TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: August 8, 2025

VOTING MEMBERS PRESENT	(1) Paula Bergon (2) Reagan Bollig, MD (3) Oseana Bratton, RN (4) Bracken Burns, DO (5) Anissa Cooper, RN	(6) Amber Greeno, RN (7) Darrell Hunt, MD (8) Nicholas Jensen, MD (9) David Kerley, RN (10) Robert Maxwell, MD	(11) Renee Mills, RN (12) Jeff Levine, MD (13) William Nolan (14) Regan Williams, MD
VOTING MEMBERS ABSENT	(1) Dave Bhattacharya, MD (2) Marc Campbell, MD	(3) Brad Dennis, MD (4) Steve Hamby	(5) Andy Kerwin, MD (6) Natalie Whitmer
GUESTS	(1) Muyiwa Adedokun (2) Helen Brooks (3) Saskya Byerly (4) Bill Campbell (5) Ben Dart (6) Theresa Day (7) Kristin Dury (8) Dina Fililbeao (9) Nathanial Flinchbaugh	(10) Kay Garrett (11) Tyler Haines (12) Andrew Holt (13) Andrew Hopper (14) Beth Jackson (15) Emily Lenart (16) Bryan Metzger (17) Lindsay Mcknight (18) Erica Neisser	(19) Brent Nix (20) Habeeba Park (21) Mayur Patel (22) Anita Perry (23) Rob Seesholtz (24) Stephanie Spain (25) Caroline Tippens (26) Kennedy Toban
NEXT MEETING DATES:	**2025** Friday August 8th – Paris Landing State Park Friday November 14th – Nashville		

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TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
Announcements	R. Seesholtz	A reminder to please register your attendance on the meeting sign in sheet so that we can capture your attendance. Welcome to Renee Mills who is the CoPEC representative on the council. Also, a welcome to Abby Cook, who is the new Asst. Trauma System Director for the Commission.		
Statute Rules	R. Williams	Required to have majority voting members present to have a quorum.	Roll call – Quorum present	
I. Approval of Minutes	R. Williams	Approval of 5-30-25 TCAC minutes.	Motion to approve and seconded.	
II. Old Business Trauma Fund Report	R. Seesholtz	3rd quarter disbursement calculations are complete with a disbursement total of $1,008,473.14. Letters and checks were dated for June 13th.		
	R. Seesholtz	I was asked by F&A Director John Carr to inform the council that the cigarette tax apportionment budget estimate was revised as voted on by the council at the last meeting from $8.5M to a little over $6M dollars. Our operating budget for fiscal year 25/26 is a little over $11M.		
	R. Seesholtz	I also wanted to provide the council an update from the last Commission meeting. Both data release policies and the new trauma funding formula were presented to the Commission and subsequently approved.		
III. Subcommittee/Ad Hoc Committee Reports				
a. Registry	B. Dennis/R. Seesholtz	Dr. Dennis sends his regrets. It is that time of year to make the decision on the elements in our data dictionary and whether or not any additional elements. I've not heard any feedback from council members and it's my view that we accept the data		

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		dictionary as is. Please remember that the requested "sport" injury mechanism field is active for 2026.		
	R. Bollig	Motion to leave the dictionary as is.		
	B. Burns	Second.		
	R. Williams	Now the floor is open for discussion. Any discussion, recommendations? Hearing none, roll call vote.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye Anissa Cooper – aye Amber Greeno – aye William Nolan – aye Paula Bergon – aye	Unanimous aye votes – motion passes.
b. IP / Surveillance	R. Seesholtz	Terry expresses regrets.		
c. System Development/ Outreach	R. Williams	We had a great trauma symposium yesterday. We had about 110 registrants. We went from 8 to 4 with amazing presentations from folks throughout the state as well as a visiting Professor from the University of Pittsburgh who talked about prehospital anticoagulation management and resuscitation. We also had a cameo from an ED Doctor who does air medical from the East side of the state and an injury prevention presentation on distracted driving from an organization called Lutz43. Overall, I felt that the presentations were great and good participation from across the state. We encourage all of you to send topics for next years trauma		

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		symposium. We have a wealth of knowledge from trauma centers across the state and we encourage all to attend next year.		
d. PI/Outcomes	R. Bollig	We briefly talked about this last time, but I haven't gotten it set up yet. Instead of doing TTACO before the TCAC meetings because of time constraints, Dr. Williams has been great with our COT meetings online, we will get those set up to discuss our collaborative data and opportunities for discussion. There has not been a new TQIP report since I reported out at the last meeting.		
	R. Williams	How often do we get those?		
	R. Bolig	Usually about twice a year, in the spring and in the fall.		
e. CECA	R. Mills	• The pediatric trauma rules will go live on October 8th of this year. • The committee continues to work on surveyor guidance. • Star of life awards will be on May 13, 2026. • The CECA conference for 2026 will be held in Knoxville, they are still working on finalizing the date. • Please continue to use the CECA website for education needs and updates for CEU's.		
f. Legislative	R. Seesholtz	No legislative update.		
g. Finance	R. Seesholtz	No other financial updates.		
IV. New Business				
a. Site Review Policy	R. Seesholtz	The site review policy was developed and presented at the last TCAC meeting. While there was good discussion, and it was realized early on that additional work need to be done and to bring this back to the council for further discussion. The lions share of the policy remains the same. The only additions are the highlighted yellow areas at the end of the		

