FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL

FLORIDA DEPARTMENT OF HEALTH

2555 Judge Fran Jamieson Way
Viera, Florida 32940

May 24, 2018
Commencing at 9:00 a.m.

Present: David Summers, R.N.
Mark McKenney, M.D.
Zeff Ross
Malcolm Kemp
Joseph Ibrahim, M.D.
Robert "Larry" Reed, M.D.
Donna York, R.N.
Darwin Ang, M.D.
Nicholas Namias, M.D.
Lisa DiNova, R.N.
Glenn Summers, M.D.
Brad Elias, M.D.

Also Present: Leah Colston, Bureau Chief, Em. Med. Oversight
Cindy Dick, Assistant Deputy Secretary
Amanda Bush, Esq., Office of General Counsel
Kate Kocevar, Trauma System Administrator
Michael Leffler, OMC Manager

Court Reporter: Elizabeth J. Beyer, FPR
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MS. COLSTON: We do have a few folks here, it looks like, attending from the public, so we are very excited. This is our first Florida Trauma System Advisory Council meeting. We're very excited about this.

We do have a court reporter here today, which is standard with all of our advisory council meetings, so we would ask, for the purposes of our court reporter and for people attending on the phone, that you please use the microphones that are available. If we have to pass them, we'll try to be proactive and get the microphones where they're needed.

We are definitely looking forward to setting up the council today. It will be a primarily administrative meeting for us today as we look to solidify our bylaws and work through our plan of action at least for the next year.

We have some activities by statute that we're going to be required to do by December 31st, so we have some priorities that are already set.

We are going to be looking forward to receiving recommendations from you about what our other priorities will be, as far as addressing some things in the trauma system and looking at areas that we can work on. I know there are a lot of good ideas that are ready to be floated. We want to get those documents as well, and start thinking about how we can begin to address those things.

I'd like to introduce Dr. Maria Stahl. She's a county health officer here. Her team and herself has been gracious enough to allow us to use this facility for our first meeting. So, Dr. Stahl?

MS. STAHL: Thank you, Leah. I know there's many physicians here, but I'm not a physician. I'm a nurse NP doctor, just to clarify.

Welcome to Brevard County. I'm glad that we were able to host you all here. I don't know if any of you have been to Brevard County before, but it's nice and sunny yesterday and today. It's going to probably be rainy after today. We have had ten days of clouds and yuck, but it really is a beautiful county with 72 miles of coastline.

I hope you found us okay. I know there are some here that drove this morning from Tallahassee. Oh, my goodness, I don't think I could do that.

Welcome. It's wonderful that you're all volunteering and are willing to get together and look at the trauma system here in the state of Florida. It's just wonderful. If there's anything we can do, if there is anything you ever want to use this building for, it's open anytime you guys want it. We host a lot of state meetings, a lot of local meetings.

For anyone that needs the restroom -- if you haven't found them already -- it's out in the lobby. Men's

is to the left; women's to the right, just before you go through the front door.

You're welcome if you ever want to come and see the rockets, enjoy the space center, go to Port Canaveral and take a cruise. We're here for you. I was just telling Leah that I'm going on a cruise tomorrow, a three-day cruise. It's going to be nice and rainy, so I don't know if I'm going to enjoy it.

But welcome to Brevard County. I'm going to hand it back over to Leah.

MS. COLSTON: For the court reporter's benefit, my name is Leah Colston. I am the bureau chief for emergency medical oversight. I know most everybody here, but just for the record. We'll also introduce Kate Kocevar in the back, the trauma system administrator. Amanda Bush, who is with our general counsel's office. Our interim division director, Doug Woodlief. Raise your hand, Doug. Our assistant deputy secretary, Cindy Dick, is here as well.

Special recognition, Michael Leffler, who is also with the trauma program at the state. He's been very active in coordinating all of this.

So I guess we'll go ahead and get started. Would you please rise for the Pledge of Allegiance?

(Pledge of Allegiance.)

MS. COLSTON: Thank you.

MR. LEFFLER: Are we going to do some council introductions?

MS. COLSTON: If we could, since this is our first official council meeting, I want to kind of just go around the table. I have already introduced our staff. If you could each give an introduction and what your representation is, and then we'll also acknowledge our members, other members that are here as well. Starting here with Dr. Elias.

DR. ELIAS: I'm Brad Elias. I'm an emergency physician in Jacksonville. I guess I represent the nontrauma hospitals. Baptist Medical Center is a large community medical center in downtown Jacksonville, primarily stroke and cardiovascular hospital, but we get our share of traumas, and transfer out.

I also served as a medical director for Jacksonville Fire Rescue, one of the largest fire rescue departments in the state.

DR. SUMMERS: Glenn Summers, from Sacred Heart Pensacola. We are a pediatric and Level II trauma center. I also teach residents. I'm representing the Panhandle, and happy to be here.

MS. DiNOVA: Hi. I'm Lisa DiNova. I am the Florida Hospital Association representative on this council. I am from St. Joseph's Hospital in Tampa. We're an adult

Level II and pediatric trauma center. I'm excited that we get to have this council reinstated.

DR. NAMIAS: I'm Nick Namias. I'm from Jackson Memorial Hospital. I was appointed as the member of the community on trauma with pediatric surgical experience, but my main role is I'm a medical director of a not-for-profit Level I trauma center.

DR. ANG: My name is Darwin Ang. I'm the trauma director of Ocala Regional. It's a Level II trauma center, both state- and national-verified. I represent investor-owned trauma centers in the state of Florida.

MS. YORK: I am Donna York. I'm from UF Health Shands Hospital in Gainesville, and I'm representing the nonprofit trauma program managers.

DR. REED: Larry Reed. I'm from IU Health Methodist Hospital in Indianapolis. I'm an acute care surgeon there. I am the state trauma medical director. By virtue of my position, I cannot live in the state of Florida.

DR. IBRAHIM: Joe Ibrahim. I work at Orlando Health as trauma medical director. I'm here in the role of trauma surgeon working at a Level I center.

MR. KEMP: Mac Kemp. I'm deputy chief of Leon County EMS. I'm here to represent Florida EMS Advisory Council.

MR. ROSS: Good morning. I'm Zeff Ross. I'm the executive vice president with Memorial Healthcare System and the CEO of Memorial Regional Hospital. I represent the Safety Net Alliance. Thank you.

MR. SUMMERS: I'm David Summers. I'm the trauma nurse outreach coordinator for the Trauma Agency for the Health Care District of Palm Beach County. I represent the trauma agencies.

MS. COLSTON: We have a couple of attendees in the room. We'll go ahead and introduce them.

MS. HOLZER: Kathy Holzer, Safety Net Hospital Alliance of Florida.

MS. STRENTH: Michelle Strenth, Orlando Health.

MR. SPIVEY: Rob Spivey, Holmes Regional Medical Center.

MS. COLSTON: Thank you. I know we have several attendees on the phone. In the interest of time, we will not open the phone line at this time. This is a publicly noticed and, of course, documented meeting, so there will be an opportunity, based on what we have on the agenda, for public comment. We do have speaker cards in the back for the attendees that are in the room. Those attending by phone, if you wish to make a public comment please send an e-mail to Kate.Kocevar, K-o-c-e-v-a-r, @FLhealth.gov, for the attendees on the phone.

We're going to go ahead and move forward. Just to kind of give you guys an overview -- you have the agenda in front of you. This is our first meeting, and our goals today will be to go ahead and set the foundation for the function of the advisory council as well as to get some draft bylaws or some good draft bylaws that we can submit to our legal folks so we can get those approved and done. Those will be the bylaws that you all operate as a council by, so you want to have some good documents.

We have developed a draft based on other advisory councils that we currently have, I think the EMS Advisory Council. But we'll take a look at those, we'll go through those. We will make sure that operationally those work for this council. Then we're going to go ahead and try to get those finalized once we leave here.

We also want to work through a charter, which is actually documenting what this council is developed to do. It's also going to, more importantly, lay out our tasks for the next year. Typically a work plan or charter is good for a year. We can extend it, we can amend it however you all want to, but for this first year we know that we have some work that we need to do.

So we want to go ahead and look at the other things that we might be able to complete in this year. We'll have the draft developed, hopefully the final draft. We do have

a finite amount of time to do that in. No rush, because we can develop a draft. We can all go and digest it, and in another week we'll collect comments, and then we'll finalize something that we can move forward to.

Primarily those are the things that I really want to try to get through, so we can all have a good path moving forward on what the council intends to complete over the next year. Some things we already know are in the statute. There are other priorities that we may want to outline as well, so let's think about that.

As part of our orienting you to your duties on this council, we're going to have a presentation from our general counsel's office, by Amanda Bush. There are very specific laws that govern the activities of this council, including communication between members. Some of you are already familiar with these rules and responsibilities, but we want to make sure that we're giving everybody the same information right offhand so we can move forward.

At this particular point in time, Amanda is going to talk to us about our sunshine laws.

MS. BUSH: It's a thrilling, thrilling topic. Hopefully I won't make all you guys fall asleep this morning.

So government in the sunshine of course is a very important part of your responsibilities on this council.

Florida's Government in the Sunshine Law is found in Chapter 286 Florida Statutes, and Article 1, Section 24, of the Florida constitution. Both provide a right of access to governmental proceedings of public boards.

The sunshine law applies to any board or commission of any state agency. It includes elected and appointed boards and commissions, advisory boards and committees. Private organizations that have been delegated authority to perform a government function or that play an integral role in the decision-making process of an agency have also been found to be part of the -- required to comply with the sunshine law.

I'm sorry. I have some notes here which unfortunately don't show up. So there are some limited exceptions. If the board or committee is only for the purpose of fact-finding, not making any recommendations or decisions to the agency, those are not -- those do not follow the sunshine law.

All right. So requirements under the sunshine law. This is found in Section 286 of the Florida Statutes. All meetings of public boards and commissions must be open to the public at all times. Reasonable notice of such meetings must be given, and minutes of the meetings must be taken and open for public inspection. That's part of the public records law, which we'll touch on at the end of this

presentation.

So what triggers the sunshine law? When two or more members of a board or commission -- or council, in your situation -- are gathered together to discuss issues on which foreseeable action or recommendations may be taken by the council. Telephone calls between members are included. This applies to all functions of the board and commission, including formal and informal functions.

So not only official votes and recommendations, which of course would be the formal actions, but also any sort of deliberations or discussions which lead up to those formal actions are also included.

You cannot use nonmembers to act as liaisons to get around the sunshine law. You may not engage in written correspondence, including e-mails, regarding council matters. Of course there is an exception to that. Reports can be circulated, again, with the understanding that any sort of discussion or comments must be had at a publicly-held meeting. Of course that written report is subject to public disclosure under public records law.

Council meetings may be conducted by telephone conference, as long as the procedural requirements are adhered to; and, of course, a quorum of the members must be present on the call.

Council members can attend social events where

there may be more than one council member. Of course, the important thing there is that you don't discuss any matters that may come before the board or are presently before the board for consideration.

One of the procedural technical requirements: reasonable notice, including time; place; agenda, if available, or a statement of the general subject matter to be considered. Those notices must be published seven days in advance of the meeting, unless there's an emergency session. Notice should generally be published in the Florida Administrative Register, and also needs to be physically posted in a location where the public may have access to it, or placed on the agency's website.

Meeting minutes should be kept; can be a brief summary or memorandum reflecting the events of the meeting. Verbatim transcripts are not required, although sometimes we may elect to have that. Minutes should capture all members in attendance and their votes and/or recommendations.

If the meeting is being held by conference call or conference call participation is allowed, then the notice should include any conference call number and any required passcodes.

As far as the publication of the notification, department staff takes care of that and assists with that function.

We must allow the public a reasonable opportunity to be heard on board actions before any sort of official action, such as a vote, is made. You may set reasonable rules and policies for conduct at a public meeting, to ensure orderly conduct. You can limit comments to items on the agenda. You can allow for reasonable time for the length of comments. And you should, of course, have a large enough space to accommodate attendees.

Avoid -- again, these are just kind of some general things. Avoid inaudible discussions. Open to the public means everyone: staff, media, public, everyone. You cannot prohibit the use of nondisruptive recordings.

If a council meeting is adjourned and will reconvene at a later date, you have to notice that second meeting.

Penalties. Courts interpret sunshine laws liberally, and exceptions very strictly. Actions taken at meetings held in violation of the sunshine law are void. There are ways to correct that, but generally the recommendation, of course, is don't do it.

Public officers who violate can be found guilty of a noncriminal infraction, and fined up to $500. Members who knowingly violate can be found guilty of a second-degree misdemeanor. That would include violations that occur outside of the state. And that second-degree misdemeanor

may be sentenced to prison, not to exceed 60 days, and/or a fine up to $500.

Let's talk a little bit about, what is a public record. So you see here a laundry list. This includes documents, letters, maps, et cetera, regardless of the physical form in which they exist; electronic records, e-mails, text messages, handwritten comments, regardless of their location, whether it's on e-mail, it's in a file somewhere; those are public records if they're made or received pursuant to law or ordinance in connection with a transaction of official business.

So generally the courts have found that any material used to perpetuate, communicate, or formalize knowledge is a public record. Agendas, meetings, materials associated with this council are public record. The record does not need to be in the final form; it may be a draft. If that draft has been circulated for review or comment, that is considered a public record.

Situations where you may have a private entity that is subject to the sunshine law, those records in possession of that private entity will also fall under the requirements of sunshine.

E-mail and text messages in connection with council business, regardless of what phone or computer you're using, are considered to be public records.

So what is not? As I hinted at before, personal drafts or notes that you may take for your sole use are not a public record. As I mentioned, if those drafts or notes are communicated to one another or used in any way to perpetuate, communicate, or formalize that knowledge, it is a public record.

Personal e-mails and records that are not related to official council business are not public record. But, again, be careful with that, because your personal e-mails, especially if you have it on your business system, your work system, could still be subject to review under public records, to make sure that all of the public records have been disclosed. Again, because public records are interpreted broadly, the possibility exists that e-mail you believe is private could be determined to be a public record.

Also, a record not in existence. So do not create a record to summarize or explain other records in response to a public records request. If you do create that record in response, that becomes a public record.

So just in general, tips. Consider each council-related e-mail to be a public record. Don't mix your personal and council records or your personal and council e-mails and texts. Again, text messages are public records. I suggest avoiding using text messages for that

purpose.

Do not destroy public records. Of course, as you may be familiar, we have the public records law under Section 119.07. Every person who has custody of a public record shall permit that record to be inspected and copied. So no purpose or reason is to be given by the requestor for asking for those records. If they ask for it, we don't get to ask them why they want it. They are not required to be in writing.

Then we'll touch on what happens if you violate the public records law. They allow for an immediate hearing upon filing of court matters. If the court finds that the agency has withheld, you have to comply with that court order within 48 hours. Reasonable costs and attorney's fees will be assessed if the public record was unlawfully withheld. Violations (sic) are guilty of a noncriminal infraction and a fine up to $500. Again, a knowingly violated public records law is subject to suspension and removal. A person who commits does commit a first-degree misdemeanor, which will subject you to a year prison, a fine of $1,000, or both.

So that is a very brief kind of overview. The First Amendment Foundation publishes a Government in the Sunshine manual, which is a very helpful resource. You can find it here at their website. They also have it online as

well as in the printed version.

Any questions?

DR. IBRAHIM: So if we have a Florida Committee on Trauma Meeting -- because there are several of us here that attend those meetings as well -- and some of the same issues come up, how does that apply? Is that considered a public meeting?

DR. NAMIAS: The Florida Committee on Trauma is not a public government meeting, but I suppose now if you and I are there we can't discuss the business of this council, but as the chair of the committee I could probably stand at the podium and present what happened at this meeting, right, without public notice?

MS. BUSH: Correct.

