMENT

Trauma Center Closure Log

Trauma Center Anytown Hospital

Quarter January 2012

31 days X 24 hours = 744 Total Hours

Date	Time Frame	Authorized Closure Explanation	AuthTime	Verified	NA Time
1/9	14:55 – 17:30	2 TP arrived at 14:20 – within 3 hours	2:35	(name)	
1/12	12:00 – 24:00	NA (No neurosurgeon available)		NA	12:00
1/13	00:00 – 12:00	NA (No neurosurgeon available)		NA	12:00
1/16	00:00 – 24:00	NA (No ICU beds)			24:00
1/17	00:00 – 12:00	NA (No ICU beds)			12:00
1/19	01:00 – 24:00	5 TP arrived at 24 hours	23:00	(name)	
1/22	00:00 – 24:00	NA (No ICU beds)			24:00
1/23	00:00 – 24:00	NA (No ICU beds)			24:00
Totals			25.35 Hrs		108:00 Hrs
Total Hours Less Authorized Diversion Time			718.25 Hrs	% NA Time	15.0%
			Allowable time on diversion		10.0%
			Excessive Time On Divert		5.0%

Tabulating Payment

- The 31 days in January X 24 hours = **744** hours in month
- Less **25.35** hours (authorized diversion time) = **718.25** hours
- **108:00** hours of non-authorized diversion/718.25 hours = **15.0%**.
- 15.0% - 10% (allowable time on diversion) = **5.0%** excessive time on divert (ETD)
- Potential PBP payment less **10.0%** (5.0% ETD X 2% penalty) is **90% of Potential PBP Payment**

IV. MAINTAINING GEORGIA TRAUMA CENTER STANDARDS

Description

This PBP concept will reward trauma centers for maintaining Georgia trauma center designation standards, which provide a basic foundation for their accountability. Standards will be categorized by priority as follows (see attached sample):

- Category 1 Deficiency – *Lack of major trauma call panel (Surgery, orthopedics, neurosurgery)* – 3 points
- Category 2 Deficiency – *Lack of other call panels, PI program does not meet standards, etc.* – 2 points
- Category 3 Deficiency – *Lack of injury prevention program, outreach, etc.* – 1 point.

Any points would reduce a trauma center's PBP payments.

The impact of different PBP concept on the same issue should be considered (e.g., diversion due to lack of neurosurgery coverage that is also a Category 1 standard).

Implementation: Trauma centers would be reviewed periodically by OEMS/T to determine deficiencies; an annual review of Category 1 standards and a full review every 3 years of all standards can be considered. Trauma center deficiency points would be added annually and would reduce payments based upon a formula.

Timeframe: This can be considered for implementation in FY 2011 once OEMS/T is appropriately staffed.

Suggested Standards: 20% of Trauma Center Readiness pay would be at risk annually due to deficiencies. For each deficiency point the trauma center would lose 10% of PBP funds.

Costs: Added costs would be for additional OEMS/T personnel time to review and report each trauma center's deficiencies and tabulate resulting payments.

Example: A trauma center with one Category 2 and one category 3 deficiencies and would receive 70% of its potential PBP payments (i.e., lose 30%) since 3 points = 30% loss.) (see attached)

Alternatives: The annual GTCNC readiness cost survey can be considered a support mechanism in that it discerns whether a trauma center is actually allocating resources to functions required by Georgia trauma center standards such as outreach, education, injury prevention, registrars, etc. Another PBP approach would be to reward them for doing so.

Another alternative to PBP funding is publically reporting trauma center criteria deficiencies as does Colorado.

SAMPLE LIST OF TRAUMA CENTER PBP STANDARDS

[E = essential requirements] [D = Desired but not essential]

A. Institutional Organization	Levels	I	II	III	IV	Deficiency	Points
1. Trauma program		E	E	E	E-1		
2. Trauma service		E-2	E-2	E-2			
5. Trauma multidisciplinary committee		E-2	E-2	E-2	D		
6. Trauma coordinator/TPM		E	E	E	E-1		
C. Clinical capabilities							
(Specialty immediately available 24 hours a day)							
1. General surgery		E-1	E-1	E-1	D		
On call and promptly available 24 hours/day							
2. Hand surgery		E-2	E-2	D		*	2
4. Neurologic surgery		E-1	E-1	D			
6. Ophthalmic surgery		E-2	E-2	D			
8. Orthopedic surgery		E-1	E-1	E-1	D		
9. Plastic surgery		E-3	E-3	E	D		
D. Clinical qualifications							
1. General/trauma surgeon							
b. 16 hours CME/year		E-3	E-3	D	D		
2. Emergency medicine							
b. Trauma education: 16 hours CME/year		E-3	E-3	D			
3. Neurosurgery							
b. 16 hours CME/year		E-3	E-3	D	D		
4. Orthopedic surgery							
b. 16 hours CME/year in skeletal trauma		E-3	E-3	D	D		
E. Facilities/Resources/Capabilities							
c. Presence of surgeon at resuscitation		E-1	E-1	E-1	D		
F. Performance Improvement							
1. Performance improvement programs		E-1	E-1	E-1	E-1		
5. Trauma conference, multidisciplinary		E	E	E	D		
G. Continuing Education/Outreach							
3. Programs provided by hospital for							
a. Staff/community physicians (CME)		E-3	E-3	E-3	D		
b. Nurses		E-3	E-3	E-3	D		
c. Allied health personnel		E-3	E-3	E-3			
d. Pre-hospital personnel		E-3	E-3	E-3	D		
H. Prevention							
7. Collaboration with national and state programs		E-3	E-3	D-3		*	1
8. Participation in community prevention activities		E-3	E-3	E-3	D-3		

