ADMINISTRATIVE REPORT

January 2010

Superspeeder Law goes into Effect:
Superspeeder Law went into effect on 01 January 2010. To kick off implementation, four news conferences were held across Georgia; Atlanta (16 December), Savannah (18 December), Columbus (21 December) and Macon (22 December). Attached is 16 December conference media release. Similar releases were made for other cities. Bill Moore represented the Trauma Commission at the December conference. Dr. Gage Ochsner trauma medical director from Memorial Health University Hospital in Savannah spoke at the Savannah news conference. Dr. Scott Hanney trauma medical director from Columbus Regional Medical Center spoke at Columbus conference. Ben Hinson represented the Trauma Commission at the Macon news conference. The Superspeeder Law is expected to generate approximately $23 million a year for trauma system development funding.

08 January 2010 Trauma Commission Workshop:
Meeting Notes Attached.

Trauma Commission FY 2010 Treasurer's Report:
Attached.

FY 2011 Trauma Commission Draft Budget for Discussion:
Attached.

22 January 2010 Meeting with State Agencies to Discuss Communication Center Operations:
Meeting Notes Attached.

New Trauma Center Startup Grants Application:
DRAFT attached: to be discussed at 28 January Commission meeting.

New Trauma Center Funding Statement:
Trauma Commission will consider this policy statement at 28 January meeting. Statement is part of DRAFT New Trauma Center Startup Grants Application, attached.

FY 2010 EMS Vehicle Equipment Replacement Grants Application:
DRAFT attached: to be discussed at 28 January Commission meeting.

FY 2010 Distribution Plan for EMS First Responder and Trauma-related Equipment Grants:
DRAFT attached: to be discussed at 28 January Commission meeting.

Readiness Costs Determination Webinar: 11 December 2009:

Meeting Notes and Process Timeline Attached.

Georgia Trauma Center Readiness Costs By Designation Level Survey:
Survey resulting from 15 January Face-to-Face summit attached.

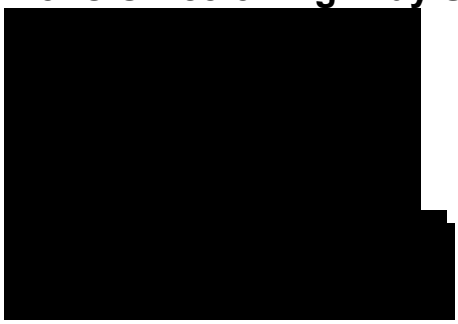
Georgia Assessment of Trauma Center Financial Viability:
Assessment resulting from 15 January Face-to-Face summit attached.

Trauma Commission Procurements and Contracts Update:
Update presented by OEMS/T at 28 January 2010 Commission meeting, report attached.

Attorney General Review of SB 156 impact on Regional Emergency Medical Services Councils and Trauma Commission's Rule Making Authority.
Alex Sponseller's letter attached.

Governor's Office of Highway Safety

MEDIA ADVISORY
FOR IMMEDIATE RELEASE
December 16, 2009



New State Law Gets Tough on Illegal Speeders

NEW 'SUPER SPEEDER LAW' STARTS NEW YEAR WITH NEW FINES

Georgia's new state *'Super Speeder Law'* goes into effect **January 1st, 2010** and
high-risk drivers who ignore posted speed limits will be the first to feel the weight of higher state fines during the New Year. *'SuperSpeeder'* is designed to save lives on our highways by changing the way high-risk speeders drive in Georgia.

SUPER SPEEDER LAW NEWS CONFERENCE

NEWS MEDIA INVITED! KICK-OFF NEWS CONFERENCE

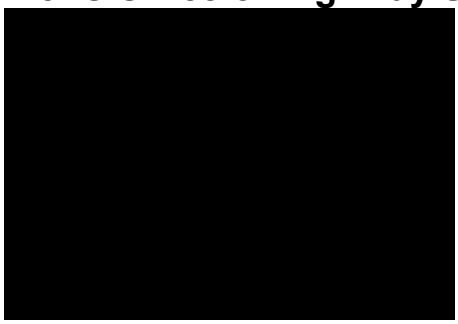
WHAT: **'SuperSpeeder Law' Campaign Kick-off News Conference**
WHO: The Governor's Office of Highway Safety issues a statewide *Speed Advisory* for high-risk drivers in Georgia to slow down.
WHEN: **News Conference, Wednesday, December 16, at 10:30AM**
WHERE: **5th Street Bridge at Techwood over Atlanta Downtown Connector**

WHAT IS A SUPER SPEEDER? Under the provisions of this new Georgia law, any driver convicted of violating HB160 will now be classified by the state as a *'Super Speeder'* and subject to an additional fine. The new 'SuperSpeeder Law' is designed to get tough on high-risk drivers who've been endangering other motorists and ignoring warnings to slow down. On average, there's a speed-related *death-a-day* in Georgia!

- ***HOW MUCH?*** The new *'Super Speeder Law'* adds-on two-hundred-dollar *state*-fines for any driver convicted of speeding at 75-or-more on any *two-lane* roads.. OR convicted of speeding at 85-and-over on multiple lane roads *anywhere* in Georgia. The new state fines will be in addition to any local fines already in effect in the jurisdiction where the speeding offense occurs.

- ***STARTING WHEN?*** Beginning Friday, January 1st, 2010, Traffic Enforcement Units across the state will begin enforcing the 'SuperSpeeder Law' to crack-down on illegal speeders and make Georgia a safer place to drive.

Governor's Office of Highway Safety



WHAT'S NEXT? **Fees collected under the new *'SuperSpeeder Law'* will be used to help fund Georgia's trauma care hospital system where approximately sixty-percent of all trauma-care-patients are crash-related. Now for the first time, *'SuperSpeeders'* will help pay for the hospital beds where crash-victims are being treated. Georgia's new *'SuperSpeeder Law'* and fines go into effect January 1st, 2010. Learn more at www.superspeedergeorgia.org .**

Governor's Office of Highway Safety Public Information Unit
34 Peachtree Street—Suite 800—One Park Tower—Atlanta, Georgia 30303
Visit us on the web at www.georgiahighwaysafety.org 404-656-6996
Sonny Perdue, Governor **Robert F. Dallas, Director**

Workshop: brief notes
08 January 2010
GTCNC Workshop in Rome, GA

Attendees:
GTCNC: Dr. Dennis Ashley, Rich Bias, Linda Cole, Dr. Leon Haley Jr., Ben Hinson, Bill Moore, Dr. Joe Sam Robinson (teleconference line), Kurt Stuenkel, Kelli Vaughn, Jim Pettyjohn, Greg Bishop (teleconference line)

DCH: Dr. Pat O'Neal, Kurt Chronister,

AG OFFICE: Alex Sponsellor (teleconference line)

GTRI: Rachel Duke, Scott Sherrill

GHA: Karen Waters

Workshop Agenda:

- Senate Bill 156 discussion
- New Trauma Center/System development discussion
- FY 2011 budget discussion

Workshop Discussion:
Dr. Ashley called the meeting to order at 8:30 am and announced the agenda for the day's workshop.

Senate Bill 156 discussion:

As a segue into SB 156 discussion, Dr. Ashley led with a general discussion of the **budget** that proceeds from a recent meeting between several Commissioners and Irene Munn of the Governor's Office. In this meeting, **Irene Munn requested that the Trauma Commission present an optimal trauma budget for the Legislature's consideration.**

Dr. O'Neal of DCH then made a recommendation concerning the Trauma Commission's fiscal independence. He recommended that the Commission assume a more advisory nature with respect to its budget. He commended the Commission for its wise and effective expenditure of the budget and its ability to get work done, but warned that the Legislature may look more favorably upon budget requests coming to it through DCH, to which the Commission is an Attached Agency.

After some discussion, the issue was referred to Ben Hinson's Legislative Affairs subcommittee for further consideration.

Jim Pettyjohn stated that he provided to the Governor's Office the latest draft of the Commission-approved **SB 156** on January 4, 2010.

Ben Hinson then requested discussion on the organization of the DCH-Division of Emergency Preparedness-Office of EMS & Trauma (OEMS&T) as it relates to SB 156. He pointed to the organizational structure of the OEMS & T and to the discrepancy between the large number of personnel dedicated to EMS within the Office, and the two personnel assigned to Trauma. He inquired of Dr. O'Neal how these two components, the EMS component and the Trauma component, could be better connected.

Dr. O'Neal had two points to make in response.

1) First, he pointed to the difficulties of hiring additional personnel to support Trauma due to the bureaucracy surrounding state-funded positions, despite the fact that he would like to hire additional FTEs.
2) Second, he introduced Kurt Chronister, who he would like to hire as a liaison between Trauma and EMS, and between the Trauma Commission and DCH in general. He asked for the Commission's blessing to hire Kurt in this capacity with funds set aside by the Commission specifically for OEMS&T.

The Commission agreed that the OEMS & T should hire Kurt Chronister as a liaison officer. This position will be paid for by funds already granted to the Office of EMS & Trauma. Kurt's primary responsibility is to the Commission, though he will have other duties related to EMS. Specifically, Kurt will work closely with Jim Pettyjohn, as the Commission's administrator. Dr. O'Neal assured the Commission that Jim and Kurt will have unlimited access to the appropriate personnel within DCH to accomplish the Commission's work with as little delay as possible. No motion was required.

Linda Cole expressed her wish that the hire of Kurt Chronister not delay the hire of a Lead Position for Georgia Trauma Communication Center (GTCC) operations. Previously, Dr. O'Neal understood that the Lead Position should not be hired until GTCC software was purchased. **Linda clarified the Commission's need for a Lead Position hire as soon as possible. Dr. O'Neal committed to expedite the process.**

New Trauma Center/System Development Discussion:

After a coffee break, discussion resumed at 10:30.
Jim Pettyjohn led a discussion of strategic distribution of funds for the development and designation of new Trauma Centers. The Trauma Commission currently has no authority to accept or reject petitions for Trauma Center designation. This is a duty of the OEMS & T. It would be wise, however, for the Commission to formally state its policy and strategy for Readiness Cost funding and thus funding new trauma centers.

Dr. O'Neal recommended that the Commission consider a map that was previously developed under a grant. The map identifies geographic locations to target for Trauma Center development that would put any injury in the state of Georgia

within 35 minutes of a designated Trauma Center. This map could theoretically be used to develop a weighting strategy for distribution of Trauma Commission funds for Readiness Costs. Map was displayed during meeting.

Dr. O'Neal also suggested that Regional Trauma Advisory Councils (RTAC) be formed as subcommittees of each EMS Regional Council and would be an appropriate venue for discussing Trauma Center development in particular regions. Several Commission members expressed support for the RTAC role in Trauma Center designation.

Dr. O'Neal suggested that the Commission should resolve any conflicts in existing code concerning the Office of EMS, prior to an SB 156 rewrite. He recommended that Alex Sponsellor conduct a legal review of the existing code and use the review to advise the Commission on SB 156. This should be done before the 28 January Commission meeting. Dr. O'Neal will email Alex Sponsellor and cc Ben Hinson with the specific request.

The Commission resolved to write a "Statement" that could be issued through the OEMS & T regarding future Trauma Center funding policy. This policy will support the Commission's strategy for new Trauma Center designation and funding, once that strategy is finalized. It would clearly inform prospective Trauma Centers whether they would be eligible for Readiness Cost funding from the Trauma Commission. **Bill Moore will pose this in a motion at the January 28th Commission Meeting.**

Additionally, the OEMS & T should keep the Commission apprised of which facilities have expressed interest in becoming designated. This should be a regular update at each regular Commission meeting.

FY2011 Budget Discussion:

Linda Cole presented the FY2011 Operations budget spreadsheet.

