FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL

MEETING

November 16, 2022

Location:

Tallahassee Memorial Hospital Auditorium
1300 Miccosoukee Road
Tallahassee, Florida

Reported via conference call by:

Ray D. Convery, Court Reporter
For the Record Reporting, Inc.
1500 Mahan Drive - Suite 140
Tallahassee, Florida, 32308

P R O C E E D I N G S

(Following several attempts to achieve satisfactory audio quality, the proceedings commenced as follows:)

MS. DiNOVA: All right. For the third attempt, thank you everyone for your patience. Clearly we're having technical difficulties today.

I want to remind everyone that you have a court reporter on the line with us. So, prior to making any statements, please make sure that you state your name. I am Lisa DiNova. Sorry. Also that we are recording this. So, by being participants on line in this meeting, you're giving consent to being recorded.

We're going to initially call the meeting to order at 13:18 on November 16th, 2022. We are here at Tallahassee Memorial Hospital, and we'll start off our meeting by giving the pledge of allegiance, please.

(Pledge of allegience.)

MS. DiNOVA: Thank you everyone. I'm going to go through and do a role call. So I'm looking for Dr. Reed. Are you on the line?

(No response.)

Malcolm Kemp.

MR. KEMP: Yes.

MS. DiNOVA: David Summers.

MR. SUMMERS: Yes, on Zoom.

MS. DiNOVA: Dr. Summers?

(No response.)

Dr. Ang.

DR. ANG: Present.

MS. DiNOVA: Dr. Namias.

DR. NAMIAS: Here.

MS. DiNOVA: Lisa DiNova. That is I.

Dr. Ibrahim.

(No response.)

MS. DiNOVA: And Dr. McKenney.

DR. McKENNEY: Present.

MS. DiNOVA: All right. Fantastic. So I show six members here presently. We'll do another roll call if anybody else joins on. We're going to start with a few opening remarks from Ms. Joe (phonetic) to tell us about Tallahassee Memorial, our lovely host.

MS. JOE: Good afternoon, this is a Joe. I'm the Trauma Program Manager for Tallahassee Memorial. As you know, we're a Level II state-designated trauma center. (inaudible) just a little bit about us.

If you're here in person, thank you for those that came, the road trip up, I appreciate it, from certain areas. We started in 2006 with preparation. Our last designation was 2015 and we've got one coming up in 2023.

Just a little bit about our center. We have nine trauma surgeons, three trauma acute care surgeons. Our trauma program medical director (inaudible). We also have five general surgeons that take trauma calls for us, five neurosurgeons, two orthopedic traumatologists, two (inaudible) pulmonary and critical care intensivists, and anesthesia 24/7 and general surgery residency. We also have a wide variety -- thanks to all our specialties that help take care of our trauma patients, and my trauma office staff, myself, my performance improvement advisor, Ms. Dee (phonetic), and I have four registrars that help us keep our registry up to date.

From a resource perspective, if you're not familiar with our hospital, we're a 772-bed acute-care hospital with 53 emergency room beds. We have critical care, non-ped critical beds, 34 intermediate care, 23 operating rooms, two hybrids that includes three CT scanners and one MRI. So I

just want to thank you for coming up to the panhandle today because I know it's not everybody's favorite thing to do.

All right. And welcome. And there's food and drink in the back.

MS. DiNOVA: Thank you, Ms. Joe, we appreciate you hosting for us today.

So that everyone else on the line is aware, we'll be looking for other hosts later on into next year. So if you're interested, let me know.

We are going to review some old business that we have. Our meeting minutes are the court reporter notes. They are posted onto the Advisory Council on the Florida DOH web site. So you'll be able to access those there. And then also for followup on old business, we have Charter Priority No. 2. For No. 5 in that section, we had to develop a literature review relating to the quality of each system of verification, being ACS versus state designation, and Dr. Ang has done that for us, and I believe is going to give us a bit of a primer for that. I'm going to try to pull it up. And this will come in handy as we are discussing -- later on as we're doing our Florida standards revisions, and then talking about where we want --

what direction we want to take the state later on. I am trying really hard to be able to (inaudible). All Right. There we go. Dr. Ang, if you want to go ahead and tell us what you found.

DR. ANG: Sure. Just to remind everybody, last FTSAC meeting I volunteered to kind of do a literature search on comparing ACS versus state designation. I used pubmed Google citation index, then pulled up the articles and used references to crossreference their reference to see if there are any other articles and whatnot. Key words used was American College of Surgeons trauma designation, state trauma designations and points looked up, primarily anything related to trauma, mortality, length of stay, et cetera.

Interestingly, there's not much written on the topic -- I pulled up about seven articles I thought kind of addressed this question specifically, which was ACS versus state designation and outcomes, and I'll kind of go over some of the articles in brief, but I think in general the best way to go about this is -- you know, I've provided these articles in bullet points, but I also provided the actual articles for the FTSAC members to review, and I think we can table our thoughts on this until

everybody's had a chance to kind of review the articles and give their thoughts about it, but I just kind of give an overview of the major points about some of the articles that I found.

So the first one was published in Injury, and it was one of the more recent ones in 2019, and they did look at the specific question, ACS-verified versus state-designated facilities, and what they found was that they had similar risk-adjust mortalities with the relative risk of one and a confidence interval that crossed one. So there are no significant differences between the two.

The second article I found was from our very own Dr. McKenney in his group in Kendall, and they actually also looked at the impact level of ACS verification. The study didn't directly compared ACS to state designation but, rather, more ACS Level I to Level II and then state Level I to Level II, but I did bring this one up because they did have ODE ratios. The risk adjustment model that they used was different than the one from the 2019 Injury article, but you can see here that the ODE ratios were basically pretty similar, particularly if you compared like ACS Level I to state Level I.

The ODE ratio for the ACS was .73, and for those that don't know what an ODE ratio is, that's the actual observed death divided by the expected death. And so, if your ratio is greater than one, then you have more deaths than expected, and the expected deaths is calculated by either regression model or some sort of risk-stratification model that people choose. And so, for a Level II in this study, there's essentially not much difference, .75 for ACS and .74.

