30 July 2009

ADMINISTRATOR'S MONTHLY REPORT

Brief Outline of Activities

FY 2008 EMS Vehicle Replacement Grant and Hospital Capital Grant awards:
See report (Attachment A.) showing dates of funds dispersal. Bradley Marshall from Public Health Division states EMS providers and trauma centers have well into next calendar year to send in receipts for payment. Trauma Centers and EMS providers should be aware effective dates on their contracts and submit reports and receipts accordingly.

EMS Vehicle Replacement Decals:
See attached letter (Attachment B.) from Benhhinson detailing decal dispersal process and decal example (Attachment C). These events are currently being scheduled through Mid Georgia Ambulance.

Bishop+Associates Agreement for Services in FY 2010
DHR provided a "no cost extension" to Bishop+Associates FY 2009 contract through 30 June 2010. Attachment D is the final negotiated agreement with associated costs for services to GTCNC during FY 2010. This statement of work with associated funds will become an amendment to the extended FY 2009 contract and include Attachment D tasks with deliverables and budget. This amendment process precludes having to execute a new contract.

Grant Development for GTCNC Funding:
Dr. Robinson and I met with Michelle Mindlin via conference call on 01 July to discuss ideas and opportunities for GTCNC to receive grant funding for strategic planning and system development and or implementation. Dr. Robinson will meet with Joe Binns from National Strategies on July 29th for similar discussions. Dr. Robinson will provide recommendations on how to proceed. The Institute of Medicine released its top "100 Initial priority Topics for Comparative Effectiveness Research" on 06 July. Attachment E. It is widely held these are most likely to be the areas where the feds put money for research.

FY 2010 Budget Development Process:
This section deferred to GTCNC budget subcommittee leads: Linda Cole for GTCNC Operations, Ben Hinson for EMS and Dr. Leon Haley for Trauma Center and Physicians.

Super Speeder Implementation Committee:
I am representing GTCNC on this committee to develop a draft implementation plan to be presented to the Governor the first week of August. The plan once approved by Governor will go into effect 01 January 2010. Committee has been meeting weekly. Meetings often conflict with other scheduled GTCNC-based meetings. GTCNC's role is to supply trauma system description and content and background to be used in plan development and rollout. Attachment F and five-year strategic plan with email revisions are content provided to date.

30 July 2009

Georgia Trauma Care Economic Profile Subcommittee Development:
Copied here is Task 3 of Greg Bishop's FY 2010 agreement (Attachment D) with the GTCNC:

> ***Conduct/Update Trauma Care Economic Profile for 2008 (During FY 2010)***
> *B+A prepared an economic profile of the Georgia Trauma System for 2006 and 2007, which will be updated in conjunction with OEMS/T and the GTCNC Administrator. B+A will lead in the development of the revised survey instrument (coordinating with OEMS/T and GTCNC administrator) and perform the 2008 profile assessment. The goal is for OEMS/T and GTCNC to assume responsibility for the economic profiling process by end of this contract period in order to develop future Georgia Trauma Care Economic Profiles in the ensuing years. The 2008 assessment or profiling process will incorporate query on trauma center use of state funds. Written final Trauma Care Economic Profile for 2008 and new survey instrument to be delivered to GTCNC chair and administrator prior to the submission of the FY 2012 budget (September 2010.)*

This agreement has yet to be effectuated by contract amendment, as described above, but we are not delaying our work described within it. I am coordinating with Kelli Vaughn to develop a workgroup (to include member of the GCTE) and GTCNC members to get this accomplished.

Obtain Permanent Funding for Trauma System Development:
Charlie Hayslett and Brian Noyes (Brock Clay) will present at the 30 July GTCNC meeting historical background re work in building support for trauma system funding from the legislature and a current events/environment perspective re the same. Charlie has permitted me to share with you his "*2008 – 2009 Statewide Trauma System Campaign: A Brief Report*" (Attachment G) he prepared for Gary Nelson for Healthcare Georgia Foundation. Charlie's and Brian's presentation will provide the occasion for the GTCNC, with stakeholders present, to discuss its involvement, or not, in activities in the run up to and during the 2010 legislative session. Obtaining permanent funding is your #1 immediate objective for this year. Has that been achieved? If not what are your next steps?

Meetings over the past month:

- Arnita Watson, Grants and Contract Manager, DCH re. Process for RFP development and solicitations' description
- Clyde White, Director of Contracts Administration, DCH re. Information/instruction on DCH contracting process and moving forward after GTCNC budget is developed
- Multiple GTCNC budget subcommittee conference calls re FY 2010 and 2011 budget development
- Multiple GTCNC stakeholder groups and individuals meetings
- GTCC software development
- GTRI contract management discussions e. GTCC and GPS-based AVL
- Region 5 EMS and Region 5 RTAC development
- Georgia Committee for Trauma Excellence

Ongoing Tasks:

- GTCNC administration and operations management
- FY 2010 and FY 2011 Budget development

- FY 2010 GTCNC contracts development
- FY 2009 GTCNC funds dispersal and the point of contact for recipients re system interface difficulties and rumor control
- Translation of GTCNC budget to state/DCH categories and ready for submission to OPB
- EMS trauma stakeholder communications
- EMS provider email list development
- Determining Georgia EMS providers with GPS-based AVL and interest in participating in GTCNC GPS-based AVL program
- Determine GTCC software standards and RFP development
- GTCC operations development
- Five-Year Strategic Plan Revision process
- Direct liaison with Bishop+Associates
- Documents under development:
  - Pilot Project plan (white paper) describing goals and objectives, timeframe, oversight, relationships of stakeholders, PR campaign, metrics of success and process for review and improvement to include next steps to roll out the GTCC statewide
  - Georgia Regional Trauma Plan base document (outline of essential elements) a la BREMSS Regional Plan. This regional plan with be the base document for State Trauma Plan as well.
  - Beginning draft of the Georgia Trauma Rules and Regulations ...OEMS/T is Georgia's lead agency for Trauma Systems regulation and they must have influence here and we cannot fail in achieving coordination and collaboration as to document's structure and content.
  - GTCC lead-position (administrative position) job description
  - GTCC policy and procedure manual

Attachment A

Trauma Commission Money Payments

Equipment	Amount	Date Paid out	Ref #
MCG	$ 150,000.00	6/12/09	154981
Grady	$ 2,600,000.00	6/22/09	155819
John D Archbold	$ 74,767.00	6/25/09	156039
Floyd Medical	$ 74,767.00	7/10/09	998105