- "Software—First Year purchase" Line Item presentation by Scott Sherrill of GTRI
- "Regionalization" Line Item refers to the concept of providing $100,000 grants to five different EMS regions for the development of a regional approach to trauma planning. The appropriateness of creating five of these grants, as opposed to one single grant to Pilot Region V, came into discussion. Jim Pettyjohn and Kurt Chronister will discuss the line item **(can the Commission grant funds directly to EMS regional offices)** and Jim will make a recommendation at the January 28th Commission meeting on the number of $100,000 grants to be provided.

Greg Bishop dialed in by teleconference number to present the "optimal" budgets as requested by Irene Munn of the Governor's Office for FY2011. He spoke of two alternative budget concepts for:
"GTCNC FY 2011 Budget—Essential Funding + New Trauma Centers, TRAUMA CENTER/PHYSICIAN ALLOCATION" Created January 5, 2010.

While on the topic of these budgets, it was determined that **Leon Haley's Subcommittee should work to determine the appropriate performance based payments (PBP) percentage of Readiness Cost, as well as PBP criteria**. The budgets presented by Greg Bishop place the PBP percentage of readiness cost at 50%, though this should perhaps be lowered. It was suggested that 20% of readiness funding could be directed to PBP funding.

The meeting was adjourned at 2:00 pm.

Georgia Trauma Care Network Commission
Treasurer's Report
July 1, 2009 through December 31, 2009

	Actual Balance	
Beginning Balance		
Revenues:		
July	$ 1,916,666.70	
August	1,820,833.33	
September	1,820,833.33	
October	1,820,833.33	
November	1,820,833.33	
December	1,820,833.33	
Total Revenues		11,020,833.35
Expenditures:		
National Foundation of Trauma Care		
Membership dues	1,500.00	
Bishop & Associate	245,950.00	
Classic Party Rental	324.29	
Total Expenditures		247,774.29
Ending Balance, December 31, 2009		$ 10,773,059.06

Georgia Trauma Commission FY 2011
$23 Million Budget
General Trauma Fund Allocations

DRAFT DOCUMENT

Proposed[1]	$ 23,000,000		
2011 Available Budget	$ 23,000,000	$ 23,000,000	
OEMS/T Allocation [2]		$ 690,000	
Trauma Commission Operations [3]		$ 1,000,000	
Communication Center Operations [4]	$ 667,000		
Communication Center Capital Expenditures[5]	$ 1,333,000	$ 2,000,000	
Total:		$ 19,310,000	$ 19,310,000
EMS Distribution [6]			$ 3,862,000
Trauma Centers/Physicians Distribution[7]			$ 15,448,000
		Remaining:	$ -

Notes:

[1] Governor's proposed FY 2011 budget released 15 January 2010

[2] "up to 3%" of Commission's available budget (SB 60)

[3] Commission operations including administration, regional infrastructure development and projects

[4] Communication Center Operations and Capital Expenditures

[5] One time purchases

[6] 20% of funds after OEMS/T, Commission Operations and Communication Center allocations [2, 3, 4, 5]

[7] 80% of funds after OEMS/T Commission Operations and Communication Center allocations [2, 3, 4, 5]

All funds remaining unspent, not allocated or not under contract at the beginning of 4th quarter FY 2011 will be redirected to stakeholders

Georgia Trauma Commission FY 2011
$23 Million Budget

Trauma Commission Operations (12 Months)

DRAFT DOCUMENT

Available Operations Budget	**$ 1,000,000**		
Administration and Commission Support			
Administrator	$ 138,000		Salary, benefits, travel and overhead via professional services contract
Administrator assistant	$ 50,000		Administrative support, salary, office and overhead support via state contracted services
Conference call account	$ 7,200		$600.00 per month
Website design and maintenance	$ 1,600		$60.00 per month maintenance plus $800.00 design services
Commission Travel/Per Diem	$ 11,340		$105.00 per member (9) per month (12)
Monthly Commission meeting support	$ 2,400		$200.00 per meeting
Total:	**$ 210,540**	**$ 210,540**	
New Projects and Contracts			
Regionalization	$ 500,000		$100,000 regionalization grants for 5 EMS regions
Bishop+Associates	$ 50,000		Financial Consultants
National Foundation for Trauma Care	$ 1,500		Annual membership
Telemedicine	$ 100,000		Partnership for Telehealth
Pediatrics	$ 100,000		Broselow system
Total:	**$ 751,500**	**$ 751,500**	
Projected Earmarks Total:		**$ 962,040**	
Remains for additional contracts and costs		**$ 37,960**	For additional contracts, accommodating State budget short fall and or increased costs
	Total	**$ 1,000,000**	

Georgia Trauma Commission FY 2011
$23 Million Budget

Trauma Communication Center (12 Months)

DRAFT DOCUMENT

Available Communications Center Budget	**$ 2,000,000**		
One Time Capital Expenditures:			
Communications Center Software	$ 1,200,000		Estimated Costs
Hardware	$ 100,000		
Backup generator	$ 5,000		
Call recorder	$ 8,000		
Workstations	$ 20,000		
Capital Expenditures Total:	**$ 1,333,000**	**$ 1,333,000**	
Operations:			
Communication Center Staff (24/7 Operators)	$ 308,000		5.5 FTE ($56,000 per)
Communication Center Lead position	$ 100,000		One FTE professional services contract
Building Lease and Utilities	$ 25,000		Estimate
Total:	**$ 433,000**	**$ 433,000**	
Contingencies:	**$ 234,000**	**$ 234,000**	For additional contracts, accommodating State budget short fall and or increased costs
Operations Total with Contengiencies:	**$ 667,000**		
Total:		**$ 2,000,000**	

Georgia Trauma Commission FY 2011
$23 Million Budget
Trauma Center / Physician Allocation

DRAFT DOCUMENT

	Exisitng Trauma Centers		New Trauma Centers	Total Trauma Centers	
	Amount	Fixed/Variable[8]	Amount	Amount	Percent
Trauma Center Startup Grants[1]	$1,000,000	Fixed		$1,000,000	6.5%
Level IV Trauma Centers[2]	$27,000	Fixed	$54,000	$81,000	0.5%
Sub Total	$1,027,000			$1,081,000	7.0%
Trauma Center Readiness Payments[3]	$5,480,336	Variable	$524,713	$6,005,049	38.9%
Performance Based Payment (PBP)[4]	$1,370,084	Variable	$131,178	$1,501,262	9.7%
Sub Total Readiness Payments	$6,850,421		$658,358	$7,506,312	48.6%
Uninsured Patient Care Payments[5]	$6,850,421	Variable	$10,268	$6,860,689	44.4%
Total Trauma Center Allocation[6]	**$14,727,841**		**$668,626**	**$15,448,000**	**100.0%**

Hospital/Physician Fund Division[7]	Hospital (75%)	Physician (25%)	Total
Trauma Center Readiness Payments	$5,629,734	$1,876,578	$7,506,312
Uninsured Patient Care Payments	$5,145,516	$1,715,172	$6,860,689
Subtotal	**$10,775,250**	**$3,591,750**	**$14,367,000**
Trauma Center Startup Grants			$1,000,000
Level IV Trauma Centers			$81,000
Total Trauma Center Allocation[6]			**$15,448,000**

Notes:

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

[2]Three Level IV Trauma Centers, including two new ones (predicted by OEMS/T to be designated by 01 July 2010) will receive $27,000 each in total funding.

[3]Trauma Center readiness payments are described on "Readiness Costs" page.

[4]A state-of-the-art performance based payment (PBP) program continues to acknowledge trauma centers that meet defined critieria. For FY 2011, 20% of trauma center readiness payments or approximately 10% of total Trauma Center funding will be set aside for PBP. Specific FY 2011 PBP criteria will be determined by Trauma Commission.

[5]Uninsured trauma patient care payments are described on "Uninsured Patient Costs" page.

[6]Amount allocated to Trauma Centers by the Georgia Trauma Commission

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

[8]Amounts that are fixed, or are variable depending upon changes in the overall Trauma Center allocation, are indicated.

Georgia Trauma Commission FY 2011
$23 Million Budget
Trauma Center Readiness and Performance Based Payments (PBP)

DRAFT DOCUMENT

Trauma Center	Readiness Payments[1]	Potential PBP [2]	Total Readiness Payments
Archbold	$349,809	$87,452	$437,261
Atlanta	$349,809	$87,452	$437,261
Columbus	$349,809	$87,452	$437,261
Floyd	$349,809	$87,452	$437,261
Gwinett	$349,809	$87,452	$437,261
Hamilton	$349,809	$87,452	$437,261
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**

New Trauma Centers	Readiness Payments[1]	PBP[2]	Total Readiness Payments
Athens Level II	$349,809	$87,452	$437,261
Walton Level III	$174,904	$43,726	$218,630
New Trauma Centers	**$524,713**	**$131,178**	**$655,891**
Existing Trauma Centers	$5,480,336	$1,370,084	$6,850,421
All Trauma Centers	**$6,005,049**	**$1,501,262**	**$7,506,312**

Notes:

[1] From a total readiness fund allocation, each Level II trauma center received 60% ($437,261) of the payment given to each Level I trauma center ($728,768). Level III trauma centers receive 50% ($218,630) of amount given to Level II trauma centers.

[2]Performance Based Payments (PBP), if fully earned, will be distributed to trauma centers based upon the readiness payment formula.

Georgia Trauma Commission FY 2011
$23 Million Budget
Trauma Center Uninsured Patient Care Payments

DRAFT DOCUMENT

	Self Pay Patients Meeting SB 60 Requirements[1] (Numbers are from 2007 data)					Cost Norm Based Allocation of Funds[2]			
Trauma Center	**ISS 0-8**	**ISS 9-15**	**ISS 16-24**	**ISS >24**	**Total**	**Severity Adjusted Cost Norms**	**Total Based Upon Cost Norms**	**Allocation Based On % of Norm Cost Total**	
Archbold	29	24	12	2	67	$10,544	$706,417	1.3%	$91,448
Atlanta	122	108	38	30	298	$14,345	$4,274,826	8.1%	$553,389
Columbus	15	14	11	6	46	$14,012	$644,553	1.2%	$83,439
Floyd	13	21	7	1	42	$10,923	$458,786	0.9%	$59,391
Gwinett	38	90	28	35	191	$15,059	$2,876,269	5.4%	$372,341
Hamilton	8	9	2	1	20	$10,459	$209,185	0.4%	$27,080
North Fulton	27	38	17	6	88	$12,225	$1,075,785	2.0%	$139,264
Egleston	9	9	3	2	23	$14,100	$324,306	0.6%	$41,982
Scottish Rite	6	15	3	2	26	$12,107	$314,790	0.6%	$40,750
Level II Totals	**267**	**328**	**121**	**85**	**801**		**$10,884,917**	**20.6%**	**$1,409,085**
Grady	556	551	292	233	1,632	$16,544	$27,000,039	51.0%	$3,495,234
MCCG	55	68	34	15	172	$15,303	$2,632,032	5.0%	$340,724
MCG	96	78	67	34	275	$16,667	$4,583,543	8.7%	$593,353
Memorial	91	137	104	74	406	$19,255	$7,817,699	14.8%	$1,012,024
Level I Totals	**798**	**834**	**497**	**356**	**2,485**		**$42,033,313**	**79.4%**	**$5,441,336**
Total LI/LII	**1065**	**1162**	**618**	**441**	**3,286**		**$52,918,230**	**100.0%**	**$ 6,850,421**

New Trauna Centers	Allocation Based Upon 2010 Norm
Athens Level II [4]	
Walton Level III	$10,268
Total New Trauma Ctrs	**$10,268**
Existing Trauma Ctrs	**$ 6,850,421**
All Trauma Centers	**$6,860,689**

Notes:

[1]Trauma Centers will report number of uninsured trauma patients meeting SB 60 requirements by Injury Severity Score (ISS) category for calendar year 2008. Actual payments to hospitals for self pay patients meeting SB 60 requirements will be calculated from the 2008 data. That survey underway Jan/Feb 2010.

