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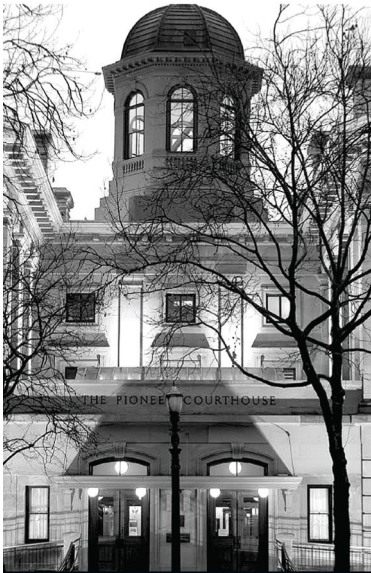
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**FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL**

**SEMINOLE HARD ROCK HOTEL  
1 SEMINOLE WAY  
HOLLYWOOD, FL 33314**

**AGENDA**

**FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL MEETING**

**HELD ON  
WEDNESDAY, JUNE 14, 2023  
1:00 P.M.**

**FORT LAUDERDALE, FLORIDA 33314**



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**FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL**

Mac Kemp, Chair

Lisa DiNova, Chair

Laura Hamilton

Mark McKinney

Kate Kocevar

Darwin Ang

Nicholas Namias

Joseph Ibrahim

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**AGENDA**

**FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL MEETING**

**HELD ON**

**WEDNESDAY, JUNE 14, 2023**

**1:00 P.M.**

**CHAIR DINOVA:** So, thank you, everyone, for joining us today for our Florida Trauma System Advisory Council. It just would not be a meeting of this group if we didn't have some technical challenges at the beginning. So, now that we have that underway, I'm going to go ahead and call this meeting to order, and we'll start with the Pledge of Allegiance, please.

**(Thereupon, Pledge of Allegiance recited)**

**CHAIR DINOVA:** Thank you. And now, we'll do a roll call. Kate?

**COUNCIL MEMBER KOCEVAR:** All right. Is this on? No. But I think everybody can hear me. All right. Dr. Ang?

**COUNCIL MEMBER ANG:** Present.

**COUNCIL MEMBER KOCEVAR:** Lisa DiNova?

**CHAIR DINOVA:** Present.

**COUNCIL MEMBER KOCEVAR:** Joseph Ibrahim?  
Mac Kemp?

1           **CHAIR KEMP:** Here.

2           **COUNCIL MEMBER KOCEVAR:** Mark McKinney?

3           **COUNCIL MEMBER MCKINNEY:** Yeah.

4           **COUNCIL MEMBER KOCEVAR:** Nicholas Namias?

5           **COUNCIL MEMBER NAMIAS:** Here.

6           **COUNCIL MEMBER KOCEVAR:** David Summers?

7           **COUNCIL MEMBER SUMMERS:** Remotely.

8           **COUNCIL MEMBER KOCEVAR:** Thank you. Glenn  
9 Summers? Candace Pineda, co-moderator? And then  
10 myself, Kate Kocevar. Present.

11           **CHAIR DINOVA:** All right. Thank you all.  
12 Just a couple of housekeeping reminders. We're  
13 working right now. They're still trying to figure  
14 out how to be able to get those of you on Teams to  
15 be able to speak. So, for the time being, if you  
16 need to make a comment or wish to have your  
17 microphone un-muted, please raise your hand in the  
18 chat and they'll be monitoring that. Also, we will  
19 be recording this with a court reporter here in the  
20 room, so please make sure that you preface all of  
21 your comments before with your name prior to making  
22 those comments so that she can capture that for the  
23 record, which will be utilized for the minutes.  
24 Speaking of minutes, our meeting minutes are now  
25 posted on the FTSAC webpage on the Florida Health

1 website, so if you wish to go back and see those  
2 transcriptions/minutes, those are there posted for  
3 your review.

4           And I also would like to look at some old  
5 business that we have. At our last meeting, we  
6 discussed the fact that we as a Council do not have  
7 a quorum, so we can't conduct any official business  
8 because we can't have a vote, including a vote to  
9 change the rules so that we can have a vote. So,  
10 what we're going -- what we have done is I did  
11 create that letter to the Governor's office as we  
12 discussed last time. This is the letter that I sent  
13 to him. I have it posted up on the screen for you,  
14 and I did send that in the beginning of April. Thus  
15 far, I have not heard back from anyone from the  
16 Governor's office, but I believe we have a couple of  
17 other folks who have also sent some letters that I  
18 think we'll hear about as we get to our report outs.  
19 So just --

20           **COUNCIL MEMBER NAMIAS:** I have a quick  
21 question.

22           **CHAIR DINOVA:** Yes, sir.

23           **COUNCIL MEMBER NAMIAS:** Okay. So, we  
24 constitutionally don't have enough remaining members  
25 to ever have a quorum because the quorum is a

1 percentage of the people who were supposed to be on  
2 the committee.

3           **CHAIR DINOVA:** The way our charter was  
4 drafted and our bylaws were drafted is that it's to  
5 have an official vote, we have to have three-  
6 quarters of the appointed members. So, once we  
7 finally get a quorum, we're going to change that to  
8 the seated members as we discussed before, but --  
9 so, I think what we're going to do is we're just  
10 going to continue to have business as usual and  
11 we're going to continue on with the work of this  
12 group, and when we get to a point where we get some  
13 more folks appointed to it, then we'll go back and  
14 vote on these things that we've done and make them  
15 official. But I think we're just going to keep  
16 moving right ahead and actually have -- still keep  
17 some forward momentum going with this group at least  
18 that's my goal.

19           **COUNCIL MEMBER KOCEVAR:** Lisa?

20           **CHAIR DINOVA:** Yeah.

21           **COUNCIL MEMBER KOCEVAR:** Kate Kocevar.  
22 Just affirming that you are keeping track of the  
23 number of items that a quorum will then have to vote  
24 on.

25           **CHAIR DINOVA:** Indeed.

1           **COUNCIL MEMBER KOCEVAR:** Okay.

2           **CHAIR DINOVA:** And at the end of this  
3 meeting for part of our closing remarks, I actually  
4 have a -- or with our future business, I actually  
5 have a list, a running list on our slides so that  
6 it'll be part of the presentation, so we'll know  
7 what to go back and vote on later.

8           **COUNCIL MEMBER KOCEVAR:** Very good. Thank  
9 you.

10          **CHAIR DINOVA:** Thank you. All right. So,  
11 I think that's it for old business. Time for some  
12 updates and some report outs. First I have Ms.  
13 Kocevar from the Department of Health, please.

14          **COUNCIL MEMBER KOCEVAR:** All right. Thank  
15 you, Lisa. So, we know that we had legislation,  
16 legislators' word -- (inaudible) -- over the last  
17 few months passing vigorous things. Trauma I  
18 believe did not actually come up. I guess that's  
19 good or bad. I'm not sure. But we do know that  
20 there was some talk in regards to board  
21 certification per physicians.

22                 And of course, that caught my attention  
23 because that could also affect our trauma standards  
24 and our ability to function the way we are trying to  
25 do. That actually was in committee, but never made

1 it to a point where there was going to be a bill  
2 brought up. Now, the thing that concerns me though  
3 is we know that we're starting to see a shortage in  
4 healthcare workers.

5           And it's not just nursing anymore. It is  
6 doctors, it is ED doctors, it's anesthesiologists,  
7 it's neurosurgeons, you know, this type of thing.  
8 So, it is something that I think we all have to  
9 strongly look at and figure out how our healthcare  
10 system is going to continue to function at the high  
11 level we want it to.

12           And at the same time, recognize that we  
13 may not have as many dedicated individuals who want  
14 to do those long hours in trauma, let alone work in  
15 hospitals. So, it's something that I just hope that  
16 this Council kind of keeps in mind as we go forward  
17 because it not only affects who will work in trauma,  
18 but it'll affect you as a patient as well.

19           And so, something that we want to kind of  
20 bear in mind as it goes through. At this point, I  
21 have not received any word that it's going to be  
22 taken up once again but, you know, as Mac can attest  
23 to, you never know what the legislators are going to  
24 decide to do next session.

25           And so, I will continue to kind of monitor



1 that activity to see if and when this should be of  
2 some -- raise some alarm to what we have to address  
3 here. As far as the big thing that is going on  
4 right now in trauma is the trauma assessment, the  
5 2023 Trauma System Assessment is due April -- excuse  
6 me, August. Pardon me. August 31st of 2023.

7           At this time, I am receiving information  
8 from the party that is going to be working with the  
9 data, and we are continually reviewing the  
10 information that is coming through. My hope is that  
11 by the end of June, early July, I will be able to  
12 get that information.

13           We will take the information that was  
14 provided with the original -- I guess it was like  
15 three meetings ago, Lisa, I think when you provided  
16 some updates in the language, you know, that should  
17 just go to the preface of the report. It does not  
18 in any way change the final fundamental data part of  
19 the report, and then it will begin its long trek up  
20 through the Department of Health for review, all  
21 right.

22           So, that takes a little while. So, I have  
23 have kind of explained to our third party of the  
24 imperativeness of me receiving that report in a  
25 timely fashion so that I'm able then to move that

1 information through the different channels that  
2 eventually ends up at the Governor's office along  
3 with a copy to both the Senate and the House, all  
4 right, so that it'll be handled that way. At this  
5 point in time, I can tell you that I have not seen  
6 anything that I can report on, of course, because  
7 that would not be appropriate.

8 But more importantly, just waiting to  
9 receive that data information back so that we can  
10 then put it into the report version and then send it  
11 up the chain of command, as you say, with that.  
12 Other than that, I think that's kind of the biggest  
13 things.

