FLORIDA TRAUMA SYSTEM

ADVISORY COUNCIL MEETING

SEPTEMBER 14, 2022

OMNI HOTEL AT CHAMPIONSGATE

1500 MASTERS BOULEVARD

CHAMPIONSGATE, FLORIDA

Reported By:

Cindy R. Green, Court Reporter

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COUNCIL MEMBERS PRESENT

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LISA DINOVA, MODERATOR

CANDACE PINEDA, CO-MODERATOR

KATE KOCEVAR, TRAUMA SYSTEM ADMINISTRATOR

DARWIN ANG, MD

MARK MCKENNEY, MD

NICHOLAS NAMIAS, MD

LARRY REED, MD

MAC KEMP

JOSEPH IBRAHIM, MD (NOT PRESENT)

DAVID SUMMERS (NOT PRESENT)

GLENN SUMMERS (NOT PRESENT)

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P R O C E E D I N G S

September 14, 2022 **1:03 p.m.**

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

MS. DINOVA: So I'm going to officially go ahead and call this meeting together at 1:03. And I want to make sure that everybody is aware that we are recording this meeting via Teams and that we do have a court reporter live in the room for the record.

If we could, please everyone join us for the Pledge of Allegiance. (Recited.)

Thank you. Just going to do a quick look at the agenda here and we're going to go ahead and perform our roll call. Ms. Candace is going to do that for us.

MS. PINEDA: Okay. For roll call we have Dr. Ang?

DR. ANG: Present.

MS. PINEDA: Lisa DiNova?

MS. DINOVA: Here.

MS. PINEDA: Dr. Ibrahim? (No response.)

Mac Kemp?

MR. KEMP: Here.
MS. PINEDA: Dr. McKenney? (No response.)
Dr. Namias?
DR. McKenney: Mark McKenney here. Mark McKenney here, sorry.
MS. DINOVA: Thank you.
MS. PINEDA: Thank you, Dr. McKenney.
Dr. Namias? (No response.)
Dr. Reed is present.
DR. REED: Here.
MS. PINEDA: David Summers? (No response.)
Glenn Summers? (No response.)
And Candace Pineda, present.
Kate Kocevar?
MS. KOCEVAR: Here.
MS. PINEDA: Present.
MS. DINOVA: All right. I show that we have five members present at the moment. Maybe a couple more will join online. That means that we do not have a quorum for today's meeting so we will be going through, looking at things, making recommendations and hopefully for the November meeting, we will have a quorum and be able to vote.
All right. On that note, please make sure

that you reach out to your government relations folks. I know that we have had a vast interest in people joining this Advisory Council. We do have some slots open as well as all of us are back up for reappointment, so please have your government relations folks reach out to the Governor's office so that maybe we can get these appointments fulfilled and be able to meet our statutory requirements.

I want to cover some old business as we get started here. Something that I know Kate and her team have been working on is getting our web page updated and getting down all of those old documents that hadn't been updated in recent times; getting the new things put up.

So we have -- I was going to try to share a link here, but it's not going to let me; so let me show it to you this way. You can actually go to the DOH website and find the Trauma tab and then we actually have a Florida Trauma System Advisory Council tab.

So here you'll find all of the current and upcoming agendas.

I'm sorry. Is someone on the line? (No response.) Okay.

You'll also see the transcripts which is what we use for the minutes for these meetings. The official court reported transcripts will be post there once the copy has been certified. You will see any of the drafts and updated products that the Workgroup has put together. So Charter that the Council revised and approved last meeting is up there for your review again. Also, the draft of the Trauma Center Standards that was completed in January of '22, that is the current working document right now; however, good news, the subcommittee is up and running. We're going to talk about that in just a few minutes. But you'll be able to find all of these updated forms and any of the meetings that will be coming up. The announcements will be posted here. And then once we start having Commons Hours Meetings again, those will also be posted. So you'll be able to find all of the latest and updated information for this Advisory Council now posted on to that DOH website.

Bear with me as each time I switch screens, I have to actually stop sharing and bring it back up.

All right. There we go. Okay. So, I

think that was it for the website.

We do have an update from Ms. Candace. At our last meeting we had talked about the EMSTARS project that is going around the State and the potential for the trauma centers to get involved in that. And Candace had a meeting with the ESO team, so I'm going to let her give us an update on how that project is looking.

MS. PINEDA: Thank you. So immediately following our last meeting, we had a call with ESO, with the Department of Health.

THE REPORTER: Will you state your name, please.

MS. PINEDA: Sure. This is Candace Pineda.

And immediately following our last Florida Trauma Advisory Council, we had a meeting with ESO, the Department of Health, the different collaboratives to look at sharing our data that most all trauma centers collect.

In previous versions of the National Trauma Databank, there were specific EMS prehospital interventions and filters that were collected, and the latest version of the data dictionary; removes some of those elements as mandatory.

So since we adopted whatever happens to the

American College of Surgeons, although most centers still collect this data, it is not automatically transmitted neither to the State or nationally. So we had a discussion of if those data points are in there, can the State see them? Can we use them? Can we link this data and look at it similar as we do for the CARES data. So really looking at it in a full hybrid model with Biospacial. So the answer to that from legal team was essentially that we would have to update the Florida Trauma Data Dictionary to re-include or re-mandate those fields so that it then can be viewed at the State level. And we asked our legal team to also please investigate if we could, in fact -- if centers already collect that data and are willing to share, can that feed automatically link? So those teams are looking into it. The person that took that lead has since retired at ESO, but their ticket is still in and they're investigating how we can view this data that we're all collecting.

Kate, do you have anything you want to add to that?

MS. KOCEVAR: Yes. Thank you, Candace.