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		document. The final two bullets are new, the preceding language contained in yellow is already contained in draft trauma rules ready to be moved to rule making hearing. The differences with the last two bulleted items are that depending on the deficiencies identified, if a center is noncompliant with up to two type II standards, then focused review is conducted either through desk review or on-site review depending on the site review team. If a center is noncompliant with any type I standard or noncompliance with three or more type II standards then an in person focused review will take place. I would respectfully ask the council to approve this as our policy for site reviews. This will take place of current rules until rules are promulgated. We also have an accompanying document that I've been asked to generate, interpretative guidance for the revocation of designation. Site reviewers have struggled on occasion to equitably define and approach centers on deficiencies and areas for improvement. We've had some difficult discussions and decisions on this over the last 15 years. I was asked if there is any additional guidance that you can provide the site reviewers that when poor performance at an institution is discovered, this may involve the revocation discussion. This document was forwarded to all voting members. I would respectfully ask the council to approve this as interpretative guidance for the site review process. I had emailed our national group, the national association of state EMS officials asking how states handled revocation of designation. The answers were varied. In Wisconsin, if you have a type one or type two deficiency, your designation is revocated, there is no gray area. The document that was completed and forwarded to council members comes from the Pennsylvania Trauma Systems Foundation. That document was the best in describing at a 30,000-foot level if requirements are not met, then discussion on revocation needs to be had and this document is a start. I'll call on Dr. Burns as he was pivotal with the site review		

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		process and as a reviewer and trying to address some of his concerns as a reviewer here in the state.		
	B. Burns	Thanks, Rob. as many may recall, part of delaying this was for Rob and I to kind of dig into this a little bit. And I think after several conversations, what we figured out was what I was trying to do was to incorporate those two things that he's talking about into one, and they don't really go together. So, the first we needed a policy that says, when does the site review team absolutely have to come back versus when you got a little, you know, check marks on your report card. If you can fix these things, we don't need to come back if you can prove that those things have been corrected. So that's what the site visit policy shows. The other thing that I was trying to do, which is now a separate document, was to give guidance to site visit teams, because it's not always clear at what point you hit that threshold where you say, is this center measuring up to the standard such that we should continue to offer them that chance to come back in one year. Rob did his due diligence to try to get some information and put something forward. So, it is not a policy. Heaven, forbid I endorse interpretive guidance, but it is interpretive guidance for site visitors so that have something. For those of us that have sone site visits, that's always the beginning of the conversation, okay, what's our overall thoughts? You know, where do we go from here? And so, this gives us at least a framework to say, do we need to be in that discussion of not recommending this place continue to be designated or not? We certainly hope that's not the case. But there's never been anything for a site visit team to rely on that says, okay, we've reached this threshold. We need to have this conversation, and that's why those two things are separate.		
	J. Levine	I'm just reading the document now. The only comment I would make is b dot subsection two. I think I know what you're trying to accomplish, but the way it reads, you've made it dependent on patient outcome, and I don't think you're really trying to do that, it		

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		says the inability to critically analyze loop closure for patient care issues resulting in negative patient outcomes. I don't think you intend to give people a flyer on horrible loop closure, just if the outcome is ok, because even in section one clinical care process, means it's not outcome based. So, I think I know what you were trying to do, but that statement is an outcome based statement. I'm not sure that was really the intent.		
	R. Williams	Bracken, do you have a response to that?		
	B. Burns	I know Rob took a lot of this from the preexisting document. And so, again, I don't know that this is set to be set in stone and is really more of the guidance for people that are doing the site visits to say when, when is when. You know, I think the site visit policy outlines deficiencies and at what level those would require a repeat visit. Even this document can be interpreted in different ways, and that's why there's not a policy that says when you hit this, recommend for revocation.		
	R. Seesholtz	We can certainly change the wording or strike some of the language.		
	J. Levine	I just wanted to point out that it's about the only statement on this page that is truly outcome based. I mean, even Part A is process, albeit involved in clinical care, that's the only statement I can see where, literally, it's not just the process, but as it relates to negative outcome. So, I didn't know if that was your intent or not.		
	R. Bollig	I see your point, I read it as that's the, that's the reason for that process of critically analyzing, not necessarily just that they're having negative outcomes.		
	J. Levine	Fair enough, it just didn't read that way. And I thought that was the intent, I understand it, it just didn't read that way.		
	R. Williams	Is there are way to change the wording?		