DR. NAMIAS: But you and I, and anyone else that participates in this committee, can't -- Darwin also --

DR. IBRAHIM: We couldn't even openly discuss -- like if you were saying something and I had a question on that? That's kind of my concern.

DR. NAMIAS: I would interpret that, for fear of prison, as no, because I present it informationally. I suppose -- I don't think it would be a proxy if others who are not on this council discussed it at COT, but the three of us and anyone else who comes to COT couldn't participate in that discussion; is that fair?

MS. BUSH: That would be the recommendation, always proceed with caution, you know, err on the side of caution perhaps. Again, nobody wants to go to jail.

Any other questions?

MS. COLSTON: Dr. Ibrahim, we will, as part of council activities, set up commons hours. We're going to set those up regularly, especially in the interest of fostering an environment where you guys can do the work that you need to do, where these discussions and formal discussions can be held. We will still notice them publicly, but it will be an opportunity for you guys to get on this call and able to have discussions that you need to.

Yes, ma'am?

MS. DICK: I have a question in general. I know some of our council -- sometimes our councils e-mail each other. They will e-mail the whole group, thinking they're not having individual sidebar meetings. None of that information is public notice. Is that permissible activity? Can they discuss, as a group, outside of publicly noticed meetings --

MS. BUSH: No.

MS. DICK: That includes e-mail, phone calls, anything like that?

MS. BUSH: Right. Exactly.

MS. COLSTON: Typically what we've done is, if

there's a message that needs to go out to the group, we, as administrators of the group, send it out to the broad group. We set up a time where we can talk about whatever was sent out.

So there's a lot of formalities. We're pretty used to negotiating and navigating all these different things. We're going to facilitate that, make sure you guys have the opportunities that you need to talk. At any point in time you can call us and say, hey, we think we need to have a call or a commons hour. We can set something up. We're happy to facilitate that, as well. Just keep in mind that we do have to notice these things at least seven days in advance, you know, unless it's an emergency. I don't know what would constitute an emergency.

MS. BUSH: Well, that's a whole other discussion.

MS. COLSTON: We will always set something up, and we can do it as regular as weekly right now if you guys want to, in the interest of getting this set up. It's not going to be mandatory attendance, but it will give you an opportunity, if you guys do want to talk about business, you can call into that number, and we'll leave the line open for however long and have someone on there to facilitate whatever it is that y'all need to get this thing going.

I see Dr. McKenney just came in. We had introductions, so I'll give you the opportunity to be

introduced.

DR. McKENNEY: Mark McKenney. I'm the medical director at Kendall SM.

MS. COLSTON: Thank you so much.

So next we're going to talk about what brought us here to this state. You guys know that we had House Bill 65 that was successfully passed, giving us the ability to have a trauma system advisory council with some defined roles. We're very excited about that. It does more than just that, but that is one of the key things that it does do.

We want to talk about -- a little bit about the statutes, not necessarily so much the rules. There are rules that govern us. I'm sure many of you are aware of those rules. We do want to talk about the statutes as they relate to the rules and responsibilities of this council.

I keep talking about an assignment that is due at the end of the year. That is one thing that's outlined in the statute, that we do have to do. We will facilitate the completion of that study with you. You guys can estimate -- we'll make sure we create some dates and deadlines, so that we can successfully get that submitted.

Kate Kocevar, our trauma system administrator, is going to come up and talk to you about the rules and statutes that kind of govern our council and all the activities that relate to trauma.

MS. KOCEVAR: Good morning, everyone. My name is Kate Kocevar. I am a trauma system administrator. I get the pleasure of discussing the wonderful things in the Florida Statutes, rules, and standards.

As indicated, House Bill 65 gave us this advisory council that we sit here today with. Part of that is to really go through and find out what exactly the statute empowers this council to do. As indicated, we talked about homework assignments, and we do have one. This one is due by January of 2019. That is for us to take a look at a pediatric study. So that, unfortunately, is our first homework assignment as this council.

That said, let us kind of take a look at our slides here and go through things. All right. So this is going to be Florida constitutional statutes. You can probably see that. Okay. So the role of the Department of Health. People wonder who we are sometimes, so this is who we are. Chapter 395, Part 2 of Florida Statutes: to plan, establish, and maintain an inclusive trauma system. In that, what we look at is defined roles for trauma centers and acute care hospitals. Part of that, as we talked about with the standards and rules that we have, we have these things that allow us to go in and look at facilities, make sure everything is flowing properly. So you wonder why we do come in, this is part of why we do.

We establish local and regional trauma systems designed to meet the specific needs of the population, actively foster the provision of trauma care, and serve as a catalyst for improvements. I think everybody wants to continue to make our trauma centers the best here in this state.

A statute means a codified law that's enacted by the Florida legislature and approved by the governor. Chapter 395, as I talked about, are the Florida Statutes that govern the Florida trauma system.

Rule means each agency's statement of general applicability that implements, interprets, or prescribes law or policy. So a lot of times we talk about the rules. We have to say, look, we have these statutes. Does the statute give us the authority to make the rules? Those are one of the things we have to look at, do the standards fully connect with one another. A lot of times when we've found ourselves saying, well, we'd like to do something different; here's the standard conversation that would come back, that would say, well, do we have statutory authority to make a new rule? Do we have statutory authority to essentially change a rule? Those are things that we have to kind of work on with this council, and just advise them when they come up on issues of whether it's provided in the statute or whether they have rule authority to do such a thing.

The statute must grant the department authority to make a rule, as I said. Rules must be adopted using the statutorily prescribed process. So there is a process. We don't just sit down and make a rule, and say, that's what we want to do. There's an entire process. There's a hearing, public notice, this type of thing before really a rule can be fully developed. Then, as you can imagine, it goes through general counsel to ensure that we have that statutory authority to be able to implement that rule.

Rules may not enlarge, modify, or contravene specific provisions of the law implemented. Rules must be supported by logic or facts. Rules may impose requirements or solicit information not specifically required by the state.

Chapter 395, this is the statute that we were referring to. First and foremost we're just going to do the brief topics of the statutes; we're not going to go into extreme detail into all the statutes. The first one is 395.40. It says: legislative findings of intent. That is actually the title of that particular section. It requires the establishment of an inclusive trauma system designed to meet the needs of all injured trauma victims who require your care; encourages the Department of Health to actively foster the provision of trauma care, and serve as a catalyst for improvement. As you can see, there are some words that

keep coming back each time we look at these things, and "improvement" is one of them.

The next section, 395.401, trauma system service plans; approval of trauma centers and pediatric trauma centers; procedures; renewal. A long topic title, but it allows the department to adopt standards for verification of trauma centers, based on national guidelines, including those established by the American College of Surgeons.

So in the book that you have here today, you'll see that the standards are in the back, 1150-9, which are the standards that we use when we come into a trauma center. Those are the standards that you will use when you set your trauma centers up, and follow what's in there.

We also have an outline that requires for the establishment of local and regional trauma agencies. As you know, we have some in our -- there are some agencies here in the state of Florida, and others that are in the process of developing one. So those rules also kind of are an area to guide them.

395.4015 is state and regional trauma planning and trauma regions. This requires the department to create a state trauma system, plan and use the state trauma system plans as a basis for establishing a statewide inclusive trauma system. It directs the department to use the Regional Domestic Security Task Forces, also known as RDSTF,

use them to develop regional trauma agencies.

Now, 395.402, legislative findings and intent. This assigns counties. As you're aware with Bill 1165 we went from 19 counties to 18 counties, combined one. So we are down to 18 now. It allocates the number of trauma systems to each TSA, and establishes the Florida Trauma System Advisory Council. This is where we come in. So that was the rule that kind of came through here.

One of the things that I want to kind of specifically read from the actual statute that was written indicates that when the decision to apply to create the Florida Trauma System Advisory Council -- it specifically noted, "to promote an inclusive trauma system and enhance cooperation among trauma system stakeholders. The advisory council may submit recommendations to the department on how to maximize existing trauma center, emergency department, and emergency medical services infrastructure and personnel to achieve the statutory goal of developing an inclusive trauma system."

That is what the advisory council's basis is. That is kind of like your motto. This is what you're going to be handling. It's important to realize as an advisory council group you can certainly provide a lot of leadership, but we must ensure to include all stakeholders when these ideas come through the council, and make sure we address everyone

equally in that way.

All right. 395.4025, trauma centers; selection; quality assurance; records. It delineates the trauma center selection and designation process. It requires the department to conduct an analysis of the Florida trauma system by August 2020, and every three years after that. It grants authority to the department to collect trauma registry data, so that's still part of the statute, the registry is still part of that.

Trauma payments, which is Section 395.4036, directs the distribution of red light camera and other traffic fine revenues to state-verified trauma centers. Funds are to ensure the availability and accessibility of trauma services throughout the state. The statutory reference now requires the department to use the Agency for Health Care Administration -- also known as AHCA -- data to evaluate trauma patient volumes.

Reviewing trauma registry data -- this is Section 395.404 -- requires that all trauma centers participate in the National Trauma Data Bank. The use of what we call the NTDB data is limited to quality improvement and trauma system assessment purposes. It directs all trauma centers and acute care hospitals to report all transfers of trauma patients and the outcomes. Just remember when you're filing this NTDB, that's what you'll be

filing through the state trauma registry.

395.4045, emergency medical service providers; trauma transport protocols; transport of trauma alert victims to trauma centers; interfacility transfer -- also known as TTP, so you know that language. That establishes the requirements for EMS providers and trauma agencies for the development of trauma transport protocols. It directs the department to develop trauma triage scoring for adults and pediatrics. In this section you'll be able to see that it's outlined very clearly about what measures those adult scorecards and pediatric scorecards.

So that is a little bit about what we have to work with in our division. We want to make sure that we stay within all the statutes, rules, and standards. As the council gets underway to the business at hand, we are here to guide you through that. We just have to make sure that we continue to use these boundaries that we have, and we work within them in order to establish council activity or recommendations that you want to provide to the department, so that we know that meets all the standards that we have here.

Does anybody have any questions?

DR. NAMIAS: Will these slides be posted on the DOH website?

MS. KOCEVAR: They're already on there. All right.

Thank you very much. I appreciate it.

MS. COLSTON: Thanks for that question, Dr. Namias. We did post on the trauma website all of the documents we are handing out today. For those who are accessing those documents, please remember these are all drafts, but in the interest of putting out public documentation we will always post our documents on the website. Those things are subject to change. Once we revise those, we'll walk away today with some new draft language and we will relay those documents with the new updated drafts, so everyone should always have access to those.

Typically no more than a 24-hour delay, but sometimes we have issues, so we will try to stay on top of that as best as we can, and also send things out by e-mail. That makes it easier for everybody. Just in the interest of ensuring that gets out, we will send everything to council members. Again, these are public records so you may forward them as you see fit. We're probably going to go ahead and do that as well.

So, no other questions about statutes and rules? Great. So I'm going to change the order of the agenda a little bit. Sorry, Amanda. We will still cover the same content -- I'll just put that as a qualifier. We're going to talk about bylaws next. We are getting ready to move to the section of this council meeting where we're going to

look at our bylaws. Understand that the bylaws that you have in front of you are simply a draft, so your input is appreciated and desired. If you see something in here that you're uncomfortable with, this is the forum and we will change things as we need to. But these are drafts. We currently use a very similar model for our EMS Advisory Council. This is a template that has been vetted thoroughly by our legal office, so it contains a lot of the required elements in there.

Michael Leffler is going to talk to you about that a little bit. There are some differences between the EMS Advisory Council structure and this particular advisory council structure. But, again, any input that you may have or ideas that you may have to make these bylaws a good operational document for you, we'll welcome those comments. Mike?

MR. LEFFLER: Good morning. There should be a handout for each of you there, that has a copy of draft bylaws. I'm going to walk through it a little bit, and just let you know where we came from and where we're going with some of this stuff in each article.

The difference between EMS bylaws -- we looked at several different councils and commissions that the department does. We incorporated ideas that we thought would best work for this council. Ultimately, the bylaws

are by and for this council, so this is a draft. We are looking for input and change. Our hope is to give you a little bit of a chance to look over these as we go through them; and when we meet again in July we hope to take that up as the first order of business of the council, would be to vote in approved bylaws.

Article 1 talks about naming the council. In statute this is the Florida Trauma System Advisory Council. We came up with the shortened name of FTSAC or just Council as a short name. FTSAC is not the most audibly pleasing name, so there may be some opportunity for improvement there.

Council composition and membership. Council membership is outlined in statute. Council members are appointed by the governor, and, you know, we've aligned with that. Council membership is voluntary. The statute also says that we cannot reimburse you for travel and per diems to participate in council activities; however, if you're a Department of Health employee and would otherwise receive compensation outside of council, certainly there's nothing to prohibit you from getting reimbursement for activities that you otherwise would have gotten reimbursed for; but you cannot be reimbursed for travel or per diem for council activities.

Attendance requirements: Council members who fail

to be physically present for two consecutive or three total regular meetings within their term shall essentially be considered to have abandoned their position, and it may be reappointed. I know that you guys are all very busy. There's lots of scheduling conflicts. The department will work with you all to find meeting times that work for all of us.

Article 3 is the council's purpose. We've outlined six items that we have felt, you know, truly embody the idea of what the department and the division of the council is doing. I will let you guys do that. That's another opportunity where we can possibly enhance the division of the council.

Article 4 is officers. This is probably an area where we change the greatest from EMS and some of the other councils that you may be familiar with. We're appointing a moderator and a secretary, two officers. The moderator will essentially chair the meetings, will be responsible for facilitating the meetings, working with the department on agenda setting, but doesn't have the normal powers we have given to chairmen of other advisory councils.

The secretary, the role of secretary is going to determine the presence of a quorum. Will be in line with the normal duties of a secretary under Robert's Rules of Order. The council can adopt additional officers. Looking

at this, we didn't see a need to do that at this time. If you guys have visions for additional officers, we would certainly like feedback in terms of that.

All members of the council are eligible to serve as officers of the council, so whether -- whatever your affiliation, it does not prevent you from being an officer on the council.

Role of the Department of Health. The Department of Health is directed under Florida statute to administer the council. So we will work to provide meeting space; do the scheduling; public notices; agenda setting. We will facilitate the activities of this council. That is our role. Ultimately council business that we come together and put in our charter is the responsibility of the council, but we will help you put the meetings together, and we'll help make the council activities happen.

There are a couple of different kinds of meetings. I just want to kind of run through them. Regular meetings, the statute requires us to meet at least quarterly, so those will be our regular meetings. If there's need to have a formal meeting outside of the quarterly meeting, we'll call those special meetings. They're required to be noticed seven days in advance. We are going to try to provide as much advance notice as possible for those meetings, to ensure that everybody has the opportunity to facilitate.

There are more people, obviously, that need to facilitate than just the council members. We hope to get everybody in the trauma community to be engaged in council activities, so, you know, we will put that notice out as soon as possible for regular and special meetings.

Emergency meetings are very complicated, but there is a procedure in Statute 120 that allows us to schedule emergency meetings. This is determined if there is a public health emergency or something that affects the safety and welfare in the state of Florida, there is a procedure for us to schedule emergency meetings.

I want to talk about the commons hour concept. What this is, is an idea where we provide a telephone line, or a meeting space, or both. The council doesn't take any official action. It's an informal opportunity for council members to dialogue and take up council business informally. Anybody can listen in. Anybody can participate, but it allows -- I think it will facilitate some of the work of the council inside of the sunshine, and be as least disruptive to everybody as possible.

What we would require is that you guys come to us and say, we'd like to have a meeting to discuss trauma transport protocols, or whatever the issue is. We can go ahead and notice those meetings with an agenda. The agenda will simply say "informal discussion," so there's an

opportunity to deviate from there. But I think it provides us an opportunity to have constant dialogue in the sunshine.

