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

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

Meeting began at 12:12 p.m.:

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

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

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

(Brief interruption.)

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

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

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

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

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

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

THE GROUP: (Complies.)

MS. DINOVA: Thank you very much.

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

We are also going to have a couple of updates,

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

Dr. Ang, are you on the line?

Okay. Dr. Nemias?

Dr. McKenney?

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

MS. KOCEVAR: Lisa DiNova.

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

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

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

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

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

(Brief interruption.)

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

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

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

(Brief interruption.)

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

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

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

Lisa, what else do I need to give you?

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

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

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

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

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

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

Does anyone have any questions of me?

Yes, Michael. Michael Taylor.

MR. TAYLOR: Michael Taylor from Hillsborough County.

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

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

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

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

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

Anyone online have any questions of me?

All right. Well, thank you very much.

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

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

DR. PAPPAS: Okay.

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

DR. PAPPAS: The magic microphone water bottle.

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

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

(Brief interruption.)

DR. PAPPAS: Hi, Mark.

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

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

(Brief interruption.)

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

And that concludes my reports.

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

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

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

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

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

(Brief interruption.)

MS. DINOVA: He's back.

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

We're going to be looking at the Florida

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

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

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

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

MS. DINOVA: For today?
DR. MCKENNEY: Yeah. I just got it.
MS. PINEDA: I'll send it to them.
MS. DINOVA: Candace is going to send it to them right now.
MS. PINEDA: I'm trying. It's not letting me.
MS. DINOVA: Try Dr. Nemias. He was on earlier.
MS. KOCEVAR: Nemias sent it. So I'll send it out to Nemias.
DR. ZITO: Yeah, when you guys were talking, I texted everybody and --
DR. MCKENNEY: Yeah, I just got it.
MS. DINOVA: Thank you, Dr. McKenney. And hopefully now, Dr. Ang will get it and be able to join us as well.
So we will make sure -- we'll double-check the -- the website. But usually, the links are posted there with the announcements that are up there. So we'll double-check that the Teams links are -- are adjoined also.
Okay. So, again, moving forward, we're going to be looking at these six standards today. This is your opportunity to throw in your questions, your comments, your concerns, any language changes

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

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

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

All yours, Laura.

MS. HAMILTON: Laura Hamilton, Bayfront Health.

So first, thank you to everybody that has been

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

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

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

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

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

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

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

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

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

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

MS. DINOVA: Thank you.

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

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

MS. PINEDA: Okay.

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

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

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

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

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

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

You want to get the whole thing then . . .

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

So in reviewing that --

(Brief interruption.)

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

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

(Brief interruption.)

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

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

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

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

DR. MCKENNEY: No, no comment right now.

MS. DINOVA: Okay. Thank you.

Dr. Ang, were you able to join?

No?

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

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

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

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

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

attendance.

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

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

DR. ANG: Okay.

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

DR. ANG: Thank you.

MS. DINOVA: No one in the room.

No one online.

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

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

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

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

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

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

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

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

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

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

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

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

MS. DINOVA: I agree.

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

I don't see anybody reaching for a microphone.

So anyone online?

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

These will also be posted after the meeting. We'll get these posted to the advisory council website so you can review it further before they come to the AFTC and FCOT for final approval.

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

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

And let's just stop there for a sec.

Council, any comments on the diversion section?

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

MS. HAMILTON: Yes. It was.

DR. ANG: Okay.

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

DR. ANG: Yeah, I agree with that.

MS. DINOVA: Okay.

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

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

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

Is that 400 hours --

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

DR. SMITH: Steve Smith, UF Gainesville.

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

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

UNIDENTIFIED SPEAKER: Sorry. What was the question?

MS. DINOVA: It's probably about that.

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

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

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

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

years.

DR. SMITH: Okay.

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

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

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

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

MS. DINOVA: One year.

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

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

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

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

This is Candace Pineda, Memorial Regional.

MS. HAMILTON: Thank you for that.

DR. SMITH: Sure.

MS. HAMILTON: So then that would be changed

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

(Brief interruption.)

MS. HAMILTON: -- 400 hours annually.

Any other stakeholder comment?

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

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

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

All right. Moving on to the next section.

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

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

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

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

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

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

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

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

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

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

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

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

DR. ANG: Okay. Sounds good.

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

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

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

Okay. Anyone online have any additional comments or feedback?

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

MS. KOCEVAR: Not all today.

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

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

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

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

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

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

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

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

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

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

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

Dr. McKenney or Dr. Ang?

