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STATE OF FLORIDA

DEPARTMENT OF HEALTH

FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL MEETING

JULY 12, 2018

1:06 P.M. - 3:53 P.M.

CARIBE ROYALE ORLANDO, CARIBBEAN BALLROOM VII

8101 WORLD CENTER DRIVE

ORLANDO, FLORIDA, 32821

RECEIVED AUG 31 2018

ORIGINAL

Reported by:

Cynthia R. Green, Court Reporter

Notary Public - State of Florida

1 **PERSONS PRESENT:**

2

3

MAC KEMP

4

BRAD ELIAS, MD

5

LISA DINOVA, RN, BSN

6

DAVID SUMMERS, RN

7

ZEFF ROSS, FACHE

8

NICHOLAS NAMIAS, MD

9

ROBERT REED, MD

10

JOSEPH IBRAHIM, MD

11

DONNA YORK, RN, MSN

12

DARWIN ANG, MD

13

MARK MCKENNEY, MD (phone)

14

GLENN SUMMERS, MD (phone)

15

LEAH COLSTON, BUREAU CHIEF, BUREAU OF EMO

16

MICHAEL LEFFLER, OPERATIONS MANAGEMENT CONSULTANT, MANAGER

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P R O C E E D I N G S

July 12, 2018

1:06 p.m.

(The Florida Trauma System Advisory Council Meeting was called to order, after which the following took place:)

MR. LEFFLER: I'm going to call the meeting to order. Thank you guys for coming to the July 12th Florida Trauma System Advisory Council. This is our third time getting together and our first formal Council meeting.

We have a very aggressive agenda today. There are members on the phone. There is a public access to the telephone. If there's any questions, please e-mail me at michael.leffler@flhealth.gov.

If you'd all please stand for the Pledge of Allegiance.

(Please of Allegiance.)

Thank you. I'm going to go ahead and call the roll.

David Summers?

MR. SUMMERS: Here.

MR. LEFFLER: Dr. McKenney?

DR. MCKENNEY: Here.

1 MR. LEFFLER: Mr. Ross?

2 MR. ROSS: Here.

3 MR. LEFFLER: Mr. Kemp?

4 MR. KEMP: Here.

5 MR. LEFFLER: Dr. Ibrahim?

6 DR. IBRAHIM: Here.

7 MR. LEFFLER: Dr. Reed?

8 DR. REED: Here.

9 MR. LEFFLER: Donna York?

10 Donna sent me an e-mail. She is on her
11 way. We will amend the roll when she gets here.

12 Dr. Ang?

13 DR. ANG: Here.

14 MR. LEFFLER: Dr. Namias?

15 DR. NAMIAS: Here.

16 MR. LEFFLER: Ms. DiNova?

17 MS. DINOVA: Here.

18 MR. LEFFLER: Dr. Summers? Dr. Summers,
19 are you on the telephone? (No response.)

20 Dr. Elias?

21 DR. ELIAS: Present.

22 MR. LEFFLER: Are there any members that I
23 missed? (No response.)

24 Show the roll all present with the
25 exception of Ms. York and Dr. Summers.

1 Yesterday we met to finalize our Council
2 bylaws and work charter. So in order for us to
3 move forward with any official business, we will
4 need to review those bylaws.

5 We sent them out last night. I hope you
6 guys got a chance to look at them. Based off
7 the changes that we made yesterday.

8 We'll need to adopt the bylaws by
9 two-thirds vote and then we will conduct officer
10 elections.

11 Is there a motion to -- on the bylaws.

12 DR. NAMIAS: Motion to approve the bylaws.

13 MR. LEFFLER: Motion to approve bylaws by
14 Dr. Namias.

15 Is there a second?

16 DR. IBRAHIM: Second.

17 MR. LEFFLER: Seconded by Dr. Ibrahim.

18 We'll do a roll -- we'd do a rollcall vote
19 on -- excuse me --

20 MR. ROSS: You might want discussion.

21 MR. LEFFLER: Discussion. Is there
22 discussion?

23 MR. ROSS: Yeah, just some.

24 MR. LEFFLER: Mr. Ross, you're recognized.

25 MR. ROSS: Didn't want to disappoint.

1 A few minor changes. Very truthfully most
2 of it is either grammatical, typographical.

3 One question that I had, I would start on
4 Article 4. On the second line, I think we can
5 eliminate the words "the officers shall be
6 selected by majority vote of the Council"
7 because it already states above that all Council
8 officers shall be elected by a majority vote.

9 So I would suggest that as a motion.

10 MR. LEFFLER: Is there a second?

11 DR. REED: Second.

12 MR. LEFFLER: Second by Dr. Reed.

13 Is there further discussion? (No
14 response.)

15 All those in favor of Mr. Ross' amendment
16 to the bylaws, say aye. (Council members
17 responded.)

18 On the phone, is there any members that
19 have -- want to approve Mr. Ross' motion? (No
20 response.)

21 Hearing none, is there opposition? (No
22 response.)

23 All those opposed, say nay. (No response.)

24 Seeing no opposition, show the correction
25 Mr. Ross has suggested as amended to the bylaws.

1 Is there more discussion?

2 MR. ROSS: Yes.

3 MR. LEFFLER: Mr. Ross, you're recognized.

4 MR. ROSS: Oh, I'm sorry.

5 That was on Article 4. The very first
6 paragraph, second line, third sentence can be
7 removed.

8 MS. COLSTON: I'm sorry, one moment.

9 MR. ROSS: Okay.

10 MS. COLSTON: Article 4?

11 MR. ROSS: Article 4 in the first
12 paragraph. It is on the second line, third
13 sentence, that begins, "The officers shall be
14 selected by a majority vote of the Council,"
15 should be removed.

16 (Ms. Donna York entered the meeting room.)

17 UNIDENTIFIED SPEAKER: That's not the same
18 version as this.

19 UNIDENTIFIED SPEAKER: Yeah.

20 MR. LEFFLER: We will make the --

21 UNIDENTIFIED SPEAKER: The correction.

22 MR. LEFFLER: -- the correction. We're
23 just going to document the correction at the
24 moment.

25 UNIDENTIFIED SPEAKER: Yeah, it was in the

1 thing that Michael just sent out.

2 MR. LEFFLER: Yeah.

3 UNIDENTIFIED SPEAKER: From yesterday.

4 DR. NAMIAS: I make a motion to approve
5 Mr. Ross' typographical and grammatical errors
6 en masse.

7 MR. ROSS: I do have more.

8 I think it may be appropriate if the -- if
9 there's a motion for the Department to be able
10 to correct technical changes to the bylaws to
11 include punctuation, grammar, etcetera, without
12 substantive change.

13 DR. NAMIAS: So moved.

14 MR. LEFFLER: Good.

15 MR. ROSS: Second.

16 MR. LEFFLER: Second by Mr. Ross.

17 Back on the bylaws as amended --

18 MR. ROSS: We need to vote on that?

19 MR. LEFFLER: Yes. So is there --

20 MR. ROSS: One further question.

21 MR. LEFFLER: Yes, Mr. Ross, you're
22 recognized.

23 MR. ROSS: I recognize and this one took me
24 a little while to go through, within the
25 document, on the voting, under the addition of

1 officers, for example, on Article 4, the formal
2 motion requires a three-quarter vote to amend.

3 And it didn't say of the full Council or
4 participating members. On page three it says,
5 two-thirds vote for approval of motions of all
6 participating Council. On the last page, it
7 went into bylaws would require two-thirty --
8 two-thirds majority of the full Council.

9 And although we can follow it and the
10 parliamentarian will need to do such, do we want
11 to make this simpler and say three-quarters
12 everything?

13 DR. REED: Actually, I agree with that
14 concept that we need to have a single number so
15 we don't have to keep track of which is which.

16 And it might help to define what a
17 supermajority is at the beginning of the
18 document. In fact, put definitions in for any
19 of these references.

20 So, if we say supermajority in one of the
21 texts you'll be able to see in the definitions
22 --

23 MR. LEFFLER: I think yesterday when we
24 went through this we had removed all the words
25 supermajority and either put three-quarters or

1 two-thirds.

2 DR. REED: Right. But we need --

3 MR. LEFFLER: But we'll -- we can
4 standardize that, but as I understand it, the
5 motion by Mr. Ross would be to standardize
6 across the board three-quarters and two-thirds.

7 Is that correct, Mr. Ross?

8 MR. ROSS: Correct.

9 DR. REED: So replace all two-thirds with
10 three-quarters?

11 MR. ROSS: Correct. And if it does say
12 supermajority anywhere where I did read it once,
13 three-quarters.

14 MR. LEFFLER: Dr. Namias, you're
15 recognized.

16 DR. NAMIAS: At our first meeting I recall
17 this wasn't an oversight, having three-quarters
18 for one thing and two-thirds for another. We
19 had a -- we had a good reason, which I can't
20 recall.

21 But we had a reason. I think we made it --
22 I think what we did is we made it harder to make
23 a bylaws change than to just pass something of
24 our -- of our business.

25 And that's why they were different from

1 each other.

2 MR. LEFFLER: And in this case they are
3 two-thirds, where some of our business is
4 three-quarters.

5 MR. ROSS: Right. And in contradiction to
6 what was stated, if the bylaws are supposed to
7 be harder to change, this is only two-thirds
8 majority.

9 DR. NAMIAS: But it might have been
10 two-thirds of the whole Council for bylaws and
11 three-quarters of those present for regular
12 business.

13 MR. LEFFLER: Can I entertain a motion for
14 an amendment?

15 MR. ROSS: I would entertain -- I would
16 make the motion that everything is
17 three-quarters.

18 MR. LEFFLER: Is there a second? (No
19 response.)

20 Is there discussion? (No response.)

21 All those in -- Mr. Kemp, you're
22 recognized.

23 MR. KEMP: I fear and have to just state
24 that if we say three-quarters on everything,
25 this Council's not going to get anything done.

1 Just stating a fact.

2 So that's a pretty high number. So I think
3 it's unobtainable and we're not going to move
4 anything forward with that level of consensus.

5 So I would say we go to two-thirds.

6 MR. LEFFLER: Dr. Namias, you're
7 recognized.

8 DR. NAMIAS: The reason that we decided to
9 have a supermajority is that the contentious
10 nature of the trauma system is not that far in
11 the rearview mirror and in the spirit of trying
12 to get to work together this would get --
13 somebody would have to cross the aisle so that
14 we could actually do something good for the
15 patients together, rather than protect our own
16 turf.

17 MR. LEFFLER: Mr. Kemp.

18 MR. KEMP: That is -- that is exactly my
19 point. I don't want to, you know, and I will, I
20 mean, I'm here. I've been appointed by the
21 Governor. But I hate to be a part of a council
22 where nothing gets decided.

23 So we could be here a year later and say,
24 all right, we've taken 30 votes and we've turned
25 down 30 votes. So I just, you know, as long as

1 we're cognizant of where we're headed with this
2 and, you know, I'll be honest with you, as from
3 the EMS perspective, I don't have a dog in the
4 fight.

5 So my main purpose in being here is
6 representing EMS to get the patient to you. But
7 we -- I just would like to see something that's
8 reasonable.

9 DR. REED: I agree with that concern and
10 that's why if I think we define a couple of
11 terms, we haven't called a majority, which would
12 be our simple thing at two-thirds and the other
13 would be a supermajority for the really, you
14 know, tough stuff, the stuff that we really need
15 everybody's buy-in on.

16 Define those at the beginning of the
17 document and then when we're reading the actual
18 bylaws, those terms would be asserted where it's
19 appropriate based upon the concern for getting
20 it done versus the concern for everybody's
21 buy-in.

22 MR. LEFFLER: I understand. Thank you,
23 Doctor.

24 Dr. Namias, you're recognized.

25 DR. NAMIAS: We really established the

1 supermajority thing at the first session because
2 our history has been not a good one and it won't
3 take much for this -- this committee,
4 unintentionally, to be an n+1 majority.

5 And then we'll see everything either go the
6 way that the public hospitals and the safety net
7 wants or we'll see everything the way the
8 investor-owned hospitals want it to go.

9 And there are things that matter to both.
10 And so I think it's better to get cooperation
11 for the patients by having someone have to swing
12 from either side to get something done.

13 MR. LEFFLER: Is there any further
14 discussion? (No response.)

15 So Mr. Ross' motion is to amend all -- all
16 voting to three-quarters, correct? (No
17 response.)

18 Is there a second?

19 DR. NAMIAS: Second for everything to be
20 three-quarters.

21 MR. LEFFLER: Second by Dr. Namias.

22 All those in favor, say aye. (Council
23 members responded.)

24 All those opposed? (Council members
25 responded.)

1 Let's do a rollcall on that.

2 David Summers?

3 MR. SUMMERS: No.

4 MR. LEFFLER: Dr. McKenney?

5 DR. MCKENNEY: What does aye get me? I'm
6 sorry.

7 MR. LEFFLER: Aye would -- aye would -- the
8 aye would signify that you're in favor of
9 changing all voting requirements to be
10 three-quarters as -- to pass Council business.

11 DR. MCKENNEY: Aye.

12 MR. LEFFLER: Mr. Ross?

13 MR. ROSS: Yes.

14 MR. LEFFLER: Mr. Kemp?

15 MR. KEMP: No.

16 MR. LEFFLER: Dr. Ibrahim?

17 DR. IBRAHIM: Yes.

18 MR. LEFFLER: Dr. Reed?

19 DR. REED: No.

20 MR. LEFFLER: Ms. York?

21 MS. YORK: Yes.

22 MR. LEFFLER: Dr. Ang?

23 DR. ANG: No.

24 MR. LEFFLER: Dr. Namias?

25 DR. NAMIAS: Yes.

1 MR. LEFFLER: Ms. DiNova?

2 MS. DINOVA: Yes.

3 MR. LEFFLER: Dr. Summers?

4 DR. SUMMERS: Yes.

5 MR. LEFFLER: Dr. Elias?

6 DR. ELIAS: Yes.

7 MR. LEFFLER: Did all members vote? (No
8 response.)

9 Show the motion passed eight to four.

10 MR. ROSS: I have one additional item.

11 MR. LEFFLER: Mr. Ross, you're recognized.

12 MR. ROSS: I beg your indulgence. On the
13 last page where it's Article 7, number one,
14 committees will be made up of three to 10
15 people, etcetera, it says, committees shall be
16 chaired by a member of the Council, on the
17 subcommittees it'll be led by a committee
18 member.

19 Yesterday we had the discussion and the
20 difficulty in getting a chair for that
21 committee. May I suggest that we change,
22 committee shall be chaired by and put the word
23 in led by.

24 MR. LEFFLER: Is there discussion? (No
25 response.)

1 Is there a second to Mr. Ross' motion?

2 DR. ANG: Second.

3 MR. LEFFLER: Second by Dr. Ang.

4 All those in favor, say aye. (Council
5 member responded.)

6 All those opposed? (Councils members
7 responded.)

8 Members on the phone, is there any
9 opposition to changing the word chaired to led
10 in the Council's subcommittees, committees and
11 workgroups?

12 DR. MCKENNEY: No opposition.

13 DR. SUMMERS: No objection.

14 MR. LEFFLER: Show the edit amended.

15 Any further discussion on the bylaws? (No
16 response.)

17 So as we have it right now, when we go to
18 vote on these bylaws, it will require a
19 three-quarter pass or three-quarter vote in
20 order to adopt the bylaws.

21 Can I entertain a motion to approve the
22 bylaws?

23 MR. ROSS: So moved.

24 MR. LEFFLER: Motion by --

25 DR. NAMIAS: Second.

1 MR. LEFFLER: Second by Dr. Namias.

2 New rollcall vote on the bylaws.

3 Mr. Summers?

4 MR. SUMMERS: Pass them.

5 MR. LEFFLER: Dr. McKenney?

6 DR. MCKENNEY: I'm sorry, tell me what the

7 two votes are again. What does each side --

8 MR. LEFFLER: We're voting to approve the

9 bylaws as amended.

10 DR. MCKENNEY: Agree.

11 MR. LEFFLER: Mr. Ross?

12 MR. ROSS: Yes.

13 MR. LEFFLER: Mr. Kemp?

14 MR. KEMP: Yes.

15 MR. LEFFLER: Dr. Ibrahim?

16 DR. IBRAHIM: Yes.

17 MR. LEFFLER: Dr. Reed?

18 DR. REED: Yes.

19 MR. LEFFLER: Ms. York?

20 MS. YORK: Yes.

21 MR. LEFFLER: Dr. Ang?

22 DR. ANG: Yes.

23 MR. LEFFLER: Dr. Namias?

24 DR. NAMIAS: Yes.

25 MR. LEFFLER: Ms. DiNova?

1 MS. DINOVA: Yes.

2 MR. LEFFLER: Dr. Summers?

3 DR. SUMMERS: Yes.

4 MR. LEFFLER: Dr. Elias?

5 DR. ELIAS: Yes.

6 MR. LEFFLER: Show the bylaws adopted

7 unanimately.