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	B, Burns	You can just take out resulting in negative patient outcomes.		
	C. Tippens	So, one thing that we've thought about internally is, obviously, this is a designation, a provisional designation, and if you revoke a designation, I don't want to muddy the waters here, but I do want to explain a process. If a designation is revoked and the deficiencies are such that they might be severe and pervasive, they could be turned into a complaint about conditions for coverage and Conditions of Participation, which would merit CMS involvement and potential deficiencies being cited by other survey teams or possible state disciplinary action. So, I don't want to have you all discuss this policy without realizing that if you do revoke a designation, it could be grounds for state disciplinary action on the hospital's license. So, don't panic, but I see your faces. But, I mean, I want you to be realistic and understand, yeah, right, yeah. And that is exactly right. But I want you to understand that that is the process that things like this would normally follow, because we have other provisional designations, or we're moving toward for burn units and for NICUs as well. And so, you know, just understanding if there's disciplinary action on a designation, we also have designations like rural emergency hospitals and critical access hospitals, and if you have a problem with your designation, sometimes that can translate to the underlying hospitals licensure. So, I wanted to be clear and tell you that on the front end, that sometimes if we find such severe and pervasive deficiencies, we need to open up, you know, federal complaints on some of this, and that may translate in state licensure or federal action. So, I just wanted to set the stage.		
	R. Williams	I think it would be important to note that in this, so when the site teams are deciding, not that they shouldn't do it, because if it's really terrible, then the designation should be revoked, but then they would know.		

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	B. Burns	I think that's important, but we actually don't do the revocation. We just make a recommendation as a site visit team. So, this guidance is for the site visit team. I don't know that I want language in there that says, if you do this, then other bad things could happen to people right? Because now you're just putting additional strain on people who are trying to make a designation determination strictly on their care of the injured patient.		
	C. Tippens	And I understand that, but I also think that it's important to think about if you do see such severe and pervasive deficiencies that there might need to be a conversation that you have with us as the Health Facilities Commission. I know that, but you, as site reviewers, are also mandatory reporters, and we would need to have that conversation with you as well if you've seen a poor patient outcome such that you think it might need to merit a complaint and that that needs larger investigation. So, I mean, I think that does have its place. It might not necessarily need to be totally stated within the interpretive guidance, but it could be something you know, that we have a larger discussion surrounding, and I understand that the council would be making the decision to revoke the provisional designation, but ultimately that goes before the full health facilities commission as well. So, all those processes are still intertwined.		
	R. Seesholtz	There's been only one institution in the last 15 years that we were prepared to make revocation recommendation towards, because the care was substandard. We've not had to do that since that time. Everybody steps up to the plate, provides as good care as they can. This is really meant for the site reviewers to provide a little bit more guidance on if any of these issues were to rise to that level then hey, we've got at least a document that's been approved and reviewed by council members that if they are missing some of these things, those discussions need to be had. Even with the institution, we were going to recommend revocation, we had that conversation with the hospital CEO, the trauma medical director as well, and they were well		

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		aware of what the potential outcome was going to be.		
	A. Greeno	It seems like the outcomes are the same. You're either going to have a year to fix it, if it's not fixed within that year, then it'll be presented to the board. So, whether it's a type one or five type twos, it's the same outcome. So does it need to specify that, since we as reviewers wouldn't be the one saying, like, you're not going to get it, somebody else has to decide, because, like, you go by ACS, you lose your verification if you have a type one, or if you don't meet the needs of the action plan. So, if you have a year, you fix it. If you don't fix it, you lose it. If you have a single type one you lose it right then. So, as a reviewer obviously you're like, I get the point. You're trying to say you don't want to put us in that position, unless you're going to give me security. I don't want to do that. But are we saying that these hospitals can have type one deficiencies of unknown amounts and same type two, and then whatever the Commission hears, if they seem to think it's fine that the center still functions as a trauma center that's been designated by the state.		
	R. Seesholtz	Yes, there is difference between the two with the type two standards and type one. The only difference is that with non-compliant, with up to two type two standards is that the site team can recommend either an onsite visit or desk review.		
	A, Greeno	I believe that with ACS if you fail a type one, you have to go through the whole process again.		
	B. Burns	I just want to add a little of the conversations and stuff so agree with what is being said. The state has always been and again, Rob has looked across all the different states, and they have different things, and the ACS has their criteria. These are our criteria. And as a state, we've always wanted to give people the benefit of the doubt. And so that's why there's the two bullet points. There was		