14 The other two things that we'll be looking  
15 at, we have in the fiscal year of 2023, 2024 since  
16 the state starts their fiscal year in July, we'll  
17 have two trauma centers that are going to be up for  
18 re-designation. We also discussed at some of our  
19 AFTC meetings about the possibility of doing some  
20 interim surveys since our seven year certificate  
21 causes a lot of issues. It is too long of a period,  
22 we've all agreed in the past. Unfortunately, that  
23 did not get taken up again as proposed, but I have  
24 done, once more, for the upcoming legislation to put  
25 it in once again. But in the meanwhile, some of the

1 interim surveys might be a possibility. We did take  
2 an advisement, a request that if you had ACS  
3 verification done, we understand that there's a lot  
4 of people coming in and out of your hospital, wake  
5 up to wait month after month looking at this. And  
6 so, we are taking that under advisement as we try to  
7 proceed forward with the design of whatever interim  
8 surveys may look like and who would be, you know,  
9 affected by this.

10           So, nothing is written in stone by any  
11 means. I have certainly been told, well, you know,  
12 you would have the ability to go in any time you  
13 want. Yes, I understand that. But the question  
14 really is is I want to make sure that we're making  
15 quality decisions, all right, in what we're trying  
16 to do with this. So, it is important. We know that  
17 ACS does verifications every three years, and that  
18 has been what their recommendation has been to align  
19 to that. I'm just hoping that at some point we do  
20 get the ear of the legislators to understand the  
21 importance of that. And as I reiterated so many  
22 times over all those who have legislative people who  
23 work in your hospitals to also make that noise also  
24 to say that as stakeholders, this is what you're  
25 wanting to have.

1 So, that is kind of my report. I'm  
2 certainly open for anyone who has any questions for  
3 me. Yes.

4 **COUNCIL MEMBER NAMIAS:** Nick Namias.  
5 Thanks, Kate. My question is regarding the  
6 legislation that was -- that didn't make it  
7 regarding board certification. What was the gist of  
8 the change they were seeking?

9 **COUNCIL MEMBER KOCEVAR:** The gist of the  
10 change that they were seeking was is that they were  
11 looking to accept physicians' credentials who may  
12 not have gone through board certification here in  
13 the United States.

14 **COUNCIL MEMBER NAMIAS:** So through the  
15 college at least for the American surgeons  
16 verification is an alternate pathway for those  
17 people, and it's, it's fairly rigorous. It demands  
18 certain CMEs and participation in educational  
19 things. Was the state going to ask for any of that?  
20 I mean, I don't -- I think as an advisory council to  
21 the state, right, I think that we should have a  
22 position as an advisory council. And there's a role  
23 for non-board certified physicians who can't become  
24 board certified because they're foreign trained, but  
25 I think that there has to be some standards like the

1 American College of Surgeons alternate pathway.

2 **COUNCIL MEMBER KOCEVAR:** And again, that  
3 is something that as the Council, I would highly  
4 recommend for us to take a look at. We do not have  
5 a particular position at this point. I just happen  
6 to see that that was actually on the list of  
7 committee assignments, and I found myself a little  
8 intrigued trying to see how this would all kind of  
9 work itself out. Correct me though, is it for all  
10 physicians or was it just for EDs and alternate  
11 criteria?

12 **COUNCIL MEMBER NAMIAS:** No, the surgeons  
13 can have alternate criteria. The ED doctors just  
14 have to show they're board certified and show having  
15 taken ATLS once. The non-surgical specialist,  
16 there's no requirement from the college.

17 **COUNCIL MEMBER KOCEVAR:** Okay. So again,  
18 something that -- yes. You know, something again  
19 that I would strongly encourage this Council to take  
20 under, you know, advisement and to provide, you  
21 know, as you say, a position on it as well. It was  
22 something that I just happened to kind of catch one  
23 day when I was listening to session, and then I'm  
24 thinking, well, okay, you know, that could certainly  
25 because some ripple effects in trauma.

1           **CHAIR DINOVA:** Dr. Namias, this is Lisa  
2 DiNova. Dr. Namias, is that something that as a  
3 member of the council you would like to take up and  
4 maybe we should write a position statement to have  
5 it at the ready in case that comes back up for next  
6 session, which we -- well, we have some time since  
7 that won't be until next March, but perhaps we need  
8 to start drafting a position statement to bring back  
9 to the next --

10           **COUNCIL MEMBER NAMIAS:** Shouldn't be too  
11 hard. I'm happy to do it. It'll be just a brief  
12 letter stating our position and I'll gather  
13 consensus.

14           **CHAIR DINOVA:** That seems very --

15           **COUNCIL MEMBER NAMIAS:** I'll prepare it.

16           **CHAIR DINOVA:** Mixed data.

17           **CHAIR KEMP:** Next question back there.

18           **CHAIR DINOVA:** Yes. Yes, Dr. Ginzburg.

19 Come up.

20           **ENRIQUE GINBZRUG, MD:** (Inaudible)

21           **CHAIR DINOVA:** You have to come up to the  
22 microphone so they can hear you on the phone.

23           **ENRIQUE GINZBURG, MD:** (Inaudible)

24 Enrique Ginzburg, Jackson South, Trauma Medical  
25 Director. Just to clarify, you're talking about

1 board certification of both trauma surgeons and  
2 subspecialists OR just about subspecialists? Because  
3 I think one of the issues that was discussed with  
4 regards to this issue was the difficulty sometimes  
5 in finding board certified subspecialists in certain  
6 trauma centers.

7 **COUNCIL MEMBER KOCEVAR:** Doctor, as far as  
8 what I was referencing, they did not zero in on  
9 trauma. They zeroed in on medical specialists so --  
10 okay. So, it wasn't necessarily just the trauma  
11 that would be affected. It would be anyone who  
12 served in a hospital. You know, so it was a  
13 discussion about just looking at what type of  
14 credentials would be accepted, and it didn't get to  
15 the point of just zeroing in on the trauma section.

16 **ENRIQUE GINZBURG, MD:** That's what I --

17 **CHAIR DINOVA:** Is there a way that we can  
18 get whatever document that they were reviewing so  
19 that we could see what they were considering and we  
20 can have our position statement address those things  
21 that were under consideration originally?

22 **COUNCIL MEMBER KOCEVAR:** What I could  
23 certainly try and attempt to do is, you know --

24 **CHAIR DINOVA:** Right, just go through --

25 **COUNCIL MEMBER KOCEVAR:** Right. It was in

1 committee, you know, this type of thing is to be at  
2 least be able to provide and send you what the house  
3 bill number was.

4 **CHAIR DINOVA:** Okay. We can start from  
5 there.

6 **COUNCIL MEMBER KOCEVAR:** I can kind of  
7 start from there.

8 **CHAIR DINOVA:** Okay. Thank you.

9 **COUNCIL MEMBER KOCEVAR:** You're welcome.

10 **CHAIR DINOVA:** All right. Anyone have  
11 anything else for the Department of Health? Any  
12 questions, comments, anything online? Yes.

13 **MICHAEL TAYLOR:** Michael Taylor from  
14 Hillborough County. Kate, I understand the grand  
15 approval process through the bureaucracy of  
16 government and getting the assessment up to the  
17 Governor's office, but is there a point before the  
18 Governor's office signs off or something that the  
19 report will be public or are we --

20 **COUNCIL MEMBER KOCEVAR:** No, it actually  
21 has to go through that process.

22 **MICHAEL TAYLOR:** It has to be signed off  
23 by the Governor's office --

24 **COUNCIL MEMBER KOCEVAR:** That is correct.

25 **MICHAEL TAYLOR:** -- before it can be made



1 public. So, it'll be at least -- even though it's  
2 due this fall, it may be sometime before we actually  
3 see it even though it'll be done?

4 **COUNCIL MEMBER KOCEVAR:** Right. My  
5 deadline to submit it is August 31st of 2023, yes.

6 **MICHAEL TAYLOR:** Okay. Thank you.

7 **CHAIR DINOVA:** I see some things going on  
8 in the chat, but it looks like everybody's just  
9 saying hi.

10 **COUNCIL MEMBER KOCVAR:** Okay.

11 **CHAIR DINOVA:** Okay. Not seeing anymore  
12 questions coming up in the chat, we will move  
13 forward with our Florida EMS Advisory Council  
14 update, and Mr. Mac Kemp, please.

15 **CHAIR KEMP:** Yeah. Not a lot to report.  
16 The EMS Advisory Council meeting will be Friday  
17 morning and we will talk about a lot of stuff there.  
18 The stuff related to trauma, you probably saw if you  
19 were in the opening meeting there with -- the folks  
20 from San Antonio were here where they're running a  
21 full whole blood program in the field. They've  
22 given over 1,200 units of whole blood with great  
23 success for trauma patients. And there are  
24 probably, I would guess, 12 to 15 agencies,  
25 including my own, in Florida that are either giving

1 whole blood now or moving toward that.

2           So, we expect that that will expand.

3 There are -- we do have a Florida whole blood  
4 coalition that's working on this issue, and San  
5 Antonio is working on a national whole blood  
6 coalition effort for pre-hospital care. So, I think  
7 you're going to see a lot more of that. So,  
8 everyone in trauma should just be prepared and  
9 should be integrated as a part of that discussion as  
10 that happens throughout Florida. There is still the  
11 discussion about the triage guidelines. I think Dr.  
12 Pappas has been working with a lot of the EMS  
13 agencies and different parts of the Council to  
14 determine if we're going to adopt those national  
15 guidelines either in whole or in part, and I think  
16 we will figure that out.

17           The third thing is I did talk to Dr.  
18 Pappas before this meeting, and we are very close to  
19 introducing to the EMS Advisory Council what's  
20 called the pit crew model approach for EMS in the  
21 field with critical trauma patients. This is a  
22 model that has worked very well with cardiac arrest.  
23 It works well in event medicine. There's a lot of  
24 other types of issues where we're looking at pit  
25 crew approaches to those, and that is moving

1 forward, and we expect that it'll be introduced to  
2 the advisory council on Friday, and will be voted on  
3 and adopted if they approve it at the October  
4 meeting, which would be the first week of October of  
5 this year, which I'll not be chair anymore at that  
6 point. But the new chair will take that up. I think  
7 that concludes my report.