8 The next order of business that we have, in
9 conjunction with approving our new bylaws, is to
10 nominate Council officers.

11 As the bylaws state, the Department will
12 serve as the parliamentarian and secretary for
13 the Council. However, we need to elect a
14 moderator.

15 Dr. Namias, you're recognized.

16 DR. NAMIAS: I nominate Mr. Leffler to be
17 the moderator.

18 MR. LEFFLER: Is there a second?

19 DR. ELIAS: Second.

20 UNIDENTIFIED SPEAKER: Second.

21 MR. LEFFLER: I will -- I should point out,
22 I did receive two nominations for Mr. Ross to
23 serve a moderator.

24 Mr. Ross, do you accept your nominations to
25 serve as moderator?

1 MR. ROSS: No. At this point I don't. I
2 like the idea, as mentioned, of having you do
3 such. So, thank you.

4 MR. LEFFLER: Is there -- so, Dr. Namias'
5 motion to nominate me as the moderator. Is
6 there discussion? (No response.)

7 Is there a second?

8 DR. ANG: Second.

9 MR. LEFFLER: Second by Dr. Ang.

10 All those in favor of me being the
11 moderator of the Florida Trauma System Advisory
12 Council, say aye. (Council members response.)

13 All those opposed? (Council members
14 responded.)

15 Showing no opposition, thank you.

16 With that said, I mean, one of the things I
17 want to point out is, this is you guys' council.
18 You know, my involvement is to facilitate
19 meetings and strictly carry out the role of the
20 moderator.

21 And I'm honored for the appointment, but I
22 don't want it to overshadow -- my involvement to
23 overshadow the autonomy of this Council. Thank
24 you.

25 We have a couple of old business items. In

1 your meeting packets on the left-hand side,
2 there is the copy of the minutes from the May
3 24th meeting. They are abbreviated. We have a
4 full court reported transcript of the meeting.

5 Can I entertain a motion to approve the
6 minutes from May 24th?

7 MR. ROSS: So moved.

8 MR. LEFFLER: Motion made by Mr. Ross.

9 DR. NAMIAS: Discussion. So it's in the
10 minutes. So we had -- what we had done was we
11 said two-thirds for all business and that a
12 quorum was three-quarters, and two-thirds for
13 the bylaws.

14 So it really -- it really was -- we already
15 had in place two-thirds. What we did today was
16 we made it harder up to three-quarters.

17 MR. LEFFLER: That is correct. Which is
18 nine members.

19 Is there a second to approve the minutes?

20 UNIDENTIFIED SPEAKER: We have 12 members?

21 MR. ROSS: Yes.

22 MR. LEFFLER: Correct.

23 UNIDENTIFIED SPEAKER: Three-quarters would
24 be eight.

25 MR. LEFFLER: Excuse me. Yes, it would

1 require eight members. Thank you.

2 Second to approve the minutes.

3 UNIDENTIFIED SPEAKER: That would be nine.

4 MR. ROSS: It's nine.

5 UNIDENTIFIED SPEAKER: It would be nine.

6 UNIDENTIFIED SPEAKER: It would be nine.

7 Two-thirds would be eight.

8 Well, yeah, you were right.

9 Yeah, two-thirds is eight.

10 MS. DINOVA: Two-thirds would be eight,
11 three-quarters is nine. It's a difference of
12 one vote.

13 DR. REED: Yeah, one vote. Yeah.

14 DR. NAMIAS: So, you know, we were -- we
15 were arguing about majority, not majority. Make
16 it a difference of one vote and I'm afraid now
17 that what we've done by making it three-quarters
18 instead of two-thirds is we might realize, Dr.
19 Kemp -- Mr. Kemp's nightmare.

20 I think two-thirds is -- I don't know if I
21 can make this as a motion to change all the
22 three-quarters to two-thirds. Anything but n+1.
23 Anything but n+ -- see, what we had -- we were
24 trying to avoid that.

25 You missed the first meeting. Was, we're

1 trying to avoid the n+1 situation.

2 Three-quarters might make Mac's, you know,
3 doomsday scenario a reality.

4 Two-thirds still would mean that someone
5 would have to cross over -- cross the aisle
6 here.

7 MR. LEFFLER: Can I make the -- a
8 suggestion? For today's business, I recommend
9 that we proceed with the bylaws as adopted and
10 we can certainly revisit the bylaws. We can
11 call a special meeting, even if it's via
12 telephone. And we can make a separate meeting
13 to once again address the bylaws and polish
14 them.

15 This is, obviously, the foundation of this
16 Council. It's obviously our founding document
17 at this point and I think we're going to have to
18 probably make some amendments along the way.
19 But in the spirit of keeping business moving
20 today, I recommend that we move that to a
21 telephone conference call meeting.

22 DR. REED: I think if we feel that there's
23 some action that should be happening and it's
24 not happening, that's when we would start to
25 focus on, should we reduce the majority

1 requirement.

2 Of course, that would depend upon what the
3 opinion is of those people who are blocking it.
4 You know, it could come up as a specific issue.

5 MR. KEMP: Michael?

6 MR. LEFFLER: Mr. Kemp.

7 MR. KEMP: I would like to point out that
8 the two votes that we've taken since we've
9 started that failed were eight to four. And if
10 we had already passed this, we wouldn't have
11 made a decision.

12 It wouldn't be enough to pass.

13 DR. NAMIAS: But it would be by two-thirds.

14 MR. KEMP: Yes, it would be by two-thirds,
15 but it will not be by three-quarters. So the
16 votes so far has split eight to four. Just
17 consider that where we are and I think we're
18 headed toward -- to do nothing.

19 MR. LEFFLER: As a point of order here,
20 we'll withdraw the motion on the minutes and
21 reopen discussion here on the bylaws.

22 It would require three-quarter majority
23 vote to change from three-quarters to
24 two-thirds. So, Dr. Namias or Mr. Kemp, would
25 you -- either of you like to make a motion to

1 amend the bylaws to two-thirds?

2 MR. KEMP: I've had two failed motions, so
3 I'll make -- I'll make another failed one. It
4 doesn't bother me.

5 MR. LEFFLER: So Mr. Kemp --

6 MR. KEMP: Let's have a motion to make
7 everything two-thirds instead of three-quarters.

8 MR. LEFFLER: Mr. Kemp's motion is to
9 reopen the bylaws and to change everything to
10 two-thirds.

11 Is there a second?

12 UNIDENTIFIED SPEAKER: I second.

13 MR. LEFFLER: Second.

14 Is there discussion?

15 DR. NAMIAS: Just a question. Is it
16 two-thirds, then, of the members that are
17 present? So if we are missing -- if a Council
18 member or two is absent, what is the number
19 we're using at that point?

20 UNIDENTIFIED SPEAKER: It should be
21 two-thirds of the quorum, is how we had looked
22 at that before.

23 MS. DINOVA: And the quorum was
24 three-quarters?

25 DR. ELIAS: Yeah. If you have a quorum of

1 two-thirds of the people here?

2 UNIDENTIFIED SPEAKER: The quorum is
3 three-quarters. So if you have quorum, you have
4 a meeting and of those who are here voting
5 two-third passes.

6 MR. LEFFLER: All right. The motion with a
7 second that all voting be changed to two-thirds
8 from three-quarters in the previously approved
9 bylaws is on -- is on the floor.

10 And I'll go ahead and take a rollcall vote
11 on that motion.

12 Mr. Summers?

13 MR. SUMMERS: Yes.

14 MR. LEFFLER: Dr. McKenney?

15 DR. MCKENNEY: Nay.

16 MR. LEFFLER: Mr. Ross?

17 MR. ROSS: No.

18 MR. LEFFLER: Mr. Kemp?

19 MR. KEMP: Yes.

20 MR. LEFFLER: Dr. Ibrahim?

21 DR. IBRAHIM: Yes.

22 MR. LEFFLER: Dr. Reed?

23 DR. REED: Yes.

24 MR. LEFFLER: Ms. York?

25 MS. YORK: Yes.

1 MR. LEFFLER: Dr. Ang?

2 DR. ANG: Yes.

3 MR. LEFFLER: Dr. Namias?

4 DR. NAMIAS: Yes.

5 MR. LEFFLER: Ms. DiNova?

6 MS. DINOVA: Yes.

7 MR. LEFFLER: Dr. Summers? (No response.)

8 Dr. Summers, are you on the line? (No
9 response.)

10 Dr. Elias?

11 DR. ELIAS: Yes.

12 MR. LEFFLER: (Phone ringing.)

13 Dr. Summers, are you on the line?

14 DR. SUMMERS: Yes. I'm sorry. I had a
15 little technical difficulty.

16 MR. LEFFLER: Yeah. Understand. The
17 motion that we are voting on at the moment is to
18 amend our bylaws that we just approved to change
19 all voting requirements for passage of Council
20 business from three-quarters to two-thirds.

21 DR. SUMMERS: That seems like the thing to
22 do. I agree.

23 MR. LEFFLER: Dr. Summers votes yes.

24 The motion passes -- Mr. Kemp's motion
25 passes 10 to two to amend the bylaws to require

1 two-thirds vote across the bylaws.

2 Show the bylaws amended.

3 Any other discussion on the bylaws? (No
4 response.)

5 All right. Like I said, we had -- in your
6 meeting packets are the minutes from the May
7 24th meeting. They -- can I entertain a motion
8 to approve the minutes?

9 MR. ROSS: There is a motion.

10 MR. LEFFLER: The motion is to -- can I
11 entertain a second?

12 DR. NAMIAS: Second.

13 MR. LEFFLER: Motion and a second.

14 All those in favor of approving the minutes
15 from May 24th meeting? (Council member
16 responded.)

17 All those opposed? (No response.)

18 Seeing no opposition, show the minutes from
19 May 24th approved.

20 The next item on our agenda is, yesterday
21 we worked on -- excuse me, I want to backtrack
22 for a minute.

23 We just did officer elections a few minutes
24 ago. We did not select a co-moderator. Is
25 there a nomination for a co-moderator?

1 DR. REED: Ms. Colston?

2 DR. NAMIAS: Second.

3 MR. LEFFLER: Ms. Colston, you've been
4 nominated to be co-moderator. Do you accept?

5 MS. COLSTON: Sure.

6 MR. LEFFLER: All right. There's a motion
7 and a second for Ms. Colston to be co-moderator
8 of the Florida Trauma System Advisory Council.

9 All those in favor -- is there further
10 discussion? (No response.)

11 All those in favor, say aye. (Council
12 members responded.)

13 All those opposed? (No response.)

14 Showing no opposition, show Ms. Colston as
15 the co-moderator for the Florida Trauma System
16 Advisory Council.

17 THE REPORTER: Could I get who made that
18 motion and who seconded.

19 DR. REED: I did.

20 MR. LEFFLER: The motion was made by
21 Dr. Reed and it was seconded by Dr. Namias.

22 THE REPORTER: Thank you.

23 MR. LEFFLER: The next item of business is,
24 yesterday we worked on the Council charter. You
25 should find the most current version of our

1 Council charter in the work packet. This is a
2 document that we can continue to modify as we
3 move along, but it is the product of what we did
4 yesterday in our meeting.

5 Can I entertain a motion related to the
6 charter? Whether to approve or to amend?

7 MR. ROSS: I'd like to make a motion to
8 approve the charter with, as we stated before,
9 grammatical corrections able to be made, as
10 well.

11 And I'll give you a list of what needs to
12 be done.

13 MR. LEFFLER: Is there a second?

14 MR. SUMMERS: Second.

15 MR. LEFFLER: Second by Mr. Summers.

16 All those in favor of adopting one --

17 MR. ROSS: Just one --

18 MR. LEFFLER: Mr. Ross, you're recognized.

19 MR. ROSS: For discussion purposes, thank
20 you.

21 Did we want to change the December 15th
22 date to amend it to the December 1 date to make
23 it in concert with what was done yesterday that
24 is on priority assignment five?

25 It says December 15th. I know it's first

1 2019, but in concert with the recognition that
2 it's going to take a month to process, might as
3 well make it December 1 or November 30th.

4 MR. LEFFLER: Is there a motion to amend
5 the Council's charter on tasking number five to
6 December 1st rather than December the 15th?

7 UNIDENTIFIED SPEAKER: (Nonverbal
8 response.)

9 MR. LEFFLER: Is there a second?

10 DR. NAMIAS: Discussion before a second?

11 MR. LEFFLER: Yes. Dr. Namias, you're
12 recognized.

13 DR. NAMIAS: So that's one of those things
14 I -- also I think that we spent time on, picking
15 dates. And there are no good dates. And, you
16 know, December 15th you're getting closer to
17 Christmas. December 1st, you're right after
18 Thanksgiving.

19 All the dates stink. So I don't know that
20 we really need to change it. We sort of
21 deliberated to come up with that date.

22 DR. REED: Yeah. Maybe we need to outline
23 the steps in that under the action steps before
24 we focus on the date.

25 MR. LEFFLER: I did -- Ms. Colston wanted

1 me to remind that on this particular item it's
2 not statutorily mandated, so you guys set the
3 date on this.

4 MR. ROSS: Right. Okay. Thank you for the
5 discussion.

6 UNIDENTIFIED SPEAKER: I think TBD --

7 UNIDENTIFIED SPEAKER: TBD --

8 UNIDENTIFIED SPEAKER: -- without the
9 December 15th would be fine.

10 MR. LEFFLER: Without the December 15th.
11 So I -- there's two motions. There's Mr. --

12 MR. ROSS: I remove mine.

13 MR. LEFFLER: Mr. Ross withdraws his
14 motion. And is there any other motion to amend
15 the charter? (No response.)

16 All right. Showing no -- Dr. Reed?

17 DR. REED: I would amend the deliverables
18 to just TBD with no date.

19 MR. LEFFLER: All right. There's a motion.

20 MS. DINOVA: (Nonverbal response.)

21 MR. LEFFLER: A second by Ms. DiNova.

22 Is there discussion? (No response.)

23 All right. All those in favor, say aye.
24 (Council members responded.)

25 All those opposed? (No response.)

1 Hearing no opposition --

2 DR. REED: Further discussion on the
3 charter. We do have a three-quarters on Page
4 5-of-6. Does that need to be changed to
5 two-thirds as well?

6 MR. LEFFLER: Yes. Can there be a motion
7 to amend the two -- three-quarters to two-thirds
8 to align with the bylaws?

9 DR. NAMIAS: So moved.

10 MR. LEFFLER: So moved. Is there a second.

11 MS. YORK: (Nonverbal response.)

12 MR. LEFFLER: Second by Ms. York.

13 Is there any further discussion? (No
14 response.)

15 All those in favor of amending the charter
16 to align with the bylaws, say aye. (Council
17 members responded.)

18 All those opposed? (No response.)

19 All right. Is there -- is there another
20 motion related to the Council charter? (No
21 response.)

22 Is there a motion to approve?

23 MR. KEMP: So moved to approve.

24 MR. LEFFLER: Motion made by Mr. Kemp.

25 Is there a second?

1 MR. SUMMERS: Second.

2 MR. LEFFLER: Second by Mr. Summers.

3 All those in favor of adopting the charter
4 as amended, say aye. (Council members
5 responded.)

6 All those opposed? (No response.)

7 Hearing no opposition, see the charter
8 adopted.

9 The next item on the agenda relates to our
10 pediatric center verification work plan and
11 study that we worked on yesterday. We came up
12 with a timeline.

13 I don't know that we need to take an
14 official action to adopt the timeline. We're
15 going to have a commons hour discussion on July
16 the 18th and we're -- and we're going to move
17 there with the tentative schedule and we will
18 lock that down as we start to come into little
19 bit better focus of what our needs are.

20 Ms. DiNova, did you have discussion?

21 MS. DINOVA: Yes, please.

22 I sent out a document this morning that I
23 think got sent out to the group that was, as you
24 guys had requested, pulling out that second
25 section and adding page numbers to it.

1 I also have -- went ahead and created just
2 a basic template and took those sections and put
3 them in and then added columns for price costing
4 out for the pediatric centers and then also for
5 adults, since we have already said that we're
6 going to go across the board with it.

7 I think if we try to send out two separate
8 surveys asking one for pediatric costs and one
9 for adult costs, they're going to see it as a
10 second survey and it's not going to get filled
11 out. So I believe that we should probably try
12 to get that incorporated into one survey.

13 I also would recommend that we split that
14 up because yesterday we were discussing that
15 we're all going to go back to our centers and
16 come back and e-mail in questions for the survey
17 for the DOH to distribute for us. But I believe
18 that maybe we should each take either a chapter
19 or a couple of pages so that we're not
20 duplicating work, so that we're not all looking
21 at questions one through five.

22 Because what we're going to need to do is
23 take those standards and convert that into a
24 question. And I know that we're all going to
25 start at page one and then we're all going to

1 get to page four and then pages, you know, 19
2 and 22 and not going to get done.