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		a third bullet point that really kind of came off of that and then turned into interpretive guidance. That was when you get beyond one type one is that really when we need to say, you know, and so that appropriately does not necessarily fit into policy, but that's why this other document was created. So just because you have deficiencies. That doesn't mean that this other document can't be used by the site visit team to say they don't get a year, this doesn't measure up the standard, we need to make the recommendation, and so…		
	A. Greeno	So, your saying if you don't think that they should continue on then you could…**inaudible**		
	B. Burns	Correct. Option three was, where is, which isn't on there is, where was that threshold that makes that conversation have to happen, this place shouldn't continue.		
	A. Greeno	That's a great bullet point, because you have EMS trying to decide between two centers. And let's say the bullet point that deficiency was in the center's neurosurgical coverage and not being consistent. So, then EMS goes to the one that they thought or is a designated level I center as as opposed to one that has different everything else going, then you're going to have a guy or a girl or a child go to hospital who may not have neurosurgery and end up getting transferred to another one which would be a detriment to the patient, and that's ultimately what I think is the most important. Type ones are really big deals. They're the basic foundation of providing quality trauma care. And so if they cannot pass that, I like his stipulation that it's up to the reviewers to have the ability to say, for right now, you are on probation. You are not going to be a trauma center or have something like that. So that EMS will know I can't take the arrow from this hospital and make sure that patient gets to the right place within a certain amount of time. But I like his statement of saying, like surveyors, judge the		

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		criticalness of that level one even though all the level one deficiencies are big deals. And so, if you have multiple, let's say you have five level twos. It's not great, but somebody decided that's enough to keep you still open seeing patients in Tennessee for a year, and then even after that year, you might not fix it, and we still know what's going to happen, because it's going to be a facilities board, and they're going to decide based on input of the surveyors.		
	C. Tippens	Yes, I'm glad you brought that point up, because anything you do in a site review, if we're thinking about revoking a designation that's likely going to turn into a contested case hearing. So I just want to level set expectations, and when I say contested case hearing, that generally means a trial. So if the site reviewer is making that recommendation to revoke a designation, I think you need to be prepared that it's likely that you would be called to testify about why you felt that way, and to produce evidence that you found in your site reviews, review visit to substantiate that.		
	A. Greeno	Did you guys have to give pass the fail because of ACS we have to wait three months for when they get though all the paperwork…**inaudible**, but that way it's a more thoughtful process of we've gone through the entire application. The reviewers did, Rob's office went through everything, make sure they're checking all the boxes, and then in that three months, they still have to pass the ACS…**inaudible** I'm taking you to court for this…**inaudible** clearly didn't meet that.		
	C. Tippens	So, what would normally happen if we were going to consider any sort of state licensure disciplinary action on any healthcare facility, including the hospital, would be that just like with our surveyors for nursing homes, assisted living facilities and RHAs, you as the surveyors and site reviewers would send us the documentation. Dr burns would make the recommendation that, hey, I'm seeing really severe and pervasive deficiencies. Maybe it's at level one, maybe it's not maybe it's something else with bad		

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		patient outcome. Then you would share that with Rob. Rob would share that with me, and I would ensure it goes through something we call a case review process. Our case review process is where we have an outside consultant with experience in the field, reviews the case, with our legal counsel, with leadership and with the surveyor to make a determination as to whether or not we should proceed with disciplinary action or enforcement action on the on the state side. So that's probably the process that it would go through. So there would be a time frame. It wouldn't be like a light switch that it would be immediately revoked. There would be a time frame. And then chances are, if we were pursuing state licensure disciplinary action, our legal team would also send offers of settlement before we, even, you know, brought it fully, potentially, to the Commission for ratification.		
	A. Greeno	I think it's a good answer, It made me nervous, type I could still be going through all of this for a year and then maybe not fixed. Like a stroke center functioning for a full year and then they come up and say you still haven't fixed it and your having other patients still.		
	C. Tippens	And I think that's where it's important, where you would have that history that you would provide. So for example, if they were under the, what we can call on the state side, plan of correction, they were under the plan of correction for a year, still couldn't get it correct. And then, you know, the site review would provide that history. Here was the date of the initial survey. Here was the time frame that they were under, the plan of correction. They've been working toward it. They've been unable to, you know, correct it, even though we've had an in-person site review and tried to look at this. And so that's why I'm making this recommendation. That would be important to put that together.		
	R. Seesholtz	Yeah, and certainly Amber, if, if we, if the site team goes to an institution where it is obvious, gross negligence in patient care. I		