Ambulance	Amount	Date Paid out	Ref #
Mid Georgia Ambulance	$ 71,428.57	6/25/09	994631
Mid Georgia Ambulance	$ 71,428.57	6/25/09	994631
Mid Georgia Ambulance	$ 71,428.57	6/25/09	994631
Seminole County	$ 71,428.57	6/25/09	156048
Irwin County	$ 71,428.57	6/25/09	994627
Wilcox County	$ 71,428.57	6/25/09	994918
Ogelthropre County	$ 71,428.57	6/25/09	994634
Meriwether County	$ 71,428.57	6/25/09	994630
Crisp County	$ 71,428.57	6/25/09	994633
Montgomery	$ 71,428.57	6/25/09	994632
Telfair County	$ 71,428.57	7/1/09	996151
Randolph County	$ 71,428.57	7/1/09	156460
coweta county	$ 71,428.57	7/10/09	998104
screven county	$ 71,428.57	7/10/09	998113
Bacon County	$ 71,428.57	7/10/09	157433
Regional EMS	$ 71,428.57	7/10/09	998112
Talbot County	$ 71,428.57	7/10/09	998116
Toombs County	$ 71,428.57	7/10/09	998117
Warren County	$ 71,428.57	7/24/09	999732
Mitchell County	$ 71,428.57	7/24/09	999727

Attachment B

Georgia Trauma Care
NETWORK COMMISSION

Date: 15 July 2009

To: Georgia EMS Vehicle Replacement Award Recipients

From: Ben Hinson, EMS representative on the Georgia Trauma Care Network Commission

Re: Decals for your Replacement Ambulance

As you know, one requirement of the EMS Vehicle Replacement Grant award is to place a decal on the rear of your ambulance crediting the purchase of the vehicle, at least in part, to state funds distributed by the Georgia Trauma Commission.

Those decals are ready to be distributed. The Trauma Commission would like to encourage you to partner with us to show gratitude to your local state representatives for their support of trauma system development within all of Georgia.

Our idea is to collaborate with you and your local media to have the placement of the decal on your new ambulance to be an opportunity to publicly thank your local State Representative and Senator and showcase your professional and dedicated service to your community.

When you receive your ambulance, please notify my assistant Dawn Burgamy at 478.207.3309 and we will work with you to get you your decal and schedule your event.

Thank you for all you do for the people in your community and working with us to build the trauma system Georgians require!

Attachment C

THE PURCHASE OF THIS VEHICLE WAS MADE POSSIBLE IN PART BY A GRANT FROM THE

Georgia Trauma Care

NETWORK COMMISSION

FOR THE PEOPLE IN THE 911 ZONE OF BAKER COUNTY.

Attachment D

BISHOP + ASSOCIATES

July 10, 2009

To: Georgia Trauma Care Network Commission

From: Greg Bishop

Subject: B+A Work Proposal for FY 2010

Proposed Support For GTCNC For FY 2010
For this next year, we will respond to specific needs determined by the Commission based upon a defined work plan. The tasks requested by the GTCNC are as follows:

1. Provide counsel to GTCNC in preparing FY 2010 & FY 2011 budgets

2. Develop performance based funding measures and/or a simplified relative value units (RVU) type funding approach for Georgia trauma care.

3. Coordinate and collaborate with GTCNC and OEMS/T to develop 2010 trauma center financial survey tool and process, conduct the assessment and write economic profile report.

4. *As determined and directed by GTCNC and in collaboration with OEMS/T, provide support for Georgia hospitals interested in becoming new trauma centers.*

5. *Other duties as requested and defined with tasks and costs.*

6. *Transition all support activities to GTCNC administration and OEMS/T staff by end of contract period (In addition to transition that occurs in Task 3).*

We have prepared a work plan for the first three tasks, but will need to learn more regarding the Commission's and OEMS/T's needs on the final three (we included transitioning our role as a Task) and then will provide an appropriate work plan at a future date.

PROJECT WORK PLAN

I. PROVIDE COUNSEL TO GTCNC IN PREPARING FY 2010 & FY 2011 BUDGETS

B+A will continue supporting the GTCNC budgeting process as follows:

- Provide information on state payment models and trends re: trauma system funding.
- Secure necessary 2007 data clarifications from trauma centers on trauma patient volume, severity and payer class as needed by FY 2010 and FY 2011 budget process.
- Analyze Georgia hospital discharge dataset to verify reported trauma center volume and to identify trauma volume by ISS category of non-trauma center hospitals.
- Suggest 2010 and 2011 budget formula alternatives as requested.

- Prepare/update financial model for use in assessing impacts of budget formulas, and use to finalize 2010 and 2011 budget.
- Support discussion on FY 2011 budget alternatives for fully funded budget. These may include rehab, burn, stroke, etc. as well as other strategic plan objectives.
- Prepare/update financial model for 2011 budget.
- Estimate costs for alternatives for comprehensive trauma system ($80 million budget).

II. DEVELOP PERFORMANCE BASED FUNDING FOR GEORGIA TRAUMA CARE.

A. Develop state-of-the art system for rewarding excellence in trauma care quality as follows:

B+A will work with the Trauma Center Committee, trauma center stakeholders, GTCNC and OEMS/T to collaboratively define a state-of-the art system for rewarding excellence in trauma care as follows:

- Provide information on other state's progress/status on performance based funding.
- Coordinate efforts with Arkansas pay for performance initiative (Dr. Mabry).
- Access national sources of information on patient outcome performance measures.
- Contact Georgia Medical Care Foundation or other organization to seek collaborative support.
- Prepare list of alternatives that can serve as starting point for collaborative approach.
- Work with, GTCNC, OEMS/T and stakeholders to define optimal approach for Georgia Trauma System to reflect rewarding excellence in trauma care.
- Prepare concise documents for presentation to legislators/press/stakeholders on GTCNC's mechanism to assure exceptional accountability.

B. Develop Simplified Relative Value Unit (RVU)/Case Rate Funding Approach TO Promote Cost-Effectiveness In Georgia Trauma System

B+A will work with the Trauma Center Committee, trauma center and trauma physician stakeholders, GTCNC and OEMS/T to collaboratively define a state-of-the art system for cost effective reimbursement in trauma care as follows:

- Provide information on other state's progress/status on simplified RVU/case based funding approaches.
- Suggest approaches that may be considered in Georgia and provide basic assessments.
- Work with stakeholders, GTCNC and OEMS/T to define optimal approach for Georgia Trauma System.
- Written final report of this task addressing recommendations to be delivered to GTCNC chair and administrator.

III. COORDINATE WITH GTCNC AND OEMS/T TO DEVELOP NEW TRAUMA CENTER FINANCIAL SURVEY INSTRUMENT AND PROCESS AND DEVELOP GEORGIA TRAUMA CARE ECONOMIC PROFILE FOR YEAR 2008.