3 So if maybe we could look at that. I don't
4 know that we have it that we can see it up on
5 the screen that I sent out. That maybe we could
6 agree to either take a chapter or a few pages
7 each so that we're not duplicating work.

8 DR. REED: How many --

9 MR. LEFFLER: I'll make sure that it gets
10 sent out to the group. I apologize.

11 DR. REED: How many pages were there total?

12 MS. DINOVA: I believe on the new copy it
13 was 20.

14 DR. NAMIAS: Twenty's not bad.

15 DR. REED: No, and the number --

16 MS. DINOVA: No. So if we each --

17 DR. REED: -- the number of items on each
18 page, however, varies a little because some are
19 longer than others.

20 MS. DINOVA: Right. And also it varies.
21 It was hard to say, too, that if we each took a
22 chapter because some chapters only had two or
23 three things --

24 DR. REED: Right.

25 MS. DINOVA: -- to look at and some

1 chapters had 22 things to look at. But if I can
2 get logged in here real quick I can tell you
3 exactly how I had it separated out.

4 But I would hate for all of us to be
5 rephrasing the same ones.

6 DR. REED: Right.

7 MS. DINOVA: So I have it here and it was
8 20 pages when we looked at just that second
9 section.

10 And then all I did, I think they're trying
11 to get it up on the screen, but all I did was I
12 took the ACS chapter that it was part of, I took
13 the standard that we had out of there and added
14 a column for estimated cost to meet standard for
15 pediatric program and estimated cost to meet
16 standard for adult program.

17 That then we could take those individual
18 standards and convert them into a question to
19 put onto the survey.

20 DR. REED: Right.

21 MR. LEFFLER: And I have not sent the cost
22 analysis tool that Ms. DiNova's created out to
23 the group yet. I will do that this afternoon.

24 You did get a revised version of the
25 crosswalk with the page numbers.

1 MS. DINOVA: Yeah, I did this after.

2 MR. LEFFLER: Would you prefer the
3 Department to divide up the sheets and send them
4 out to each of the members as assignments?

5 MS. DINOVA: That would be fine. I just
6 don't want us all working on the same ones and
7 then the other things not get addressed.

8 MR. LEFFLER: Okay. Is there a motion to
9 have the Department divvy up the standards for
10 development of questions?

11 MS. DINOVA: Yes.

12 DR. NAMIAS: Second.

13 MR. LEFFLER: Motion by Ms. DiNova. Second
14 by Dr. Namias.

15 All those in favor, say aye. Or, excuse
16 me, is there discussion?

17 DR. ANG: Will the Department give us some
18 clarity on what the expectations are? I mean I
19 assume there could be multiple different work
20 products coming out of it. So we need some sort
21 of guideline, basically, is what I'm asking.

22 MR. LEFFLER: Where we have -- let's -- the
23 -- the discussion has led so far is that we want
24 to take the standards there and compare them and
25 develop -- and determine whether there was a

1 need -- there was a cost increase to switching
2 to ACS. And if there way, how do we estimate
3 that cost.

4 So the -- it would be to compare the
5 standards and develop a question to ask a
6 hospital on what their cost would be to
7 implement that standard.

8 DR. ANG: Okay.

9 MR. LEFFLER: And then the Department would
10 create a survey --

11 DR. ANG: All right.

12 MR. LEFFLER: -- and send it out to the
13 trauma centers.

14 DR. ANG: All I'm asking is the Department
15 provide some documentation and guideline that's
16 consistent for every single member on the
17 Council so that we all end up with the same work
18 product.

19 MR. LEFFLER: Okay. Yes, we will assure
20 that that is -- that is in place.

21 DR. ANG: Thank you.

22 MR. LEFFLER: And we'll work with Lisa --
23 Ms. DiNova, to ensure -- to ensure that that
24 moves fluidly.

25 MS. DINOVA: Got it.

1 MR. LEFFLER: So there's a motion on the
2 floor that's seconded to have the Department
3 divvy up the standards and assign them to the
4 members.

5 Is there further discussion? (No
6 response.)

7 All right. All those in favor, say aye.
8 (Council members responded.)

9 All those opposed? (No response.)

10 Hearing no opposition, show adopted
11 Ms. DiNova's motion to have the Department send
12 out assignments related to development of survey
13 questions.

14 Is there any other discussion that members
15 feel that we need to have related to the
16 pediatric study?

17 Dr. Ibrahim?

18 DR. IBRAHIM: I know we discussed the
19 timeline for the assignment. Is that anything
20 that needs to be voted on? You know, we talked
21 about -- Ms. Colston gave us a good timeline
22 yesterday, which I'm all fine with, but I don't
23 know that we actually discussed it and voted.

24 Is that okay?

25 MR. LEFFLER: We can -- we can vote on

1 that. The schedule that was -- that we came up
2 with yesterday was that we would meet on July
3 the 18th during our commons hour to discuss
4 possible questions then questions would come --
5 would come together by July the 26th and the
6 Department, in the first week of August, would
7 send out the survey to the trauma centers.

8 We would give them 30 days to complete the
9 study. We would provide DOH support to reach
10 out to the trauma centers to encourage response
11 to the survey. We also wanted members to
12 individually reach out in their networks and
13 encourage response to the survey.

14 And then we would come together to analyze
15 the data to develop a policy recommendation in
16 our October meeting.

17 MS. COLSTON: And, I mean, if you want to,
18 you can, you know, motion to approve, but it's
19 really -- the -- what you're completing is
20 already approved by the Council and statutorily
21 required.

22 DR. IBRAHIM: Okay.

23 MS. COLSTON: We just want to make sure
24 that we'll send that out to everybody so that
25 everyone will have that schedule. And if we

1 need to amend it, we can do that as well.

2 I don't -- but I know we're being very
3 formal and we want to be, you know, very formal
4 with many of the things that we're doing
5 initially until we get to a certain point where
6 the level of formality is not so -- not so
7 necessary.

8 But for this, I think we'll be okay with
9 just doing it as a, you know, a timeline or
10 something of that nature.

11 MR. LEFFLER: Is there further discussion
12 related to the pediatric study? (No response.)

13 All right. Seeing none, we have something
14 -- a couple of presentations this afternoon that
15 we felt would be important to bring to the
16 Council relating to things that are going on
17 within Florida's trauma system already and tools
18 and developments of products that are used for
19 public health elsewhere in the Department that
20 we think may have a good use in trauma.

21 And so the first of those presentations
22 today is going to be by Josh Sturms. Josh is
23 the administrator for our Health Information and
24 Public Policy Section in the Bureau of Emergency
25 Medical Oversight.

1 And they've been working essentially with
2 EMS data and opioid surveillance data on a
3 product called Biospatial. Some of you that are
4 more familiar with the EMS activities have
5 probably seen it.

6 What we wanted to do is walk through a
7 little bit about what Biospatial is about, some
8 of the capabilities.

9 We also, in addition to Mr. Sturms we have
10 Josh Walters from Biospatial, who's the vendor
11 rep. They can answer any kind of technical
12 questions that the Council may have.

13 And we also have Steve McCoy, our EMS
14 administrator, who can, you know, answer any
15 kind of questions related to -- policy-related
16 questions on how it's -- the tool's been used
17 and implemented.

18 But with -- I'm going to go ahead and turn
19 it over to Mr. Sturms.

20 MR. STURMS: Thank you very much. I'm
21 going to go ahead and get this pulled up. The
22 computer timed out just as the microphone was
23 being passed over.

24 So we formed a partnership last year with
25 Biospatial to kind of help us meet a new

1 statutory requirement. So last year, with the
2 passing of House Bill 249, we had a focus on
3 overdoses and we had to, you know, develop a
4 capability to provide information within 120
5 hours to local law enforcement, public health
6 officials and fire and EMS.

7 And the only way to do that kind of
8 effectively is to have an automated system. If
9 you have all those agencies trying to request
10 information on a recurring basis without an
11 automated solution, it becomes quite cumbersome.

12 So the timing worked out perfectly where
13 Biospatial had some presentations at the
14 National Association of State EMS Officials to
15 show that -- the tool that they were working on
16 and their desire to get EMS data to be a part of
17 what their -- one of their core data sets.

18 So I have some slides that Josh Walters,
19 that's on the phone, has developed. It's just a
20 handful to kind of go over what Biospatial is as
21 an entity and kind of where they kind of fit
22 into this equation.

23 And then I was going to show you the system
24 and kind of show you how we're using it with EMS
25 data and with motor vehicle crash data and, you

1 know, see if there's any interest from the
2 Advisory Council to see, you know, how it could
3 be leveraged for trauma, if at all.

4 So this first slide that kind of explains
5 the, I would say, the mission statement that
6 Biospatial has. So they want to create some
7 data-driven actual insights from timely
8 health-related data. You know, ultimately to
9 improve patient care, you know, enhance, you
10 know, health and safety and to decrease
11 healthcare costs.

12 The way their software works, a number of
13 different steps. So their goal was to get, you
14 know, near realtime information. So the origin
15 of this company kind of originated with a grant
16 from the Department of Homeland Security to the
17 University of North Carolina to create a
18 biosurveillance platform.

19 And, you know, getting information in a
20 timely manner is kind of an essential part of
21 that process. The information is kind of
22 collected near realtime. They have a
23 cloud-based system that they can use to kind of
24 scale up and, you know, do whatever they need to
25 in terms of, you know, bringing on new data

1 partners.

2 And then, you know, provide analytics, you
3 know, with the appropriate levels of security
4 and appropriate levels of functionality within
5 their interface.

6 One of the important questions that comes
7 up is, you know, how much does this cost. You
8 know, what is the Department paying for. And,
9 Biospatial has a model that, you know, it's free
10 to us as a state and free to the users of the
11 system because they work in a two-part model.

12 So the data providers -- so the State of
13 Florida being the data provider, doesn't get
14 charged to use the system. They provide
15 analytics that are helpful for what we do and
16 what the individual agencies that are accessing
17 system, what they do.

18 And the way they kind of stay afloat and
19 have taken that grant that was coming to an end
20 and turned it into a -- basically a company that
21 can be kind of self-sustaining, was they had to
22 have a business side of it.

23 So what they do is, the analytics they
24 provide to us, they provide a aggregated version
25 of that to commercial and federal subscribers.

1 So when you see some of the dashboards when I
2 pull up the system, it'll make more sense at,
3 you know, what those subscribers would be able
4 to see.

5 And through some of the discussions that
6 we've had with them and that they've had with
7 other states, they came up with a couple of
8 ideas related to, you know, trauma capabilities
9 if states had an interest in sending trauma data
10 into their system.

11 Obviously one of them is, you know, trauma
12 specific analytics dashboards related to trauma.
13 The platform is very geographical-based. So a
14 lot of mapping capability and, you know, pulling
15 up heat maps, looking at, you know, trends
16 across a geographical area. And one of the main
17 things is, you know, linking data sets.

18 So we currently have EMS and traffic
19 records that are linked. That is a recent
20 addition that they just rolled out operationally
21 this past weekend.

22 But if -- once you start to see what we're
23 doing with EMS, you know, it might kind of, you
24 know, give you an idea -- a sense of, you know,
25 what may be possible if there was, you know, if

1 some element of trauma data that was available
2 to link with with EMS records and also with the
3 traffic records.

4 So they're still trying to develop what
5 this will actually look like with the trauma
6 dashboard. I believe they just started
7 receiving some information from Montana and
8 they're still trying to develop a concept of
9 what's important as it relates to trauma data
10 and how it can be represented in a consumable
11 way that, you know, provides some value to the
12 people that send them information.

13 And one of the things they have on here was
14 one specific example of how the system was used.
15 The system generates signals based on syndromes
16 to look for anomalies in the data. So one thing
17 that kind of popped up within their system was
18 the wildfires in California.

19 You know, as a outcome of those fires,
20 there was an increased number of respiratory
21 illnesses in Arizona and that was something that
22 was able to be kind of detected within their
23 system and with the defiance syndromes in --
24 that are available within the system and that
25 can be created, you know, similar things are

1 certainly available.

2 And then this was the last of their slides.
3 We do have Josh on the phone to answer any
4 specific questions regarding their company and
5 their setup, but I really wanted to hop in and
6 show you the system as we see it and what we
7 have in terms of a capability just to give you a
8 sense.

9 All right. So this is a national project.
10 So, you know, Florida is not the only state that
11 is sending data. They have data flowing in from
12 many different partners. Some of them at the
13 state level, some at the city or county level.

14 They also have a couple -- I believe they
15 have a partnership with American Medical
16 Response for all their ambulance services. But
17 you see that there's data flowing in from many
18 different locations and they've been
19 aggressively pursuing new partnerships that, you
20 know, provide some enhanced value to the system.

21 So the main dashboard, when you pull in, is
22 the generic analytics dashboard. It's generic
23 because it has a lot of flexibility. So right
24 now we're able to see some basic information at
25 the county level in terms of all EMS calls.

1 That, on the surface, you know, may be
2 useful, it might not, but the power comes within
3 the Search Manager and changing what you're
4 looking for.

5 This screen also shows you alerts. So
6 those signals that kind of exceed the threshold
7 within their system can generate an alert and
8 let you know that something's going on with a
9 particular syndrome in a particular county.

10 So if we pick one of these diamonds I can
11 click on it and there was a large number of
12 motor vehicle crashes in Madison County on April
13 18th. So I'll hop into Search Manager.

14 Currently we have a feed direct from our
15 EMS vendor that sends data into their system
16 multiple times throughout the day. So it's near
17 realtime. We also have been sending them motor
18 vehicle crash data. Motor vehicle crash data
19 becomes public record 60 days after the
20 incident, so we don't have a realtime feed of
21 that happening.

22 So once a quarter we get data from Highway
23 Safety and Motor Vehicles and we get it pumped
24 in the system. However, our goal is to kind of
25 build that relationship and find a way to get

1 that near realtime feed of motor vehicle crash
2 data.

3 Number of syndromes they've already
4 predefined. There are, you know, ones that are
5 kind of specific to opioids with some of the
6 work that we've done here in the state of
7 Florida. We have a opioid surveillance grant,
8 ESOOS.

9 There's also another state that has some
10 ESOOS definitions in the system. So they have
11 built definitions in the system for us. They
12 have some syndromes related to cardiac arrest,
13 motor vehicle crashes based on severity,
14 influenza-like illness and a number of others.

15 There's also, you know, for the different
16 data types that kind of get pumped into the
17 system, you're able to kind of filter and, you
18 know, look at a specific data type.

19 So, as a quick example, we'll choose our
20 Florida opioid case definition for our grant and
21 we can look at, you know, EMS information and we
22 can look at the state of Florida. And just
23 click apply.

24 And, you know, it'll give us back
25 information relating to where those cases are

1 that meet that case definition. If you click on
2 accounting it'll give you some generic counts.
3 It will also give you, you know, counts based on
4 the per capita rate and the coloring that's on
5 the map can be based on pure number of counts or
6 you can modify it to show it based on a per
7 capita basis.

8 What you see here at the county level is
9 the default level of access. So if anyone has
10 access to the system, they can see information
11 at a county level. But one of the things that
12 we've been using the system for is kind of to
13 provide that data back to the local EMS agencies
14 so that they can see greater detail about their
15 own data.

16 So if you have a higher level of access you
17 can zoom in and see heat maps, which I'll show
18 you here in a second.

19 And with the heat maps and with anything
20 else on the map, if you scroll down to the
21 bottom it'll show you the number of events over
22 time. So it's interactive in a sense that if
23 you find a particular timeframe that is of
24 interest you can click on it and it will show
25 you the information for that timeframe.

1 It's also animated. So in the case of
2 opioids, if you want to see how things are
3 changing or if drugs are moving from one area to
4 another, there's a play function so -- let me
5 zoom out a little.

6 You can see it as it cycles through. So if
7 an individual EMS agency is looking at what's
8 happening, you know, in their local area with
9 their data, they can -- they can zoom in pretty
10 far and see, you know, what's happening in
11 particular neighborhoods or particular parts of
12 town.

13 There's some other widgets kind of built in
14 here so you can take at, you know, when alerts
15 are happening. Kind of over time. And then
16 there's some things that you would kind of
17 expect to see, some distribution based on age
18 and gender and there are some additional ones
19 I'll show you based on race and ethnicity.

20 There are few other dashboards that they
21 have built and they have a monthly development
22 cycle. So as a new need is developed, they've
23 been great to work with in terms of, you know,
24 helping us hash out that need and kind of
25 putting it into their system.

1 So we've had, you know, regular updates,
2 very responsive to, you know, anything that we
3 have asked of them so far.

4 So if we jump into our motor vehicle crash
5 dashboard, you'll notice that a number of
6 different widgets and their dashboard allows you
7 to look at the crash data based on what was
8 submitted by EMS, what was submitted by crash or
9 you can look at the linked data set where they
10 have linked the two together.