The next article I pulled up was an older one in 2013, and this one was pretty interesting. This one looked at trauma-center certification versus state-designation, specifically asking questions about Level II and whatnot, and they found basically, when comparing the ODE ratios, the Level I ACS verified centers as a group, they had a lower median ODE ratio, .95, versus the state at 1.02, but you can see their inter-quartile range, which is something similar to a confidence interval, but not exactly. An inter-quartile range would be like 75 percent or whatnot. It still crosses one on both of those inter-quartile range. So probably not much difference. There was no difference in the median ODE ratio in Level II trauma centers

that you could see at .94 versus .87 with a P value of .3. Now the other one -- even though the inter-quartile range crossed, they did have a P value of .01.

And so they did do a regression analysis later on where they put designation ACS verification as part of the model, and they did find that it was not associated with survival in Level I centers, but for Level II centers it did.

The next article we got from the American Surgeons, a little bit older as well, in 2011. This is with Dr. Dimetrioti (phonetic) out at UCLA. And they looked at whether or not Level I trauma centers are equal in comparison of ACS and state-verified centers. In their risk-adjusted model, they basically found no survival advantage of either type, 4.9 percent for ACS and 4.8 for state centers, and their P value was not less than .05, and it was up .311.

The fifth article I pulled up was actually a really interesting article. This came out of FOS-1 (phonetic), which is a pretty reputable open-source journal. It was the first open journal I think. It kind of pioneered this idea of, you know, unbiased review, but what they found in their

article -- they actually looked at the conference effect, and so the idea here was that, if you had a robust system with stopgaps in place like the ACS verification does, then, even with decreased resources, say around conference times, you should not notice a difference in mortality, you know, during those times. And so they compared verified centers with non-verified centers, and basically what they found was trauma centers without ACS verification during non-conference dates had an odds ratio that was significantly higher at 1.2. So that means that -- a 20-percent more likelihood of mortality during those conference dates with ACS on the P value, and this was after risk adjustment.

The second to the last article that I pulled up was a really old article from 2003. I actually liked the design of this one because it's not just comparing ACS versus non-ACS. This is comparing before and after ACS verification, and, you know, depending on the duration that they looked at, the control group might be more accurately -- you know, because you're looking at the same system and comparing the same group of surgeons, the same state and et cetera, and you're kind of removing some of those confounding biases, but they actually

found that there was overall improvement after ACS verification in terms of length of stay, and mortality was significantly different at .81 versus .59, and their final conclusion with ACS Level II trauma center verification appeared to result in desired outcomes.

And then the last one that I pulled up was from 2017, and this was published in The Journal of Surgical Research. And this was an interesting one because, you know, we don't have Level III and Level IV centers here, but they did compare Level I and Level II. They didn't see a difference between Level I and Level II ACS versus state Level I and Level II, but they did see the biggest difference among Level III and Level IV ACS versus state with ACS having better outcomes than state.

So I encourage everybody to read these articles and -- you know, because there's a group effort to kind of like evaluate the existing data. I'll continue to look for more articles. I'm sure Dr. McKenney has done a literature search based on the fact that I pulled up one of his articles as part of this, but, you know, the data for head-to-head direct comparison between ACS and state designation isn't a lot. These articles are

limited by the fact that, you know, each state has a different state-designation criteria. Also, each one of these articles, if you notice, the older articles tend to show ACS verification as having better outcomes and the more later articles showing really no differences. So that might be secondary to the quality of data. We don't know. Or it might be differences in the fact that maybe the state-designation systems have kind of matured over time because some of these, you know, we can't account for. And lastly, you know, there's always variation in practice. So a lot of these retrospective studies lack clinical variables, lack the ability to determine whether or not there are variations in clinical practice and whether or not people are adhering to evidence-based practice, and those things really can't get measured, you know, in a study like this, but this is kind of what we have.

And so I think I'll end it there and open it up for any questions.

MS. DiNOVA: Does anyone have any questions for Dr. Ang?

I just want to say thank you for doing this for us. It's just a little bit of light reading

that we sent out this morning. I do think that this is something that, since we have some time, we know that we have the Standards Subcommittee working, so it will be something that I feel like you guys are leaning towards having this kind of conversation later on. So this gives us some research to look at and see where that conversation needs to head. So thank you so much for doing that for us, Dr. Ang.

MR. SUMMERS: Yeah, Dr. Ang, David Summers. Thanks for doing the legwork.

DR. ANG: Oh, my pleasure.

MS. DiNOVA: Okay. Let me get us back to our Powerpoint. All right. So that brings us up to doing some new business. So, looking at some updates from some folks -- so, Ms. Kocevar, do you have an update from the DOH? You may want to come closer to this microphone.

MS. KOCEVAR: Hi, Kate Kocevar. I am the Florida Department of Health Trauma System Administrator. So a couple of things. First of all, we had what I think to be a successful hybrid survey done, just recently done in the HCA Florida Lake Monroe, and that just took place this past Monday. So this is the first time that we have now

instituted a hybrid survey designation process. Dr. Pappas is here in the room, was kind enough to be our trauma medical director for that hospital, and so he had the pleasure of being the very first one. I think overall it went well. I think that, with the pandemic we were forced to do it looking at things differently, and out of it I think we were successfully coming up with some ideas of how we could make our on-site process much more engaging. And so, in doing that, that allowed us the opportunity to not only walk around the hospital as we did our survey, but engaged with a lot of individuals and made them understand why we were there and what we were doing. And then the best part about all of it is we didn't tie up the hospital for 12 hours. We were able to get in and out in a reasonable time and not tie up all those resources. So I think that it was a win all the way around, and so we're looking forward to our next one down in. Osceola next month -- is it next month -- it may be January, excuse me -- I don't want to put that out -- Osceola, I thinks it's January, you know, with that, so -- you know, with that. So that's the first thing. So I think it was -- overall, it was a success. Our surveyors

seemed to enjoy assisting in the process as well.

Secondly, just a heads-up that the legislative session is going to start March 7th through May 5th. Mac, am I correct on those dates? All right. So, just bear in mind that the things that we're talking about here at the Council today, some of it may actually require that you actually get active with your government people, with your legislator people, and talk to them and let them know what's happening, because the best thing that we can do is get this information in front of them, so that, as they are having their meetings and they're having session, it's an opportunity for them to learn more about us and for them to understand how imperative it is for their action items that we need for them to do. So very important there.