Kate Kocevar. I agree with that we have to take a look at that because back in 2018 is when the statutes went in and it was the (unintelligible).

THE REPORTER: I can't hear you.

AUDIO TECHNICIAN: Step up to the mic.

MS. KOCEVAR: Okay. So, can you hear me? Good. Okay. All right.

So, in 2018, it was decided that the college data dictionary would be the one that we would accept and not have any Florida-specific fields.

So in this process we would have to open the Rule, once again, to determine what specific fields and, you know, obviously, we would have to have workshops and hearings in order to make all of this happen.

So, preliminarily, Candice is spot-on with us trying to take a look at what is ESO's ability to get that information out of what's being sent. And then we would certainly have to go the trauma community next to have those further discussions on accepting what particular fields we would like to see and then the idea of then opening up the Rule and taking it from

there.

Thank you.

MS. DINOVA: Okay. So it sounds like that would have to be -- it's going to be a really long process to get that accomplished since we'd have to reopen Rule and everything, so as we get more information from the legal teams and from ESO, we'll look at the proper form for that. It may not be through here. It may be through the AFTC or probably through the Florida collaborative -- TQIP collaborative. So we'll look at that as we get further details.

So we do have some updates to share. If Ms. Kocevar would like to give the DOH Department update.

MS. KOCEVAR: All right. Kate Kocevar again.

So, as far as our updates are concerned, we are currently doing the Standards. As we talked about, we issued that track again to try to get the activity moving once more that was dealt in subcommittees prior to unfortunately COVID hitting, and now we have resurrected and Laura Hamilton has been gracious enough to become our leader.

We had a preliminary meeting -- was it last week, Lisa? That's correct?

MS. DINOVA: I think so. Laura's going to give us a full update, too.

MS. KOCEVAR: Fabulous. I love it even better.

So, as far as that is concerned, that is something that we need to continue to move forward as we take a look at that.

The TQIP collaborative is also going to be, you know, certainly involved with taking a look at what we were talking about prior with our ESO fields and what we want to do there.

As far legislatively at this point, we do not have anything that was put forth as far as being a particular one item. We certainly have sent in information to the legislative group indicating some things that we'd like to see, but at that point in time we do not have any further feedback on that yet, so I don't have anything to report.

So, right now, I think our biggest thing is moving the Standards forward and then working very close with the TQIP collaborative to see what type of information. Data is certainly

very key to drawing new things and that's what we're looking to do.

MS. DINOVA: All right.

MS. KOCEVAR: Thank you.

MS. DINOVA: Sounds great. Now, how about an update from the Florida EMS Advisory Council.

Mr. Kemp?

CHAIR KEMP: Yes. We've been meeting all week. This week, we will -- a formal Advisory Council meeting will be tomorrow morning at 9:00 a.m. I believe in this same building here.

Things -- the main issues right now related to EMS and Trauma would be EMSTARS 3.5 update which is the NEMSIS update also. As far as collecting data which includes all trauma data, prehospital is on track right now for January 2023. We'll start that transition over. Some agencies have already begun that process with their vendors, so that will hopefully upgrade some of the trauma and trauma alert information that we collect.

We do, in my opinion, need to move, you know, at least think about linking State Trauma Data with EMSTARS, so that should be a future project that we put on our agenda.

State Plan is moving forward. We're waiting on the Department of Health to finalize their State Plan so that we help match our plan for EMS with that. Most of our work is already done. We're just ready to connect it with the general DOH plan, so I think that will work.

The other thing that's going on in Florida as far as Trauma goes is I know there's many more agencies right now that are looking at adding whole-blood in the field. There's four or five agencies that are currently doing it and are having amazing results with critical trauma patients. I know my agency is working on it right now and there's several others also that are in process. So I think we're going to see a lot more of that.

Also, I know that there's some prehospital whole-blood studies that are engaging right now and I think we all want to be a part of that process. And, as usual in Florida we like to be the lead dog. If you're not the lead dog the view never changes; so, we like to be in front. So that's what we're trying to do.

That ends my report. Thank you.

MS. DINOVA: Mr. Kemp, can I ask a

question?

CHAIR KEMP: Yes.

MS. DINOVA: With the EMSTARS and the NEMSIS updates, will that increase how many departments are using that UUID?

CHAIR KEMP: Well, as far as emergency calls right now, as of yesterday we are currently connecting 97.3 percent of all scene 911 emergency calls. What we're not collecting as much that we're starting to work on is trying to collection data on inter-facility transports because that does relate to trauma patients also, that when a patient's been take to a primary care hospital for immediate care and then they need to be transferred to a trauma center secondary.

So that's something that we need to -- we're working now to try to start picking that up. And, hopefully, 3.5 will help us have the fields to collect that data better.

MS. DINOVA: I'm hoping that it'll start showing on some of the reports because I know in my area right now only one of the BLSs are printing that number on there for the hospitals to see. So maybe the update will change the

recording, too. Okay.

I am getting a message, too, that Dr. Namias is on the call.

DR. NAMIAS: Present.

MS. DINOVA: Awesome. Thank you. I got that message through, so he's present for the roll call.

MS. PINEDA: And we'll do a roll call at the end.

MS. DINOVA: Thank you. Okay.

So, we've had some hints about the Florida Standards Review Subcommittees and that Ms. Laura Hamilton is heading that up for us.

Laura, would you like to give an update about where those substandards come -- I was going to say come up to the microphones so she can hear you.

MS. HAMILTON: Laura Hamilton. Good afternoon.

MS. DINOVA: Close to the mic.

MS. HAMILTON: Okay. Better.

THE REPORTER: Yes. Thank you.