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

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

[4] Athens Regional was not a designated trauma center during calendar year 2008 so no self pay patients meeting SB 60 requirements.

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

Georgia Trauma Commission FY 2011
$23 Million Budget
Trauma Centers: Individual Hospital Payments

DRAFT DOCUMENT

Trauma Center	Readiness Payment	Potential PBP Payments[2]	Total Readiness Payments	Uninsured Patient Payment	Total Payments	Percent
Archbold	$349,809	$87,452	$437,261	$91,448	$528,709	3.4%
Atlanta Medical	$349,809	$87,452	$437,261	$553,389	$990,650	6.4%
Columbus	$349,809	$87,452	$437,261	$83,439	$520,700	3.4%
Floyd	$349,809	$87,452	$437,261	$59,391	$496,652	3.2%
Gwinett	$349,809	$87,452	$437,261	$372,341	$809,602	5.2%
Hamilton	$349,809	$87,452	$437,261	$27,080	$464,340	3.0%
North Fulton	$349,809	$87,452	$437,261	$139,264	$576,524	3.7%
Egleston	$349,809	$87,452	$437,261	$41,982	$479,243	3.1%
Scottish Rite	$349,809	$87,452	$437,261	$40,750	$478,011	3.1%
Level II Totals	**$3,148,278**	**$787,070**	**$3,935,348**	**$1,409,085**	**5,344,432**	**34.6%**
Averages	$349,809	$48,535	$398,344	$156,565	$554,909	3.6%
Grady	$583,015	$145,754	$728,768	$3,495,234	$4,224,003	27.3%
MCCG	$583,015	$145,754	$728,768	$340,724	$1,069,492	6.9%
MCG	$583,015	$145,754	$728,768	$593,353	$1,322,121	8.6%
Memorial	$583,015	$145,754	$728,768	$1,012,024	$1,740,792	11.3%
Level I Totals	**$2,332,058**	**$583,015**	**$2,915,073**	**$5,441,336**	**8,356,409**	**54.1%**
Averages	$583,015	$80,892	$663,906	$1,360,334	$2,024,240	13.1%
Total Existing Trauma Centers	**$5,480,336**	**$1,370,084**	**$6,850,421**	**$6,850,421**	**13,700,841**	**88.7%**
New Trauma Centers						0.0%
Athens Level II	$349,809	$87,452	$437,261		$437,261	2.8%
Walton Level III	$174,904	$43,726	$218,630	$10,268	$228,898	1.5%
Total New Trauma Centers	**$524,713**	**$131,178**	**$655,891**	**$10,268**	**$666,159**	**4.3%**
Trauma Center Startup Grants					$1,000,000	6.5%
Level IV Trauma Centers					$81,000	0.5%
Total Trauma Centers					**$15,448,000**	**100.0%**

Georgia Trauma Commission FY 2011 $23 Million Budget EMS Allocation			
			DRAFT DOCUMENT
Available EMS Budget	**$ 3,862,000**		
Center for Health Organization Transformation (CHOT)	**$ 50,000**		Statewide EMS Systems Study
Total :			

Meeting Report
"GTCC Operations"
Hosted at Georgia Department of Transportation, Transportation Management Center—Atlanta, GA
1/22/2010

Attendees

Rich Bias (GTCNC)
Anthony Bradford (DOT)
Randy Clayton (GOHS)
Linda Cole (GTCNC)
Rachel Duke (GTRI)
Debra Elovich (State Properties Commission)
Ben Hopkins (DOC)
Paul Mewin (GA Bldg. Auth.)
Dwayne Morgan (Baldwin Co. Fire Rescue)
Renee Morgan (DCH-OEMS/T)
Dr. Patrick O'Neal (DCH-OEMS/T)
Carolyn Perra (DPS)
Jim Pettyjohn (GTCNC)
Ralph Reichert (GEMA)
Elaine Sexton (GEMA)
Scott Sherrill (GTRI)
Courtney Terwilliger (GAEMS)
Billy Watson (DCH-OEMS/T)

Purpose of Meeting

To discuss and advise the Georgia Trauma Care Network Commission (GTCNC) on Trauma Communications Center (TCC) operations.

Discussion

A. Linda Cole (GTCNC) gave a presentation that introduced the Pilot Project for Georgia Trauma System Regionalization. The pilot will introduce regional trauma planning within the pilot region (EMS Region Five) as well as a Trauma Communications Center (TCC). In a statewide Trauma System, the TCC would serve as the centralized communications component of a statewide system. Individual regions will conduct their own trauma system planning process. Ms. Cole explained in detail the background and vision for the TCC.

B. Scott Sherrill (GTRI) presented progress on issuance of an RFP for TCC software. With this software in place at a TCC location, hospitals could update their availability directly to the TCC, which would

communicate directly with EMS providers and hospitals to recommend patient destination based upon availability for the most critically injured trauma patients.

C. Ms. Cole and Mr. Sherrill solicited input regarding TCC operations, including input regarding TCC hosting, staffing, and location. They believe that an economically viable option would be to share a facility with an existing bricks-and-mortar location already housing a state agency. Representatives of various state agencies volunteered suggestions ranging from virtual hosting to utilizing vacant facilities with security and infrastructure already in place. Debra Elovich (State Properties Commission) stated that she has the capability to look into all state-owned space, and will investigate possibilities for the TCC location if the GTCNC will provide its square footage, technical infrastructure, and ancillary requirements.

D. Ms. Cole and Rich Bias (GTCNC) asserted that TCC operations should be fully integrated with existing emergency preparedness plans in order to have the capability to provide reliable real-time information in mass casualty situations. Ralph Reichert (GEMA) affirmed that statement and reiterated the need to integrate all components of emergency preparedness.

E. Billy Watson (DCH-OEMS/T) suggested possibly co-locating an EMS Regional Office with the TCC in whichever region is determined will host the TCC.

F. Jim Pettyjohn (GTCNC) thanked everyone for attending and stated he would be working to follow up on the suggestions made at the meeting.

Georgia Trauma Care
NETWORK COMMISSION

New Trauma Center Startup Grants Program FY 2010 Application

The Georgia Trauma Care Network Commission has approved a "New Trauma Center Startup Grants Program" for FY 2010. Total funding for this program is limited to $1,000,000.

All or part of these funds may be distributed to hospitals based upon a competitive application process, attached guidelines and as approved by majority vote of the Trauma Commission.

The application process will be from 01 February 2010 to 01 April 2010. The Commission will provide an application and Grants Program Question & Answer opportunity via conference call during the first two weeks of February.

Applications will be submitted electronically to: Jim Pettyjohn, Commission administrator via email at jim@gtcnc.org 706.398.0842. Applications must be submitted complete and received by midnight 01 April 2010 to be considered. The application packet will include a completed Attachment B and all supportive documentation as described in Attachment A and Attachment B.

Each submitted application will include a cover letter from the hospital's chief executive officer agreeing to and approving application as submitted.

Hospitals receiving new state trauma center designation status between 30 June 2009 and 01 February 2010 may apply for these funds.

A subcommittee of Trauma Commission members will determine awards and grant amounts. Grant amounts will follow guidelines described in Attachment A and additional policies adopted by the Commission. See Attachment C.

The Georgia Trauma Commission at the April Commission meeting will approve awards. Awards will result in a contract between individual hospitals and the Department of Community Health. All awards will be subject to the policies and procedures of the Department of Community Health Office of Procurement Services and Contracts Services.

Attachment A:
Grants Program guidelines approved by Trauma Commission on 19 November 2009

Attachment B:
Application Worksheet- an EXCEL spreadsheet to be completed as directed and submitted as part of the complete application.

Georgia Trauma Care
NETWORK COMMISSION

Attachment C:
"Trauma Center Funding Statement" approved by Georgia Trauma Commission on 28 January 2010.

Georgia Trauma Care NETWORK COMMISSION

Attachment A

FY 2010 GTCNC

New Trauma Center Startup Grants Program

Hospital MUST demonstrate a clear COMMITMENT to the Georgia Trauma System and Designation as a Trauma Center.

Applicant hospitals[1] must:

- Receive a pre-application survey visit from OEMS/T and GTCNC representative(s) to:
  - Determine appropriate designation level;
  - Understand application and designation process;
  - Understand GTCNC trauma system development activities; and,
  - Begin participating in the Trauma Registry
- Receive "approval" from Regional Emergency Medical Services Council for designation and at determined designation level.[2]
- Present signed Letters of Commitment from:
  - Hospital Board of Directors (indicating resolution to seek designation);
  - Hospital Administrative Team; and
  - Chief Medical Officer (representing medical staff.)
  - Letters of Commitment must:
    - Indicate an understanding of standards and requirements for Level of designation sought;
    - Describe the commitment of resources and efforts to become a designated trauma center within 18 months from date of designation application;
    - Indicate immediate participation in Trauma Registry; and,
    - Describe the commitment in GTCNC-directed Trauma System development activities (pilot project and/or regionalization of trauma system)
- Provide a "Statement of Need" describing use of grant funds
- Make application for state trauma center designation

Grant distribution and funding amount guidelines[3, 4]:

#2 $300K "grants" to hospitals "COMMITTING" to designation as a Level II trauma center
#2 $100K "grants" to hospitals "COMMITTING" to designation as a Level III trauma center
#4 $50K "grants" to hospitals "COMMITTING" to designation as a Level IV trauma center

Awarded hospitals will:

- Stipulate trauma physicians (as defined by GTCNC past practices) will receive at least 25% of grant award for services rendered;
- Receive one-half (50% of award) award upon signing contract;
- Receive one-half of remaining funds (25% of award) after 6 months successful registry use; and,
- Receive remaining 25% of award upon designation within 18 months after submitting application for designation.

[1] There will be a 60 calendar-day window for hospitals to submit applications.

[2] Georgia Office of EMS – Rules and Regulations Effective June 18, 2009 – Published July 2, 2009, 290-5-30-.03 Emergency Medical Services Advisory Councils.

[3] Actual fund distribution among designation Levels and amount of each grant will be determined by the Georgia Trauma Commission.

[4] Geographic location of hospital, level of designation sought and statement of need will be considered in determining awards.

Attachment B

Georgia Trauma Care Network Commission New Trauma Center Startup Grants Program FY 2010	
Application Worksheet [1]	
Hospital Name:	
City:	
County:	
Hospital contact for the purpose of this application: name, position, email address and telephone number: [2]	
Date Complete application submitted:	
Application Requirements: [3]	**List supporting documents submitted with this worksheet, which indicate requirement has been met:**
Application visit with OEMS/T GTCNC representatives:	
Understanding of Application and Designation Process:	
Understanding of GTCNC trauma system development activities:	
Approval from appropriate Regional Emergency Medical services Council:	
Trauma Registry Participation:	
Letters of Commitment:	
Board of Directors	
Administrative Team	
Chief Medical Officer	
Statement of Need:	
Physician Funding Stipulation:	
Application for state trauma center designation submitted:	

Notes:

[1] Complete this sheet and save file with hospital's name in title. File is to be submitted as part of application.

[2] Who is the point of contact at hospital for follow-up regarding this application?

[3] See Appendix A for requirements detail. Supportive documents must be attached to application upon submission.

Georgia Trauma Care
NETWORK COMMISSION

Attachment C

TRAUMA CENTER FUNDING STATEMENT

The Georgia Trauma Care Network Commission ("GTCNC") is committed to stabilize, strengthen and thus maintain Georgia's existing trauma centers and expand the number of trauma centers, based upon need, strategically across the state.

Beginning FY 2011, when determining whether and how much to fund a new trauma center, GTCNC will give consideration to: 1) a hospital's historic participation in providing trauma care to its community; 2) degree of satisfaction of applicable trauma Level designation standards; and, 3) the hospital's geographic location within the State.