And then the last thing I'll just talk about is the ACS TQIP meeting is going to be held this coming December, December 11th to the 13th. That's going to be in Phoenix, Arizona this year. We're certainly hoping that all of you will have a chance to get out to the ACS TQIP. The Florida Collaborative will also be having a meeting that Monday morning, and it's very imperative that everybody participates, not only because you said

you would participate in the collaborative and 50 percent participation is it, but because of the fact that we really take a look at data. We know that it drives how we approach things. The six indicators have been on the books since 2018. They were only supposed to be there for two years. We're learning how to measure things better, but we need your input and we need to make sure that you stay active with all of that.

Luckily for us, we've now engaged a great guy, Fahad Shan (phonetic), who is going to be helping trauma with a lot of the data and driving that. And so we're hoping that, with the kickoff in December with the ACS Collaborative (inaudible) while we're there, we'll have our state one as well, and then really kind of kick it into gear about really getting our activities moving in a direction that is data-driven.

So I think that's kind of what I have right now. Anybody have any questions of me?

MS. DiNOVA: I do.

MS. KOCEVAR: Okay.

MS. DiNOVA: I know the session starts in March. Are they doing the trauma dates in February, or do we know what dates or --

MS. KOCEVAR: Well, I have not heard anything specific. I have looked to Dr. -- I think they mentioned something about February -- look to Dr. Pappas, you know, for that. I have not received anything specific yet.

MS. DiNOVA: Okay. And (inaudible) --

(Cross talk.)

MS. KOCEVAR: Yeah I don't know. Mark, do you have a calendar of anything that's going on just yet? Okay. If I do get that data, I could certainly, you know, send it out. I'll send that to you, Lisa, and you can certainly do it and get it out to everyone, and we'll get that information out as soon as possible, but, yes, that's a great opportunity, and we'd really love to see a lot of you up here speaking on behalf of trauma. I think that -- I think the wonderful thing about it is we're getting along so well that we've sort of forgotten who we are. So we want to make sure that everybody gets reintroduced, you know, in a positive way, that we need to do it. I think, if nothing else, we've seen over the last few months, unfortunately, a lot of the tragedy that may have hit our state through our storms and some loss of life, and the amount of activity that we need

everyone to come together with. So it's just so important that the trauma system works that way, and that we're all in this -- we're all in the same boat together. So let's, you know, make sure that we keep everything moving forward and staying afloat. That's my analogy with my boat.

MS. DiNOVA: Does anyone on line have any questions for Ms. Kate?

Okay. All right. Moving on then, Mr. Kemp, would you like to give us an update on the EMS Advisory Council.

MR. KEMP: Thank you, Madam Chair. Just a few things. At EMS we have started a pre hospital whole-blood coalition, it's Florida and Beyond, pre hospital agencies. We had our initial kickoff call two weeks ago. There were about 200 folks and agencies that were represented in that. So we're sharing information. Whole blood is really getting going, and you're going to see a lot more of that. If you haven't seen that at the local EMS agency near you, you will soon. So that's something that it's definitely going pretty strongly.

The Florida EMS Strategic Plan has been on and off and on and off, and we're hoping that it's going to be on again soon. We're reporting on

that, hopefully will have something to report back to you have soon on that, but if you have anything that you feel like needs to be included in that plan, please get that to us because pre hospital -- this is for the next five years. So, if there's anything that you think needs to be addressed trauma-wise in the pre hospital plan, get that to us so we can get it in there now.

As Ms. Kate said, the legislative session will begin March 7th. With the elections just finishing, what you should be doing now is reaching out to your newly-elected or reelected legislators and talking to them. Be aware that committee meetings are going to start in December, unfortunately, but they are starting. They're going to be here in Tallahassee. So that's when you really need to start lobbying is at committee hearings. If you wait until the day that the session starts, you're already behind. So committee meetings will be starting way ahead of that.

The next EMS Advisory Council meeting will be held in Daytona Beach, January 18th through twenty (inaudible). So I believe this meeting -- I believe that Ms. Kayla (phonetic) is working on

trying to get a concurrent meeting with this body. So kind of put that on your radar because I believe that is one that is kind of slated to meet again. That concludes my report.

MS. DiNOVA: Thank you, sir. Anyone have any questions for Mr. Kemp?

(No response.)

All right. Thank you so much.

All right. Let's do an update on our Florida Standards Review Subcommittee, Ms. Laura Hamilton, do you want to --

MS. HAMILTON: Good afternoon, Board.

MS. DiNOVA: Yeah. Go ahead. Sorry.

MS. HAMILTON: Okay. No worries. Good afternoon. Laura Hamilton. The Subcommittee continues to meet regularly and everything is going really well. There is great participation and discussion and agreement amongst the group as far as what we should align with and maybe what we shouldn't. So we're currently on Standard 6 of 9 that we will be reviewing tomorrow, and we're still on track for mid-December completion, and from there I'll be sending out to FCOT and AFTC for an evaluation after that.

MS. DiNOVA: Laura, this is Lisa. Do we think

that we might possibly have maybe a recommendation to be able to put to the FTSAC in January, because I think we're meeting mid-January? Do you think to you guys might have put in enough to present --

MS. HAMILTON: We'll be able to give a recommendation in December. So I guess that would depend on FCOT and AFTC coming together to meet and discuss to provide a final recommendation.

MS. DiNOVA: All right. Great. At least we'll have something that we'll be able to hold over, if nothing else, until the next meeting. That's fantastic. Thank you so much for your hard work on that.

Does anybody have any questions for Ms. Laura?

(No response.)

Okay. Next, our FCOT chair, Dr. Pappas.

DR. PAPPAS: Thank you, Lisa, and thank you, members of the committee. First of all, I just want to make sure that everyone can hear me all right?

(No response.)

Great. I'll take that as a yes. Thank you for the opportunity to address the Florida Trauma System Advisory Council today. I am Dr. Peter Pappas, and I am speaking to you all in my official

capacity as Chair for the American College of Surgeons, Florida Committee on Trauma.