11 One thing to note, we've only received
12 crash data through the first quarter of 2018.
13 So the linked data will only kind of contain
14 that timeframe.

15 But if we scroll down you can take a look
16 at this first widget on the left-hand side. You
17 can see for, you know, the year-to-date, it
18 shows the number of motor vehicle crash events,
19 the number of people that were involved in those
20 crash events, and then the number of motor
21 vehicle crashes as identified by EMS and then
22 ultimately, you know, the number of, you know,
23 linked records between the two.

24 It also breaks it out by severity. And
25 they pointed out that, you know, one of the key

1 reasons why the linkage to motor vehicle crash
2 was so important was the unreliable nature of
3 motor vehicle crashes KABCO scoring.

4 So if we remove some of these unknown and
5 nonsevere elements you can get a sense for the
6 severity of those injuries for those crashes.

7 There's also some widgets to look at, you
8 know, how things are happening over time.
9 Again, age and gender distribution and then
10 information about when the crashes are
11 happening.

12 So right now, you know, you can see the day
13 of the week. Sunday appears to be on the top of
14 the scale. And then also this is a clock
15 position graph so 11 to 12 is when the majority
16 of those patients are resulting from a motor
17 vehicle crash.

18 And there's some information that will pop
19 in here once we actually start to use crash
20 data. So that was all from EMS. But if we
21 switch over to the linked motor vehicle or the
22 actual traffic records, we can see greater
23 detail.

24 So you could take a look at the vehicle
25 type, the make and model, if there was any

1 special details about the crash. So was there
2 distracted driving involved, non-motorist,
3 school bus, work zone, alcohol or drugs.

4 And then there's some additional, you know,
5 maps that are kind of generated as a part of
6 this. But one of the important things that we
7 were kind of excited about is, you know, you
8 have some of these filters, you can dive into
9 the information.

10 So if you wanted to take a look at -- of
11 this linked data set, patients that were severe,
12 likely fatal or fatal that had alcohol involved,
13 you can quickly get some information to see, you
14 know, where are the opportunities for some
15 injury prevention efforts or possibility, you
16 know, who's being injured, when they're being
17 injured and maybe why they're being injured if
18 you know a particular type of vehicle is the
19 culprit.

20 So, you know, looking at this for those
21 severe injuries that involved alcohol, 25
22 percent involved an injection or ejection,
23 excuse me. And only about five percent involved
24 distracted driving.

25 So definitely a lot of information that can

1 be pulled through that linked data set and if
2 you were to mix trauma data in there to have
3 some outcome information, it could be a powerful
4 tool for the Advisory Council.

5 There's some additional filters that can be
6 used if you wanted to take a look at
7 motorcycles. So you can select motorcycles from
8 the vehicle type and we'll get rid of alcohol
9 and just look at the severe, likely fatal and
10 fatal injuries from motorcycle accidents.

11 And, again, get that same information and
12 quickly have maybe some data points that you
13 need for a presentation or something to kind of
14 spur some additional research.

15 One of the first dashboards that they built
16 was to help us with the opioids. To give you an
17 example, there's a lot of things that they can
18 do once you establish what your requirements are
19 or what you're trying to accomplish.

20 There's a couple things on this dashboard
21 that I wanted to point out that were -- they
22 came across as something viable that, you know,
23 can provide some additional insight to our
24 responders to the opioid crisis.

25 So if we -- if we scroll down here we can

1 take a look at some of the naloxone
2 administrations. So we can see the total
3 naloxone that was administered. We can take a
4 look at the average naloxone dosage per patient
5 and see if there's a trend there.

6 We can also take a look at how naloxone is
7 being used and this is an important part for us
8 because we recently received a five million
9 dollar appropriation to provide naloxone to
10 emergency responders. So knowing what the need
11 is, is kind of helping us determine, you know,
12 how those grant dollars should be utilized.

13 And, again, some basic information.
14 There's a map here at the bottom that I thought
15 was something unique and worth kind of pointing
16 out. They have a slider built into this map
17 that you can see the events based on how much
18 naloxone was administered for those overdose
19 patients.

20 And if you slide the -- if you slide the
21 bar over, the system will update and you can
22 take a look where, you know, more naloxone is
23 being administered, which, you know, may be an
24 indication of a possible higher strength of
25 opioid that's out there.

1 So a lot of cool things that are being
2 added into this system that we're trying to
3 leverage and we're trying to kind of spread the
4 word to our EMS providers that, you know, we
5 have some tools to help you in your response.
6 You know, I think the same can be done when it
7 comes to the trauma system.

8 A number of other dashboards that have been
9 built. The one other one that I wanted to show
10 was the EMS performance dashboard. And the
11 reason I wanted to show this is because we are
12 looking to use a similar setup for our EMS state
13 plan measures.

14 So if we have performance measures we want
15 to take a look at, we can have them, you know,
16 set up in the system and be able to look at a
17 performance over time, look at it for a specific
18 category or even set up scheduled reports that
19 can be delivered into your e-mail or I think
20 they mentioned coming soon they're going to have
21 those, I think, available through SMS text
22 messages.

23 But for these individual measures, which
24 are based on the Compass measures, we want to
25 kind of take the state plan measures, hash up

1 the definitions and get it in here so an EMS
2 provider can see where they stand and how
3 they're doing and what the EMS community has
4 determined as important measures. Something
5 similar, you know, might be of value for the
6 trauma community if the data is available.

7 And I don't want to go on through every
8 dashboard. I wanted to kind of give you a sense
9 of what we're doing and how we're using this
10 system and, you know, allow for questions. And
11 if there's things that I can't answer,
12 Josh Walters from Biospatial is on the phone
13 that can kind of help with that as well.

14 MR. LEFFLER: I want to go ahead and open
15 the floor for questions or discussion. Ms.
16 York.

17 MS. YORK: So how are you linking -- how
18 are you linking the data?

19 MR. STURMS: Okay. So when we send
20 information we cut out the information from the
21 EMS record that's personally identifiable. We
22 cut out, you know, name, Social Security number
23 and what they're using is location, time, gender
24 and -- I believe that's everything.

25 Josh can correct me if I'm wrong, but

1 they're using a number of different -- a number
2 of different elements to get a likelihood of a
3 link and then they went back and, you know, did
4 some verifications to see the effectiveness.

5 And I think Josh has some of those stats
6 that he might be able to tell us.

7 MS. YORK: So one of the concerns that the
8 trauma program managers had about submitting
9 some things -- because the state's wanted to
10 link multiple reports for some time.

11 MR. STURMS: Right.

12 MS. YORK: But some of our legal
13 departments don't like you to submit Social
14 Security numbers. Some have prohibited us.
15 Some of us, you know, we can do four numbers,
16 not, you know, the whole number.

17 How would you link trauma data with your
18 other data?

19 MR. STURMS: So a couple things that could
20 be of use, you know, they went and they kind of
21 developed that methodology and kind of verified
22 its effectiveness. But I would imagine, you
23 know, if you knew an approximate age and gender
24 and a location for traumatic injury that would
25 help narrow down the pool and there might be

1 some additional things that they can pull from
2 the trauma record. Maybe mechanism of injury.

3 And I think that between those -- I mean,
4 how many -- let's take an example. How many
5 50-year-old females in Leon County got shot at,
6 you know, 12 p.m. on the first of April. I mean
7 that kind of helps narrow the pool down for that
8 linkage.

9 MS. YORK: I can narrow it. I sometimes
10 have trouble getting EMS run reports knowing a
11 estimate age, sex, date. I'm just throwing it
12 out there.

13 MR. STURMS: Right.

14 MS. YORK: Because I spent a lot of time
15 trying to figure that out because the estimated
16 age sometimes does not come anywhere close to
17 the real age that we find out later.

18 MR. STURMS: Okay.

19 MS. YORK: And so I -- that's why -- that's
20 why I asked. Because it's not always as easy as
21 it would appear. Some of it's pretty easy.

22 If you're going around saying, okay, who
23 had a spinal cord injury on this date, there
24 aren't that many of them. You're going to be
25 able to narrow that down.

1 However, that also means, if you're
2 reporting on spinal cord injuries in some way,
3 shape or form as a result of an MVC, that may
4 not be de-identified. I could probably figure
5 it out, who it was if it was somebody in my area
6 because there's not that many of them.

7 MR. STURMS: Right. And that's a -- that's
8 a valid concern and that's why we wanted to kind
9 of show you the system, show you how we're using
10 it with EMS and kind of let the Advisory Council
11 kind of lead a discussion of, will this be --
12 will this be useful for trauma and, if so, you
13 know, what are the key elements that need to go
14 into the system, do we want it to link with
15 anything or do you just want to provide some,
16 you know, basic information, basic analytics,
17 you know, what are the concerns and then we can
18 kind of work through those, you know, if there's
19 a desire.

20 MS. YORK: I mean I can see where it would
21 be very helpful with, say, the mosquito-borne
22 diseases that were rampant in Miami, you know.
23 It would be nice to know exactly where they are
24 in a realtime kind of thing.

25 It's helpful to have an automatic system

1 where you could say, hey, this intersection in
2 Gainesville had, you know, 50 crashes in it,
3 when are y'all going to do something about it.

4 I mean I think that there's a benefit
5 there, but I wasn't sure how the linkage was
6 going to go.

7 MR. STURMS: Okay.

8 MR. LEFFLER: Dr. Namias.

9 DR. NAMIAS: Very nice work and then I know
10 some of the research this was based on and it's
11 sort of become well-known in the trauma
12 community.

13 And I think, like all software, you know,
14 in the beginning you have some data you can pull
15 up and there's some things that you can't do.
16 So, you know, you really can't yet link the
17 field trauma score with ultimate ISS because we
18 don't have a linkage.

19 And Dr. Nelson's sitting back there and
20 he's worked for years to get a uniform
21 identifier from the field to rehab. But still
22 it's a great thing and I think it's step one of
23 ultimately getting a way to really follow our
24 patients through the system.

25 I promise you, if you -- if you make this

1 tool accessible to us, Dr. Ang's going to have
2 five papers next year at the AAST for minutes.

3 DR. ANG: I second that. No, just, I think
4 it's a great tool. You know, we have to move
5 towards a transparent trauma system in order for
6 us to make moves in a positive direction.

7 And I think, without data, we're really
8 handicapped and so I applaud you guys for
9 putting the data together.

10 As far as the linking stuff, I mean, I kind
11 of have the feeling that we need to make sure
12 that this data is accurate using identifiers.
13 As long as the output doesn't identify anyone.

14 I mean that's what counts. Right? We
15 don't know who these people are, but we need the
16 accuracy of the data. And I would advocate
17 linking to death records as well. And also
18 outpatient.

19 Because the state of Florida is a geriatric
20 state and we have the healthcare utilization now
21 and trauma, as everybody knows here in this
22 room, is a spectrum of care. It's not just EMS,
23 it's not just a hospital, but it's where these
24 patients go and do they become functional after
25 we treat them.

1 And I think it's our obligation to the
2 people in Florida to make sure that we kind of
3 optimize the healthcare system so that they can
4 get back on their feet again. And I think, you
5 know, data like this has an opportunity to be
6 able to used like that and I think we can all
7 agree, in this room, that we want to improve
8 patient care in Florida.

9 So, and that's my two cents.

10 MR. LEFFLER: Mr. Kemp.

11 MR. KEMP: Yeah, as a current Biospatial
12 user and a long-term EMS Data Committee, over a
13 dozen years, a couple things.

14 First off, linkages and tracking patients
15 has always been historically difficult. There
16 are some technical solutions, not through
17 Biospatial, but through other software companies
18 now.

19 My agency is starting in to using them and
20 many, many agencies across Florida. I think
21 it's going to become universal where when we
22 actually have a patient we get to the hospital,
23 we take a scanner and scan whatever the hospital
24 code is into -- we plug in a scanner into our
25 report, scan the hospital tag, whatever it is,

1 and it instantly links that patient with the
2 hospital data.

3 So it allows both information back and
4 forth between EMS and the hospital. And once
5 you've linked with EMS that's going to link with
6 crash data. So there's a way that all of this
7 is starting to work out and link.

8 The second part of this is that the real, I
9 mean there's a lot of great analytics, but the
10 real strength of this is the geospatial analysis
11 of data in looking at where events occur and how
12 they happen.

13 Just an interesting thing we saw a couple
14 days ago was, we were track -- they were just
15 demonstrating some opioid stuff and they were up
16 around the South Georgia/Jacksonville area and
17 as they clicked through the days, those dark
18 blobs on the map started moving south. And
19 somebody just made a funny observation. Said,
20 must have been people headed down to Bike Week.

21 Well, we checked the dates and actually it
22 was. And so the narcotics and the opioid
23 overdoses were moving south by day down to Bike
24 Week. So that was just sitting there in the
25 room, making an amazing correlation. I thought

1 that, isn't that interesting and would that be
2 -- could be valuable information for law
3 enforcement and EMS to know, you know, you're
4 going to have some increase in opioid responses
5 during this time period so maybe you should
6 staff accordingly.

7 So it's just -- it's just information.
8 It's data. But if we can get the right linkages
9 together I could see where it would really be
10 beneficial here.

11 MR. LEFFLER: Is there any further
12 discussion or questions?

13 DR. IBRAHIM: It's not just staffing. It's
14 other resources, too. Like Narcan, those kinds
15 of things. I mean you kind of prepare for what
16 you need. Makes sense.

17 MR. LEFFLER: Mr. Summers?

18 MR. SUMMERS: Do we have access to this
19 now?

20 MR. STURMS: So we have made the system
21 available to fire and EMS. We've made it
22 available to local law enforcement and public
23 health officials.

24 I think that there needs to be a little bit
25 more internal discussion of, you know, how do we

1 make it available to trauma centers or globally
2 to hospitals. So the way the system is set up,
3 if you have access to the system at any level, at
4 a minimum you can see county level data for all
5 the data sets they receive.

6 So you could see information related to
7 motor vehicle crashes, you could see it for EMS
8 records. We're working on getting data from the
9 ODMAP platform, which is run by the Washington
10 Baltimore HIDTA, getting those pumped in as
11 well.

12 And if you have access to the system, you
13 have access to that aggregate little
14 information. And maybe that's something we
15 could take back and see if we can get access to
16 the Council members or get access to the trauma
17 centers if there is a desire to see the system,
18 you know, use it in action and see if there's a
19 fit for trauma in it.

20 MR. LEFFLER: And also, looking at it from
21 the trauma agencies' perspective, too.

22 MR. STURMS: Right.

23 MR. LEFFLER: Trauma agencies have certain
24 performance improvement quality assurance
25 protections in the statutes and that may be one

1 avenue that could be explored first.

2 MR. SUMMERS: Because I could put this to
3 work.

4 MR. STURMS: Right.

5 MR. LEFFLER: Is there any --
6 Dr. Namias?

7 DR. NAMIAS: If you have any doubts, the
8 trauma centers want access to this. And I think
9 that'll probably be your -- you'll really get a
10 lot of bang for buck out of this because we have
11 all sorts of faculty and fellows and trainees
12 who are going to -- going to whip into this data
13 set and come up with observations we haven't
14 even thought of yet.

15 MR. STURMS: Okay.

16 MR. LEFFLER: Ms. York.

17 MS. YORK: I would say that you can't limit
18 it to one county. When you start looking at
19 trauma centers, some trauma centers are --
20 basically get all their patients from one
21 county, but I'm from a more rural area and our
22 counties are a little bit more widespread.

23 So looking at one county would not be as
24 helpful as looking at all of the places that we
25 get out patients from.

1 MR. STURMS: Right. And there might be
2 ways to kind of address those concerns if,
3 maybe, you know, that we have it set up where,
4 you know, you look at regions. Again, there's
5 going to be trauma centers that there's only one
6 trauma center in that region, but there might be
7 a way that we can define some boundaries that
8 make sense and is appropriate.

9 MR. LEFFLER: Dr. Ibrahim.

10 DR. IBRAHIM: Do you have anybody that's
11 using this for things like staffing issues and
12 those kind of things? EMS agencies that are
13 using it specifically for time periods, you
14 know, seeing if they're busy at certain times.
15 Those kind of things?

16 MR. STURMS: One of the things that we've
17 done -- we're still kind of new in this process.
18 So the system went live in October and we
19 started off with a small group of pilot
20 agencies. And then we kind of, you know, went
21 through some initial testing.

22 A number of updates got put in place by a
23 Biospatial team and then we kind of opened it up
24 to some early adopters. And we're just now kind
25 of opening up the floodgates.

1 And part of that process is, we've been
2 seeking out value stories, right? You know,
3 trying to hear from people using the system of,
4 you know, what have you done with this system
5 and, you know, has it had a positive impact in
6 your operations.

7 And we set up a survey and, to my
8 knowledge, I don't believe we received any
9 feedback, but that's part of that process. We
10 want to hear how people are using it so we can,
11 one, give ideas to other users to let them know,
12 hey, this is what -- this is what the folks down
13 in Palm Beach are doing or this is -- this is
14 what's happening up in the Jacksonville area.