8           **CHAIR DINOVA:** Okay. It still makes me  
9 very sad that Mac's not going to be apart of these  
10 councils later on this year. I hope that you can  
11 still participate at our third quarter. I'm going  
12 to call it our third quarter meeting since we don't  
13 know when it's going to be quite yet. But I did  
14 have up on the screen those National Field Guideline  
15 in case anybody in the room or online has not seen  
16 this.

17           If you are looking at it through your  
18 local advisory boards or your local councils, there  
19 are a few things that we know that Florida's a  
20 little bit different when it comes to trauma, being  
21 that we don't use level threes and fours, and their  
22 level ones and level twos are very closely aligned  
23 with the care that they provide. And so, there's a  
24 couple of things in here that might be concerning to  
25 us across the state not the least of which is the

1 line that says that anybody with a red criteria has  
2 to be transported to the highest level trauma center  
3 available. With our ones and twos being so close in  
4 their clinical skills, that might be challenging if  
5 you're much closer to a level two than a level one  
6 when you go to transport.

7           So, I know that some of you have been  
8 looking at this at your local level. So, please  
9 make sure that you get that feedback over to either  
10 the EMS Advisory Council I guess would probably be  
11 the best place to send that through. Okay. I think  
12 they're still having a little bit of technical  
13 challenges online, but we're going to keep pushing  
14 through here.

15           Our next update is from Dr. Peter Pappas  
16 with the FCOT update, please.

17           **PETER PAPPAS, MD:** Thank you, Lisa, and  
18 good afternoon to the members of the committee. I'm  
19 Dr. Peter Pappas. I'm here in my capacity as  
20 chairman for the Florida Committee on Trauma, and  
21 we're representing, of course, our respective  
22 centers and our membership. Several issues, a lot  
23 of which have already been touched in previous  
24 reports that I didn't want to update the committee  
25 on. First of all, being, of course, the committee

1 itself and our efforts, certainly, as an  
2 organization to support the full reappointment and  
3 the reinvigoration of the Florida Trauma System  
4 Advisory Council given its significant importance to  
5 our overall administrative and regulatory framework  
6 for trauma here in Florida.

7           In compliment really to Lisa's letter from  
8 April, we also drafted a to them supported by our  
9 executive committee consisting of our vice chairs  
10 and our past chairs on April 10th to the Surgeon  
11 General, again requesting the full reappointment and  
12 reestablishment of the Florida Trauma System  
13 Advisory Council as a functioning voting body. We  
14 have yet to hear back also. But I would like to  
15 enter a copy of this letter for the record, and also  
16 stay the course that we continue to support as a  
17 Florida Committee on Trauma a fully-functioning  
18 Florida Trauma System Advisory Council.

19           In the interim, a couple other issues I  
20 wanted to bring up. An additional document that  
21 we're also preparing that's still in draft form is a  
22 document also stating -- (Inaudible) -- trauma  
23 surgeons are general surgeons. This was a question  
24 actually presented to us from a member of the  
25 Florida Committee on Trauma looking, I guess,

1 involving essentially the credentialing process of  
2 their respective system. Some queries have been  
3 moved forward from their medical executive  
4 committee, and we essentially, of course, restate  
5 and certainly agree with both Florida trauma  
6 standards and the grandfathered surgeons that trauma  
7 standards -- that trauma surgeons are general  
8 surgeons and require privileging as such, and that  
9 is a topic, of course, that we hope we'll be able to  
10 put to rest.

11 In terms of looking forward in terms of  
12 both continued coordination between the Department  
13 of Health and the Florida Committee on Trauma, first  
14 time, of course, that is still pending and is really  
15 -- do we want to go ahead and consider formal  
16 request for a state consultated visit for the  
17 upcoming year in 2024? I think we can all agree  
18 that Florida has changed dramatically since our last  
19 state consultated visit in 2013, and the least of  
20 which we noticed an almost 50% increase in the  
21 number of trauma centers, about 15% increase in our  
22 state population.

23 And then of course, continued increased  
24 needs for not only geriatric trauma but also  
25 pediatric trauma, and also a continued rebalancing

1 of our population as areas that were once rural and  
2 out of town become within driving distance of your  
3 job as our metro areas continue to grow. So, lots  
4 of opportunities there. I do look forward, again,  
5 to moving forward a formal request to the Department  
6 of Health in the coming weeks.

7           Some of the other issues that were touched  
8 on in Chief Kemp's report, whole blood, yes. It is  
9 at this point we can safely say that the majority of  
10 Florida's trauma centers either have implemented  
11 whole blood programs or are actively in the process  
12 of doing so. And I think this is an area, of  
13 course, that both the Florida Committee on Trauma  
14 can work closely not only with FTSAC but also with  
15 the NASAC in terms of moving this forward, ideally  
16 coming down with some general guidelines that can be  
17 applied not only for trauma centers but also for  
18 EMS. The key to successful programs as the San  
19 Antonio presentation mentioned to me and that I've  
20 heard also from institutions working with EMS  
21 agencies here in South Florida has been a good and  
22 efficient cycle for whole bloods to minimize wastage  
23 under essentially you are rotating between trauma  
24 center and EMS Agency or vice versa, but a good  
25 partnership, a three-way partnership between the

1 flood bank, the trauma centers, and the EMS agencies  
2 appear to be the way to go and appear to be where  
3 the most more successful models are here in Florida.  
4 And that, I believe is initiative that we overall in  
5 Florida to trauma can continue to support.

6           As far as the continued debate or concerns  
7 over the trauma triage guidelines, prior to this  
8 meeting, I did have an opportunity to speak again  
9 with Dr. Peter Fischer, the chair of the ACS  
10 guideline committee who is also one of our trauma  
11 leaders at Memphis, at the University of -- the  
12 Memphis Trauma Center in Tennessee. The picture  
13 painted for me in terms of quote,unquote "highest  
14 level" is also for it to be taken into context. When  
15 we consider that the American College of Surgeons is  
16 pretty much in a situation where recommendations and  
17 guidelines must be drafted for the very significant  
18 diversity of practice environments in North America,  
19 it is important at that point for individual regions  
20 to really think about how the criteria -- how the  
21 triage criteria fit in for their particular regions.  
22 For example, we are fortunate in Florida to have a  
23 very robust system; not only world class level ones,  
24 but also to have those level ones supported by a  
25 very robust system of level twos.



1 That because of our state statutes pretty  
2 much ensure that for any given adult patient, the  
3 resources of a level two will be complimentary to  
4 that of a level one. In other states, that is not  
5 the case. And in states where you may have a  
6 situation where the nearest center might be level  
7 three or even a four, a level one or two might be  
8 further away, then, of course, that's where the  
9 highest level numbers comes in. Because of our sort  
10 of both simplified and robust system -- so I'd like  
11 to call it elegant -- we don't necessarily have that  
12 issue. And where there are safe practice  
13 variations, those conditions are done within a  
14 regional level. So, the only recommendation I would  
15 have at this point is we somehow find a way to not  
16 worry too much about the highest level language and  
17 understand that Florida is already functioning at  
18 the highest level. And again, then we can move  
19 specifically to things like burns, free flaps,  
20 reimplantations, pediatric care, and then make --  
21 then make the amendments as need be at the state  
22 level, which, of course, is what is always the  
23 design of the American College of Surgeons. We can  
24 start with what the ACS has given us, and then work  
25 from there.

1           Then finally, on a high note, I'd like to  
2 end my comments, the trauma pit crew model that  
3 Chief Kemp talked about. There are three pit crews  
4 being developed by the EMS Advisory Councils. One  
5 is for stroke, one is for STEMI, one is for trauma.  
6 We were the last to start, but it looks like we're  
7 going to be the first to finish. So, we have went  
8 ahead this morning. Dr. Barnes (phonetic) and I in  
9 the Medical Care Committee, we're working closely  
10 with Dr. Ennis Jenson (phonetic), state EMS  
11 director, and Dr. Marshall Friend (phonetic), the  
12 chair of the medical care committee, we were able to  
13 move through, I would say, a very much more  
14 structured and nearly finalized draft of the trauma  
15 pit crew. This week, we present some more at the  
16 EMS medical directors meeting, and then finally  
17 present it to the EMS Advisory Council for review  
18 and hopefully approval between now and the next  
19 meeting, which will be in October. So overall, some  
20 good progress there. And I continue to thank both  
21 the Department of Health, the EMS Advisory Council  
22 System, and the Florida Trauma System Advisory  
23 Council, continue to be good partners and  
24 collaborators with the Florida Committee on trauma  
25 as we continue to advance our core mission of

1 optimal care for our patients. Thank you.

2 **CHAIR DINOVA:** Thank you, Dr. Pappas.

3 Anyone in the room or on the line have any questions  
4 or comments for Dr. Pappas and the FCOT?

5 **COUNCIL MEMBER MCKINNEY:** Yup. Mark  
6 McKinney. I have a question. And the timing is good  
7 because I wasn't sure who to bring it up to, FTSAC  
8 or FCOT. The TQIP now allows for a pediatric  
9 collaborative, and through HCA we've signed up and  
10 are supposedly going to get our first collaborative  
11 report in the fall. And I find the Florida and, you  
12 know, the other collaboratives, HCA in all the  
13 states, you know, who want to get involved, very  
14 helpful looking at the system. So, I was trying to  
15 find a way for Florida to get a Florida pediatric  
16 collaborative together, and then all the care of our  
17 pediatric patients, you know, at a state level would  
18 be clearer, but I'm not sure who's going to -- who  
19 would be in charge of, you know, putting that  
20 together. And there's some financial costs, too.