Several issues I did want to discuss that certainly have been relevant to our assembled membership, as well as our stakeholders and partners in the Association of Florida Trauma Coordinators. First and foremost, of course -- I think it's rather high on everyone's mind -- is the status of FTSAC appointments. We've certainly, within the FCOT, encouraged our leaders and stakeholders to follow up on appointments and certainly also to apply for this. And we're hopeful to -- I think we all are hopeful to see some movement on this front in the coming weeks and months. We're pleased, of course, to see continued work on state standards. We really have to applaud Laura Hamilton and her leadership in being able to bring everyone together, and I certainly -- I'm very pleased to see so many of our FCOT and AFTC members actively involved in that process.

As Kate Kocevar alluded to, the Florida TQIP Collaborative is certainly a major priority for us. And we are looking forward to continuing to partner with not only the AFTC, but also the Department of Health to really reach a point where now we not

only have the data, are able to assess the data and really take action based on that data, and I believe in many ways that our Florida Collaborative meeting at the national TQIP meeting in December will be a great starting point for future collaboration.

And as regards to the earlier question regarding a trauma-related event, through our Advocacy Committee, FCOT is working with AFTC to schedule some sort of event in Tallahassee, and really the idea there is to really reintroduce our specialties, reintroduce trauma and reintroduce both the role of the FCOT and AFTC in our state trauma system to our legislators. So this will be very much sort of an informational session and we'll really want to be in a position to pretty much ask our elected representatives what they may need of us and know that we are available to them as the state subject-matter experts for clinical care and trauma.

A number of items I also wanted to touch on from our FCOT membership. First of all, from our Level II Committee, an interesting question regarding the future of standards, and this was brought forward and certainly brought to everyone's

minds during COVID is the growing role of telehealth, and is there, in any part of the trauma chain of care, a role for telehealth in trauma care? And should this be addressed at some point in our standards? So given the growing role of telehealth overall, this may be worthwhile to set discussion for our Standards Subcommittee and for FTOC once the heavy lifting is done with our state standards.

In addition, I recently attended the national COT meeting in San Diego in the earlier part of October, an opportunity to speak with COT leadership in the trauma systems program, and what we did discuss was the potential for on ACS COT consultative visit. This has been brought up, of course, over the past several years. The last visit itself was in 2013. What I can say from the standpoint of the COT, they are available to proceed, with the earliest optimal timeframe being in the first quarter of 2024. To self-support decision-making of this committee as to whether it is appropriate to proceed, I have had an opportunity to forward to Kate Kocevar a copy of the recently-updated Trauma Systems Guidelines, currently known as the white book, along with the

peer-reviewed questionnaire. As I mentioned, the last visit was in the 2013 timeframe. So at least from the point of view of the Florida COT, our state trauma system and Florida's overall system of health care delivery has certainly undergone significant changes in the past decade.

An external review, honestly, may provide a little bit of a pulse-check on our current system of care, and also help us to identify opportunities for the coming decade and really giving us a road map to seize on those opportunities.

Finally, and speaking of dramatic change to our state trauma system over the past decade, you know, it's clear there is an interest within both the FCOT and the AFTC in reevaluating the timing, potentially, of our state site surveys. The pace of change in modern health care practice and health care systems is accelerating. In such an environment, seven years may simply be a little too long. A model where site surveys occurred potentially on a three-to-four-year basis may be much more in touch with the needs of our trauma centers and their parent institutions for relevant and timely feedback on trauma center organization processes.

From the point of view of the FTOC, greater collaboration and/or coordination between DOH and ACS FCOT verification for ACS verified centers would be encouraged. A potential model for coordinated DOH and ACS evaluations every three to four years, in three-to-four-year intervals with an ACS state consultative visit once a decade. This seems to be the potential for the best of all possible worlds, where we ensure the strength of both our individual trauma centers and our system as a whole.

That concludes my remarks. I thank the committee again for their time.

MS. DiNOVA: Thank you. Anyone on the line have anything for Dr. Pappas?

(No response.)

All right. This is Lisa again. I just want to address a couple of things with that. Dr. Pappas, thank you for bringing up so many great points. I know we had talked about the ACS consultative visits. Before we were looking into that, ACS had stopped doing those state surveys during the whole COVID pandemic and whatnot. It's good to hear that those are starting to get geared back up. I know previously one of the things that

we had to do -- because the Department of Health basically has to foot that bill for us, since that's the way our system is built and the statutes are written. So I think we would have to take that to them as a possible recommendation or a request and then have them put in for funding for that. So I don't know if we'd be able to in early 2024, but maybe late 2024 or early 2025, depending on what the funding cycle is. So that is definitely something that we as a council can look at considering writing a recommendation for. I'll make sure to put it on for our future because, unfortunately, right now I don't have a quorum. So maybe at the next meeting I'll have one. So I'll definitely put that onto our thing that the FCOT has brought that to us and definitely we can make a recommendation for that so that they can start looking for possible funding streams for that later on.

And then the other thing that you brought up was the timing of the surveys. I think everybody -- we did discuss that as a council previously, and everybody was in agreement that we agree with you that seven years was far too long. We wanted it to align with the ACS as well, doing

the every three years. Unfortunately it's written into the statute, the seven years, but that is part of the statute kind of requests that we had put into the legislative body to look at for us to change that, and I know we've taken it to them twice and they failed to pick it up and even evaluate it. So I think that we can try for that again and hopefully all of our trauma partners around the state, our shareholders in the system can help support that in the legislative sessions in talking to your government relations folks, and when they're going in to talk to these legislators, putting that bug in their ear that we want them to look at that so that we can change that statute because right now it's written into the law and we can't change that. I think that's why the DOH was doing the interim evaluations, was trying to get around the seven-year. So it's good to have the FCOT on board with that as well. So thank you.

DR. PAPPAS: Thank you.

MS. DiNOVA: I'll make sure to get those put in for some future business to come back and evaluate.

All right. I think that's everything for the updates.