15 MR. LEFFLER: Any further questions or
16 discussion?

17 I think what might be helpful. I see
18 amongst the Council members there's quite a bit
19 of interest in this product. Is there -- can we
20 entertain discussion about maybe what our next
21 step would be if we were to try and provide this
22 product to the Florida trauma system.

23 Should, you know, should we set up a
24 committee to explore data elements that might be
25 useful, to develop -- to help develop dashboards

1 that we could maybe provide just at this point
2 maybe linking or just the trauma data that we
3 could provide to the trauma centers.

4 Dr. Namias.

5 DR. NAMIAS: So I think -- don't
6 underestimate the talent in the trauma centers.
7 All of the trauma centers have, to some degree,
8 some responsibility for research and outreach
9 and many of the trauma centers really could use
10 as much raw data as they can get their hands on.

11 When we hand a young faculty member, a
12 fellow or a research scholar a data set, a raw
13 data set, they're very sophisticated with
14 statistics and manipulating the data sets.

15 So I think it would be a big mistake to
16 give them a couple of selected data points if
17 there's a rich data set underlying it. And I
18 would make that, you know, the same way that you
19 have to agree, you know, if you want to get the
20 AHCA data set, for instance, the discharge data,
21 you have to agree you're not going to use it to
22 make billboards out of or you're not going to
23 use it to disparage, you're not going to reverse
24 engineer it to figure out exactly who's who.

25 That's fine. But you can still make some

1 interesting observations with broad data. So I
2 would not dumb it down at all. As much as you
3 have, you should release to the trauma
4 community.

5 DR. REED: Yeah. I agree with that. I
6 think that, you know, if it's just the Advisory
7 Council having it, well, you know, we'd be
8 interested in seeing what it could do and what
9 it could indicate for state trauma management
10 and so forth, those kind of issues.

11 But, yeah, this is potentially a massive
12 source of research for several organizations
13 that have to do research in order to be a trauma
14 center. The Level 1s, the pediatric centers,
15 are required to do research.

16 MR. LEFFLER: Dr. Ang?

17 DR. ANG: Just looking at our charter,
18 priority assignment five, I think a geospatial
19 analysis, this would fit in its wheelhouse. So,
20 you know, I suggest that we use the tool for
21 addressing the issues of priority five.

22 UNIDENTIFIED SPEAKER: And I can tell you
23 that when we first started discussing bringing
24 the Biospatial product to the Council, that was
25 one of our initial targets was the assessment

1 that comes in 2020. And the assessing the
2 entire trauma system.

3 This would provide some very powerful tools
4 when you start looking at ICA scoring and some
5 of these other tools that we're required to use
6 to make that analysis. That was one of the
7 thoughts that kind of spurred Josh and I's first
8 conversation about this.

9 DR. REED: Are hospitals part of your data
10 set income -- incoming data set?

11 MR. STURMS: Not currently unless that
12 hospital has an EMS system or a EMS service as
13 part of it.

14 DR. REED: Right. But isn't this linked to
15 AHCA?

16 MR. STURMS: It is not. We have -- we have
17 an EMS and AHCA link data set, but that does not
18 happen within -- within this tool. We've had
19 some discussions with the Biospatial team and
20 with the AHCA Health Information Exchange Team
21 to see, you know, are there opportunities there
22 to get some information pumped in from the HIE
23 to, you know, fill in the gaps of knowledge that
24 we're kind of missing with some of the EMS stuff
25 and see, you know, how -- how can we leverage

1 that system to get some additional insight.

2 UNIDENTIFIED SPEAKER: So you mentioned
3 earlier there were some linkages. So which data
4 sets were linked?

5 MR. STURMS: Currently the ones that are
6 linked are, EMS and motor vehicle crash. There
7 are some other data sets that are going to
8 provide some support information, but it's been
9 kind of a step wise process, right. We get one
10 data set in, work through the kinks, work out
11 the dashboard, work out any kind of issues and,
12 you know, we've been looking for new
13 opportunities to kind of leverage the system.

14 So I think that there's a possibility of
15 getting AHCA data in there and I think that, you
16 know, from our office, our point of view, that's
17 something that would be great.

18 We haven't had that discussion with AHCA
19 specifically about their inpatient or emergent
20 department discharge set.

21 MR. LEFFLER: Any other questions or
22 discussion?

23 Is there a group that would be best to get
24 together to look at not only data elements,
25 whether to release all of this, as Dr. Namias

1 talked about, or to release select elements? Is
2 there a group that's best targeted to get
3 together to come up and have a recommendation
4 for the Council?

5 I know that Dr. Kerwin here, shortly, is
6 going to provide a presentation related to
7 Florida TQIP Collaborative. I don't know if
8 that would be an appropriate group to provide
9 recommendations on the use of Biospatial.

10 Any discussion related to that?

11 DR. NAMIAS: The committee on -- the
12 Florida Committee on Trauma would be happy to
13 provide some input, but there might be other
14 groups as well. It could be an open call.

15 MS. COLSTON: So probably what the best
16 thing is, I think that when Josh came to present
17 this, I think we wanted to gauge the interest of
18 the Council. So I think what we can do here,
19 because Biospatial is -- they're trying to work
20 on -- so what they would need to know is, what
21 trauma data elements we might be able to feed
22 into this system in order to get some valued
23 reporting out of it.

24 Is that correct?

25 MR. STURMS: So if there is an interest and

1 there's some elements, we can send a test data
2 set over that they can start kind of working
3 through and maybe develop some mock-up
4 dashboards of what it would look like or how
5 that would work.

6 I mean I'm sure that's something that they
7 would be willing to kind of, you know, partner
8 with us on. Essentially what we need is, you
9 know, what will provide the most value and, you
10 know, how much do we get for our test data set.
11 Do we get a quarter? Are we looking a year's
12 worth of data? Are we looking at a specific
13 geographical area?

14 You know, some of those questions would
15 kind of have to be answered.

16 MS. COLSTON: And so, you know, all of
17 these -- really, I'm not sure if they have to
18 make a decision today. Primarily because you
19 guys have a couple of other priorities that we
20 want to work on getting done first.

21 But in the meantime, you know, we've got
22 this on the table now so that, you know, you
23 guys can think about it. We can start to maybe,
24 during one of the commons hours, you know, in a
25 month or two, come up and just say, you know,

1 talk about -- we can have Josh on the commons
2 hour and we can kind of talk about some data
3 elements that you all might think are useful.

4 So maybe we can dedicate it to Biospatial,
5 depending or not depending. But really, we just
6 wanted you to have the information right now.
7 We can followup more later and start to try to
8 figure out, you know, maybe some of these things
9 we can do offline, which is thinking about the
10 data elements that might be useful so that we
11 can start to generate some information.

12 And you guys can kind of, well, just look
13 at that and not really focus too much on it, but
14 know that it's there until at a later time, as
15 Dr. Ang pointed out, we can use it for the
16 geospatial information analysis thing that you
17 guys are going to look at in your priorities.

18 So if you guys are okay with that, we want
19 to do that?

20 UNIDENTIFIED SPEAKER: Yes.

21 UNIDENTIFIED SPEAKER: Yes.

22 MS. COLSTON: Okay. So, Josh, we
23 definitely appreciate your presentation on
24 Biospatial. And, on the phone, we definitely
25 appreciate the Biospatial people that we've been

1 working with. They've been very helpful and
2 they're very excited to be able to work with us
3 to maybe even look at how we could use their
4 trauma data to feed into this system and provide
5 some useful information for the trauma
6 community.

7 So thank you.

8 MR. LEFFLER: Is there a -- I think we want
9 to take a recess for a few minutes.

10 Is there a motion?

11 UNIDENTIFIED SPEAKER: I so move.

12 MR. LEFFLER: So moved.

13 Is there -- is there a second?

14 UNIDENTIFIED SPEAKER: That would be me. I
15 seconded that.

16 MR. LEFFLER: Second.

17 All in favor? (Council member responded.)

18 All right. We're going to recess for 10
19 minutes.

20 (A break was had.)

21 MR. LEFFLER: I see the presence of a
22 quorum, so I'm going to go ahead and call the
23 meeting back to order.

24 Our next agenda item is Dr. Pappas, who is
25 going to give us an update on his long-going

1 Region 5 project, the model trauma agency.

2 I'll turn it over to Dr. Pappas.

3 DR. PAPPAS: Thank you, Mr. Leffler. And
4 thank you, members of the committee. And those
5 assembled here, it's truly an honor to have an
6 opportunity to speak at what I supposed is
7 actually one of the inaugural sessions of our
8 State Trauma Council.

9 I am Dr. Peter Pappas. I am a trauma
10 surgeon at Central Florida Regional in Seminole
11 County, Florida, part of the HCA, USF network.
12 But I'm speaking today in a capacity as a member
13 of the board of the Central Florida Disaster
14 Medical Coalition and also the executive
15 director of our Regional Domestic Security Task
16 Force, Region 5 Trauma Advisory Board, the
17 State's first trauma advisory for an RDSTF.

18 Just a quick outline of the geography.
19 Region 5 encompasses what is essentially the
20 east Central Florida coast, running -- including
21 Volusia, Lake, Seminole, Orange, Brevard,
22 Osceola, Indian River, St. Lucie and Martin
23 counties. Nine countries all together, which
24 includes six trauma centers, one Level 1 at
25 Orlando Regional in Orlando, and then five Level

1 2s.

2 The goal of this organization, in the
3 standpoint of the stakeholders is really to
4 create a body representing our trauma system
5 stakeholders within Region 5. We've been
6 working for the past almost three years now to
7 develop a form for best practice across the
8 spectrum of trauma care.

9 And also provide a new link for
10 communication -- two-way communication between
11 what's happening at the local and regional level
12 back to our statewide bodies. And that would
13 certainly, at this point, also include our state
14 trauma council.

15 Key points here is that this advisory board
16 is a voluntary organization. It is not a
17 regulatory body. It is designed to focus on
18 areas of common interest, as we will see in our
19 presentation.

20 And it's also here to provide trauma
21 expertise for our RDSTF Council. Recall also
22 that the Regional Domestic Security Task Forces
23 have a specific set of goals outlined for them.
24 And certainly the ability to have both emergency
25 medicine and trauma expertise in support of that

1 is certainly seen as a net positive.

2 And ultimately, of course, do we want to
3 really create a form for collaboration and
4 dialogue across the different stakeholder groups
5 in our trauma system and, of course, ultimately
6 moving to do an even better job on top of what
7 we're already doing for the care of our
8 patients.

9 Stakeholders, as they've been defined, are
10 our law enforcement, our trauma centers, which
11 are represented on the executive committee of
12 our advisory board by a chair, a vice chair, a
13 Level 2 representative. Our EMS agencies that
14 are represented by a chair, a vice chair and a
15 non-transporting but 911 responding EMS agency
16 representative.

17 Notice, if you will, there is a equal
18 burden of leadership, as it were, between our
19 trauma centers and our EMS agencies.

20 Also represented, of course, are our key
21 care hospitals, our county health departments,
22 extended care/rehabilitation care centers as
23 well as municipal and county government.

24 So we have the -- essentially the elected
25 representatives of our patients along with those

1 that are involved in pre-hospital, in-hospital
2 and post-hospital care for our patients.

3 So we have tried to cast a wide net in
4 terms of making sure that our constituent
5 stakeholders are represented.

6 Committee structure at this point, we have
7 11 voting members. There is an executive
8 director, a position that I'm currently honored
9 to hold. And we have five ex officio members.
10 And if you'll notice, there are major statewide
11 organizations represented.

12 We have the Florida Committee on Trauma,
13 the Association of Florida Trauma Coordinators,
14 the Emergency Medicine -- EMSAC, the Florida
15 Highway -- the Florida Hospital Association and,
16 of course, the CFDMC, the Central Florida
17 Disaster Medical Coalition that is the parent
18 entity for the advisory board.

19 Currently our position of trauma chair is
20 held by Orlando Regional Medical Center. Our
21 Level 1. The vice chairmanship position is held
22 by Halifax Hospital, a Level 2 trauma center in
23 Daytona. Our Level 2 representative is Central
24 Florida Regional in Sanford, Florida. Our EMS
25 chairmanship is held by Martin County. Our vice

1 chairmanship by Indian River County. And our
2 non-transporting agency representative is the
3 City of Palm Bay in Brevard County.

4 Notice, if you will, I've noted -- I've
5 mentioned here institutions, not individuals.
6 The concept here is for institutional
7 representation and for the institution to
8 essentially coming forward with a delegation, if
9 you will, of individuals who can speak on behalf
10 of the institution, but also reach out to their
11 partners and colleagues to really be
12 representative of these constituencies.

13 Acute care hospitals are represented by
14 Florida Hospital Adventist Health. County
15 public health is currently represented by the
16 St. Lucie County Department of Health. Standard
17 care is represented by the Consulate System of
18 Acute Rehabilitation Facilities.

19 County government is represented by Orange
20 County and municipal government by the City of
21 Leesburg in Lake County.

22 We have developed a committee structure.
23 Beyond our executive committee we have what we
24 term the system support committee. And the true
25 focus at this point, of course, has been

1 organization of it, but beyond that, certainly
2 working on coordinating opportunities for injury
3 prevention and outreach in terms of both EMS and
4 our trauma centers.

5 We are looking at education and training.
6 We are looking at ways that we could support the
7 assimilation and use of EMSTARS, for example,
8 among our EMS agencies. And the also
9 communicating grant opportunities and
10 coordinating joint initiatives for things like
11 best practice, injury prevention and, of course,
12 clinical research.

13 Our preparedness committee and certainly a
14 topic that is very much in our minds,
15 particularly in Region 5, in terms of being able
16 to be prepared and continue to be prepared for
17 trauma and burn mass casualty events. We're
18 certainly looking at training and education
19 activities.

20 I just attended a session on Stop the Bleed
21 Training for state law enforcement, just
22 actually an hour ago. That was supported, in
23 part, by our trauma advisory board, led by our
24 trauma chair organization, Orlando Regional.

25 And certainly, again, as I've noted, we're

1 looking at long-term seeing how we can better
2 integrate and interweave our mass casualty
3 plans, coordinating joint exercises in
4 conjunction with our Central Florida Disaster
5 Medical Coalition and then, of course, getting
6 to the point where we can communicate grant
7 opportunities for further training and
8 education.

9 Probably one of the most talked about
10 aspects of our committee has been our trauma
11 agency development committee. This title is
12 actually held by our executive committee. And
13 the idea here was to create, at the request of
14 the Department of Health, and specifically by
15 the Bureau of Preparedness and Response in
16 connection with an underlying grant, as it were,
17 from -- actually to the Central Florida Disaster
18 Medical Coalition.

19 The concept here was to -- was for our
20 board to create essentially a template or a
21 pilot plan for what a generic regional domestic
22 security task force region trauma agency might
23 look like.

24 This is in line with the 2015 Department of
25 Health trauma system plan and is ultimately

1 linked to Florida Statute 395.4015, which
2 states, the ability of the -- of -- states the
3 potential for the creation of regional trauma
4 agencies that are coterminous with the Regional
5 Domestic Security Task Force regions.

6 We worked on developing an ad hoc committee
7 and we are fortunate to have subject matter
8 experts which to take on this task. And this
9 template was created, approved and now
10 submitted.

11 From that, it was the decision of the
12 executive committee at our June 8th workshop,
13 the final workshop on this template agency plan,
14 to move forward with creating a ad hoc committee
15 more specific to Region 5. With the goal being
16 to bring together stakeholders from our
17 constitute groups to go ahead and take this
18 template document and work towards creating, for
19 the first time in Florida, an RDSTF, a
20 region-wide trauma agency coterminous with the
21 RDSTF boundaries that is something would make
22 sense for our region and that could achieve
23 broad consensus.

24 I'm happy to say, at this point, we already
25 have several leaders in both trauma and EMS that

1 have volunteered to take on this task. And I
2 think it is an exciting development as we
3 continue to work towards developing our trauma
4 system for the 21st century.

5 And in the meantime, remember we also have
6 our other projects in terms of injury
7 prevention, outreach and preparedness. These
8 are and will remain certainly under the guidance
9 of our leadership on the executive committee, a
10 major focus of our activities as we continue to
11 work to bring everyone together for the benefit
12 of our communities, our institutions and, of
13 course, our patients.

14 So in conclusion, this has been, is and
15 likely will remain for a while a big challenge.
16 But it is an even greater opportunity. And
17 there really is a chance here for all of us to
18 unite to create a seamless system of trauma care
19 from the field to the bedside and beyond. And
20 really an opportunity for all of us to come
21 together for our communities and our patients.