B+A will work with the GTCNC, OEMS/T, the Trauma Center Committee and trauma center stakeholders to collaboratively define a state-of-the art reporting system to

include development of appropriate survey instruments for trauma center economic data as follows:

A. Refine Approach For Reporting Trauma Center Use Of Trauma Funds
The initial project benchmarked trauma hospital costs in comparison with national trauma care benchmarks and produced a reliable economic framework for determining and assessing such costs in Georgia based upon a methodology proven in other states and regions. This approach will be refined as necessary to provide Georgia a state-of-the–art system for assessing trauma center costs, and particularly their use of state trauma system funds. Written final report of this task addressing recommendations to be delivered to GTCNC chair and administrator.

B. Readiness Cost Analysis
Review Georgia readiness costing methodology in comparison with approaches used in Florida and Virginia and refine to assure results are reasonably accurate and credible to trauma system policymakers. Written final report of this task addressing recommendations to be delivered to GTCNC chair and administrator.

C. Conduct/Update Trauma Care Economic Profile for 2008 (During FY 2010)
B+A prepared an economic profile of the Georgia Trauma System for 2006 and 2007, which will be updated in conjunction with OEMS/T and the GTCNC Administrator. B+A will lead in the development of the revised survey instrument (coordinating with OEMS/T and GTCNC administrator) and perform the 2008 profile assessment. The goal is for OEMS/T and GTCNC to assume responsibility for the economic profiling process by end of this contract period in order to develop future Georgia Trauma Care Economic Profiles in the ensuing years. The 2008 assessment or profiling process will incorporate query on trauma center use of state funds. Written final Trauma Care Economic Profile for 2008 and new survey instrument to be delivered to GTCNC chair and administrator prior to the submission of the FY 2012 budget (September 2010.)

SCHEDULE, FEES, AND EXPENSES

These tasks will be completed over the Georgia State FY 2010 under the direction of the GTCNC, specifically the GTCNC Chair and Administrator and will be completed by end of contract period. The professional fees for this engagement are $105,000. Travel expenses are estimated at $5,250, and will be incorporated in the contract for a total cost of $110,750. Monthly progress reports and invoices will be submitted to GTCNC Administrator in addition to reporting requirements of DCH. Written reports will be provided as tasks are accomplished.

Breakdown Of Fees

I. Provide Counsel To GTCNC In Preparing FY 2010 & FY 2011 Budgets - $32,000
II. Develop Performance Based Funding For Georgia Trauma Care - $37,500
III. Coordinate With GTCNC And OEMS/T to develop Trauma Center Financial Survey Tool And Process and perform 2008 Trauma Care Economic Profile- $36,000

Total Fees	$105,500
Expenses (5%)	5,250
	$110,750

BISHOP + ASSOCIATES FY 2010 CLIENT DISCLOSURE

For 15 years Bishop + Associates has enjoyed the high level of credibility and trust necessary for this firm to work with both state and regions and their trauma centers to develop the best trauma systems possible. The states have included South Carolina, New Mexico, Texas, Arizona, Illinois, Oklahoma, and Georgia. In each case, we contracted with a state organization and multiple trauma centers within the state to collaboratively address challenges they were facing with the state trauma system and within trauma hospitals.

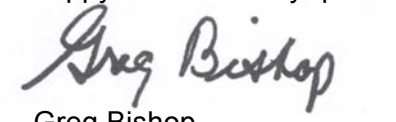
In Georgia over 5 years we have or are contracted with Hamilton Medical Center, Floyd Medical Center, CHoA's Egleston and Scottish Rite Campuses, Phoebe Memorial Hospital, Grady Memorial Hospital, Healthcare Georgia Foundation, Northeast Georgia Health System, and the State of Georgia. (We have also worked in Florida, South Carolina, North Carolina, Tennessee but have no current or in process clients as of now).

Another example is Oklahoma where we advise the state trauma agency on trauma care funding strategies and methods, contract with their major trauma centers to assist on finance and medical staff issues, are working collaboratively with their Oklahoma region to bring up a new Level II trauma center, and are developing an enhanced Level II trauma center model for their rural regions.

The potential for conflict includes us showing any kind of favoritism to a client, sharing confidential hospital data with the public or competitors, etc. Our approach has been to be entirely transparent with all involved (we identified our clients in Georgia the first time we met with the Commission), and avoiding any perceived conflict (we are clear with our clients that we cannot advocate on their behalf in anyway whatsoever).

The potential for synergy is also strong and we take full advantage on behalf of the trauma system. It is very helpful to understand the issues trauma centers at the local level are facing in helping develop a state system (e.g., the need for a transfer management system).

As consultants we are proud to enjoy the trust and credibility necessary for our role and are happy to answer any questions that may arise.



Greg Bishop
President

Attachment E

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

100 Initial Priority Topics for Comparative Effectiveness Research

The American Recovery and Reinvestment Act of 2009 called on the Institute of Medicine to recommend a list of priority topics to be the initial focus of a new national investment in comparative effectiveness research. The IOM's recommendations are contained in the report, *Initial National Priorities for Comparative Effectiveness Research*. The list of priority topics is provided below. The topics are listed by quartile (groups of 25). The first quartile is considered the highest priority group and the fourth quartile the lowest. Within each group, however, the order of individual topics does not indicate rank.

The list provides a starting point for what the report says should be a sustained effort to conduct comparative effectiveness research. As this research initiative progresses, the priorities will evolve as well. Ultimately, research on these and future topics will not yield real improvements unless the results are adopted by health care providers and organizations and integrated into clinical practice.

First Quartile

Compare the effectiveness of treatment strategies for atrial fibrillation including surgery, catheter ablation, and pharmacologic treatment.

Compare the effectiveness of the different treatments (e.g., assistive listening devices, cochlear implants, electric-acoustic devices, habilitation and rehabilitation methods [auditory/oral, sign language, and total communication]) for hearing loss in children and adults, especially individuals with diverse cultural, language, medical, and developmental backgrounds.

Compare the effectiveness of primary prevention methods, such as exercise and balance training, versus clinical treatments in preventing falls in older adults at varying degrees of risk.

Compare the effectiveness of upper endoscopy utilization and frequency for patients with gastroesophageal reflux disease on morbidity, quality of life, and diagnosis of esophageal adenocarcinoma.

Compare the effectiveness of dissemination and translation techniques to facilitate the use of CER by patients, clinicians, payers, and others.

Compare the effectiveness of comprehensive care coordination programs, such as the medical home, and usual care in managing children and adults with severe chronic disease, especially in populations with known health disparities.