I would like to go ahead and -- something that we had discussed at our last meeting were recommendations to the Department of Health so that they can start doing that assessment that they are required to do by statute. Again, unfortunately, unless some folks have joined us on the line, I do not believe that we have a quorum. Let me see who we're missing and see if I can possibly see if anybody has joined. I'm looking for my list here. Sorry. Oh, here. Dr. Reed, have you joined on the line? Dr. Summers, or Dr. Ibrahim?

(No response.)

Okay. So, unfortunately, without them joining on the line, the way our bylaws are written right now, we can't hold an official vote on this. So what I would like to do for the six of us that are here is I'd like to go ahead and run through this so that I can make this from a draft into a final copy that we might perhaps be able to vote on at some point. So let me switch which screen we have up here.

All right. So going through here, we discussed it last time, so I went through and made the changes that we had talked about. So let's run through this page by page real quick.

So the first thing we did was change the title for this to be the Florida Trauma System Advisory Council FTSAC Recommendations pursuant to the statute. I changed the date to be to today. And this was written in 2018, so it had a lot of history behind it, and it had a lot of steps put into it that they were taking to do these first assessments. So I changed some of that verbiage to make it now more of a concurrent document. So what we are looking at now is at -- the first survey was to be done by August 31st of 2020 and then every three years after, and also that the Department has respectfully requested that the Advisory Council provide recommendations. So again, just changing some of the language. The State's requirements do provide the general framework for performing the assessment. That was just a typo there to correct.

And as I'm going through, if you guys have any comments from the council members, if you could please just speak up and let me know what else I need to change. Okay. On here what I did is changed this to be a category of history because I thought it was important that people be able to go down -- since this is an every-three-year process, so that they would be able to go back and see what

we did and what we're changing each time we go to do this. So I left in the history that -- to -- in order to develop the procedure to complete the assessment, this is what they did. But then I just changed it down here so that -- I took all of the sections out here where they had gotten input from everybody and changed it to, for the 2022 update, the FTSAC reviewed and revised the 2019 recommendations as follows, and allowed for public comment at the September 14th and November 16th FTSAC meeting. The transcripts are available on the Department of Health on the FTSAC tab, and I gave the web site address so that, if anybody wants to go back and see what those public comments are, they can look them up for themselves, versus having to have them attached as an addendum making this a giant document.

I took out this section here because this was just talking about what the Department had to do. We don't need that anymore because what we are providing for them now are just the recommendations versus the actual process that they -- to create the first assessment.

Hold on. My computer is doing funny things on my screen.

So what I did here is just deleted the section that says that the Department recognizes the statutory prescribed assessment, because, again, we want to leave just the recommendations now. The document that I had been given when I took over this role was the Advisory Council's Recommendations along with the steps that they took after that, so that's why it's a little bit different this go round. So we want to ensure that the Department can complete this statutory responsibility. We want to provide a means of assessing Florida's trauma system utilizing contemporary measures, subject-matter expertise, and the Department of Health resources. We want to ensure that all stakeholder groups have the opportunity to provide recommendations, comments, or include any analysis that will be captured in the assessment, and that, by utilizing the three-part system, the Advisory Council can assure that the recommendations put forth create a comprehensive assessment that can be referenced by policymakers when evaluating future changes to Florida's trauma system. So that would wrap up recommendation one.

I'm sorry, I can't get it all onto one screen,

but it won't let me delete those big blank lines without putting big red lines through it.

So does anybody have any input on the changes that I made to Recommendation No. 1? And I know we can't officially vote, but what I would like to do is, when we get to the end of this document, just make sure that we're accepting it as is for now to be able to put it forth for a permanent vote. So, as we go through again, please let me know any commentary.

MR. SUMMERS: Lisa, David Summers. I don't have any issues.

MS. DiNOVA: Thank you. All right. I'll go through and we'll look at Recommendation No. 2. Again, this was just a bit of housekeeping to change it from the Department making recommendations to the Council making recommendations, and what this is for is to lay out where the population estimates need to come from, and basically utilizing the same ones that they used three years ago, just using the updated versions of it so they can ensure they're using the U.S. Census Bureau as directed by statute, and, looking at the PSA population growth, using the American Community Survey Five-year Estimates by

the U.S. Census Bureau, and then we are actually going to go through and remove Appendix C because that would be actual statistics, but it was back, again, from 2018. That will be part of the actual assessment and not part of the recommendations document. Any comments on Recommendation No. 2?

(No response.)

Okay. We'll move forward to Recommendation No. 3 then. And what we did here is we have to define the term "acute-care hospital." It is not defined by Florida Statutes. I took out the commentary about what they did back in 2018. That's what all of the red line is is removing how that was done, and I just left it to where we are referring back to the actual statutes, themselves, that requires the office to maintain an inventory of all hospitals with emergency-department capabilities, and the hospital emergency-services inventory is publicly available on the AHCA web site. We actually will get rid of this as well because Appendix D will then get moved to the actual study versus the recommendation. So this Recommendation No. 3 is just saying that we agree with the statute and that they should use the AHCA data set. If it says it has emergency services,

then it is an acute-care facility. Any commentary on Recommendation No. 3?

(No response.)

Okay. Moving on to Recommendation No. 4, we discussed this last time. We really didn't make any changes to this at all. This is how it was previously. The only thing I changed was that I took out "Department," again, because this isn't coming from the Department this go round. This is coming from the council, and we discussed leaving it with the ICA (phonetic) score that's already laid out and just moving forward with that one as intact. Anybody have any commentary on Recommendation No. 4?

(No response.)

You guys are making this way too easy.

Okay. Recommendation No. 5, again, we left this one intact because it was a big point of discussion originally, just using the survival risk ratio based on the ICA scores as laid out under the statute. I plan on just leaving that alone unless you have additional commentary.

Okay. Recommendation No. 6 is, define critical care and trauma surgical subspecialty medical resident or fellow as follows. We

discussed that last time, went round and round, and decided we should just leave it as is, talking about emergency and trauma residents and fellows and not getting into the minutia of orthopedics and neurosurgery and whatnot. Do we still agree with that or do we have any additional commentary for that?

(No response.)

Okay. We will leave the residents and fellows alone.

Recommendation No. -- I'm sorry, go ahead.