22 I thank the Council for the opportunity to
23 speak and I would be happy to entertain any
24 questions at this time.

25 MR. LEFFLER: Is there questions for

1 Dr. Pappas? (No response.)

2 Is there discussion amongst the Council?

3 Dr. Namias, you're recognized.

4 DR. NAMIAS: I just wanted to point out,
5 Dr. Pappas has been working on this tirelessly
6 for over two years and very grateful for his
7 efforts in doing this. No one else has stepped
8 up to take on this gargantuan task.

9 DR. PAPPAS: Thank you.

10 MR. LEFFLER: I'd like to second that on
11 behalf of the Department of Health. When we
12 started looking at some of these issues, the
13 requirement to align regional trauma agencies to
14 the RDSTF regions, was made in 2004. And it's
15 been -- nobody has been able to do it.

16 It's been such a monumental task that no
17 one has been willing to try. So, certainly,
18 Dr. Pappas, your efforts are commendable.

19 Dr. Ang, you're recognized.

20 DR. ANG: Will we be able to have an
21 opportunity to hear updates from the Region 5 as
22 you guys progress?

23 DR. PAPPAS: If the Council so wishes, I
24 would be happy to provide an update.

25 DR. ANG: I think that your lessons would

1 be greater learned by all the different agencies
2 that could be potentially representing the rest
3 of Florida.

4 MR. LEFFLER: Thank you, Dr. Ang.

5 Mr. Summers?

6 MR. SUMMERS: Watching success of Region 5,
7 what's the State office's thought process on
8 expanding it to other regions?

9 MR. LEFFLER: So as it stands right now,
10 anybody could put together a trauma agency plan
11 in any RDSTF region and submit it to the
12 Department for consideration. Nobody has been
13 willing to take that on.

14 But what -- the original -- what the
15 original contract with the Bureau of
16 Preparedness and Readiness was for was to
17 develop a template that could be modified in any
18 of the RDSTF regions.

19 So, if someone wanted to take the tool that
20 Dr. Pappas has developed and modify it to meet
21 the needs of their region, they certainly would
22 have that ability.

23 The whole idea of trauma agencies, whether
24 they're local trauma agencies, like down in
25 Broward County or in Palm Beach County or in

1 Hillsborough County, and regional trauma
2 agencies, is, it's about developing policy that
3 meets local needs.

4 In state of Florida we certainly have, in
5 every part of the state, different demographic,
6 different political structures, different
7 challenges. And the idea is that you could
8 coordinator resources at a local or regional
9 level for the purpose of -- for the purpose of
10 improving patient -- delivering patient care.

11 And, you know, the RDSTF structure is
12 cumbersome to use because some of these
13 alliances and partnerships form organically and
14 they do require participation by all the
15 stakeholders. And over such a large area that's
16 sometimes very much a challenge.

17 DR. PAPPAS: And I would like to add that,
18 because of the unique, I would say, genesis of
19 this and in terms of how the Bureau of
20 Preparedness and Response's grant was
21 structured, we needed to jump in essentially
22 almost immediately into developing a trauma
23 agency plan.

24 Simultaneously, while we're developing our
25 other committees, building confidence in one

1 another, and essentially for all practical
2 purposes, building the airplane while we're
3 flying it.

4 So I would say that, as you can take sort
5 of two tracks to this. The first track would
6 be, of course, to go ahead and go directly with
7 organizing a group, getting these respective
8 stakeholders together and moving towards
9 developing an agency plan -- a formal trauma
10 agency for your particular RDSTF.

11 The other option is a more, I would say,
12 transitional approach -- evolutionary approach
13 where you begin by getting representation of
14 your respective stakeholders, form the executive
15 committee, create the nucleus with, say, a
16 preparedness group, a system support group where
17 you're looking at things like outreach, injury
18 prevention. Slowly add in issues like registry
19 support, etceteras.

20 Then build, you know, go through the
21 process of using that as a confidence-building
22 exercise, as a communication exercise and then
23 work towards developing a trauma agency plan
24 from that.

25 And I think we have -- we have been able to

1 hold things together in the process of
2 essentially trying to do everything at once.
3 And now that we are -- have this template
4 formed, we can now focus, I think, on the more
5 specific issues that are important to our
6 stakeholders within Region 5.

7 And certainly I'd also like to take a
8 moment to thank Dr. Ibrahim for his leadership,
9 specifically as our chairman. And certainly he
10 has done a lot to guide this process and
11 actually invigorate it and keep us all going.
12 So certainly I want to personally thank him.

13 And, yes, there is a conflict of interest.
14 He's been my friend for a very long time.

15 DR. IBRAHIM: So, if it's okay, I'd like to
16 (unintelligible) -- and actually, Peter has put
17 in a lot of work. I mean it can't be
18 overemphasized.

19 (Not using microphone.)

20 THE REPORTER: Please use your microphone.

21 DR. IBRAHIM: There are some successes. I
22 agree with the disaster preparedness, outreach.
23 Those are the really, as we always talk about,
24 the low lying -- the low hanging fruit to pick
25 from.

1 You've got to be careful if you are
2 thinking about creating this and that you try to
3 bite off too much. And try to create other
4 policies and those kind of things that are very
5 still somewhat of a -- conflictual, if you will.

6 So I think you really have to keep it
7 simple and be consistent with the outreach, with
8 the disaster planning, as Peter kind of alluded
9 to, and build those relationships first.

10 Because were we still -- you know, it's
11 been almost three years. We are just now
12 getting some people back to the table because
13 they want to relook at some things and weren't
14 really sure how this was going to play out or
15 didn't know how this was going to play out and
16 now they want to reevaluate some of the things.

17 So we, in some ways, have, you know, you
18 take two or three steps forward and take one
19 step backwards. So, I agree, it's a necessity.
20 We need to have something like this to help with
21 the outreach with the disaster planning, but it
22 still takes some time and it's still going to
23 take us some time moving forward.

24 So I would just be, you know, cautious with
25 those kind of things.

1 DR. PAPPAS: Go slow to go far.

2 And, unfortunately, because of the way it
3 was structured, we did have to take a very big
4 bite. Essentially had to dislocate our jaw to
5 be able to take this bite. But we were able --
6 we were able to do it.

7 And it's a new day now. I think with our
8 ad hoc committee all of the issues potentially
9 around -- surrounding the development of an
10 agency now, we have a focused place where those
11 stakeholders that are interested in this, no
12 matter what perspective they have, can meet, can
13 come together and can decide on something by
14 consensus.

15 And in the meantime, we are free to
16 continue with preparedness work, which is
17 vitally important, along with, of course, our --
18 continuing to develop our system, injury
19 prevention, outreach, education, what have you.

20 All of the low hanging fruit, the fun
21 stuff, the stuff that in a lot of ways we really
22 care about and, frankly, also, a lot of the
23 things that many in the public assume we're
24 already doing or already seeing.

25 Many in the public would probably already

1 see a well-honed machine or assume that we are a
2 well-honed, completely integrated machine. And
3 I think we can finally work towards that.

4 MR. LEFFLER: Mr. Summers?

5 MR. SUMMERS: So with this RDSTF concept
6 for the region and Palm Beach, Broward,
7 Miami/Dade, Monroe and even looping over to
8 Collier County being Region 7. And two of those
9 counties already have established trauma
10 agencies.

11 How do you see that?

12 DR. PAPPAS: In ancient times, when I first
13 stated on this project, and we're talking now
14 about probably somewhere around version six or
15 seven and we're up to about version 20 at this
16 point, the established agencies, per statute
17 were, of course, included.

18 And, essentially, if you had a trauma
19 agency that existed prior to the RDSTF agency
20 coming into existence, they would be -- have at
21 least one seat at the table as a voting member
22 on the executive committee.

23 MR. LEFFLER: So to clarify that point, in
24 395.4015, is any trauma agency that was in
25 existence prior to 2004 is able to continue

1 their operations. The best example of that is
2 North Central Florida's trauma agency. That
3 trauma agency actually straddles two RDSTF
4 regions.

5 There's some challenges there, but that
6 agency is allowed to operate, you know, within
7 it's 1990 interlocal agreement that included
8 counties that stretched across both RDSTFs.

9 The local trauma agencies in Broward and
10 Palm Beach and Hillsborough County can certainly
11 continue to operate. If there was a trauma
12 agency developed in one of those RDSTFs, what
13 that relationship between the local trauma
14 agency and the regional trauma agency is for
15 them to determine and incorporate in part of
16 their plan.

17 The Department is, you know, has promoted
18 and stood by the existing trauma agencies and
19 there's no plan to alter the existing trauma
20 agencies.

21 Dr. Ibrahim, did you want to --

22 DR. IBRAHIM: Yeah.

23 MR. LEFFLER: -- followup?

24 DR. IBRAHIM: You may have had it in there,
25 Peter, and I may have missed it, but one

1 additional stakeholder that we commonly left out
2 at the beginning and we've finally gotten them
3 more involved, is law enforcement.

4 Especially when you talk about moving
5 forward with disaster preparedness and those
6 kind of endeavors, you real -- they really need
7 to be a part of the discussion and part of the
8 conversation for preparedness. We've found that
9 in our own experience and are big advocates of
10 that moving forward.

11 So I just want to make sure those on the
12 Council kind of understood that aspect as well.

13 DR. PAPPAS: Dr. Ibrahim has really taking
14 ownership of our preparedness committee and has
15 done a lot to get law enforcement involved at
16 that level.

17 And to the point about RDSTFs in other
18 regions, again, with the original drafts, trying
19 to look at the entire state, certainly RDSTFs in
20 another part of the state will need to consider
21 whether there needs to be a seat at the table
22 for Department of Defense installations or
23 self-governing tribal areas, along with existing
24 trauma agencies.

25 So there's a lot of -- there's a lot of

1 almost, you know, not necessarily legalities,
2 but you've got to think in terms of how do we --
3 how do we get not only the right people, but all
4 of the right people at the table. And that's
5 where each region needs to sort of look at its
6 particulars in terms of developing that.

7 And, again, you know, echoing Dr. Ibrahim
8 as well, confidence-building starts first.
9 Start with the low hanging fruit. Even if it's
10 just something as simple, I would say, in my
11 opinion, just getting everybody together to put
12 on a coordinated Stop the Bleed day. All right?
13 In terms of doing tourniquet training throughout
14 your region. Just at least so people exchange
15 e-mails and know who does what and who's who.

16 Something as simple as that could be the
17 nucleus of this.

18 MR. LEFFLER: Dr. Elias.

19 DR. ELIAS: Just a question. How does your
20 agency then interact with the Healthcare
21 Coalition? Seems like there a -- potentially
22 some redundancy on preparedness and --

23 DR. PAPPAS: So, at this point, it is not
24 an agency. We are a -- we are an advisory
25 board. We're essentially a group of

1 well-meaning individuals and institutions who
2 volunteer their time.

3 The Central Florida Disaster Medical
4 Coalition is our parent group. So, and we have
5 some administrative support through them. And
6 indirectly, of course, through DOH.

7 When you speak of a healthcare agency and,
8 again, I apologize. Remember, I am at the end
9 of the day just a practicing trauma surgeon. So
10 I want to make sure I get all the -- all the --
11 all the pieces and parts and names correct.

12 Can you tell me a little bit more by what
13 you mean by healthcare agency?

14 DR. ELIAS: Well, I guess your organization
15 that you are forming.

16 DR. PAPPAS: Yes.

17 DR. ELIAS: It seems like your membership
18 is very similar to the healthcare coalition's
19 membership and I'm just --

20 DR. PAPPAS: And when you say healthcare
21 coalition, you mean something like the Central
22 Florida --

23 DR. ELIAS: Correct.

24 DR. PAPPAS: -- Disaster Medical --

25 DR. ELIAS: Exactly.

1 DR. PAPPAS: Great. I understand now.

2 Yes. And that was intentional because that
3 was an easy template to follow and also in the
4 sense that with what instructions we had with
5 the request for proposals from the Department of
6 Health, these were the same groups that wished
7 to be included.

8 The good news about that is, when there is
9 overlap like that healthcare coalition becomes a
10 resource, both in terms of contact information
11 for the stakeholders and both in terms of
12 helping establish those initial -- that initial
13 relationship.

14 So, yes, I think certainly this project
15 would not have been able to advance as far as it
16 has without the support of our healthcare
17 coalition. And for that I would like -- and my
18 title cite as well, I have Mr. David Freeman
19 there, who is our executive director for the
20 coalition. Certainly he deserves significant
21 applause for his support of this projects.

22 As well, of course, as Lynn Derouty (ph),
23 who's our administrative director and has really
24 sort of helped hold things together.

25 I would say that if you are looking to

1 start an RDSTF entity, say beginning with an
2 advisory board and then, from that board,
3 developing an agency, working with the coalition
4 would probably be key. And it also ties you in
5 directly with DOH.

6 Remember, the coalitions also have a dashed
7 line support back to the Department of Health
8 and Human Services, which certainly, when you're
9 talking about things related to Emergency
10 Support Function 8, might be very useful in
11 terms of support for looking for grant funding,
12 etcetera, or carrying out preparedness type
13 activities.

14 So, yes.

15 MR. LEFFLER: Other questions or
16 discussions for Dr. Pappas? (No response.)

17 Dr. Pappas, thank you so much for your
18 presentation today.

19 Next we're going to do a presentation by
20 Dr. Kerwin on Florida TQIP Collaborative. I'm
21 going to need just a minute to set up. I've got
22 a -- Dr. Kerwin is on the phone and he's going
23 to present remotely and I'm going to move his
24 slides for him.

25 Give me just a second to get set up.

1 MR. KERWIN: Good afternoon. I just wanted
2 to enlighten the Council with one of the
3 projects we've been tackling in the Florida
4 Committee on Trauma. And so what I had was
5 three things that I had written out here on my
6 second slide. Three things that I wanted to try
7 and just accomplish in the next few minutes.

8 Just for those that aren't familiar with
9 TQIP, I wanted to explain a little about TQIP
10 and what a TQIP Collaborative is.

11 What we've done with the Florida Committee
12 on Trauma, what we have accomplished and where
13 we plan to go to. And so if you go -- the next
14 slide is TQIP overview. And TQIP stands for the
15 Trauma Quality Improvement Program and it's
16 analogous to NSQIP, the National Surgical
17 Quality Improvement Program, that's run through
18 the American College of Surgeons.

19 And it started in 2010 at Level 1 and Level
20 2 trauma centers around the country with a goal
21 of improving trauma care for patients through
22 data that would be submitted and then submitted
23 to a risk-adjusted analysis for mortalities and
24 morbidities. And trying to identify best
25 practices and programs.

1 So that -- okay. Someone's started music
2 playing.

3 The goal is to improve outcomes for trauma
4 patients.

5 MR. LEFFLER: Dr. Kerwin, if you'd press *6
6 and that way we can mute everybody in the
7 background.

8 DR. KERWIN: Can you hear me now?

9 MR. LEFFLER: I can hear you now.

10 DR. KERWIN: All right. Good. All right.
11 So our goal is to improve outcomes for trauma
12 patients all across, you know, all across the
13 state. And so over time people -- individual
14 hospitals and groups got interested in
15 collaboratives where states or regions or
16 hospital systems wanted to examine their
17 outcomes from a systems standpoint.

18 And so in 2014 the collaboratives were
19 formed and these were collaborative -- a TQIP
20 collaborative is a group of TQIP hospitals
21 working together with a shared goal of
22 performance improvement.

23 And when it first started it was Level 1s
24 and Level 2 centers that are -- that were
25 eligible to participate in TQIP collaboratives.

1 If you'll go to the next slide.

2 The benefits of collaborative participation
3 were system level performance improvement. And,
4 again, it's risk-adjusted outcomes comparing to
5 national risk-adjusted outcomes to have system
6 level performance improvement and identify
7 performance improvement opportunities that would
8 exist within that collaborative.

9 The TQIP allows individual centers or
10 collaboratives, in this case, to drill down on
11 that data and ensure that there's good data
12 validation, that we're training all of the
13 centers on submitting the correct data for
14 analysis, and allowing, again, system level
15 performance improvement and opportunities that
16 can be -- opportunities for improvement that can
17 be disseminated.

18 And so next slide.

19 Really, the goals, sharing, learning and
20 understanding best practices.

21 So our next slide is talking about the
22 reporting. And so all hospitals participating
23 in a collaborative, in this case the Florida
24 collaborative, would have the data aggregated
25 into one entity and that data, as a whole, is

1 assessed and compared, in this case, against
2 national benchmarks for us to determine how
3 we're doing.

4 And it's a nice summary. The TQIP
5 collaborative report provides us with nice
6 graphical depictions of how we're doing compared
7 on a national basis. And it's, again, it's a
8 systems performance analysis as opposed to just
9 looking at my specific hospital.

10 So it boosts the statistical power of our
11 data analysis and allows us, again, to improve
12 the entire system, rather than just focusing on
13 one hospital.

14 So on that slide, using the collaborative
15 report and so in using that we would identify
16 where in the system we have really good
17 performance, which is a low outlier or a very
18 poor performance, a high outlier.

