

Transcript of Florida Trauma System Advisory Council
(FTSAC) Meeting

DATE TAKEN: Thursday, October 5, 2023

TIME: 12:12 p.m. - 2:07 p.m.

PLACE: UF Health Professional Park
330 SW Williston Road
1st Floor
Gainesville, Florida 32608

STENOGRAPHICALLY REPORTED BY:

Erica Owen, Notary Public
and Florida Professional Reporter

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A P P E A R A N C E S

Lisa DiNova	FTSAC moderator
Candace Pineda	FTSAC co-moderator
Kate Kocevar	FDOH trauma section administrator
Laura Hamilton	Bayfront Health trauma program manager
Dr. Peter Pappas	FCOT chairman
Dr. Darwin Ang*	HCA Florida Ocala
Dr. Mark McKenney*	HCA Florida Kendall
Dr. Tracy Zito	Orlando Health
Dr. Steve Smith	UF Health Gainesville
Dr. Michael Taylor	Lakeland Regional Health
Dr. David Ebler*	UF Health Jacksonville
Dr. Michael Taylor	Lakeland Regional Health
Dea Sowers	St. Joseph's Children's Hospital
Lianne Brown*	Ascension Sacred Heart Pensacola
Melanie Sinclair*	Ascension Sacred Heart Pensacola
Susie Mitchell*	
Amy Berger	
Alisha Douglas	Lakeland Regional Health
Tabitha**	
Magda**	Jax South

* Participating via Microsoft Teams

** Unidentified speakers

1 Meeting began at 12:12 p.m.:

2 MS. DINOVA: Okay. Welcome, everyone. I'm
3 going to go ahead and call this meeting to order of
4 the Florida Trauma System Advisory Council and our
5 stakeholder meeting for October 5th.

6 Thank you to all of you who are here in
7 person. I love this. And thank you to all who
8 joined online. I see that there are a ton of you.
9 I hope that you can hear us and see our screen
10 well.

11 A few housekeeping things to -- to go over is
12 if you are online, please make sure that your
13 microphone is muted unless you are getting ready to
14 make a comment. If you are going to make a
15 comment, please state your name and your facility
16 before doing so so that our court reporter, who is
17 here in the room can, catch that information for --

18 (Brief interruption.)

19 MS. DINOVA: I don't know how to make that
20 stop.

21 Sorry. We were making sure that we have
22 everybody muted because we're getting a lot of
23 feedback.

24 MS. KOCEVAR: Hold on. Everyone who is
25 online, please mute.

1 MS. DINOVA: Okay. So a couple more
2 housekeeping things so I can finish up, since I've
3 completely lost my train of thought, is that there
4 will be no official voting at this meeting today.
5 As you know all, we don't have a consensus to do
6 that voting.

7 But what we are working on is creating a
8 consensus document and having consensus minutes to
9 go forward and keep the business of this council
10 active as we wait for the appointment process to
11 move through. We're going to talk about some of
12 that in a bit.

13 As we are a state meeting, will you please
14 rise and state the pledge of allegiance with me.

15 THE GROUP: (Complies.)

16 MS. DINOVA: Thank you very much.

17 So moving through our agenda, the next thing
18 would be for meeting minutes. Because we cannot
19 vote to approve minutes, I just want to remind
20 everyone that they are now posted on the FTSAC web
21 page on the Florida health website. So just go to
22 the DOH website, look for trauma and then find the
23 Trauma System Advisory Council, and those court
24 reported minutes are posted there for your review.

25 We are also going to have a couple of updates,

1 but first, I need to do a roll call for council
2 members. It will only take a second.

3 Dr. Ang, are you on the line?

4 Okay. Dr. Nemias?

5 Dr. McKenney?

6 Okay. And myself. I'm here. Glad to see
7 you-all today.

8 MS. KOCEVAR: Lisa DiNova.

9 MS. DINOVA: Lisa DiNova. Sorry. I'm so used
10 to having the thing.

11 All right. We're going to move straight into
12 doing some updates. We're going to start off with
13 Ms. Kate from the state and have her give our DOH
14 update, please.

15 Oh, if you're online, you don't get to witness
16 the fact that we have a lavalier mic taped to a
17 water bottle, so we're passing it back and forth.
18 Please excuse the background noise.

19 MS. KOCEVAR: All right. So thank you, Lisa.
20 Appreciate it.

21 Kate Kocevar from the Florida Department of
22 Health, trauma section administrator. First update
23 will be regarding the council. As you know, back
24 in July, we did --

25 (Brief interruption.)

1 MS. KOCEVAR: We were -- we were instructed to
2 try and collect applications from individuals who
3 wanted to serve. Please understand that we were
4 just the collection body to such a thing. We did
5 receive applications and the necessary information
6 that was required. We then provided that to our
7 bureau chief, on to our division director, and it
8 is currently, as far as I know, with the DOH
9 leadership. So we were just the deliverer of the
10 package. All right? So I want to make sure
11 everybody understands that.

12 At this point in time, it's still a
13 gubernatorial appointment, and that is what we are
14 waiting to see what happens. So as soon as we have
15 some information, we will be glad to pass it on to
16 everyone else.

17 Secondly is the trauma system assessment. As
18 I have stated in our meetings prior -- some have
19 heard this numerous times; others will hear it for
20 the first time -- the assessment --

21 (Brief interruption.)

22 MS. KOCEVAR: -- was actually completed as
23 required on August 31st, 2023. As most of you
24 might know, living here in Florida, we did a
25 hurricane that was happening during that time also.

1 And so the resources and attention had to be given
2 to the citizens of Florida who suffered through
3 that. That said, the report then was put into what
4 we consider a core flow floater that starts to move
5 through the DOH leadership. The information has
6 been sent over to them. They are currently
7 reviewing that information. Any feedback that we
8 get, we will certainly pass on. I do not have a
9 particular date at this point to say when it will
10 be published. What I will tell everyone is that
11 when it is published, it will show up on the
12 Florida Department of Health trauma's website. If
13 you go out there now, the 2020 version is still
14 sitting there. So you may want to refresh your
15 memory about some of the definitions in the
16 application and all the things that kind of go into
17 that report so that when the 2023 is green-lighted
18 to be published, we will put it out there. And so
19 you'll have an opportunity then to review it,
20 download it and whatever you would like to do, but
21 that will be out there at that time. I just don't
22 have a specific date at the moment.

23 And then lastly, I'm trying to think if
24 there's anything else I need to report on.

25 Lisa, what else do I need to give you?

1 MS. DINOVA: I think that's about it.

2 MS. KOCEVAR: Is that it? The two pieces were
3 the things most important as far as that is
4 concerned.

5 I will say lastly, I would love to make sure
6 that everyone who is listening today, as we get
7 into looking at our draft standards, the
8 subcommittee on comments hours has been very busy.
9 It's been very productive and I thank everyone for
10 participating in that.

11 The standards that will be reviewed today are
12 going to be the culmination of feedback from our
13 public sector, our stakeholders, from our advisory
14 council members who did not vote on anything during
15 that time, it was just discussed, and will have an
16 opportunity then to see where we are headed.

17 I do know that Laura Hamilton will be giving
18 us some updates on what new dates we'll be having
19 for comments hours and we will certainly get that
20 published out onto the website. For anyone who's
21 not aware of it, there is a comments hours tab and
22 every comments hours listed out there with the work
23 product that has been created so far to the
24 standards. So you'll get an idea, following the
25 story along from day to day.

1 We also have the transcripts that are
2 published of all those who participated so that
3 there is complete sunshine on the information and
4 data that we're doing. But we'll get ready to
5 start rolling again in mid October, once we get
6 through these meetings here.

7 Does anyone have any questions of me?

8 Yes, Michael. Michael Taylor.

9 MR. TAYLOR: Michael Taylor from Hillsborough
10 County.

11 Kate, when the -- when the report does come
12 out, will you -- will you keep the old report on
13 there so we can have the two for comparison, or
14 does the -- does the old one have to come off?

15 MS. KOCEVAR: Michael, I am not aware that the
16 old one would have to come off. I would certainly
17 have to discuss that, probably with general
18 counsel, you know, to -- to get that. I can say at
19 this point, that has not really been mentioned, so
20 I don't have a reply at this point. But I will
21 certainly try and investigate that for you.

22 MR. TAYLOR: It just -- it just would be nice
23 to -- as the -- as -- since there are going to be
24 three years, which is kind of a short time frame,
25 that -- it would be nice to see for comparison, you

1 know, that they're there for comparison and we know
2 where they are. We don't have to go downloading
3 them and saving -- saving them ourselves and that.
4 Just a thought.

5 MS. KOCEVAR: Okay. Well, thank you. I will
6 certainly take that back with me.

7 Anyone online have any questions of me?

8 All right. Well, thank you very much.

9 MS. DINOVA: Okay. Normally, I would ask for
10 an update from the EMS advisory council. As you
11 guys know, Mac Kemp has retired or is in the
12 process of retiring, so he is not here today to
13 give us an update. We will be reaching out to both
14 the EMS medical director and EMS advisory council
15 to see whom they'd like to start sending to these
16 meetings so we can keep getting those reports in.

17 There's Dr. Pappas. So we'll move on to the
18 Florida committee on trauma update from Dr. Pappas.
19 Come share our water bottle.

20 DR. PAPPAS: Okay.

21 MS. DINOVA: I think we're working on getting
22 another microphone for the audience, but until
23 then . . .

24 DR. PAPPAS: The magic microphone water
25 bottle.

1 Thank y'all very much. Just want to say,
2 Florida committee on trauma, many if you were
3 there, actually, we just completed our business
4 meeting about half an hour ago. Successful
5 meeting. Major issues I think that are relevant to
6 this -- this group, number one, we certainly,
7 again, reinforced our -- reinforced our great
8 desire to see the Florida Trauma System Advisory
9 Council reconstituted and all seats fully
10 reappointed so that we can have a quorum and really
11 proceed with the people's business when it comes to
12 our state trauma system.

13 As I mentioned in our business meeting in
14 April of this year, I, on behalf of Florida
15 committee on trauma, did send a letter to Surgeon
16 General Ladapo, asking for just that, for a
17 reappointment or reconstitution of the FTSAC. And
18 separately, in August of this year, Florida
19 committee on trauma sent forward a letter asking
20 again for the Department of Health to begin the
21 process of preparing for an ACS state-level
22 consultative visit for Florida. Both I think are
23 critical issues and certainly, along with our
24 trauma standards, will certainly require a
25 functioning Florida Trauma System Advisory Council.

1 (Brief interruption.)

2 DR. PAPPAS: Hi, Mark.

3 In addition, as I mentioned -- as I mentioned
4 in the meeting, we are also establishing an EMS
5 committee for the Florida committee on trauma with
6 the goal again to further bridge the link between
7 this committee, once it's reconstituted, with the
8 EMS advisory council. And Dr. Jose Diaz, trauma
9 medical director for Tampa General, will be our
10 first vice chair. And by special dispensation from
11 the central committee of the committee on trauma,
12 Dr. David Shatz, formerly of the University of
13 Miami, currently of the University of California,
14 Davis, will be allowed to act as an ad hoc advisor
15 for the group. And as many of you may recall,
16 Dr. Shatz was instrumental in many of the
17 initiatives that have been established over the
18 years for trauma and EMS here in Florida.

19 So certainly looking forward to the future and
20 certainly looking for collaboration with the future
21 FTSAC and the Florida committee on trauma to only
22 strengthen. And, again, we all eagerly await
23 continued work on behalf of our state trauma
24 standards and certainly want to really --

25 (Brief interruption.)

1 DR. PAPPAS: -- thank Laura Hamilton and her
2 group for her hard work.

3 And that concludes my reports.

4 MS. KOCEVAR: Dr. Pappas, will you just kindly
5 identify yourself for the court reporter and where
6 you're from.

7 DR. PAPPAS: I am Dr. Peter Pappas, three Ps
8 altogether, two in the middle, chair of the
9 American College of Surgeons -- chair of the
10 American College of Surgeons, Florida committee on
11 trauma.

12 MS. DINOVA: I just would like to remind
13 everybody, if you're joining us online, to please
14 mute your line.

15 Okay. Thank you-all. Hey, this is a village
16 here.

17 All right. So moving forward. Looking at
18 some -- okay. Sorry, y'all. So moving forward
19 today, we're going to be starting to look at some
20 of our trauma center standards.

21 (Brief interruption.)