MR. ROSS: Excuse me. A question: If indeed public attends that meeting, since it's publicly noticed, are they permitted to be part of that discussion as well?

MR. LEFFLER: The question is, is public participation allowed during those meetings? Yes. This is an informal opportunity. The stakeholders obviously have business that's affected by -- whether it's council subcommittees or other things that are going on, so we encourage everyone to participate.

MS. COLSTON: However, the same rules apply. They will complete a speaker card and be able to provide public comment at the end.

MR. LEFFLER: Correct.

The next article is Article 6. It relates to committees, subcommittees, and ad-hoc workgroups. Council can create its own committees and subcommittees as they need. We would like to work together to keep council subcommittees anchored on the charter of the missions of council, so we want to kind of have some oversight and thought when we create these subcommittees. But the council has the opportunity to create those committees. It should be headed by a member of council, and are generally made up of three to ten persons. Subcommittees are two to five

persons. It just needs to be a member of the committee, so if you have someone who is not a council member, they can head up a subcommittee. Ad-hoc workgroups are designed for special assignments.

Annually, council will create a charter. We'll work with the department to create a charter. This will guide the activities of those committees, subcommittees, and workgroups.

Article 7 just says that the council will approve bylaws by a two-thirds vote.

Anyway, we'd like you guys to look over this in the next couple of weeks, and provide input. My hope is that when we come back together in July, this can be the first order of business of the council so that we can set up and institute rules that we need to function.

Are there any questions?

DR. ELIAS: I just have a question regarding subcommittees. So if two and three committees are doing work, how does that affect sunshine?

MR. LEFFLER: If there's a subcommittee and there are two people who are not appointed to the council doing work for the council, is that considered sunshine activity?

DR. ELIAS: Or even if they are council members.

MR. LEFFLER: If they are council members, it would certainly need to be public notice.

MS. BUSH: Certainly. Absolutely. So we're talking about a subcommittee. If they're talking about issues that are going to foreseeably come before this council or are before this council, then it either needs to be publicly noticed, or you need not to discuss it.

Again, if it's a subcommittee, there certainly could be nuances if there's a subcommittee that comes out of this group.

MR. LEFFLER: The department is going to notice, err on the side of caution, all meetings that are related to council business.

DR. NAMIAS: So I sit on the Florida EMS Advisory Council, which Mr. Kemp chairs. As an outsider to government coming in, this thing is serious. Basically, if you're going to talk to somebody else about anything to do with this committee, it's got to be in the sunshine. It seems onerous, but if you think about it, it's probably a good thing; it's just a little difficult.

MS. COLSTON: Again, we will pretty much facilitate as we need to, as we need meeting time. We're going to establish a schedule of meetings today, so those will be opportunities, especially with the commons meetings, that we can set up where you don't have to be there, but if you want to talk about stuff you can.

MR. LEFFLER: And a copy of these bylaws is

available on the Florida Trauma System Advisory site.

DR. NAMIAS: I have a bunch of -- first I want to thank you for -- although these were provided sort of last-minute, thank you for providing a few weeks now to go over these, so that we're not just pushing these things through today.

But this is the only chance to talk about it with council, so I'd like to make a few comments that people might want to think about. I guess we'll need to know and have as part of this what will constitute a quorum when we get together. If three members show up and two vote, does that count? I don't know if that's a state law, or rule, or whatever, but --

MR. LEFFLER: I believe the quorum question is addressed in there. I believe it's 50 percent plus one. If not, we certainly can add that.

DR. NAMIAS: It did say that some things would be voted on by 50 percent plus one. The reason we got to this place where we are now is because of the contentiousness there's been in the state for the last almost ten years now. So 50 percent plus one would allow there really to be voting blocs without consensus.

I think we should adopt something like two-thirds or 75 percent, so that way even if there is a bloc it would require, reasonably, people from the other bloc, so

hopefully what we're serving is the people and not our --

MR. LEFFLER: I agree. If that's something you suggest, that you guys feel is necessary, we certainly would be open to that. I will say that this council (sic) will listen to all points of view of the council. If the council passes a resolution, it doesn't mean that the other side of the issue is not heard, and the department hasn't gleaned concepts from that. But we would certainly be open to 75 percent, or whatever you guys feel is necessary.

MS. COLSTON: What I'm hearing is that one of the recommendations, just so that we're clear -- because I'm taking notes -- is that we want to make it a 75 percent majority with the vote. So we will insert that in. Does everybody understand what that recommendation is, what we're asking?

DR. REED: I heard suggested two-thirds.

DR. NAMIAS: I don't know, but not 50 percent plus one. If there's some other set of rules of procedure that has a standard set for this, then we should do that, but I think 50 percent plus one really puts a risk that we get a bloc.

MS. COLSTON: I definitely understand.

DR. NAMIAS: Our goal is to serve the people.

MS. COLSTON: We're going to go ahead and -- here's what I recommend that we do. This is a little bit out of

the Robert's Rules of Order type of meeting, because it's a workgroup session.

Can we entertain a motion to change the bylaws to --

DR. NAMIAS: Can we do that?

MR. LEFFLER: Just before we take that up, I just want to be clear. These bylaws belong to the council. These are your bylaws, so it's up to you guys to decide what is the way you want to do business. This was just recommendations from the department, from looking at different councils and other workgroups within the department.

DR. REED: It says draft all over it.

MS. COLSTON: Correct, sir. I'll entertain a motion and a second. I need to note -- we have a court reporter, but Kate if you could also be documenting our action items from here, and I am as well.

DR. NAMIAS: We make a motion to change a draft; is that what we're doing?

MS. COLSTON: We're making a motion to change something very specific. It's kind of outside what the standard is.

DR. NAMIAS: I make the motion that all of our business, in order to pass, has to pass by a two-thirds majority of those present.

MS. COLSTON: Of the membership. Our quorum would be two-thirds. We're kind of redefining our quorum at this particular point. There's a motion on the floor to amend. Is there a discussion? Questions?

DR. McKENNEY: Sometimes the meetings will be inconvenient with the call schedule. Is there a way to phone in so you have all 12 members? You start getting down to small numbers and --

MS. COLSTON: Absolutely. Yes, absolutely. We did have a phone line for today and we will --

DR. McKENNEY: Going forward, we'll have a phone line, and you can vote on that phone line if you're present on the phone?

MS. COLSTON: Absolutely, as long as it's you and not your clone or anything like that. We want a real member of council.

DR. NAMIAS: What if it is your clone? Let's say Dr. McKenney happens to be called into a mass casualty and he has to go operate. Can his trauma program manager sit in? Can he have a clone, subject to the rules of attendance? I would say -- this says that if you miss two consecutive meetings, you're out. If he sends his proxy to two consecutive meetings, he's still out -- or me, or whoever.

MS. COLSTON: I will defer to our general counsel

on that.

MS. BUSH: The question is whether or not their proxy can vote?

DR. NAMIAS: Yeah. Like you said, there's a lot of trauma surgeons here, busy people, not really very well scheduled. So, for instance, if I can't make it because I'm called away to an emergency, or I have a planned something that I have to go do; instead of losing the voice of my position, can a proxy take my position for that vote or the next one, still subject to -- you can't be appointed and then delegate to somebody. If you do it twice in a row, it counts for two absences, and you're fired.

MS. BUSH: The question for me is, are you allowing for proxies within your bylaws?

DR. NAMIAS: Can we do that?

(All talking at once.)

MS. BUSH: -- appointed by the governor's office --

MS. COLSTON: Yes, and that's where I hesitate. I would assume if we can document proxy votes --

MS. BUSH: We have to confer with the governor's office on that. We have to get back to the group.

MS. DICK: I think the issue that's a little gray for me is that these are appointments by name. Some are done by agency only. So I'm drawing an analogy to the Domestic Security Oversight Council, which Dr. Philip is

actually the appointed member, but I serve at every meeting and vote. But I don't know. We'll have to work with the governor's office to determine if it's -- since these were appointments that were applied for and selected by name, if it's different in this case. We'll certainly get back to council.

DR. NAMIAS: My only point is -- as you bring this to the governor's office -- we are not trying to lighten the responsibilities of the member. The member needs to find the proxy. The proxy has to be there. If you send a proxy twice in a row, you're absent twice in a row.

MS. DICK: Understood. It may be a case where -- I don't know, we have to find out the legal answer to this -- but it may be a case where you designate a specific proxy, if it's allowed, and that specific person is the only person that can come. That's a great question. We'll get that information and bring it back to you.

MR. LEFFLER: I will take that up next time, as soon as we get back.

DR. NAMIAS: One more question. We made a motion and a second. Do we vote?

MS. COLSTON: Do we have any other discussion about changing it to a two-thirds vote of the quorum, so the actual membership of the council, 12 members, two-thirds of that, we are going to change that --

DR. SUMMERS: I think there's confusion. Two-thirds of the members represent a quorum? That's totally different than a vote of two-thirds.

MS. COLSTON: I'm sorry. So it's two-thirds of the membership would equal a quorum? Thank you.

DR. NAMIAS: No, that just means that we can vote with two-thirds of the people there. What I'm saying is whatever we define a quorum as, if we make quorum, of those who are voting you need a two-thirds majority to pass any --

MR. LEFFLER: I'm not trying to confuse the question on the floor, but you're saying that a quorum is 50 percent, but two-thirds to pass a resolution?

DR. NAMIAS: I haven't said what the quorum should be. I don't know what the quorum should be. Whatever the rules for a quorum are, I'm good with it, whether it's two people, or five people, or ten people, or all the people, whatever that is.

Of those -- if we have established quorum so that we can have a meeting and business, of those members that vote there should be a two-thirds majority to make anything happen, so that we avoid the risk of a bloc vote.

MR. ROSS: As an example, if I understand correctly -- there are 12 members on the council. If we do a quorum at three-quarters, that would be nine people. Then two-thirds of the quorum, you would need six to pass the

vote --

MR. SUMMERS: Eight.

MR. ROSS: No, of those present would be six, of those present to have a quorum. I'll repeat it. Maybe I said it incorrectly.

If we have 12 people on the council, and a quorum is three-quarters, it's nine people. To pass something is two-thirds. You would need six people.

DR. NAMIAS: Exactly right. Yes.

MS. COLSTON: Okay. Any comments or questions about that?

MS. YORK: I think it goes back to if you can't be here, how can you vote?

DR. McKENNEY: Well, you could be on the phone; right? You don't have to physically be here. You can be on your phone, but if you're not at your phone then you get the quandary if you can have a representative or not.

DR. NAMIAS: And that's a separate question. We've already said -- and I didn't know that -- if Dr. Ang can't make it, he can call in on the phone and be present, and he can vote; right?

MS. COLSTON: That's correct.

MS. DICK: Hang on, Leah, for just one second. Just for clarity's sake, there's really two issues on the table here, and I think we should separate them. One is

what a quorum is.

DR. NAMIAS: And I didn't ask that. Whatever a quorum is.

MS. DICK: So that's either part of this motion or not. Do you want quorum to not be part of what you're discussing right now?

DR. NAMIAS: No. I don't want it to be part of this.

MS. DICK: Your motion is that two-thirds of the members present --

DR. NAMIAS: Of the members voting.

MS. DICK: Takes two-thirds to pass, of the members voting. I'm assuming you wouldn't have a vote if there wasn't a quorum.

DR. NAMIAS: Correct.

MS. DICK: So that's two different issues there. We heard -- I heard discussion initially, two-thirds of the whole council.

DR. NAMIAS: No. No.

MS. DICK: So the motion is, two-thirds of the members voting to pass, period?

DR. NAMIAS: Correct. Yes.

MS. DICK: More discussion on that issue?

MS. COLSTON: So what are we defining quorum as?

MS. DICK: Don't do that yet.

MS. COLSTON: Okay.

MS. YORK: I thought I got it, but now I'm confused. I thought your initial concern was having a bloc of people. So if you have a vote in an official quorum, and you only need two-thirds of that, you could in fact then have a bloc.

So that's different than saying two-thirds of the council have to approve it. So that's where I got confused.

MS. DICK: That's what I was trying to clarify.

DR. NAMIAS: I think if you accepted this appointment, you need to make it a point to be here. If you choose to abdicate your responsibility to be here, then you've given up your position to whatever bloc might form. You need to be here.

It needs to be noticed well in advance, so we can confirm our schedules. You need to have the opportunity to do it by phone if we can't do the travel. That's a good thing. I didn't know we had that. We're going to ask if we can get a proxy --

MS. DICK: We're going to find out.

DR. NAMIAS: We're going to find out. That would also make it easier to vote. But, yes, it does mean that if the members who chose to come were all on one side or the other of an issue, yes, they could be a bloc -- that's how politics and government work -- so be here, I guess.

MS. DICK: I'm just trying to clarify what the discussion is.

DR. NAMIAS: So you're saying if, for instance -- what is typically a quorum in these councils?

MS. DICK: Fifty percent, plus one.

DR. NAMIAS: So 50 plus one, so we need six?

MR. LEFFLER: Plus one, so seven.

DR. NAMIAS: So if we have seven, two-thirds of that seven, what does that work out to?

MS. DICK: Two and a third.

DR. REED: Say a couple of members are carpooling, and crash, and are hospitalized. Okay.

MS. DICK: The other members are operating on them, and the meeting is canceled.

DR. REED: My question relates to unavoidable nonattendance, meaning you can't even get on the phone. Do we have an option to later cast our vote on an issue?

MS. DICK: I want to be really clear -- this is what I whispered in Michael's ear before, that he tried to iterate on my behalf -- this is all up to you, these entire bylaws. If you want to say you can be absent all the time; if you want to say people can never be absent; if you want to say they're absent but they have a justifiable reason, so it shouldn't count against them; these are your bylaws.

DR. REED: I think on the issue of voting on

things, it is separate from the quorum for an actual meeting, a public -- publicly noticed meeting. For the actual vote we would like the input of all members, whether they attend or not. I don't see why we can't get votes from the people who are there, but then follow up with e-mail or whatever to those members who are not.

MS. DICK: You can't follow up. You can't follow up, because voting has to be in the sunshine. You can't follow up. It has to be in the sunshine.

DR. REED: What I'm saying is, the members who were unable to attend for unavoidable --

DR. NAMIAS: That's the problem. That vote is out of the sunshine. Their vote would have to be publicly noticed.

MS. DICK: What I would suggest in that circumstance is that you defer that vote until everybody is ready. You can hold these commons hours, you can do a week's notice, and we can convene for that specific issue and revote.

DR. NAMIAS: Can we vote at commons hours?

MS. DICK: You can. We publicly notice it and --

DR. REED: I think that would be preferable, so we get input from all the members on any votes, any issues, you know. So we have to have a full vote cast.

MS. DICK: That's up to you guys. There's a motion

on the floor -- I'm trying to -- we're getting into multiple things.

DR. NAMIAS: Two-thirds of the vote --

MS. DICK: The motion on the floor is two-thirds of the people present, which is very different than two-thirds of the council. The motion on the floor is two-thirds of the people voting --

DR. NAMIAS: Let's say people voting. It sounds like we're also about to change who might vote and when.

MS. DICK: Two-thirds of the people voting on an issue; that's your motion?

DR. NAMIAS: Yes, that's the motion.

MS. DICK: Even if -- I'm not going to confuse anybody.

DR. NAMIAS: -- rabbit-hole scenarios.

DR. REED: That carries the vote.

MS. DICK: Two-thirds of the people vote, is the motion?

DR. NAMIAS: Yes.

MS. DICK: Are we good? Any more discussion on that? Do you guys want to officially vote on it? Do you want to just nod if that's something you want us to -- we're going to continue these bylaws at another meeting. We can agree that we're going to edit the bylaws to incorporate that change.

DR. NAMIAS: This is a discussion. So if anyone wants to discuss it -- but it seems like no one is really objecting to that idea.

DR. REED: Here's the rabbit hole. Do we need two-thirds to pass this vote?