To determine the strategic need and therefore funding for additional trauma centers, GTCNC will give consideration to some or all of the following: 1) the location of and distance between proposed trauma center and the nearest existing trauma center; 2) the demographic density of the population to be served; 3) level of community support; and, 4) the commitment to trauma care and system participation exhibited by the affiliated hospital.

GTCNC reserves the right not to fund any new state designated trauma center if, in the opinion of GTCNC, said trauma center does not demonstrate need based on the criteria listed above

Georgia Trauma Care
NETWORK COMMISSION

Georgia Trauma Care Network Commission

FY 2010 EMS Vehicle Equipment Replacement Grants Program

The Georgia Trauma Care Network Commission has approved an EMS Vehicle Equipment Replacement Grants Program for FY 2010. Total funding for this program is limited to $2,125,000. These funds will provide approximately 29 grants at $73,275 each to go toward the purchase of a qualifying replacement EMS vehicle and eligible equipment.

These grants will be awarded based upon a competitive application process, a complete application, and the attached scoring criteria and as approved by majority vote of the Trauma Commission. A subcommittee of the Trauma Commission will oversee scoring to ensure accuracy and fairness.

Any agency or organization may submit up to five (5) qualifying replacement ambulances. Each ambulance must have separate application. ***** The Trauma Commission will determine the actual number of grants awarded and amounts of each grant.

The Georgia Trauma Commission at its April 2010 meeting will approve awards. Awards will result in a contract between individual agencies or organizations and the Department of Community Health. All awards will be subject to the policies and procedures of the Department of Community Health, Office of Procurement Services, and Contracts Services.

The application process will be from 07 February 2010 until 07 March 2010. The Commission will provide an application and Grants Program Question & Answer opportunity via conference call during the last two weeks of February 2010.

Attachment A will be submitted electronically to: Jim Pettyjohn, Commission administrator via email at jim@gtcnc.org. Attachment A must be submitted complete and received by midnight 07 March 2010 to be considered.

Attachment B must be submitted on agency letterhead and postmarked by midnight 07 March 2010 to:

Jim Pettyjohn, Commission administrator
14353 West Highway 136
Rising Fawn, Georgia 30738
706.398.0842

****** Limits and numbers awarded needs to be discussed by GTCNC**

Georgia Trauma Care
NETWORK COMMISSION

Attachment A:
Grants Application: Application is a Microsoft Excel© spreadsheet file. Each applying agency must complete spreadsheet and "save as" using agency name in file name. File must be submitted electronically.

Attachment B:
Stipulations Affidavit Instructions: Stipulation Affidavit original must be mailed via USPS or other delivery service.

Attachment C:
Application Scoring Criteria

Attachment D:
Vehicle Mileage Calculator

Attachment E:
Qualifying Vehicle and Eligible Equipment

Attachment A

Georgia Trauma Care Network Commission FY 2010 EMS Vehicle Equipment Replacement Grants Program	
Grant Application:	
Applicant Information:	
Date Application Completed:	
Applying Agency Name:	
Applying Agency Contact for the purpose of this application: **Name, position at agency, telephone number and email address**:	
Applying Agency USPS Mailing Address:	
County:	
EMS Region:	
Georgia EMS Provider's License Number:	
Did applying agency receive a Vehicle Replacement Award from the Georgia Trauma Commission in a previous year?	
Zone Information:	
Has applying agency been assigned a 911 Zone by a Regional EMS Council? Yes or No.	
Describe location of 911 Zone:	
What Regional EMS Council assigned 911 Zone to agency:	
Area of 911 Zone (in square miles):	
Population of 911 Zone:	
Describe resources used to determine 911 Zone area and population.	
Organization Information	
In EMS Vehicle replacement grant is awarded based upon this application, what organization or entity would take ownership of replacement vehicle?	
Organization or Entity Contact if award is made: **Name, position within organization, telephone number and email address:**	
Organization or Entity Contact's USPS mailing address:	
Organization Federal Tax ID #	
Did this organization receive a Vehicle Replacement Award from the Georgia Trauma Commission in a previous year?	
Ambulance Information	
Provide a copy of your most recent GA EMS form 1000 Schedule B and include current mileage for all vehicles listed.	
Make, Year and Model of Qualifying Replacement Ambulance	
Milage on Qualifing Replacement Ambulance as of Date of this Application	
Trauma Transport Information	
To what hospital do you transport most of your seriously injuried patients?	
What hospital is your closest Georgia Level I or Level II Trauma Center to the furthest point within you 911 zone?	
What is the USPS address of that furthest point within your 911 Zone?	

Georgia Trauma Care
NETWORK COMMISSION

Attachment B:

Provide a notarized affidavit on applying agency letterhead that affirms to the following:

1. Agree that this equipment will be maintained in good working order for a period of no less than 5 years.

2. Agree that if this equipment is disposed of or otherwise discontinued a replacement plan will be implemented that is approved by Georgia Trauma Care Network Commission.

3. Agree to utilize this equipment within the 911 zone described in the application for the grant.

4. Agree that if the equipment is sold Georgia Trauma Care Network Commission will approve the disposal before the disposal is effected.

5. Agree that this equipment will not be used as collateral for a loan beyond the amount of local contribution.

6. Agree that this equipment will remain titled to the original grantee unless permission is obtained from the Georgia Trauma Care Network Commission to reallocate this equipment to another 911 providers.

7. Agree that these grant monies will not be used to supplant, decrease or reallocate the existing budgeted monies to the local 911 EMS Response system.

8. Agree to insure the unit for appropriate replacement/repair costs and agree to use funds received from any insurance settlement to either replace or repair the unit.

9. The agency receiving this unit agrees to participate in Georgia Trauma Care Network Commission-sponsored programs or initiatives in trauma system development, and to provide all data to the Trauma Commission as requested in this program.

10. Applying agency did bill for services in a manner consistent with CMS regulations and at a level at least equivalent to the current Medicare rates as of 31 December 2009.

Attachment C

Agency Eligibility	
Population Density of Predominant County of 911 Zone covered by Replacement EMS Vehicle	**Score**
More than 1000 per sq/mile	0
More than 500 but less than 1000 per sq/mile	10
More than 100 but less than 500 per sq/mile	20
More than 50 but less than 100 per sq/mile	35
More than 25 but less than 50 per sq/mile	55
Less than 25 per sq/mile	60
Possible Points for this section:	**60**
Distance between closest Level I or II Trauma Center and the furthest point within 911 Zone	**Score**
Less than 25 miles	0
26 to 50 miles	10
51 to 100 miles	25
Over 100 miles	35
Total Possible Points for this section:	**35**
Hospital Bed Size in Predominant County of 911 Zone	**Score**
Over 400 beds	0
200 – 399 beds	10
100 - 199	20
25 – 99 beds	30
25 Beds or less	40
No Hospital in the County	50
Total Possible Points for this section:	**50**
Equipment Eligibility	
Mileage on Ambulance to be replaced	**Score**
See attached FY2010 EMS Vehicle Milage Calculator	
Total Possible Points for this section:	**60**
Age of the Ambulance to be Replaced	**Score**
Less than 5 years	0
5 to 7 years	10
8 to 10 years	20
11 to 15 years	30
Over 15 years	40
Total Possible Points for this section:	**40**
Overall Total Possible Points:	**245**

Attachment D

Actual Mileage	(Complete this block only)	
Maximum Mileage Considered		**300000**
Maximum Potential Points		**60**
Awarded Points		#N/A

Georgia Trauma Care
NETWORK COMMISSION

Attachment E:

EMS Vehicles must be new-manufactured or a "remount" from reputable dealer.

EMS Vehicles and eligible equipment purchased after 01 January 2010 to replace a vehicle used as basis for an awarded application will qualify for this program.

Eligible equipment for this grant includes: the vehicle itself, an ambulance stretcher and appropriate radio communications equipment. Awardees are not required to purchase the additional equipment but can do so as part of the EMS Vehicle Equipment Replacement Grant.

Georgia Trauma Care
NETWORK COMMISSION

Proposed Sole Source Contract with GAEMS FY 2010

The Georgia Trauma Commission requests a sole source contract with Georgia Association of Emergency Medical Services, Inc. for the distribution of FY 2010 EMS allocated funds as described below.

The total amount approved for distribution via this sole source contract is: $676,900. The following tasks and deliverables shall be included in contract Scope of Work:

Develop First Responder Training Program: $338,450
This program will provide for approximately sixty-five (65) courses with the potential for training and equipping 1300 First Responders. The program will consist of a competitive application process for individual awards going to organizations or agencies based upon an approved scoring process. Application, scoring process, provided equipment and course curriculum would be approved by majority vote of the Georgia Trauma Commission. The development of this Program will be guided by the Attachment A. Attachment A was generally agreed to during the 11 November 2009 EMS stakeholder meeting.

Develop Program for the Distribution of Trauma Related Equipment: $338,450
This program would have the purpose to provide Trauma Related Equipment to Georgia ambulances that is above the state requirement list to enhance and improve trauma care in Georgia. To be eligible, ambulance services must be licensed by the State of Georgia OEMS/T and be zoned a 911 provider for a community in Georgia. Approved equipment and process for distribution would be approved by majority vote of the Georgia Trauma Commission. Attachment B will guide the development of this Program. Attachment B was generally agreed to during the 11 November 2009 EMS stakeholder meeting.

The contract deliverables and tasks regarding the First Responder Training Program and the Program for Distribution of Trauma Related Equipment will be developed in consultation with the Georgia Trauma Commission EMS subcommittee.

The contract will be reviewed and approved by the Georgia Trauma Commission EMS subcommittee prior to finalization by Department of Community Health.

Attachment A:

First Responder Course Curriculum
60 Hour Course

1800-1900	Chapter 1:	Intro to the EMS System
1900-2000	Chapter 2:	Well Being of the First Responder
2000-2100	Chapter 3:	Medical, Legal, and Ethical Issues
1800-1900	Chapter 4:	The Human Body
1900-2000	Chapter 7:	Patient Assesement
2000-2100	Chapter 6:	Airway Management
		- Discussion on HAPE/AMS with Elevation
2100-2200	Airway Management Skills	
	-Opening an airway (Headtilt/Jaw thrust)	
	-Checking for obstructed airway, suctioning, and placing patient in recovery position	
	-Measuring and placing oral/nasal airways	
	-Check for breath and delivering rescue breathing with Bag/Mask, Mouth/Mask for adult, child, and infant	
	-Removal of FBAO	
1800-1900	Patient Assessment Practice with taking vital signs (BP, HR, RR, BGL, AVPU)	
1900-2000	Chapter 8:	Communications/Documentation
2000-2100	Chapter 21:	First Responder Supplemental Skills **(Review DVD in Textbook)**
1800-1900	Skills Practice Supplemental Skills **(Review DVD in Textbook)**	
1900-2100	Chapter 10:	Medical Emergencies
	-Emphasis on Heart Attack and Stroke	
1800-1900	Chapter 11:	Poisoning and Substance Abuse
1900-2000	Chapter 12:	Behavioral Emergencies
2000-2100	Chapter 13:	Bleeding, Shock, and Soft Tissue Injuries
2100-2200	Skills Practice bandaging wounds, bleeding control, and shock treatment	
1800-1900	Chapter 14:	Injuries to Muscles and Bones
1900-2100	Skills Practice splinting fractures, assessing circulation, spinal immobilization, and chest injuries	
1800-1900	Chapter 5: Lifting and Moving Patients	
1900-2000	Skills Practice lifting and moving patients and spinal immobilization	
1900-2000	Chapter 15: Childbirth	
1800-1930	Chapter 16: Pediatric Emergencies	
1930-2000	Chapter 17: Geriatric Emergencies	
2000-2200	Skills Practice-Patient Assessment and Vital Signs	
1800-1900	Skills Practice, Bringing it all together	