22 MS. DINOVA: He's back.

23 Hi, Dr. McKenney. I have your attendance down
24 for the -- for the record. Thank you.

25 We're going to be looking at the Florida

1 trauma center standards that we have been reviewing
2 in the comments hours. I appreciate everybody
3 who's been joining on those comments hours. And if
4 you have not, I would encourage you to please start
5 stalking the advisory council tab on the DOH
6 website and start monitoring when those meetings
7 are going to be. The Teams links are there and
8 we'll get you in.

9 Also, Dr. Pappas and Candace have been kind
10 enough to start sending those e-mails out,
11 reminding everybody when those meetings are because
12 the more participation we get, the better our rule
13 book will be moving forward.

14 So today, Laura is going to walk us through
15 about six of those standards that we have come to
16 some consensus language on. We're looking for some
17 additional feedback from the group today. We'll
18 start with -- by acknowledging the council members
19 first to see if they have feedback and then out to
20 our stakeholders and then for public comments.

21 DR. MCKENNEY: And one quick second. This is
22 Mark McKenney. I just wanted to record my
23 attendance. And I don't think I got the invite,
24 and there's a few other people that have texted me.
25 But I am on the --

1 MS. DINOVA: For today?

2 DR. MCKENNEY: Yeah. I just got it.

3 MS. PINEDA: I'll send it to them.

4 MS. DINOVA: Candace is going to send it to
5 them right now.

6 MS. PINEDA: I'm trying. It's not letting me.

7 MS. DINOVA: Try Dr. Nemias. He was on
8 earlier.

9 MS. KOCEVAR: Nemias sent it. So I'll send it
10 out to Nemias.

11 DR. ZITO: Yeah, when you guys were talking, I
12 texted everybody and --

13 DR. MCKENNEY: Yeah, I just got it.

14 MS. DINOVA: Thank you, Dr. McKenney. And
15 hopefully now, Dr. Ang will get it and be able to
16 join us as well.

17 So we will make sure -- we'll double-check
18 the -- the website. But usually, the links are
19 posted there with the announcements that are up
20 there. So we'll double-check that the Teams links
21 are -- are adjoined also.

22 Okay. So, again, moving forward, we're going
23 to be looking at these six standards today. This
24 is your opportunity to throw in your questions,
25 your comments, your concerns, any language changes

1 that you'd like to propose so that we can start
2 moving forward with getting this consensus document
3 pulled together. Once this document has been gone
4 through, all of the standards, we'll then turn it
5 back over to the AFTC and the FCOT to get their
6 formal agreement that they are -- that they also
7 align with this language, bring it back to the
8 council, and then we will present it to the DOH
9 at -- like I said, as a consensus document from our
10 stakeholders.

11 So with no further adieu, give me just a
12 second to switch screens, and we're going to look
13 at the Word document live. And Ms. Laura is going
14 to walk us through the changes for six of these
15 standards so that we can get your comments.

16 I've been asked to please remind everyone
17 again, before you make comments, whether you are in
18 the room or online and even if it's your 17th
19 comment, please make sure that you state your name
20 and where you are from so that the court reporter
21 can catch that for the minutes. Thank you.

22 All yours, Laura.

23 MS. HAMILTON: Laura Hamilton, Bayfront
24 Health.

25 So first, thank you to everybody that has been

1 on these calls every single week. Lisa said it's,
2 you know, a village, and it really is taking a
3 village to do all of this. I'm just -- yeah.

4 Okay. I'm going to start here with the
5 administrative standard.

6 MS. DINOVA: Sorry. I don't know what's going
7 on right now.

8 MS. HAMILTON: So the administrative standard.
9 So I'm just going to read through -- oh, yours?
10 Okay. It just doesn't have all of the red.

11 MS. DINOVA: Oh, let's see. Sorry, guys.
12 We're -- we're sharing a laptop as well, so we want
13 to make sure that we can see all of the changes.

14 And bear with some of the content because we
15 know that it's a challenge when we're doing these
16 red-line versions. So sometimes it's a little bit
17 challenging to see where the changes have been
18 made. So Laura has added those all up to the top
19 now, and you'll see the red-line version of what
20 we've taken out below it. I think this is the --
21 it should show it now.

22 MS. SOWERS: Dea Sowers, St. Joe's Children.

23 Is there any way we can close the chat on the
24 screen so -- because it's very difficult for us to
25 see in the room.

1 MS. DINOVA: Yeah. We can now. I just wanted
2 to see if anybody was trying to log in before.

3 MS. PINEDA: I'll monitor it for you.

4 MS. DINOVA: Thank you.

5 MS. HAMILTON: Is that better? I can probably
6 go a little bit bigger.

7 MS. DINOVA: Yeah. She's trying do that over
8 there.

9 MS. PINEDA: Okay.

10 MS. HAMILTON: Okay. So for the
11 administrative standard, just to orient you to the
12 page here, normally, when we talk about these
13 things, all of the texts in red are the 2022 ACS
14 standards that were recommended to be included into
15 the new document by the subcommittee. And when we
16 look at it today, there's going to be more red than
17 you're used to seeing and that's because, just for
18 clarity, I took everything that we've been working
19 on plus the stuff that we were keeping from Florida
20 and smooshed it all together and added it up top.
21 And that's just so that we can actually see it
22 without stumbling over all of the red lines, but
23 they're all still in here, if that makes sense.

24 So for the administrative standard, no wording
25 changes to the introduction. And so starting with

1 A, there shall be demonstrated commitment to trauma
2 care by the hospital's board of directors,
3 administration, medical staff and nursing staff to
4 treat any trauma patient presented to the facility
5 for care. Methods of demonstrating commitment to
6 the trauma center and system by the hospital shall
7 include but not be limited to the following:
8 Establishment of policies and procedures for the
9 maintenance of the services essential to a trauma
10 center and system as outlined in the standards
11 document, providing patient care data as requested
12 by the department or its agents. Every trauma
13 center is required to establish well-defined
14 transfer protocols that encompass patient types,
15 anticipated time frames for the initiation and
16 acceptance of transfers and pre-identified
17 destination facilities for outbound transfers.

18 And Number 4, in every trauma center, the
19 choice to transfer an injured patient must be
20 solely determined by the patient's requirements
21 without taking into account their health insurance
22 plan or payment status.

23 And all trauma centers, when transferring
24 trauma patients, the health care provider
25 initiating the transfer must establish direct

1 communication with the receiving provider to
2 guarantee a safe transition of care. This
3 communication may take place via a transfer center.

4 You want to get the whole thing then . . .

5 Okay. Yeah. Let's -- let's break this up
6 into little bits.

7 So in reviewing that --

8 (Brief interruption.)

9 MS. HAMILTON: Okay. So first, I'm going to
10 open this up to council for any comment.

11 MS. DINOVA: This is Lisa DiNova. I did just
12 want to point out one other thing. As we go
13 through this document, you guys will -- you will
14 see that how our current Florida standards are
15 right now, we have basically three sets of
16 standards, one for Level 1, one for Level 2 and one
17 for pediatrics. What we've done for this document
18 is taken --

19 (Brief interruption.)

20 MS. DINOVA: We've taken a more direct
21 approach, such as laid out in the Gray Book, where
22 we're going to have one set of standards. And if
23 something only applies to a particular level, it
24 will be noted in the standard. So that's why
25 you'll see that most of these will say in all

1 trauma centers or in every trauma center. We're
2 encompassing all three of the types that we have in
3 Florida into one unless noted otherwise. Okay? So
4 that's something for that.

5 Dr. McKenney, I know you're on the line. As a
6 council member, do you have any comment on this
7 section?

8 And I don't know if Dr. Ang was able to join.

9 DR. MCKENNEY: No, no comment right now.

10 MS. DINOVA: Okay. Thank you.

11 Dr. Ang, were you able to join?

12 No?

13 MS. PINEDA: I think he was getting on. I
14 know he said (unintelligible).

15 MS. DINOVA: Okay. Candace is watching that
16 too. Okay.

17 And I also, as a council member, I'm -- I
18 agree with -- with this first section that we
19 reviewed.

20 So we'll open it up to our stakeholders and
21 the public. Does anyone in the room or online have
22 comment or want to have discussion about this first
23 section?

24 Oh, Dr. Ang, I see you joining in now. Thank
25 you. This is Lisa. I've got your name on for

1 attendance.

2 DR. ANG: Thanks. I didn't see this on the
3 calendar invite. I apologize. It didn't show up.

4 MS. DINOVA: I think they went out as all
5 separate invites, so it was easy to miss one.
6 We're just getting started on the revision of the
7 standards. This is the very first section that we
8 have reviewed and gone over. This is for
9 Standard I --

10 DR. ANG: Okay.

11 MS. DINOVA: -- the administrative standard.
12 And we've only looked at this very first section.
13 So if you could take just a brief moment and read
14 through, these are the proposed language changes to
15 it, basically encompassing the ACS standards into
16 it with some wordsmithing so that we don't
17 plagiarize. And then if you have any comment or
18 language changes that you'd like to present, we're
19 open to that. And we've opened up to stakeholders
20 and the public, anybody online.

21 DR. ANG: Thank you.

22 MS. DINOVA: No one in the room.

23 No one online.

24 Okay. We'll move on to the next section.

25 MS. HAMILTON: Okay. So next, in all trauma

1 centers the institutional governing body, hospital
2 leadership and medical staff must consistently
3 exhibit unwavering dedication and allocate the
4 essential human and physical resources required to
5 effectively deliver trauma care in alignment with
6 the verified level throughout the verification
7 cycle.

8 Examples of demonstrating this commitment
9 include approval of the establishment of the trauma
10 center by the hospital board of directors or other
11 administrative governing authority, demonstrated
12 commitment to adhere to the standards mandated for
13 the level of verification and committing to provide
14 the essential personnel facilities and equipment
15 required to facilitate compliance with the
16 prescribed standards.

17 C, hospital administration must display its
18 backing for the research program.

19 And that you can see is for Level 1 in
20 pediatric centers only.

21 Evidence of support for the research program
22 entails documenting aspects such as the following.
23 And that's basic laboratory space, sophisticated
24 research equipment, advanced information systems,
25 biostatistical support and salary support for basic

1 and translational scientists or seed grants for
2 junior investigators. There must also be
3 commitment to postgraduate education.

4 And I will stop right there. So let's open
5 that up for council comment.

6 MS. DINOVA: Okay. There's the whole section
7 that we've reviewed.

8 Dr. McKenney or Dr. Ang, do you have any
9 comments?

10 DR. ANG: No, I think this looks good.

11 MS. DINOVA: I agree.

12 So I'd like to open it up to the room. Anyone
13 in the room, stakeholders?

14 I don't see anybody reaching for a microphone.

15 So anyone online?

16 Okay. We'll move on to the next section.

17 These will also be posted after the meeting.

18 We'll get these posted to the advisory council
19 website so you can review it further before they
20 come to the AFTC and FCOT for final approval.

21 MS. HAMILTON: Okay. Next, in all trauma
22 centers, diversion protocols must receive approval
23 from the trauma medical director and encompass the
24 following elements: The trauma surgeon's
25 concurrence in the decision to implement the

1 diversion, a procedure for notifying dispatch and
2 EMS agencies and a diversion log for documenting
3 the reason for diversions and their duration.
4 Additionally, all trauma centers must ensure that
5 the total duration of diversions during the
6 reporting period does not surpass 400 hours.

7 And let's just stop there for a sec.

8 Council, any comments on the diversion
9 section?

10 DR. ANG: So was that 400 hours derived from
11 the ACS requirements?

12 MS. HAMILTON: Yes. It was.

13 DR. ANG: Okay.

14 MS. DINOVA: Yes. It lays out 400 hours
15 through the reporting period, which then is three
16 years. We may need to define that here. We're
17 going to have to define the reporting period,
18 because currently in Florida, our reporting period
19 is seven years, so we may need to change that
20 from reporting period to every three years, would
21 be my recommendation.

22 DR. ANG: Yeah, I agree with that.

23 MS. DINOVA: Okay.

24 DR. MCKENNEY: Yeah, that seems -- this is
25 Mark McKenney. That seems reasonable.

1 MS. HAMILTON: Stakeholders, are you in
2 agreement with that?

3 DR. SMITH: Question. Steve Smith,
4 UF Gainesville.

5 Is that 400 hours --

6 MS. DINOVA: She's bringing -- she's bringing
7 you a microphone.

8 DR. SMITH: Steve Smith, UF Gainesville.

9 Is that 400 hours equivalent to 5 percent of
10 the time during the reporting period?

11 MS. DINOVA: I'm looking for my math majors in
12 the room.

13 UNIDENTIFIED SPEAKER: Sorry. What was the
14 question?

15 MS. DINOVA: It's probably about that.

16 MS. SOWERS: Dea Sowers, St. Joe's Children.

17 I don't know about percentage-wise, but it
18 averages, like, 183 hours per year and
19 11.something-something-something hours per month
20 over a three-year period.