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		mean, those conversations will happen almost immediately, at the end of the review, then with general counsel in how to best proceed moving forward.		
	R. Williams	Thankfully that happens so infrequently, thankfully that we don't have to go those things.		
	B. Burns	I just want to speak as an individual, I have always respected and appreciated the state having a policy that gives a little flexibility. I respect the comments. Nobody wants bad outcomes for patients, but you could get a type one deficiency if you're a level three center, and you had a locum orthopedic doctor on the way in and they died in a plane crash, and you don't have an orthopedist for one day. Should you close down that trauma center? I don't think so. So you may have to say you have this deficiency, you have a year to fix it. We will be back. And I think this document provides that flexibility to site visit teams. I think the second document, unfortunately is necessary to give them that guidance as to when you maybe need to say, Okay, this is way too far into the danger zone, and maybe a different recommendation needs to come. So that is why it's not the ACS. We aren't the ACS. I don't want to be the ACS.		
	A. Greeno	But for the reviewers of the state, you look at trends, and not just one case. It compares one case identified. Look at the loop closure not just necessarily say no, in my opinion, I wouldn't say no. I'd say, was this a trend? And then that particular case loop closure was, they died. Then the reviewers would recognize that they did an investigation, but their trends speak for…**inaudible**.		
	R. Williams	Which is, I think, kind of laid out in this document, the interpretive guidelines. So, I think we've, yeah, I think we have two things I would like to vote on them separately. So, we have the site review, which is all the new stuff in yellow. The important things are the bottoms, which are what happens with non-compliance, type two standards and non-compliant type ones		

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		or a bunch of type twos. So we're going to, is there a motion to approve or disapprove this Bracken? All right. Is there a second? any more discussion, just on this part.	Motion to approve site review policy, Burns. Second. Hunt	
	D. Hunt	I think what was proposed is very fair.		
	A. Greeno	You had mentioned…**inaudible** really bad, need to do something, how the site reviewers have the right to shut it down, a hospital say that's not listed…**inaudible.** Why can't shut us down because we have a year…**inaudible**.		
	B. Burns	That's not the case, and that's always been and it's part of the whole process. It says that you have to pass or not pass, and so this is when you don't get a straight pass or the straight not passed. This is the gray area in between so, and that's mentioned at every site visit at the beginning, and it's in all the stuff. So I think we're creating problems that don't exist. And for clarity, the site visit team does not revocate anything. They make a recommendation that has to go to the licensing commission that then says we uphold this recommendation. That's the only way the site visit team does not have the ability to revocate or stop care or anything.		
	A. Greeno	I was just concerned when Rob said if he saw something at a hospital, he would make an effort to do something.		
	R. Seesholtz	Absolutely, how that is defined, though step by step is not in this document. We would never…		
	R. Williams	It's the natural process that happens throughout the state for any kind of…**inaudible**		
	C. Tippens	I think that happens against you all as physicians and mandatory reporters. If you see something that is tantamount to something that you would think is a severe and pervasive deficiency or violation that affected patient care and resulted in a very poor		

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		patient outcome that yes, you would report that to us and we would take that through the normal channels.		
	A. Greeno	And that would go against a facility needing a year to fix it...		
	R. Willams	No, that is separate outside of the trauma center designation,		
	C. Tippens	If you find something at any time that you think needs to turn into something else, you can always come to one of us and we will handle that. Okay, well, then call me anytime.		
	R. Maxwell	So, this single page handout. This is a proposal to go to an effect in additional to the highlighted things.		
	R. Williams	This is interpretive guidelines for the site reviewers, to give them some guidance, not guidelines. It's interpretive guidance for the site reviewers. Yeah. As a guidance to this, but we're going to vote on this first as the policy, and then we'll vote on the guidance to the policy separate.		
	C. Tippens	And remember these things, where you would be bringing these forward? Because I know it says in here 30 days you would be making that recommendation, but it would still have to come before Trauma Care Advisory Council to approve that and….		
	R. Seesholtz	I doesn't come before the full council, it only comes before the Commission.		
	C. Tippens	Well, that's what I'm talking about. But you got to remember that the 30 days you're going to have to tie that to a commission meeting. So remember, there may be a lag in that between commission meetings, because if you're going to go through the case review process, there's still going to be a lag. So think about that when we read back your 30 days.		
	D. Hunt	Do we need to change something before we can vote on it?		