21 **PETER PAPPAS, MD:** So, this was something  
22 that we did discuss at the last -- the national  
23 collaborative meeting in Phoenix in December when we  
24 had our Florida collaborative, establishing a  
25 pediatric collaborative. There was actually strong

1 support from the membership there. As part of this  
2 process, my first step as the chair, I established  
3 pediatric trauma -- vice chair, established as vice  
4 chair as a pediatric trauma committee. That was --  
5 currently, we do have our full vice chair, Dr. John  
6 Druss (phonetic) who is from Wilson's Children in  
7 Jacksonville. And one of the charges for the  
8 committee, of course, is to go ahead and proceed  
9 with this, helping establish a pediatric trauma  
10 collaborative consistent and concurrent with our  
11 current Florida TQIP collaborative. That is  
12 something we're working on.

13           And the easy thing, Dr. McKinney, is when  
14 I get your contact information for Dr. Druss, and  
15 let's see if we can get this collaborative up and  
16 running as soon as possible. I'm happy to hear that  
17 you've already joined a national collaborative to  
18 look at that. Clearly, when we look at Florida, we  
19 have the extremes. And in some ways, that is also  
20 what the grade book, our next set of standards from  
21 the ACS or guidelines from the ACS is also noticing.  
22 We have a geriatric population. We also have a  
23 pediatric population. I believe within ten years,  
24 not to speak out term, but we'll probably wind up  
25 with geriatric TQIP as well, not just pediatric

1 TQIP.

2 **COUNCIL MEMBER MCKINNEY:** Good idea.

3 **PETER PAPPAS, MD:** And but for right now,  
4 yes, I am interested in that, somebody that has  
5 strong support within the pediatric trauma section  
6 of the COT -- of our state COT to establish  
7 pediatric collaborative. We absolutely want all the  
8 level ones engaged along with their dedicated  
9 pediatric centers. So, thank you for bringing that  
10 up.

11 **CHAIR DINOVA:** Dr. Pappas, for centers who  
12 are interested in getting involved in that, who  
13 should they send their contact information to?

14 **PETER PAPPAS, MD:** That would be Brian  
15 Hart (phonetic).

16 **CHAIR DINOVA:** Brian Hart.

17 **PETER PAPPAS, MD:** Brian Hart, our  
18 executive director, Florida Committee on Trauma.  
19 And Lisa, I'll go ahead and e-mail you and get you  
20 Dr. Druss' contact information and Brian's as well.

21 **CHAIR DINOVA:** Okay.

22 **PETER PAPPAS, MD:** I think it would be a  
23 great thing and I think, clearly, it's time has  
24 come.

25 **CHAIR DINOVA:** As you guys all know, I

1 also have a -- I'm in a weird situation where my  
2 center that I work for is an adult level two, but we  
3 are also a pediatric center. So, pede is -- and  
4 pedes is where I started, so that's where my heart  
5 lies. So, if you're having trouble getting in  
6 contact with these folks, just e-mail me and I will  
7 make those connections for you if need be because I  
8 think everybody's got my e-mail address like in the  
9 free world. Yes, sir.

10 **COUNCIL MEMBER NAMIAS:** So Mark. I  
11 support a pediatric collaborative, but, I mean, our  
12 adult collaborative, our Florida collaborative is  
13 through the DOH, right? I mean, that's who pays for  
14 this collaborative. That's where the money comes  
15 from. So, I guess as the FTSAC, are we asking the  
16 state to pay? Because if you participate in  
17 pediatric TQIP equip, so that's what each center can  
18 do individually, to get a collaborative, we just  
19 need the state to say to take our advice that there  
20 should be a pediatric -- a Florida pediatric  
21 collaborative. Like HCA pays for your HCA  
22 collaborative, and the state pays for our adult  
23 collaborative. But I guess we would be going to the  
24 state asking for a pediatric collaborative.

25 **PETER PAPPAS, MD:** Yeah, I can't give

1 advice, but I can give an opinion. It would be nice  
2 to have a pediatric collaborative.

3 **COUNCIL MEMBER MCKINNEY:** So, maybe if  
4 FCOT and FTSAC advises, that idea would be more  
5 likely to happen.

6 **CHAIR DINOVA:** Am I hearing the need for  
7 another letter of recommendation to be written  
8 before our next meeting? Is that from the Advisory  
9 Council saying that we would support and would like  
10 to see a pediatric FCOT or a pediatric TQIP  
11 collaborative be established?

12 **COUNCIL MEMBER NAMIAS:** Dr. McKinney  
13 volunteers.

14 **CHAIR DINOVA:** I love it.

15 **COUNCIL MEMBER MCKINNEY:** It'll be short  
16 just like the other one, but I'll put one together.

17 **CHAIR DINOVA:** Perfect. Thank you. Look  
18 at this. Things to not vote on next time. I love  
19 it. All right. Okay. Anything else for FCOT? All  
20 right. So, moving onto some new business. Many of  
21 you have been involved with our Florida Standards  
22 Revisions subcommittee that Ms. Laura Hamilton has  
23 been chairing for us. What we're going to do is  
24 actually have Kate give us a little primer on how  
25 we get these things changed again because I did not

1 have a light bulb moment until like two days ago  
2 with it even though we've been talking about it for  
3 three years. So, Kate's going to help us have a  
4 light bulb moment about how we're going to get these  
5 changes moved through, and then Laura's going to  
6 walk us through some of those changes that you guys  
7 as a subcommittee have been working on.

8 **COUNCIL MEMBER KOCEVAR:** Okay. Thank you,  
9 Lisa. So, I'm going to try and make this really,  
10 really short and sweet because you guys are writing  
11 short, sweet letters. I like that. Okay. So, make  
12 it pretty easy. You know, for years, we talked  
13 about the trauma standards. The trauma standards  
14 are a pamphlet, all right. The pamphlet is  
15 referenced in rule. The rule is referenced in  
16 statute. All right. So, does everybody follow  
17 that? We've got statute, rule, pamphlet; pamphlet,  
18 rule, statute. All right. So, in order to try and  
19 take a look at our trauma standards, we would have  
20 to then decide, do we want to open -- we want to  
21 open up the rule, all right. That's what we're  
22 going to do. We're not going to open up the  
23 statute. We're opening up the rule. That is where  
24 we would then get into doing a workshop and/or a  
25 hearing depending on what is the request from our



1 stakeholders and the public are allowed to, you  
2 know, certainly do this also.

3           So, one of the important things that we  
4 have to remember is just because we decide to change  
5 it here, it doesn't mean that it instantaneously  
6 happens. All right. There are processes that you  
7 have to go through. Now, they reminded me, I guess,  
8 about a year or so ago, I tried to give a very brief  
9 report to FCOT and how the new rulemaking gets  
10 placed, and it was only 50 slides. I don't  
11 understand why that was such a problem, but -- you  
12 know, and that was the condensed version, you know,  
13 of understanding how this works. And I know Ms.  
14 Hamilton has been doing some research, and she, too,  
15 has found out how convoluted this can actually be.  
16 So, I'm trying to make this as streamlined as  
17 possible for us to understand that we need to get  
18 through the standards first. Once revised, you give  
19 us a draft revision of the standards that will then  
20 gets submitted to the Department of Health. The  
21 Department of Health will then submit it to the  
22 general counsel for the general counsel, as they  
23 like to call me, doing legalese, you know, and go  
24 through and make sure that we're not in any way  
25 going to because any riffs or problems.

1           Of course, we'll hear in our conversations  
2 over the next few weeks as we're looking at  
3 standards, is there a cost to be bearing -- to these  
4 changes that we're making? And we have to be  
5 cognizant of that because if you do go over  
6 \$200,000, there is the famous -- and I heard some  
7 people say it -- the CERT famous 120 rule starts to  
8 come into play. So, it's \$200,000, and it's over a  
9 million dollars in five years. And so, financial  
10 assessment, for the lack of describing this, would  
11 then actually have to get -- taken place to take a  
12 look at how -- what kind of burden that might put on  
13 a trauma system/trauma center.

14           All right. So, we've been kicking these  
15 ideas around for a while. I know that the  
16 subcommittee has done great work, and now that great  
17 work has come out, and trying to compare and  
18 contrast and figure out what is going to be best for  
19 Florida. I think that Dr. Pappas in his report  
20 about the ACS is saying that these are guidelines  
21 that they have to write kind of for the entire, you  
22 know, country, you know, as opposed to saying  
23 they're just writing it for one particular state.  
24 So, we have to take a look at what they have put  
25 into their guidelines, and we have to decide what

1 our standards, you know, will accept. Maybe we want  
2 to tweak our standards. Maybe we want to say, hey,  
3 we like this particular standard still and it fits  
4 well with our system.

5           So, I think that the train was really  
6 moving on this unfortunately until the pandemic came  
7 along. And now, thank goodness, Laura has picked  
8 the torch up once again and has really wrangled a  
9 lot of people to get talking about this again to  
10 make sure that we can take our truly 25-year old  
11 standards -- that's what they are, all right --  
12 based on where they came from originally. We call  
13 them the 2010 standards, but it was really based on  
14 books before that and the standards written by the  
15 college. I know they have lots of colors of yellows  
16 and greens and, you know, oranges and this type  
17 thing. But when you really look at it, these  
18 standards are 25 years old, and we know medicine has  
19 rapidly changed in 25 years.

20           I think we can all agree on that. And so,  
21 that's the important part. But remember, that we  
22 have to look at the standards first. Once we do  
23 this, we are going to have to have a workshop and/or  
24 possibly a formal hearing on these works on this,  
25 and then we'll -- in opening the rule up, that's

1 where that activity takes place. And then we get  
2 through all of that, you know, then we're going to  
3 be able to say that the reference of statute that  
4 talks about 64J-2 and where the -- you know, the  
5 pamphlet is listed or the standards are listed, or  
6 in this case, trying to even get away from using the  
7 word pamphlet and be able to call it, you know,  
8 maybe just the Florida Trauma Standards, which would  
9 then allow us to segue into the Council being able  
10 then to review the standards on a regular basis,  
11 maybe once a year to determine if a change in the  
12 standards -- a particular standard might need to be  
13 -- you know, might be necessary in the fact of how  
14 we now practice trauma. And so, I think that it's a  
15 big thing to chew, but I think if we can get this  
16 quality work product at least into a working  
17 functional document, it allows now for the process  
18 to move forward. Does that help everybody in a  
19 short version?