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

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

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

DR. ZITO: I still have one.

UNIDENTIFIED SPEAKER: I still have one.

MS. DINOVA: We still have them.

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

MS. DINOVA: We do both.

DR. ZITO: We do both.

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

MS. DINOVA: Okay. Thank you.

Any other comments?

All right. Anyone in the room?

Yes.

MR. TAYLOR: Michael Taylor from Hillsborough County.

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

Is it on?

It is on.

Michael Taylor, Hillsborough County.

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

MS. HAMILTON: Any comments on that?

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

MS. DINOVA: Nope. Go ahead.

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

MS. DINOVA: That's Dr. Zito.

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

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

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

MS. DINOVA: So for --

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

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

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

Why don't we use the word bidirectional?

MR. TAYLOR: That's good.

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

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

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

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

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

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

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

DR. ZITO: I would leave the term --

MS. PINEDA: Tracy Zito, Orlando Health.

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

MS. DINOVA: Go ahead, Dr. Zito.

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

MS. DINOVA: Okay.

MS. PINEDA: This is Candace --

DR. EBLER: This is Dave Ebler from UF Health

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

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

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

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

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

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

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

Sorry. This is Tracy Zito again.

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

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

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

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

MS. DINOVA: So leave --

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

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

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

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

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

it's in there.

DR. EBLER: Right.

MS. PINEDA: This is Candace Pineda.

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

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

MS. PINEDA: Yes.

MS. DINOVA: Okay. So including radio.

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

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

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

That may be down with the pagers, Number 12.

MS. DINOVA: So --

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

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

MS. HAMILTON: A system to communicate immediately --

MS. PINEDA: With the trauma team.

MS. HAMILTON: -- with the trauma team.

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

MS. PINEDA: And this is Candace Pineda again.

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

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

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

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

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

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

(Off-the-record discussion.)

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

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

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

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

DR. ANG: This is Darwin Ang.

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

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

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

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

I think it should just say including video,

not should. Because should leaves open to interpretation.

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

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

MS. HAMILTON: Okay.

Michael?

MR. TAYLOR: Michael Taylor.

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

No? Okay.

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

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

MS. DINOVA: Yeah. This is the minimum.

MR. TAYLOR: Okay.

MS. DINOVA: Okay.

MS. PINEDA: Candace -- Candace Pineda,

Memorial.

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

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

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

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

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

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

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

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

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

MS. HAMILTON: -- levels of care.

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

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

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

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

MS. DINOVA: Just pass it around?

DR. ZITO: Yeah.

DR. MCKENNEY: This is Mark --

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

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

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

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

because of the way it's broken out.

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

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

(Multiple speakers.)

MS. PINEDA: In the comment box --

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

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

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

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

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

DR. MCKENNEY: Hey, this is Mark McKenney.

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

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

No? Okay.

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

DR. ZITO: Yes.

MS. DINOVA: Okay.

MS. SOWERS: Well, ER, PICU and adult trama.

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

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

MS. DINOVA: Changes?

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

MS. DINOVA: Changes?

MS. HAMILTON: Financial changes, yeah.

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

MR. TAYLOR: Mike Taylor again.

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

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

MS. KOCEVAR: How (unintelligible)?

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

MS. KOCEVAR: Give me the microphone.

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

MS. DINOVA: Kate --

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

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

MS. DINOVA: I've lost all control.

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

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

MS. KOCEVAR: I'd love to.

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

UNIDENTIFIED SPEAKER: Workshops?

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

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

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

MS. DINOVA: Okay. Perfect.

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

MS. DINOVA: Okay. Thank you.

All right. Any further comment?

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

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

UNIDENTIFIED SPEAKER: Pupillometry.

MS. PINEDA: -- pupil response.

Pupillometry? Pupillometry metrics.

MS. DINOVA: Pupillometry equipment?

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

MS. PINEDA: Device to measure pupils objectively.

DR. MCKENNEY: There we go.

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

MS. PINEDA: Yes.

MS. DINOVA: Okay.

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

MS. DINOVA: Okay.

MS. HAMILTON: All right.

MS. DINOVA: Moving on to the OR.

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

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

Open that up to council.

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

DR. MCKENNEY: No. Looks good to me.

That's Mark.

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

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

MS. DINOVA: Okay.

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

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

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

MS. KOCEVAR: We can hear you.

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

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

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

MS. DINOVA: Oh, my goodness.

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

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

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

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

MS. DINOVA: Anything, Dr. McKenney?