MS. DICK: No, because we're not voting. You will when you get to adopting bylaws, but we're not -- I want to make sure that we're --

DR. NAMIAS: These bylaws are ours, you know. Larry, you know, you're sort of the moderator by default today because you're sort of from outside. We'll just look to you, since you're holding the microphone.

MS. DICK: What might be easier is -- so we've got this issue to incorporate into our edits. I understand you've not made a final decision on anything. What might be beneficial is to just take these bylaws out and just go through them one by one. I heard you discuss quorum, how many. I heard you discuss voting. I heard you discuss attendance.

Why don't you just go through them, and whatever collective suggestions you want to make for edits, you want us to bring back to the group when next you meet, then you guys can discuss and vote on them.

DR. REED: Did we ever second the two-thirds?

MS. COLSTON: No.

MS. DICK: I think we had a nod, a bunch of nods.

MS. COLSTON: Do we have a second?

DR. IBRAHIM: Second.

MS. COLSTON: Dr. Ibrahim seconds. Okay. So we're going to insert that.

We're going to go ahead and walk back, start on the first page and discuss what the bylaws are. So the name, Article 1, the name of the council. The short title; do you guys want to revisit the short title, either Council or FTSAC? Any changes?

DR. NAMIAS: It's fine. We need not worry about the name.

MS. COLSTON: Excellent. So we're good with Article 1.

Article 2 is composition and membership. So it kind of just lays out what Statute 395.402(2)(b) outlines --

DR. NAMIAS: That's in statute; right? So there's nothing to discuss.

MS. COLSTON: Absolutely.

DR. NAMIAS: Is the part about attendance in the statute?

MS. COLSTON: No. That would be our next point of discussion. So this is -- you have a question?

MR. KEMP: I would say for the members failing to be physically present or if they can't make a phone call, I

think we should allow the moderator, if there is a good excuse, if someone gets in a car wreck and can't get here, that the moderator has the ability to give -- excuse that absence, so that people are not thrown off council.

DR. NAMIAS: I suppose that, since this is a trauma council, that we wouldn't schedule these meetings during the meetings of the Eastern Association, the Western Trauma Association, The American Association for the Surgery of Trauma, the American College of Surgeons, the American Surgical Association, the Southern Surgical Association, all of the things that many of us are likely to be at.

MS. COLSTON: Absolutely.

DR. McKENNEY: You could call in if they were at the same time. There's six or eight meetings --

DR. NAMIAS: It will be tight.

MR. LEFFLER: We're taking this up as a different agenda item later on, but at least for this first year our vision is that this council meets in conjunction with the EMS Advisory Council. I know you have lots of other things that you attend, but we felt that was the most natural link as far as facilitating an inclusive trauma system, was to have all the components at the table if possible.

So at least for the next year we're looking at meeting in conjunction with the EMS Advisory Council, but that's up to you guys.

MS. COLSTON: Today if we can get kind of those dates, so we can look at trying to schedule -- walk out of here with at least a meeting schedule for the next --

DR. NAMIAS: EMSAC is probably scheduled; isn't it?

MS. COLSTON: EMSAC is scheduled for July 9th through the 12th right now. That is our next anticipated meeting for the EMS Advisory Council.

We're doing that because we have got a task in front of us and we want to give you guys the opportunity to start working on that. But we do want to get these other dates that we're talking about, so when we discuss the meeting schedule development after this, we'll kind of start looking at dates.

DR. NAMIAS: So, Mac, you're proposing that the moderator get to decide if someone's excuse is reasonable?

MR. KEMP: Yes.

DR. NAMIAS: I like that.

MS. COLSTON: Is there a motion to make that change in the bylaws, the draft bylaws?

MR. KEMP: I make that motion.

MS. COLSTON: So we're going to leave the council members failing to be physically present for two consecutive or three total regular meetings, we're going to leave that language in there. We're just going to add, moderator may excuse the absence for good cause. Is that language okay

with everybody?

DR. NAMIAS: Yes.

MS. YORK: Is this going to be defined? Do you have to be physically present, or does physically present include phone?

MS. COLSTON: We can just remove the word "physically," and just leave "must be present." That would cover us for telephonic --

MS. YORK: Okay. Because being physically present and being on the phone is not the same thing.

MS. COLSTON: So the ask is to remove "physically." Motion?

MR. KEMP: So moved.

MS. COLSTON: Second?

DR. McKENNEY: Second.

MS. COLSTON: Okay. So that is our edits that we're going to incorporate for Article 2, composition and membership.

Moving forward to Article 3, purpose. So the purpose of the council is kind of just very generic. I think we pulled this language out of statute and some other areas.

Do we have any recommendations for edits to this particular section?

DR. NAMIAS: Would the council participate in rule

development?

MS. COLSTON: Yes.

DR. NAMIAS: Is that in this somewhere?

MS. COLSTON: Number 3, "Provide recommendations to the department on state statutes, administrative rules, planning documents, and policies related to the care of severely injured persons."

MR. ROSS: Something that I would suggest -- we recognize that every topic is going to have pros and cons. We are going to make reports and/or recommendations. I think it would behoove us and be of benefit if at the end of the report we put in the minority opinion, so that advice is heard.

MS. COLSTON: Your recommendation is to include some statement in here about providing recommendations, maybe in Number 3 --

MR. ROSS: That's where I put it.

MS. COLSTON: Okay. So give me the language again. Minority opinion --

MR. ROSS: Minority opinion be expressed.

DR. NAMIAS: Like the supreme court.

MR. LEFFLER: That's what I was saying earlier. The department is going to hear feedback from all points of view, regardless of what the council's recommendation --

MR. ROSS: It's good to have a council -- the

recognition by others that the council discussed this.

MS. COLSTON: Okay. So I'm going to draw up some draft language. You guys can shoot it up as you want to. Minority opinions shall be represented in all recommendations provided by this council.

DR. McKENNEY: It's probably a dumb question, but where does the majority opinion go?

MR. KEMP: It's in the main recommendations.

DR. McKENNEY: But who does it go to? Literally, where does it go? Where do we send it?

MS. COLSTON: So that would depend. We're your administrators. We're going to take that, whatever it is -- it depends on what it is. We would then put that through our chains as far as -- let's say, for example, it's a rule change. So the recommendation comes from this council, then of course it would come to us as the trauma section folks. We would then push it to our general counsel, our executive leadership team, so that we can manage it appropriately and make sure that whatever the recommendations are, our legal has had -- then we would conduct the rule workshops and all of the rule promulgation activities associated with that.

MS. DICK: There also is, I think, an expectation that this council creates and submits to the legislature a report at the end. There's a specific statutory requirement for that.

MS. COLSTON: Yes.

MS. DICK: That report would then go to the legislature. Other kind of more routine business would funnel up from the surgeon general.

MR. LEFFLER: Like I said, part of the advantage of this council is the ability to talk about some of these administrative rule changes before we have formal workshops and formal hearings where our communication is somewhat limited. It allows us to have collegial discussion outside of the rule promulgation process.

DR. NAMIAS: What this is doing is basically what the Florida COT used to do, which is good, except now you have it legislatively mandated, balanced membership, you know, so that it's, theoretically, if it works the way it's supposed to, truly representative.

MR. LEFFLER: Correct.

MS. COLSTON: Okay. Any other discussion?

MR. ROSS: I had one other thought. That is on page 2, last sentence: "The council shall have a defined charter or work plan approved by the department and the council." I think it should state with priorities, you know, listing the priorities as such, in order, so that we'll know what we're working on first and what's going to come up at the end.

MS. COLSTON: Okay. Once we discuss that, I'm

happy -- is that a recommendation through a motion?

MR. ROSS: Motion.

MS. COLSTON: Second?

DR. McKENNEY: Give me the motion one more time.

MS. COLSTON: So the motion for Article 3 -- I'll list both of them -- is to add to Number 3, "Minority opinions shall be represented in all recommendations provided by the council."

And at the very end where it talks about, "The council shall have a defined charter or work plan approved by the department," we are going to add, "with defined priorities."

DR. REED: With prioritization of issues.

MS. COLSTON: Excellent.

DR. McKENNEY: Second.

MS. COLSTON: So we have a motion and a second. Moving on to article -- did that answer your question, Dr. McKenney?

DR. McKENNEY: Yes.

MS. COLSTON: Article 4, officers. As Michael mentioned, we said we have a moderator and secretary. If you decide otherwise, we can change that. As it stands now, the recommendation is to have a moderator and a secretary. These officers are going to be selected by majority vote of the council, and approved by the state surgeon general.

These officers will serve a one-year term, much like the EMS Advisory Council chair does, and may be reappointed for consecutive terms, not to exceed two.

Are we good with this first statement, the definition of officers? Mac?

MR. KEMP: Being the chair of a council, this may sound silly. But a parliamentarian has been of great assistance to me, because you're so intent on running the meeting and doing whatever, that when something comes up on how to proceed through the Robert's Rules of Order, all that sort of thing -- it's not what I'm thinking about. So just having someone that I can turn to and say, what's the proper process to go forward. Just having someone in that role that understands.

MR. LEFFLER: We considered a parliamentarian. We certainly can add that to this as a recommendation. We could also provide department staff that can serve as parliamentarian. Obviously, we're not a member of council.

MR. KEMP: It's just helpful to know how to proceed when you get stuck.

MS. COLSTON: All right. We can do a combo, add a parliamentarian to be filled by department staff, if that's okay. Is that a motion, Mac?

MR. KEMP: Yes.

MS. COLSTON: Second?

MR. SUMMERS: Second.

MR. ROSS: One other thought that I had with regard to secretary. Rather than having anyone on the council doing this with any slant possible, DOH may be the one, rather than us designating somebody here. DOH has the transcripts, DOH has the administrative issues dealing with the meetings. I would suggest that the secretary be the DOH.

MS. COLSTON: Okay. Any questions or discussion?

DR. REED: Do we even need that position, then? Can we just have the DOH staff support that role?

MR. LEFFLER: The motion would be that DOH would serve as secretary and parliamentarian?

DR. REED: Second.

MS. COLSTON: We have a second. So when we define the secretary we are going to just change some language. Secretary will be staffed by department program staff to ensure accurate minutes, et cetera.

DR. NAMIAS: Not being a parliamentarian myself, does anything in Robert's Rules of Order contradict what we said about what we're going to require for a majority? Does Robert's Rules just say who gets to speak when, or does it define what is a majority, and a quorum, and all that?

MR. LEFFLER: My understanding with Robert's Rules of Order is that it allows the institution to set up those

rules. We can certainly provide the background on that issue. We'll clarify that. My understanding is that it allows the institution to decide.

MS. COLSTON: Mr. Ross?

MR. ROSS: If indeed Robert's Rules may not permit such, I would suggest -- I know that a number of legislative bodies, of which I guess this is one, distant cousin, call it what you want -- use Mason's Manual. That may be more in concert with what we've already stated. So you may want to use that.

MR. LEFFLER: We'll look at that, too. We could even add a statement in there that says the council shall use modified Robert's Rules of Order, as approved by the council. We'll find a way to incorporate that.

MS. COLSTON: So I'm going to go back. I'm not sure, did we second changing parliamentarian being a DOH position and also --

DR. NAMIAS: I second.

MS. COLSTON: Okay. Great. Do we want to add any other officers, other than parliamentarian?

MS. DICK: Just a suggestion for the group. If you're only having a moderator as the only council officer, maybe you want a comoderator or a second --

MR. LEFFLER: The bylaws do allow the moderator to appoint a moderator pro tem.

MS. COLSTON: That's temporary.

MR. LEFFLER: But they could serve --

MS. COLSTON: Do you want to have a comoderator, or something along those lines?

MS. DICK: The person then automatically takes that role if the moderator is, you know, called away to surgery or --

MS. COLSTON: I'm sorry. That's not an official recommendation, just the council --

DR. REED: I think it would be at the time of a meeting. If the moderator is on the phone and goes away, he could say, Nick, would you continue moderating until I get back.

MS. DICK: What if you're the one in the car? If you're the moderator and you're the one --

DR. REED: Well, you could still do that by designating that person -- or your surviving spouse.

(Laughter.)

MS. DICK: I guess that's my question. Do you want to designate in advance somebody who would serve in that capacity in the moderator's absence, or do you just want the group to point at somebody and say, it's you today?

MR. ROSS: It makes sense to have another moderator.

MS. COLSTON: Is there a motion to add a

comoderator position?

MR. ROSS: Yes.

MS. COLSTON: So pretty much the same language, it will just say the comoderator will preside in the absence of the moderator, or as otherwise designated.

MS. YORK: That gets rid of that pro tem?

MS. COLSTON: Yes, that's correct.

DR. NAMIAS: So we have to make sure they don't travel to the meeting in the same mode of conveyance, separate flights, or buses, or vehicles.

MS. COLSTON: Is there a motion to add a comoderator, Mr. Ross?

MR. ROSS: Yes.

MS. COLSTON: Second?

MS. DiNOVA: Second.

MS. COLSTON: And a second. Any other additions? Any other comments regarding Article 4, officers?

Moving forward, Department of Health's role. This is just kind of basic generic language of what the department is responsible for doing, as outlined in statute. Do we need to look at that?

MR. ROSS: No. I would just reflect now the secretarial and parliamentarian.

MR. LEFFLER: Ex officio?

MR. ROSS: Right.

MS. COLSTON: Moving to Article 6, meetings. Michael talked to you a little bit about regular meetings, special meetings, emergency meetings, and commons hours meetings. Do we have any additions? Do we need to add anything or edit any language?

DR. NAMIAS: The third line says physical attendance. We talked about phone.

MS. COLSTON: Excellent. We'll say, "Attendance of a majority of appointed council members." Where is that?

DR. NAMIAS: Article 6, fourth line.

MS. COLSTON: Okay. We'll change it. We'll make sure that that lines up.

MR. SUMMERS: You just drop the word "physical"; right?

MS. COLSTON: Yeah. That's okay. I just changed it. I took off the word "physical."

Any other comments?

DR. NAMIAS: Now we talk about the quorum.

MS. COLSTON: Okay. Let's talk about the quorum.

MR. ROSS: Exactly. My opinion, you were appointed by the governor. You really have a responsibility to be here. So I think two-thirds is even light, but two-thirds would constitute a quorum.

DR. NAMIAS: I'm okay.

MR. ROSS: Three-quarters is better, to be honest.

DR. McKENNEY: You can call in.

MR. KEMP: If that works, that's fine. Just be aware -- being in another environment -- if you can't, for some reason, have a quorum -- storm's coming is most common -- it's embarrassing to have a publicly noticed meeting and all that stuff, and no quorum. All you can do is sit and talk and take no votes, do nothing. You're just kind of just there.

So I understand. The higher you set the bar, though, the more chance of likelihood there is that you're going to have a meeting with nothing getting done of value whatsoever.

DR. McKENNEY: A hurricane is really the one thing that could bugger up a big chunk of the state. Maybe it's best not to have a meeting where votes are taking place if you're struggling to help get people or get yourself through a hurricane. We can reschedule; right?

MR. LEFFLER: I can tell you from a department point of view, if there's a hurricane we would cancel the meeting.

MS. COLSTON: We'll do that with sufficient notice. Hopefully by setting up a meeting schedule well in advance we'll have some options. I know things change, but hopefully having a meeting schedule well in advance -- we want to try to get at least six months to a year, as far as

knowing when our meetings are, so that y'all can plan accordingly. We're going to try not to schedule on top of other things. It's going to be an intricate dance that we'll have to do, but we'll do our best.

But it's up to you guys if you want to set the bar high. I think everybody here -- sometimes we go in with good intentions. If this doesn't work for us our first year, we're going to look at these again next year and we can change it that particular point.

DR. McKENNEY: I like three-quarters. You can call in. It seems like there should be very little to get in your way.