Compare the effectiveness of different strategies of introducing biologics into the treatment algorithm for inflammatory diseases, including Crohn's disease, ulcerative colitis, rheumatoid arthritis, and psoriatic arthritis.

Compare the effectiveness of various screening, prophylaxis, and treatment interventions in eradicating methicillin resistant*Staphylococcus aureus* (MRSA) in communities, institutions, and hospitals.

Compare the effectiveness of strategies (e.g., bio-patches, reducing central line entry, chlorhexidine for all line entries, antibiotic impregnated catheters, treating all line entries via a sterile field) for reducing health care associated infections (HAI), including catheter-associated bloodstream infection, ventilator associated pneumonia, and surgical site infections in children and adults.

Compare the effectiveness of management strategies for localized prostate cancer (e.g., active surveillance, radical prostatectomy [conventional, robotic, and laparoscopic], and radiotherapy [conformal, brachytherapy, proton-beam, and intensity-modulated radiotherapy]) on survival, recurrence, side effects, quality of life, and costs.

Establish a prospective registry to compare the effectiveness of treatment strategies for low back pain without neurological deficit or spinal deformity.

Compare the effectiveness and costs of alternative detection and management strategies (e.g., pharmacologic treatment, social/family support, combined pharmacologic and social/family support) for dementia in community-dwelling individuals and their caregivers.

Compare the effectiveness of pharmacologic and non-pharmacologic treatments in managing behavioral disorders in people with Alzheimer's disease and other dementias in home and institutional settings.

Compare the effectiveness of school-based interventions involving meal programs, vending machines, and physical education, at different levels of intensity, in preventing and treating overweight and obesity in children and adolescents.

Compare the effectiveness of various strategies (e.g., clinical interventions, selected social interventions [such as improving the built environment in communities and making healthy foods more available], combined clinical and social interventions) to prevent obesity, hypertension, diabetes, and heart disease in at-risk populations such as the urban poor and American Indians.

Compare the effectiveness of management strategies for ductal carcinoma in situ (DCIS).

Compare the effectiveness of imaging technologies in diagnosing, staging, and monitoring patients with cancer including positron emission tomography (PET), magnetic resonance imaging (MRI), and computed tomography (CT).

Compare the effectiveness of genetic and biomarker testing and usual care in preventing and treating breast, colorectal, prostate, lung, and ovarian cancer, and possibly other clinical conditions for which promising biomarkers exist.

Compare the effectiveness of the various delivery models (e.g., primary care, dental offices, schools, mobile vans) in preventing dental caries in children.

Compare the effectiveness of various primary care treatment strategies (e.g., symptom management, cognitive behavior therapy, biofeedback, social skills, educator/teacher training, parent training, pharmacologic treatment) for attention deficit hyperactivity disorder (ADHD) in children.

Compare the effectiveness of wraparound home and community-based services and residential treatment in managing serious emotional disorders in children and adults.

Compare the effectiveness of interventions (e.g., community-based multi-level interventions, simple health education, usual care) to reduce health disparities in cardiovascular disease, diabetes, cancer, musculoskeletal diseases, and birth outcomes.

Compare the effectiveness of literacy-sensitive disease management programs and usual care in reducing disparities in children and adults with low literacy and chronic disease (e.g., heart disease).

Compare the effectiveness of clinical interventions (e.g., prenatal care, nutritional counseling, smoking cessation, substance abuse treatment, and combinations of these interventions) to reduce incidences of infant mortality, pre-term births, and low birth rates, especially among African American women.

Compare the effectiveness of innovative strategies for preventing unintended pregnancies (e.g., over-the-counter access to oral contraceptives or other hormonal methods, expanding access to long-acting methods for young women, providing free contraceptive methods at public clinics, pharmacies, or other locations).

Second Quartile

Compare the effectiveness of therapeutic strategies (e.g., behavioral or pharmacologic interventions, the combination of the two) for different autism spectrum disorders (ASD) at different levels of severity and stages of intervention.

Compare the effectiveness of the co-location model (psychological and primary care practitioners practicing together) and usual care (identification by primary care practitioner and referral to community-based mental health services) in identifying and treating social-emotional and developmental disorders in children ages 0-3.

Compare the effectiveness of diverse models of comprehensive support services for infants and their families following discharge from a neonatal intensive care unit.

Compare the effectiveness of treatment strategies for vascular claudication (e.g., medical optimization, smoking cessation, exercise, catheter-based treatment, open surgical bypass).

Compare the effectiveness of mindfulness-based interventions (e.g., yoga, meditation, deep breathing training) and usual care in treating anxiety and depression, pain, cardiovascular risk factors, and chronic diseases.

Compare the long-term effectiveness of weight-bearing exercise and bisphosphonates in preventing hip and vertebral fractures in older women with osteopenia and/or osteoporosis.

Compare the effectiveness of shared decision making and usual care on decision outcomes (treatment choice, knowledge, treatment-preference concordance, and decisional conflict) in children and adults with chronic disease such as stable angina and asthma.

Compare the effectiveness of strategies for enhancing patients' adherence to medication regimens.

Compare the effectiveness of patient decision support tools on informing diagnostic and treatment decisions (e.g., treatment choice, knowledge acquisition, treatment-preference concordance, decisional conflict) for elective surgical and nonsurgical procedures—especially in patients with limited English-language proficiency, limited education, hearing or visual impairments, or mental health problems.

Compare the effectiveness of robotic assistance surgery and conventional surgery for common operations, such as prostatectomies.

Compare the effectiveness (including resource utilization, workforce needs, net health care expenditures, and requirements for large-scale deployment) of new remote patient monitoring and management technologies (e.g., telemedicine, Internet, remote sensing) and usual care in managing chronic disease, especially in rural settings.

Compare the effectiveness of diverse models of transition support services for adults with complex health care needs (e.g., the elderly, homeless, mentally challenged) after hospital discharge.

Compare the effectiveness of accountable care systems and usual care on costs, processes of care, and outcomes for geographically defined populations of patients with one or more chronic diseases.

Compare the effectiveness of different residential settings (e.g., home care, nursing home, group home) in caring for elderly patients with functional impairments.

Compare the effectiveness (including survival, hospitalization, quality of life, and costs) of renal replacement therapies (e.g., daily home hemodialysis, intermittent home hemodialysis, conventional in-center dialysis, continuous ambulatory peritoneal dialysis, renal transplantation) for patients of different ages, races, and ethnicities.

Compare the effectiveness of treatment strategies (e.g., artificial cervical discs, spinal fusion, pharmacologic treatment with physical therapy) for cervical disc and neck pain.