21 DR. SMITH: The ACSU looks at it as -- if
22 you're dovetailing, as 5 percent during the
23 reporting period, which is a year.

24 MS. DINOVA: So the current Gray Book says
25 400 hours per -- per reporting period of three

1 years.

2 DR. SMITH: Okay.

3 MS. PINEDA: 400 is a little less than 5
4 percent. So (unintelligible).

5 DR. SMITH: 5 percent per year during the
6 period.

7 MS. DINOVA: Okay. Candace just did some math
8 for us, and she said that it is -- 400 hours is
9 just under 5 percent.

10 MS. PINEDA: 438 hours would be 5 percent of
11 one year.

12 MS. DINOVA: One year.

13 DR. SMITH: Yeah. I think it's one year
14 because the PRQ only looks one year back.

15 MS. HAMILTON: Oh, right. The reporting
16 period is the 14 months or so, right, or --

17 DR. SMITH: The reporting period is one year
18 for the PRQ. So 400 hours or 5 percent during one
19 year, I think, is what that is intended to be.

20 MS. PINEDA: So annually instead of every
21 three years for that sentence.

22 This is Candace Pineda, Memorial Regional.

23 MS. HAMILTON: Thank you for that.

24 DR. SMITH: Sure.

25 MS. HAMILTON: So then that would be changed

1 to, additionally, all trauma centers must ensure
2 that the total duration of diversion does not
3 surpass --

4 (Brief interruption.)

5 MS. HAMILTON: -- 400 hours annually.

6 Any other stakeholder comment?

7 MS. DINOVA: Anyone online have any comment
8 for the . . .

9 Candace is watching the chat. I just see a
10 red dot, so I can't . . .

11 Okay. We'll make those -- we'll note those
12 changes there then.

13 All right. Moving on to the next section.

14 MS. HAMILTON: Next, the hospital's chief
15 executive officer has overall responsibility for
16 compliance with all trauma center standards. The
17 CEO or his or her designee shall ensure that all
18 staff involved with the care of the trauma patient
19 are aware of their responsibilities as required by
20 the trauma center standards.

21 The hospital shall ensure that the trauma
22 medical director is responsible and accountable for
23 administering all aspects of patient -- of trauma
24 care. Therefore, the trauma medical director shall
25 be empowered to enforce the trauma center standards

1 with other medical and clinical departments in the
2 hospital. The trauma program manager shall perform
3 under the direction of the trauma medical director
4 and shall interact with all departments on behalf
5 of the medical director.

6 When there are issues that the trauma medical
7 director has been unable to resolve through the
8 hospital's organizational structure, the hospital
9 shall provide a specific mechanism to ensure that
10 the medical staff or CEO address such unresolved
11 issues. This mechanism shall include direct
12 consultation with the affected services, including
13 but not limited to trauma and emergency services.

14 And last, when the trauma medical director is
15 unavailable to the trauma service, such as
16 vacation, out-of-town conferences, illnesses, the
17 medical director shall delegate authority to
18 another trauma surgeon to carry out the above
19 administrative functions.

20 And that would be the end of the
21 administrative standards. So let's open that up to
22 council comment.

23 MS. DINOVA: Dr. McKenney or Dr. Ang?

24 DR. MCKENNEY: No -- no, issues on that.

25 DR. ANG: I have no issues, what is written.

1 There was previously a section in terms of vetting
2 consultants. Is that still within the standards?

3 DR. ZITO: I think that's under the trauma
4 medical director.

5 MS. DINOVA: I think so too. I think that's
6 in a different section for the trauma medical
7 director duties.

8 DR. ANG: Okay. Sounds good.

9 MS. DINOVA: I think that -- yeah. So we
10 moved over to the other standard.

11 MS. HAMILTON: Yes. Those were moved over to
12 the Standard II.

13 MS. DINOVA: Okay. Any comment from anyone in
14 the room?

15 Okay. Anyone online have any additional
16 comments or feedback?

17 All right, guys. I think we have a consensus
18 on Standard I. One down, 19 to go.

19 MS. KOCEVAR: Not all today.

20 MS. DINOVA: Okay. Give us just a second.
21 We'll get Standard II pulled up and go through the
22 same way.

23 MS. HAMILTON: Next is going to be
24 Standard IX.

25 MS. DINOVA: Oh, I lied. Standard IX.

1 MS. HAMILTON: Yes. So -- and, again, at the
2 end of the document is all of the carefully edited
3 content with the recommended standards and the --
4 the current Florida standards all mixed together.
5 So I've just taken that and recreated it up top to
6 make it a little easier.

7 So for equipment, we didn't change anything
8 with the introduction. The rapid resuscitation,
9 emergency management and subsequent care of trauma
10 patients requires specialized equipment and
11 supplies. This equipment may be expensive and
12 unique to the care of trauma patients so personnel
13 should have appropriate training and orientation of
14 the use, care and maintenance of this equipment.

15 Medical supplies and equipment requirements
16 for the care of adult and pediatric trauma patients
17 in the treatment areas indicated below shall be
18 readily available and shall include at a minimum
19 the following.

20 For the trauma resuscitation area, cerebral
21 monitoring equipment, airway control and
22 ventilation equipment, including various sizes of
23 laryngoscopes and endotracheal tubes, bag valve
24 mask resuscitator, mechanical ventilator, oxygen
25 masks and cannulae and oxygen, cardiopulmonary

1 resuscitation cart, including emergency drugs and
2 equipment, Doppler monitoring capability,
3 electrocardiograph, oscilloscope, defibrillator,
4 monitoring equipment for blood pressure and pulse
5 and then electrocardiogram, pacing capability,
6 pulse oximetry, standard devices and fluid for IV
7 administration, sterile surgical sets for airway,
8 chest, vascular access and burr hole capability,
9 suction devices and nasogastric tubes, telephone
10 and paging equipment for priority contact of trauma
11 team personnel, ultrasound for fast examination,
12 thermal control devices for patients, IV fluids and
13 environment, two-way radio communication with
14 prehospital transport vehicles. Radio
15 communication shall conform to the state EMS
16 communications plan.

17 So let's stop there for the resuscitation
18 area. And, council, comments?

19 MS. DINOVA: So this is Lisa. I just wanted
20 to remind everyone that during the comments hours,
21 we had some discussion about these and did we need
22 to list equipment. And it was felt that because
23 these standards will be utilized by new programs,
24 by new program managers, by new medical directors
25 that we did sort of need to have a minimum

1 standards recipe book out there for them to be able
2 to have those check boxes to go through. So it was
3 felt that we did need to have just a list of
4 minimum requirements for folks to be able to -- to
5 utilize. So that's why we do have some of this
6 listed out still. So that's my only comment on
7 this.

8 Dr. McKenney or Dr. Ang?

9 DR. ANG: I don't see a problem with this list
10 as a minimum standard.

11 DR. MCKENNEY: Hey, this is Mark. I don't --
12 Mark McKenney.

13 I don't have an issue either in terms of it
14 being the minimum. But, you know, pager is getting
15 to be a dated term. I haven't seen a pager in a
16 hospital in --

17 DR. ZITO: I still have one.

18 UNIDENTIFIED SPEAKER: I still have one.

19 MS. DINOVA: We still have them.

20 DR. MCKENNEY: Okay. Some -- some people have
21 moved on to iPhones.

22 MS. DINOVA: We do both.

23 DR. ZITO: We do both.

24 DR. MCKENNEY: Okay. It works
25 (unintelligible) you know, either/or.

1 MS. DINOVA: Okay. Thank you.

2 Any other comments?

3 All right. Anyone in the room?

4 Yes.

5 MR. TAYLOR: Michael Taylor from Hillsborough
6 County.

7 Along with using old terms right there in
8 Number 5 -- oh, hello.

9 Is it on?

10 It is on.

11 Michael Taylor, Hillsborough County.

12 Number 5 is on the screen. The
13 electrocardiograph, oscilloscope, defibrillator.
14 Is oscilloscope really necessary to -- to call that
15 out? I mean, that's -- that's very old term.
16 '50s. I heard, Doctor, '50s.

17 MS. HAMILTON: Any comments on that?

18 DR. ZITO: I have no problem getting -- sorry.

19 MS. DINOVA: Nope. Go ahead.

20 DR. ZITO: I have no problem getting rid of
21 it.

22 MS. DINOVA: That's Dr. Zito.

23 DR. ZITO: Sorry. Tracy Zito from Orlando
24 Regional.

25 DR. TAYLOR: And -- and the other piece, if

1 you could scroll down, which was about the radio to
2 EMS equipment. Two-way radio communication, just
3 so you're aware, the -- over at the -- at the EMS
4 meetings in Destin this week, we heard that the
5 state now has a contract with Pulsera, and that
6 system allows communication but not so much -- it's
7 not a two-way radio communication. It's a text
8 messaging --

9 MS. DINOVA: So for --

10 DR. TAYLOR: -- type thing. So -- so that --
11 I mean, I -- two-way radio communication I think
12 ought to remain for now, but I just want you-all to
13 be aware that as technology progresses, EMS
14 hospital communications may move away from the
15 actual radio communications.

16 MS. DINOVA: So how about if we strike the
17 word radio and just leave two-way communication in
18 both places?

19 MS. KOCEVAR: Yes, hi. Kate Kocevar from
20 Florida Department of Health.

21 Why don't we use the word bidirectional?

22 MR. TAYLOR: That's good.

23 MS. DINOVA: Bidirectional. That's good. I
24 like it. Okay. All right. We'll change that to
25 bidirectional communications.

1 Dr. McKenney, Dr. Ang, are you good with those
2 changes?

3 DR. ANG: I'm good with those changes.

4 About the airway, since we're modernizing this
5 a little bit, the standard of care really is video
6 laryngoscopy now for airways, you know . . .

7 DR. MCKENNEY: This is Mark. No -- no
8 concerns.

9 MS. DINOVA: Okay. So we could put -- maybe
10 we could put sizes of laryngoscopes including video
11 laryngoscopy, if available.

12 DR. ANG: Yeah. I mean, I think -- I think
13 that's the safest way of getting in airways to --

14 DR. ZITO: I would leave the term --

15 MS. PINEDA: Tracy Zito, Orlando Health.

16 DR. ZITO: I know even if I talk 455
17 times . . .

18 MS. DINOVA: Go ahead, Dr. Zito.

19 DR. ZITO: I would definitely leave the term
20 if available because as yet, not everyone has that
21 equipment, and I don't think it should be
22 100 percent mandated right now.

23 MS. DINOVA: Okay.

24 MS. PINEDA: This is Candace --

25 DR. EBLER: This is Dave Ebler from UF Health

1 Jax. I -- I would like to go revisit the
2 communication. Specifically, you know, during mass
3 casualties, you know, during 9/11, all the cellular
4 communications went down, and the only
5 communication that was available was -- was radio
6 for the most part. So in addition, you know, for
7 our kind of mass casualty plan and event planning
8 out in the community, radio remains one of our
9 primary, you know, methods of -- of communication.
10 So I think we should just, you know, reconsider,
11 you know, just leaving it as bidirectional
12 communications. I do think that our communication
13 system is vulnerable, and radios do play a major
14 part of our -- our, you know, mass casualty
15 planning.

16 MS. DINOVA: So would you -- are you proposing
17 that we leave the term radio in there or --

18 DR. EBLER: Or at least have some type of
19 acknowledgement that we should have a radio or
20 something beyond cellular communication or -- I
21 think that should be in there.

22 DR. ZITO: I think just -- Dave, I think just
23 putting bidirectional communication with
24 prehospital transport vehicles suffices and
25 actually is a rather all-encompassing term.

1 MS. HAMILTON: It would open it up to more --

2 DR. EBLER: I understand. You know, leave it
3 at that. Maybe consider removing cellular. Okay
4 if we have bidirectional communication and then,
5 you know, if the cellular network was down, which
6 could happen. It has happened. And then there
7 will be no method of communication in a mass
8 casualty situation.

9 DR. ZITO: So then you would want to put some
10 sort of language in about --

11 Sorry. This is Tracy Zito again.

12 Put multi -- put language in there as far as
13 bidirectional communication and backup
14 bidirectional communication, I think is what you're
15 looking for.