1900-2030 Chapter 18: EMS Operations

1800-1900 Chapter 19: Terrorism Response/CERT
1900-2000 Chapter 20: Special Rescue
2000-2100 Skills Practice, Bringing it all together

1800-2000 Course Review
2000-2200 Course Final Exam
(Make up day...Weather, etc)

1800-2100 Skills Practice and Skills Final Exam
(Make up day...Weather, etc)
(Can also be CPR Recertification as needed Chapter 9)

Must have 8 clinical hours on a emergency vehicle and 4 hours of policy and procedures.
must be completed by the end of the class

1800 Tentative State Exam

PROPOSED GRANT APPLICATION	
(A separate Grant Application must be submitted for First Responder Course)	
APPLICANT INFORMATION	
Agency Name:	
Georgia EMS Providers License Number:	EMS Region:
ZONE INFORMATION	
Have you been assigned a 911 zone by the Regional EMS Council? ☐ Yes ☐ No	
Where is the zone located you are applying to assistance for?	
Under which EMS Regional Council was the Zone assigned?	
Size of your 911 zone (in square miles):	Population of your 911 zone:
Please describe the 911 zone you cover.	
ORGANIZATION INFORMATION	
Please describe your organization. (Check all that apply) City Government ☐ Hospital Based Ambulance Service ☐	County Government ☐ Private Corporation ☐ Fire Based Ambulance Service ☐
Name of the County Administrator/CEO:	Name of the Authorized Agent for this Ambulance Service:
Signature: Date:	Signature: Date:
TRAUMA INFORMATION	
Where so you typically deliver your seriously injured trauma patients?	
What trauma center is your nearest Level 1 or 2 Trauma Center?	
How far is this Level 1 or 2 trauma center from your base location?	
EMS/HOSPITAL	
Total number of First Responders:	
Total number of EMS Units:	Hospital Name:
Total number of Hospital Beds:	

PLEASE PROVIDE A COVER LETTER THAT STATES YOUR AGENCY WILL:

- Agree that this equipment will be maintained in good working order for a period of no less than 5 years.
- Agree that if this equipment is disposed of or otherwise discontinued a replacement plan will be implemented that is approved by Georgia Trauma Care Network Commission.
- Agree to utilize this equipment within the 911 zone described in the application for the grant.
- Agree that if the equipment is sold the disposal will be approved by Georgia Trauma Care Network Commission before the disposal is affected.
- Agree that this equipment will not be used as collateral for a loan beyond the amount of local contribution.
- Agree that this equipment will remain titled to the original grantee unless permission is obtained from the Georgia Trauma Care Network Commission to reallocate to another 911 providers.
- Agree that these grant monies will not be used to supplant, decrease or reallocate the existing budgeted monies to the local 911 EMS Response System.
- Agree that the county will provide all the First Responder students with proper immunizations. (i.e. Hepatitis and Tetanus)
- Agree that the county will provide a location for the course to be taught.

FIRST RESPONDER COURSE

PROPOSED APPLICATION SCORING CRITERIA

911 ZONE:

1) NO EMS UNIT 40 POINTS
2) ONE EMS UNIT / NO HOSPITAL 30 POINTS
3) TWO EMS UNITS / NO HOSPITAL 20 POINTS
4) EMS UNIT / ONE HOSPITAL 10 POINTS
5) OTHER 05 POINTS

POPULATION OF YOUR 911 ZONE:

1) 2000 / 5000 40 POINTS
2) 5001 / 10,000 30 POINTS
3) 10,001 / 50,000 20 POINTS
4) 50,001 / 100,000 10 POINTS
5) 100,001 / 05 POINTS

TRAUMA CENTER: (LEVEL ONE OR LEVEL TWO TRAUMA CENTER)

1) 100 / MORE MILES 40 POINTS
2) 99 / 60 MILES 30 POINTS
3) 59 / 20 MILES 20 POINTS
4) 19 / 00 MILES 10 POINTS

Attachment B

Trauma Related Equipment
Budget $338,450.00

Purpose:
To provide Trauma Related Equipment that is above the state requirement list to enhance and improve trauma care in Georgia.

Eligibility
Ambulance Services must be licensed by the State of Georgia OEMS/T and be zoned a 911 provider for a community in Georgia.

Available Equipment:
Equipment eligible to be purchased through this grant is described below. Any equipment not described below must be approved through the appropriate process. Equipment will be purchased by the service. A receipt of purchase shall be presented to the Trauma Commission and the service will be reimbursed less applicable sales tax.

Approved Equipment:
Adult Interosseous Supplies
Capnography
External Blood Clotting Supplies
ResQGaurd
ResQPod
Eject Helmet Removal System
Scoop Stretcher
Pediatric Broselow Resuscitation Items
Commercial made Pelvic Stabilization Devices
Commercially made Tourniquet Devices
Commercially made Eye Irrigation Devices
Pressure infusion bags
(Other items to be added)

Distribution of Funds:

Option:
There are approximately 1541 ambulances that are licensed, 911 zoned ambulances, as reported by the Georgia State Office of EMS/Trauma.
Divide 1541 into the budget of $ 338,450.00.
The amount comes to $219.63.
Each zoned, licensed ambulance service can receive up to the dividend amount, times the number of licensed ambulances.

Readiness Costs Determination, Webinar
Georgia Trauma Care Network Commission (GTCNC)

MEETING MINUTES
15 December 2009

I. ATTENDEES (see attached list from GHA)

Ann Lin (Bishops + Associates)
ARMC Kathy
Bryan Forlines
Cherry Jones
Children's Healthcare of Atlanta
Daniel Thompson
Dawn Stone
Debra Kitchens (Subcommittee)
Dennis Ashley (GTCNC)
Doctors Hospital Augusta
Floyd Medical Center
Fran Lewis
Rachel Duke (Georgia Tech)
Greg Bishop (consultant and facilitator)
Gwinnett Hospital System
Gwinnett Medical
Janet M. Schalbe
Jeff Salomone
Jim Pettyjohn (GTCNC Administrator)
Jim Sargent
Kelli Vaughn (GTCNC)
Lauren Kubik
Leon Haley
Linda Cole (GTCNC)
Lisa Napier
Lynn Lambert
Marie Probst
Mark Benak
Matthew Crumpton
Memorial Health University
Perry Mustian
Public Access
Rich Bias (GTCNC)
Regina Medeiros (Subcommittee)
Renee Morgan (Subcommittee)
Rochella Mood
Rochelle Rodocker
Sue J. McCarthy
Tanya Simpson
Carie Summers
Taylor Regional Hospital

II. DATE & LOCATION

The webinar was hosted by WebEx on Wednesday, 16 December 2009 from 8:30 until 10:45. Participants received instructions (via email) to view the webinar upon submitting their RSVP.

III. PRESENTATION & DISCUSSION

Opening *(Greg Bishop, facilitator)*

Greg Bishop called the meeting to order and announced the purpose of the Readiness Costs

Determination meetings. These two meetings will enable the Commission to accurately determine what the readiness costs for trauma centers are in the state of Georgia.

Greg introduced Dennis Ashley, Kelli Vaughan, Rich Bias, Renee Morgan, Regina Medeiros, Debra Kitchens, and Jim Pettyjohn. Greg announced that the meeting would follow an agenda and PowerPoint Presentation. He referenced the handout "Cost Criteria By Designation Level" and other handouts available at the website GTCNC.org.

Welcome and Meeting Purpose (Dr. Dennis Ashley)

Dr. Ashley welcomed all attendees and affirmed the importance of this particular meeting. He thanked the Georgia Hospital Association for their partnership with the Commission in the production of the webinar. He discussed the background of Readiness Costs Determination and presented the FY10 budget.

Over the last year as the Commission has worked with Greg and conducted a survey to determine readiness costs for trauma centers, there was much variability among cost reports from the various trauma centers. While each trauma coordinator did his or her best to interpret the survey items and extrapolate readiness costs, it is clear that some standard definitions of readiness are needed in order for all trauma centers to assess their costs in a fair, standardized way. We must define for Georgia what comprises readiness, and then conduct a meaningful survey.

The purpose of this meeting is to show attendees what the Readiness Costs Determination Subcommittee proposes as Costs Determination Criteria, give attendees some questions to consider, and provide a basis to make final Readiness Cost Determination decisions in January. This is a consensus-building process; while our conclusions may not be 100% correct, at least they provide a common basis for discussion and a level playing field as the Commission distributes Readiness funds.

Dr. Ashley apologized for the short timeline and stated the importance of having accurate Readiness Cost definitions and estimates prepared for the legislative session.

It is critical to the discourse to establish the meaning of "Readiness Cost". The question the Subcommittee is attempting to answer is this: how much additional money does a trauma center spend by virtue of its designation as a trauma center that it would not have to spend if it were non-designated? In other words, if a facility weren't a designated trauma center, how much money could it avoid spending?

On the issue of uncompensated care, Dr. Ashley reminded webinar attendees that SB60 specifies the Commission can only use Fund money as a means of last resort when there is *no other source* to cover a specific patient's care. The formula to reimburse uncompensated care costs to trauma centers remains unchanged: it 1) identifies indigent patients, 2) breaks down cases by Injury Severity Score, and 3) puts cost data with those scores based on national cost data. Each trauma center gets a percentage of that cost of uncompensated care they are providing.

Dr. Ashley stated that last year the Commission tried to get sustainable funding passed because the original allotment of $60 million had been spent. The governor was aware that the money from the Super

Speeder Bill won't adequately sustain the Fund, but the Bill was expected to generate $23 million. The legislature went ahead and appropriated $23 million even though the bill will not enter effect until January 2010. The Commission is currently planning that the original budget will be cut by 5% to $21.9 million, with an additional cut likely.

Based on this budget, Dr. Ashley presented a slide showing the approved FY2010 allocations to each Level I and Level II trauma center. Dr. Ashley also displayed the Total Trauma Fund Distribution for FY 2010 and explained several new payment types that did not exist last year.

Dr. Ashley explained the expectations of the Performance Based Payments Program. In general, the Commission wishes to show accountability to the legislators and tie funding to performance. Sometimes this gets a bad name because at the federal level "performance-based payments" can be used to save the government money or to prevent payments being made. Dr. Ashley stated the Commission's desire to tie payments to positive improvements in patient care at trauma centers, and emphasized the only five percent of readiness funding is tied to this base. There are only two criteria for FY2010 required of trauma centers to demonstrate "performance." These are 1) Submission of required data and reports to OEMS & Trauma, and 2) Participation in the Commission-sponsored Readiness Cost Determination Activities (webinar, Summit, and cost survey completion within timeline). The idea is that that these performance measures will improve patient care, not prevent payments from being made.

Dr. Ashley attested that the Commission took criticism for not starting up any additional trauma centers with the original $58.9 million allotment. Measures are underway to encourage hospitals to become designated trauma centers.

Finally, Dr. Ashley presented a list of all the work the Commission is doing to improve and assist trauma centers. This concluded Dr. Ashley's report.

No attendees presented any questions.

FY2010 Hospital Contract Update (Renee Morgan)

Centers will be paid FY 2010 trams funds through an amendment to their existing contracts. Once amendments are executed, trauma centers will have the ability to invoice immediately for readiness funds. Renee stated that once the trauma center (administration) has signed and returned the contract with amendment to her, it is only a matter of time before that contract will successfully process through DCH and the trauma center can invoice directly for readiness funding. Renee stated that while this is a high priority, it would not be completely accomplished for at least a couple of weeks.

No attendees presented any questions.

National Perspective *(Greg Bishop)*

Greg explained that over the years his firm has done financial performance analysis on trauma care in various states. In the cases studied, hospital CFOs typically determined that trauma medical staff payments for call should be added as extraordinary costs (i.e., readiness costs) on top of fully allocated patient care costs. Some CFO's advised including costs for maintaining in-house OR staff at nights and weekends and the trauma patient portion of any loss on air transport programs.