MS. HAMILTON: So, Laura Hamilton, and we met as a group on September 8th, actually, and talked about how we were going to accomplish

this. And amongst the nine 2022 ACS Standards we divided that up amongst the group for everyone to review. And then, beginning September 20th, we are going to have weekly meetings to discuss as a group.

MS. DINOVA: All right. Great.

Does anybody have questions about that?

(No response.)

If you had not e-mailed me previously about wanting to be a part of these subcommittees, but still have interest, feel free to shoot me an e-mail and I'll get your information sent over to Laura. We're always looking for feedback as the process goes on.

I don't see anything online.

All right. Thank you.

MS. HAMILTON: All right. Thank you.

MS. DINOVA: All right. Just trying to keep the chat up, too, so I can see everybody.

All right. So, one of the things that we discussed at our last meeting is we created the updates to the Charter and our first priority was to create the Florida Trauma System Advisory Council recommendations to the Department of Health so that they can work on that required

State assessment that they have to do every three years.

Well, that State assessment is coming up due next August, so we need to give them as much time as possible to start pulling that data and start crunching those numbers for us.

So, what I would like to do today is take a look at this document -- hopefully we can make some inline changes. We had discussed last time about just using the previous recommendations and just updating them for 2022, so that's what I've gone ahead and done, making some changes previous to today. So let me get that shared up on the screen. All right. There we go. So hopefully everyone can see this.

All I've done on the front page here is I took out the DOH Proposal changed it to be the FTASC Recommendations because that's really what this is. They'll be making the actual assessment later on, but this is our recommendation to them about what that assessment should require.

So, getting into the first sections -- I'm hoping it comes. There's a little bit of a lag. (Audio visual delays.)

All right. I hope you guys can read this.

So, in the overview, I left it exactly as is and what it does is it goes through and explains that the statute required to conduct an analysis of the Florida Trauma System, the first one was due August 30th of 2020, and then it is due every three years after that.

The Florida Trauma System Assessments intended to fulfil the following obligations in that statute which is to identify trauma service areas where a hospital is eligible for designation as a trauma center or a trauma center is eligible for a change in designation pursuant to the statute.

Then also to determine if a hospital in the TSA meets special trauma center application review requirements as outlined in the statute, and based on existing trauma centers in the TSE exceeding patient volume requirements outlined in the statute, which is in Appendix A. We'll get -- we'll show you that. I don't want to scroll to it right now because I'm afraid it will stagger too long.

The Department is respectfully requesting that the Trauma System Advisory Council provide

recommendations to the Department for the purpose of developing and executing this assessment.

My recommendation would be to remove that line because that's a line from the Department versus coming from us. Would that be suitable to everyone? Okay.

And this lays out the actual requirements from the statute that are -- have to be in the assessment and that shows us that we have the population growth for each TSA for the State utilizing estimates from the US Census Bureau, so it even tells us where we have to get the data.

Number of high risk patients treated at each trauma center within each trauma service area including pediatric trauma centers. The total number of high risk patients treated in all acute hospitals including non trauma centers in each trauma service area. And the percentage of trauma center sufficient volume of trauma patients, plus additional caseload volume req1uirements for those trauma centers with graduate medical education programs.

The statutes requirements do not provide

the general framework for performing the assessment, but it does not clearly outline a number of technical definitions and calculations; so we must provide the definitions.

So previously, we had defined critical care and trauma surgical subspecialty medical resident or fellow as described by the statute. We had laid out that the methodology for determining the number of critical care and trauma surgical subspecialty medical residents or fellows at each trauma center. Definition of acute care hospital and also that we needed to have a procedure for calculating the ICISS from hospital discharge data available from the AHCA data set.

Any recommendations for changes on this page? I'll also make sure to get this out to you prior to the next meeting since we can't have the official vote. (No response.)

We also had to define the time period or version of ICD-10 Codes for calculating the survival risk ratios. And, in addition, that statute doesn't address the unavoidable step of converting from ICD-9 to ICD-10. What I would

say is I think we have been to ICD-9 -- away from ICD-9 long enough that we could probably take that out because I think everyone is one 10 now.

So I added that this now history, that in order to develop a procedure to complete the assessment, the Department presented the FTSAC with an overview of the assessments requirements and challenges during a Commons Hour conference call on February 12th of 2019, and that presentation included an initial set of definitions, procedures and recommendations that had been developed by the Department staff. And then per the Council's recommendation, the Department invited all trauma centers and acute care hospitals to attend an informal webinar on March 1st for the purpose of soliciting feedback from the stakeholders.

The Department provided stakeholders the same presentation that was given to the Advisory Council members of their Commons Hour call and subsequently opened a 15-day comment period to allow stakeholder feedback and recommendations.

I took out all of the feedback that was receive because, again, this just for history.

When we hear for the 2022 update, the Advisory Council reviewed and revised the 2019 recommendations and allowed for public comment at the September 14th, 2022 Advisory Council meeting so we're going to open this up for comment here in just a little bit and take feedback, and it will probably have a little more feedback at the next meeting when we go through the final draft for vote.

So our recommendations at that time, the Department took the following into consideration when developing the recommendations for consideration. They took in the statutory alignment. The Department is prohibited from deviating or expanding the scope of the statute.

Transparency. We are advocating use of publicly available populated data sources so that anybody can pull the same data.

Methods for gathering, synthesizing and presenting information should be completed using clearly documented processes and procedures and it should be a consensus.

Definition and calculation should be created in partnership with all the stakeholder groups.

So previously our recommendation number one was for the Florida Trauma System assessment should contain three parts.

The first part shall contain the information required for the Department to fulfil its statutory functions.

Part two shall contain the Trauma System analysis and recommendations made by the Advisory Council after we receive the data.