19 And then we can drill down on that data
20 that comes back in our collaborative report and
21 identify best practices, see who does something
22 really well and mirror those practices at that
23 facility to be disseminated across the system
24 and then allow for improvement across the system
25 and sharing of best practices to make the entire

1 system better.

2 So our next slide, using the collaborative
3 report again, examining variances. So if I do
4 something really poorly at my place, I have a
5 lot of UTIs, say, or a lot of surgical site
6 infections, I can say, well, this is what I do
7 and if, say, Darwin had really good performance
8 at his place and low number of UTIs, he could
9 say, well, this is how we do it in Ocala, and we
10 could adopt that and try to reduce that variance
11 and allow for better system performance and kind
12 of focus our PI efforts on those areas of
13 variance and improve the quality and improve our
14 outcomes.

15 So our next slide kind of talks about, what
16 are the key parts of a successful collaborative.
17 Again, it would be system-wide goals initiative,
18 clear roles and responsibilities. A key thing
19 is really networking of the hospitals across the
20 state in our case.

21 And I think Nick's comments earlier about
22 kind of trusting in our data and trusting in our
23 relationships that we're not going to use data
24 to say, my place is really great or my -- this
25 place is really bad. So building trust. That

1 we share those results and get really good data
2 that allows for system enhancement.

3 So next slide, what have we accomplished.
4 Well, we put together an advisory committee,
5 which I have shown here, to try to provide a
6 broad representation of trauma care in this
7 state with the executive director being one of
8 the state Florida Committee on Trauma vice
9 chairs. The Florida Committee on Trauma state
10 chair having a seat. And then representation
11 from Level 1s, Level 2s and pediatric centers,
12 both on the trauma medical directors side and
13 the trauma program managers side.

14 And then to allow the partnership with the
15 advisory -- the state advisory council position
16 for the Department of Health.

17 At our meeting on Tuesday we also discussed
18 adding registry representatives and so far we've
19 identified one registrar, Tabitha Harris from UF
20 Gainesville to participate on this advisory
21 committee. We're going to look for a pediatric
22 registrar so that we can have good
23 representation.

24 And part of -- a real key part of the
25 collaborative is understanding the data that's

1 submitted from each facility so that we're all
2 reporting good quality and consistent data to
3 get the best results.

4 So, next slide. We developed Mission,
5 Vision and Purpose statements that were -- that
6 are shown on this slide. And then we've begun
7 to develop kind of a list of expectations that
8 we're going to have for our collaborative and
9 for each trauma center to participate in the
10 collaborative. Again, to drive our system
11 performance and to really improve quality.

12 And the reason this is important, I didn't
13 put any of the data in there, but first report
14 was the spring of '17 and there were -- there
15 were plenty of opportunities for improvement.
16 Our fall of '17 report looked a little bit
17 better, but still some key opportunities for
18 improvement in both morbidities and mortalities.

19 And so where do we need to go from here?
20 Our next slide. And then I think what we would
21 like to see, looking at my last slide there,
22 what -- what do we need.

23 We'd like to have from the Trauma System
24 Advisory Council endorsement of our purpose and
25 endorsement of our collaborative advisory

1 committee members that I've presented there.

2 And then I think to allow us to build a
3 partnership between both the Florida TQIP
4 Collaborative and the System Advisory Council,
5 build a partnership for us that would allow for
6 reporting of data and our progress on PI
7 projects.

8 Or a TQIP collaborative be recognized as a
9 subcommittee of the Florida Trauma System
10 Advisory Council to allow that partnership to
11 exist and allow us to move forward across the
12 state to drive our quality and really improve on
13 what we're doing now.

14 So that's all I have on the Florida TQIP
15 Collaborative. If any questions, I'm happy to
16 try to answer them for everybody.

17 MR. LEFFLER: Thank you, Dr. Kerwin.

18 Are there questions?

19 Dr. Reed?

20 DR. REED: Yeah. Thanks, Andy. This is
21 Larry Reed. Maybe I missed it, again, are you
22 starting your own TQIP process in terms of
23 getting the registry data and then doing the
24 analysis as the college's TQIP, or are you
25 simply having facilities in Florida participate

1 in the college's TQIP and get a Florida
2 download, if you will from their data?

3 DR. KERWIN: It's the latter. So everyone
4 -- every center is required to participate in
5 TQIP and as a result of that we've been able to
6 have the college give us a collaborative report
7 for all of the participating centers in Florida.

8 DR. REED: Yeah. That's makes sense.
9 Yeah. What's wonderful about TQIP is, even if
10 you find that you're performing well, you know,
11 above the -- that standard line or that OE ratio
12 line and you're doing well, you can still see,
13 in things like, for example, the complications.
14 You can see where you stack up compared to other
15 facilities and adjust those things accordingly.

16 So it's got a wealth of information that I
17 think the whole state can obviously benefit
18 from.

19 DR. KERWIN: Yeah. I think it's exciting
20 and it will work to really to bring all the
21 centers together, driving for the one mission of
22 improving quality as opposed to what we've been
23 through over the past several years.

24 MR. LEFFLER: Further questions of
25 discussion Dr. Kerwin?

1 DR. MCKENNEY: Yeah. Mark McKenney from
2 Kendall. I have a question if -- when I get a
3 chance -- when you get a chance.

4 DR. KERWIN: Yes.

5 MR. LEFFLER: Dr. McKenney, go ahead.

6 DR. MCKENNEY: Andy, Mark McKenney.

7 Hey, that was great. TQIP is an amazing
8 document. It's an amazing venture. Many lives
9 have been saved because of it. I just wanted to
10 say, you know, it's stupendous what you and the
11 college have done to get us information
12 comparing us to, you know, our peers and being
13 able to look at it from multiple different
14 angles and, you know, look for ways to always
15 get better.

16 So I just want to say, thank you very much.

17 DR. KERWIN: Thanks, Mark, for saying it.

18 MR. LEFFLER: Dr. Ang.

19 DR. ANG: Hey, Andy, great talk. This is
20 Darwin.

21 So I just wanted to also highlight that
22 TQIP not only allows us to short of benchmark
23 within Florida, but across the whole United
24 States. And if we're going to, you know, make
25 Florida one of the best places in the country to

1 get their trauma care, we need something like
2 TQIP.

3 The other thing, it's the only
4 risk-adjusted benchmarking tool that we have in
5 Florida right now. And this is all the more
6 important to support this because we need risk
7 adjustments in order to compare apples to apples
8 and oranges to oranges. To be able to compare
9 mortality rates from one place and complication
10 rates from one place and be able to look
11 objectively at, you know, why people do better
12 at some things and why others don't.

13 And so I'm in full support of the use of
14 TQIP in Florida.

15 MR. LEFFLER: Dr. Ang.

16 DR. ANG: Yeah. You know, the other piece
17 about TQIP I can tell you from experience is
18 that it does make the hospitals capture their
19 data better.

20 I remember when TQIP first came out, Glen
21 Tinkoff, who was the chair of the college's COT
22 PIPS committee, was frustrated because his
23 Christiana Hospital, large hospital trauma
24 center, had the worst outcomes for penetrating
25 trauma to the abdomen. And he couldn't

1 understand it. And turned out it was just
2 because the way the data were being entered that
3 they weren't accurately entered.

4 Our own program at Methodist in Indiana,
5 when I was looking through our complications, we
6 have the worst outcomes being the norm for the
7 -- or the benchmark for our head injury
8 patients. And, you know, we have in -- one of
9 the only places in the country where we had
10 inhouse neurosurgical attending coverage 24/7.
11 We had 65 neurosurgeons that are, you know,
12 bound at the hip to our hospital because their
13 clinic is right next to us and connected.

14 And so I couldn't understand it. So we
15 reviewed all the data that were entered and it
16 turned out that the registrars were entering
17 patients who came in, fell down, they became a
18 trauma activation, we'd get a scan and find they
19 had an intracerebral bleed, no traumatic event,
20 and we'd transfer the patient, obviously, to
21 medicine or whatever.

22 But the registrars were entering these as a
23 head injury because it was a trauma activation.
24 And, you know, once you get those out of your
25 data set, then your results look pretty good.

1 So it does make us become increasingly
2 accurate with the data that we're collecting by
3 having that comparative tool for use.

4 MR. LEFFLER: Thank you, Dr. Reed.

5 DR. KERWIN: That was brought up by
6 Donna York at our COT meeting on Tuesday. I
7 don't know if she's still there.

8 But that was the key reason for adding in
9 registrars on our advisory committee, so that we
10 ensured that data was accurate and consistent
11 across the state and we didn't have outlier --
12 high outliers showing poor performance when it's
13 really just bad data being entered into the
14 database.

15 MR. LEFFLER: Dr. Namias.

16 DR. NAMIAS: Andy, great presentation.

17 This really is the road forward for the
18 Florida Committee on Trauma is TQIP. That's
19 really going to be our major focus. It's
20 quality improvement and everyone can agree on it
21 and it's on a level playing field. And each
22 hospital really chooses if they want to play on
23 that level playing field.

24 If you don't devote resources to your data
25 collection and your registrars, you're going to

1 have bad data. And stories like Dr. Reed
2 mentioned are routine.

3 If you go to the national TQIP meeting,
4 basically almost every abstract is, we had
5 something we were doing poorly on, we reviewed
6 the data, we discovered we were putting it in
7 wrong, we weren't doing so bad after all.

8 So once we -- once everyone gets past that
9 we're not doing so bad after all, then we'll
10 have a baseline where we're all putting the data
11 in properly and we can work from there.

12 So it's a great thing and FCOT really wants
13 to, you know, I think what's happened
14 historically over the years, there used to be a
15 direct channel from FCOT to the DOH and now what
16 we really have is this FTSAC intermediary
17 between FCOT and the DOH, which is fine because
18 now we have a broader representation of
19 stakeholders before the information goes on to
20 the DOH and FCOT looks forward to contributing
21 this way.

22 MR. LEFFLER: Further discussion of
23 question of Dr. Kerwin?

24 DR. KERWIN: I don't have any more. Just,
25 you know, the -- just on my last slide is what

1 we need is the partnership and the subcommittee.
2 I don't know if we -- if we take a vote on that
3 now or we talk about it or the Council talks
4 about it and gets back to us, but that -- I
5 think that's kind of the one action item that
6 comes from this.

7 MR. LEFFLER: Thank you, Dr. Kerwin.

8 Can I entertain a motion related to
9 Dr. Kerwin's recommendations?

10 DR. REED: Yeah. I move that we form a
11 partnership with the Florida TQIP, yes.

12 MS. YORK: Second.

13 MR. LEFFLER: Second by Ms. York.

14 I think what we'll do is we'll vote to form
15 the partnership. The details of the partnership
16 will probably have to come back before the
17 Council so that we can make sure, but obviously
18 Dr. Kerwin has a membership roster that he wants
19 to start working with. How the connection
20 between the Florida Committee on Trauma and the
21 Advisory Council will need to be delayed a
22 little bit more in depth before we start
23 operations.

24 So any further discussion related to the
25 motion?

1 Dr. Ibrahim.

2 DR. IBRAHIM: Don't we have anything on
3 there that says, you know, maybe we have --
4 maybe this is understood. Again, this is my
5 simple mind. A report from TQIP at each of our
6 quarterly meetings just to say where they are
7 and what's going on with that as part of that
8 partnership.

9 MR. LEFFLER: Yeah, so TQIP puts out
10 semiannual report. I'm looking back at Josh,
11 our data administrator.

12 We could certainly -- we could certainly
13 provide the statewide quarterly or semiannual
14 report to the Council. As far as reporting that
15 the collaborative generates with -- through the
16 assistance with the Department, if that's what's
17 asked of us, we could certainly incorporate that
18 into future meetings.

19 DR. REED: Yeah. I mean that -- that can
20 start to become part of our charter as well, is
21 helping to develop the Florida TQIP program.

22 DR. KERWIN: And just for the record, the
23 spring '18 report has not been released yet. So
24 the most recent we have is fall of '17, which
25 was November-ish of '17 when it was released.

1 MS. COLSTON: Thanks, Dr. Kerwin.

2 So one thing, what you all may want to do
3 -- and I think the quarterly -- if they can
4 report quarterly, not necessarily data, but just
5 on the activities that they're doing until we
6 can establish -- I think -- so is the ask that
7 we add the Florida TQIP Collaborative as a
8 subcommittee of the Florida Trauma System
9 Advisory Council?

10 And I, you know, I think it's a great idea.
11 I know that there are things that we need to do
12 on our end. So we recognize that partnership
13 and then we're going to go and do our homework
14 and probably next time you all meet we can have
15 that as an agenda item to vote to add it once we
16 make sure we've wrapped up all our ends.

17 Will that work for everybody? (Council
18 members responded.)

19 Perfect. Okay.

20 MR. LEFFLER: All right. So the motion is
21 to formulate the subcommittee that is a
22 partnership between the FCOT and the Florida
23 Trauma System Advisory Council related to the
24 TQIP Collaborative.

25 And so I have a motion open?

1 DR. NAMIAS: Motion.

2 MR. LEFFLER: Motion by Dr. Namias.

3 DR. ANG: Second.

4 MR. LEFFLER: Second by Dr. Ang.

5 All those in favor, say aye. (Council
6 members responded.)

7 All those opposed? (No response.)

8 Let me turn off presentation mode for the
9 members on the phone.

10 Dr. McKenney and Dr. Summers, do you have
11 -- how do you feel about the motion to formulate
12 a subcommittee of the Florida Trauma System
13 Advisory Council that is a partnership between
14 FCOT and the Council for the TQIP Collaborative?

15 DR. MCKENNEY: All for it. Mark. All for
16 it.

17 MR. LEFFLER: All right. Any opposition?

18 All opposed say nay. (No response.)

19 Hearing no opposition, show the formation
20 of the new subcommittee that is a partnership
21 between FCOT and the Florida Trauma System
22 Advisory Council related to the TQIP
23 Collaborative.

24 We will entertain procedures and
25 organization at a future agenda item. All

1 right.

2 The next order of business is future
3 meeting schedule. We wanted to, you know, as
4 you can see, there's been some debate or some
5 discussion yesterday about meeting with -- in
6 conjunction with EMS Advisory Council. I know
7 that all of you have your own schedules and
8 challenges.

9 We want to come up with at least a couple
10 of meetings out at this point of what you all
11 would find as available for future meeting dates
12 and locations.

13 I'll open the floor to discussion.

14 DR. REED: Well, the date we picked
15 yesterday for the next meeting is not going to
16 work, I think, because we're doing site surveys.

17 MR. LEFFLER: That's the --

18 DR. REED: Right.

19 MR. LEFFLER: -- EMSAC Council meeting --

20 DR. REED: Right.

21 MR. LEFFLER: -- which is in October --

22 UNIDENTIFIED SPEAKER: Sixteenth, 17th.

23 DR. REED: Right.

24 MR. LEFFLER: -- 16 and 17 in St.

25 Augustine, Florida.

1 Dr. Reed, do you -- do you know which dates
2 you're doing the site surveys?

3 DR. REED: I can tell you in just a second.
4 There are two trauma centers we're surveying on
5 the same trip. So it's, yeah, the 14th through
6 the 8th -- through the 17th.

7 MR. LEFFLER: Would it be possible to meet
8 on Wednesday, after you guys come from Broward
9 County or do you need -- is that unavailable?

10 DR. REED: I think -- let's see. Wait.
11 One of them, I think, is an all day. I've got
12 to check the schedule for that.

13 MR. LEFFLER: Because we could align to
14 Wednesday or Thursday of that week and it would
15 align with --

16 DR. REED: Right.

17 MR. LEFFLER: -- still align with EMSAC.

18 DR. REED: Yeah. Let me see if I can find
19 the exact schedule. Tuesday. Okay. Yeah.
20 We're supposed to return home on Wednesday the
21 17th. So Wednesday would be fine.

22 MR. LEFFLER: All right. Any further
23 discussion about October meeting date? (No
24 response.)

25 Is there a motion?

1 UNIDENTIFIED SPEAKER: So moved.

2 MR. LEFFLER: So moved would be to meet --
3 Dr. Reed, is your availability Wednesday or
4 Thursday?

5 DR. REED: Wednesday --

6 MR. LEFFLER: Wednesday.

7 DR. REED: -- and Thursday.

8 MR. LEFFLER: And the specific date of that
9 is the --

10 DR. REED: Seventeenth --

11 MR. LEFFLER: -- 17th?

12 DR. REED: -- is Wednesday. Thursday is
13 the 18th. Either one would work for me.

14 MR. LEFFLER: Okay.

15 DR. REED: I'd just have to change flight
16 schedule.

17 MR. LEFFLER: I anticipate the October
18 meeting would be a one-day meeting versus what
19 we did this time, which was a working meeting
20 and then advisory council meeting.

21 So, would Wednesday the 17th work for you
22 all?

23 DR. NAMIAS: So --

24 MR. LEFFLER: Dr. Namias, you're
25 recognized.

1 DR. NAMIAS: For the EMSAC meetings in
2 October, is it going to be constituency leading
3 up to an EMSAC committee meeting on the last
4 day?