Compare the effectiveness of film-screen or digital mammography alone and mammography plus magnetic resonance imaging (MRI) in community practice-based screening for breast cancer in high-risk women of different ages, risk factors, and race or ethnicity.

Compare the effectiveness of new screening technologies (such as fecal immunochemical tests and computed tomography [CT] colonography) and usual care (fecal occult blood tests and colonoscopy) in preventing colorectal cancer.

Compare the effectiveness of coordinated care (supported by reimbursement innovations) and usual care in long-term and end-of-life care of the elderly.

Compare the effectiveness of pharmacologic treatment and behavioral interventions in managing major depressive disorders in adolescents and adults in diverse treatment settings.

Compare the effectiveness of an integrated approach (combining counseling, environmental mitigation, chronic disease management, and legal assistance) with a non-integrated episodic care model in managing asthma in children.

Compare the effectiveness (including effects on quality of life) of treatment strategies (e.g., topical steroids, ultraviolet light, methotrexate, biologic response modifiers) for psoriasis.

Compare the effectiveness of treatment strategies (e.g., cognitive behavioral individual therapy, generic individual therapy, comprehensive and intensive treatment) for Post-traumatic Stress Disorder stemming from diverse sources of trauma.

Compare the effectiveness and outcomes of care with obstetric ultrasound studies and care without the use of ultrasound in normal pregnancies.

Compare the effectiveness of birthing care in freestanding birth centers and usual care of childbearing women at low and moderate risk.

Third Quartile

Compare the effectiveness of different opioid and non-opioid pain relievers, in different doses and durations, in avoiding unintentional overdose and substance dependence among subjects with acute and non-cancer chronic pain.

Compare the effectiveness of aggressive medical management and percutaneous coronary interventions in treating stable coronary disease for patients of different ages and with different comorbidities.

Compare the effectiveness of innovative treatment strategies (e.g., cardiac resynchronization, remote physiologic monitoring, pharmacologic treatment, novel agents such as CRF-2 receptors) for congestive heart failure.

Compare the effectiveness of traditional risk stratification for coronary heart disease (CHD) and noninvasive imaging (using coronary artery calcium, carotid intima media thickness, and other approaches) on CHD outcomes.

Compare the effectiveness of different treatment strategies (e.g., modifying target levels for glucose, lipid, or blood pressure) in reducing cardiovascular complications in newly diagnosed adolescents and adults with type 2 diabetes.

Compare the effectiveness of acupuncture for various indications using a cluster randomized trial.

Compare the effectiveness of dietary supplements (nutriceuticals) and usual care in the treatment of selected high-prevalence conditions.

Compare the effectiveness of different treatment options (e.g., laser therapy, intravitreal steroids, anti-vascular endothelial growth factor [anti-VEGF]) for diabetic retinopathy, macular degeneration, and retinal vein occlusion.

Compare the effectiveness of treatment strategies for primary open-angle glaucoma (e.g., initial laser surgery, new surgical techniques, new medical treatments) particularly in minority populations to assess clinical and patient-reported outcomes.

Compare the effectiveness and cost-effectiveness of conventional medical management of type 2 diabetes in adolescents and adults, versus conventional therapy plus intensive educational programs or programs incorporating support groups and educational resources.

Compare the effectiveness of alternative redesign strategies—using decision support capabilities, electronic health records, and personal health records—for increasing health professionals' compliance with evidence-based guidelines and patients' adherence to guideline-based regimens for chronic disease care.

Compare the effectiveness of adding information about new biomarkers (including genetic information) with standard care in motivating behavior change and improving clinical outcomes.

Compare the effectiveness of different quality improvement strategies in disease prevention, acute care, chronic disease care, and rehabilitation services for diverse populations of children and adults.

Compare the effectiveness of formulary management practices and usual practices in controlling hospital expenditures for products other than drugs including medical devices (surgical hemostatic products, radiocontrast, interventional cardiology devices, and others).

Compare the effectiveness of different benefit design, utilization management, and cost-sharing strategies in improving health care access and quality in patients with chronic diseases (e.g., cancer, diabetes, heart disease).

Compare the effectiveness of HIV screening strategies based on recent Centers for Disease Control and Prevention recommendations and traditional screening in primary care settings with significant prevention counseling.

Establish a prospective registry to compare the effectiveness of surgical and nonsurgical strategies for treating cervical spondylotic myelopathy (CSM) in patients with different characteristics to delineate predictors of improved outcomes.

Compare the effectiveness of traditional and newer imaging modalities (e.g., routine imaging, magnetic resonance imaging [MRI], computed tomography [CT], positron emission tomography [PET]) when ordered for neurological and orthopedic indications by primary care practitioners, emergency department physicians, and specialists.

Compare the effectiveness of comprehensive, coordinated care and usual care on objective measures of clinical status, patient-reported outcomes, and costs of care for people with multiple sclerosis.

Compare the effectiveness of treatment strategies for obesity (e.g., bariatric surgery, behavioral interventions, pharmacologic treatment) on the resolution of obesity-related outcomes such as diabetes, hypertension, and musculoskeletal disorders.

Compare the clinical and cost-effectiveness of surgical care and a medical model of prevention and care in managing periodontal disease to increase tooth longevity and reduce systemic secondary effects in other organ systems.

Compare the effectiveness of atypical antipsychotic drug therapy and conventional pharmacologic treatment for Food and Drug Administration-approved indications and compendia-referenced off-label indications using large datasets.

Compare the effectiveness of management strategies (e.g., inpatient psychiatric hospitalization, extended observation, partial hospitalization, intensive outpatient care) for adolescents and adults following a suicide attempt.

Compare the effectiveness of different strategies to engage and retain patients in care and to delineate barriers to care, especially for members of populations that experience health disparities.

Compare the effectiveness of topical treatments (e.g., antibiotics, platelet-derived growth factor) and systemic therapies (e.g., negative pressure wound therapy, hyperbaric oxygen) in managing chronic lower extremity wounds.

Fourth Quartile

Compare the effectiveness of smoking cessation strategies (e.g., medication, individual or quitline counseling, combinations of these) in smokers from understudied populations such as minorities, individuals with mental illness, and adolescents.

Compare the effectiveness of computed tomography (CT) angiography and conventional angiography in assessing coronary stenosis in patients at moderate pretest risk of coronary artery disease.

Compare the effectiveness of anticoagulant therapies (e.g., low-intensity warfarin, aspirin, injectable anticoagulants) for patients undergoing hip or knee arthroplasty surgery.

Compare the effectiveness of focused intense periodic therapy and usual weekly therapy in managing cerebral palsy in children.

Compare the effectiveness of different disease management strategies in improving the adherence to and value of pharmacologic treatments for the elderly.