MR. SUMMERS: Hey, David Summers. I picked up on a spelling mishap. I looked up -- I'm trying to find it. I have it printed. I'll find it and I'll let you know, since we don't have to vote on it.

MS. DiNOVA: Yeah. Thank you.

All right. Recommendation No. 7 was that, trauma centers, at the request of the Department, shall submit NASA (phonetic) station along with supporting documentation declaring the number of surgical specialty medical residents and fellows. This just said that we agreed on who a resident and fellow is, and now we're going to sign an attestation telling them how many we have. This is word for word how the recommendation stood before

and the process that we did for the previous assessment. Anybody have any commentary or changes to make to Recommendation No. 7?

(No response.)

Okay. Moving on, so Appendix A is just the Florida Statute itself that lays out where we have -- where the Department has to do this assessment every three years and that the Advisory Council has to provide the recommendations. So this is straight out of the statute. So clearly we're not making any changes to that one.

I deleted Appendix B, the public comments, because we refer to the minutes from the Advisory Council that is now posted onto the web site now that we have that up and current, instead of having to print all that and attach it to the recommendations. And then also removed Appendix C and Appendix D as those there actually pieces that will go into the actual assessment and don't need to be part of the recommendations paper itself.

So does anybody have any comments or changes or things that we need to do?

(No response.)

I know we can't vote, but what I would like to do is make sure that we can mark this as a final

draft so I can go ahead and take all of these red lines out, make it easy to reformat, and bring it to the next meeting and pray that we have a quorum.

MR. SUMMERS: So, Lisa, David Summers.

MS. DiNOVA: Yes, sir.

MR. SUMMERS: Can we scroll back up one page before the Appendix A. Okay. The spelling -- go up a little higher, please, below -- yeah, right there. Paragraph No. 2, trauma centers are prohibited from declaring an individual -- go up.

MS. DiNOVA: Oh, yes, individual.

MR. SUMMERS: And then.

DR. McKENNEY: The same in the next paragraph down, declare (inaudible).

MR. SUMMERS: How's that for typing under pressure.

MS. DiNOVA: I'm going to take it up with Michael Ressler (phonetic). He's the one who typed this initially.

MR. SUMMERS: Yeah. The problem is we read this over a thousand times.

MS. DiNOVA: I know. Okay.

MR. SUMMERS: And I think Mac found one more, next paragraph.

MS. DiNOVA: And what is --

MR. SUMMERS: To declare an individual.

MR. KEMP: (Inaudible.)

MR. SUMMERS: And then I have one other area.

MS. DiNOVA: Yes, sir.

MR. SUMMERS: Scroll down two more paragraphs. Right there. Okay. So, "in developing recommended definition," and then you mention the "resource optimal care." You need to put the 2022 version.

MS. DiNOVA: Yes, sir. Perfect. Thank you.

MR. SUMMERS: You're welcome.

MS. DiNOVA: Okay. Anybody else have any clerical issues or recommendations to change to our recommendations for the DOH?

(No response.)

I just want to mark this as a final draft so that I can get this to Kate and her team. They're going to be under pleasure now to get this done by the deadline of August. So I want to get them at least a working document.

MR. SUMMERS: David Summers again. We can't vote on it, but I would recommend that we push it forward.

MS. DiNOVA: Okay. I'll take it. Barring any other contacts, emails sent to me, I will send this through as a final draft so that the Department of

Health can get working, and we'll bring it back to our next meeting. So, if you have any additional comments or changes that need to be made, send me an e-mail and I'll get those put in in the next seven days and then we will -- I'll get it over to Kate so her and her team can start pulling numbers. That work? All right. Thank you so very much.

The next thing that I wanted to discuss -- again, we're not going to be able to vote, which is actually the crux of the problem. So we have our bylaws of the Florida Trauma System Advisory Council. They've not been revised since March of 2020, and what I had wanted to look at is specifically down -- starting with Section -- or with Article 4 -- let me pull it up here for you. We have things written in that refer to the full council as well as, when it comes down to voting -- and I'll show you, but basically we have limited ourselves by these bylaws that, even though we have vacancies available -- right now we have only nine of the 12 seats officially appointed at the moment because we've had three people who have resigned from retirement and not fulfilling the roles anymore and whatnot. What I wanted to do was look at our bylaws and try to change some of the

verbiage to give us a little more leniency with our voting. So, instead of it being -- like in this instance, when we're voting for officers, that it would be -- instead of "the full council" here, we would change it to "the seated council" so that it would be actual people who are currently on the council in one of the appointed roles.

Interestingly enough -- and I wasn't going to bring this up, but it says that officers should serve for one year, which means in January we're going to have to have a conversation about my role and Candice's role as moderator and co-moderator also. So I believe it was January when I -- I can't remember if it was January or March. It was January that we were appointed. So, at the January meeting, we're going to have to discuss who is going to be in those roles again, whether we're going to continue on or not.

But what I would like to do is look at this here in Article 4 where we would change it to "majority of the seated council," and then also down in Article 6 where it talks about the meetings, it's the same thing. We have a quorum defined as 75 percent or three quarters of -- it currently says "appointed council members." I

would propose changing that to "seated council members" so that we can get away from being held to that nine council member because there are 12 seats available. But if they haven't been vacated, then we can use three quarters of the seated, or if we wanted to look at -- instead doing three-quarters, we wanted to change it to a majority plus one, so if I wind up with six of us and -- you know, four would pass a vote. I know that we can't vote on that today, but I wanted to get your feedback about changing this verbiage to our bylaws and whether we would be more comfortable leaving it at three quarters of the seated members or changing it to a majority plus one, and even possibly bringing up the conversation of proxies again for council members who, due to their clinical requirements, are unable to attend the meeting today, but they could appoint a proxy to sit in and vote for them for like a meeting or something like that, not somebody who comes to every meeting, but who could place their vote for them for a particular meeting. So I would like to have some conversation around that and get your thoughts, please.

MR. KEMP: I think we're going to have to do something because we have forces that we cannot

control, and if you want to keep this -- I mean, otherwise, for this meeting, for the (inaudible). So I agree with you.

MS. DiNOVA: Would you prefer to keep the three quarters or a majority plus one or -- you've been on several councils --

MR. KEMP: A majority plus one.