And the third part shall contain any public comment, analysis or recommendations received by the Department from the Trauma System stakeholders.

If you recall or if you have that document from before you will actually go back to an appendix and every single letter that was sent in and all of the public comment that was recorded at the Commons Hour meetings was actually attached as an appendix to the assessment, so that will come with the actual assessment.

The Department recognizes that the statutorily prescribed assessment requirements are not the only means for evaluating Florida's Trauma System. In an effort to create a system

evaluation tool that comprehensively addresses all system needs, the Department recommended a three-part assessment described above for these reasons. So we recommended to them that it needed to contain everything that was laid out in the statute and they came back to us and say, yes, we agree. Okay.

Part two provides a means of assessing Florida's Trauma System utilizing contemporary measures, subject matter expertise and departmental resources.

Part three should ensure that all stakeholder groups have the opportunity to provide recommendations, comments or include analysis that will be captured in the assessment and creates a comprehensive assessment that can be referenced by policymakers when evaluating future changes to Florida's Trauma System.

I think I would recommend, and you guys let me know, but I think I think we should change some of these because I believe that when this was written before, there was someone from the Department of Health who was helping us write it and some of the wording is kind of from their viewpoint versus our recommendations to them, so

I would just make some language changes to say like part three should ensure, not that it does, because they're going to do that part later on. So, if you guys are okay with that, I will make those updates, too, as we go. Okay.

Recommendation number two came in as population and population growth rates shall be calculated using the most recent five years of population data available from the American Community Survey, five-year estimates by the US Census Bureau as directed by the statute, and to disseminate the ACS Population Data the Department shall use American FactFinder Populated Florida County Population Tables to calculate TSA population and growth rates. And the Department shall calculate growth rate an the TSA based on the percentage increase or decrease of the total population of the counties and the TSA from Year 1 to Year 5. So this is just laying out that they're going to use data that anybody can pull and what their methodology is going to be.

We recommend that the use of the most recent five years of population data available from the ACS five-year estimates by the US

Census Bureau is prescribed by the statute, and the Census Bureau ACS website outlines several tools that can be used to disseminate that data in order to ensure accuracy, transparency and efficiency. And they -- we would recommend the use of the Populated Florida County Populations Chart available through the American FactFinder tool.

I deleted out Appendix C because that actually will be part of the actual assessment versus the recommendations and that what Appendix C was is all of those charts of population that they had pulled and the statistics that they used to create their findings. So that will actually be part of the actual assessment versus part of the recommendations.

Recommendation number three was that for purposes of the assessment an acute care hospital shall be defined as a facility licensed under Chapter 395 of the Florida statutes that has presence of a dedicated emergency room department on the hospital emergency services inventory which is published by AHCA in accordance with the statutes.

So we went on to further define that the terms "acute care hospital" is not defined by the Florida statutes. So for simplicity the Department should use the definition of acute care hospital include all healthcare facilities licensed as a hospital and be disseminated using the AHCA's Florida Health FactFinder -- Health Finder-Facility locator tool.

The definition would have to include specialty hospitals, long-term care, psychiatric facilities, State prison facilities and hospitals without emergency rooms that do not routinely care for injured patients. The initial recommendation was based on the anticipation that the hospitals did not routinely care for injured patients would likely have a minimal impact on the number of high-risk patients in each TSA.

However, there was feedback received during the comment period that it should be clearly demonstrated that stakeholders felt the definition an acute care hospital should include facilities with an emergency department, so they amended the initial definition again. I think this is just language changes to show that this

is how we're getting those calculations.

So, the Department also sought an alternative data source that more clearly identified hospitals with emergency departments and requires AHCA maintain an inventory of all hospitals with emergency department capabilities, which was Appendix D, which actually I also deleted out of because it was 40 pages of every hospital listed in the state of Florida and what their capabilities were, and what their AHCA volumes were. So, that will be part of the -- again, part of the assessment versus part of the recommendations.

Hospital Emergency Services Inventory publicly available. And hospitals with 24-hour emergency departments can easily be identified without manipulating any of the data. The use of the Hospital Emergency Services Inventory Data Source is recommended over the Florida Health Finder because it requires less data manipulation to identify facilities. Basically, it is a much more concise tool to be utilized.

Recommendation four was to define the high-risk patient as a trauma patient with an ICISS injury score of less than 0.85 and, again,

changing the language just to show that this the calculation that is used off of ICD-9 based on the prediction model that calculates the likelihood of survival in an injured patient based on the assumption that all injuries contribute to the overall severity.

The Department shall calculate the ICISS score based on those data points. I'm not going to go through all of this for you, but we can -- this is just telling where the Department got it. Again, I think a good portion of this would be moved over to the actual assessment and not in the recommendation fields.

DR. ANG: (Not using microphone.)

MS. DINOVA: Yes. They have the reference listed here also that -- yes, sir. The proposed ICISS definition was based on definition found in this particular journal and article here.

DR. NAMIAS: May I say something about the ICISS score?

MS. DINOVA: Yes, please. State your name for the court reporter, please.

DR. NAMIAS: Dr. Namias. I know it's in there, but I think it's a horribly-flawed thing. It gives a lot of weight to things that are --

that can be suffered in a serious trauma and it gives them the same weight if they were suffered falling off a park swing.

So things like a forearm fracture carried a lot of weight because you break your arm when you crash your car and have a TBI and a bunch of rib fractures; you also have a forearm fraction. The forearm fracture gains a lot of weight.

I never liked this system. I wish Dr. Chesla (ph) was still with us. He would argue for it. Maybe Dr. Ang may have done some work with him on it. I'm not sure if Dr. Ang is here. But I think the ICISS is flawed. I don't think we can change it at this point in time in this round. But as a major goal, I think (unintelligible) should look at other systems.