As a reference point to understand our task in Georgia, Greg explained how two other states, Florida and Virginia, had categorized and assessed their respective Readiness Costs.

No attendees presented any questions.

Georgia Trauma Center
Readiness Costs Determination Activities *(Kelli Vaughan)*

Kelli Vaughn began by introducing the Readiness Costs Determination Subcommittee. She then presented the definitions agreed upon for "Existing Trauma Center Readiness Cost" and "Trauma Center Start-up Cost." The goal of the Subcommittee is to provide a rigorous and transparent methodology for determining these costs.

Kelli explained the Subcommittee's past work and methodology.
PAST: Bishop and Associates conducted a survey of Georgia's trauma centers, however, there was a lot of variance in interpretation and reporting of costs.

PRESENT: The Commission is conducting a webinar and Summit to come to consensus with the trauma centers on readiness cost criteria and definitions.

FUTURE: In the future there will be continuous evaluation of these criteria and definitions.

Kelli announced that the Subcommittee's work up to the present has relied upon the American College of Surgeons Resources for Optimal Care of the Injured Patient, the Florida Costs of Readiness Care Summary, and work with Bishop and Associates.

In this first comprehensive effort to accurately assess Readiness Costs, the Subcommittee has categorized Readiness Costs as Administrative, Clinical, or Education and Outreach. The "Readiness Costs Criteria by Designation Level" handout lists these categories and the corresponding costs within each category.

In this process, Kelli would like for all trauma centers represented to work on definitions of readiness inclusion criteria. Criteria should be evaluated to determine feasibility of use. At the Readiness Costs Summit in January, we will develop a mutually agreed to framework for determining readiness costs.

Bishop and Associates will take the results of the Summit and develop them into a final survey tool with agreed upon criteria. This will be distributed to trauma centers with a timeline for response. Bishop will

develop a report within two weeks and preliminary findings will be presented at the February Commission meeting. This is a tight timeline to get all accomplished so as soon as participants leave the Summit they should start thinking about dollar figures so that they are prepared to complete the survey when it comes out.

No attendees presented any questions.

Next Kelli requested that the group consider the handout "Readiness Costs Criteria By Designation Level". In the document you will see the criteria broken into the administrative, clinical and education & outreach cost categories. The Subcommittee must account for the fact that different facilities compensate physicians in different ways. The key is for you to consider what you do in your institution and bring it forward so we can decide what we're going to accept.

What is listed in this handout comprises ALL of the criteria. Kelli recognized that this criteria is extremely conservative but expressed her desire to operate clearly and transparently, namely by citing the requirements of each level of trauma center and agreeing to consider only the funding directly associated with these requirements. So in accordance with the timeline, all trauma centers should put forth their working definitions for each of these categories. At the January Summit trauma centers will group themselves by designation level and come to agreement upon these definitions. A final report of Readiness Determination Costs will be issued in March.

CRITERIA CATEGORY: ADMINISTRATIVE COMPONENT

Greg announced that the next item of business was to talk through each of the criteria as needed and address questions from webinar attendees. As an example he questioned Rich Bias as to how Rich would assess the first criterion of the list, "Administrative support-% of time by Senior Administration to focus on trauma." They agreed that Rich should estimate the portion of his time he spends on trauma-related activities relative to the time dedicated to trauma through his normal salary.

Dr. Hawkins of MCG raised a question. "Obviously our funding will be inadequate to meet all the needs of the entire state. Will the emphasis rest upon starting up Level III and IV trauma centers, or upon sustaining the existing trauma centers?"

Dr. Ashley replied to the question by stating that the main goal of this particular discussion is to determine Readiness Costs whether there were one trauma center or fifty. In the past the Commission's goal has been to stabilize the centers that already exist. Recently other hospitals have been encouraged to come online [step up as trauma centers], so although that is a priority, it is different from the goals of the Readiness Cost determination.

Greg added that the allocation to existing Level Is and IIs is currently 70%, so the budget would indicate that the emphasis is on maintaining existing centers over building up new ones.

On a different note, Regina and Rich then made a comment regarding the inclusion of specific personnel costs mentioned on the "Criteria" handout. The approach of the Subcommittee was to pursue readiness costs as defined by ACS, so if a personnel type was required for a designation level, it is on the "Criteria" list. For example, if a Level IV trauma center has a Trauma coordinator, that is commendable. Nevertheless, that coordinator would not be included as a Readiness Cost because it is not an ACS requirement for a Level IV.

CRITERIA CATEGORY: CLINICAL COMPONENT

Kelli provided background on the issue of physician compensation. She stated that this will be a particularly difficult area to determine Readiness Costs because some facilities pay physician stipends, some have employed physicians and some pay ED call pay.

Rich emphasized that the goal of this discussion is not to agree on a statewide call pay standard. The goal is to get an acceptable definition concerning the Readiness Costs of paying physicians to be available for trauma care. This may require the CFO's to "impute" a percentage of call pay that would be tied to emergent general surgery. We are not setting a dollar amount to pay physicians to be on call, rather we are determining the costs of readiness.

Dr. Jeff Salomone of Grady Memorial Hospital raised a question. "On the clinical category it appears that emergency medicine is missing. I believe that for all levels of designation except IV, emergency medicine is required. Why isn't it there?"

Kelli replied that the Commission isn't paying for a 24/7 physician to be on call. Dr. Salomone focused his question by suggesting that trauma centers usually add (physicians) to their emergency departments due to their trauma center status. He believes it should be included.

Rich then delved into the questions surrounding the Readiness Costs of Residents. Since the focus of this determination is "What does a trauma service require financially above and beyond normal operating costs?" it should be noted that payment of Residents is an "extraordinary" cost that Level Is face. Level I CFOs should provide their opinions on how to assess this cost, taking into consideration that federal funding provides some coverage for Residents.

EDUCATION & OUTREACH

Kelli summarized this category by explaining that in order to perform the education and outreach expected of designated trauma centers, they need supplies and they may need to bring in courses. The Commission must determine what these needs are and then look at the costs associated.

Questions & Answers *(Greg Bishop)*

Bryan Forlines of MCCG raised a question. "The one thing that concerns me about putting this together is that all we have discussed is cost. Trust me, the money is appreciated. But shouldn't the money that trauma centers make as a result of trauma center-designation be taken into the equation?"

Greg replied that while today's topic is just readiness cost, the revenue side of the equation been addressed for the past two years. This included the surplus generated on insured patients as well as losses on underinsured and uninsured patients.

Bryan noted that it would be interesting if each hospital had an understanding of its balance sheet relative to trauma care. He does not believe that facilities are always losing money on trauma, and wants to ensure that when the Commission reports a dollar amount lost on trauma care, both sides of the equation are taken into account.

In response, Greg stated that an estimated $66 million was lost on trauma care in 2007, and this includes all revenue and both patient treatment and readiness costs for existing trauma centers. Rich reminded the group that the goal is to enhance and expand services available. It's good that non-designated facilities can provide care, but the goal is for there to be reasonable access statewide to designated trauma centers. Also there are many facilities in our state that have chosen not to be designated trauma centers because it would create additional costs, even though they have a lot of capabilities. We want to encourage some in the extremities of the state to come on board.

Rochella Mood of Atlanta Medical center raised a question. "Under the clinical component [of the criteria] we may wish to consider including 'vascular' in addition to 'microvascular.' This is definitely a cost that would go away for us if we were not a designated trauma center."

In response, Rich and Kelli reiterated that the conservative approach here was to list only those services required by ACS. The Subcommittee is hesitant to make exceptions to the ACS requirements for fear that it will "muddy the waters" and compromise the accountability and transparency of the process.

Kelli stated that any additional comments or questions should be emailed to Jim Pettyjohn at jim@gtcnc.org.

Closing Comments *(Dr. Dennis Ashley)*

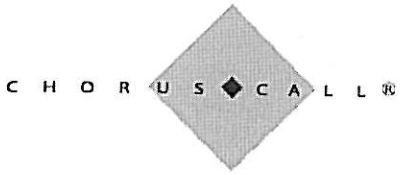
Dr. Ashley thanked everyone for his or her willingness to contribute and announced before closing the meeting that the Readiness Costs Determination Summit will be held 15 January from 10:00 am until 2:00 pm at the Atlanta Medical Center. In advance of the Summit, all attendees should consider the Readiness Costs Determination Criteria and consider determination methods for the criteria.

CHORUSCALL®

To:	Rochelle Rodocker
Date:	Wednesday, December 16, 2009 8:30AM
E-Mail Address:	
Company Name:	GA Hospital Assoc.
Host's Name:	Greg Bishop, et al.
Conference Name:	GA Hospital(8:30A)Rodocker
Conference Title:	"Readiness Cost Determination"

Participant Information

1. C/Rochelle Rodocker (MON)
2. Memorial Health University
3. Floyd Medical Center
4. Georgia Tech Research Inst.
5. Columbus Regional Healthcare S
6. Hamilton Medical Center
7. Children's Healthcare of
8. Children's Healthcare
9. Archibald Medical Center
10. Athens Regional
11. Medical Cnt of Central GA
12. Walton Regional Medical Center
13. Taylor Regional Hospital
14. Gwinnett Medical Center
15. Norfolk Regional Hospital
16. Grady Health System
17. Bishop and Associates
18. Floyd Medical Center #2
19. Doctors Hospital of Augusta
20. Taylor Regional Hospital #2
21. Grady Memorial Hospital
22. Georgia Hospital Association
23. Medical Center of Central GA
24. Grady Health System
25. C/Renee Morgan
26. Grady Memorial Hospital #3
27. Grady Hospital
28. C/Carrie Summers
29. C/Greg Bishop
30. C/Jim Pettyjohn
31. Medical Assoc. of Georgia
32. Grady Health System
33. Atlanta Medical Center
34. Childrens Healthcare of
35. Gwinnett Hospital System
36. Gwinnett Medical #2
37. MCG Health Inc.
38. Medical Association of GA
39. Morgan Memorial Hospital
40. Medical College of Georgia



41. Atlanta Medical Center 2
42. Children's HC of Atlanta
43. Memorial Health University 2
44. Doctors Hospital in Augusta
45. GA State Office of EMS/Trauma

Georgia Trauma Center Readiness Cost Determination Activities and Timeline		
Date	**Event**	**Expectations**
16-Dec	Webinar	GTCNC will provide details on FY 2010 trauma center funding and update on trauma center funding contracts, describe trauma center readiness cost determination history to date; describe "performance based payments" concept and use during upcoming years to fund centers; current process ("why we are here at this meeting") for determining trauma center readiness costs for 2011 and beyond; identify Readiness Cost Criteria by designation level for Georgia Trauma Centers; introduce process for developing consensus on criteria definitions; and, assign homework to trauma centers to have completed by 15 January
15-Jan-10	Face to face summit in Atlanta at Atlanta Medical Center, 10:00 am until 2:00 pm	Reach consensus definitions on all criteria; Trauma centers understand role, responsibilities in process and timeline.
22-Jan-10	Trauma Centers receive Readiness Cost survey instrument	Trauma Centers have two weeks to complete
28-Jan-10	January GTCNC meeting	Kell Vaughn to report on process to date.
5-Feb-10	Completed survey returned to Bishop+Associates	Trauma Centers will return completed survey to B+A by 05 February.
15-Feb-10	Draft report to GTCNC subcommittee	Subcommittee to review and provide comments back to B+A by 22 February 2010
16-Feb-10	Draft report shared with Trauma Center/Physician Funding Subcommittee (Dr. Haley's subcommittee)	Kelli Vaughn to brief Leon Haley's subcommittee before full GTCNC meeting on the 18 February 2010
18-Feb-10	February GTCNC meeting	Kelli Vaughn provides preliminary report of salient and overarching concepts from Draft to GTCNC
22-Feb-10	Subcommittee(s) comments back to B+A	Both subcommittees to have read and provided comments back to B+A
1-Mar-10	Final report completed	B+A to submit final report to subcommittee
before 18 March 2010	Final report disseminated to full GTCNC as "final draft"	Final read by GTCNC members to approve and support findings
18-Mar-10	March GTCNC meeting	Final report presented to and approved during Commission's March meeting.

