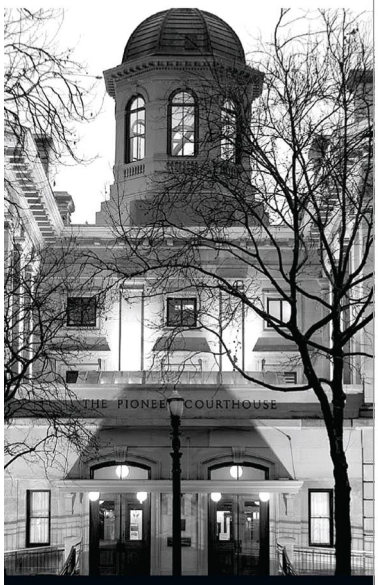

FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL

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

FLORIDA TRAUMA SYSTEM ADVISORY COUNCIL

Mac Kemp, Chair

Lisa DiNova, Chair

Laura Hamilton

Mark McKinney

Kate Kocevar

Darwin Ang

Nicholas Namias

Joseph Ibrahim

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?

CHAIR KEMP: Here.

COUNCIL MEMBER KOCEVAR: Mark McKinney?

COUNCIL MEMBER MCKINNEY: Yeah.

COUNCIL MEMBER KOCEVAR: Nicholas Namias?

COUNCIL MEMBER NAMIAS: Here.

COUNCIL MEMBER KOCEVAR: David Summers?

COUNCIL MEMBER SUMMERS: Remotely.

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

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

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

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

COUNCIL MEMBER NAMIAS: I have a quick question.

CHAIR DINOVA: Yes, sir.

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

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

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

COUNCIL MEMBER KOCEVAR: Lisa?

CHAIR DINOVA: Yeah.

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

CHAIR DINOVA: Indeed.

COUNCIL MEMBER KOCEVAR: Okay.

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

COUNCIL MEMBER KOCEVAR: Very good. Thank you.

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

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

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

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

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

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

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

And so, I will continue to kind of monitor

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

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

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

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

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

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

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

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

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

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

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

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

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

American College of Surgeons alternate pathway.

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

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

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

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

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

CHAIR DINOVA: That seems very --

COUNCIL MEMBER NAMIAS: I'll prepare it.

CHAIR DINOVA: Mixed data.

CHAIR KEMP: Next question back there.

CHAIR DINOVA: Yes. Yes, Dr. Ginzburg. Come up.

ENRIQUE GINBZRUG, MD: (Inaudible)

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

ENRIQUE GINZBURG, MD: (Inaudible) Enrique Ginzburg, Jackson South, Trauma Medical Director. Just to clarify, you're talking about

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

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

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

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

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

CHAIR DINOVA: Right, just go through --

COUNCIL MEMBER KOCEVAR: Right. It was in

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

CHAIR DINOVA: Okay. We can start from there.

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

CHAIR DINOVA: Okay. Thank you.

COUNCIL MEMBER KOCEVAR: You're welcome.

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

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

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

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

COUNCIL MEMBER KOCEVAR: That is correct.

MICHAEL TAYLOR: -- before it can be made

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

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

MICHAEL TAYLOR: Okay. Thank you.

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

COUNCIL MEMBER KOCVAR: Okay.

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

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

whole blood now or moving toward that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

optimal care for our patients. Thank you.

CHAIR DINOVA: Thank you, Dr. Pappas. Anyone in the room or on the line have any questions or comments for Dr. Pappas and the FCOT?

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

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

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

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

TQIP.

COUNCIL MEMBER MCKINNEY: Good idea.

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

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

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

CHAIR DINOVA: Brian Hart.

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

CHAIR DINOVA: Okay.

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

CHAIR DINOVA: As you guys all know, I

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

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

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

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

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

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

COUNCIL MEMBER NAMIAS: Dr. McKinney volunteers.

CHAIR DINOVA: I love it.

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNCIL MEMBER KOCEVAR: That it is.

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

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

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

CHAIR DINOVA: 21 days?

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

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

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

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

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

CHAIR DINOVA: Okay.

COUNCIL MEMBER KOCEVAR: What do we have?

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

COUNCIL MEMBER KOCEVAR: That's correct.

CHAIR DINOVA: -- or a formal hearing.

COUNCIL MEMBER KOCEVAR: That's correct.

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

COUNCIL MEMBER KOCEVAR: Move forward with the formal process.

CHAIR DINOVA: For the formal process.

COUNCIL MEMBER KOCEVAR: That's right.

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

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

COUNCIL MEMBER KOCEVAR: You got it right.

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

COUNCIL MEMBER KOCEVAR: Okay. All right.

CHAIR DINOVA: Go ahead.

COUNCIL MEMBER HAMILTON: Good afternoon.

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

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

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

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

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

COUNCIL MEMBER HAMILTON: Okay.

CHAIR DINOVA: Excuse me, folks.

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

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

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

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

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

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

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

else?

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

COUNCIL MEMBER ANG: Okay.

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

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

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

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

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

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

COUNCIL MEMBER KOCEVAR: Yes.

COUNCIL MEMBER ANG: All right.

COUNCIL MEMBER KOCEVAR: Absolutely.

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

COUNCIL MEMBER ANG: Okay. Thank you.

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

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

COUNCIL MEMBER HAMILTON: This standard

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

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

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

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

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

COUNCIL MEMBER HAMILTON: Well, yeah. So

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

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

COUNCIL MEMBER HAMILTON: That's what I was --

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

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

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

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

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

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

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

COUNCIL MEMBER MCKINNEY: Sounds good to me.

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

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

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

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

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

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

CHAIR DINOVA: All right. Did you want to --

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

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

operating rooms.

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

COUNCIL MEMBER NAMIAS: I don't know.

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

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

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

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

CHAIR DINOVA: Yes.

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

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

CHAIR DINOVA: I do.

MICHAEL TAYLOR: Okay.

CHAIR DINOVA: So, I think that --

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

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

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

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

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

COUNCIL MEMBER HAMILTON: Yes.

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

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

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

CHAIR DINOVA: It is.

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

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

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

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

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

CHAIR DINOVA: Yes.

SUSAN EMMA: -- slow down progression, and

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

CHAIR DINOVA: Set minimum standards.

SUSAN EMMA: Yes.

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

SUSAN EMMA: Which again, definitely needed.

CHAIR DINOVA: Definitely want them.

SUSAN EMMA: Definitely needed.

CHAIR DINOVA: Definitely need them.

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

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

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

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

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

COUNCIL MEMBER KOCEVAR: Yes.

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

COUNCIL MEMBER KOCEVAR: Right.

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

CHAIR DINOVA: Yes, that's --

SUSAN EMMA: Okay.

CHAIR DINOVA: That is definitely the goal.

SUSAN EMMA: Okay. Awesome. Thanks.

CHAIR DINOVA: Anything else? Yes. Come on up.

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

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

CHAIR DINOVA: So there's --

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

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

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

MICHAEL TAYLOR: Yes.

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

MICHAEL TAYLOR: Okay.

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

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

CHAIR DINOVA: Yeah.

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

MICHAEL TAYLOR: Yeah.

COUNCIL MEMBER KOCEVAR: But ironically,

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

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

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

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

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

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

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

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

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

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

CHAIR KEMP: Madam Chair?

CHAIR DINOVA: Yes, sir.

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

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

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

(Applause)

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

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

CHAIR KEMP: Thank you.

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

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

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.

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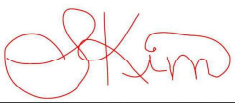

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