16 DR. EBLER: Yeah. Or -- yeah, something like
17 that 'cause I just -- I don't think we are
18 acknowledging the vulnerability of the cellular
19 communication system, which I think -- what we
20 might be moving towards.

21 MS. DINOVA: I have a question. What if we
22 left this as the everyday and in the disaster
23 standard, we add something that says that we need
24 to have a backup communication system from our
25 primary system?

1 DR. EBLER: I -- I think that would be more --
2 more than adequate.

3 MS. DINOVA: So leave --

4 MS. HAMILTON: Shall conform to state EMS
5 communications plans. So if we were to pull that
6 up, I wonder if there would already be something in
7 place there.

8 MS. DINOVA: That might also cover it in
9 there. So we could cover that, but we could -- so
10 we could leave it like this in -- in this standard.
11 And then in the disaster standard, we can make a
12 note to add that each facility needs to have a
13 backup communications plan in the event of an MCI
14 or radio -- or just have a backup plan. I don't
15 know how to word it right this second.

16 MS. HAMILTON: And we'll cover that one today
17 too, so . . .

18 DR. ZITO: Yeah. This is Tracy Zito again.

19 I am -- I think if we look in that EMS
20 communication plan, we probably will find exactly
21 what you're talking about because that was a
22 lesson -- that was a lesson learned in the entire
23 country about cellular networks going down. And I
24 think everybody was kind of almost mandated to have
25 some sort of noncellular comm. So maybe, Dave,

1 it's in there.

2 DR. EBLER: Right.

3 MS. PINEDA: This is Candace Pineda.

4 Maybe bidirectional communication including
5 radio, only because radio is a requirement for the
6 state EMS communication, and it's an -- as
7 Dr. Ebler said, it's something that most people
8 have. Remember that this is the absolute minimum
9 standard for all Florida trauma standards. So if
10 we don't put it in there, some places won't be able
11 to do it because it doesn't have this line item.

12 MS. DINOVA: And the EMS communications plan
13 says radio in it?

14 MS. PINEDA: Yes.

15 MS. DINOVA: Okay. So including radio.

16 MS. PINEDA: There's also a comment in the
17 chat from Melanie Sinclair about to avoid
18 (unintelligible), can we use a term like a system
19 to communicate immediately with the trauma center
20 or trauma team personnel?

21 MS. DINOVA: I'm sorry. Say that again,
22 Candace. I mean, is that for this also?

23 MS. PINEDA: Yes. It says -- it says to avoid
24 (unintelligible), a system to communicate
25 immediately with trauma team or trauma personnel.

1 That may be down with the pagers, Number 12.

2 MS. DINOVA: So --

3 MS. SINCLAIR: This is Melanie Sinclair from
4 Ascension Sacred Heart in Pensacola.

5 And yes, that was in reference to Number 12,
6 telephonic paging equipment. If we could just say
7 a system to communicate immediately or priority
8 contact with trauma personnel. That way, we don't
9 have to worry if we go to a (unintelligible) or
10 stick with pagers or (unintelligible) comms or
11 whatever. It's just a -- just more general term.

12 MS. HAMILTON: A system to communicate
13 immediately --

14 MS. PINEDA: With the trauma team.

15 MS. HAMILTON: -- with the trauma team.

16 MS. DINOVA: And then strike that whole . . .

17 MS. PINEDA: And this is Candace Pineda again.

18 Going back to the airway thing, if video
19 laryngoscopy is a gold standard, if we don't put it
20 in there, then centers won't have the
21 administrative support to get it when they probably
22 should, even just one. So is that something that
23 should be a minimum requirement?

24 MS. DINOVA: That's something I have to open
25 up for comment because that would be a financial

1 impact on the centers, and we have to remember
2 to -- our 200 per year (unintelligible).

3 DR. ZITO: They can be cheap. They can be
4 expensive. It depends on the -- and what I'm
5 concerned about is requiring equipment that may not
6 right now be in all the centers.

7 I -- Darwin and Mark, would you consider that
8 to be --

9 Did I do it again? I'm sorry. I'm Tracy Zito
10 from Orlando.

11 (Off-the-record discussion.)

12 DR. ZITO: Anyway, Darwin and Mark, do you --
13 do we feel that this is 100 percent standard of
14 care and should be required by all trauma centers?

15 Well, here's -- here's the thing. Is it -- is
16 it required to be on any difficult airway cart?

17 DR. MCKENNEY: This is Mark. You know, to me,
18 it is. And it's not very expensive in terms of a
19 hospital budget. You know, maybe on the Mark
20 budget, but the hospital budget, it's kind of a
21 rounding error. And -- and you're right, if you
22 don't put in that it's required, there will be a
23 few hospitals that are -- you know, kind of divide
24 about that expense and might not have it. I mean,
25 for a difficult airway, it can be super helpful.

1 So I think the cost is modest and the benefit is
2 there. So if you require it, everybody will have
3 it.

4 DR. ANG: This is Darwin Ang.

5 I agree with Mark. You know, I'm thinking
6 about this from the patient perspective. When you
7 have a difficult airway, you don't want to be
8 dealing with instruments that don't give you
9 optimum visualization to at least try. And, you
10 know, people will die if they don't -- they don't
11 get the right equipment. So I do personally think
12 this is important.

13 DR. ZITO: Yeah. I -- as we're talking about
14 this and as I started to think about the difficult
15 airway cart, I thought, it -- it really needs to be
16 there. I mean, it's pretty much on every ground,
17 intubating vehicle now. It's on every air. You
18 know, so I agree.

19 MS. DINOVA: So what we just did here is we
20 added -- so we've got airway control and
21 ventilation equipment including various sizes of
22 laryngoscope and then in parentheses put should
23 include video laryngoscopy capability.

24 MS. SOWERS: Dea Sowers, St. Joe's Children.

25 I think it should just say including video,

1 not should. Because should leaves open to
2 interpretation.

3 MS. DINOVA: Okay. As long as everybody's on
4 board with the financial component.

5 MS. PINEDA: Including various sizes of
6 laryngoscopes, video laryngoscopy, ET tubes.

7 MS. HAMILTON: Okay.

8 Michael?

9 MR. TAYLOR: Michael Taylor.

10 You have endotracheal tubes. What about the
11 other tubes that are not being used? Are they --
12 are they using those on the trauma bay or not?

13 No? Okay.

14 MS. DINOVA: How about we put -- we could add
15 a line that just says rescue airways and then leave
16 that open, or difficult airway options. I mean,
17 'cause if we go down the list of listing all of the
18 airway things, the list is going to be, you know,
19 this long.

20 DR. ZITO: What we're doing here is -- it's
21 honestly basic. It's basic intubation.

22 MS. DINOVA: Yeah. This is the minimum.

23 MR. TAYLOR: Okay.

24 MS. DINOVA: Okay.

25 MS. PINEDA: Candace -- Candace Pineda,

1 Memorial.

2 MS. DINOVA: I'm going to have to shut this
3 side of the room down for a minute and ask for
4 comments from this side of the room.

5 MS. PINEDA: Moving Florida trauma centers
6 forward in looking at equipment, do we need to add
7 pupillometer? Not all centers may have it yet. It
8 is starting to become the standard of care. It is
9 \$5,000 even if you just get one. So it's way under
10 the \$200,000 cost. Throwing it out there.

11 DR. ZITO: How did you know? This is Tracy
12 Zito again.

13 I don't disagree with Candace. I think it has
14 become standard of care for any trauma center,
15 especially taking care of traumatic brain injured
16 adults at least. I'm not sure about children, but
17 definitely adults.

18 And so what about children? Does anybody --
19 can anybody comment on the kids' literature?

20 But I think it should be required. It -- it
21 took me an ungodly amount of effort to get it, but
22 I got it because it's standard of care.

23 MS. HAMILTON: Would you include the
24 pupillometer under all areas, just trauma
25 resuscitation and maybe critical care or the

1 whole -- we've split these up into different --

2 MS. DINOVA: Yeah, different areas of the
3 hospital.

4 MS. HAMILTON: -- levels of care.

5 DR. ZITO: Definitely the trauma resusc
6 because that's where the first pupillometer reading
7 should occur. Definitely critical care. I'm not
8 sure the operating room necessarily counts.

9 MS. DINOVA: So now we're talking about three
10 or four or five of them.

11 MS. PINEDA: Not necessarily, if you say you
12 have one.

13 DR. ZITO: You can have one and move it
14 around.

15 MS. DINOVA: Just pass it around?

16 DR. ZITO: Yeah.

17 DR. MCKENNEY: This is Mark --

18 MS. HAMILTON: If we put one under each of
19 these, then you would have to have one each.

20 MS. SOWERS: Dea Sowers, St. Joe's Children.

21 Can you put it under the resuscitation area
22 and say with capability of using throughout the
23 hospital, available in the resuscitation area, or
24 no?

25 MS. DINOVA: I don't think -- I don't think so

1 because of the way it's broken out.

2 DR. ZITO: Do you have any section that's
3 all-encompassing?

4 MS. HAMILTON: No. Every section is just
5 redundancy.

6 (Multiple speakers.)

7 MS. PINEDA: In the comment box --

8 MS. HAMILTON: (Unintelligible) add a section
9 at the end for all hospitals must have a
10 pupillometer available somewhere.

11 MS. PINEDA: Lianne Brown is suggesting for
12 the ICU and resusc areas as a minimum.

13 DR. ZITO: That's the area we use them.

14 MS. PINEDA: So two, 10,000 -- still under
15 \$200,000, and gives each center, including new
16 centers or anyone the ability to purchase that.

17 MS. HAMILTON: Any comments from this side of
18 the room or online?

19 DR. MCKENNEY: Hey, this is Mark McKenney.

20 You know, we use it also all the time. Once
21 you use it, it's hard to go back to not using it.
22 The expense doesn't seem excessive and certainly
23 well under the 200,000. And I guess the advantage
24 is that every center that can have it will show the
25 administration (unintelligible).

1 MS. DINOVA: All right. Anyone else in the
2 room? I see a sidebar going on.

3 No? Okay.

4 All right. It's going to get added. All
5 right. So we're going to add the pupillometer to
6 the trauma resusc area and then when we get down to
7 ICU, we'll add it there too?

8 DR. ZITO: Yes.

9 MS. DINOVA: Okay.

10 MS. SOWERS: Well, ER, PICU and adult truma.

11 Dea Sowers, St. Joe's Children. Sorry.

12 MS. HAMILTON: Okay. So I'm just going to --
13 you want to keep a list of --

14 MS. DINOVA: Changes?

15 MS. HAMILTON: -- a shopping list here of --

16 MS. DINOVA: Changes?

17 MS. HAMILTON: Financial changes, yeah.

18 Just so that at the very end, we can come back
19 and say, here's every little 5- and 10,000
20 increment that we made and see where that brings us
21 and if maybe we need to reevaluate some of the
22 additions.

23 MR. TAYLOR: Mike Taylor again.

24 Just a question on the cost. And this would
25 be for Kate. The -- after -- after you went all

1 through it and (unintelligible) all the 5 and 10
2 cent stuff all adds up to -- if it's -- if it's up
3 there, is it possible to implement these over --
4 over time, not -- not just say, they're in place
5 today, but implement them over time so that the
6 cost would be -- that hospitals that are saying
7 it's too costly could spread the cost out?

8 MS. KOCEVAR: How (unintelligible)?

9 MR. TAYLOR: It's just -- it's just --

10 MS. KOCEVAR: Give me the microphone.

11 All right. So when we create standards,
12 Michael, how would I then relay portions of
13 standards in a bit at a time? You know, the
14 standards have to be equitable across standards set
15 at equal both new trauma centers coming in and
16 trauma centers that are currently in play. So
17 there is no way that I could gradually roll out the
18 standards --

19 MS. DINOVA: Kate --

20 MS. KOCEVAR: -- to do such a thing.

21 Kate Kocevar, Florida Department of Health,
22 trauma section administrator.

23 MS. DINOVA: I've lost all control.

24 Okay. Here's my question, though. It's not
25 really a question, but here's my comment. And,

1 Kate, you can correct me if I'm wrong.

2 MS. KOCEVAR: I'd love to.

3 MS. DINOVA: So once we get this consensus
4 document, we then will submit it to the Department
5 of Health. We will then be holding public -- not
6 hearings -- public --

7 UNIDENTIFIED SPEAKER: Workshops?

8 MS. DINOVA: -- workshops -- workshops to
9 where we would have that. So any of these
10 changes -- and then we'll have to set a time frame
11 for these to be implemented. So it's probably
12 going to be a year or two lag, even from the time
13 we get the consensus document and hand it over to
14 the DOH. So the trauma centers will have a couple
15 of years. And then if they've already just had a
16 survey, they'll have until their next survey cycle.
17 So they should have some lag time built in to be
18 able to buy one pupillometer this year and one next
19 year before their -- before the standard is used
20 for the survey. So just like the -- the Gray Book
21 came out in December of 2022, they're just now
22 starting to use it for surveys. It will be the
23 same thing for this document. Even when it gets
24 put through the process, there's going to be a lag
25 time for implementation.