Compare the effectiveness of care coordination with and without clinical decision supports (e.g., electronic health records) in producing good health outcomes in chronically ill patients, including children with special health care needs.

Compare the effectiveness of coordinated, physician-led, interdisciplinary care provided in the patient's residence and usual care in managing advanced chronic disease in community-dwelling patients with significant functional impairments.

Compare the effectiveness of minimally invasive abdominal surgery and open surgical procedures on post-operative infections, pain management, and recuperative requirements.

Compare the effectiveness of traditional behavioral interventions versus economic incentives in motivating behavior changes (e.g., weight loss, smoking cessation, avoiding alcohol and substance abuse) in children and adults.

Compare the effectiveness of diagnostic imaging performed by non-radiologists and radiologists.

Compare the effectiveness of different techniques (e.g., audio, visual, written) for informing patients about proposed treatments during the process of informed consent.

Compare the effectiveness of different disease management strategies for activating patients with chronic disease.

Compare the effectiveness of different delivery models (e.g., home blood pressure monitors, utilization of pharmacists or other allied health providers) for controlling hypertension, especially in racial minorities.

Compare the effectiveness of alternative clinical management strategies for hepatitis C including alternative duration of therapy) for patients based on viral genomic profile and patient risk factors (e.g., behavior-related risk factors).

Compare the effectiveness of different treatment strategies in the prevention of progression and disability from osteoarthritis.

Compare the effectiveness (e.g., pain relief, functional outcomes) of different surgical strategies for symptomatic cervical disc herniation in patients for whom appropriate nonsurgical care has failed.

Compare the effectiveness of different treatment strategies on the frequency and lost productivity in people with chronic, frequent migraine headaches.

Compare the effectiveness of monotherapy and polytherapy (i.e., use of two or more drugs) on seizure frequency, adverse events, quality of life, and cost in patients with intractable epilepsy.

Compare the effectiveness of surgical resection, observation, or ablative techniques on disease-free and overall survival, tumor recurrence, quality of life, and toxicity in patients with liver metastases.

Compare the effectiveness of hospital-based palliative care and usual care on patient-reported outcomes and cost.

Compare the effectiveness of different treatment approaches (e.g., integrating mental health care and primary care, improving consumer self-care, a combination of integration and self-care) in avoiding early mortality and comorbidity among people with serious and persistent mental illness.

Compare the effectiveness of traditional training of primary care physicians in primary care mental health and co-location systems of primary care and mental health care on outcomes including depression, anxiety, physical symptoms, physical disability, prescription substance use, mental and physical function, satisfaction with the provider, and cost.

Compare the effectiveness of different treatment strategies (e.g., psychotherapy, antidepressants, combination treatment with case management) for depression after myocardial infarction on medication adherence, cardiovascular events, hospitalization, and death.

Compare the effectiveness of different long-term treatments for acne.

Compare the effectiveness of different strategies for promoting breastfeeding among low-income African American women.

Attachment F

17 July 2009

Georgia Trauma Care Network Commission

Efforts to prevent injuries or decrease injury severity are integral parts of an effective trauma system. As reported in the Governor's 2009 Strategic Highway Safety Plan, aggressive speed-related crashes contribute to 21% of Georgia's highway fatalities annually. The estimated cost of motor vehicle crashes in Georgia totals over $7.8 billion a year. House Bill 160 provides needed preventative measures to decrease motor vehicle crash injuries in Georgia and will generate nearly $23 million for trauma care.

Inevitably, injuries do occur. The Georgia Trauma Care Network Commission believes every person in Georgia should have quick access to excellent trauma care. In the initial 2006 Georgia Strategic Highway Safety Plan and again supported in the 2009 Plan, the need for Education, Enforcement, Engineering and Emergency Medical Services or the "4-E" approach is put forward as the "strategic, comprehensive and collaborative countermeasures" required for reducing crashes, injuries and fatalities. We believe our work to develop an organized and inclusive trauma system with a coordinated multidisciplinary response to provide appropriate trauma care to all Georgians is in complete alignment and supportive to that Plan.

The system we are building can best be viewed as a continuum of care; one that prevents injuries and will enable the injured to access appropriate care and return back to society at their most productive level. The Georgia trauma system will include:

- Injury prevention and risk reduction programs;
- Medically supervised prehospital emergency medical services (EMS) with statewide 911 dispatch services and statewide trauma system triage criteria;
- Ground and air medical transportation, which is safe and available statewide;
- Ongoing assessment of EMS and hospital resources and capabilities and the effective use of a state-of-the-art EMS vehicle locating system;
- Integration with disaster preparedness and medical surge capabilities planning;
- State designated trauma centers;
- Trauma registry and epidemiology for data-driven system improvements;
- Acute inpatient care (including emergency services, surgery and intensive care, mental health and social services);
- Committed and participating local community hospitals;
- Rehabilitative services; and
- Regulatory policies and procedures to assure performance and provide accountability measures.

During our first year, the Commission determined it imperative to use the $58.9 million to stabilize and strengthen the existing trauma system. We assessed the costs related to maintaining designated trauma centers' "readiness" and provided centers a fraction or 40% of those costs. Readiness costs are the additional resources required by a hospital to maintain status as a state designated trauma center. Funding also went toward covering some of the uncompensated trauma patient care costs for trauma centers, participating trauma physicians and EMS. An EMS competitive grants process to replace 56 old and high mileage ambulances (out of 153 applications) and a trauma center capital equipment grants program are being funded. A down payment toward the development of a state trauma system patient transfer center and state-of-the-art EMS vehicle locator system is in process. That initial investment of nearly 60 million taxpayer dollars has been helpful. We believe we have stabilized the existing system. Whereas

several trauma centers and physicians had contemplated dropping out of the trauma system, we were successful in that all centers, for now, remain on board and functioning and there will be new ambulances serving rural communities of our state.

We undertook a thorough assessment of the existing Georgia trauma system using national benchmarks to identify limitations, requirements and opportunities for future planning and development. We utilized the American College of Surgeons Trauma Systems Consultation Program, nationally recognized trauma system economic expertise and an aggressive Trauma Commission subcommittee structure that put each Commission member to work in an expanded process to develop the best possible vision for the Georgia trauma system for the decades ahead. What resulted is our vision for a new public service for Georgians. That vision is a comprehensive five-year plan with six prioritized and immediate goals and nine strategic objectives and is offered with this letter for your review.

The return on Georgia's investment to injury prevention and trauma care through the development of an organized and inclusive trauma system will include: a reduced death rate from injury; access to timely, available and exceptional trauma care throughout the state; cost savings in patient treatment; the economic benefits of saving lives of younger, productive people; as well as direct benefits to all emergency care- e.g., stroke and cardiac care and disaster response for Georgia.