MS. DiNOVA: Okay. I would be very -- other council members on the line, any input on this?

DR. McKENNEY: This is Mark, Mark McKenney, Kendall. So I agree that 75, you know, seems like a -- it seems like we should do it, with so many having left. So a majority plus one really, you know, is often defined as a quorum. And then changing "three quarter vote of all participating" versus "all seated," what's the difference there?

MS. DiNOVA: So my only concern with saying participating or active is that that might be -- somebody's definition of who's active. If I miss a meeting, am I no longer active, versus I'm still in my -- I'm still in the seat. I'm still on the council. That was my only concern.

DR. McKENNEY: But still, a super majority, but you have to be seated.

MS. DiNOVA: Correct. So right now we have

nine seated members of a 12-person panel.

DR. McKENNEY: Okay. Got it. Sounds pretty reasonable to me. You know, Mark McKenney, sounds reasonable.

MR. KEMP: The only other word that you may use would be "appointed."

MS. DiNOVA: Well, it's appointed right now, but the problem isn't -- if we're not -- do you count as appointed if you were appointed by the governor four years ago but you've resigned? That seat's now empty.

MR. KEMP: Okay. Okay. So you're fine.

MS. DiNOVA: All right. Dr. Ange.

DR. ANG: So I think I agree with what you're saying. I just think you should just -- applying the word "seated member" so there's no confusion as to, you know, what that means, but I agree with the "majority plus one."

MS. DiNOVA: Okay. I'm trying to think of words on the fly here of how we would define -- yeah. Do you have any suggestions for the language to define seated? I know what I'm trying to say, but I don't know how to say it.

UNIDENTIFIED SPEAKER: You know, I remember when we did the super majority versus majority plus

one, and I'm sorry if I'm missing the argument for why we should get away from that, but if it's just because of a lack of participation, then I think what we need to do is improve participation. We did that very intentionally because we were concerned that you could get people jockeying for position just to shape the trauma system in the way they wanted, which is much harder to do with a super majority than with, you know, majority plus one, or whatever you want to call that, a plus-one majority.

MS. DiNOVA: And I could go either way with the number of people. My bigger concern is right now saying, you know, "the appointed members" because technically we have members who have resigned who were appointed and nobody has been appointed back into their seats. So we have empty seats that we have no control over filling.

UNIDENTIFIED SPEAKER: Right.

MS. DiNOVA: So I think we need to change the wording from "appointed" to "seated" and then define "seated".

DR. McKENNEY: So seated -- okay. And then -- but then it should still -- I think it should still be a super majority of the seated, not a plus one.

MS. DiNOVA: Okay.

DR. McKENNEY: Okay. So then it would be -- "seated" would be defined as a member who is appointed and remains on the council right, because you have people who resigned and those seats weren't filled. So seated members, one who was appointed and remains on the council.

MS. DiNOVA: Okay.

MR. SUMMERS: Lisa, David Summers. Do we have any word on when the vacant positions might be assigned on this committee and any other state committees?

MS. DiNOVA: Not that I've heard. I know that I have had my government relations folks reach out from my facilities that I work for. They have tried to reach out to the Governor's Office a couple of times, and also I sit on this council as the Florida Hospital Association Representative, and I know that my government-relations folks are trying to team up with FHA to also approach the Governor's Office. I think it is going to take council members and stakeholders who have an interest in being on this council to reach out to the Governor's Office and -- we're going to -- remember the squeaky wheel because, right now, as

far as anybody is concerned, we're moving smoothly and we're not creating a ruckus, but the problem is we're also stalled in doing any official business. So we may have to make our own noise as stakeholders in the trauma system. I think Ms. Kate has -- no, she's nodding. So, no, my people have not heard anything. I don't know if anyone else has heard anything.

MR. McCOY: No, I just -- you know, we'll make it a priority and push through our chief of staff and Department of Health (inaudible)?

MS. DiNOVA: And, for the court reporter.

MR. McCOY: That was Steve McCoy.

MS. DiNOVA: Okay. So we can get the Department of Health on board with us. They're going to try. I think we need to get all of our government-relations folks involved and start making that push. I know many of you out in the audience have applied to be part of this council and want to be active participants. It's going to take us making noise to get some people appointed.

So I'll add a definitions section here to the end and fit it in where it should be properly, but -- so that we have something to look at here.

DR. McKENNEY: And remain on council.

MS. DiNOVA: Is this where we should add a note of, "as active members," or -- because --

DR. McKENNEY: Do we have any inactive members? I mean, is that -- do we have something other than an active member?

MS. DiNOVA: I mean, we have nine of us that could be on the meeting today, and there's six.

DR. McKENNEY: I don't understand. Members who are appointed to council and remain on council. That's us.

MS. DiNOVA: Okay.

DR. McKENNEY: Right.

MS. DiNOVA: Looking here, we lay out any way that -- in Section 2, Article 2 -- I know we have this here somewhere. I'm trying to get to it without making you dizzy. In Article 2 we lay out that "Council members failing to be present for three regular meetings during a single calendar year shall be considered to have abandoned their appointment. So as long as we're -- and again, that's got a three quarters, so we'll have to make sure that aligns. So we've already laid out that, if you miss more than three meetings, you're considered inactive and we could replace you anyway. So I think that will --

DR. McKENNEY: Right. So either we vote you out and you're out, or we don't vote you and you're staying, you're still active.

MS. DiNOVA: That works for me. Okay. Anybody have any additional comments or --

DR. GINZBURG: I was going to make a comment. Dr. Ginzburg. What we're saying about, if they don't make three, then they automatically abandon. Instead of having -- at that point maybe it's -- can you make it so that the council -- remaining council decides the new appointees instead of having to sit around and wait for the Governor's Office?

DR. McKENNEY: No, you can't. It's a gubernatorial appointment?

MS. DiNOVA: Yeah. Unfortunately it's written into the statute that this is a council that has to be gubernatorial appointments.

DR. GINZBURG: I see. So, in essence, if you knocked a person out or two, it may impact voting.

MS. DiNOVA: Absolutely. That's why --

(Cross talk.)