20 **CHAIR DINOVA:** It's easier than trying to  
21 change the law.

22 **COUNCIL MEMBER KOCEVAR:** That it is.

23 **CHAIR DINOVA:** So, we have hope. What I'd  
24 like to say is this is our chance, okay? These are  
25 going to be the rule book -- this is going to be the

1 rule book that we have to follow, and that we as  
2 trauma centers have to abide by. So, this is our  
3 chance to have your input heard, have the rules  
4 changed so that we can meet the highest level of  
5 expectations for our patients. So, as we talk about  
6 what the process and the steps are going to be  
7 upcoming, just keep in mind, when we start talking  
8 about having meetings and comment hours and whatnot,  
9 we need your involvement. We were very fortunate  
10 before. We had 32 of the 36 trauma centers in  
11 Florida involved, and we started this process before  
12 grade book came out, and I want to get all 32 to 36  
13 of you involved again, okay? All right. Laura, we  
14 have a comment. I can't see it on here because I'm  
15 sharing here.

16 **EDMUND MILLS:** It's from Tracy Zeto  
17 (phonetic). Just wondering what timeframe would be  
18 once we have the workshop and open the rule.

19 **CHAIR DINOVA:** 21 days?

20 **COUNCIL MEMBER KOCEVAR:** Well, timeframe  
21 of what? I need a little bit more definition on  
22 what she's trying to ask of me.

23 **CHAIR DINOVA:** Timeframe for  
24 implementation, Tracy? So, I -- it looks like we're  
25 maybe not getting our -- so, I think Kate can speak

1 to how long it would have to be posted and whatnot  
2 to get the rule changed, but implementation would be  
3 a date that we would have to agree upon and set  
4 forth. I would, you know --

5 **COUNCIL MEMBER KOCEVAR:** Yeah. So, as far  
6 as, you know, the -- once the standards get through  
7 the departments and say, yes, we're going to open  
8 the rule up, we post it for 21 days. We'll let  
9 everyone, you know, make sure everyone is aware that  
10 this is going to happen. Someone may ask at this  
11 point in time, no, I want a workshop on this. And if  
12 so, then we have to host that. If someone says, no,  
13 I want a formal hearing on this and they decided  
14 that this is the request, then I have to honor that  
15 request also, and we would have a formal hearing on  
16 that. What we're hoping as we've kind of been  
17 talking about this for ad nauseum now and you  
18 realize to some extent about wanting to do this  
19 change that we have the opportunity through the  
20 comments hours, through the subcommittees, as  
21 indicated, 32 of the 36 trauma centers, you know,  
22 had participated, you know, that we're really  
23 getting a lot of feedback, you know, to how we can  
24 make sure that these standards really kind of fit  
25 everyone, all right. No one is going to win, and no

1 one's going to get all the standards just the way  
2 they see it. We know this, all right. But we're  
3 looking for a set of guidelines, a set of standards  
4 that will be beneficial to the care of the patient,  
5 and that's what we're looking to try and do.

6 **CHAIR DINOVA:** Okay.

7 **COUNCIL MEMBER KOCEVAR:** What do we have?

8 **CHAIR DINOVA:** So, Tracy said, okay, so  
9 rule gets open for 21 days with changes and then to  
10 have a workshop if someone requests. This could  
11 potentially go on for a long time. So, the 21 days  
12 is to open it up to see if anybody requests a  
13 workshop --

14 **COUNCIL MEMBER KOCEVAR:** That's correct.

15 **CHAIR DINOVA:** -- or a formal hearing.

16 **COUNCIL MEMBER KOCEVAR:** That's correct.

17 **CHAIR DINOVA:** If nobody requests a  
18 workshop or a formal hearing because we get  
19 everybody involved earlier, then after the 21 days,  
20 then we would be able to close it and then move  
21 forward with presenting it.

22 **COUNCIL MEMBER KOCEVAR:** Move forward with  
23 the formal process.

24 **CHAIR DINOVA:** For the formal process.

25 **COUNCIL MEMBER KOCEVAR:** That's right.

1 Because in my 50 slides, believe it or not, there's  
2 a whole other group that actually then has to look  
3 at it, you know, to determine any second linear of  
4 any concerns.

5 **CHAIR DINOVA:** So the rule change process  
6 is a challenge. It is a longer term process, but  
7 it's a much shorter phase than if we were to have to  
8 actually change the statute. We don't have to wait  
9 for open session or any of that kind of thing. This  
10 is something that can go through the rulemaking  
11 process instead of the full legislative process.  
12 So, correct, it's not going to be tomorrow or  
13 probably even three months from now, but we also  
14 don't have to wait for session and then have a  
15 legislator pick it up and make it a priority and  
16 then get heard and then change the bill and go  
17 through all those committee hearings. That part  
18 will be taken out because we can change it through  
19 the rule instead. I think I got that right.

20 **COUNCIL MEMBER KOCEVAR:** You got it right.

21 **CHAIR DINOVA:** Okay. Does that answer  
22 your question, Tracy? Yup. Okay. She's good.

23 **COUNCIL MEMBER KOCEVAR:** Okay. All right.

24 **CHAIR DINOVA:** Go ahead.

25 **COUNCIL MEMBER HAMILTON:** Good afternoon.



1 So, as you know, last year, the revision  
2 subcommittee began creating that crosswalk between  
3 the 2022 ACS standards and that Florida Department  
4 of Health draft standards that had been created and  
5 approved by a prior subcommittee. The crosswalk was  
6 completed and then we turned our attention to  
7 deciding which of those ACS standards should be  
8 merged into the final draft standard to update the  
9 trauma care in Florida. The recommendations were  
10 sent to FCOT and AFTC for review and feedback. The  
11 revision subcommittee met again last week to review  
12 that feedback and then talk about the next steps. I  
13 think you're pulling up --

14 **CHAIR DINOVA:** Yeah, I'm trying. He's  
15 trying to make -- I think those of you online can  
16 actually see the working document better than those  
17 of us in the room, so we're -- I think we're trying  
18 to see if we can get it to come up better on the  
19 scene because right now, it's illegible.

20 **COUNCIL MEMBER HAMILTON:** So, this is an  
21 example though of how we can approach changing this.  
22 So, all of the deletions that you don't see here,  
23 but if Lisa were to scroll down, basically I deleted  
24 the entire original standard and then I just added  
25 in the ACS 2022 equipment standards that the

1 revision subcommittee was aligned on bringing in  
2 Florida as well as the equipment -- required  
3 equipment from that draft standard as well. So,  
4 this is what it could look like. It could be very  
5 short and sweet. We could decide that it doesn't  
6 need to be by department. That didn't really seem  
7 to make much sense to me. It just if a facility  
8 needs equipment, then they need it to be readily  
9 accessible and they should be able to decide where  
10 that need is in my opinion but --

11 **CHAIR DINOVA:** We're going to try  
12 something real there.

13 **COUNCIL MEMBER HAMILTON:** Okay.

14 **CHAIR DINOVA:** Excuse me, folks.

15 **COUNCIL MEMBER HAMILTON:** Well, while  
16 we're doing that, thank you to everyone that's been  
17 helping out in the revision subcommittee and all of  
18 the work that you've done to get us to this point.  
19 And like Lisa kind of alluded to, going forward, we  
20 will be having comments hours, and this is just  
21 going to allow for discussion between the Council,  
22 the stakeholders, and the public so that we can get  
23 going on making some actual change.

24 **CHAIR DINOVA:** All right. So, it looks  
25 like we can see it online and in the room now. So,

1 what I would like to do, I know we're not voting on  
2 anything today, this is -- but if we could look at  
3 this standard, have some conversation about the  
4 changes that have been made, get some  
5 recommendations, some commentary on what's posted,  
6 this will be sort of the process that we'll have.  
7 So, our next steps from here will be that we'll be  
8 setting up some commons hours meetings. Those will  
9 be meetings where the Council can have open  
10 discussion. It will be open to our stakeholders and  
11 to the public.

12           They will be publicly noticed on the  
13 website so that anybody can have comment. And those  
14 are where I would like to encourage all of you to  
15 please log onto those meetings, get with your trauma  
16 program managers, your trauma medical directors,  
17 your administrators, and start looking at these and  
18 providing feedback during those official comments  
19 hours so that we can take all of these  
20 recommendations, present them back out to FCOT and  
21 AFTC to get their support on it because since we  
22 cannot officially vote on things here right now  
23 without our quorum, what we can do to try to move  
24 this forward is show a consensus. So, if we can get  
25 all of us involved, get everyone's feedback, get

1 that put through our state committees. So, after  
2 you got -- after we work on the comments hours,  
3 we'll be presenting these en bloc, so we'll discuss  
4 a few more of these standards at the next advisory  
5 council meeting.

6 We as a group agree on those, we'll then  
7 send them out to FCOT and AFTC so that they can  
8 discuss them at their next meetings, get any of  
9 their feedback, and make a working document so that  
10 hopefully in the next -- after the next couple of  
11 rounds of meetings that we all have, we'll actually  
12 have a full draft of new Florida standards for us  
13 that we then can present to the Department of Health  
14 as not a voted on piece, but a consensus piece from  
15 all of the stakeholders in the state as a thing that  
16 they then could take through the next steps to the  
17 lawyers to get on legalese for us, okay. So, this  
18 is what I mean about how we're just going to keep  
19 working on things. We'll take it, give our input,  
20 we'll get it to FCOT and AFTC, get their input, and  
21 then all of us together will present that to the  
22 DOH's document, okay. Yes, Dr. Ang.

23 **COUNCIL MEMBER ANG:** Darwin Ang. On the  
24 Florida Trauma System Advisory Council website, I  
25 don't see this document. Is it posted somewhere

1 else?

2           **CHAIR DINOVA:** This particular version of  
3 it is not posted yet.

4           **COUNCIL MEMBER ANG:** Okay.