1 So those centers should have time to be able
2 to sort it out. But we still need to be cognizant
3 of not going over that 200,000 for that per year of
4 continual cost also.

5 MR. TAYLOR: And that's -- that's what I was
6 asking about, talking about, exactly -- exactly
7 what I was asking about.

8 MS. DINOVA: Okay. Perfect.

9 MS. KOCEVAR: Yeah. I think the other thing
10 that we have to consider is, is while we're talking
11 about this, we have no idea that two years from now
12 that there might be a new piece of equipment out.
13 So medicine moves at the speed of sound. But yes,
14 I think for now we would address it that way, Lisa.
15 Thank you.

16 MS. DINOVA: Okay. Thank you.

17 All right. Any further comment?

18 MS. PINEDA: Question in the chat that kind of
19 addresses it. So is the pupillometer an ACS
20 standard or what if there is similar devices?

21 So pupillometer is a generic term for a device
22 that measures pupils. We don't have to call it
23 pupillometer. We can say a device that objectively
24 measures --

25 UNIDENTIFIED SPEAKER: Pupillometry.

1 MS. PINEDA: -- pupil response.

2 Pupillometry? Pupillometry metrics.

3 MS. DINOVA: Pupillometry equipment?

4 DR. MCKENNEY: Yeah. The generic term might
5 be a pupillometric.

6 MS. PINEDA: Device to measure pupils
7 objectively.

8 DR. MCKENNEY: There we go.

9 MS. DINOVA: All right. So does pupillometry
10 equipment -- is that generic enough across the
11 board?

12 MS. PINEDA: Yes.

13 MS. DINOVA: Okay.

14 MS. HAMILTON: Any other comments about the
15 trauma resusc area?

16 MS. DINOVA: Okay.

17 MS. HAMILTON: All right.

18 MS. DINOVA: Moving on to the OR.

19 MS. HAMILTON: In the OR, we will have
20 cerebral monitoring equipment. Again, the airway
21 control and ventilation equipment. I will just go
22 ahead and assume that we want to update that to
23 reflect the video laryngoscopes. Anesthesia
24 monitoring equipment. Cardiopulmonary bypass
25 equipment must be immediately available in all

1 trauma centers, or a contingency plan must exist to
2 provide emergency cardiac surgical care. Must be a
3 cardiopulmonary resuscitation cart, including
4 emergency drugs and equipment, craniotomy, burr
5 hole and intracranial monitoring capabilities,
6 endoscopes, invasive hemodynamic monitoring and
7 monitoring equipment for blood pressure, pulse and
8 ECG, operating microscope, orthopedic equipment for
9 fixation of pelvic, long bone and spinal fractures
10 and fracture table, pacing capability, standard
11 devices and fluids for IV administration, thermal
12 control devices for patients, IV fluids and
13 environment and X-ray capability.

14 Open that up to council.

15 MS. DINOVA: Dr. McKenney, Dr. Ang, any
16 comment on our OR shopping list?

17 DR. MCKENNEY: No. Looks good to me.

18 That's Mark.

19 MS. DINOVA: Okay. We're going to pull down
20 that video laryngoscopy down into there as well.

21 DR. ANG: Can I read that one more time? Just
22 pull it down. I'll look at it.

23 MS. DINOVA: Okay.

24 MS. PINEDA: While that's being looked at,
25 there's a question in the chat from Susie Mitchell.

1 Susie, you can take yourself off mute and
2 share away.

3 MS. MITCHELL: Sorry. I -- can you hear me
4 now? I'm sorry. I'm having trouble with my audio.

5 MS. KOCEVAR: We can hear you.

6 MS. MITCHELL: Okay. That was me with the
7 pupillometer. I just wasn't sure -- that was my
8 question with the standard and you changed it. So
9 thank you.

10 MS. DINOVA: Dr. Ang, is this the section that
11 you wanted to see again here?

12 DR. ANG: Yes. Can you scroll down just a
13 little bit to the next page.

14 MS. DINOVA: Oh, my goodness.

15 MS. HAMILTON: That is not me, y'all.

16 DR. ANG: So does X-ray capability include
17 fluoroscopy?

18 MS. DINOVA: No. The -- I think what's listed
19 is the -- the minimum of -- of X-ray capability in
20 the OR. Just plain, I think.

21 DR. ANG: Oh, okay. That's probably okay.

22 MS. DINOVA: Anything, Dr. McKenney?

23 I think he already said --

24 DR. MCKENNEY: Yeah. This is Mark.

25 Nothing else from me. Thanks.

1 MS. DINOVA: Okay.

2 MS. HAMILTON: Thank you.

3 MS. DINOVA: And now from the room.

4 Dr. Zito?

5 DR. ZITO: Tracy Zito, Orlando.

6 Do we have rapid infusers on here? Because it
7 says standard equipment for IV fluid
8 administration.

9 MS. DINOVA: I don't believe we have that in
10 either section, do we?

11 MS. HAMILTON: You know, that is --

12 DR. ZITO: I'm wondering if we have it in the
13 resuscitation section. I know you have external
14 devices for IV fluids in here. But do you have --

15 MS. HAMILTON: Now that we say that, it's
16 weird that it's not there.

17 DR. ZITO: Yeah. Rapid infusers probably
18 should be in all three areas for (unintelligible)
19 administration, et cetera. What do you guys think?

20 DR. SMITH: Yeah, if -- if pupillometry is
21 considered standard of care -- and I'm not sure it
22 is, but I'm not opposed to it -- certainly rapid
23 transfusion --

24 Steve Smith, Gainesville.

25 I will -- I will not repeat my disarranging

1 comments about pupillometry. If -- rapid
2 transfusion devices are standard of care. There's
3 no question about it, in the trauma bay and in the
4 operating room and in the ICU. There's no question
5 that they are standard of care.

6 DR. ZITO: In all areas.

7 MS. HAMILTON: Okay. Is that okay, the way I
8 worded that, equipment for rapid infusion of blood
9 and blood products?

10 DR. ZITO: Yes.

11 MS. DINOVA: Ma'am?

12 MS. SWEENEY: Jennifer Sweeny (phonetic),
13 Sarasota.

14 We -- the peanut gallery and I here are
15 sitting here thinking that it is definitely in the
16 standards somewhere, just we can't remember where.

17 MS. DINOVA: I think this peanut gallery is
18 having the same --

19 MS. SWEENEY: Oh, Tabitha is saying it's in a
20 box somewhere.

21 TABITHA: It's a box in the beginning of
22 the -- of what you guys went over in the beginning.

23 DR. ZITO: You can control F probably,
24 but . . .

25 MS. DINOVA: Yeah, but it -- that might be

1 scary in this document.

2 MS. SWEENEY: Maybe by rapid?

3 DR. MCKENNEY: I tried rapid. I couldn't find
4 it. There's a few rapids, but not with the word
5 infuser in front.

6 MS. DINOVA: I think it was the rapid
7 resuscitation. We're going to add it.

8 MS. HAMILTON: It is added.

9 MS. DINOVA: And we're going to add it to OR
10 and we'll add it to ICU.

11 MS. HAMILTON: So is everybody okay if we move
12 on to PACU?

13 Michael?

14 MR. TAYLOR: Cardiac pacing. You say pacing
15 capability -- capability. You should say cardiac
16 pacing. That's . . .

17 MS. HAMILTON: Okay.

18 So the addition cardiac. Anyone opposed to
19 that change?

20 All right. Thank you.

21 All right. In PACU we will -- I'm going to --
22 oh, my goodness -- paste the airway changes that
23 we've already mentioned. There should also be,
24 again, that cardiopulmonary resuscitation part with
25 all the drugs and equipment. Intracranial pressure

1 monitoring, invasive hemodynamic monitoring and
2 monitoring equipment for blood pressure, pacing
3 capability.

4 Cardiac. Let's just do it.

5 Pulse oximetry, standard devices and fluids
6 for IV administration, sterile surgical sets for
7 airway and chest, thermal control devices for
8 patients, and IV fluids.

9 MS. DINOVA: And we'll add the rapid
10 resuscitation -- or the rapid infusers to this
11 section as well.

12 MS. HAMILTON: You need those in PACU?

13 MS. DINOVA: Oh, no, not in PACU. I'm sorry.

14 MS. HAMILTON: Why do we have the airway and
15 chest sets in PACU? Is that . . .

16 DR. ZITO: Because of the emergencies that can
17 happen in a PACU, yeah.

18 MS. HAMILTON: Okay. Thank you. I just
19 wanted to make sure I didn't jumble something
20 somewhere.

21 Any other comments, requested changes to the
22 PACU section?

23 MS. DINOVA: Starting with Dr. McKenney and
24 Dr. Ang.

25 DR. MCKENNEY: Nothing else from me.

1 This is Mark.

2 DR. ANG: I'm good as well. Thank you.

3 MS. DINOVA: Thank you.

4 All right. Open up comments to the room.

5 Wow. All right.

6 Any comments online?

7 All right. We're going to move on to ICU and

8 PICU then. And we're going to add --

9 MS. HAMILTON: Pupillometry.

10 MS. DINOVA: We'll change the airway language.

11 MS. HAMILTON: Change airway.

12 MS. DINOVA: And add the rapid infuser. This
13 is where I want the rapid infuser added.

14 MS. HAMILTON: So in addition to the
15 pupillometry equipment, there will be cerebral
16 monitoring equipment, again, pulmonary
17 resuscitation cart with meds and equipment,
18 compartment pressure monitoring devices, invasive
19 hemodynamic monitoring, orthopedic equipment for
20 the management of pelvic, lung, bone and spinal
21 fractures, cardiac pacing capabilities, pulse
22 oximetry scales, standard devices and fluids for IV
23 administration, sterile surgical sets for airway
24 and chest, and thermal control devices for
25 patients, IV fluids and environment.

1 MS. DINOVA: Any comments from the council,
2 Dr. McKenney, Dr. Ang?

3 DR. MCKENNEY: Nothing from Mark.

4 DR. ANG: I think this is appropriate for post
5 anesthesia recovery.

6 MS. DINOVA: This is -- this is ICU now.

7 DR. ANG: This is ICU?

8 MS. DINOVA: Yes, sir. ICU and PICU.

9 DR. ANG: Okay. Then ICU should have the
10 massive transfusion. Oh, there you go.

11 MS. DINOVA: Anything else? Anything else,
12 Dr. Ang?

13 DR. ANG: I don't see anything else.

14 MS. DINOVA: Thank you.

15 Okay. To the room.

16 Oh, sorry. Go ahead.

17 DR. ANG: No, I'm good.

18 MS. DINOVA: Okay. Now, open to the room.

19 MR. TAYLOR: Am I not seeing it or is it not
20 there, like, we have pulse oximetry, we have
21 scales, we have invasive monitoring, but I don't
22 see anything that's standard cardiac
23 (unintelligible) monitors, standard noninvasive
24 blood pressure cuff. Is that -- am I just not
25 seeing where it is or does that matter that -- that

1 it's there, it's just -- just assumed to be there?
2 Do we need it? Do we not need it? I just don't --
3 I'm just not seeing it.

4 MS. PINEDA: I think that's standard for ICU.
5 This is above and . . . It says monitoring for
6 blood pressure.

7 MS. HAMILTON: Is it in the resuscitation --
8 there's -- oh, it's invasive and monitoring.

9 MS. DINOVA: We can just copy that and pull it
10 down there.

11 MR. TAYLOR: Okay. I missed it. I'm sorry.

12 MS. DINOVA: No, we're going to add it down
13 there. I think it kind of fell out when we were
14 copying and pasting.

15 MS. HAMILTON: Okay.

16 MS. DINOVA: Oh, this says invasive, so it's
17 got both.

18 MS. HAMILTON: The discussion may have been do
19 we need to have that and that's okay.

20 MS. DINOVA: Okay. Any other comments in the
21 room?

22 All right. Any commentary online?

23 All right. We're going to keep moving then
24 because I think I'm losing my audience.

25 MS. HAMILTON: Med surg. Ready?

1 MS. DINOVA: Yeah.

2 MS. HAMILTON: Yeah. I'll change the airway
3 control equipment. Cardiopulmonary resuscitation
4 cart with drugs and equipment, standard devices and
5 fluids for IV administration and suction devices.