DR. ANG: So I can provide a little bit of clarity for ICISS.

So, when you look at something like a forearm fracture that Dr. Namias speaks of, it looks at those that died with a forearm fracture. So, sometimes polytrauma patients can have forearm fracture plus a liver injury, plus a pelvic fracture. And so the forearm fracture will get the death probably because of the

polytrauma.

However, having said that, you're not going to die from a forearm fracture unless you have other injuries. And so some of that gets diluted out from these other forearm fractures from falls. And so, you know, I will say, you know, in defense of Dr. Namias' position that this ICISS scoring is based on ICD-9 coding not ICD-10. And so it hasn't been validated really for ICD-10 coding, although a lot of people use it because it makes sense, but that's something to consider.

So, it's not perfect because it hasn't been validated for the updated coding probably, you know, as far back as 2017.

So, in any case, I like the ICISS coding because it is a rough estimate. Although Dr. Namias is right, the forearm fraction gets counted as a death in polytrauma or single trauma, that percentage gets diluted out because there's far more people with, you know, forearm traumas that don't die and that's why the survival risk ratio works. That calculates the SSR, sorry, the SRR. And then if you have a liver injury that gets included in there as

another one. And then a DBI is another SRR and that's the product of all those give you the whole ICISS or the ICISS scoring.

So I probably would, you know, say that this is the best that we have at the moment, but if there's any other, you know, risk calculators that are better, you know, I'd like to hear about them.

MS. DINOVA: This is Lisa again. I think the other thing that we'll have to verify, too, is I believe that the statute actually laid out the scoring methodologies that we had to use for some of this data. So I'll pull the statute back out and look and see. I know it tells us that we have to use the AHCA data set versus the Trauma registry, which we're a little disgruntled over, but it's there now in the law, so we have to follow that.

I feel like it told us that we had to use ICISS scores also, so I will make sure that I pull that statute and bring it for us next time as well.

DR. ANG: I believe you're correct.

MS. DINOVA: I think it's laid out in there.

DR. ANG: You know, in older times we used to use TRISS scores which were even worse, so the ICISS scoring I think is better than TRISS.

MS. DINOVA: Okay.

DR. REED: In the future we're going to have this gizmo called a crystal ball.

MS. DINOVA: I thought we had that now. Okay.

So we'll leave this in for now and, again, just make some wording changes to make this more of a recommendation versus -- I think what happened is the recommendation went out plain and then some of the what happened also got put into the recommendation documents, so I'll clean those out for us.

Recommendation number five revolved around that the Department shall define survival risk ratio, as we were just talking about. An estimate of survival associated with each injury field related to the ICD-10 codes, injured patients treated in Florida trauma centers during the previous five years and the Department may utilize a conversation tool developed by the United States Department of Health and Human Services CMS to convert ICD-9

to ICD-10. Again, I think we're probably beyond that now. For the purposes for calculating the SRRs where only ICD-9 codes were available in the AHCA discharge data set. I'm assuming that everyone is up to ICD-10 now and that the AHCA data set only includes that. All right.

The Department was recommending the use of five years of ICD-10-based SRR scores for calculating the ICISS and that's a procedural change from the Department's previous use of SRRs based on 20 years of ICD-9 data. They acknowledged that the 2020 assessment it must perform conversations from ICD-9 to ICD-10 for at least one year of data and the use of five years has definite advantages. So following a 2020 assessment, the Department would no longer be required to do any of the ICD -- I guess that answers my questions -- I forgot about this -- required to do any ICD-9 conversions until the AHCA mandated ICD-10 goes to 11 or future versions. And then the continued use of 20-years-based SRRs would require the Department to perform ICD-9 conversions on all assessments through the year 2036. So for five years they won't have to do that conversation anymore. For

20 years, they would.

We recommended that the Department should define critical care and trauma surgical subspecialty medical residents or fellows as followed, and this was our recommendation to them was any -- an individual who is enrolled in an ACGME accredited or AAST approved program in general surgery, surgical critical care, acute care surgery, orthopedic surgery or neurosurgery that is matched or assigned to a hospital designated by the Florida Department of Health as a trauma center.

Trauma centers are prohibited from declaring an individual as a resident or fellow if an individual takes rotations, provides clinical services or otherwise employed, but is matched or assigned to one of these programs at another hospital.

Trauma centers are permitted to declare an individual as a resident or fellow that is matched or assigned to a qualifying approved program at their hospital, but takes rotations, provides clinical services or is otherwise employed at another hospital.

I want to make sure that we look at this

and these definitions. This was a topic of conversation when we were making our first recommendations several years ago. And this is where we all landed. So I want to make sure that we are still in agreeance that these definitions still apply as meted out on here. And I'll give you a second to read it because I know it's a lot.

DR. ANG: Do we know why we included orthopedic surgery or neurosurgery as part of the critical care and trauma surgical subspecialty resident or fellow?

DR. REED: Yeah. I think that's because those specialties interact with trauma patients fairly significantly.

DR. ANG: Okay.

MS. PINEDA: This is Candace Pineda.

I believe in part of the discussion at that time some of the other surgical specialties rotated on trauma --

DR. REED: Right. That's true.

MS. PINEDA: -- as part of the rotation, so you may have LMFS residents or orthopedic residents rotating in trauma.

DR. ANG: We also had anesthesia and EM

residents rotating through trauma as well.

DR. REED: I'm not sure that's as common. I mean, we don't have our anesthesia rotate through trauma.

DR. ANG: I know EM is very common.

DR. REED: Yes.

MS. DINOVA: So would we want to add EM to this existing list.