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/ Criteria Deemed Essential For Level In ACS Gold Book	LEVEL I	II	III	IV	SURVEY INSTRUCTIONS Do Not Respond To Item If Your Trauma Center Level Is This Color As It Is Not Essential For Your Level*	AMOUNT Use Actual Costs in 2008
ADMINISTRATIVE						
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	• 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 STAF	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 Medical Staff Compensation Do not include amounts paid for administrative duties.							
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.		
Opthalmic					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.	
IN HOUSE OR AVAILABILITY	Level I hospitals require in-house 24 hour availability and some Level IIs maintain this as well. • 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						

EDUCATION & OUTREACH	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						

Phase 2
CY 2008 GEORGIA ASSESSMENT OF TRAUMA CENTER FINANCIAL VIABILITY
Georgia Trauma Care Network Commission

January 27, 2010

To Georgia Trauma Centers,
This is Phase 2 of this year's trauma center financial survey. It covers calendar year 2008. You should have already received and started working on Phase 1 - Trauma Center Readiness Costs – which has a due date of February 5, 2010. This Phase 2 survey has a due date of February 26, 2010

Please immediately acknowledge that you have received this Phase 2 survey by replying to the email from Ann@traumacare.com.

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: _____

All hospital data will be kept confidential; it will be reported on a consolidated basis that precludes the disclosure of individual hospital information. The exception will be the total patient volume and volume of self pay patients by injury severity category that each trauma hospital treats; this provides a basis for allocating Georgia trauma funds.

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

_____CFO

SECTION 1 – TRAUMA REGISTRY AND FINANCIAL INFORMATION

A. Volume & Severity Mix of Admitted Patients

For this table, please include trauma patients who **meet Georgia trauma registry criteria and were admitted** to the hospital during the full 12 months of 2008. Do not include DOA's, ED deaths and ED transfers in this table.

ISS Category	# of Patients	Total Hospital Days	Total ICU Days*
0 – 8			
9 – 15			
16 – 24			
>24			
Totals			

* Also include in total hospital days

B. DOA, ED Deaths & ED Transfers

In this table include only **trauma patients who meet Georgia trauma registry criteria but were not admitted to the hospital**. Include only DOA's, ED deaths and ED transfers in this table.

Patient Category	# of Patients	Total Cost*	Your Hospital's Definition of DOA vs. ED Death
Dead on Arrival			
ED Deaths			
OR Deaths			Do you include OR deaths in admitted patients?
ED Transfers Out			NA

* Total costs include fully allocated patient treatment costs

C. Patient Treatment Costs, Revenue, Payer Mix

In this table please **include all patients who meet Georgia trauma registry requirements**. "Estimated final collections" is what you expect to collect on remaining account balances."

Payer Type	# of Patients	Total Charges	Total Costs	Actual Payments	Remaining Balances	Estimated Final Collections
Commercial (Non Contracted)						
Managed Care(Contracted)						
Medicare						
Medicaid						
Self Pay						
Other						

Totals						

D. CY 2008 Self Pay Volume and Severity Mix

For the self pay patients included in the above table, please review each patient against hospital/state contract requirements regarding uninsured patient eligibility for payment from Georgia Trauma Care Network Commission (based upon SB 60). Then include only such patients in the table below right.

Relevant contract language is as follows:

Contract Page 8 Under Uncompensated Care

"To ensure that all reasonable collection efforts as defined by the Commission are made by Contractor prior to payment for services. Collection efforts will include payments from private insurance coverage or any other public medical assistance program (i.e. Medicaid, Medicare Part B, Workers' Compensation, etc.). It is understood that payments made through this program shall be deemed as "payer of last resort". No payment will be made to supplement any third party payment. However, where the recipient of services is making payment, any partial payment of less than 10 percent on such self-pay account will qualify that account to be deemed uncompensated."

2008 Uninsured Patients Meeting SB 60 Requirements

Admitted Patients By ISS Score	# of Pts
0 - 8	
9 - 14	
15 - 24	
24+	
Total Admitted Patients	
Non Admitted Patients	
Dead on Arrival	
ED Deaths	
ED Transfers	
Total Non-Admitted Patients	

Contract Annex B Definitions

"uncompensated" services means care provided by a designated "trauma center" in the State of Georgia emergency medical services provider, or physician to a trauma patient as defined by the Georgia Trauma Care Network Commission who:

(a) Has no medical insurance, including federal Medicare Part B coverage;
(b) Is not eligible for medical assistance coverage;
(c) Has no medical coverage for trauma care through workers' compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage; and
(d) Has not paid for the trauma care provided by the trauma provider after documented attempts by the trauma care services provider to collect payment. O. C. G. A. Section 31-11-100 (4)

GTCNC FY 2010 Budget Procurements and Contracts Update Worksheet

Budget Item	GTCNC FY 2010 Approved Budgeted Amount	Status	15 October GTCNC Update (Renee Morgan and Dr. O'Neal)	19 Novemeber GTCNC Update (Renee Morgan)	Update for December (Jim Pettyjohn)	Update for January 1.21.2010 (J Howgate)
Administrator	**$ 135,200**	**Pending**	J Pettyjohn sevices agreement for FY 2010 added to B+A amendment "has been processed"[1] but "cannot verify whether a check has been cut or give a timeline on the payout.".	Still waiting for Contract to be approved. Once approved, contract will be sent to Bishop+ Associates for signature. Once Bishop + Associate signs, will be returned for DCH Commissioner to sign. Once Commissioner signs, Mr. Bishop can invoice for funds and pay Mr. Pettyjohn.	Contract approved and signed by Commissioner. Bishop+Associates signed and expedited back to OEMS/T on 24 November. Invoice form B+A sent to DCH per instructions on 12 December.	Need to decide Contract vs. State employee and begin process by late Feb or early March in order to be in place by July 1, 2010.
Administrative Assistant	**$ 50,000**	**Human Resources**	Renee reported she is working with the No. Georgia office of the Temporary Staffing agency that will provide these services. No start date available.	This is now in DCH personal office for action.		**1.21.2010** - Hiring package with Dr. Edwards for approval. JP will have option to interview candidates who qualify.
Conference Call Account	**$ 7,200**	**Complete**	21 September: received account specifics			
Website Design	**$ 15,000**	**Procurement**	Renee reported that DCH procurement office noted that these services can be provided internal to the state and the GTCNC will need to work that way Jim will follow up with Renee.	Mr. Pettyjohn getting quotes for services under $5,000 and those will be submitted to Office of Procurement for approval. Once approved contract will be written.	Quote received for under $5K.	**1.21.2010** - Current proposal tentatively approved by relevant players in DCH. JP drafting proposal. EPR staff initiating purchase request. JCH confirming sourcing procedure.
FedEx Office Account	**$ 2,400**	**Pending**	Renee said she has confirmed these accounts do exist and continues to investigate how to effect one for the Commission.	Printing accounts do not exist. Mr. Pettyjohn will need to supply receipts for reimbursement as per OEMS/T direction. These instructions will be forthcoming.	Based upon further conversation with Renee Morgan it was decided Jim Pettyjohn would save receipts and submit to B+A for reimbursement once those funds are available.	**1.21.2010** - It has been decided that JP will continue to use FedEx as needed and be reimbursed through B&A account. This will need to be addressed as a part of "Administrator" item.
Commission Travel/Per diem	**$ 10,000**	**Pending**	Renee stated she would mail each GTCNC member a form to complete and mail back to her in order to become a state vendor. This is required for each GTCNC member to receive the $105.00 per meeting as stipulated in SB 60 and interpreted by DCH travel office.	Renee passed out forms for each commission member to sign and return to her. This form will establish each member as a state vendor allowing them to receive stipend.	Need report of this process and fund dispersal.	**1.21.2010** - Per RM, waiting for all vendor applications from all Commission members to be submitted at one time. Decided to encourage all members to submit DCH vendor apps regardless of their intention to submit for reimbursement.
Communications Center Lead Position	**$ 100,000**	**Pending**	Renee stated she was unclear until the 15 October GTCNC meeting that this position was to be a contract position and will investigate how to move forward with it.	This is now in DCH personal office for action.	No further information available.	
Communications Center Software	**$ 300,000**	**Procurement**	06 October: Received Procurement Planning Document and Procurement Authorization Sheet from S. Sherrill. 10 October: All submitted to Renee Morgan. 1 5October: Renee stated this procurement is in process.	Office of Procurement is allowing RFP development to proceed. Renee is working with Arnita Watson to develop.	Scott Sherrill (GTRI) and Jim Pettyjohn working with Arnita Watson from OPS to write supporting documents for RFP. SOW submitted to Ms. Watson on 30 December. Goal is to have RFP posted by 15 January.	**1.21.2010** - Specs received in DCH procurement. JCH will contact Arnita Watson to determine current status. Will need to go through DOAS due to $ amount.
Web-based Registry Support	**$ 49,550**		To be added to the Digital Innovations (registry vendor) contract as a separate task. That contract is under development.	no update provided	No further information available.	
B+A Amendment	**$ 110,750**	**Complete**	"has been processed"[1] but "cannot verify whether a check has been cut or give a timeline on the payout."	see Administrator documentation above.	see administrator notes above	**1.21.2010** - Contract amendment complete. Invoice paid to B&A.
Trauma Center Association of America a/k/a National Foundation for Trauma Care	**$ 1,500**	**Complete**	"has been processed" but cannot verify check has been cut or give a timeline on the payout.".	No check has been cut as of yet.	check received on 30 November. Membership active	
Broselow and Lutin System	**$ 200,000**	**Procurement**	Renee stated has worked with DCH Procurement using Sole Brand justifcation documents supplied by GTCNC and feels "hopeful" this procurement will proceed as a sole brand contract.	Awaiting Office of Procurement to approve Sole Brand contract.	No further information available.	**1.21.2010** - D Greer denied sole source, but sole brand may be an option. JCH to follow up with Theresa Walker to determine current status of procurement.