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	C. Tippens	Well, I mean, I just want you to take a look at that provision pretty closely and think about, do you want it directly 30 days, or do you want to give yourself some sort of leeway?		
	R. Williams	It's 30 days to submit a corrective action plan. It's not 30 days to accept it or to make the change. It's just 30 days for each center to submit the corrective action plan. So, I don't think that that has to be tied to a commission, because the corrective action plan doesn't have to be approved by the Commission.		
	C. Tippens	I'm thinking about if you get a violation of a corrective action plan and you do a site visit and you want to move quickly on something, just understand the timing.		
	R. Williams	Yes, there's the 30 days in here. Doesn't have to do with like moving forward. It just has to do with submitting the corrective action plan, and then it says within one year. So, I feel like that's like a lot of leeway if we needed to do something different, like within a year. So it's anything less than a year.		
	C. Tippens	You want to give yourselves an out to waive the 30 days if you have to, if it's severe and pervasive, I guess is my question. And that kind of brings you back to your interpretive guidance.		
	B. Burns	Yeah, I think that's we're talking again in a different category. So those two bullet points that are on the highlighted page, those are for when, basically, as a site visit team, you're there. There's some things that aren't right, but you don't think you need to pull the plug. And so that says you have 30 days to give a written plan as to how you're going to fix it, and you have up to a year to fix it. If you're in the we think you need to pull the plug. Second page interpretive guidance, then the old bets are off. Nobody's giving you 30 days to do anything. Rob's going to make the report with the site visit team and submit it to the Commission to say we think this needs to go away. So there's no 30 day report,		

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		there's no one year revisit if the recommendation is your done.		
	C. Tippens	And that's exactly what I'm getting at. But that's not in this portion of the site review policy. So, if you want to give yourselves an out to say the drop dead date, whatever term you want to call it. Do you want to put that in this policy too? Because, as it stands right now, the way this is written, and you correct me, if you interpret this differently, is that they've got 30 days, and then they've got a year. You've got your interpretive guidance here, interpreting this policy, but you're not explicitly stating that there's another, you know, avenue that you can go down that is more severe.		
	A. Greeno	Is it a year from the time of the visit, so when your designation would expire is it a year from…**inaudible**		
	R. Seesholtz	A year from once the hospital CEO, Trauma Medical Director, program manager receives the final report.		
	A. Greeno	Because we have to renew before our expires where your saying you are going to give them a year from when the report comes out.		
	R. Bolig	Can we add something on that first blurb, if there egregious deficiencies or the survey teams feels that immediate action should be taken or towards revocation of designation. Out this and then if this is bad then check this out.		
	C. Tippens	Yes, the reason that I bring this up is that you are going to have to give the provider notice. You can't as a site reviewer make a recommendation that we are going to revoke this designation and there's no notice of that written in policy or regulation. If you are going to revoke a designation, then that has to go into rule. Because then this is disciplinary action. Part of this will have to be put into rule, you can still use your interpretative guidance to give yourselves guidance on how you're going to interpret the		

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		regulation, this will become a due process issue very quickly if we try to revoke a trauma designation and a facility wants to dispute that. I agree that we can come up with some language to put in there, if severe and pervasive deficiencies affecting health, safety and welfare are found site reviewers may make recommendations for termination of the designation.		
	N. Flinchbaugh	So, what I drafted out is immediate referral for termination of designation may be made by the review team if deficiencies are determined to be severe and pervasive.		
	D. Hunt	Madam chair, I move that we table this until the language is clear.		
	R. Willams	Is there a second? The motion is to table until the language can be cleared up with the addition of the law speak.		
	C. Tippens	Well, let me, let me ask one question. We can add this on separately. You can vote on it as is, and just make a motion and say, Hey, we like this part of the policy in yellow, but we want to, Dr Hunt's point, to add additional language to it, so you could accept this part and then make a motion to add additional language, and which we will distribute out and discuss at the next council meeting, but that's up to you. I'm not trying to monkey with your motion. Just an idea.		
	R. Seesholtz	I was hopeful that this was going to be approved today, and then subsequent visits, with two level threes upcoming and a new level four it would be in place for those reviews, but if that's not the case, we just continue the review process under existing rule which gives an unreasonable timeframe for compliance. Most of our site visits the deficiencies identified surround performance improvement. Current rules say you have 15 days to correct that deficiency. We've never seen a hospital be able to correct performance improvement in 15 days. That's current rule. This was an attempt to provide an updated review process that is the		

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		same language that's current in draft rule, but with a couple of different options to provide a little a little better guidance for our site reviewers. And this is not meant as interpretive guidance for this policy. This is meant just for the site reviewers when they're having to take a hard look at revocation. This is at least some guidance to consider.		
	C. Tippens	Yeah, but I think you have to put if you're going to, like I said, it's a notice issue. You have to put that in here if that's a potential issue.		
	R. Williams	Is there nothing in the current rules that talk about revocation?		
	B. Burns	I certainly hope so, because we've been doing it that way for at least the last decade that I've been doing site visits. You have the site visit team has the ability to make that recommendation to revocation.		
	R. Seesholtz	Here you go, the commission may revoke, suspend, place on probation, or otherwise discipline the designation or provisional status of a center when an owner, officer, Director, manager, employee or independent contractor fails or refuses to comply with the provision of these rules, makes a false statement of material fact, prevents interference or an attempt to do impede any way the work of the representative of the commission falsely advertised. It's substantially out of compliance with these rules and has not rectified such compliance. There is additional language as well.		
	C. Tippens	But it's not in this policy that you're trying to adopt.		
	R. Williams	Why do we need to add it to this if its already enrolled? Like, why does it need to be in two places.		
	C. Tippens	Because this is your policy that goes along with your rules.		