I think he already said --

DR. MCKENNEY: Yeah. This is Mark.

Nothing else from me. Thanks.

MS. DINOVA: Okay.

MS. HAMILTON: Thank you.

MS. DINOVA: And now from the room.

Dr. Zito?

DR. ZITO: Tracy Zito, Orlando.

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

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

MS. HAMILTON: You know, that is --

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

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

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

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

Steve Smith, Gainesville.

I will -- I will not repeat my disarranging

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

DR. ZITO: In all areas.

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

DR. ZITO: Yes.

MS. DINOVA: Ma'am?

MS. SWEENY: Jennifer Sweeny (phonetic), Sarasota.

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

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

MS. SWEENY: Oh, Tabitha is saying it's in a box somewhere.

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

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

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

scary in this document.

MS. SWEENY: Maybe by rapid?

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

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

MS. HAMILTON: It is added.

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

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

Michael?

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

MS. HAMILTON: Okay.

So the addition cardiac. Anyone opposed to that change?

All right. Thank you.

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

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

Cardiac. Let's just do it.

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

MS. DINOVA: And we'll add the rapid rescusitation -- or the rapid infusers to this section as well.

MS. HAMILTON: You need those in PACU?

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

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

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

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

Any other comments, requested changes to the PACU section?

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

DR. MCKENNEY: Nothing else from me.

This is Mark.

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

MS. DINOVA: Thank you.

All right. Open up comments to the room.

Wow. All right.

Any comments online?

All right. We're going to move on to ICU and PICU then. And we're going to add --

MS. HAMILTON: Pupillometry.

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

MS. HAMILTON: Change airway.

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

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

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

DR. MCKENNEY: Nothing from Mark.

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

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

DR. ANG: This is ICU?

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

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

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

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

MS. DINOVA: Thank you.

Okay. To the room.

Oh, sorry. Go ahead.

DR. ANG: No, I'm good.

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

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

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

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

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

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

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

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

MS. HAMILTON: Okay.

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

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

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

All right. Any commentary online?

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

MS. HAMILTON: Med surg. Ready?

MS. DINOVA: Yeah.

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

Council?

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

DR. MCKENNEY: Nothing from Mark.

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

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

DR. ANG: I see.

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

Do we need video laryngoscope for a med surg unit?

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

So we can take the video laryngoscopes away

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

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

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

MS. DINOVA: Yes, sir. Thank you.

All right. Fantastic. Any commentary on the phone?

MS. HAMILTON: Yes.

MS. R. HAMILTON: Rachel Hamilton, Halifax.

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

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

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

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

MS. R. HAMILTON: Or access to an increased

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

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

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

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

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

MS. DOUGLAS: Yeah.

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

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

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

MS. HAMILTON: So we can just keep that.

MS. DINOVA: You want to keep that language

for the med surg and not change it?

I hear groans.

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

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

MS. DINOVA: Okay.

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

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

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

MS. SOWERS: That's a code cart.

(Multiple speakers.)

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

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

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

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

DR. ANG: I would.

This is Darwin.

MS. DINOVA: Dr. McKenney?

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

Yes, I agree with Darwin.

This is Mark.

MS. DINOVA: Okay.

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

MS. DINOVA: Anybody else in the room?

Anyone online?

All right.

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

MS. DINOVA: Two standards down, my friends.

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

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

Let's -- is that it, actually?

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

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

conduct laboratory studies for injured patients.

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

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

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

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

DR. ANG: This is Darwin.

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

DR. MCKENNEY: Yeah. Mark.

No problem with that at all.

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

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

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

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

MS. DINOVA: Okay.

DR. ANG: Cryoprecipitate.

MS. DINOVA: Okay.

Okay. Any comment in the room?

Oh, yeah, I see all kinds of hands.

DR. ZITO: This is Tracy Zito.

I have a comment.

MS. DINOVA: Yes, ma'am.

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

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

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

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

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

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

Sorry. Just for, like, the ease of the document, Number 2 says all trauma centers must have sufficient blood products readily available and then it kind of tells you what you need to have below. Can we just make that all one thing, just for ease of access for people --

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

It's not a minimum.

Okay. Michael?

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

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

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

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

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

MR. TAYLOR: Yep.

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

Do you guys agree with that?

MS. DINOVA: Yes.

MS. HAMILTON: Yes.

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

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

UNIDENTIFIED SPEAKER: No.

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

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

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

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

All right. How about online?

Is anybody still awake online?