MS. DiNOVA: -- people who have resigned or don't fulfill their role anymore, and so they've resigned for that reason. So that's exactly where

we find ourselves right now.

DR. GINZBURG: That's a problem.

MS. DiNOVA: I agree. I've been in the role since January and we haven't been able to take an official vote yet. The last official vote was naming me.

DR. GINZBURG: Well, that's ridiculous. So you can't -- so what Nick was saying is you want to include those that have more on the council and -- on the advisory counsel as part of the voting members, correct?

MS. DiNOVA: I'm not sure I understood that.

DR. GINZBURG: So, for example, if you've been on the council and now you're no longer on the council -- for example, you've been retired from the council -- should those be allowed to vote, be part of the vote? Can you put that in the bylaws?

MS. DiNOVA: Yeah, they've resigned their posts. So, no. That's part of why I wanted to get -- wanted to change the wording from "appointed" to "seated" so that it's the actual people who are still participating and have not resigned their posts.

DR. GINZBURG: Yeah. I see.

MS. DiNOVA: Okay. Well, I will make those

changes to this and bring it back when we meet again. I would like to -- does anybody have any other changes to our bylaws that you would like to make?

(No response.)

When I was reading through -- I think, when we last updated them, we pretty much left them intact other than that. That was only big thing that I thought has been a stumbling block for us was the voting.

Okay. Hearing none, I was going to ask for future business, does anybody have any suggestions -- it's a little hard for me to create future business at this point since we can't vote on anything. But does anybody have anything you would like for us to start looking into before our next meeting that we would bring up for suggestions?

DR. GINZBURG: Maybe those who don't attend could supply a reason for not attending. You know, if it's time, we could think about it. You know, it will be tough to accomplish anything if we don't get a quorum on -- at least on somewhat a regular basis.

MS. DiNOVA: I think what I'll try to do is

get an e-mail out to all of the seated members right now, all nine of us, and basically put forth that (inaudible) in January so that we can get some of this business done. Again, that would be where maybe in January we have the conversation about allowing for a proxy, even if we put a time limit of you could have a proxy sit in for one of the four meetings per year or two of the four meetings or something, that at least you would make a formal notification that this person is sitting in proxy for me for this particular date and this particular vote, just something to consider between now and January.

DR. GINZBURG: I think that's a great idea. That's what we use at the University of Miami Senate. You would send a designee if you can't make it. There's no limit to that. So I think it's a great way to assure that someone has been designated, you know, probably a week before the meeting by whoever is directing it, and in that fashion you won't have anyone falling out from the quorum, and since the positions are only, what, one year, it's -- you know, it really preserves the voting --

MS. DiNOVA: We have three levels of

positions, actually. We have one-year, two-year and three-year positions. They divided it up that way so that not everybody would be coming out of date at the same time. We would kind of cycle. So we have members who were originally allotted in 2018 to a one-year term who are still active, and we have some of us who are -- started a three-year tour who are still active. So --

DR. GINZBURG: (inaudible) good idea, a designee without a limit (inaudible).

MR. SUMMERS: Lisa, David Summers. We would just have to check with the office, probably the Governor's Office to see if we can have a designee since this is a governor-appointed committee.

MS. DiNOVA: Okay.

MR. SUMMERS: Just a thought.

MS. DiNOVA: Yeah, just a thought. Okay. I will write that down and we'll get someone to look into that for us. I'm looking at Kate. Okay. I will definitely -- we'll definitely put that in there.

All right. Time for some public comments. So anyone other than council members have any public comments, any things that you would like to bring up or discuss?

Okay. Yeah -- oh, is that you.

MS. ONL: Yeah, that's me. I just put in my comments, I know that you are planning on making this a final draft, but perhaps you could keep it (inaudible). I know you mentioned removing all of the marks, but it is helpful for people to know what's been changed when they're going through for their final vote next meeting?

MS. DiNOVA: That's true.

THE COURT REPORTER: This is court reporter could I got the identity of the last speaker?

MS. ONL: Susan, S-u-s-a-n, O-n-l.

MS. DiNOVA: Thank you, Susan. I saw that you just put that in the chapter. Thank you. Yeah, you're probably right. So at least I can send it to the DOH as a working draft.

All right. Any other public comments? Anything anybody would like to bring up?

(No response.)

All right. So then, in closing, our next meeting will be the week of -- it's actually the 17th now, January 17th to 20th, some day in there. Ms. Kayla (phonetic) is working on getting us a date. So sometime -- do you want to go from the 16th to 20th -- so the week of January 16th,

somewhere in there, we will be meeting in Daytona Beach for our next meeting. I will get an email out to all of the council members and basically beg everyone to attend for that meeting so that we can have a quorum to do some votes, and unless anyone has anything else, I would take a motion to adjourn, but I don't know that I need one.

I'll take a motion to adjourn the meeting unless anybody has something to add.

UNIDENTIFIED SPEAKER: I have a question. This Zoom thing is great for this meeting. I mean, it turns it from a two-day meeting to a two-hour meeting. Are we doing this under some special dispensation from the Governor's Office or can we continue this? Or is this strictly during the COVID emergency?

MS. DiNOVA: No. We've had an option so that people could attend, just like for the comments hours, we have a virtual motion, and I think -- I will go back and read in the bylaws and make sure, but I'm pretty sure we even counted -- attendance is counted as either in person or on line. So I think that we're good to keep this as an option for people who can't travel. I know lots of us have critical duties that sometimes preclude us from

that. So, as far as I know, we can keep doing it.

DR. McKENNEY: All right. Well, I second your non-motion. I second the non-motion to adjourn.

MS. DiNOVA: Non-motion I love it. I'm using that from now on.

All right, in that case, thank you, everybody, for participating and for putting up with me for the AV technicalities in the beginning, and I will see you sometimes in January in Daytona.

(Proceedings concluded.)

CERTIFICATE OF REPORTER

I, RAY D. CONVERY, do hereby certify that I was authorized to and did report the foregoing proceedings, and that the transcript, pages 2 through 56, is a true and correct record of my stenographic notes.

Dated this 16th day of December, 2022, at Tallahassee, Leon County, Florida.

Ray Convery

RAY D. CONVERY

Court Reporter