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	R. Williams	So you have to restate everything in policies that…		
	C. Tippens	Not necessarily, that's kind of like the belt and suspenders approach. That's very, very broad language that says, just generally speaking, and you correct me if I'm wrong on any of this, that you can revoke for the following reasons, but this is but what you're wanting to do is put some very specific bright line guidance about when you can revoke, and then use this as your belt and suspenders on how to interpret when you can revoke. So, and we're going to have to amend the rules anyway, because you're making provisions in a policy that's going to have to be a change in a rule. So there's a law in the state of Tennessee, you can't put things in policy if parts of it aren't in regulation. So, it's going to have to be in corporate, and this is if you're going to revoke a designation that's definitely going to affect the hospital's licensure.		
	R. Williams	But it is in rule, and I think, you can correct me if I'm wrong what you wrote in yellow is part of the draft rules that haven't been accepted, but have already been done by us, and like, sent over to the next person these two so we won't, like, have to add something new to rule because it's sort of already in the process, and this policy is just putting into the policy what's in the draft rules.		
	R. Seesholtz	Yes, ma'am.		
	C. Tippens	Rulemaking is belt and suspenders. You draft policy first.		
	N. Flinchbaugh	The issue is going to be that this is based off of the recommended rule changes. And if you're going to adopt recommended rule changes and have that be your standard, everything that is being changed, which will include the immediate referral, needs to be properly noticed, so that the facilities know what their rights and abilities are to object to your immediate referral. So if you don't put that in here, it looks like you're now removing that as		

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		part of your standards, and I don't think that would be the intent.		
	R. Williams	So we shouldn't do any of this until the rules are done, because we've gotten into like, total loop right now.		
	C. Tippens	No, no. So you can always adopt policy first, and that becomes your recommendation for the rule making, because rulemaking realistically takes 12 to 18 months. So I mean, and then when you do your rule making, it has to go before government operations, and then government operations looks to see what you had in place while the rule was pending, which is your policy that covers.		
	B. Burns	I'm going to argue against tabling and just say that simply, the only thing we need to do is to add a third bullet point that says that under the policy that gives the site visit team what we already know they have the ability to make that recommendation, and then we're done. If this is egregious, then we do have the right to do that. Rob and I did not discuss putting that in because we thought it was in the rules, so it didn't need to be in the policy. And I know it's confusing when we got rules and policies and interpretive guidance, but I understand the point, but I hate to table this when all we really need to do is to add something that we already have, which says is, if you suck, we're taking your designation.		
	R. Maxwell	Then just amend the policy to what he said.		
	R. Williams	Well, please read what you said, because I didn't hear a time frame on it, but I keep hearing you say there has to be a time frame.		
	N. Flinchbaugh	Immediate referral for termination of designation may be made by the review team if the deficiencies determined to be severe and pervasive. It is going to be up to the site team to determine what that is. So there's going to be all facts are different for each		

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		so it's up to the site team to be able to justify that later. But if it's severe and pervasive, I think everybody kind of understands it's going to have to have to be kind of shock the conscience kind of stuff.		
	C. Tippens	Yes, it has to be a threat to health, safety, and welfare because…		
	R. Williams	We don't have to put a time frame, because you it, you made it sound like we had, or is immediate the time frame? Okay? Yeah, and that's okay, let's giving notice, because that doesn't sound like giving notice to a hospital, because it's immediate. There's no notice.		
	A. Cook	Well, the policy is the notice that this could happen.		
	C. Tippens	Correct		
	R. Williams	I'm happy with it.		
	B. Burns	And to be honest, the way the site visit process works is you flat out tell people that. That's why I always make sure I know where the exits are, and I make sure that I stay fit and I'm faster than Rob, because I just want it to be Rob and not me, right? So.		
	R. Williams	So the current motion is to amend, with that statement, this policy and to accept the amended policy. Is that correct? Bob, yeah, okay, we have a second.		
	B. Maxwell	You're on a site visit. You say, Gosh, this is awful, Rob can have this interpretative guidance here.		
	R. Willams	Do we have a second to Bob's motion?		
	A. Greeno	Second		
	R. Williams	Any further discussion? Alright, roll call vote		

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	R. Seesholtz	Vote on site review policy with amended language.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye Anissa Cooper – aye Amber Greeno – aye William Nolan – aye Paula Bergon – aye	Unanimous aye votes – motion passes.
	B. Burns	I would like to make a motion make to accept the interpretive guidance document minus the words resulting in negative patient outcomes under b2.		
	R. Willams	Is there a second on Bracken's motion?		
	D. Hunt	Second		
	R. Williams	Any discussion on the interpretive guidance minus the negative outcomes being removed? Roll call vote.		
	R. Seesholtz	Vote on interpretative guidance document minus the words resulting in negative patient outcomes under b2.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye Anissa Cooper – aye Amber Greeno – aye	Unanimous aye votes – motion passes.