Attachment G

The 2008-2009 Statewide Trauma System Campaign: A Brief Report

Background

In July 2008, Healthcare Georgia Foundation awarded a $398,000 grant to Hayslett Group LLC for the purpose of creating, implementing and managing a statewide public awareness and will-building campaign to build demonstrable public support for sustainable trauma system funding in Georgia. The campaign began in earnest in August 2008 and continued through the conclusion of the 2009 Georgia General Assembly on April 2, 2009.

Organization

Hayslett Group's first major action was reconstituting the Georgia State Trauma Action Team, or GSTAT, as a means of engaging an array of stakeholders and creating an informal steering committee. Organizational meetings were held in Atlanta and Tifton, attracting interested stakeholders and positive media coverage.

Beyond representatives from groups that had a long-standing interest (physicians, hospitals, EMS providers, etc.), GSTAT's membership was broadened to include business and government groups, including the Georgia Chamber of Commerce, the Association County Commissioners of Georgia, and the Georgia Municipal Association.

Representatives of these and other groups were actively involved and played an important advisory role throughout the campaign. While the basic GSTAT structure and membership was established within weeks of the grant being awarded, the group continued to attract support and expand throughout the campaign. Shepherd Center, for instance, became involved several months after the campaign got underway and played a highly significant role through the end of the General Assembly.

Media Coverage

One of the campaign objectives was to generate sustained media coverage that would build awareness and sustain interest in the issue. Over the course of the campaign, more than 500 reports were printed or broadcast and most also appeared on the Web sites of outlets.

Coverage ranged from news briefs in small weeklies to front-page stories in the Atlanta Journal-Constitution and significant reports on television stations throughout the state. Between August 1, 2008, and the end of the General Assembly, 49 Georgia newspapers published 266 articles dealing with trauma while 19 Georgia television stations broadcast 184 reports on the issue. Most of those same newspapers and TV stations posted

versions of their print and broadcast reports to their Web sites. Radio coverage was pervasive but impossible to track.

Following the campaign, one online analytical tool calculated the advertising value of the media coverage between January 1 and April 2 at more than $4 million – without including radio and Web coverage. We think that's high, frankly, but through an independent analysis arrived at an advertising equivalency figure, for the entire campaign, well in excess of at least $1.5 million.

Editorial Support

Beyond stimulating coverage, the campaign also focused on newspaper editorial pages, with twin goals of generating editorial support for trauma system funding and putting a spotlight on legislative leaders to hold them accountable for the outcome.

Over the course of the campaign virtually every major daily newspaper in the state (and many weeklies) endorsed statewide trauma system funding using facts and message points provided by the campaign. The Albany Herald, Athens Banner-Herald, Atlanta Journal-Constitution, Augusta Chronicle, Columbus Ledger-Enquirer, Gainesville Times, The Macon Telegraph, Rome News-Tribune, Savannah Morning News and Tifton Gazette all ran editorials supporting trauma system funding.

Moreover, many of these editorials put pressure on House Speaker Glenn Richardson and Lieutenant Governor Casey Cagle to shepherd trauma funding through the House and Senate. Citing the collapse of trauma system funding legislation on the final night of the 2008 legislative session, the AJC opined: "Amid the finger-pointing between House Speaker Glenn Richardson and Lt. Gov. Casey Cagle, you'd have thought the two sides were bargaining over cattle, not human lives." That view echoed an earlier lament from the Albany Herald: "Frankly, if you're badly injured and in need of trauma care [in South Georgia], your chances of survival are simply not as good as they should be, largely because the members of the General Assembly have given this problem lip service and not much else."

Marketing, Advertising and Promotional Efforts

The campaign involved significant marketing, advertising and promotional components, including:

- 11 billboards on major interstates and highways around the state;
- Advertising in 47 daily and weekly newspapers in South Georgia;
- Advertising and public service announcement placements on 64 stations across the state (including PSAs done by the recently retired voice of the Georgia Bulldogs, Larry Munson);
- 351,049 Google ad impressions;

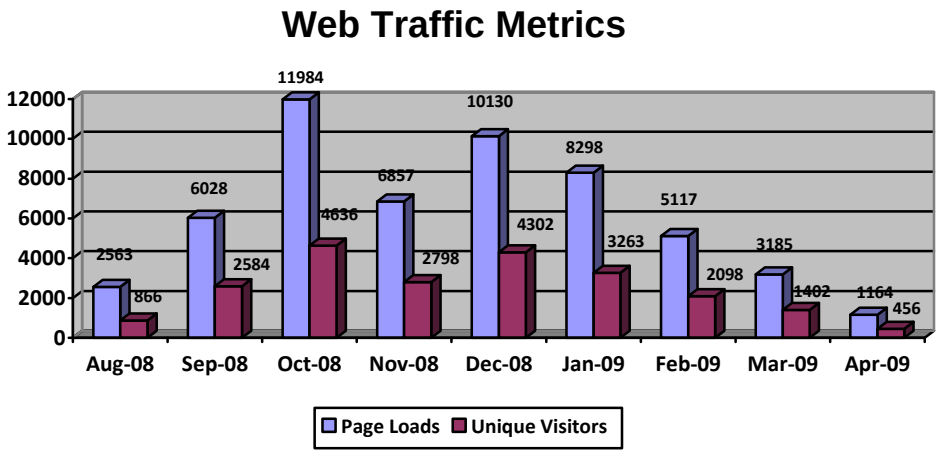
- 22,034 brochures and 9,305 bumper stickers that were distributed to supporters throughout the state;
- Seven e-newsletters;
- Two organizational meetings in Atlanta and Tifton; and,
- A February 23, 2009, Capitol Day rally attended by an estimated 300 people which generated an estimated $66,000 of print and broadcast coverage.

The Web Site

The campaign Web site – www.georgiaitsabouttime.com – served as a virtual campaign headquarters. All campaign materials were housed on the site – from standardized graphics files to press materials to campaign brochures and bumper stickers. Moreover, as the media and other independent groups (e.g., the Medical Association of Georgia) generated reports and studies, those materials were also posted on the site.

It was where citizens registered their support for trauma system funding (see below). It was where campaign supporters went to download campaign materials. And it was where journalists and legislators went to research the issue.

Virtually every campaign communication drove traffic to the Web site. Every press release, print and radio ad, billboard and e-mail featured the Web address. As the chart below shows, Web traffic grew dramatically as the campaign got underway in August 2008, spiking in the wake of ad buys in late September and November.



From August 2008 through April 2009, the Web site attracted 22,387 unique visitors who viewed a total of 55,325 pages on the site.