DR. REED: And we may be able to submit proxies.

MR. LEFFLER: So we have a motion on the floor for three-quarters?

DR. ANG: Second.

MS. COLSTON: So three-quarters of the council constitutes a quorum. I'll put that language in.

Any other discussion about any of these meeting types, committee, subcommittee, workgroup meetings?

MR. ROSS: Yes. One suggestion. With regard to the regular meetings properly noticed to the public. At the same time can the materials be sent to us, so that we have at least seven days, which I think is even minimal?

MR. LEFFLER: I can tell you, we'll try and get

stuff out as quickly as possible. We're looking at 30 days at a minimum.

MR. ROSS: That would be perfect, because all of us have lives and schedules.

MS. COLSTON: Absolutely. This time we were under the gun to get the meeting scheduled. We'll have time for you all to take a look at what's out here and what you have in front of you, so we can vote on it, which is why we're not looking at taking any action. We want to have something good that we can walk away with, that we'll be voting on at the next council meeting.

Any other discussion regarding Article 6?

DR. REED: Under special meeting, are we going to change the physical attendance on special meetings, as well?

MS. COLSTON: We will change the word "physical" in areas with reference.

DR. REED: Then the quorum for the special meeting, as well?

MS. COLSTON: Yes.

DR. McKENNEY: Three-quarters.

MS. COLSTON: Okay. The last article is just a statement that the bylaws may be established until otherwise amended by two-thirds majority vote of council. Okay.

There are no other changes or edits --

DR. NAMIAS: I'm sorry. Where?

MS. COLSTON: Article 7, last page.

DR. NAMIAS: A two-thirds majority. Is that where we voted a two-thirds majority of the entire council, or of those present when voting? What is that; same as everything else?

MR. LEFFLER: I would say -- my recommendation would be for the adoption of bylaws to be two-thirds of the council, the entire council.

MS. COLSTON: If we're going with three-fourths, I would say three-fourths.

MR. LEFFLER: Excuse me.

DR. NAMIAS: Whatever it is, make it consistent.

MS. COLSTON: Absolutely. Got it.

DR. REED: Again, there is the issue of quorum versus vote. We said three-quarters of the appointed membership.

MS. COLSTON: Two-thirds of the members voting.

DR. REED: Two-thirds of the quorum?

MS. COLSTON: Okay. So maybe we need to change wording here.

DR. NAMIAS: We said three-quarters is a quorum. Then separately, whatever we vote on, it takes two-thirds to pass a vote.

MS. COLSTON: Two-thirds of the voting members?

DR. ANG: Specific to the bylaws. It's not like

other recommendations. The bylaws should have a more stringent --

DR. NAMIAS: A higher bar if you're going to change the bylaws.

DR. ANG: Yes.

MS. COLSTON: So Dr. Ang made a comment -- so everybody can hear -- that the two-third majority vote is specific to the bylaws. He's stated that should probably be more stringent criteria.

DR. NAMIAS: Two-thirds of what?

DR. ANG: Of everybody on the council as it is right now.

MS. COLSTON: So just leave it as is?

DR. ANG: Correct, I'm saying as is. We made changes to recommendations and voting by the council for representation of those that are voting and present, but this is for the bylaws, which I think should be more stringent. Leave it as is.

MS. COLSTON: Okay. So a motion to leave it as is, Article 7, bylaws?

DR. NAMIAS: Yeah.

MS. COLSTON: Second?

DR. NAMIAS: That's fine.

MS. COLSTON: Okay. All right.

MS. YORK: So once I get home this evening when

it's raining, and I go through these again, how do I provide any comments that I may or may not have?

MR. LEFFLER: I think the best thing to do is you can send them to me. I could provide a document to the entire council once I get everybody's comments. We can put them at the top of the items -- motions to hear before we vote on the bylaws. We can do live edits when we -- before we vote on them, to make sure they're in line with what council has.

So we can perform this exercise briefly once again before we actually take up a vote on the bylaws.

DR. NAMIAS: I just feel compelled to make it clear to people that might not have been involved in sunshine before. The point is, you can send it to him because he's not a member of the council.

MR. LEFFLER: I can communicate with all of you.

DR. NAMIAS: We can't send it to each other.

MR. LEFFLER: Right.

MS. COLSTON: We can disseminate them, because it is a public document. We will disseminate everyone's comments out prior to the meeting well in advance. But we will take a discussion of the concerns at the next council meeting. But you will send everything to the Department of Health.

MS. YORK: Is there a deadline time?

MS. COLSTON: Not yet. We'll set that up and contact you. We are going to pull all this stuff together. We're going to have a draft, a new draft of the bylaws. We'll go ahead and get that out, get that up on the web so everybody will have access to it, so you can digest what was discussed here, and then we'll have a call for comments.

Okay. So at this point, unless there's further discussion, we're going to conclude the discussion of the bylaws. We'll make the appropriate edits, and we'll move forward. Okay.

MS. COLSTON: Do you want to take a break?

MR. LEFFLER: For the record, we'll take ten minutes.

MS. COLSTON: We'll reconvene at 10:45.

(A break was taken.)

MS. COLSTON: We'll reconvene right now. Before we move to our next order of business -- we're going into discussion of the charter -- Donna, you have a question?

MS. YORK: I have a question. Under the bylaws on Article 2 -- because it says council membership shall be on a voluntary basis, and members receive no compensation. Is this expected to come out of my pocket, versus my work people? That is my question.

MS. COLSTON: Well, you're asking if your job can pay for your travel?

MS. YORK: Exactly.

MS. COLSTON: Yes.

DR. REED: It should be, there's no compensation from the state.

MS. COLSTON: We can make that change. No compensation from the state. That is correct. That is in the statute. It was surprising to us, because there is no -- we will not pay for travel.

MS. YORK: I just wanted to make sure I was legal.

MS. COLSTON: It's not specific to who can pay for it, but we can't pay for it.

MS. YORK: Okay. That's fine.

MS. COLSTON: Any other questions? Okay.

In your packets that you received you should have a draft charter, kind of like this. Does everybody have one? So this is what is referenced in your bylaws document. This is going to be your charter work plan. We will work through this with you. This will become the public record for the priorities, so we can amend the bylaws to discuss priorities. We'll get to where those priorities are going to be listed.

Then once we complete this document and adopt it, we will post this on the website as well. But this will become our work plan for the year. We are going to define what we want to do. One of the things is already

prepopulated in there, because the statute says so. We'll add additional things as necessary, based on council recommendations.

I just want to walk through this. It's kind of simple. There's little qualifying statements in gray, just to kind of help you guys understand what this is. We give a background on the charter that defines why this team is in existence. It's not just because of HB 1165, although that's what gives us the authority, but also because this is a group to kind of give us recommendations on our trauma system. You can amend that statement, add to it, as you please. If you want to add more, try to keep it very simple for purposes of discussion.

Council mission is the next area. It outlines what's important to this particular council, what is our mission, what do we want to do. I didn't feel like the Department of Health should even try to prepopulate that. This mission is going to be something that's defined by members of council, so you guys can think about that, what you want the mission to be.

Again, this is going to become something that is our guiding document for when you're talking about business, if you're giving updates, you can disseminate this as you want: here's what the Trauma System Advisory Council is currently doing. So think about what you want your mission

to be, so that way we can accurately provide details on what that is.

Dr. Reed?

DR. REED: Shouldn't the mission be the same as the purpose?

MS. COLSTON: It should be, if that is the recommendation. Okay.

DR. NAMIAS: You mean in the bylaws?

DR. REED: No, purpose meaning what's in this background here: "The purpose of the council is to promote an inclusive trauma system and enhance cooperation among trauma system stakeholders by providing recommendations to the Department of Health on how to maximize existing trauma center, emergency department, and emergency medical services infrastructure (including personnel)."

DR. NAMIAS: I second that. We could spend the next three days wordsmithing a mission.

MS. COLSTON: All right. So motion and second for moving the mission or defining the mission as "promoting an inclusive trauma system," all that language all the way down to the end of what is currently listed in that line.

DR. NAMIAS: Although I seconded it, it only maximizes existing trauma centers, emergency department, and EMS infrastructures. There's nothing about growth or change.

MS. YORK: Right.

DR. REED: Okay.

MS. COLSTON: So let's add to that, then.

DR. REED: Existing and future. Existing and future trauma centers.

MS. COLSTON: Any discussion or any other recommendations on that? So if I might make a suggestion for background, since we are going to move a majority of this -- I'll leave the definition of the statute as our background as to how it was created. If you guys have any other background information that you want -- you know, really we try to cite the authority, so that way -- our authority is found in the statute, so we can leave it as generic as the statutory language. Is that amenable? Yes? Okay.

Any other changes, then, to our mission? Okay. So the next section on the left, then, is council members appointed by the governor. Of course, that is in need of no edits. It's just simply an outline of who you are and what your statutory representation is.

Lisa?

MS. DiNOVA: Under mine they have it as FHS. It's FHA. It's a typo.

MS. COLSTON: Thank you. And we're going to place some M.D.s on here. We do realize that -- I think we

populated this based on something, so we're going to edit that as well to add the M.D.s.

DR. NAMIAS: The time frame. So my understanding -- I don't remember if it was in the law or where else I might have read it -- my understanding is that this is a three-year council. I understand that some people were to have been appointed for one, some for two, and some for three, so there's staggered turnover. This just says one year, it doesn't say --

MS. YORK: Under the charter.

DR. NAMIAS: The charter is one year?

MS. COLSTON: Yes. Because the time frame -- this is really defining our time frame for completing things. If we talk about -- so I have the initial meeting being 5/24, but we can say one year effective whenever this is approved to the next year. It depends on how you want to qualify the time frame. It's really just saying a definitive date to accomplish whatever our priorities are going to be that are outlined in this particular document.

MS. DiNOVA: Should we then, under council members where our names are, should we put what our appointment date time frames are?

MS. COLSTON: No. You don't have to worry about that. We'll manage that and update it as needed.

But the time frame, this is a time frame relative

to what we identify as priorities and what we're going to complete. We're going to talk about, at the bottom of the page where it says assignments, action steps, and deliverable -- it's anticipated that those are the things that we want to complete in the next year.

We can change this time frame and make it two or three years, whatever the case may be, but typically you're going to want to update this. So once that pediatric study is completed, that's going to fall off. It's easy sometimes when you're going in to update your bylaws, that you update your work plan as well. You can carry things over, add new things, you can do whatever you want to, but this document is really intended to kind of make sure we don't work on things that we haven't identified as priorities. It kind of helps us not do the scope creep thing, and keeps us lined up and focusing in on the priorities at hand.

Any other questions? Okay. So we've got some corrections to do with council members. We'll take care of that. Moving over to stakeholders. This really kind of just helps us keep in mind who our stakeholders are internally, external to the council. I tried to put down the ones that just immediately popped into my mind. If there are others that are not included -- I know that there are -- we want to kind of think about those as well.

If there are things that need to be communicated

out -- this is going to help us in a number of different ways. For us, as administrators of the group, if we need to be communicating, messaging, doing anything of that nature, we want to be able to identify if we have addressed that stakeholder group and we haven't left that stakeholder group out.

If we're thinking along the lines of data collection or any information that we might need from interested stakeholders, we need to identify who those folks might be, and if there is a mechanism to obtain that data so that we can make informed decisions as a council -- so that you can, not me -- that we have reached out appropriately to that particular group. It just kind of helps us understand who might be impacted by the activities that are being undertaken by this council.

Dr. Reed?

DR. REED: In Indiana when we set up our trauma system -- which was really recent, just within the past decade -- we also looked at rehabilitation, long-term acute care facilities, those kinds of end-of-the-road care facilities for trauma, because it does hit the continuum. In fact, we have all of those facilities even submitting data to the trauma registry, so we can get a complete continuum of care story about how trauma patients are managed.

I think this council would be very interested in making sure that those aspects of the trauma patient's journey are also reviewed, or changed, or fixed, whatever needs to be done. That could be a part of this continuum.

MS. COLSTON: Absolutely. We actually do have a registry, RMIS, Rehabilitation Management Information System, with our Brain and Spinal Cord Injury Program, that collects a lot of that data. We're going to try to tie those two sets of data together.

That's a good call. Any other recommendations? Donna, and then Dr. Ibrahim.

MS. YORK: I'd sort of like to see these realigned, put the citizens and visitors at the top, because that's really who we serve, then put everything else beneath it.

Should we have something in there, like the doctor was talking about, with trauma and what you're going to do with that? That's not listed.

MS. COLSTON: Absolutely.

DR. NAMIAS: Since the American College of Surgeons verified this, and it's part of our -- part of this charter later on is to study the use of the ACS versus the Florida system for verification, is the college or college's -- this is for discussion, I really don't know the answer -- do you think the college's committee on trauma is a stakeholder?

MS. DiNOVA: I actually thought the same thing for

FCOT or for AFTC also, the trauma coordinators, because they'll be wanting reports back.

DR. NAMIAS: I think they probably are, at least the Florida COT, and maybe the national COT or the American College of Surgeons, but I guess then you get into whatever college of neurosurgeons, orthopedists, all of them. Maybe just COT, because that invites participation by all members.

MS. COLSTON: Any recommendation?

DR. ANG: What about health care providers that provide trauma services, like physicians and nursing, as opposed to one organization?

MS. DiNOVA: Where it says "trauma centers" -- "and providers"; does that cover it?

DR. ANG: Yes, I think so.

MS. COLSTON: Trauma care providers, something along those lines maybe.

DR. SUMMERS: Maybe that's a separate entity, because that then becomes exclusive when you put trauma centers there. Trauma health care providers is a lot of folks at hospitals that are not trauma centers, that provide a lot of initial care.

MS. COLSTON: So I'm going to remove trauma centers and acute care hospitals, and put trauma care providers?

DR. SUMMERS: I think they certainly can be there.

MS. COLSTON: So leave them, but we'll add in

trauma care providers. Let me recap to make sure. We've gone over a lot.

We're going to move Florida citizens and visitors to the top; add rehabilitation and long-time care. Disaster management partners -- I'll come up with some folks. If you have any specific ideas on who that might be, let me know. We do work with disaster preparedness at the Department of Health, so we can come up with some things.

I have American College of Surgeons or the National Committee on Trauma, FCOT, trauma program managers, trauma care providers. That's where we are right now.

Let me get Dr. Ibrahim now.

DR. IBRAHIM: They may be included in this, but you said disaster management, so we're kind of on the same page. What about law enforcement? Do they fall under any of these, or should we include them separately? They are involved in a lot of it as well.

MS. COLSTON: I think that would be separate.

MR. ROSS: Any local trauma agency, if there are any out there, I think that's important.

MS. COLSTON: Adding in local/regional trauma agencies.

Dr. Elias?

DR. ELIAS: Health care coalitions.

MS. COLSTON: Is everyone here familiar with what a

health care coalition is from the Department of Health standpoint?

Do you mind talking about that a little bit?

DR. ELIAS: So across the state there are health care coalitions, which are basically a collaboration of a full spectrum of providers: EMS, hospitals, nursing homes, dialysis care centers, things like that. Basically it's a gathering of medical providers.

There are 16 of these health care coalitions scattered throughout the state, and we are kind of combining them also to correlate with the RDSTF, the Regional Domestic Security Task Force regions. We're trying to consolidate them in some form or fashion.

It is a way to reach a wide variety of medical providers, from EMS through hospital systems. That's how some of the federal funding passing through the state is being distributed amongst the locals.

So I think that's a good gathering point to reach a wide variety of health care providers.

MS. COLSTON: Thank you. Any questions for Dr. Elias on that?

Okay. Any other partners, stakeholders?

MR. KEMP: Yes. Rural health care providers. I know they're included in some of this, but I think we need to be very specific to include them because they're

underserved and forgotten.

MS. COLSTON: Excellent recommendation. Any others?