5           **CHAIR DINOVA:** We were going to get it  
6 posted because we'll be posting it with the comments  
7 hours when we put the comments hours postings out.

8           **COUNCIL MEMBER KOCEVAR:** Lisa, I think you  
9 just want to explain that this was just an example  
10 of how they were going to proceed forward during the  
11 comments hours so that everyone could have an  
12 opportunity.

13           **COUNCIL MEMBER ANG:** Well, we have the  
14 most recent edited version. I understand it's a  
15 live edited version going back and forth with FCOT  
16 and AFTC.

17           **CHAIR DINOVA:** We will have a -- we will  
18 have them for the comments hours. That's what we'll  
19 be presenting is -- so for comments hours, number  
20 one, that we present out hopefully the 27th. Mm-Hmm.

21           **COUNCIL MEMBER ANG:** Yeah, I'm saying will  
22 the the members have it before the comments hours to  
23 review?

24           **CHAIR DINOVA:** Yes, we can get that sent  
25 out.

1 COUNCIL MEMBER KOCEVAR: Yes.

2 COUNCIL MEMBER ANG: All right.

3 COUNCIL MEMBER KOCEVAR: Absolutely.

4 CHAIR DINOVA: We'll have it out to our  
5 members and then we'll also post it when we post the  
6 comments hours announcement, we'll post it with that  
7 also so that everybody -- all of the stakeholders  
8 can review what was agreed upon during the  
9 subcommittee, and then we can have that discussion  
10 on each standard as we go through like we did  
11 before.

12 COUNCIL MEMBER ANG: Okay. Thank you.

13 CHAIR DINOVA: So, on this standard, since  
14 we do have it here, does anyone have any comments or  
15 questions, concerns, commentary that we could build  
16 into it prior to posting it through?

17 PETER PAPPAS, MD: Just to -- under  
18 Standard 9E, Immediate Access to Cardiac Pulmonary  
19 Bypass Capability or a contingency plan must exist,  
20 provide emergency cardiac surgical care for ones and  
21 twos, this is usually a minutes sort of situation.  
22 What kind of contingency plan were you all  
23 considering or that a center could have to still  
24 meet the standard?

25 COUNCIL MEMBER HAMILTON: This standard

1 and that wording was exactly taken out of the 2022  
2 standards from ACS.

3 **PETER PAPPAS, MD:** Okay. And do we know  
4 what the grade book standards mean or is this  
5 something that I can help with on my end in terms of  
6 clarifying these sorts of remarks?

7 **CHAIR DINOVA:** So, that would be something  
8 that if you want to get some clarification, because  
9 I know that you have the in with the ACS, if you  
10 want to get clarification of what they are  
11 considering immediate and then bring it to those  
12 comments hours, those are the kinds of things that  
13 we could then change this language to make it match  
14 what we expect as a state.

15 **PETER PAPPAS, MD:** Right. Because may be  
16 mindful someone -- I mean, you really don't have  
17 time to be driving or helicoptering people around  
18 with a gunshot wound to the chest. You either have  
19 bypass capability or you don't. So, it's just  
20 interesting to see what that might be, but I'll be  
21 happy to explain for us. Thank you.

22 **CHAIR DINOVA:** All right. So, I'll make a  
23 note there that we need to find the contingency  
24 plan.

25 **COUNCIL MEMBER HAMILTON:** Well, yeah. So

1 one of the questions that I had, you can see on J  
2 there where I put invasive and non-invasive  
3 hemodynamic monitoring capabilities, and I wanted to  
4 ask this group if you guys are okay with that  
5 language as opposed to listing out pulse oximetry  
6 and title monitoring on A lines as opposed to  
7 separating them out like that?

8 **COUNCIL MEMBER ANG:** I think it's good to  
9 be general. There's a lot of new technology out  
10 there.

11 **COUNCIL MEMBER HAMILTON:** That's what I  
12 was --

13 **COUNCIL MEMBER ANG:** Right. Different  
14 institutions use for especially measuring preloaded  
15 minimum. And these invasive lines are older  
16 technology, more transcutaneous ways of measuring  
17 changes in pulse pressure, blood volume variation,  
18 things like that. So, I think just keeping it in  
19 general is good idea.

20 **COUNCIL MEMBER HAMILTON:** The ACS  
21 notations are just showing which of the items, which  
22 is E, L and M are the 2022 ACS standards that the  
23 revision subcommittee recommended for alignment.  
24 So, I just wanted to note those. And, you know, I  
25 think it's currently the pamphlet 150-1 is split up



1 into level one, level two and pediatric, and I think  
2 the big question moving forward is should that stay  
3 all separated or should we have one document that  
4 says level one here, level two there just as we move  
5 forward and we are setting it up.

6 **CHAIR DINOVA:** So, my comment for that --  
7 this is Lisa -- is I think just as the ACS has moved  
8 towards this, I think having one document and then  
9 if there is something specific to one of the levels  
10 noting that in that that same paragraph is probably  
11 easier than having three separate documents as it is  
12 right now because technically right now we have  
13 basically three books to one set of standards. So,  
14 my suggestion would be to leave it all in line and  
15 then just make specialty notifications, if needed,  
16 in the same paragraph. I don't know what anybody  
17 else thinks about that.

18 **COUNCIL MEMBER MCKINNEY:** What do you mean  
19 specialty notifications? Like this applies to level  
20 one?

21 **CHAIR DINOVA:** Yes. So, there's certain  
22 ones that'll just say in parentheses, for level one  
23 you have to do this, for pede you have to have that,  
24 but they just have one standard listed instead of  
25 right now we have level one standards, level two

1 standards, and pede standards that are basically  
2 repeats of each other with little word changes here  
3 and there. I know when I was trying to do the  
4 crosswalk, trying to figure out what was different  
5 just between those three documents was challenging.  
6 So, having it all on one standard, you know,  
7 Standard 4.12 is this, and if there's something  
8 specific that level ones need to have or level pedes  
9 standards needs to have, then you would mark that in  
10 4.12 still.

11 **COUNCIL MEMBER MCKINNEY:** Sounds good to  
12 me.

13 **CHAIR DINOVA:** I see head shaking -- I see  
14 nodding in the crowd. Okay. So, tell me if I'm  
15 wrong, crowd. I think the crowd agrees with one  
16 document with specialty -- notifications is the word  
17 that keeps coming up. Notations. Specialty  
18 notations as needed. Yes. All right. Okay. I'm  
19 going to take that as general comment.

20 **COUNCIL MEMBER KOCEVAR:** But -- this is  
21 Kate -- I think obviously as we get to the comments  
22 are is we can, you know, have you kind of draft out  
23 an example of how that notation would be indicated  
24 so that everyone has that understanding of whether  
25 it all applies to level one, applies level two,

1 applies to level pedes, this type thing. So, I  
2 think that we could certainly take a look at how the  
3 ACS has framework their guidelines and do something  
4 similar so that we don't have aggressive change in  
5 trying to understand how to look at things.

6 **CHAIR DINOVA:** Just trying to save these  
7 comments so that we have it in the document. All  
8 right. Anyone want to --

9 **COUNCIL MEMBER KOCEVAR:** And again, one  
10 thing I just want to remind everyone, too, the  
11 comments are is, you know, is the council meeting is  
12 sunshine. There'll be no voting going on during  
13 that time, all right. But we will be also for --  
14 you know, for those who may have participated in the  
15 comments hours prior, they were very effective. They  
16 allowed the Council to kind of discuss business  
17 first. Stakeholders were then able to discuss and  
18 provide some information to the Council as well as  
19 the general public. So, it is open to everyone to  
20 participate. There's just that we always have the  
21 council members discuss, you know, their thoughts  
22 first and then it kind of goes down the line. But  
23 at this point in time, no voting is ever done during  
24 that time on -- it is purely to have the public  
25 understanding what the Council is trying to address,

1 and the Council then have the opportunity to hear  
2 from the public.

3 **CHAIR DINOVA:** All right. Did you want to  
4 --

5 **COUNCIL MEMBER HAMILTON:** The last  
6 question about this document is prior to all of the  
7 deletions, it was all separated for trauma  
8 resuscitation area, ICU, I think med-surg, PACU,  
9 whatever, it was all separated out, and then there  
10 was different equipment listed under each  
11 department. And it seems to me that having a list  
12 of required equipment and then allowing the  
13 facilities to make sure that there's immediate  
14 access in the areas they're needed is better than  
15 saying that, well, on med-surg, you need to have  
16 this one thing right here. Maybe it's not in that  
17 facility workflow or doesn't work for all  
18 facilities.

19 **COUNCIL MEMBER NAMIAS:** So maybe, but  
20 maybe not. I mean, we just need to provide a  
21 minimum standard, right? I mean, you don't now have  
22 a med-surg without a, I don't know, Ambu bag  
23 somewhere or a code card. So, you know, I think  
24 that resus units -- you know, resus bays need  
25 different things than PACU need different things and

1 operating rooms.

2 **COUNCIL MEMBER HAMILTON:** For sure. But  
3 shouldn't the facility be the one to decide and --

4 **COUNCIL MEMBER NAMIAS:** I don't know.

5 **COUNCIL MEMBER HAMILTON:** The  
6 establishment of an airway is on their immediate  
7 access, too. So, in my mind, it covers all areas,  
8 but maybe it doesn't.