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

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

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

MS. MAGDA: Perfect.

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

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

MS. DINOVA: Okay.

MS. MAGDA: Thank you.

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

Fantastic. Moving on.

MS. HAMILTON: Moving on.

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

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

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

MS. DINOVA: That terrifies me.

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

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

Council?

MS. DINOVA: I'm okay with that.

Dr. McKenney? Dr. Ang?

DR. ANG: I agree.

This is Darwin.

DR. MCKENNEY: (Unintelligible).

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

Thumbs ups and head shakes.

Any comments online?

A standard done in 30 seconds. All right.

MS. DINOVA: Oh.

MS. HAMILTON: Oh, Michael.

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

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

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

MR. TAYLOR: In house. Okay.

MS. DINOVA: However that is.

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

(Multiple speakers.)

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

MS. SOWERS: Just a reminder we all have to

talk at one -- one at a time.

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

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

I'm Tracy Zito from Orlando.

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

Moving on.

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

And let's stop there for a sec.

And, council, any comments?

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

DR. ANG: So the inter- -- this is Darwin. So the interventional radiology procedures within one hour, how is that defined? From consult to treatment or intervention?

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

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

MS. HAMILTON: Puncture time.

DR. SMITH: Puncture time.

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

DR. ZITO: Commencement of procedure.

DR. SMITH: Consult to catheter in the artery.

DR. ZITO: Okay.

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

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

DR. ANG: Okay.

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

DR. ANG: No.

DR. MCKENNEY: No, not from Mark.

MS. DINOVA: Okay. Commentary in the room? And anybody online?

All right. Moving to Section B.

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

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

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

And we will stop there for a moment.

Council?

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

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

I'm fine with the language as written.

DR. MCKENNEY: This is Mark.

It seems very reasonable.

MS. DINOVA: Thank you.

Comments in the room?

Yes, Candace.

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

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

MS. KOCEVAR: I thought it was 60.

DR. ZITO: The consult.

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

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

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

same.

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

MS. DINOVA: Okay. Any other comments?

All right. Moving forward.

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

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

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

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

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

DR. ANG: This is Darwin.

I don't have any issues either

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

All right. Anyone online?

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

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

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

MS. HAMILTON: Where are you referencing?

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

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

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

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

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

MS. DINOVA: Who was it, Candace?

MS. PINEDA: She said radiology within 15 minutes.

MS. HAMILTON: That is in x-ray.

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

Candace, who was it online?

MS. PINEDA: It's Lianne.

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

MS. DINOVA: That would be within the PI.

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

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

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

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

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

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

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

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

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

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

MS. PINEDA: This is Candace.

MS. DINOVA: It gave up on you.

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

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

MS. HAMILTON: So we did discuss PI staffing.

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

DR. ANG: This is Darwin Ang, Ocala.

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

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

I don't need the microphone.

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

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

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

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

Yes, Dr. Smith.

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

I think these times are important. I mean,

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

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

MS. DINOVA: Dr. Smith.

DR. SMITH: Steve Smith, Gainesville.

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

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

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

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

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

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

Yes, Candace.

MS. PINEDA: Candace Pineda, Memorial Regional.

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

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

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

this is going to be a PI burden.

Lianne, does that meet your concerns?

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

MS. DINOVA: Okay.

All right. We have made note of that.

Any other commentary about this section?

No.

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

MS. HAMILTON: Here.

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

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

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

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

And should I close it out with the CT?

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

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

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

Dr. McKenney? Dr. Ang?

DR. MCKENNEY: Hey, this is Mark.

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

MS. DINOVA: Okay. Dr. Ang?

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

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

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

All right. Any commentary online?

All right. Moving on.

MS. HAMILTON: That's the end.

All right.

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

MS. HAMILTON: You've got this.

MS. DINOVA: One more to do today.

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

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

MS. DINOVA: Perfect. Okay.

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

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

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

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

MS. DINOVA: This is Lisa.

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

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

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

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

MS. DINOVA: Okay.

DR. ANG: Yes.

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

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

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

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

MS. DINOVA: Okay.

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

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

standard.

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

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

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

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

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

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

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

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

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

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

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

DR. EBLER: Okay. Thank you.

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

Dr. McKenney or Dr. Ang?

DR. ANG: Standard looks fine to me.

MS. DINOVA: Okay. And Dr. McKenney?

DR. MCKENNEY: This is Mark.

Same thing.

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

Comments online?

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

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

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

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

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

Anybody online have anything that they need to

add?

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

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

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

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

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