So if you guys think about other stakeholders later on, that's great, just make sure you include that when we send out the drafts, so that we can edit accordingly. I think we have a really good beginning list. So there is no further recommendations on this?

We'll look at the time frame really quick, then we'll have some discussion about the time frame. Is a year sufficient? Do you want to reevaluate in another year, have some defined things that we're going to get done this year, and keep it at a year? It's not locked into this, so if we adopt it for a year this time, and then we revisit next year, we can make a two-year plan. This is just a work plan. It outlines what we're doing over the next year pretty solidly. Any comments, recommendations, changes?

MR. SUMMERS: The last one to add to stakeholders would be injury prevention expertise.

MS. COLSTON: Thank you. Under stakeholders we're going to add injury prevention partners, or something along those lines.

The time frame? Is council good with the time frame?

MR. ROSS: One year from adoption?

MS. COLSTON: One year from adoption, yes, sir. The date will be updated once these are adopted. Okay.

Sorry this got cut off a little bit, but the next section is where we're going to outline what it is that this council is working on. It's going to outline your priorities, but in addition to outlining priorities -- because it's great if we identify a priority for the council, but we also want to identify what we're doing to address that priority.

So it's very important that be identified as something that we want to get done. We identify the work that's associated with that, the steps that we need to take, major steps. Then, you know, what the deliverable is going to be. You know, we want some tangible things that tell us, here's where we are, here's what we're going to do to address that: recommendations to the department, recommendations to the governor's office or whomever.

Then we want to go ahead and document what that is, because also our checklist says, hey, we've got a great council. We finally got what we wanted. Here are the things we said we were going to do in the first year. Here's what that stuff is, and here's what the data is associated with whatever it is that we're doing.

Ideally, let's think through all those things logically. I filled in what we have to start with, because

that's the one thing I know we've got to do. We will definitely be the ones to facilitate that. We're going to talk about what our ideas are for when we should have kind of a finished product, because, working in state government, when they get ready to turn things in to the governor's office there's a whole approval process that adds probably two to four weeks to that. So in order to make sure that we have it in by December 31st, which is also prime time holiday time, everybody's doing Christmas and Thanksgiving, that sort of thing, we want to make sure we can get the group where we need to be so we can have that done.

DR. NAMIAS: Question about that item. As I'm reading it -- I know it's in statute. Why is this in statute? Why is -- you know, this can be blah, blah, blah, and the process for standalone pediatric trauma; but why not for combined adult/pediatric? Why not for adult only? Why this? What was -- what is the point of contention that led to this being in the statute? We can't discuss this in the hallway, so we have to do it here.

MS. COLSTON: I agree. I wish I had an answer for you. That was another Department of Health item that was introduced as part of the language. It was initiated between the folks that developed the language.

DR. REED: I mean, on a study there's usually a hypothesis. Was any hypothesis given? What data are we

going to be analyzing and measuring?

MS. DICK: Really, honestly, DOH was not privy to the conversation that led to the language of the statute. We were asked to do legislative bill analysis on the impact of the statute. Chair Young, Senator Young was the primary driving force.

You know, we tried last year. I mean, you guys all know the history of trauma shenanigans over the last 20 years in this state. This particular bill language was brought forth by Senator Young. We understand that she brought various stakeholders together to craft the language. DOH was not privy to those conversations.

The one thing I can suggest, if you want some insight into that, go back and get on the house or senate websites and find the hearings that this bill was discussed. Just watch it, watch the presentations that were given by different people, watch the language.

The honest answer -- not trying to be -- the honest answer is we don't know.

DR. NAMIAS: I understand that. So my question, I guess, is partly rhetorical. There's no medical mystery here; right? This was baked into the legislation. There's some stakeholder that needed this, and this was part of a horse-trade to get this in here.

So what I would say our Numbers 2, 3, 4, 5, 6,

and 7 should be: ACS verification process versus Florida verification process for all trauma centers -- for not standalone -- for every variation on this should be included in this study, and would satisfy the statute mandate to study this, but we shouldn't limit it to this.

MS. DICK: Again, that's entirely up to you.

DR. NAMIAS: That would be my motion for the group, that we expand this. And, Larry, as far as the word "study," I don't think they mean a scientific study with a hypothesis. They're looking for guidance, it appears, from hopefully a supermajority --

DR. REED: So all we need is pros and cons?

DR. NAMIAS: Yeah, from a supermajority. It's funny that this one thing of all the things in the world would be the thing in the statute.

My motion is to -- if we're taking motions yet -- my suggestion is that we should expand it to not just standalone pediatric trauma centers, but to all varieties of trauma centers, every permutation we can come up with.

DR. ANG: (Raises hand.)

DR. NAMIAS: Is that a second?

DR. ANG: (Nods head.)

DR. NAMIAS: We have a second to my right.

MS. COLSTON: Motion to expand this to a study of all trauma centers.

DR. NAMIAS: All types.

MS. COLSTON: Motion on the floor has been seconded?

DR. ANG: I second.

DR. REED: The types are actually variable. Florida has Level I, Level II, pediatric. A college can do Level III. Florida doesn't.

DR. NAMIAS: That would be part of this study.

MS. COLSTON: So we're going to change that to cover all types. I don't know what that entails, so I'll need your help. Is that going to be feasible to be completed by the deadline of December 31st?

DR. REED: Oh, yeah, if all we need is pros and cons.

DR. NAMIAS: A study of this, volumes, utilization -- once you're getting those numbers for any one kind of trauma center, I don't think it's any harder to get it for all the trauma centers.

DR. ANG: There's going to be different opinions on all those different levels of trauma centers and stakeholder interest. I think if we're to prioritize, we should prioritize -- I'm not saying don't study all the different permutations, but prioritize the one thing that's in the statute as number one, then kind of go through the rest of them, so at least we get that done by December 31st.

DR. NAMIAS: How many standalone pediatric trauma centers are there in Florida?

MR. LEFFLER: Nicklaus and All Children's, and Wolfson is a provisional. So Wolfson is a provisional pediatric in Jacksonville. All Children's is in St. Pete, and Nicklaus Children's Hospital in Miami.

DR. NAMIAS: You've already got one lawsuit, I heard the other day. Are you guys going to be able to talk about that? Are any of us going to be able to talk about that, because of this lawsuit?

MS. DICK: You guys can talk about pediatric care and trauma transport protocols, anything you want to talk about on this council. We obviously can't talk about the specific details of ongoing litigation.

DR. NAMIAS: We can, but you guys won't be able to. All right.

MS. DICK: You're not a party to the lawsuit. You can discuss it all you want.

DR. McKENNEY: Who are the parties to the lawsuit; Nicklaus and the Department of Health?

MR. SUMMERS: And Kendall, I believe.

DR. NAMIAS: Is Kendall a party to the lawsuit? I knew it was Nicklaus and the Department of Health. I didn't know about Kendall.

MS. DICK: Listen. Listen. That's okay. I don't

expect the council to take up -- I don't expect the council to take up the issues related to whether pediatric trauma patients go to Nicklaus or Kendall.

The council is going to take up the issue of, what is the best system that we can create for the transport of pediatric patients or whomever else. If you discuss conceptually things that may or may not end up being a part of a specific discussion in court, that's okay. You're not trying to mediate this particular issue; you're talking about a statewide system. That's fine. They're looking for that.

DR. NAMIAS: We have -- by statute we have to address this. This is not an option. Whether it's prioritized or not, this is the one thing we have to do.

I'm just saying, for the sake of -- the legislators, obviously they weren't sitting there between, you know, parks and environment, and came up with standalone pediatric trauma centers. There's a reason it's there.

As a council we have to do that, but we can expand it to the logical thing, which is all kind of trauma centers.

DR. ANG: I agree. I just want to make sure that we're prioritizing.

MS. COLSTON: So is the recommendation to separate it out? Still address it as a priority, but to ensure that

we meet the deadline, we separate it?

DR. NAMIAS: Maybe we should, so there's no question that we didn't fulfill our responsibilities.

DR. REED: Pediatric should be the first one. That will be the model for how we do the other ones.

MS. COLSTON: We're going to talk about what it's going to take to do this study. Again, I'll want some kind of key milestone steps for what it would take for y'all to complete that study, so we can kind of keep the progress moving forward on that, ensure we are going to be able to get our purpose of, number one, doing the pediatric study. What are some key things we are going to need to do; identify the data set we are going to need to use?

DR. ANG: We need to define the context of the study. Dr. Reed mentioned you need a hypothesis for the study, and Dr. Namias says this is not the type of study that needs a hypothesis. Who's going to define the study? That will determine everything else.

DR. REED: We're looking at the verification process by the two types, then we have a listing of what the verification process is for the state of Florida. The college has their PRQ, or whatever it is, that you've got to complete. That process is available on the websites. We can certainly have access to COT personnel.

Now here's the question I have, though. Does

working on the study have to live under the sunshine stuff? We can't do any work on the study unless we're all together in a publicly noticed forum?

MS. COLSTON: You can do your work on it, you just can't work together. You can do your work. You can get together --

DR. NAMIAS: You can't discuss it.

DR. REED: So if we need to discuss it, we need to pull up one of the commons things: we've got some data, is this where we want to go with it?

MS. COLSTON: That's correct.

DR. NAMIAS: Which is why I keep -- it seems like we keep coming to a closure, but I keep saying that once we leave here we can't talk about it.

MR. LEFFLER: We can facilitate that discussion as you guys need it or request.

MR. KEMP: I don't know how to itemize the items we need for data for this kind of study.

DR. SUMMERS: We kind of just did this in our institution. We looked at going with ACS certification, and we looked at the differences. They're pretty easy to quantitate. You can just put them side by side, in terms of the things that the ACS asks for that are different and unique from what Florida does. A lot of them are overlapping, with minor differences. That's pretty easy,

just to quantify that.

DR. REED: Do you have that, that that could be a starting point for us?

DR. SUMMERS: I mean, that could be something that I could provide through Michael.

MS. COLSTON: So let me just read the language out of the statute, because there are certain things we really do have to address, and also requirements associated with obtaining and maintaining verification; which pediatric trauma centers in the state have obtained, are in the process of obtaining, or are capable of obtaining such verification; the barriers to obtain verification -- this is related to the American College of Surgeons verification -- barriers to obtain; then policy proposals that address the need and value of such verification. Those are the things that --

DR. McKENNEY: Can you read that list again?

MR. LEFFLER: It should be the last page in your book.

MS. COLSTON: We did include statutes in there. It looks like this. It looks just like this.

DR. McKENNEY: So this is the primary issue that we have to address, by statute.

MS. COLSTON: That's correct.

DR. McKENNEY: We can go above and beyond, but we

can't go below addressing this issue?

MS. COLSTON: That's correct.

DR. REED: So Glenn's got sort of a comparison list that could give us aid, I think.

DR. SUMMERS: At least a framework that we could put the different centers in. The centers we need to look at for our charter are going to be different than my place, but the framework is going to be same; just put their numbers in.

MS. COLSTON: Can you share that with us, so that we can kind of share -- you know, I don't know how you guys want to do this. This is something that the council is charged with doing.

Do you want to identify specific folks who are going to work on this? Certainly you can have your own little workgroup that's going to develop this. Already there's a few major folks that are --

DR. REED: I think we can communicate through messaging, having stuff on the website, maybe.

DR. NAMIAS: Commons meetings.

DR. SUMMERS: Tell me if this is allowable. I can send -- obviously, my folks will want to redact some of the things in terms of specific costs.

MS. COLSTON: Absolutely.

DR. SUMMERS: But I can send the framework to

Michael, and Michael can then disseminate it to the group. We can decide whether that's something we can use going forward or not.

DR. REED: Don't redact the dollar sign, but redact the number.

DR. SUMMERS: My considerable fee will be redacted.

(Laughter.)

DR. REED: Redact the numbers, but we want to know that that's where to put the money in.

DR. SUMMERS: It actually worked well for us. We kind of exhaustively looked at this as our institution was trying to make this decision. We've done a comparison. We can do a better comparison, probably, with this group of people. It's a place to start.

MS. COLSTON: So we'll look for you to send that to Michael, once you've done the redactions, and we'll get that out to the group as well.

DR. REED: Great. Then the state should have at least some information on which pediatric trauma centers have obtained or are in the process of obtaining --

MR. LEFFLER: We can provide that. Molly Lorenzo has been very helpful with us in providing information on which trauma centers are pursuing various ACS --

DR. REED: You have them for the state, too; right?

MR. LEFFLER: Yes.

DR. NAMIAS: Our charter says standalone. If I'm looking at the right thing in the statute, it doesn't say standalone. Is it Section 13? I'm looking at 2018-66, Law of Florida, Section 13. It doesn't say standalone.

MS. COLSTON: Is that in the statute?

DR. REED: No. It says pediatric.

DR. NAMIAS: Study the national certification of pediatric trauma services.

MS. KOCEVAR: That was directly out of the statute. That was copied there. That was just physically copied.

MS. COLSTON: Which one?

MS. KOCEVAR: What you see right there.

MS. COLSTON: Okay. So it's not "standalone," so where did that come from?

DR. NAMIAS: Maybe the horse-traders forgot to get their word in the statute.

MR. KEMP: I've got the statute here. It doesn't say standalone.

MS. COLSTON: Okay. So we'll strike that. That's a typo on our part. So it's all; it's not just standalone.

DR. REED: It varies, obviously, based upon the data we get.

MS. COLSTON: What other data do you think we're looking at, as far as verified centers?

DR. REED: Well, there's going to be issues related

to cost. There's issues that are going to be related to personnel requirements for facilities.

DR. SUMMERS: Some of it will be difficult to quantify as well, because they charge an institution fees for getting it done, but then there's costs that would be associated with the state for having a different set of reviewers, those types of things. That's going to be a lot more difficult to pull.

DR. REED: But the state knows what it charges per survey.

DR. NAMIAS: But the statute says that the product we have to provide is a study evaluating the laws, rules, regulations, standards, and guidelines for the designation of pediatric trauma centers in this state -- in this state -- as compared to national, so that's ACS.

So, I mean, that shouldn't be hard to get our hands on at all; right? We know what a doctor costs, what a nurse costs, what a TPM costs.

MS. YORK: I mean, you're going to have assumptions, but you're going to have assumptions in any kind of study like this. Cost is going to vary a little bit from a more rural place to a more populated place, just because of what you have to pay individuals. But you should be able to make some assumptions.

DR. REED: There's going to be ranges, minimum of

this, maximum of that.

MS. DiNOVA: We're not looking at how much it would cost to become a pediatric center. What we should be looking at is, how much would it cost for a state-verified or state-designated center to become an ACS-verified center. That's what we're comparing; isn't it?

DR. SUMMERS: Initially. Then there's the continuum as well.

MS. DiNOVA: Right, the continuum. But we're not talking about a facility that's not already a pediatric trauma center becoming a pediatric trauma center. We're talking about what is the cost difference between what Florida requires and what the ACS requires.

DR. REED: There could be some issues related to becoming a trauma center. If Florida requires all this equipment, for example, in their statutes, and the college doesn't specify as detailed equipment and resources. So there could be some piece of equipment they have got to have -- which they probably already have -- but it could be a cost item if the facility doesn't, because it's different.

MR. LEFFLER: Let's try to use the microphone.

DR. REED: I think there could be differences in the cost of becoming a trauma center, if the requirements are different in some specific areas. I know, for example, for Level I, Florida requires an operating microscope for

neurosurgery. I'm not sure the college specifies that.

DR. NAMIAS: So Florida has always been a little more demanding than the college. A lot of us in Florida are happy with that. So there's some requirements, I think, for vascular capabilities in Florida that aren't requirements for the college.

So, I mean, I guess that's what we're going to look at and study, is the value -- cost and value of maintaining our higher standards that Florida has, versus going strictly to the college. I don't really have a dog in that fight right now, I just want to figure out what's right.