Public Engagement and Support

There are several ways of gauging public support for a statewide trauma system. One is the number of people who went to the Web site and registered their support for trauma system funding.

The grant proposal for the campaign set a goal of 3,000 e-petition signatures by the time the 2009 General Assembly convened on January 12. At close of business on January 11, there were 7,404, and that number grew during the session and today stands at 8,776. In addition:

- 5,016 of those asked to receive e-mail alerts;
- More than 4,000 took the time to offer a personal online comment on the issue;
- 2,178 volunteered to work on behalf of the issue; and,
- 142 listed themselves as trauma victims or close relative of trauma victims.

In addition, public opinion research conducted by the University of Georgia's Survey Research Center, also funded by Healthcare Georgia Foundation, provides insight. The Center's first trauma issue survey, conducted in late 2007, found broad support for a statewide trauma system and public funding. A second survey, conducted in December 2008 and January 2009 – at a time when the effects of the current economic downturn were already being felt – found rising levels of support for funding.

By the time the second survey began, the campaign had been underway for five months and respondents had been exposed to billboards, print and radio ads, and hundreds of newspaper, radio and television reports.

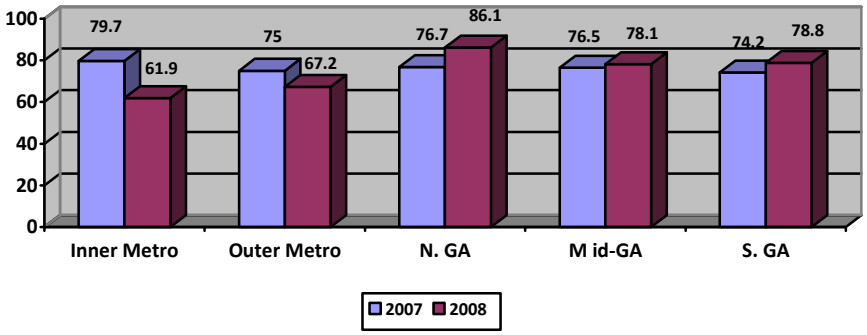
Generally, the latest survey found rising levels of support for trauma funding across a broad range of questions. But one of the most telling indicators that the campaign was being effective came in a paradoxical finding of *deteriorating* support in response to certain questions in Metro Atlanta.

It's important to keep in mind that part of messaging strategy was to hammer home the fact that trauma care was deficient in South Georgia (and to a lesser degree North Georgia); by implication, we had to emphasize the fact that the preponderance of Georgia's trauma assets were concentrated (not surprisingly) in Metro Atlanta. Poll respondents in all three areas got the message.

In both 2007 and 2008, the survey included in this question: "Do you favor or opposed creating and maintaining a trauma system supported by public funds, whether taxes, fees or fines of some sort?" Year over year, the results were essentially unchanged: 75.9 percent said yes in 2007 versus 75.6 percent in 2008.

But interesting regional differences emerged, as the chart on the next page demonstrates.

Pct Poll Respondents Favoring Public Funding of Trauma System – by Region



As the chart shows, support for public funding of a statewide trauma system dropped in Metro Atlanta but rose in the underserved areas of North Georgia, Middle Georgia and South Georgia.

There's an obvious explanation for these divergent results: As Metro Atlantans came to better understand that they already have access to a reasonable level of trauma care, their appetite for doing more understandably declined; similarly, as respondents outside the metro area came to appreciate just how underserved they are, their support levels increased.

More broadly, however, the most recent survey found levels of public support for funding that were equal to or stronger than the 2007 results, despite the economic downturn, which was clearly on the minds of the respondents.

In 2007, only 5.9 percent cited the economy as the "most pressing issue facing Georgia," putting it seventh on a list of 11 issues (including "other," which came in sixth). By 2008, however, the economy had rocketed to number one, with 41.6 percent citing it as the state's top concern.

An almost identical 41.7 percent said their personal financial situation was worse in 2008 than it had been a year before (versus only 9.9 percent who said it was better and 48.3 percent who said it was the same). So the economy was very much on the respondents' minds when the most recent poll was taken, but it apparently did little to dampen public support for trauma funding.

A detailed look at the responses to our key "willingness to pay" question is revealing. Respondents were asked: "How much would you be willing to pay per year to have a trauma system in Georgia ready to provide care 24 hours a day, seven days a week, if you or your family were seriously injured?" They were then given increments from "nothing" to "over $25."

Here's how the responses broke down, by year:

Amount Willing to Pay	*2007*	*2008*	*Change*
Nothing	15.5%	7.0%	-8.5
$1.00	3.4%	4.0%	+0.6
$5.00	6.2%	9.4%	+3.2
$10.00	8.2%	10.6%	+5.3
$25.00	22.1%	27.4%	+3.3
Over $25.00	44.6%	41.6%	-3.0

While the percentage of respondents who said they were willing to pay more than $25 a year dropped by three points, overall willingness to pay generally improved significantly. Perhaps most importantly, the number who said they weren't willing to pay anything dropped by more than half – from 15.5 percent to 7.0 percent. In all the other categories, the numbers climbed. Indeed, the percentage who said they were willing to pay at least $25 a year ticked up slightly to 68 percent in 2008 from 66.7 percent in 2007. Lowering the threshold to $10 a year – enough to fund trauma improvements at the $85 million-a-year level – raises the support level to 78.6 percent this year from 74.9 percent last year.

Conclusion

Healthcare Georgia Foundation has accomplished much through its trauma campaign. While the General Assembly's failure, for the second year in a row, to approve a sustainable funding mechanism for a statewide trauma system was frustrating to all involved, it should not mask or overshadow the considerable progress that owes, in our view, directly to Healthcare Georgia's engagement on this issue.

Healthcare Georgia quite literally put trauma on the public policy radar in Georgia. Over the course of just a few years, the foundation's investments have helped educate legislators, develop policy options, build media awareness and editorial support, and gauge and build public support.

Without Healthcare Georgia's involvement, it seems highly unlikely that the General Assembly would have established the statewide trauma commission. Or that Governor Perdue would have recommended, and the legislature would have passed, the "super speeder" bill, which is expected to generate $23 million annually in trauma funding. Or that the General Assembly will have two other live funding mechanisms sitting on the legislative table when its members reconvene next January.

We can state without fear of contradiction that these milestones constitute dramatic progress, and serve as irrefutable evidence that initiatives of this type can succeed. In our experience, it can take a decade or more to move an issue of this type from inception to successful public policy action. That Healthcare Georgia has moved the issue of trauma so far so fast is no small accomplishment. We have been proud to be part of it.