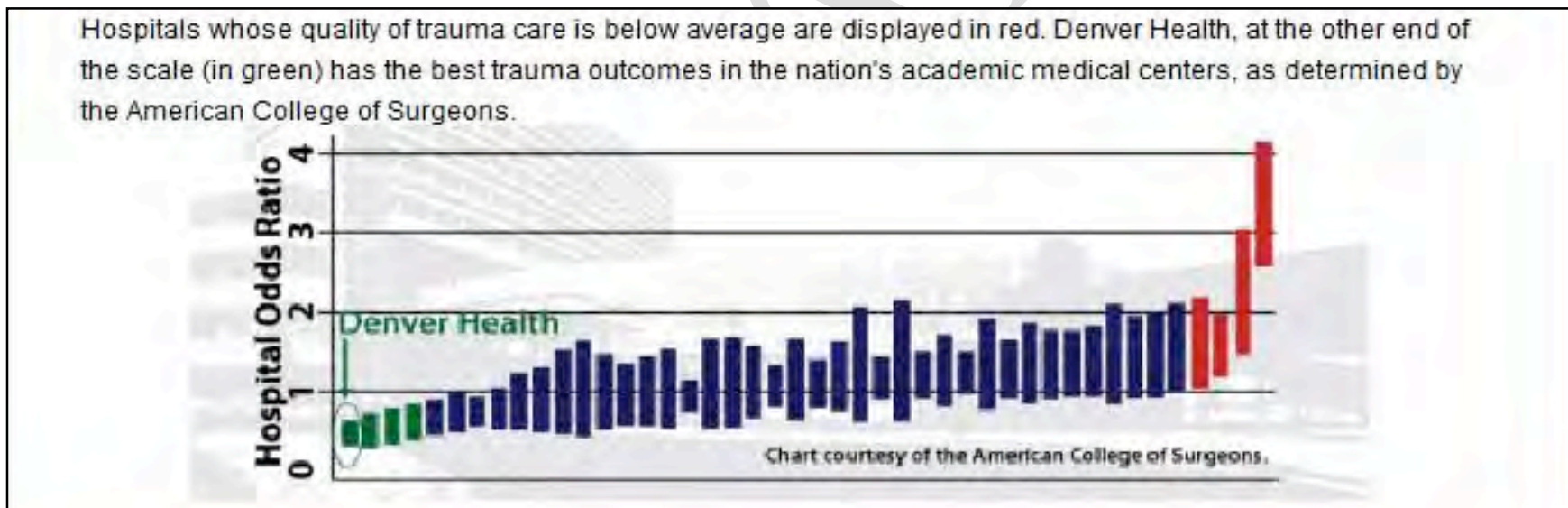
V. OPTIMIZING TRAUMA CARE CLINICAL OUTCOMES

Description

Effectively rewarding quality is the “Holy Grail” of performance based payment in health care. This requires first and foremost, a mechanism for measuring quality that has been rigorously tested and enjoys broad credibility.

The American College of Surgeons (ACS) has done this with its National Surgical Quality Improvement Program (NSQIP), the first nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care by enabling valid comparison of outcomes among participant hospitals.

More recently the ACS has completed a pilot project and opened (in January 2010) its Trauma Quality Improvement Program (TQIP) to national trauma center participation. This leverages off their NSQIP experience, as well as its National Trauma Data Bank, and provides a well tested and highly credible measuring system for severity adjusted trauma care mortality rates. As an example, Denver Health, a Level I trauma center, participated in the TQIP pilot program and posted the results on the hospital’s website:



Georgia has the opportunity to be the first state (with Arkansas close behind) to implement TQIP statewide and tie it to its performance based payment program as a cutting edge approach to fostering high quality trauma care.

Implementation: Trauma center participation in the Trauma Quality Improvement Program requires the following:

- Level I and Level II adult trauma centers (TQIP only assesses outcomes on patients ages 16 or higher)
- Participation in the ACS National Trauma Data Bank (Georgia trauma centers already participate in the NTDB)
- Training of registrars (Georgia trauma registrars meet a high threshold of training)
- Participation by each Center's Trauma Director

This program would be implemented incrementally with the first year being used to bench-mark risk adjusted mortality and then increasing levels of payment would be tied to trauma center outcomes in following years.

Timeframe: This should be considered for initial implementation in 2011 for benchmarking purposes with no financial impact beyond costs of participation. Differences between NTDB and Georgia data definitions need to be resolved.

Suggested Standards: For 2012, 10% of Trauma Center readiness payments would be tied to risk adjusted mortality. This should increase to 20% in 2013. The threshold for payment would be established based upon first year benchmark results; based upon the pilot study (see attached), 1.2 observed/expected deaths should be considered to start (19 of 23 centers in pilot study met this threshold). The payment threshold can be lowered as overall performance increases, and multiple thresholds for partial payment can be considered.

Costs: Annual TQIP fee of \$9000 per trauma center, plus trauma center costs of participation including new Trauma Director responsibilities (e.g., participation in annual conference), registrar training and travel and added costs for additional OEMS/T personnel time to tabulate resulting payments.

Example: A trauma center with more than a 1.2 ratio of observed/expected deaths would receive 90% of its potential PBP payments (i.e., lose 10%) in 2012.

Alternatives: Publication of results can be considered in third year (2013).

See attached information on ACS TQIP program including sample report trauma center report from pilot study.