MS. COLSTON: So it looks like there's some really good discussion going on about defining the parameters of this study. We can continue to do that here, but keep in mind that we are going to set up a commons hour and we're going to walk through really a lot of the details of what that should look like.

Once we define the parameters and determine the content of the study, then we're going to hold several, I guess, commons hour workgroup meetings so you guys can work through this. Whatever way the Department of Health can support that, beyond setting up the meeting space and those types of meetings for you, just let us know about that.

We want to kind of set a deadline for a final draft for this of November 30th, because that will give us a full

month -- kind of, sort of, not counting the holidays -- to get this approved through the Department of Health structure, for submission of the report.

Is that palatable? Do you think we can do that? It sounds like it is feasible if we can set up workgroups and get this thing moving forward. So will that work? Our final draft deadline will then be November 30th, so I'll go ahead and kind of just put those major steps in. I'm not going to put in the things that we have talked about, as far as what elements you guys are going to be looking at for the study. I'm going to put those very broad defining parameters.

DR. REED: I think you can put, from this Section 13, 1(a) through (d) in there as the things to be looked at in the statute.

MS. COLSTON: Okay. Yes. I'll add that in. Under our deliverable on that is going to be to develop and submit a report by December 31, 2018.

So the second thing that was discussed was expanding this study to all types of trauma centers. I would assume that it will have some of the similar things that you'd wanted to look at. We can further define that later. We can start with the very basic things. The outcome, I would assume, would be a report of a similar type.

DR. NAMIAS: Similar.

MS. COLSTON: Okay. So we have got two good things, two solid items that we're going to work through, you all will be working through.

What are some of the other priorities? I'm sorry, Lisa, did you have a question?

MS. DiNOVA: I was just going to say, if we're going to do those things do we need to set a separate deadline, or do we want to look at all of them also by the November 30th and December 31st dates?

DR. REED: No.

MS. COLSTON: Let's think about what we want our deadline to be for that.

MS. DiNOVA: Separate items?

MS. COLSTON: It's going to be a separate item. So when do we want to have that completed by? It's up to the council.

DR. REED: Let's see how the peds one is. We could finish that within a month or two, if the data comes easily, and then just set these other. I mean, this is priority two. I mean, I think prioritization of these items is all we need to do, then say we'll go from one to the other. Set the deadline when we start.

MR. SUMMERS: And then the purpose would be it would go to the legislature; correct? Of the report.

MR. LEFFLER: Yes. Yes. It goes to the speaker of the house, the president of the senate, and the governor.

MS. COLSTON: We're on the pediatric, number one. The second one doesn't have the same requirements.

MR. SUMMERS: Do you know the dates for the session for next year?

MR. LEFFLER: It starts in March next year.

MR. SUMMERS: So we have a little cushion.

DR. NAMIAS: So we could potentially get the November 30th deadline for this one; and, depending on what we find, we might set ourselves a January 30th or February 28th, so they can have it before session. We don't even know if they're going to act on it or stick it on a shelf.

MR. SUMMERS: But they'll have it.

MR. KEMP: If you want to effect legislation, even with March -- they start committee hearings and everything way into, I mean --

MS. COLSTON: January.

MR. KEMP: -- December. So that's why they wanted this report by December 31st, for the committees to start looking at this, because you have to be way ahead of it in order to get anything introduced for this coming session. You may not got this session, but that's okay, maybe get the next.

MS. COLSTON: It depends on if you're trying to propose something. If it's simply something you want to give to them to inform them on what is happening with the trauma system, I think that's fine. When you're talking about actually proposing some legislative action, a bill, or something along those lines -- but if we're not doing that, I think it's okay for us to --

DR. NAMIAS: We're not doing that, but presumably if legislators are getting this report, they're going to use it to think about legislation.

MS. COLSTON: They could.

DR. NAMIAS: Maybe we should push ourselves up to an earlier deadline than November 30th. Speaking for myself, and probably most trauma surgeons, if you give me a deadline of November 30th, it will be done on November 29th. So if you give us October 30th, it will be done October 29th. Maybe we should push the deadline up to late September, so we can get it in their hands before they go to committee.

MS. COLSTON: It's completely at the will of the council. You guys can decide.

DR. NAMIAS: I propose a September 30th deadline for the pediatric study.

MR. SUMMERS: I second.

THE COURT: Any discussion? Any dissent? So we're

adopting September 30th as the due date for the --

DR. NAMIAS: Pediatric study.

DR. McKENNEY: After we finish it, what has to be done? It has to go through the Department of Health?

MS. COLSTON: You submit it. It will come to us.

DR. McKENNEY: You have to review it?

MS. COLSTON: Not review for purposes of any more than running it through our executive chain so that they have visibility on what's happening. It has to go up through us, to the EOG.

DR. McKENNEY: That maybe takes a few weeks?

MS. COLSTON: It's possible. We can make miracles happen when we need to. I just didn't want us to back up against a wall and be rushed to try to get that done.

DR. SUMMERS: Your submission would be the end of October, if we give you this information the end of September?

MS. COLSTON: Or as soon as we can get it approved. We won't hold onto it any longer than we need to, to submit it up the chain. If everybody's happy, and nobody has questions -- for example, if Dr. Philip, the surgeon general, has questions, of course she'll call and ask questions as needed. We want to give her that opportunity. But once we get it and it's approved, we'll send it to them. It says on or before December 31st.

DR. NAMIAS: Remind us of the organizational chart. The council has to provide it -- the report -- to the -- the council provides it to the legislature?

MS. COLSTON: Yes.

DR. NAMIAS: So where does the DOH and the surgeon general fall into the org. chart, between the legislature and this council, for this purpose?

MS. COLSTON: We're the administrative arm of the --

DR. NAMIAS: So you are the council, really. You are the council?

MS. COLSTON: Well, no, we're not the council. We're the ones that are administering the support. Anything that's submitted, we, as the executive agency that supports whatever it is, will submit it as your liaison.

MR. LEFFLER: We transmit it on your behalf.

DR. NAMIAS: Does the DOH or the surgeon general have the authority to refuse it? Change it?

MS. COLSTON: I don't want to say that we do. This is a report that's developed by you as a council. I mean, the only thing that may happen is if Dr. Philip is reviewing and she has questions, you know, maybe not even for the intent of changing what your findings are, she just may have questions.

I think it's important -- you know, she's our

state's surgeon general, so she should know what is happening with this particular component that falls within the realm of regulatory responsibilities for the Department of Health. But it's not -- the intent is not to change the content of the report as the council has developed it.

DR. SUMMERS: Perhaps we can then use our December 31st deadline for our second phase of this study, for part two.

MS. COLSTON: Recommendation for December 31st as the second phase deadline.

DR. NAMIAS: Second.

MR. SUMMERS: Leah, your September 30th is a Sunday, if that changes your thought process at all.

MS. COLSTON: Can we make that October 1st, then, instead of September 30th? Thank you.

Any further discussion on this? Of course it's hard to see now, but use your imagination. We're going to have some nice little milestones there and some other things. This will be very well organized.

We've got two taskings right now: conduct the legislatively required pediatric study; and then conduct the study incorporating all of the other types of trauma centers. Due date is October 1st for the pediatric; December 31st for all the others. You are going to send us a template for review that's redacted.

So are there any other questions or discussion about those two taskings that you've identified for this council so far? Excellent.

Okay. So do we have any other priorities that we want to look at this year?

MS. YORK: I was on some e-mails this week where people were asking some questions about differences -- because our Pamphlet 150 is dated. Is that in statute, or is that rule?

MS. COLSTON: That's rule.

MR. LEFFLER: Administrative rule.

MS. YORK: So I know it's not an easy change to make changes to, but there were some issues about what is acceptable for CME, because the differences -- in line with this, because of differences between ACS verification and state verification, what will be accepted and what will not.

Maybe it's time to relook at the Pamphlet 150. I would put that not at the top, because, you know, maybe we do all this and we say, hey, maybe everybody needs to do ACS or not, I don't know. But it's a document that's been there since, I don't know --

MR. LEFFLER: 2010 was the last revision. It's certainly been in most of its substantial form for quite some time.

MS. YORK: Right. I was thinking it's from the

'80s or '90s. There were some updates done, but not substantive.

MS. COLSTON: Okay. Council, we have a recommendation to look at Pamphlet 150-9. Michael, correct me if I'm wrong, but it would be one thing for y'all to look at Pamphlet 150-9 as a group. In order to incorporate changes, then we'd need to look at rule promulgation. I don't know --

MR. LEFFLER: It really would be based on the substance of the change. If the cost, regulatory cost is going to exceed $200,000 in the first year, or a million dollars over the first five years, there is another substantial regulatory burden on the department to look at cost savings opportunities and estimate those.

MS. COLSTON: That goes to the rule promulgation.

MR. LEFFLER: That is part of the rule promulgation part. But as far as looking at -- if you want to look at a specific standard that wouldn't affect regulatory costs per se, it might be much easier for the department to take that up. It would depend on what the substance of the recommendations were. They would have to go through the rule promulgation process regardless.

MS. COLSTON: Right. But not to look at it, though. This group, as subject matter expertise, could take a look at Pamphlet 150-9, then we can do the rule

promulgation accordingly.

So I just want to put that out there. What we'll be working on is something that, in order to change it, would then necessarily need to go into a rule. The reason I caution that is because whenever we go into a rule, it turns into this big hodgepodge of stuff. We need to kind of really be cognizant about the communication, what we're trying to do with that, all that stuff, incorporate that kind of thing so that we're getting buy-in from our entire stakeholder community as we can. Maybe that will make the rule promulgation process a little smoother.

DR. NAMIAS: Optimistically, I would hope that rule change would be easier if it comes through this council. So we can go through all that stuff before then.

MS. COLSTON: I hope so, too. Yes.

DR. NAMIAS: Maybe -- to restate what Donna's saying -- maybe you're looking at recommendations for modernization, for making it more contemporary. Because it's really studying something that's part of the study that we're doing, but at the same time we can make recommendations for modernizations, just in case nothing comes out of our study.

MS. COLSTON: In order to do this, we're going to add this in. We're going to add "modernization" on that line. That's relatively nondangerous.

So let's think about how you guys want to attack that, because that's a huge thing. Are we looking at all of them? I would think so. Are we looking at all the standards? Let's think about how we would want to do that. We don't have to discuss it now, we'll just identify it as a priority. But, you know, do you want to break it up into, we'll do this by such-and-such a date? I know you've already got things on your plates, so maybe we don't identify any of that. Maybe we just identify it as a priority for now, and we can go back and revisit that. What say you?

DR. NAMIAS: Does the department have this thing in a Word document, as opposed to .pdf?

MR. LEFFLER: Yes.

MS. COLSTON: Yes, we do.

MR. LEFFLER: We will make the Word document available.

MS. COLSTON: We'll get that out to you guys, just for purposes of follow-up from this meeting.

So we're going to add that. We're not really going to add any other language as far as when we're looking at action steps. We're not going to define action steps just yet for any deliverables -- we're just going to identify it as a priority -- then we can address that.

Now do we want to identify when we will start to

look at that? To be determined on -- or in January 2019, or something along those lines, just so that we can keep that forward motion and it doesn't just sit there, nah, we'll get to it later. Even if it's to say, we might not be able to do that this year, or in January, let's do it in March, or whatever the case may be. Do you want to identify the next --

DR. NAMIAS: I think we can subcommittee that out at the same time. There's 12 of us here. Some can look at that.

MS. COLSTON: Okay. We are now entertaining a recommendation for a subcommittee to address the standards, so a trauma standard subcommittee. Do we have any volunteers?

(Several members raise their hands.)

MS. COLSTON: Okay. Trauma standards subcommittee, I've got Dr. Reed, Dr. Namias, Dr. Ibrahim, Mr. Summers, Lisa, and Dr. Summers. Anybody else that I missed?

DR. McKENNEY: What's the purpose of the subcommittee, I guess?

MS. COLSTON: The subcommittee will begin to review, for modernization purposes, Pamphlet 150-9.

So Dr. Reed, Dr. Namias, Dr. Ibrahim, Dr. Ang, Mr. Summers, Dr. Summers, Lisa, and Donna; correct?

MR. ROSS: Okay. You need an administrator.

MS. COLSTON: Mr. Ross. Excellent. That's a great deal of the council, but that's excellent. So we will also kind of work through -- I guess we'll have -- we can arrange subcommittee meetings, since we're setting that up now, so we can arrange that. Keep in mind that we are going to work on dates here in just a moment, but we'll set up the same kind of meeting concept for the subcommittee as well. So you just tell us what your needs are, and we'll get that done.

Okay. We've got three priorities now. Everybody comfortable with that? Great. Okay.

DR. SUMMERS: If you don't mind, I really feel at some point, maybe next year, the year after, somehow or another this group ought to look at access, which so much of what we are trying to do is improve access to trauma care statewide.

Really I don't know of anybody that's looked at that recently, in terms of how we are doing, what we're doing, what we should do differently. We're going to eventually need to look at allocation and all those types of things. I think that's something that we ought to put on our radar to look at in this body at some point or another, looking at access to care, trauma care, in the state of Florida in 2019, or 2020, or whatever we're going to do.

I think that's an important part of what we're

trying to set up here and what we should be looking at as providers.

DR. NAMIAS: Aren't we going to be advisory for the needs 2020 study?

MS. COLSTON: Absolutely. It's not in here. I took it out because that's three years down the road type of thing, so we'd start looking at it in at least two years or so. So we can add it here if you want. I have no problem with that, if you want to start looking at it now, but I think, you know, it depends on what you want. It is on the radar, though. It won't fall off, because we have to do that.

DR. SUMMERS: I think it ought to be on there.

MS. COLSTON: Okay. Do we want to add that as a priority?

DR. NAMIAS: I second that.

MS. COLSTON: Okay. I'm denoting "access to trauma care"; is that okay? We'll put it to be determined. I'm also going to put some language in the assessment that's going to be 2020. So it will be on this charter. We can carry things over from this charter over to next year's charter, or whatever we decide to do -- whatever you all decide to do. I say "we" because it's just we'll get you there, but you guys are going to carry the torch.

Yes, Mac?

MR. KEMP: I'm glad you brought that up. That was on the top of my list, not being a trauma center. Trauma centers are very important, but this is much larger than trauma centers. A patient has to get to the trauma center alive, so we need to look at the entire trauma system, including EMS, air, and ground. And, you know, whatever training needs to occur, maybe even law enforcement with active shooters.

All of the things that are going on now, as far as tourniquet use, different types of bandages, things like that, are things that we should weigh in on in the state of Florida. How do we want to handle these larger types of trauma incidents as they occur? And then distribution of trauma patients when we have mass events, because one trauma center -- doesn't matter which one -- cannot handle it.

So we've got to be able to look at these things on a Las Vegas-type incident basis, things like that. Geospatial analysis of what is the reach of the ground ambulance, what is the reach of an air ambulance to the trauma center, to a pediatric trauma center.

We have some tools now that Department of Health, Biospatial And some of those other things, that we can pull some of that data and get some good information about where in Florida we should look at it, from a patient perspective -- not from a trauma center or EMS, but from a patient

perspective, how well are you going to be served, based on where you are geographically.

MS. COLSTON: Excellent. Thank you.

Okay. So we've got now full priorities, one maybe we'll look at that's on our radar. Do we have any other comments or discussion about any other priorities? I know we have a motion and second. If we're good, we can move forward.

The rest of this really is just the council procedures, council lead roles and responsibilities, which we don't really need to talk about lead roles and responsibilities because we just discussed it in bylaws, except for, you know, you actively participate as council members. It's just kind of some general rules and procedures that we'll live by.