9 **COUNCIL MEMBER ANG:** You know, one of the  
10 places that gets overlooked, for example, is PACU or  
11 when you get a surveyor national state, one of the  
12 first things they ask is and what's going to happen  
13 is, you know, where is your pede's code card or  
14 where's your chest tube, you know, card or something  
15 like that. So, somebody needs it, I think there  
16 appears to be some usefulness in that because there  
17 are situations where, you know, on a regular basis,  
18 you're not going to see a lot of those, but if you  
19 need it, you need it. If you don't need something  
20 until you actually need it. And it's that scenario  
21 that trauma, we try to be all encompassing in a way,  
22 as you know, to try to save people's lives. And I  
23 think there are, it's -- if you leave it up to the  
24 institution, I think the concern is if you leave it  
25 up to the individual hospitals, they put emphasis on

1 different things, trauma may not be the main thing  
2 they look at, and so you might miss some of those  
3 things. Because of that, you might want to  
4 emphasize, you know, something needs to be done in  
5 your PACU should immediately post-op where a patient  
6 doesn't do well, you know? So, I think that's the  
7 concern that I would see; not specifying certain  
8 places meeting the bare minimum. I think if you  
9 leave it up to institutions, you know, not that they  
10 have any mal intent, but they just might overlook it  
11 because of what they're focused on.

12 **COUNCIL MEMBER HAMILTON:** Sure. Thank you  
13 for that feedback. So, what I'm hearing is let's  
14 just keep it simple. Okay. Questions? All right.

15 **CHAIR DINOVA:** Yes.

16 **MICHAEL TAYLOR:** Michael Taylor from  
17 Hillsborough County. So -- and Kate, my question is  
18 to you. The difference between ACS verification and  
19 state standards is that ACS verification is nothing  
20 that you could be held to, but the state standards  
21 is exactly what you can be legally held to. So,  
22 Kate, if you go into a trauma center and you know,  
23 where's your resuscitation bag and you say, where's  
24 the Ambu bag, we, we have that up in the ICU,  
25 technically, the standard says that they need an

1 Ambu bag. It doesn't say that they have to have it  
2 in their resuscitation bay. It's they have it, so  
3 now they're technically at medical standard, and the  
4 state can't ding them on it. So, by keeping it --  
5 by keeping it general, like you suggest, Laura,  
6 Kate, are you going to be able to enforce these  
7 silly little things that we hope don't make sense  
8 and the hospitals would, you know, would understand  
9 that they need to have an Ambu bag in the  
10 resuscitation bay. But if Kate doesn't find the  
11 Ambu bag, is she going to be able to ding the trauma  
12 center on that? Do you understand what I'm asking,  
13 what I'm saying?

14 **CHAIR DINOVA:** I do.

15 **MICHAEL TAYLOR:** Okay.

16 **CHAIR DINOVA:** So, I think that --

17 **MICHAEL TAYLOR:** It's just -- you know, is  
18 it -- you're writing a standard that's supposed to  
19 be enforceable under state law. If it's not  
20 enforceable under state law, you don't want to set  
21 yourself up for failure in that way, and we've all  
22 seen that happen in the past. Hospitals and  
23 facilities have gotten out of being dinged because  
24 of the way the state wrote its laws, regulation,  
25 standards. I just caution you, be careful in

1 writing these -- how you write these standards; that  
2 they can be enforced the way you think that they  
3 ought to be.

4 **CHAIR DINOVA:** Yeah. So, it sounds like  
5 everyone is saying beware of being too general with  
6 things, making sure that we have at least a list of  
7 at least minimum requirements for each of the areas.  
8 Okay. We will fix that before the next comments  
9 hour is in. Okay. Anything else?

10 **COUNCIL MEMBER HAMILTON:** Just look out  
11 for the invites, and please, please participate.  
12 The more participation that we have and the better  
13 consensus that we get from that participation would  
14 be less chance of us having to take anything to a  
15 hearing. And hopefully, we can just work together  
16 to go through the rulemaking and that process  
17 without having to have some long drawn-out  
18 legislative ratification.

19 **PETER PAPPAS, MD:** And these will be  
20 available on the website for everyone to look at?

21 **COUNCIL MEMBER HAMILTON:** Yes.

22 **CHAIR DINOVA:** So, the next steps that  
23 we'll be taking for this process then is we'll be  
24 getting a list of dates together. I think that  
25 we're just going to start back up with we were doing



1 rolling Tuesday, Wednesday, Thursday meetings for  
2 the subcommittee so that -- and later in the  
3 afternoon so that everybody -- that seemed to be  
4 when everybody could participate the most. So,  
5 we'll get those dates reposted and we'll have  
6 several -- the next several meetings scheduled in  
7 advance. We'll get the links set up for them. We'll  
8 get the working document posted with it. And then  
9 we'll open up those comments hours sessions so that  
10 we can start having those open in the sunshine  
11 discussions about these and start going line by line  
12 about what you guys as the stakeholders would like  
13 to see in our new set of standards. You look like  
14 you want to say something. All right. Come on up,  
15 Susan.

16 **SUSAN EMMA:** Susan Emma (phonetic). I  
17 just -- we seem -- for some people that have been  
18 here for a while, this seems a little bit like  
19 Groundhog's Day.

20 **CHAIR DINOVA:** It is.

21 **SUSAN EMMA:** So I think that that's what  
22 the epiphany was, is that we're doing the same thing  
23 over again. And so, we asked what the next steps  
24 were and how we could not end up in the same spot  
25 with no standards. And so, the idea I think is to

1 when we're looking at it this go around, we need to  
2 make sure that we're not creating another layer of  
3 things that are going to slow us down, and not  
4 complicating things. And from what I'm  
5 understanding is that if we are going to reach that  
6 financial threshold, that there -- not just the  
7 rulemaking process, but it also prolongs and adds  
8 another layer of steps that we have to go through  
9 that will prolong things. So, I just want to make  
10 sure that we're not going through the definition of  
11 insanity again and doing the same thing, expecting  
12 the same result, and not creating more work for  
13 ourselves and prolonging this process again, and  
14 then ending back up at the same spot.

15 **COUNCIL MEMBER ANG:** Yes, and I agree with  
16 you. And so, I chaired the subcommittee last time.  
17 So yes, I totally feel like I'm banging my head on  
18 the wall. However, with that being said, we now  
19 have the new understanding that we don't have to go  
20 through the full legislative process, that we can do  
21 this through the rulemaking process instead. And I  
22 think we had gotten to a full working document. We  
23 were ready with a draft when the 2022 standards from  
24 the ACS came out. And I think that's what kind of  
25 made us have to restart this, but I think because

1 we've had a lot of these conversations before  
2 already, I think that this will be a much swifter  
3 process. I hate to even say anything out loud  
4 that's going to be recorded for perpetuity, but my  
5 hope will be that by the end of this year that we  
6 will have at least a draft of the full standards,  
7 able to say that we as the stakeholders have gone  
8 through. We've looked at every line, and here's our  
9 input. So, I don't want to do the groundhog thing  
10 again. This has been three years of this. I get  
11 it. I want to try to push this forward and push  
12 this through now this time. But the easiest way to  
13 make that happen is to have those conversations and  
14 that discussion during these open comments hours  
15 because the Council will be on -- as many of us as  
16 possible will be on those calls, you guys as the  
17 stakeholders will be on, and everybody's voices can  
18 be heard most easily through there.

19 **SUSAN EMMA:** I just -- I want to make sure  
20 that we mention when we're moving forward and having  
21 the comments hours that we're mentioning that, and  
22 I'll use a quote from one of our wise TPMS in the  
23 state that we're not making perfection --

24 **CHAIR DINOVA:** Yes.

25 **SUSAN EMMA:** -- slow down progression, and

1 if we're adding a lot of the pie in the sky, the  
2 things that we definitely need and can utilize that  
3 are going to create a financial burden such as  
4 additional FTEs, which again, are needed, but if  
5 we're creating those, that we're meeting that  
6 financial burden, and already we're getting further  
7 down the road. So, I want to make sure that  
8 everybody understands that while we do want this  
9 perfection in order to maybe get into product, in  
10 the short term, we might have to --

11 **CHAIR DINOVA:** Set minimum standards.

12 **SUSAN EMMA:** Yes.

13 **CHAIR DINOVA:** Agreed, that we're looking  
14 for -- these are the minimum things that we as a  
15 community agree that we need to have. Anything  
16 above and beyond this is fantastic. But I agree  
17 with you. We don't want to try to bog down the  
18 system with what might be considered demands for  
19 like our FTE process and stuff. So, I agree with  
20 you.

21 **SUSAN EMMA:** Which again, definitely  
22 needed.

23 **CHAIR DINOVA:** Definitely want them.

24 **SUSAN EMMA:** Definitely needed.

25 **CHAIR DINOVA:** Definitely need them.

1           **SUSAN EMMA:** And then my other question,  
2 Kate, you mentioned that the pamphlet is mentioned  
3 in rule, and the rule is mentioned in statute. Does  
4 the statute refer to the pamphlet by name or does it  
5 just mention standards?

6           **COUNCIL MEMBER KOCEVAR:** It just mentions  
7 the trauma standards, and then it was the rule, the  
8 64J.

9           **SUSAN EMMA:** Okay. So, it doesn't  
10 actually mention the pamphlet?

11           **COUNCIL MEMBER KOCEVAR:** Correct. And I  
12 think that was where they -- misconstrued came for  
13 so long that everybody kept thinking that it said  
14 Florida Trauma -- (Crosstalk) -- 159 in the statute.  
15 And when I went back and kept looking at it, I'm  
16 thinking, where is everybody saying this? I don't  
17 see it. It mentions the rule. The rule that is  
18 where it's mentioned as I think we're guiding the  
19 rule and statute kind of interchanged.

20           **SUSAN EMMA:** Yeah. And I think that's  
21 really important for --

22           **COUNCIL MEMBER KOCEVAR:** Yes.

23           **SUSAN EMMA:** (Crosstalk) -- understand  
24 that. So, the pamphlet does not refer to in the  
25 statute.

1           **COUNCIL MEMBER KOCEVAR:** Right.

2           **SUSAN EMMA:** And that if we don't create  
3 anymore layers of complication for us, that we might  
4 able get an end product in through. That's the goal

5           **CHAIR DINOVA:** Yes, that's --

6           **SUSAN EMMA:** Okay.

7           **CHAIR DINOVA:** That is definitely the  
8 goal.

9           **SUSAN EMMA:** Okay. Awesome. Thanks.

10          **CHAIR DINOVA:** Anything else? Yes. Come  
11 on up.

