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)*

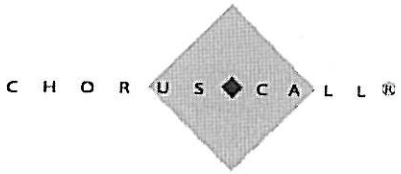
Dr. Ashley thanked everyone for his or her willingness to contribute and announced before closing the meeting that the Readiness Costs Determination Summit will be held 15 January from 10:00 am until 2:00 pm at the Atlanta Medical Center. In advance of the Summit, all attendees should consider the Readiness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

CHORUS CALL®

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

2420 Mosside Boulevard Monroeville, PA 15146 Tel: +1 412-373-6964 Fax: + 1 412-373-6967