6 Council?

7 MS. DINOVA: Dr. McKenney, Dr. Ang?

8 DR. MCKENNEY: Nothing from Mark.

9 DR. ANG: We've had equipment for placing
10 chest tubes and things as part of carts on floors
11 routinely at places I've been to. And is that
12 already imbedded in our standards or is that just
13 unique to the places that I've been to?

14 MS. DINOVA: It is not currently in our -- in
15 our Florida standards nor the ACS standards.

16 DR. ANG: I see.

17 MS. R. HAMILTON: Rachel Hamilton, Halifax
18 Health.

19 Do we need video laryngoscope for a med surg
20 unit?

21 MS. DINOVA: I was going to ask that. I was
22 going to pose the same question. Do we need to
23 have the video laryngoscopes on the floors or just
24 in the resusc bay, OR and ICU?

25 So we can take the video laryngoscopes away

1 from the med surg floors? Because if they get into
2 trouble, they're going to call anesthesia anyway.

3 DR. ANG: Yeah, I would say that's reasonable.

4 DR. MCKENNEY: And just be cognizant of the
5 cost because we're going to start getting up, you
6 know, (unintelligible) up to your maximum price

7 MS. DINOVA: Yes, sir. Thank you.

8 All right. Fantastic. Any commentary on the
9 phone?

10 MS. HAMILTON: Yes.

11 MS. R. HAMILTON: Rachel Hamilton, Halifax.

12 For mechanical ventilation, it needs to be
13 accessible mechanical ventilation, because then
14 you're asking for critical care level -- critical
15 care level nursing for that floor, so access to
16 mechanical ventilation.

17 MS. DINOVA: Oh, I see what you're saying.

18 MS. R. HAMILTON: Medical surgical floors
19 don't have (unintelligible). I don't think they
20 have access to that.

21 MS. DINOVA: That's what she's saying, because
22 now we're out on the med surg floor, instead of
23 saying that they have to have a mechanical
24 ventilator, have access to a mechanical ventilator.

25 MS. R. HAMILTON: Or access to an increased

1 level of care that could offer X, Y and Z.

2 MS. DOUGLAS: Alisha from Lakeland Regional.
3 Douglas, sorry. Yes, peanut gallery.

4 The thing is, what did the standard say
5 before, because to that point, we don't need all
6 this in the med surg unit, because they're going to
7 be coming to the unit. Like, you're not going to
8 have -- you're not going to have this patient on
9 the ventilator in the med surg unit. You're taking
10 them down to the ICU or you're taking them to
11 wherever they're going.

12 MS. HAMILTON: This is the original, airway
13 control and ventilation equipment, including
14 laryngoscopes, endotracheal tubes of all sizes, bag
15 mass resuscitator and sources of oxygen.

16 MS. R. HAMILTON: You think 6 can go, 7 stay?
17 Because 6 is inclusive of 7, right?

18 MS. DOUGLAS: Yeah.

19 MS. HAMILTON: Let me look down here real
20 quick to make sure.

21 Yeah, so that's -- that's what it said before.

22 MS. DINOVA: Yeah, so what's in blue there,
23 that was the original language.

24 MS. HAMILTON: So we can just keep that.

25 MS. DINOVA: You want to keep that language

1 for the med surg and not change it?

2 I hear groans.

3 MS. SOWERS: I think you keep 7 and get rid of
4 6. Because the med surg unit --

5 MS. R. HAMILTON: Has a crash cart, has a code
6 cart, and they don't -- and they have an airway
7 cart that is in there. So either combine them
8 or . . .

9 MS. DINOVA: Okay.

10 MS. R. HAMILTON: -- or . . .

11 MS. SOWERS: They don't really fit in here,
12 but they need a cardiopulmonary resuscitation cart
13 and then they need a plan to get their patient to a
14 higher level of care, but that's just talking about
15 equipment.

16 MS. HAMILTON: So Number 6, the way I read
17 that, that is just having a BBM and and some stuff
18 to tube them before you get them out. It
19 doesn't --

20 MS. SOWERS: That's a code cart.

21 (Multiple speakers.)

22 MS. R. HAMILTON: 6 and 7 are kind of saying
23 the same thing.

24 MS. DINOVA: I think perhaps keeping in mind
25 that these standards originally -- originated in

1 1990, so maybe they weren't on the code cart. We
2 could -- so is the suggestion -- the suggestion in
3 the room right now is to strike 6 and just leave 7,
4 assuming the cardiopulmonary -- because it says
5 cardiopulmonary resuscitation. It's covered there.

6 Okay. To the council, Dr. McKenney, Dr. Ang,
7 would you support scratching 6 and keeping 7?

8 DR. ANG: I would.

9 This is Darwin.

10 MS. DINOVA: Dr. McKenney?

11 DR. MCKENNEY: Sorry, I forgot the hit the
12 mute -- unmute button.

13 Yes, I agree with Darwin.

14 This is Mark.

15 MS. DINOVA: Okay.

16 MS. HAMILTON: Okay. So this is acceptable to
17 all?

18 MS. DINOVA: Anybody else in the room?

19 Anyone online?

20 All right.

21 MS. HAMILTON: Awesome. That is the end of
22 that one.

23 MS. DINOVA: Two standards down, my friends.

24 MS. HAMILTON: And of note, there was no auto
25 transfuser, guys.

1 Okay. Standard 10, laboratory services.
2 Starts off, service capabilities. The trauma
3 center shall have the following laboratory
4 capabilities for adult and pediatric injured
5 patients available in hospital 24 hours per day.
6 And that is including services for the prompt
7 analysis of blood, urine and other body fluids,
8 blood gases and pH determination within 5 minutes
9 90 percent of the time, coagulation studies, drug
10 and alcohol screening, microbiology, serum and
11 urine osmolality. And all trauma centers must have
12 a sufficient supply of blood products readily
13 available with an appropriately staffed blood bank.
14 The blood bank shall, at a minimum, be capable of
15 providing the following. And that's blood typing,
16 screening and cross matching, platelets and fresh
17 frozen plasma.

18 Let's -- is that it, actually?

19 Hang on. Let me just finish it out and then
20 we'll get going.

21 The trauma center shall have written protocols
22 available ensuring that injured patients receive
23 priority over routine laboratory tests. And for
24 staffing requirements, a laboratory technician
25 shall be available in hospital 24 hours per day to

1 conduct laboratory studies for injured patients.

2 And I'm going to open this up to council.

3 MS. DINOVA: So -- and I have to look at
4 the -- the Gray Book, because we took this -- is
5 this our current Florida standard or was this a
6 Gray Book edition?

7 MS. HAMILTON: Yeah, so if we look down here,
8 most of this was already in play. We did remove
9 the 10 units of Type O blood.

10 MS. DINOVA: Okay. Should -- my question
11 would be then -- scroll back up. My question would
12 be then, since we did list out platelets and FFP,
13 should we also include PRBT? Because this is,
14 again, at a minimum. Since we took out the 10
15 units rule during the discussion in the comments
16 hours. I mean, if you're going to list two you
17 might as well list the third one.

18 DR. ANG: This is Darwin.

19 I agree. We need to be very clear on what
20 they have.

21 DR. MCKENNEY: Yeah. Mark.

22 No problem with that at all.

23 MS. DINOVA: Okay. Because it's -- it's if we
24 have beyond that, then it's okay. Like, those of
25 us that are carrying whole blood or whatever,

1 that's fine and dandy. This is a minimum. But if
2 we're going to list two, we need to list all three
3 components.

4 Okay. Dr. McKenney, Dr. Ang, any other
5 comments on this section?

6 DR. ANG: You can also include cryo. I mean,
7 we use that as well.

8 MS. DINOVA: Okay.

9 DR. ANG: Cryoprecipitate.

10 MS. DINOVA: Okay.

11 Okay. Any comment in the room?

12 Oh, yeah, I see all kinds of hands.

13 DR. ZITO: This is Tracy Zito.

14 I have a comment.

15 MS. DINOVA: Yes, ma'am.

16 DR. ZITO: And I'll ask Mark and Darwin what
17 they think, but I think it's pretty standard of
18 care anymore with any massive transfusion protocol,
19 which every trauma center should have, to have some
20 sort of viscoelastics (unintelligible) assay, like
21 TEG or ROTEM. I'm pretty sure we talked about
22 this, right? Didn't we talk about this when we
23 talked about the standard?

24 MS. HAMILTON: We did talk about it and the
25 financial --

1 DR. ZITO: What did we decide, the financial
2 burden of the machine?

3 MS. HAMILTON: Right. That although it is
4 listed in the best practice guidelines and that it
5 is highly encouraged, it's also --

6 DR. ZITO: Yeah, just -- just forget it. I
7 know we had this whole discussion, but it's -- it's
8 in here with me, you know, so . . .

9 MS. SOWERS: Dea Sowers, St. Joe's Children.
10 Sorry. Just for, like, the ease of the
11 document, Number 2 says all trauma centers must
12 have sufficient blood products readily available
13 and then it kind of tells you what you need to have
14 below. Can we just make that all one thing, just
15 for ease of access for people --

16 MS. DINOVA: Include readily available,
17 including, that. Okay.

18 It's not a minimum.

19 Okay. Michael?

20 MR. TAYLOR: From a regulatory perspective, a
21 sufficient supply of brood product, how is that
22 going to be -- when you go to do a survey, how are
23 you going to look at that? Are you going to look
24 to say, in the last year we've had a sufficient
25 supply of blood for every mass transfusion

1 protocol? How are we going to do that from
2 (unintelligible)?

3 DR. ZITO: I can answer that for you. So
4 that -- it's Tracy Zito.

5 The way they can handle that is just by the PR
6 review of your MPT administration and the morbidity
7 and those sorts of things that go along with that.
8 If they're activating an MTP and they're
9 consistently running out of blood products, they do
10 not have an adequate supply of blood products. But
11 to say that every center needs to have an X number
12 of, that can lead to a lot of wastage.

13 A place like Orlando Regional that uses MTPs
14 countless times per week is going to be very
15 different than Lake Monroe that maybe uses it once
16 per week. You see what I mean?

17 MR. TAYLOR: Yep.

18 DR. ZITO: So I think -- I don't think there's
19 a minimum we can require. And I think that's how
20 we ended up with that language.

21 Do you guys agree with that?

22 MS. DINOVA: Yes.

23 MS. HAMILTON: Yes.

24 MR. TAYLOR: So should that -- should that
25 sufficient be expanded a little more to explain

1 what you just explained, very briefly explained,
2 that --

3 UNIDENTIFIED SPEAKER: No.

4 MR. TAYLOR: No? You want to leave it at --
5 just want to --

6 DR. ZITO: Oh, I think it says what it says.

7 MR. TAYLOR: -- leave it as sufficient. Okay.

8 MS. DINOVA: Okay. Any more comments in the
9 room?

10 All right. How about online?

11 Is anybody still awake online?

12 MS. MAGDA: Yes, this is Magda from Jax South.

13 I was going to ask the same question. Like,
14 my definition for sufficient and your definition
15 for sufficient are two different things -- may be
16 two different things. So I'm a little wishy-washy
17 about that sufficient word.

18 MS. DINOVA: I have a suggestion. So what if
19 at the end of the sentence there we put as
20 monitored by the PI process?

21 MS. MAGDA: Perfect.

22 MS. DINOVA: All trama centers must have a
23 sufficient supply of blood products readily
24 available, including platelets, FFT, PRBCs, cryo as
25 monitored by the PI process.

1 MS. MAGDA: That's a little better. Yeah,
2 yeah.

3 MS. DINOVA: Okay.

4 MS. MAGDA: Thank you.

5 MS. DINOVA: Okay. Anyone else online or in
6 the room?

7 Fantastic. Moving on.

8 MS. HAMILTON: Moving on.

9 MS. DINOVA: Was that a whole 'nother standard
10 down?

11 MS. HAMILTON: That's a whole 'nother one.

12 And look at this one, guys. This one is one
13 line. So let's --

14 MS. DINOVA: That terrifies me.

15 DR. ZITO: Let's see how long we can talk
16 about this.

17 MS. HAMILTON: Level 1, 2 and pediatric trauma
18 centers must have renal replacement therapies and
19 services available for the support of injured
20 trauma patients with renal failure 24 hours a day.

