



The quest for sustainable trauma funding: The Georgia story

by Dennis W. Ashley, MD, FACS, FCCM

Floyd Medical Center in Rome, GA, was the first trauma center designated by the state 29 years ago. Despite much effort by multiple stakeholders, we still do not have an optimal statewide trauma system. The best description of the Georgia trauma system was coined by J. Patrick O'Neal, MD, director, division of emergency preparedness and response in the Georgia department of community health, as "islands of excellence in a sea of chaos." Over the last 29 years, a total of 23 hospitals have been designated as trauma centers. Currently, Georgia has 16 hospitals that are state trauma centers desig-

Remarks made at American College of Surgeons State Consultation Review for the Georgia Trauma Care Network Commission. January 5, 2009.

nated by the Office of Emergency Medical Services and Trauma (OEMS/T), using the standards developed from the American College of Surgeons (ACS) verification criteria. There are four Level I, 10 Level II, one Level III, and one Level IV trauma centers. Two of the Level II trauma centers are pediatric only, while three of the four Level I centers have been recognized for their additional pediatric commitment.

Trauma center review

In 2001, the OEMS/T accomplished the first redesignation and review of trauma centers in the state. In 2002, the trauma centers received their first state funding in an annual appropriation of \$754,000 to provide registry data to the state. This

was a significant development, as it allowed all trauma centers to purchase the trauma registry of the ACS, known as National TRACS (NTRACS) and standardize data reporting to the state office.

The first funding for actual patient care came in 2006, as a \$1 million appropriation for uncompensated care, to be shared by all trauma centers. This was obviously an insufficient amount to support even one trauma center, and many of the centers were considering dropping their trauma center designation. Although much progress had been made with regard to trauma center designation and standardization of the trauma registry, there was no significant sustainable funding for trauma centers, emergency medical services (EMS), or trauma physicians. This lack of funding also prevented any statewide trauma injury data analysis or performance improvement projects, as the OEMS/T was grossly underfunded and could not provide the trauma centers any feedback on the state registry data. This prompted an outcry from the trauma community to Gov. Sonny Perdue and the legislators, noting that our state was in crisis and that immediate action was needed to save our trauma centers and develop a statewide system.

In response, the Georgia General Assembly created the Trauma Services Study Committee in 2006. This committee was composed of five members of the House of Representatives and five members from the Senate. They held five regional public meetings and heard testimony from state and national trauma experts. Their final report, released in the form of a white paper,[†] concluded the following: the Georgia trauma death rate was 20 percent worse than the national average; only 30 percent of major trauma injuries in Georgia were treated at designated trauma centers; traumatic death rates in rural Georgia were much higher than in the urban areas; and Georgia's trauma care providers (hospitals, surgeons, and EMS) delivered \$250 million in uncompensated trauma care

annually. The report recommended establishing a trauma fund, developing a statewide trauma system, and creating a trauma commission to provide oversight and accountability.

Battle cry

The committee report became a battle cry for the trauma provider and stakeholder community, as the above-average death rate translated into approximately 700 lives lost per year due to the lack of an organized system. Organized grass-roots efforts and focused communication strategies with the Georgia legislature culminated in the General Assembly passing S.B. 60 in 2007. This bill established the nine-member Georgia Trauma Care Network Commission (also known as the "Trauma Commission") with five members appointed by the governor, two members appointed by the lieutenant governor, and two members appointed by the Speaker of the House. The bill identified system stakeholders and mandated EMS, trauma centers, and trauma physicians be represented on the Trauma Commission. The charge of the Trauma Commission was clear: develop a statewide trauma system and formulas for the fair distribution of trauma funds to all stakeholders with regard to readiness costs and uncompensated care. Unfortunately, S.B. 60 came with no money allotted for the trauma fund. The Trauma Commission began holding monthly meetings, but was very limited in its function, as there was no funding. Simultaneously, Healthcare Georgia Foundation had contracted with a national trauma system financial consulting firm, Bishop + Associates, to assess the economics of the Georgia trauma system and to identify opportunities to stabilize and strengthen it for the decades ahead.

The Trauma Commission collaborated with Bishop + Associates to identify needs and assess the financial viability of Georgia's trauma centers. Surveys were developed for trauma centers to evaluate their financial performance. Compared with national data, Georgia's payor mix was lacking. In 2007, Georgia's commercial insurance was 39 percent, versus 51 percent for the national norm, and the uninsured patient population was 25 percent versus 18 percent nationally.[‡]

Readiness costs were also assessed by the

[†]Report from the Joint Comprehensive State Trauma Studies Committee (unpublished legislative subcommittee report). 2006 Legislative Session of the Georgia General Assembly.