5 MR. LEFFLER: Yes. In fact, it would be
6 the same fashion that we do it now. Certainly
7 we can make accommodations into the schedule to
8 meet all members' obligations.

9 DR. NAMIAS: Yeah. So ideally, I hate for
10 this to be personal for any one person, but, you
11 know, if we have to throw our personal things
12 in, you know, to lessen my travel time, I have
13 to be at EMSAC and FTSAC.

14 MR. LEFFLER: Yeah.

15 DR. NAMIAS: So if those are on one day
16 with our pre-work stuff -- pre-meeting stuff the
17 previous day, it cuts it down from three days to
18 two away from work.

19 MR. LEFFLER: So your motion would be to
20 have it on Thursday, October the 18th?

21 DR. NAMIAS: Yeah, Thursday October the
22 18th with whatever, you know, preliminary lead
23 up stuff would be the day before.

24 MR. LEFFLER: All right. Okay. So moved?

25 DR. NAMIAS: So moved.

1 MR. LEFFLER: Is there a second?

2 DR. IBRAHIM: Second.

3 MR. LEFFLER: Second by Dr. Ibrahim.

4 All right. Is there any further
5 discussion? (No response.)

6 All those in favor of the next Trauma
7 System Advisory Council being Thursday, October
8 18th, say aye. (Council members responded.)

9 All those opposed? (No response.)

10 Hearing no opposition, the next meeting
11 date for the Advisory Council will be October
12 the 18th, 2018.

13 Moving on into January. And I want to kind
14 of start with setting up our quarterly meetings
15 as far out as we can and we'll move back into
16 special meetings and commons hours.

17 The EMS Advisory Council is meeting January
18 24th or 22nd through 24th, 2019. And that
19 meeting will be in Daytona.

20 UNIDENTIFIED SPEAKER: I'm sorry, what were
21 the dates?

22 UNIDENTIFIED SPEAKER: I'm sorry.

23 MR. LEFFLER: January 22nd through the
24 24th. So to align with -- with Dr. Namias'
25 previous suggestion, the date would probably be

1 January the 24th, 2019.

2 UNIDENTIFIED SPEAKER: And that aligns with
3 Fire East, right?

4 MR. LEFFLER: Yes.

5 UNIDENTIFIED SPEAKER: So all the
6 infrastructure, the venue is all in place. So
7 that makes sense.

8 MR. LEFFLER: Can I entertain a motion for
9 January 24th, 2019?

10 DR. NAMIAS: So moved.

11 DR. REED: And that's where?

12 MR. LEFFLER: That would be in Daytona
13 Beach.

14 UNIDENTIFIED SPEAKER: The one in October
15 is in --

16 MR. LEFFLER: St. Augustine.

17 UNIDENTIFIED SPEAKER: -- St. Augustine.
18 Okay.

19 DR. REED: There's lots of nonstops from
20 Chicago.

21 UNIDENTIFIED SPEAKER: (Not using
22 microphone.)

23 DR. REED: You've got to take a nonstop to
24 Chicago to get there.

25 UNIDENTIFIED SPEAKER: Yeah.

1 MR. LEFFLER: Is there a second for January
2 the 24th?

3 MR. SUMMERS: Second.

4 MR. LEFFLER: Second by Mr. Summers.

5 Is there further discussion? (No
6 response.)

7 Hearing no further discussion, all those in
8 favor of the next or the -- excuse me -- the
9 winter meeting being January 24th, 2019 in
10 Daytona Beach, say aye. (Council members
11 responded.)

12 All those opposed? (No response.)

13 Hearing no opposition, the meeting -- the
14 winter meeting for the Advisory Council will be
15 January 24th, 2019 in Daytona Beach.

16 MR. KEMP: Michael?

17 Just a note to members. The January
18 meeting hotel space is somewhat limited. So
19 when the State sends out the notice to make your
20 hotel reservation, don't wait. Do it
21 immediately. Because the rooms will disappear
22 and then you'll end up having to pick a room
23 that's much farther away and very inconvenient.

24 So make your reservation early in Daytona
25 because the --

1 MR. LEFFLER: And we will work with members
2 to make sure that you guys get the first
3 opportunity in the room blocks.

4 Our next meeting is typically held in April
5 and I don't have a specific date, but it's in
6 Palm Beach. Do you guys want to continue into
7 the spring and to summer or do we want to --

8 DR. REED: I think the further ahead we can
9 plot these, the better for everybody's schedule.
10 Because that way --

11 MR. LEFFLER: We don't have -- we don't
12 have hard dates for that meeting --

13 DR. REED: Okay.

14 MR. LEFFLER: -- as of yet, but we know it
15 will likely be in Palm Beach County in April.

16 DR. REED: Well I think -- would it be
17 possible, once you have firm dates, could we
18 simply get those by e-mail and vote by e-mail?

19 MR. LEFFLER: We probably can't vote by
20 e-mail, but we could certainly vote -- we could
21 certainly set up a --

22 DR. REED: Commons --

23 MR. LEFFLER: -- a common -- not commons
24 hour, but a special meeting via conference call

25 --

1 DR. REED: Okay.

2 MR. LEFFLER: -- to specifically address
3 future --

4 DR. REED: Yeah.

5 MR. LEFFLER: -- meeting schedules.

6 DR. REED: That'd be fine.

7 MR. LEFFLER: All right. The next point I
8 wanted to make on future meeting schedules is,
9 we do have this tasking with the pediatric
10 survey. Is there a need to schedule conference
11 call special meetings to take action on the
12 pediatric survey?

13 DR. REED: Well, I think our commons work
14 will determine that.

15 MR. LEFFLER: Okay. Yeah. And I -- what I
16 would need is seven days' notice --

17 DR. REED: Right.

18 MR. LEFFLER: -- to be able to notice a
19 special meeting. And the difference being that
20 at a special meeting we could take action or you
21 could actually vote on an item whether it being
22 -- rather than being an informal discussion
23 amongst the Council.

24 So we will wait until we -- until that
25 needs arises and we will schedule a special

1 meeting, if needed.

2 DR. REED: Okay.

3 MR. LEFFLER: Next one is the commons
4 hours. We've been doing them, with the
5 exception of this week and the Fourth of July,
6 we've been doing them weekly on rotating days.

7 The next commons hour is July the 18th at
8 3:00 and July the 26th at 3:00.

9 Could I entertain a motion to continue the
10 weekly commons hours on a rotating schedule?

11 DR. NAMIAS: So moved.

12 MS. YORK: Second.

13 MR. LEFFLER: Second by Ms. York.

14 Any further discussion about commons hours,
15 needs to have more of them or is the schedule
16 working out for you all.

17 MR. ROSS: (Not using microphone.) I think
18 you've just been doing Tuesday, Wednesday,
19 Thursdays.

20 MR. LEFFLER: Yeah, it's -- it worked out
21 that way because of how the week branched one of
22 the times that we did it. But we will try and
23 do it Monday through Friday on rotating days as
24 they appear on the calendar.

25 So I -- what we will do is, if you guys

1 want to make a motion that we continue the
2 commons hours, I would be happy to schedule them
3 through September.

4 DR. NAMIAS: Motion to continue the commons
5 hours on a rotating basis.

6 MR. LEFFLER: Sorry. The motion -- as a
7 point of order, you guys have already made the
8 motion.

9 So all those in favor say aye. (Council
10 members responded.)

11 All those opposed? (No response.)

12 Hearing no opposition, I'll set commons
13 hours through the month of September.

14 All right. The next agenda item is an open
15 item for new business.

16 Are there any members that would like to
17 bring business before the Council?

18 Ms. York, you're recognized.

19 MS. YORK: So at the FCOT meeting I brought
20 up the fact with the opioid law that rolled out
21 in July you have to have an estimated ISS for
22 your trauma patients if you want a -- an ISS
23 greater than nine if you want to give them,
24 like, seven days worth of drugs.

25 So the trauma guys were pretty okay with

1 that at my place because they're going to use
2 this app that doesn't really do anything well,
3 but it gives them a number and they're happy
4 with that.

5 But my orthopedic physicians are very
6 concerned because, if you have just an upper arm
7 extremity fracture, you're never going to get an
8 ISS anything greater than four.

9 So one of my registrars tried to do a
10 condensed version of the two-day AIS book that
11 would help these folks out because normally we
12 don't code ISS scores until the patients have
13 been discharged and now you want a code so you
14 know what to prescribe as they leave the
15 hospital.

16 So she actually sent it to the AIS gurus
17 that run the course and they didn't know
18 anything like that was going on in Florida and
19 so they approved putting together something and
20 they are reviewing what she did and so they hope
21 to have something come out in the near future
22 that would be a bit of a guideline that would
23 help people at the bedside that are writing
24 scripts.

25 DR. REED: How was it decided that ISS is

1 going to correlate with the narcotic need?

2 MS. YORK: That came from the legislature
3 and I can't answer that question. I can say
4 that some of their sites to refer back to were
5 probably not the most accurate sites to utilize.

6 MR. LEFFLER: Dr. Namias?

7 DR. NAMIAS: It wasn't decided by any of
8 us. It was decided --

9 MS. DINOVA: By non-medical --

10 DR. NAMIAS: -- by non-medical people. As
11 a matter of fact, Donna, as you speak, as I
12 recall reading it, I think it does say ISS
13 greater than nine, not greater than or equal to
14 nine, doesn't it?

15 MS. YORK: It does say greater than ine.

16 DR. NAMIAS: Well that's a problem, right?

17 MS. YORK: Uh-huh.

18 DR. NAMIAS: Because, in reality -- for the
19 record, in reality the problem with it is, it
20 doesn't say an estimated ISS, it says an ISS.
21 We don't know the ISS at discharge.

22 In order to accurately -- in order to
23 really determine the ISS you have to use the
24 AIS methodology, right? And the AIS methodology
25 is not free on Google. It's several thousand

1 dollars.

2 MS. YORK: It's proprietary, yes.

3 DR. NAMIAS: It's proprietary. So nobody
4 really knows the ISS on discharge. We can make
5 a pretty good guess, but we don't really know.

6 So I think it -- I think it opens up the
7 doctors to some degree of risk if a prescription
8 is written from an estimated ISS greater than
9 nine and it ends up not really being greater
10 than nine and that patient somehow gets in
11 trouble with that opioid.

12 So it's -- that part of the law is not --
13 doesn't really work for the doctors. However,
14 like you said at the FCOT, we all got together
15 and said, we can probably make this work.

16 But I think that might be an activity for
17 us, as an advisory counselor -- council, maybe
18 to advise the DOH on this.

19 DR. REED: I guess I have a problem with
20 the legal profession thinking it knows how to
21 practice medicine. You know, they're telling
22 when doctors can and cannot prescribe
23 medications. And I don't know that we're
24 writing any laws that we expect citizens to
25 follow.

1 DR. NAMIAS: We are only -- we are advisory
2 to the DOH and --

3 DR. REED: Right.

4 DR. NAMIAS: -- and we completely agree
5 with you and our medical societies really fought
6 over this. I would talk to you about this
7 offline, but I guess I can't in the Sunshine.

8 So, can I talk a little bit about the opioid
9 law outside of this?

10 MR. LEFFLER: You are recognized.

11 UNIDENTIFIED SPEAKER: Yeah.

12 DR. NAMIAS: I'm recognized to talk about
13 it here only?

14 MR. LEFFLER: Yes.

15 DR. NAMIAS: Okay. Yeah. So --

16 DR. REED: No, if it's just talking about
17 the opioid law to fill me in, that shouldn't be
18 a --

19 DR. NAMIAS: Okay. We'll talk about it
20 offline.

21 DR. REED: Yeah, I mean, I could easily see
22 somebody with a lot of pain having a low ISS and
23 somebody with very normal pain having a high
24 ISS. You know.

25 MS. YORK: I know that --

1 DR. REED: There's no correlation.

2 MS. YORK: I know in our town, even before
3 the July 1st date, some people -- some
4 pharmacies refused to fill scripts that were
5 very reasonable scripts because they did some
6 conversion to morphine equivalence and they
7 said, oh, this is way too much, we won't fill
8 this.

9 So, you know, I think that we could have
10 potentially a problem with the patient
11 experience, patient satisfaction, return to the
12 ED, return to clinics, staying in the hospital
13 for a longer length of time, actually going to
14 rehab or SNFs because there -- that law doesn't
15 really apply to them.

16 I mean I think there's some fallout there.

17 DR. REED: Right.

18 MR. KEMP: There is, just so you know, much
19 more legislation that is being formulated as we
20 speak right now. Our agency's already been
21 contacted. I'll be interviewing with OPPAGA
22 next week regarding opioid overdoses in Florida
23 and their -- they've been -- their staff has
24 been instructed by the house and the senate in
25 Florida to find solutions, whatever they are.

1 So this next session there's going to be
2 other legislation. What it looks like, I do not
3 know yet. But, you know, there -- this is the
4 disparity between legislation and professions
5 throughout Florida occurs and the legislature
6 does not have to check with anybody before they
7 pass a law, necessarily.

8 So, getting input early and, remember, this
9 is an election year, so there's going to be a
10 lot of new legislators there. So getting in
11 touch with them early to voice your concerns
12 would be appropriate.

13 MR. LEFFLER: Further discussion? (No
14 response.)

15 Any other new business by the Council
16 members?

17 DR. KERWIN: Michael?

18 MR. LEFFLER: Yes.

19 DR. KERWIN: It's Andy Kerwin. Can I ask a
20 question about the opioid law?

21 MR. LEFFLER: Dr. Kerwin, you're
22 recognized.

23 DR. KERWIN: So my question's about the
24 opioid law. When I first was hearing about it my
25 understanding was that the ISS greater than nine

1 allowed the seven-day pain exception, but the
2 way we read it, and we went over this yesterday
3 with our pharmacy staff, is an ISS greater than
4 nine allows you to go beyond the seven days of
5 opoid prescribing.

6 Do I have that correct or no?

7 MR. LEFFLER: Dr. Kerwin, I don't have a
8 copy of the law in front of me. But I would --
9 I would defer to your institutional legal
10 counsel.

11 DR. KERWIN: Yeah. We looked at it with
12 our pharmacists for our trauma and surgical
13 services yesterday and the way we read it is,
14 you can prescribe for seven days by documenting
15 the acute pain exception and then beyond seven
16 days by documenting ISS greater than nine.

17 So I don't -- we should probably all get
18 clarification so we're all consistent across the
19 state.

20 MR. LEFFLER: Thank you, Dr. Kerwin.

21 DR. KERWIN: Thanks.

22 MR. LEFFLER: Is there any other
23 discussion? (No response.)

24 Any other motions by the members? (No
25 response.)

1 All right. Well, I think it's been a
2 productive couple of days here. We've gotten
3 bylaws established, we've gotten the Council's
4 charter established, we've got some direction to
5 our pediatric study and we'll continue to move
6 those items forward in the coming weeks and
7 months.

8 Our next meeting will be October the 18th
9 in St. Augustine, Florida.

10 I sincerely -- on behalf of the Department
11 of Health, I sincerely appreciate all of your
12 hard work and dedication to come to these
13 meetings. I know that you all have very busy
14 schedules.

15 Is there any other business for the
16 Council? (No response.)

17 Can I entertain a motion to adjourn?

18 DR. NAMIAS: Did we get the public comment?

19 MR. LEFFLER: Oh, yes. Excuse me. I
20 apologize.

21 We do want to provide opportunity to -- for
22 public comment if there is any. Do I see any
23 public comment? (No response.)

24 All right. Seeing no public comment, do --
25 can I entertain a motion to adjourn?

1 DR. NAMIAS: Is there anyone on the phone
2 for public comment?

3 MR. LEFFLER: Is there anyone on the phone
4 for public comments? (No response.)

5 DR. NAMIAS: Motion to adjourn.

6 MR. ROSS: Second.

7 MR. LEFFLER: Seconded by Mr. Ross.

8 All those in favor, say aye. (Council
9 members responded.)

10 All those opposed? (No response.)

11 Hearing none, the meeting is adjourned.

12 (The Florida Trauma System Advisory Council
13 Meeting adjourned at 3:53 p.m.)

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STATE OF FLORIDA)
COUNTY OF ORANGE)

I, CYNTHIA R. GREEN, Court Reporter,
certify that I was authorized to and did report the
aforementioned July 12, 2018 Florida Trauma System
Advisory Council Meeting, and that the transcript is
a true and complete record of my notes and
recordings.

I further certify that I am not a relative,
employee, attorney or counsel of any of the parties,
nor am I financially interested in the outcome of
the foregoing action.

DATED this 8th day of August, 2018.

Cynthia R. Green

CYNTHIA R. GREEN, Court Reporter
Notary Public, State of Florida
(electronic signature)

Notary Commission #EE 203636
Commission Expires: 06/01/20