GTCNC FY 2010 Budget Procurements and Contracts Update Worksheet

Budget Item	GTCNC FY 2010 Approved Budgeted Amount	Status	15 October GTCNC Update (Renee Morgan and Dr. O'Neal)	19 Novemeber GTCNC Update (Renee Morgan)	Update for December (Jim Pettyjohn)	Update for January 1.21.2010 (J Howgate)
GPT matching funds Grant	**$ 200,000**	**Pending**	Georgia Partnership for Telehealth received USDA Rural Development Grant confirmation on 13 October. Renee said she has the necessary information from GPT to move forward andl investigate how accomplish this GTCNC approved budget item.	No progess to report.	No further information available.	**1.21.2010 -** No apparent mechanism to provide matching grant funds. Exploring limited options. DG requested GPT grant application for background. Meeting requested for week of 1.25.2010 to discuss this an other GTCNC items in procurement.
OEMS/T 3% Allocation	**$ 655,000**	**Pending**	Dr. O'Neal reported that due to low state revenues and that effect on state budget, he is having to priortize new staffing hires. He is uncertain as to how much funding will be avaialble for these position but did say OEMS/T was moving forward with developing and hiring the EMS Region V trauma nurse coordinator as per GTCNC request.	OEMS/T is moving forward with hiring a State EMS medical director and two EMS regional program directors. Will not move forward on EMS Regional 5 Trauma nurse coordinators due to possible continued revenue shortfalls.	No further information available.	
Trauma Centers and Physician Funding Contract (readiness and uncompensated care)	**$ 14,153,600**	**Contract**	Not specifically addressed during report but after GTCNC meeting during a telephone call, Renee stated that she was investigating with DCH contracts how to construct the amendment for FY 2010 GTCNC distribution. Unlike last year's GTCNC funding to hospitals/physicians when the entire distribution amount was avaialble at one time, FY 2010 funding will be availble via monthly 1/12 allocations. She is seeking clarification on how to address that in the amemdment	Renee reported amendments to existing hospital contracts are under development. OEMS'T will provide reports as progress is made.	No further information available.	**1.21.2010** - 15 Contracts drafted, finalize and submitted for approval. **1.26.2010** - As of today, 15 contracts have been routed through DCH approvals and sent to hospitals for signature.
New Trauma Center Startup Grants	**$ 1,000,000**		Disitribution particulars and process remains under development at the Comission level. No decision made as of this time.	GTCNC to approve administrative process for grants at 17 November meeting.	Adminisstrative process approved by GTCNC on 17 November. Direction needed from DCH on how to proceed with developing the application.	
Federal Stimulus Funding Solicitation	**no funds**	**Pending**	This motion made and approved druing the 15 October meeting. J. pettyjohn to begin Procurement Authorization Sheet and Procurement Planing Documentation appropriate for Solicitation.	No progress to update.	No further information available.	**1.21.2010** - JCH will approach Rhonda Page (PH Grants) to determine if there are potential ARRA funds for which the GTCNC might be eligible.
Center for Healthcare OrganizationTransformation Membership	**$ 50,000**	**Pending**	Passed the Comission on this date. Dr. Ashley requested Alex Sponseller from AG office and Renee Morgan to review feasibility and process for GTCNC membership. Request sent to Eva Lee for all necessary and appropriate documentation.	Awaiting AG's office approval and process to be identified by office of Procurement.	AG approved moving forward with contract. Awaiting report on contract development and approval process.	**1.21.2010** - Determining how to process request. May be able to use Intergovernmental Agreement with GA Tech. To be discussed at meeting with D Greer next week.

Complete - Business related to item closed
Procurement - In procurement process ropending 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 cotnract
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.

Department of Law
State of Georgia

THURBERT E. BAKER
ATTORNEY GENERAL

40 CAPITOL SQUARE SW
ATLANTA, GA 30334-1300

26 January 2010 *By regular mail and facsimile: (478) 633-6195*

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

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

RE: Draft Revised Version of Senate Bill 156

Dear Dr. Ashley and Commission Members:

You have asked our Office to review a proposed revised draft of Senate Bill 156 (hereinafter "Revised SB 156,") prepared by the Georgia Trauma Care Network Commission ("Commission,") in connection with two questions. First, you have asked whether Revised SB 156 would change the role of Regional Emergency Medical Services Councils ("REMSCs") in assisting the designation of trauma centers. Second, you have asked whether the rule-making authority that would be given to the Commission in Revised SB 156 would be subject to final approval by the Board of Community Health.

It is my view that Revised SB 156, if passed in the form you have proposed,[1] would give the Commission final rule-making authority over the designation of trauma centers, and rules so promulgated would not be subject to approval by the Board of Community Health. This rule-making authority would most likely permit the Commission to change the designation process by changing or eliminating the role of REMSCs in the process whereby trauma centers are designated.[2]

---

[1] A different version of Senate Bill 156 was introduced in the 2009 General Assembly. A committee substitute passed the Senate and was favorably reported out of committee in the House, but did not come up for a full vote in the House before the session ended. It is my understanding that your draft was prepared at the request of the Governor's staff, but that no decision has yet been made to introduce the draft in the 2010 General Assembly.

[2] The views in this letter are based on the assumption that the General Assembly enacts Revised SB 156 in its entirety and that all other relevant statutory laws of the State remain unchanged.

I. Current Role of Office of EMS/Trauma and REMSCs in Regulating Emergency Medical Services and Trauma Center Designation.

Emergency medical services are addressed in O.C.G.A. § 31-11-1 *et seq.* Under that chapter, the Department of Community Health ("DCH") is authorized to license and regulate ambulance services, and to certify medical advisers, paramedics, and cardiac technicians.[3] O.C.G.A. §§ 31-11-3; 31-11-30; 31-11-50 through 31-11-60. To administer the EMS program, DCH is authorized to designate "local coordinating entities" to administer emergency services in each of the ten health districts in Georgia. O.C.G.A. §§ 31-3-15; 31-11-3. Under DCH's Rules and Regulations, "local coordinating entities" is interpreted to refer to REMSCs. *See* DCH Rule 290-5-30-.2(tt).

By rule, REMSCs are specifically authorized to:

1. Recommend to the board or its designee the Regional Ambulance Zoning Plan.

2. Develop the Regional Emergency Medical Services Communications Plan.

3. Recommend to the board or its designee the designation of Base Station Facilities.

4. Recommend to the Board or its designee the designation and redesignation of Trauma Centers as specified in department policy and in these Rules.

5. Make other recommendations or provide other functions as directed by the department, rules and regulations or statute.

6. Recommendations. Regional EMS council recommendations directed to [DCH] are advisory and not binding to the department unless expressly stated otherwise in statute or these rules and regulations.

DCH Rule 290-5-30-.03(3)(b) (emphasis added). As noted above, REMSCs recommend to DCH the names of particular facilities in their health district to be designated as trauma centers.

---

[3] These administrative duties were previously performed by the Department of Human Resources and were transferred to DCH effective July 1, 2009. *See* O.C.G.A. § 31-2-5.

However, the actual designation of trauma centers is performed by the Office of EMS/Trauma ("OEMS")[4] under DCH Rule 290-5-30-.04, which provides in part:

> (2) Designation
>
> (a) The OEMS shall define in policy the process for trauma center designation and redesignation.
>
> (b) The OEMS has the authority to review, enforce and recommend removal of trauma center designation for trauma centers failing to comply with applicable statutes, Rules and Regulations and department policy.
>
> (c) Designation will be for a period of three (3) years.
>
> (d) Each designated trauma center will be subject to periodic review.

DCH Rule 290-5-30-.04.

Notably, although trauma center designation is performed by OEMS through recommendation by a REMSC, the statutory authority of DCH over emergency medical services contained in O.C.G.A. § § 31-11-1 *et seq.* does not specifically mention "trauma centers" or the "designation of trauma centers." *See, e.g.,* O.C.G.A. § 31-11-5 (authorizing DCH to promulgate rules only for ambulances, EMS personnel, EMS training, etc.). Moreover, although DCH has broad authority to promulgate regulations for the licensing and classification of health care facilities, O.C.G.A. §§ 31-7-2; 31-7-2.1, and broad regulatory authority over public health in general, O.C.G.A. §§ 31-2-5; 31-2-9, there is no specific statutory reference to the designation of trauma centers. Hence, OEMS appears to derive its regulatory authority over the designation of trauma centers through DCH's general rule-making authority over public health, EMS services, and healthcare facilities.

II. Summary of Revised SB 156

Revised SB 156 would modify the Commission's original statutory authority as currently set forth in the O.C.G.A. §§ 31-11-100 through 103. The draft bill calls for the creation of a comprehensive "Trauma System," and sets forth a detailed list of that system's components. *See* Revised O.C.G.A. § 31-11-100(a). Some of those components include injury prevention and risk

---

[4] OEMS, formerly a part of the Department of Human Resources, is now part of the Department of Community Health.

reduction programs, a state-wide trauma communications center, and a trauma patient identification system. *Id.*

The draft bill also gives general rule-making authority to the Commission for the new Trauma System, *id.* §§ 31-11-100(a)(1)(15); 31-11-102(a)(5); 31-11-102(b)(1), and specifically gives rule-making authority for several components of the system, including the designation of burn centers and trauma centers, *id.* § 31-11-100(a)(2, 3), and uncompensated care, *id.* § 31-11-100(a)(8). Revised SB 156 directs OEMS to administer the new Trauma System through the rules and policy established by the Commission. *Id.* § 31-11-102(b). The Commission retains the authority to set its own budget and pursue multiple funding sources, including the ability to purchase and collect upon uncompensated claims. *Id.* § 31-11-102(a). Finally, Revised SB 156 provides that the Commission will be attached to DCH for "administrative purposes only," and that the Commission is authorized to hire its own staff. *See* Revised O.C.G.A. § 31-11-101(a) and (d).

III. Administrative Attachment and Advisory Committees

As under current law, Revised SB 156 provides that the Commission will be attached to DCH for "administrative purposes only." *See* Revised O.C.G.A. § 31-11-101(a). As set forth in O.C.G.A. § 50-4-4, an agency which is attached to a State department for administrative purposes only continues to maintain control over its "quasi-judicial, rule-making, licensing [and] policy-making functions . . . without approval or control of the department." O.C.G.A. § 50-4-4(a) (emphasis added). Attached agencies also maintain control over their budgets and may hire their own staff if authorized by statute. *Id.* Hence, although an agency may be administratively attached to a State department, the department does not exercise supervisory authority over the attached agency. *Id.* This relationship has been confirmed in previous opinions from this Office. *See, e.g.*, 1990 Official Att'y Gen. Op. 68; 1975 Official Att'y Gen. Op. 35.

In contrast to attached agencies, advisory councils are committees created by State department heads or the Governor. O.C.G.A. § 50-4-4. These councils may only act in an advisory capacity and do not have final rule-making authority. *Id.* Unless otherwise provided by statute, advisory councils may only exist for a set period of time and terminate when the Governor holding office at the time of a council's creation ends. *Id.*

IV. Revised SB 156 Would Impart Rule-Making Authority Over The Designation Of Trauma Centers To The Commission

With these principles in mind, it appears that Revised SB 156 would give the Commission final rule-making authority over the designation of trauma centers. As under current law, Revised SB 156 would authorize the Commission to act as an independent agency

and not as an advisory committee. Revised O.C.G.A. § 31-11-101; O.C.G.A. § 50-4-3(a). In addition, Revised Senate Bill 156 would give the Commission express statutory authority to promulgate regulations for the designation of trauma centers. *Id.* § 31-11-100(a)(3).

Although rule-making authority over trauma center designation is currently performed by DCH, this rule-making authority appears to derive from DCH's general regulatory authority over EMS services and there is no specific statutory rule-making authority over the designation of trauma centers in O.C.G.A. § 31-11-1 *et seq.* or O.C.G.A. § 31-2-1 *et seq.* or O.C.G.A. § 31-7-1 *et seq.* If enacted, the specific authority granted by Revised SB 156 would control over the more general rule-making authority of DCH in the matter of designating trauma centers. *Glinton v. And R, Inc.*, 271 Ga. 864, 866-7 (1999). It is also logical to conclude that if the General Assembly enacted Revised Senate Bill 156, the Commission could choose to alter the role of REMSCs in the designation process.

V. The Commission's Rule-Making Authority Is Not Subject To Approval By DCH

Under current law, the Commission's authority to adopt rules and regulations is not subject to the control of DCH. If the General Assembly enacted Revised SB 156, it is likely that the Commission would acquire final rule-making authority in those specific areas where the proposed bill specifically authorized the Commission to make rules. For example, Revised SB 156 imparts rule-making authority over the designation of burn centers and trauma centers. Revised O.C.G.A. § 31-11-101(2). In the absence of any express rule-making authority for such centers by another department or agency, the Commission would likely have final rule-making authority over the designation of burn centers as well.

As always, please let me know if you have any questions or concerns.

Yours very truly,

Alex F. Sponseller
Assistant Attorney General

cc: Commission Members
J. Patrick O'Neal, M.D., Director, Division of Emergency Preparedness and Response
Sidney R. Barrett, Jr., Senior Assistant Attorney General