DR. REED: This is one of those numbers games, you know, and that's the challenge of who's deck are you stacking?

DR. ANG: All I'm doing is answering the question, right? And the question here says critical care and trauma surgical subspecialties, medical resident or fellow. So I'm okay either way. If you just say it's only general surgery related by the AAST or, you know, any general surgery residency program or surgical critical care fellowship, that's fine. But if we're adding ortho and neurosurgery, then where do we stop from there?

MS. DINOVA: And I think that's what some of the conversation was last time.

To be perfectly honest, I don't have this program at my organization, so I'm not as well

versed in all of these different specialties, subspecialties, the different levels of the residencies. So I look to you guys that are at our training facilities to help out with this.

You're right. We have to draw a line somewhere. So I think this is where we decided a few years ago to draw that line, was to leave it directly with the actual -- the surgeons that are the component of it versus the other types of providers, the medical providers. I think that -- if I remember correctly, that was how the conversation went is that these are different surgical components.

MS. PINEDA: Reading the next two paragraphs or sentences it seems to define or -- remind us of that conversation.

It says "the suggestions range widely from different specialties". And then it said "some would include emergency medicine". And then developing recommendations they sought to include programs that best aligned with the key surgical specialties outlined in ACS.

DR. NAMIAS: So an emergency medicine resident isn't necessarily there to learn trauma. They're not necessarily a trauma

resident.

Orthopedic surgery residents aren't necessarily trauma resident. But places that have OTA-approved orthopedic trauma fellowships, that is sort of trauma (unintelligible).

And also there are fellows in some places in neurotrauma. So that makes sense. And those really are -- I mean, all the TMVs know that that's our core thing is general surgery, orthopedic surgery, neurosurgery. Everything else is a little peripheral.

I'm okay with it as is. I don't think adding emergency medicine makes sense because there's a lot of emergency medicine residents in places that don't do trauma.

MS. DINOVA: Thank you, Dr. Namias.

DR. GINSBERG: Can you hear me?

MS. DINOVA: I can. Who is that, for the court reporter, please?

DR. GINSBERG: This is Dr. Ginsberg.

Nick, I just want to remind you that the emergency medical residents, the actual rotations now require all EM residents to rotate through a trauma center.

MS. DINOVA: Okay. Thank you,

Dr. Ginsberg.

So that's why I wanted to bring this back up. Because I knew that we had discussed it in great detail a couple of years ago when we first went through this. So do we want to leave it as is with just the surgical components listed? I know it talks about EM down here, but it doesn't look like we included it in the definition.

It says here in developing the recommended definitions, the Department sought to include programs that best aligned with the key surgical specialties outlined in the optimal care of the injured patient books. So we would look for -- we could look to the grey book to see if it has a definition, but I've just combed through that thing as best as I could and I don't remember seeing that.

I know many of you have looked through the grey book as well. Do any of you all recall it defining surgical specialties? I mean, it does have the section on surgical specialties and we could just use that.

DR. NAMIAS: EM is not a surgical specialty. It's emergency medicine.

MS. DINOVA: Right. And I think that's

what we decided the last time. That's why this last paragraph here is about -- that we deferred to basically to orange book at that point to define surgical specialty. So we could do the same thing this time. It doesn't talk about it in residencies, but it does have a section on surgical specialties listed and we could just go with the ones that are -- the primaries listed on there. And I think it wind up -- we would wind up back to the same five or six that we have listed in the above paragraph.

Is that what we'd like to do?

DR. NAMIAS: I think we beat this to death last time.

MS. DINOVA: Yeah.

DR. ANG: I mean, if it's strictly surgical specialties -- this is Darwin Ang. It make sense just to limit it to ortho and neuro and general surgery.

MS. DINOVA: Okay. I will leave it as is then and we can actually -- I'll pull up the grey book section and we can add that in as an appendix and refer to it.

I'm getting some text messages about some other clerical things with some spelling things

and everything. I'll make sure I run it back through spell check. Okay.

All right. Recommendation number seven was that trauma centers at the request of the Department shall submit an attestation along with supporting documentation for declaring the number of qualifying critical care and trauma surgical subspecialty medical residents or fellows currently assigned to that approved program at their hospital. I do remember that they sent that attestation out and I assumed that we would just do the same thing again, send a new attestation and give us a head count of how many residents that we have.

Are we okay with that being the way that we measure that? (Council members respond.)

Okay. You guys are making this easy.

All right. We are down to the Appendix A and basically it's the Florida statute that lays out the need for this assessment and the required components in it, so we'll have that added into it.

This is the sections out of that statute that specifically speak to this project. I was trying to scan it really fast to look for the

ICISS. This is all the population. I don't think that section is in here, but I can add that to here so we have the reference right at hand.

Appendix B will be any public comment that we receive. So if you have public comment that you want to get on the record, either step up to the podium to get it recorded by the court reporter here today or send those public comments to myself and Ms. Kocevar and we'll get those added in.

And then, as I stated before, I took Appendix C and Appendix D out because that's going to be the calculations that they put forth to us in the actual assessment.

Are there any sections here that we need to go back and discuss further or is everyone okay with me just making those changes and taking out the DOH commentary and just listing the recommendations out for vote for next time?

DR. ANG: (Not using microphone.)

MS. DINOVA: Okay. I will get that up and going then. All right.

Bear with me while I switch screens again.

Okay. All right.

So for some future business we need to discuss what next? So when we approved our Charter last time, priority number one was to get the assessment recommendations completed. So we're working on that now.

And priority number two was the evaluation and modernization of Pamphlet 150-9 as we all know and love as the Florida Trauma Standards.