We kind of note that the meetings will be held at least quarterly, so that means that, you know, there are other things that may take place as well. Under procedures, we note the sunshine laws. We state that we will always publish agendas in advance of the meeting. We may need to amend Number 5, where we talk about to be conducted in accordance with Robert's Rules of Order, because we modified that just a little bit, change that.

Then, you know, as an ask we always want you all as active members of this council to make sure that any notes,

or minutes, or anything that's produced by us is reviewed by you, to make sure that we've captured everything correctly. We will use our court reporter's notes to kind of develop things that we miss, but I pretty much take really good notes, make sure that they're as accurate as possible, but we want you guys to review them and be active participants in that process.

We've talked about constraints and assumptions. That's, again, just something for purposes of understanding what we can and can't do, as far as our resources. There are some things that we have to complete, so we've got these deliverables. When we talk about priorities and development of such, we need to understand what are the things that are absolutely required of us, what things can we kind of push back to the wayside, the kind of proposals that should be on the radar but we understand there's a workload earlier that we've already identified, so that may not get addressed this year.

These are things that typically, if we're using this document -- it is going to be a publicly available document -- we want folks to understand what this council is faced with, and it does have unique challenges and barriers. Please feel free to amend that section or the assumptions section as you see fit. If there's anything I've missed -- I don't know everything, and certainly you guys have a

better perspective than I do, so you can complete that as necessary.

That is the end of our charter, so if there are no other questions, I think we have a good draft. We will get this disseminated out to you all as soon as we have the edits that you've recommended here. Any questions or concerns?

I just want to say that we're moving right along. It's ten minutes to 12. We have some things left on the agenda as far as developing a meeting schedule. Do you want to go ahead and move into that?

MR. LEFFLER: Yes. We have looked at what meeting schedule will work best from the department's perspective, as far as facilitating meetings using available resources. Ultimately, the meeting schedule is up to you guys and your availability to do those meetings.

Our suggestion, at least for our next regular council meeting, would be to hold it during the EMS Advisory Council week, which is January 11th and -- excuse me -- July 11th and 12th. What we had envisioned was the Wednesday, July 11th, we would have a three-hour working meeting in the afternoon. Then immediately after the EMS Advisory Council we'd take a break for an hour or so, then move into the Trauma Advisory Council on Thursday afternoon.

DR. McKENNEY: That would be July 12th --

MR. LEFFLER: Yes, correct.

DR. McKENNEY: -- at around what time?

MR. LEFFLER: The working meeting would be the afternoon of July 11th; then the council meeting would be the afternoon of July 12th, around 1:00.

DR. NAMIAS: FCOT is also at the EMSAC, so it's all there. Just have to make sure it's not at the same hour.

MR. LEFFLER: Yes. We've worked with our partners, to try to ensure there's minimal interference. I know Mac, for example, and Dr. Elias, you guys have activities that you have to participate in. We've been working with EMS staff, to make sure we can facilitate a schedule that's conducive to everyone.

DR. McKENNEY: When is FCOT? I don't have that in front of me.

DR. NAMIAS: It's at EMSAC, July 10th and 11th.

DR. McKENNEY: Where is this going to be?

MR. LEFFLER: It's going to be in Orlando at the Caribe Royale Hotel.

MS. COLSTON: We will send that information.

MR. LEFFLER: We'll send that information out. This is just, at this point, for discussion purposes. Is there any objection to July 11th and 12th?

DR. REED: I've got a conflict, but I can move it.

MR. SUMMERS: I'll have EMS meeting obligations

also.

DR. NAMIAS: It's at the EMS meeting.

DR. McKENNEY: We're working around that.

MR. LEFFLER: We're working with EMS staff, to make sure to defuse any conflicts for members of the council

MS. DiNOVA: Also FCOT organizers, so they can get the timing of what those are?

MR. LEFFLER: I believe I spoke to FCOT's executive director, Brian Hart. I think we asked them to reach out to (inaudible) who actually provides us the space to hold that, to coordinate that.

So with trauma coordinators, I think the same thing is appropriate. Certainly we're working to provide a schedule that's conducive to everybody.

As far as future meetings, at least -- that's July. October, we're looking at meeting in St. Augustine. A date hasn't been nailed down, but that's where -- the direction I was looking at for October. We can certainly schedule any special meetings or commons hours in between.

DR. REED: On the July 12th, we'll actually meet all day or --

MR. LEFFLER: We'll meet to conduct council business. The idea would be that --

MS. COLSTON: It's 1:00 to 5:00 in the afternoon.

MR. LEFFLER: -- it's an opportunity to be able to

make any amendments to the bylaws, to the charter, to do any work relating to the pediatric survey, do any other work. Then the next day during the council meeting would be official adoption of all of those things.

DR. REED: The next day being the 12th or the 13th?

MR. LEFFLER: That's correct, the 12th.

MS. COLSTON: On the 11th, what time is that?

MR. LEFFLER: 1:00 to 5:00 in the afternoon.

MS. COLSTON: On both days?

MR. LEFFLER: Yes.

MS. COLSTON: We had to do the 12th because the EMS Advisory Council meets in the morning from 9:00 to 12:00.

MS. YORK: So four hours.

MR. LEFFLER: Four hours.

DR. NAMIAS: So 1:00 to 5:00 the 11th and the 12th.

MR. LEFFLER: Correct.

MS. COLSTON: Ideally, we would want to give you more than a month-and-a-half's notice or whatever, but we figured that because FCOT was being held at the same time that we would try to squeeze it in.

DR. NAMIAS: FCOT thanks you. You just improved our attendance.

MR. LEFFLER: So are we set for July? Is that agreeable to everybody?

MR. KEMP: Yes. Just to address EMS Advisory

Council Meetings in general, we meet January, April, July, and October of each year. Generally speaking right now, the January meeting has been held the last few years in Daytona. I think the contract still extends for another year or so. It's in conjunction with one of the large fire conferences on the East Coast, Fire-Rescue East.

So the advantage of being with the EMS Advisory Council is we always have different room space available. We would make room for the trauma group here. The April meeting moves all the time. It usually is in south Florida somewhere. This past year and the year before was in West Palm Beach -- Palm Beach Gardens, that's where it was.

MR. LEFFLER: We're looking at doing Palm Beach County again in this upcoming October. It probably will not be in the same location we held it previously.

MR. KEMP: You mean next April?

MR. LEFFLER: Yes. Sorry.

MR. KEMP: October is a little bit more north. July is always in Orlando, because of a medical conference there; we kind of associate with that. Then the October meeting is sometimes north, sometimes south. I like it to be more north personally myself.

So anyway, that's just generally how it is. We will work with the department and EMS to make sure we accommodate this meeting, if you choose to combine the

meeting with what we are doing.

MR. LEFFLER: We can take an official vote on this at our first meeting, as far as adopting a future meeting schedule. This is for planning purposes and kind of understanding -- the statute directed the department to put this together with existing available resources. This is the most judicious way for us to maximize our resources.

DR. NAMIAS: The American College of Surgeons in October is the 21st through 25th. You know, some senior people might have responsibilities before or after, so I would just say like the 19th through the 27th could potentially be conflicts with the surgeons' meeting.

MR. LEFFLER: We'll work on that.

MS. COLSTON: There are other options. We don't necessarily have to hold all of the meetings in conjunction with the EMS Advisory Council. We're not locked into that. We definitely appreciate -- because it's already a standing meeting -- that we can just kind of build on that. But I know that there are other meetings that we can -- like FCOT, tag into one of their quarterly meetings, just try to figure out how to do that.

I think as we kind of think about this, maybe we can't select dates right now beyond giving you what we've already given you. And that's good information, because we already need to look at a different meeting space for

October for this group. But if we can, what we'd like for you all to do is submit to Mike Leffler a calendar of all the major meetings that are taking place, whether it's for you personally or just in general. If it's duplicative and being reported by a bunch of different folks, that doesn't matter. We'll sort it out when we get it. I'd rather have more than less. That way we can kind of look at it from our end, what dates we might be able to propose for meetings, who we might be able to tag onto, you know. If we can call the FCOT folks that we work with and say, hey, can we hold our meeting in conjunction with where you guys are, or subsequent.

So if you can get all of that. When we send out the follow-up information from this meeting, that will be something that we include as one of your deliverables back to us, is kind of a calendar of what you all have going on over the next year, so that we can set that up.

This is also going to help us -- I think what we probably want to do is go ahead and maybe set up some commons hours meetings. Do we have a day of the week that works best for everybody here? Probably not. I'm just throwing it out there hypothetically. If we do it on a Friday in the morning, or Friday in the afternoon, or Monday, whatever. What would the group recommend?

What we can do is just go ahead and set one up

every week, so whether you guys are there or not we're going to set up an hour. We'll be there, so if anybody jumps on we can kind of help take minutes in general of what's going on. If we don't need them that frequently after the next couple of months, we can kind of decrease it. We'll let you know what that is, but at least you guys will know that there's a dedicated spot available for you to be able to discuss whatever. Are you good with doing that? If so, what day would be good? Once a week.

DR. NAMIAS: I don't know that any day is better than any other, but times. I would say I know mornings are tough for the surgeons. That's when everything happens. I think 3:00 or 4:00 we could, you know, hopefully be done with rounds or whatever. You might still miss, but --

MR. LEFFLER: If you look at the bylaws suggestion, participation in the commons hour meetings is not required.

MS. COLSTON: You won't be dinged for that.

DR. NAMIAS: But if it's in the mornings, the surgeons will never be there.

MS. COLSTON: So general consensus then is 3:00 or 4:00 would be good?

DR. REED: Random days of the week. Everybody's got a different schedule.

MS. COLSTON: So is one day a week good enough right now, or do we want two days?

DR. McKENNEY: Let's start with one, then if we get bogged down --

MS. COLSTON: We're just going to start with Monday, and schedule every one after that: Tuesday, Wednesday, all at -- 3:00 or 4:00? You guys pick.

MS. DiNOVA: 3:00 to 4:00.

MS. COLSTON: Okay. So we'll go ahead and get those set up. We're going to send those out as calendar invites, so they'll be on your calendar. They're going to be weekly for right now until this group decides otherwise. Okay.

MR. LEFFLER: That will help facilitate some of the premeeting stuff, as far as the meeting in July.

So I guess the next step is, Dr. Namias, you're going to send me a list of meetings that we could possibly hold it in conjunction with. We'll plan on July for our next meeting, then we'll look, in the July meeting, what our future meeting schedule will be for the rest of the year.

MS. COLSTON: And everybody send in --

MR. LEFFLER: Everybody can send me any conflicts.

MS. COLSTON: Whatever it is, even if it's anticipated, can you just note it as anticipated, but just let us know that that may be a barrier or a taken date. But everybody can send what they have, whether you know it for sure or whether it's anticipated, so that way we can at

least try to come up with a good meeting schedule.

We would, if at all possible, like to kind of keep the January and July, at least, to try to coincide with EMSAC, because there's a lot of the trauma folks that meet during that time. We try to get more bang for the buck, and for you guys, too, since we don't pay for your travel.

MR. LEFFLER: And there are some exciting things going on at EMSAC directly related to trauma, that certainly this group, I think, would have an interest in.

MS. COLSTON: So any other questions or concerns about the meeting schedule? We'll put a deadline on there, maybe a couple of weeks. I don't know if that's too short of a time, but if you could just respond back so we can kind of collate all that information, and then we'll start looking at proposed dates.

MS. YORK: So we set a meeting for July. We're going to have these commons meetings.

We set a deadline for the pediatric stuff for October 1st, before the October meeting -- I'm just saying.

MS. COLSTON: Yes. Do you have a recommendation as to what we might want to do with that?

MS. YORK: No. I'm just throwing that out there.

MR. LEFFLER: We can schedule special meetings as necessary, too, for purposes of -- if we want to schedule a meeting specifically to discuss and adopt the study.

MS. YORK: Okay. We have a little time. Okay.

MS. DiNOVA: Why don't we change the charter to say -- instead of October 1st -- for the October meeting?

MS. YORK: Yeah. If we do it for the October meeting, we could have it done and then vote on it at the October meeting.

MS. COLSTON: Okay. Let's keep that in mind. Leave it at October 1st now, with the thought that we can change it to coincide with the meeting that's going to be held in October, if we can do it in October.

Any other comments or questions? Thank you for that. As always, none of this stuff is set in stone. This is your council. We are here to support you. We appreciate whatever you guys want to give us, opinions of, you need to fix this, we need to do that. I think this is a great thing.

I think we accomplished pretty much everything we wanted to accomplish today.

MR. LEFFLER: We did. There is a public comments section available.

MS. COLSTON: Okay. So almost done. Great work today. We want to now open the phone lines -- you'll probably need to do it -- for public comment, if any was received. We did not receive any requests to speak via the phone line. We don't have any from here in the room,

either. We appreciate those folks who were able to attend today, both in person and on the phone.

At this particular point in time, then, I would like to ask Cindy Dick, our assistant deputy secretary, to come and provide some closing remarks for us.

MS. DICK: My closing remarks will be very brief. I know it's between lunch and travel back home. It's basically this: Everybody that's sitting at this table right now on this council is well aware of the last six -- for sure -- years of the Florida trauma system, and how, I believe, our progress towards a real patient-centric, quality-driven trauma system has been distracted by a lot of other issues.

I am really, really excited that this council has been created in the statute and brought together, because you guys are the people that really are the minds that need to create and craft the trauma system in Florida, a patient-centric approach to the trauma system in Florida.

I think, as was mentioned earlier, that includes from time of injury, you know, all the way through patient rehabilitation and reintegration back into what is some sort of their new normal.

My history, for those of you who don't know me, I come from 27 years of fire service. I come from a prehospital care perspective. I was mentioning to

Dr. Reed, actually, last night, there's been a great deal of debate by a lot of really smart people about what's the most important thing for trauma patients. Is it time? Is it distance to the nearest stabilization facility? Getting them to a Level I trauma center? What is the most important thing?

The only thing I can come down with at the end is, ask any paramedic if they want to transport a trauma alert patient for two hours, you know. So I'm thrilled that we have people from the prehospital community here. We have people from trauma agencies. We have people from trauma centers, for-profit, not-for-profit. None of that should matter when it comes down to the work of this council, which is, how do you design and create a sustainable trauma system that focuses on what's best for Floridians.

The registry, I think, is a good tool that is available. Everything that DOH has, the brain and spinal cord injury registry, the trauma registry, anything that we have is available to you, to help inform your decisions.

I think that you've got one specific mandate per statute for a report, but, to me, the sky is, you know, it's unlimited for you in the work that you do. I'm just really excited. I know that you are all giving up very, very valuable time to travel here, to be here, to focus on this, without personal gain to come from it. You know, the gain

here is going to be the legacy that you leave to people that come to Florida and sustain a traumatic injury, and what the outcome is of that.

So I just want to thank you so much for your time. I'm going to attend as many of these as I can, just because I love to hear the dialogue and the good conversation. I'm going to ask that you do what I know that you will do, which is stay focused on the product, and take all the other nonsense out of the way. I'm excited. Thank you for your time. Go forth and do great things.

MS. COLSTON: Meeting adjourned. Thank you very much. There will be a follow-up e-mail out to you shortly -- well, maybe not today, it's a big drive back -- but sometime soon. Thank you.

(This meeting adjourned at 12:08 p.m.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA )
)SS
COUNTY OF BREVARD)

I, ELIZABETH J. BEYER, a Notary Public in and for the State of Florida at Large, do hereby certify that I did report the proceedings in the Meeting held on the aforementioned cause before the Florida Trauma System Advisory Council; and, that the foregoing pages 1 through 130 constitute a true and correct transcription, to the best of my ability, of the proceedings in said Meeting.

I FURTHER CERTIFY THAT I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of parties' attorney or counsel connected with the action, nor am I financially interested in the event of this cause.

WITNESS MY HAND in the City of Melbourne, County of Brevard, State of Florida, this 6th day of June 2018.

ELIZABETH J. BEYER