21 Council?

22 MS. DINOVA: I'm okay with that.

23 Dr. McKenney? Dr. Ang?

24 DR. ANG: I agree.

25 This is Darwin.

1 DR. MCKENNEY: (Unintelligible).

2 MS. DINOVA: All right. Commentary in the
3 room?

4 Thumbs ups and head shakes.

5 Any comments online?

6 A standard done in 30 seconds. All right.

7 MS. DINOVA: Oh.

8 MS. HAMILTON: Oh, Michael.

9 MR. TAYLOR: Is that available in house or
10 anybody that does it available outside?

11 MS. DINOVA: It just has to be available 24
12 hours.

13 DR. ZITO: No, it has to be -- you have to be
14 able to implement it in the hospital 24/7.

15 MR. TAYLOR: In house. Okay.

16 MS. DINOVA: However that is.

17 MR. TAYLOR: I was just thinking the type of
18 disasters and the things we get in Florida here
19 that are unique to Florida, is -- is that going to
20 inhibit folks getting out of your trauma center to
21 the dialysis center and back.

22 (Multiple speakers.)

23 MS. DINOVA: Yeah, this is acute hemodialysis,
24 not chronic hemodialysis.

25 MS. SOWERS: Just a reminder we all have to

1 talk at one -- one at a time.

2 MS. DINOVA: I'm sorry. I apologize for the
3 lack of formality and the fact that I've lost total
4 control.

5 DR. ZITO: Just for the record, this is for
6 acute intensive care unit management of the renal
7 failure patient.

8 I'm Tracy Zito from Orlando.

9 MS. DINOVA: All right. Are we good with
10 hemodialysis now?

11 Moving on.

12 MS. HAMILTON: Moving on. We are now
13 radiology. All trauma centers must have the
14 following services available around the clock and
15 accessible for patient care within the time --
16 within the specified time frames. Note that the
17 time frame refers to the duration between the
18 initial request and the commencement of the test
19 procedure, not necessarily its completion. So for
20 conventional radiology, it's within 15 minutes.
21 For CT, within 15 minutes. Point of care
22 ultrasound, 15 minutes. Interventional radiology
23 is within one hour. And MRI within two hours.

24 And let's stop there for a sec.

25 And, council, any comments?

1 MS. DINOVA: Dr. McKenney? Dr. Ang?

2 DR. ANG: So the inter- -- this is Darwin.

3 So the interventional radiology procedures
4 within one hour, how is that defined? From consult
5 to treatment or intervention?

6 MS. HAMILTON: It's from the initial request
7 to the commencement of the procedure.

8 DR. ZITO: I can -- I -- Darwin, I think -- is
9 Steve Smith still here? Yeah, still here. So if
10 I'm not mistaken, I think the Gray Book, that one
11 hour is from time of consult to time of radiology
12 arrival, correct? The radiologist's arrival?

13 MS. HAMILTON: Puncture time.

14 DR. SMITH: Puncture time.

15 DR. ANG: I think it's from the procedure,
16 yeah.

17 DR. ZITO: Commencement of procedure.

18 DR. SMITH: Consult to catheter in the artery.

19 DR. ZITO: Okay.

20 MS. DINOVA: Okay. So that's the commencement
21 of the procedure part.

22 DR. ZITO: Yeah. I think that wording works.

23 DR. ANG: Okay.

24 MS. DINOVA: Dr. Ang, any further comment, or
25 Dr. McKenney?

1 DR. ANG: No.

2 DR. MCKENNEY: No, not from Mark.

3 MS. DINOVA: Okay. Commentary in the room?

4 And anybody online?

5 All right. Moving to Section B.

6 MS. HAMILTON: All trauma centers are required
7 to establish a system for remotely accessing
8 radiographic images from referring hospitals within
9 their catchment area. These access methods may
10 encompass options such as e-mail, a phone mobile
11 application, a PAC system, and various other
12 suitable means.

13 In all trauma centers, the final
14 interpretation of CT scans must be documented no
15 later than 12 hours after the CT scan's completion.

16 And under service capabilities, the following
17 radiological service capabilities for trauma alert
18 patients must be available 24 hours a day in all
19 trauma centers. A radiologist must have access to
20 patient images and be available for imaging
21 interpretation, either in person or by phone,
22 within 30 minutes of request. And geography of all
23 types with a maximum response time until the start
24 of procedure of 60 minutes CT and routine
25 radiological studies.

1 And we will stop there for a moment.

2 Council?

3 MS. DINOVA: Dr. McKenney? Dr. Ang?

4 DR. ANG: This is Darwin. This is Darwin.

5 I'm fine with the language as written.

6 DR. MCKENNEY: This is Mark.

7 It seems very reasonable.

8 MS. DINOVA: Thank you.

9 Comments in the room?

10 Yes, Candace.

11 MS. PINEDA: There's a comment in the chat
12 from Dr. Diaz. The time limit for the IR will have
13 an impact on certain centers. Will require
14 additional manpower to staff. Will need to
15 consider time to implementation.

16 DR. ZITO: Just in response to that, I think
17 the prior requirement was 30 minutes, wasn't it?

18 MS. KOCEVAR: I thought it was 60.

19 DR. ZITO: The consult.

20 MS. HAMILTON: Just going to get down to --

21 DR. ZITO: No, I'm talking about the previous
22 Florida standard.

23 MS. HAMILTON: The previous standard here is
24 angiography with a maximum response time until the
25 start of procedure of 60 minutes. So it's the

1 same.

2 DR. ZITO: It's the same as it was before
3 then. Okay. I thought it even said 30 minutes
4 before. So I don't think it will add any
5 different . . .

6 MS. DINOVA: Okay. Any other comments?

7 All right. Moving forward.

8 MS. HAMILTON: For staffing requirements,
9 radiological personnel required to deliver
10 radiological services for trauma alert patients
11 must be accessible around the clock. At the very
12 least this should encompass the following: Human
13 and physical resources must be continuously
14 available so that an endovascular or interventional
15 radiology procedure for hemorrhage control can
16 commence within 60 minutes of request. Radiologist
17 must be board certified or actively engaged in the
18 certification process with a timeline established
19 by each faculty board and must be promptly
20 available 24 hours per day. Chief radiology
21 residents may fulfill this requirement if the
22 trauma medical director ensures the following: A
23 staff radiologist on call and available to arrive
24 promptly at the trauma center when called. The
25 trauma medical director and chief of radiology

1 provide written attestation that each participating
2 resident is capable of the following: Authorizing
3 any radiological studies required for trauma alert
4 patients, conducting appropriate evaluation of
5 radiological studies for trauma alert patients.

6 I'm going to stop there because I'm not going
7 to -- okay.

8 MS. DINOVA: Okay. So we're looking at
9 Section E now. Dr. McKenney? Dr. Ang?

10 DR. MCKENNEY: Yeah, I like it. No issues for
11 Mark McKenney.

12 DR. ANG: This is Darwin.

13 I don't have any issues either

14 MS. DINOVA: Okay. Any comment in the room?

15 All right. Anyone online?

16 MS. DINOVA: All right, guys. We're getting
17 there.

18 Oh, hold on. I think Candace has a comment.

19 MS. PINEDA: There's just a comment of who
20 will be held responsible for monitoring compliance
21 with all the benchmarks without language to require
22 specific resources rather than recommended
23 resources?

24 MS. HAMILTON: Where are you referencing?

25 MS. PINEDA: Scroll up a little bit. I think

1 it's the CT within 12 hours or some of the other
2 radiology.

3 MS. HAMILTON: The times, I will say, are
4 (unintelligible).

5 MS. DINOVA: Can you ask whoever it was to
6 help.

7 MS. PINEDA: Lianne, are you able to chime in
8 and comment?

9 MS. DINOVA: Who was it, Candace?

10 MS. PINEDA: She said radiology within 15
11 minutes.

12 MS. HAMILTON: That is in x-ray.

13 MS. DINOVA: In Section A or in a different
14 section?

15 Candace, who was it online?

16 MS. PINEDA: It's Lianne.

17 Yeah, so it is about Section A. I guess she's
18 wondering how this can be monitored or reported.

19 MS. DINOVA: That would be within the PI.

20 MS. PINEDA: I can comment. I've been looking
21 at this with my radiology department. And if you
22 have an electronic medical record, they should be
23 able to pull time to order time stamp until the
24 time of the start of the procedure, so they can
25 give you that.

1 I can tell you one challenge for my center is
2 that we prealert patients, we automatically order
3 imaging prior to the patient's arrival. So our
4 times are actually longer than actually happen
5 because we don't order right before we send the
6 patient. So there's a little bit of skewed data
7 there, but it -- if everybody has an electronic
8 medical record, someone should be able to pull that
9 and maybe report it at your operations meeting.

10 MS. DINOVA: So does that answer it for her?
11 I know she's texting or she's messaging.

12 MS. PINEDA: Does anyone else have a concern
13 or just question on how to operationalize that?

14 MS. DINOVA: Lianne, did that -- did that
15 answer your question or do you think -- do you have
16 language that you think we should add?

17 MS. BROWN: Hey, this is Lianne Brown, Sacred
18 Heart in Pensacola.

19 I just -- I just have a concern with the more
20 quality measures that we add -- it's not just
21 these, I know that there's going to be more. But
22 the more quality measures that we put in place that
23 will have to be trended and tracked, just adding to
24 the workload when we have not got language in place
25 to ensure trauma program support, such as PI

1 coordinators per total number of patients that are
2 put in, obviously (unintelligible) from a registry
3 perspective. I know that it's a known factor, but
4 without having specific language for resources, it
5 becomes more taxing and difficult for an already
6 existing staff.

7 MS. DINOVA: So to recap, the way that the
8 current Florida standard is written, it just says
9 that we have to have these capabilities. It
10 doesn't have time frames allotted to them. The
11 time frames came from the Gray Book and the
12 conversation that we had on the comments hours.

13 So I'm open to -- to comments from everyone.

14 MS. PINEDA: This is Candace.

15 MS. DINOVA: It gave up on you.

16 MS. PINEDA: This is Candace Pineda from
17 Memorial Regional.

18 Did we address -- 'cause if we're trying to
19 add or make standards similar to national, national
20 does have a requirement of PI per number of
21 patients as well as registry per number of
22 patients. Did we try to incorporate that in other
23 standards? That would help address the comment.
24 Anybody? Did we get that far yet?

25 MS. HAMILTON: So we did discuss PI staffing.

1 It's still open. However, we thought that the
2 financial burden was going to definitely outweigh
3 that 200,000.

4 DR. ANG: This is Darwin Ang, Ocala.

5 I mean, I agree. I think we do need to look
6 at a PI nurses-to-patients admitted to trauma
7 center ratios as in the Gray Book. These are a lot
8 of metrics. Our trauma centers need support to be
9 able to get these metrics done. And so I'm in
10 support of coming up with at least a minimum ratio
11 of PI to patients.

12 MS. BERGER: This is Amy from UF Health
13 Shands.

14 I don't need the microphone.

15 I'm going to let Dr. Smith just confirm what
16 I'm going to say before he leaves. Doesn't the
17 ratio say for registrars it's .5 for every
18 two-fifths to 300, whereas the PI nurse says one PI
19 over 1,000 patients? So it really -- I don't think
20 it's going to impact -- and I don't know other
21 centers -- as much as maybe we think it was because
22 I think maybe the initial understanding was it was
23 the same as the registrars.

24 MS. DINOVA: So I think that's something that
25 we'll have to look at when we -- the PI section

1 is -- as those of you that have been on the calls
2 know, that's one that we've been hashing out for a
3 little while and we're going to have to come back
4 to it. I do think that we could leave this in for
5 now, but as we keep our running list of dollar
6 signs that we're creating, we may have to come back
7 and reassess that. So maybe we can add on our
8 dollar signs list the PI staffing and then
9 reference it back to this standard so that we know
10 to come back and look at this if we think that the
11 staffing is going to be the burden, then we may
12 have to come back and look at this standard again
13 as well and say, do we take these times off because
14 it's going to be too difficult for our PI staff to
15 monitor if we can't get the funding for the
16 additional staff members.

17 Does that seem reasonable? Let's leave it how
18 it is for now and then if we decide that we can't
19 request the additional funding for the PI staffing,
20 then we may have to come back and take these times
21 off.