So we now have those subcommittees up and rolling. Ms. Laura is heading those up. I've given them some -- the document that we had as a draft from January, but I think there's ten sections to this priority that we listed in our Charter.

So the first four or so either are in process or can't be done until that process is complete. Right. Doing the crosswalk. Looking for the changes that need to be done. So we can't develop identifying the challenges that aren't covered in the grey book. We can't met out whether or not any of these changes would require, you know, a look at the 60-20 Rule. So we can't do that portion of it.

However, number five in this priority is to develop a literature review relating to the

quality of each system of verification. So looking at -- oh, it didn't do it. Hold on. Apparently you can't see what can see now. Let's try again.

DR. REED: (Not using microphone.)

MS. DINOVA: All right. I'm hoping it's just a lag time.

DR. ANG: If anybody wants to follow long online, they can go to the FTSAC website, right?

DR. REED: (Not using microphone.)

MS. DINOVA: Yes.

DR. ANG: It's the second to the last document if you wanted to follow along.

MS. DINOVA: For the Charter.

DR. ANG: Yes. 2020 Final Update 06/16/22.

MS. DINOVA: I don't know why suddenly Teams has decided to not let me share. It says that I'm sharing.

Can you folks online, can you see my screen? There's a slide that says Future Business and Charter Priority 2?

UNIDENTIFIED SPEAKER: No.

MS. DINOVA: Because it shows a red line that I'm live.

Susie or Wendy or anybody that's online,

can you see my screen. (Virtual members responded negatively.)

Okay. Hang on. Trying again.

(Virtual members responded affirmatively.)

Oh, you can see it now? It's coming up? Okay. So my folks online, you can see my screen, the Future Business Charter Priority #2?

DR. NAMIAS: Yes.

MS. DINOVA: That's so funny, we can't see it in the room. Okay. I'll just tell you.

So, Charter priority number two was the creation of the revision of the Trauma Standards, Florida Trauma Standards.

Number five on that Priority was to develop a literature review relating to the quality of each system of verification. So what we had discussed was getting someone to volunteer to do a lit review, looking at the benefits of State verification, ACS verification being used or any kind of hybrid model being utilized so that we could, after the standards are revised and have gone through or are getting ready to go through promulgation, we can look at the direction that we want to take our State, as far as the verification and designation model goes.

So is someone willing to take on that lit review topic, one of our Council members willing to step up and take that on for us?

DR. ANG: It depends when it's due.

MS. DINOVA: Well, definitely no earlier than our November meeting. But it wouldn't be fully due until we're getting down the road of the Standards revision.

DR. ANG: I can look at it.

MS. DINOVA: All right. Thank you, Dr. Ang. Fantastic.

I'm going to keep moving on like I have a PowerPoint here to show. Oh, there it goes.

All right. We do need to look at creating another priority because we only have two listed currently, which are in process. So for the November meeting, because we can't add anything today, but for the November meeting, I'd like for you guys to start thinking about what our next priorities as a Council need to be. What's the next challenge that we need to tackle.

So, we have the Standards revision team going. That's being done for us. We're going to have the recommendations that we can give the State so they can start working on that

assessment. So then what do we as a Council need to prioritize next? What's our next steps after that? Okay.

So, like I said, we can't add anything to it right now, but between now and November, if you could think about it and think what we need to -- what our next goal should be.

DR. REED: Mac Kemp, one of our members, just gave an excellent discussion earlier here about the legislative process and, you know, you kind of knew that this stuff was going on, but, you know, how the sausage is made, it's not something that is enjoyable. And, in this case, it takes a long time.

I think our ultimate goal as I still understand it is to be able to have this Council be the representative for the Trauma System in the State, and kind of continuously update, modify and maintain the Standards as we go along, and eliminate that document that was put out, what, 2005 or '10, 2010.

MS. DINOVA: Ten, technically, but --

DR. REED: Right.

MS. DINOVA: -- the last major change was '97.

DR. REED: It needs to be a living process and no a stagnant, you know, booklet that gets passed around for a decade or two.

And that's only going to happen if we can get the legislature to change the rules on how this Trauma System is managed and how trauma centers are verified and things like that.

And I'm just wondering if we should start to develop some kind of plan towards legislation in terms of getting that contacts in place and the people that we need to know and talk to, the folks who, you know, whatever senator or congressman that is going to put up a motion or a bill that can then ultimately be the new law.

And, you know, obviously, we're going to continuously redefine things, but I'd like to think that we're redefining it toward a purpose and that would be a way of getting that purpose going, that we would have things in place, a process in place to be able to get that legislation initiated.

MS. DINOVA: Yes. I know when Mr. Leffler was here leading us, we had -- the DOH had taken to the legislature, if I remember correctly, some recommendations about ways to make those

changes to the laws so that we would be able to try to update this document more easily than having to go through the whole rule promulgation and change everything.

I can go back to them and see what that process would be and what the recommendations were at the time and we can bring that back around. Because, I agree, we've got to be able to make that change. It's just getting the legislation to have an appetite for Trauma.

DR. REED: Right.

MS. DINOVA: So, absolutely, I can try to find those documents and bring them back for discussion again.

DR. REED: Thank you.

MS. DINOVA: Okay. So everybody put on your thinking caps between now and November, please and come up with some more recommendations for us for projects.

All right. I'm going to open the floor now for public comments. If anyone in the room would like to have any comments put on to the record, please come up to the podium so that we can use the microphone.

Make sure you state your name for the court

reporter. And if you are online, feel free to mute yourself, but, again, state your name for the record before you give your commentary.

DR. PAPPAS: Am I recognized?

MS. DINOVA: Yes, please, Dr. Pappas.