[‡]Meeting results, Trauma Care Network Commission webinar, December 16, 2009.

survey for each trauma center. Readiness costs included all of the variables listed in Figure 1, this page. The total readiness cost for the four Level I trauma centers was \$20,807,997, with an average cost of \$5,201,999 per center. The total readiness cost for the 10 Level II trauma centers was \$23,255,227, with an average cost of \$2,225,245 per center. At the time of the survey, there were no Level III trauma centers in Georgia. In addition, treatment costs were assessed at \$220,684,574; total trauma center cost (readiness and patient treatment) was \$264,747,798; and the total patient care revenue was \$193,999,255. The survey revealed a loss on trauma center operations of \$70,748,543. It became obvious to health care providers that the trauma centers could not maintain the current level of participation without financial support from the state.

Governor Perdue responded to the Georgia trauma care financial crisis in January of 2008 by appropriating an initial one-time allocation of \$58.9 million from the state's general fund. The Trauma Commission had its funding—at least for one year. The overarching goal during that first year of funding was to stabilize and strengthen the existing trauma centers to prevent centers or physicians from dropping out of the system. Formulas were developed for distribution of funds to trauma centers and physicians based on readiness and uncompensated care costs. The Trauma Commission determined it could cover approximately half of the Level I trauma center readiness costs at \$2.5 million per center,

and \$1.5 million for each Level II center. These funding formulas to determine readiness costs were fairly easy to develop, as they were based on the level of designation. Uncompensated care funding required a much more sophisticated approach, as there were many more variables involved.

Treatment cost norms

According to S.B. 60, patients on the state trauma registry with no insurance were eligible for uncompensated care funding. To develop a fair and consistent approach for estimating costs for these patients, national trauma center patient treatment cost norms by injury severity were used for both community and academic trauma centers. These norms were developed over the past decade by the National Foundation for Trauma Care. In essence, the formula is composed of the number of patients multiplied by the cost norm for each level of injury severity.

This analysis was performed for each trauma center, and resulted in a total uncompensated care cost of \$38,787,061 for all trauma centers. This process provided a way to calculate the percentage of uncompensated care each trauma center performed, and distribute uncompensated care funds to each trauma center based on these percentages. Therefore, all Level I trauma centers received the same compensation for readiness costs, as the designation standards for all Level I centers are the same. However, each Level I trauma center received a different amount of uncompensated care funding, as each center treated different volumes and severities of qualifying patients. The same formulas were used for the Level II centers. The Trauma Commission also set aside \$4.1 million for Level I and Level II trauma centers in a competitive capital grants program. This allowed trauma centers to apply for funding for specific capital equipment or construction funds in regard to level of designation.

Trauma physician allocation for readiness was set at 25 percent of trauma center readiness costs. This was to ensure that physicians were compensated for being on call in a trauma center, as this was seen as a readiness cost to the center. The trauma physician uncompensated care component was set to 25 percent of trauma center uncompensated care distribution. As ac-

Figure 1. Readiness cost variables

Medical staff payments for trauma call
Twenty-four-hour operating room staffing
Higher staffing levels for lab/diagnostic services
Ground or air transportation
Support services
Injury prevention
Training of nurses and physicians
Administrative infrastructure of trauma programs
Physician extenders
Verification process
Trauma specific equipment

Table 1. 2008 trauma fund allocation		
Trauma center allocation	Amount	Percent of total
Trauma center readiness costs	\$17,888,539	30.4%
Capital grants for Level I and Level II trauma centers	4,148,602	7.0
Level IV trauma centers	200,000	0.3
Uncompensated care costs	17,888,539	30.4
Total trauma center allocation	40,125,680	68.1
Trauma physician allocation		
25% of trauma center readiness costs	5,962,846	10.1
25% of trauma center uncompensated care	5,962,846	10.1
Total physician allocation	11,925,693	20.2
EMS/prehospital allocation		
EMS competitive grant program	4,000,000	6.8
EMS uncompensated care	1,479,945	2.5
GPS and automatic vehicle location system	996,452	1.7
Total EMS/prehospital allocation	6,476,397	11.0
Oversight and system development		
Trauma commission/system plan and development	375,000	0.6
Total oversight/development allocation	375,000	0.6
Total 2008–2009 Georgia Trauma Fund	\$58,902,769	100.0%

Source: Allocation of Trauma System Funding. Georgia Trauma Commission meeting, June 9, 2008. Printed with permission.