22 Yes, Dr. Smith.

23 DR. ANG: Well, I think we can -- this is
24 Darwin Ang. I'm sorry.

25 I think these times are important. I mean,

1 you do need timely CT imaging. You need definitely
2 timely IR procedure, you know. And this is part of
3 the requirement in the Gray Book. And many of us
4 are dual certified, state and ACS, so regardless,
5 you know, the majority of trauma centers are going
6 to be following these times.

7 I think our state standard should support
8 what's best for patient care. And if getting these
9 times down and getting more PI nurses is what's
10 going to be important for patients, I think that's
11 what we need to do. And so I would keep these
12 times in and we would -- we need to do a hard look
13 at the PI-to-patient ratio and then have a more
14 in-depth discussion. Because these are time
15 periods I think that are important for patient care
16 and they're supported through the Gray criteria --
17 the Gray Book and the ACS criteria for the injured
18 patients.

19 MS. DINOVA: Dr. Smith.

20 DR. SMITH: Steve Smith, Gainesville.

21 For 1, 2 and 3, I would simply say immediately
22 available. That's what the ACS looks at basically
23 when you do the reviews. And it's not a PI issue
24 unless they're not immediately available and then
25 you do the PI process. To -- to have your

1 registrars or PI nurses look at 15 minutes, 15
2 minutes, 15 minutes for every patient that comes in
3 is going to create an inordinate amount of work
4 that's probably not going to get done.

5 What Amy said is right, the -- the Gray Book
6 standard is .5 FTE for every 2- to 300 patients, in
7 other words, a max of 600 for one FTE. But the
8 Gray Book standard also is one PI nurse. That was
9 not the original discussion point. It was supposed
10 to be one per thousand and it didn't come out that
11 way in the standards.

12 MS. DINOVA: We would all love to see that in
13 a clarification.

14 DR. SMITH: Yeah, I think that's what it
15 should be, frankly. And I think that was the -- at
16 least the original discussion, but that is not the
17 standard that came out.

18 MS. DINOVA: Yeah. I think we're going to
19 have to -- I see where all of you are saying about
20 adding the times. It just is something that we may
21 have to come back and look at with the dollar signs
22 with the PI staffing.

23 Yes, Candace.

24 MS. PINEDA: Candace Pineda, Memorial
25 Regional.

1 I think that this is a nicer or more defined
2 way to restate that trauma patients should have
3 priority. When you're at a center that also does
4 many other specialty service lines, neuro and
5 transplant and other, it's hard to say one service
6 trumps the other. So if you just say injured
7 patients need this immediately available, then it
8 still gives them the priority. So I think having
9 sort of time or immediately available still gives
10 that without having to be competitive with other
11 services.

12 And two, at the beginning in the
13 administrative commitment, it says: You will
14 provide all human and other resources necessary to
15 meet the standards. So even if you don't have a
16 specific -- I know a lot of centers really need
17 some more granular level to get support, but if you
18 can't meet your requirements, administration signs
19 a document that says they'll do what's necessary to
20 make it happen, so . . .

21 MS. DINOVA: All right. So I think the
22 suggestion on the table is for right now to leave
23 it how it is and then once we get to the end of all
24 the revisions and we look at the dollar signs, if
25 we need to, we can come back and look and see if

1 this is going to be a PI burden.

2 Lianne, does that meet your concerns?

3 MS. BROWN: Yes, it does. Thank you.

4 MS. DINOVA: Okay.

5 All right. We have made note of that.

6 Any other commentary about this section?

7 No.

8 I'm trying to remember where we left off. Was
9 it --

10 MS. HAMILTON: Here.

11 MS. DINOVA: Oh, here. Yes, we did.

12 MS. HAMILTON: And I believe that was all
13 good. And then we -- so we --

14 Radiologists at trauma centers utilizing
15 teleradiology may take call from the site of the
16 off-campus computer terminal if the trauma center
17 assumes all responsibility and liability to ensure
18 that images are of such quality that the patient's
19 outcome is not compromised. Radiologists working
20 off campus must arrive promptly to the trauma
21 center when summoned.

22 And talking about CT, CT technicians must be
23 available in hospital 24 hours a day. A
24 radiological technician must be available in
25 hospital 24 hours a day.

1 And should I close it out with the CT?

2 Okay. CT scanner requirements. There must be
3 at least one CT scanner available for trauma alert
4 patients and it must be located in the same
5 building as the resuscitation area. CT scanners
6 situated in more remote areas of the hospital
7 campus necessitating patient movement from one
8 building to another and mobile units or in other
9 institutions do not meet this requirement.

10 If the trauma center only has one CT scanner,
11 there must be a written plan in place outlining the
12 steps to be taken in case the apparatus is in use
13 or temporally inoperable. This plan must include
14 agreement for transporting trauma patients.

15 MS. DINOVA: Okay. So any discussion on --
16 starting at 3 and moving to the end of the standard
17 there?

18 Dr. McKenney? Dr. Ang?

19 DR. MCKENNEY: Hey, this is Mark.

20 I got cut off for a little bit, but I caught
21 that. And I think the standard is reasonable.

22 MS. DINOVA: Okay. Dr. Ang?

23 DR. ANG: I think the standard is reasonable
24 as well. I'm assuming that no one's going to be
25 using an 8-slice CAT scan for trauma, but I assume

1 no one's going to be using those -- those
2 less-than-modern CAT scans.

3 MS. DINOVA: Okay. Any comment in the room?
4 All right. Any commentary online?

5 All right. Moving on.

6 MS. HAMILTON: That's the end.

7 All right.

8 MS. DINOVA: One more standard, guys. Hang in
9 there.

10 MS. HAMILTON: You've got this.

11 MS. DINOVA: One more to do today.

12 MS. HAMILTON: And where is Dr. Zito, 'cause
13 this is disaster.

14 MS. KOCEVAR: She's online. She had to
15 unfortunately depart, but she's online.

16 MS. DINOVA: Perfect. Okay.

17 MS. HAMILTON: Okay. The trauma center shall
18 meet the disaster-related requirements pursuant to
19 Standard 395.1055(1)(c) Florida statute -- I don't
20 really know how to say that, so I apologize -- and
21 the Agency For Health Care Administration
22 Comprehensive Emergency Management Plan, Chapter
23 59A-3.078 Florida Administrative Code, and Joint
24 Commission on the Accreditation of Health Care
25 Organizations standards.

1 That is what was there before. That's been
2 left there. No changes.

3 What we did add was: To ensure a strong
4 surgical response in the event of a disaster, it is
5 imperative to integrate all trauma programs into
6 the hospital's disaster plan. The hospital's
7 disaster committee must include a trauma surgeon
8 from the trauma panel. This surgeon should be
9 responsible for producing a surgical response
10 strategy for mass casualties. This surgical
11 response strategy should encompass essential
12 elements such as identifying critical personnel,
13 establishing communication methods, conducting
14 initial surgical triage, including subspecialty
15 triage when applicable, and coordinated secondary
16 procedures.

17 The trauma program should actively participate
18 in hospital drills or disaster plan activation each
19 year. These drills and activations should involve
20 a trauma response and be designed to enhance the
21 hospital's preparedness for a mass casualty event.

22 MS. DINOVA: This is Lisa.

23 My only comment would go back to the
24 conversation that we had earlier about the
25 redundancy plan for communication. So my

1 suggestion would be in here where it says
2 establishing communication methods, perhaps adding
3 with -- with a backup or redundancy plan.

4 Would that meet the concerns that we had
5 earlier in the communications discussion?

6 UNIDENTIFIED SPEAKER: I'm going to say it
7 does.

8 MS. DINOVA: Okay.

9 DR. ANG: Yes.

10 MS. DINOVA: With redundancy or backup,
11 whichever word you want to use.

12 MS. DOUGLAS: This is Alisha from Lakeland.
13 That's actually in A. So that's in A. The
14 communication, that -- the two-way radio and all
15 that is in A for disaster preparedness --

16 MS. DINOVA: Oh, it's in the code already?

17 DOUGLAS: Yeah, in disaster preparedness, they
18 are required to have two-way radios. That's part
19 of that. So it's in A.

20 MS. DINOVA: Okay.

21 MS. HAMILTON: So what would you guys like to
22 do? Leave that with a backup communication plan
23 out?

24 MS. DINOVA: Or I think she's saying -- so
25 what we had -- so A came from the current Florida

1 standard.

2 MS. HAMILTON: I know it's already all in
3 there.

4 MS. DINOVA: A came from the current Florida
5 standard and B came from the Gray Book, and we kind
6 of mushed them together. I think what Alisha is
7 saying that A kind of already covers B.

8 MS. KOCEVAR: Dr. Ebler was the one that was
9 asking about this.

10 MS. DINOVA: Dr. Ebler, are you online? I
11 believe you had some questions or comments about
12 this section.

13 DR. EBLER: Yeah, I'm here. I'm just trying
14 to read it.

15 The point I was just trying make, you know,
16 earlier was there should be some kind of language
17 in there encouraging the continued utility of, you
18 know, radios for two-way communication. You know,
19 my one concern is that if we leave it kind of
20 vague, then people will just put it in that they,
21 you know, rely on -- you know, on some kind of
22 cellular based communication for two-way
23 communication.

24 I'm trying to read the verbiage on that to see
25 if it -- this accounts for it or if within the

1 state EMS, you know, communication plan it has that
2 within it.

3 MS. DINOVA: I think that's what Alisha is
4 saying, is that in -- in those standards or the
5 statute that's listed up there, 395, and then the
6 EMS plan Chapter 59A, already addresses having the
7 two-way radios.

8 DR. EBLER: Yeah. That was just my -- my
9 concern. You know, I think, you know, it's been --
10 it's been 20 years since, you know, 9/11, but it
11 was a very chaotic event and the first thing that
12 went down was the cellular communication. So and,
13 you know, we relied on radios and even fax machines
14 and landlines. So, yeah, as long as that's just
15 acknowledged and there's something in there about
16 backup communication and not -- you know, having
17 radios actually as part of that plan.

18 MS. DINOVA: Yeah. And I think she's
19 confirmed, she went on and looked and it's --
20 that's in there already. So that should cover us
21 then. So we took that back out.

22 DR. EBLER: Okay. Thank you.

23 MS. DINOVA: What about the rest of the
24 standard, anybody?

25 Dr. McKenney or Dr. Ang?

1 DR. ANG: Standard looks fine to me.

2 MS. DINOVA: Okay. And Dr. McKenney?

3 DR. MCKENNEY: This is Mark.

4 Same thing.

5 MS. DINOVA: All right. Commentary in the
6 room?

7 Comments online?

8 Friends, we just have a consensus document of
9 six standards. Thank you so much for your work.

10 Don't hang up yet. I have, like, three
11 slides. I swear this is going to be quick.

12 MS. HAMILTON: You guys did so good. You get
13 next week off.

14 MS. DINOVA: That's what I was going to --
15 that's going to be next, future business. All
16 right. So I'm keeping a running list of things
17 that we will need to, as a council, come back and
18 actually vote on, was those by-laws update, the
19 charter update, getting Candace and I out of these
20 positions and putting somebody else in them. That
21 will come when we get some more people in.

22 Public comment. I'm supposed to formally open
23 this up for any public comment. I think we've been
24 public commenting the whole time.

25 Anybody online have anything that they need to

1 add?

2 All right. So our next comments hours
3 meeting, like Laura said, we're going to give you
4 next week off since we've been here for two days
5 doing meetings. Our next comments hours meeting
6 will probably be on Tuesday, the 17th. We're going
7 to get that posted, get the agenda posted and the
8 Teams links all connected for you and get the rest
9 of those dates moving forward posted. So make sure
10 that you go to the advisory council tab on the DOH
11 website to find those notices probably beginning of
12 next week sometime.

13 Our next advisory council meeting is going to
14 be January of 2024 in Orlando. We're going to meet
15 up with the other organizations and committees that
16 are meeting there that week. We will get you a
17 formal date and get that posted to the website as
18 well.

19 Okay. If nobody has anything further, I'm
20 going to call this meeting adjourned.

21 (Meeting concluded at 2:07 p.m.)

22

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CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF ALACHUA)

I, Erica Owen, Court Reporter, certify that I was authorized to and did stenographically report the foregoing meeting on the 5th day of October, 2023, and that the transcript is a true and complete record of my stenographic notes.

Dated this 1st day of November, 2023.

Erica Owen



Erica Owen