DR. PAPPAS: Thank you. Good afternoon, everyone. May name is Dr. Peter Pappas.

Good afternoon, everyone.

THE REPORTER: Perfect. Thank you.

MS. DINOVA: There we go.

DR. PAPPAS: Great. We know who's in charge here. Good afternoon, everyone. My name is Dr. Peter Pappas. I am the State Chairman for the Florida Committee on Trauma of the American College of Surgeons Committee on Trauma, and I am here speaking on behalf of my group.

With my membership, and certainly with our Executive Committee, I think there are two items that I think we all have a mutual interest in. But I would like to bring to the attention of the Trauma System Advisory Council.

First of all is working off on a statement that Dr. Reed made earlier. There certainly is consensus within the Florida Committee on Trauma

that we must have our standards be more of a dynamic living document and, frankly, just be better coordinated with the latest revision and edition of the American College of Surgeons Trauma Standards.

I'm proud to say the American College of Surgeons Committee on Trauma is certainly the preeminent subject matter expert on trauma care certainly within North America and increasingly globally. So I think it is part of our proud tradition here in Florida of really being leaders in trauma, nationally and to some extent even internationally, that we take a lot of the good things that are coming out of the ACS on a regular basis, continuing to use that to revise and improve what we're doing here in Florida.

So I welcome this. Certainly the Florida Committee on Trauma welcomes sort of comments being made by the Committee members today and we certainly hope that you consider us partners in the future as we continue to develop this process.

The second issue is really more of housekeeping. I have frankly have had a lot of comments and I would like to bring it all to

your attention and the powers that be that the FTSAC Committee nominations process and review of nominations and applications, it's certainly something out there has generated a great deal of interest within the membership and within the trauma community and I'm hopeful that at least by November if we can potentially get an update to see where that process is. In the meantime, I will keep fielding e-mails and phone calls on my end. That's something that we also look forward to. If anything, to really begin -- get us to a point where we can continue to really start making some real decisions in terms of moving forward and continuing the process of developing FTSAC as a functional and vibrant entity in cooperation with EMSAC. We all certainly consider EMSAC a very important part of what we do here in trauma, and we certainly all have a very vested interest in seeing FTSAC continue to grow and develop and have a similar role on the trauma side.

So, again, thank you all for your hard work on your volunteering, certainly from FCOT and, again, please consider us partners.

Thank you.

MS. DINOVA: Thank you, Dr. Pappas.

I just want to remind everybody if you are taking the time to send those e-mails to Dr. Pappas and to some of our other partners, please take the time to get those over to the Governor's office. Unfortunately, we have no control over any of the appointments. In fact, we all know that we are working outside of our initial appointments at this point, too. But to keep things moving, we're showing up and trying to keep everyone engaged. So, please, on a personal note, you all know that I work for one of our trauma centers in the State. I have had my government relations folks reach out to the Governor's office and encouraged them to please start looking at these appointments because as it was set in the statute, this is a gubernatorial appointment, and until the Governor's office takes action, we're just going to show up and keep trying to move things forward.

I would love to have all of our seats filled. We have three vacancies right now and, again, we all know that the nine of us that are left on there we're all working outside of our

appointments. I know that most of us have probably put in for reappointment, but we, too, are waiting on pins and needles. So, please, encourage your facilities, your organizations, your government relations folks to reach out and encourage them to look at this topic.

Okay. Any other comments from the public? (No response.)

Anyone online?

DR. GINZBURG: I'd like to make a comment. This is Dr. Ginzburg, Enrique Ginzburg, Trauma Medical Director at Jackson South, Ryder Trauma Center.

I think one of the priorities for this organization, along with FCOT is to in some way try to establish a statewide violence prevention program, youth violence prevention program which there are models that have been used in the state at least in South Florida and try to get the legislature to provide the funding for the establishment of these programs.

MS. DINOVA: Thank you. I think that's a great topic that maybe we can look into.

DR. REED: Yes. It's one of those issues where our goal is to put ourselves out of

business. Trauma is the most preventable disease on the planet. You don't need to know anymore molecular biology to figure how it happened, and yet we seem to have a very difficult time from keeping it from happening.

MS. DINOVA: Agreed. If you have information on any specific programs that you're talking about that maybe we could expand on, please send those to me. That would be great. I'd reach out to them.

DR. GINZBURG: I'll talk to Nick, Dr. Namias, who's our Chief of Trauma for the whole Ryder System to get your contact so that I can send you what we have tried to do with the Governor in the past, Scott, and also trying to get it to this Governor. We do have a huge plan. I've spoken to Dr. Pappas about it also. So, as soon as I get your contact information, I'll send you one of these programs.

MS. DINOVA: Great. Thank you.

Okay. Anyone else on line have any comment? (No response.)

Anyone else? I don't see anyone else in the room coming up to the podium. (No response.)

Okay. Thank you very much.

All right. So, just in closing, our next meeting is November 16th, 2022. We will be both live and online, as we are now. I encourage everyone to come up because we will be at Tallahassee Memorial. They have agreed to host us. We have not been in Panhandle since this Advisory Council has started, so it'll be nice to get kind of to the north part of the state this go-around.

I look forward to being able to see their facility and tour around. I haven't done that yet. So, Joe, if you're listening, I need a tour.

But, otherwise, unless anyone has any other topics for discussion? (No response.)

All right. We are adjourned.

Thank you.

(The Florida Trauma System Advisory Council meeting concluded at 2:12 p.m.)

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C E R T I F I C A T E

STATE OF FLORIDA)
COUNTY OF ORANGE)

I, CYNTHIA R. GREEN, Court Reporter, certify that I was authorized to and did report the aforementioned 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 28th day of October, 2022.

Cindy R. Green

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