Figure 2. Six immediate goals
Obtain permanent funding
Maintain and expand trauma centers: Focus on South Georgia
Strengthen EMS: Focus on rural regions
Trauma transfer and communication center
Trauma system infrastructure under Office of EMS and Trauma
Assure exceptional accountability

tual physician trauma uncompensated care data was not readily available, it was estimated that for every dollar of cost for the trauma patient, approximately 25 percent was provided by the physician. None of these funding categories covered all the costs for physicians or trauma centers.

To address the prehospital point of the trauma system care continuum, EMS received \$6.4 million, which included a competitive grant program for new ambulances in rural Georgia, an uncompensated care reimbursement program, and funding toward a GPS/automatic vehicle location system (see Table 1, this page).

After distributing funds from the one-time allotment for trauma care, the Trauma Commission worked on their second charge, which was to develop a statewide trauma system. This was developed through an aggressive assessment and planning process, including committed stakeholder input, ACS trauma system consultation, Georgia Health Policy Center economic analysis, the Healthcare Georgia Foundation report, and Trauma Commission monthly meetings and workshops. This intense and focused activity resulted in a five-year strategic plan consisting of 15 goals. The commission identified six immediate goals (see Figure 2, this page). Of these, the most important goal was to obtain adequate and permanent funding, as the \$58.9 million was only a one-time allotment.

Awareness campaign

A public awareness campaign was started by the Hayslett Group of Atlanta, GA, that used media coverage, editorial support, marketing, and public engagement to promote trauma education and the need for a trauma system in the state. This resulted in a formal website (<http://www.GeorgiaItsAboutTime.com>), which serves as a repository for all state trauma system awareness information. The statewide media response was highly supportive of the issue, as all these efforts resulted in 500-plus print, broadcast, and Web reports spanning 49 newspapers and 19 television and radio stations. We were beginning to gain public awareness, as evidenced by a University of Georgia survey conducted in 2007 on the willingness of Georgians to pay for trauma care. The poll (N=500) noted that 66.7 percent were willing

to pay at least \$25.⁸ The survey was repeated in 2008, and despite a poor economy, the number of Georgians willing to pay at least \$25 for trauma system development increased to 68 percent, and those willing to pay at least \$10 increased to 78.6 percent.

Funding

In 2009, multiple bills for sustainable trauma funding were presented at the General Assembly. Only one bill passed, which was the “super speeder” bill. This bill places a fine on moving violations that are dedicated specifically for trauma. The fine was an additional \$200 on moving violations more than 85 miles per hour (mph) on interstates, and 75 mph on two-lane roads, and increased the fines for reactivation of suspended driver’s licenses. This policy was estimated to generate approximately \$23 million annually, which would be used to maintain the trauma system under the direction of the Georgia Trauma Care Network Commission. This bill was the vision of Governor Perdue and is considered not only a funding mechanism, but an injury prevention bill, as it is hoped to change driving behavior and result in slower speeds on Georgia’s highways and roads.

The 2010 legislative session proved to be historic, as the general assembly passed S.R. 277. The resolution provides for a referendum that will go before Georgia voters in the November 2010 election. If passed, it will amend the Georgia constitution to place a \$10 tag fee for certain motor vehicle registration. All funds generated from this tag fee would be dedicated to trauma care and placed in a trust fund with some legislative oversight. This resolution is expected to generate \$80 million annually.

After many years and much effort by multiple trauma system stakeholders and providers, Georgia is on the cusp of having significant, and hopefully adequate and sustainable, trauma funding.

Keys to success

Each state has its own unique set of barriers to achieving trauma funding. There are many commonalities, however, that span across all states,

⁸Healthcare Georgia Foundation. Trauma care in Georgia: Georgians are willing to pay for a statewide system. *HealthVoices*. 2008;23(2).

and if used appropriately, will lead to success. Each state must identify the need for trauma system development or improvement and translate this into their battle cry. For Georgia, this battle cry was the above-average death rate as compared with the national average. Once we identified our need, we were able to recruit multiple groups of stakeholders, as everyone can identify with developing a system that would save lives.

It is imperative that trauma surgeons do not try to develop a system or obtain funding on their own. It was not until our surgeons joined forces with EMS, the Georgia Hospital Association, the Medical Association of Georgia, nursing associations, the Georgia Chamber of Commerce, state and local governments, and, most importantly, the public, that we started to be heard at the state capitol. This allowed us to present a consistent, unified message that trauma system funding and development was important for all Georgians. □

Acknowledgment

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Dr. Ashley is director of trauma and critical care, Medical Center of Central Georgia, and professor of surgery, Mercer University School of Medicine, Macon, GA. He is also chair of the Georgia Trauma Care Network Commission.