12          **MICHAEL TAYLOR:** Michael Taylor from  
13 Hillsborough County. So, I'll ask the question, but  
14 please don't kill me. If now we know that there's a  
15 path forward that it's not the statute that has to  
16 be changed, that it's the rule, and then why not  
17 change the rule to eliminate the pamphlet and adopt  
18 ACS? Is there -- what -- so, I've been here three  
19 and a half years in my position as trauma municipal  
20 coordinator for Hillsborough County, and all along,  
21 I keep saying, well, we have to decide if we're  
22 going to move to ACS, move ACS, move to ACS, and  
23 then went through the process of revising of  
24 revising 159, the pamphlet. What -- it's been in  
25 the process so long, I forget the history here and I

1 guess I'm just asking you to refresh my memory,  
2 maybe the memory of other people. If it's just a  
3 matter of changing rule, could we not change the  
4 rule to eliminate, delete pamphlet 159 or the rule  
5 and switch it to say that you have to be ACS  
6 verified? And then if there are other things that  
7 ACS verification doesn't provide, you can add those  
8 into that same rule as part of the standards is --

9 **CHAIR DINOVA:** So there's --

10 **MICHAEL TAYLOR:** I just -- again, don't  
11 shoot me. I'm just asking the question.

12 **CHAIR DINOVA:** So, there's two things with  
13 that, and part of it is exactly what you just said,  
14 is that there are things that Florida has and  
15 addresses that the ACS does not. The ACS is the  
16 American College of Surgeons. So, everything is  
17 very physician based and does not address things  
18 like nursing, education, and those kinds of things.  
19 So, that is something that Florida has that the ACS  
20 does not. But the other thing with that is, just to  
21 Susan's point, there are some challenges that would  
22 go with the ACS verification because there are  
23 additional FTE requirements. There are additional  
24 equipment requirements that would then put us over  
25 the 200,000 per year, 1 million in five years rule.

1 So, that would add additional layers to us -- to  
2 doing that, and actually would prolong the process.

3 **MICHAEL TAYLOR:** Yes.

4 **CHAIR DINOVA:** So, I think that's where we  
5 came upon the agreement before was we couldn't just  
6 adopt them outright because there was going to be  
7 too much of a financial burden to the centers.

8 **MICHAEL TAYLOR:** Okay.

9 **CHAIR DINOVA:** Is that correct, Kate? I  
10 believe that was the --

11 **COUNCIL MEMBER KOCEVAR:** I think that --  
12 yeah, that was kind of the gist.

13 **CHAIR DINOVA:** Yeah.

14 **COUNCIL MEMBER KOCEVAR:** I mean, there are  
15 things that we have -- we see now in the grade book,  
16 for example, they actually do talk a little bit  
17 about nursing education now that they've never done  
18 before. So, that was one of the reasons we were  
19 waiting to see what the grade book would come out  
20 with. They'd come out with the idea of outreach  
21 programs and, you know, trying to participate with  
22 that. Well, there are dollars and cents that go  
23 with that, too, you know and so --

24 **MICHAEL TAYLOR:** Yeah.

25 **COUNCIL MEMBER KOCEVAR:** But ironically,



1 it already had that, you know, as part of their  
2 standards. So, I think that there was kind of  
3 beneficial, you know, information shared back and  
4 forth as we saw the new grade book come out. I  
5 think that though the other big thing that we have  
6 to recognize is that adopting the ACS as the  
7 designation and the process, this type thing is also  
8 going to put a costly burden because you pay for  
9 that, all right. And that's -- or, you know -- and  
10 so, it's part of that we have to all think about,  
11 you know, that there may be some centers who don't  
12 bear the burden as maybe other centers might bear  
13 that burden. And then so, we have to be cognizant  
14 of that as we look at that because we are a trauma  
15 system; not just one big trauma center. And so, we  
16 have to really look at how we distinguish that, and  
17 to ensure that the quality of care, the optimal  
18 level of care that's provided, whether it's in north  
19 Florida, south Florida, or central Florida is going  
20 to be what everyone should be receiving.

21 **MICHAEL TAYLOR:** Thank you for refreshing  
22 memories and clarifying that.

23 **CHAIR DINOVA:** Yes, sir. Thank you.  
24 Okay. Anyone else? No. I haven't heard anything  
25 ping online lately. Okay. All right. So, that's

1 how this will flow. Be on the lookout for those  
2 comments hours postings, for the working document to  
3 be posted, and please get everybody involved that  
4 would like to have a say in the rules that we have  
5 to follow. Okay. All right.

6 So, for future business, I'm open to  
7 suggestions. Just a quick wrap up of once we have  
8 quorum, we will need to formally vote on our  
9 previous business that we've addressed, which was  
10 our bylaws update, our charter update. We will also  
11 have to address my position and Candace's position  
12 as moderator and co-moderator because those are one-  
13 year terms that are up now. So, we'll need to  
14 address that situation when we get a quorum.

15 And then for our action items out of this  
16 meeting, Dr. Namias will be helping draft that  
17 letter about the board certification. Dr. McKinney  
18 will be drafting a letter for the pede's TQIP  
19 collaborative. I'm going to be getting those  
20 comments hours, dates, and times from Laura and then  
21 get them over to Kate to get those posted for you  
22 guys. And do we have anything else for future  
23 business that we need to address? So, here's where  
24 I'm supposed to open it up for public comment. I  
25 have kind of a laissez faire approach to this as

1 evidenced by I just let you talk whenever you want  
2 to. So, does anybody have any further public  
3 comment that we need to discuss right now? Okay.

4 **COUNCIL MEMBER MCKINNEY:** Do we have a  
5 date on the next meeting?

6 **CHAIR DINOVA:** So, the next meeting is my  
7 next slide. It's to be determined. So, there has  
8 been a couple of calendar conflicts that have come  
9 up that we actually discovered one of this morning.  
10 Our next meeting for this council may actually wind  
11 up being a virtual meeting in August as we work with  
12 the FCOT and AFTC to determine when their next  
13 meeting is going to be in October in Gainesville is  
14 my understanding. So, we may be reaching out to the  
15 folks that are hosting that and trying to hook up  
16 with them in October. So, instead of trying to get  
17 everybody to travel in August or September, and then  
18 again in October, we may do virtual for our next one  
19 sometime in August and then travel in October. Our  
20 bylaws did allow for that. So, we would still be in  
21 good standing with that. So, I suspect that's where  
22 we're going to lean on. We're going to have to team  
23 up with Dr. Pappas and the folks at Gainesville to  
24 see if they are able to host us with that. So, next  
25 meeting, TBD, but we will get those dates out as

1 soon as we get those finalized through. All right.  
2 Anything else before we go to the order? Because if  
3 not, we're calling this a short meeting, my friends.

4 **CHAIR KEMP:** Madam Chair?

5 **CHAIR DINOVA:** Yes, sir.

6 **CHAIR KEMP:** Just very quickly, this is  
7 probably my last meeting in person. I may be at the  
8 August one or not, depending on what's going on, but  
9 I just wanted to tell everybody thank you for all  
10 the membership, for accepting that I know you had no  
11 choice. The Governor appointed me just like you  
12 did. But anyways, I appreciate it. I appreciate  
13 the discussion. I've learned a lot, and I  
14 appreciate you allowing me to provide the EMS  
15 perspective. So, I just would like to leave you  
16 with two thoughts. First, don't forget about pre-  
17 hospital care. It's very important. You don't have  
18 a patient unless EMS brings them in good enough for  
19 you to do what you do. So remember, once you move  
20 in the future to things beyond the grade book and  
21 Florida standards, which is paramount, that's the  
22 first thing, but remember, you need to think about  
23 the pre-hospital care component. We need to have  
24 the appropriate training, the appropriate equipment  
25 for pre-hospital care to do their job, to get the

1 patient to you in the right manner. The second  
2 thing is who knew but trauma in Florida has politics  
3 and money involved. Who would guess that?

4 I, of course, and one of the non-trauma --  
5 not non-trauma surgeon members, and I'm not in that  
6 direct flow of politics as it were, but I would just  
7 leave with you, when you come to these decisions and  
8 you need -- and you've got to come to something,  
9 rather than look at the political view of things,  
10 just ask a simple question: What is best for the  
11 patient in the state of Florida? What's going to  
12 keep them alive? What's going to be best for them?  
13 And then I think you can't go wrong if that's your  
14 measuring stick. So, once again, thank you. And I  
15 will say this, that the best part of being on a  
16 Council like this is that many of you not only are  
17 colleagues now but I can call your friends, and I  
18 appreciate that, and I appreciate each one of you.  
19 So anyway, continue on. Fight the good fight.  
20 Thank you.

21 **(Applause)**

22 **CHAIR DINOVA:** So, I'm hoping that Mac  
23 will be at our next meeting, even if it is virtual.  
24 I was going to wrap up by saying thank you for all  
25 of your participation in this Council, and on a

1 personal note, for being a mentor for me. You've  
2 said a great example for me coming up on how to be a  
3 good leader, and I appreciate everything that you've  
4 taught me in the last few years that I've gotten to  
5 know you. So, it won't be the same without you, but  
6 I hope you get to relax and rest some. You've done  
7 a lot of work for us around the state. So, thank  
8 you.

9 **CHAIR KEMP:** Thank you.

10 **CHAIR DINOVA:** All right. Before I cry,  
11 anything further? If not, meeting is adjourned.

12 **(The meeting concluded at 2:32 p.m.)**

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CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF BROWARD

I, STELLA KIM, Court Reporter and Notary Public for the State of Florida, do hereby certify that I was authorized to, and did stenographically report and transcribe the foregoing remote proceedings, and that the transcript is a true and complete record of my stenographic notes.

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

Dated this 26th day of June, 2023.



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STELLA KIM, COURT REPORTER  
NOTARY PUBLIC, STATE OF FLORIDA  
Commission No.: FF 018987  
Commission Exp: 05/19/2025

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