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			William Nolan – aye Paula Bergon – aye	
	R. Seesholtz	Th next item is level three collaborative. Dr hunt and Dr Levine emailed me shortly after our last Council meeting, questioning the level three risk adjusted benchmarking requirement, nothing else regarding that other than Hey, I think we need to have some additional discussion at our next council meeting. So as you guys may be aware, the level one centers participate in an ACS TQIP collaborative, where they are benchmark against institutions of similar size. Level three centers do not have that ability here in the state of Tennessee, I reached out to our own image trend vendor. They're looking to develop a risk adjusted benchmarking platform from EMS at this point, but that's not even close to development, and there is no plans currently with image trend to do the trauma patient registry aspect of it. I also reached out to the college as well. They are looking to do something like that in the future regarding that risk adjusted benchmarking, but they currently don't provide that service for level three centers here in the state. So I reached out to Dr Levine to kind of ask and talk to him briefly about it. Certainly, it is an expense. I'm not sure what the college charges for level one centers, but there is no avenue for level three centers to do that risk adjusted benchmarking in current rules. So the discussion of the group, I'll let Dr Levine talk. But is, what can we potentially put in place for level three centers to look at PI and quality? Is that correct? Dr Levine,		
	J. Levine	Yeah. I mean, this is sort of an offshoot of the discussion I started last quarter where we were talking about, why do we have to pay to get data from the state? All we're trying to do is improve quality. And even if we start, I was talking to Rob last week, I'm even okay if we could just start non risk adjusted. I mean, ultimately, we like risk adjusted data, but as a level three trauma center, there are what, 8-10, in the state, it would be nice to know if one of Bracken centers up in northeast Tennessee has like is in the top decile for elderly infraction, why? Or who's doing it Well,		

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		or even what's the state average? You know, am I performing at the level of the state average? I know what my TQIP averages. And who's doing it well and who's not, if they're doing it well, why? And, and that's how the discussion started, and, and we just have no ability to do it right now for level three centers. And given that there's so many of us in the state, I sort of asked the question, why? And that's how all this started.		
	A, Greeno	Texas has a pretty broad and well balanced regional system for level IIIs. What does Texas do?		
	R. Seesholtz	I do not know what Texas does.		
	D. Hunt	So, you say that we couldn't form a level III TTACO through ACS, that does not exist right know?		
	R. Seesholtz	That is correct. My thought and initial foray into this was I spoke to Dr Levine, and I said, I've pulled registry data based on level three complications over the last trended five years. Now this doesn't identify any institution, because current statute says you can't release anything that identifies the submitting institution, but at least this provides something. We do have that capability to break this out by level three centers as well to provide them their own report, which they can do on their own, but then maybe talk as a state of, hey, what are the level three centers doing to address some of these issues?		
	J. Levine	And, that's kind of where we left with it was, it was really my question was not we need to do this, but sort of an introduction to level ones and level twos have TTACO, and level threes have nothing, and we have more level threes then ones and twos combined in the state. Why aren't we able to get some comparative data and say, what can we do better?		
	D. Hunt	Do we have a process to deidentify those 10 centers?		

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	R. Williams	This is the average. This is all level threes. So what we thought about was sending each center this plus what they were, so then you can compare yourself to the average across the state. Now, it's not perfect, right, but it start. It's a start, and it would comply with what our rules say. So we would be getting you that, and then maybe we can change and grow and make it better over time, but that way we're not identifying anyone's information to anyone else, like you would only get yours, but you would measure yourself against the rest of the state. State average. Can you do that?		
	R. Seesholtz	Yes, we can. I will ask the council we have one of the trauma rules that states trauma centers must participate in a risk adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registered quality data that is essential for ones, twos and threes. What we are looking to develop, will that satisfy that portion of the rules?		
	J. Levine	I can't speak for all level IIIs, I know our center participates in TQIP so we get a TQIP report.		
	D. Hunt	This is not risk adjusted.		
	R. Seesholtz	Would this then be desired for level IIIs? I know that not all level IIIs submit to TQIP. Some of the pediatric centers don't submit to TQIP.		
	D. Kerley	My last TQIP invoice for the other centers that are here, the price was $9312.00. And it does not have process measures, the ones and the twos that hit you with **inaudible** or traction times. That's not on our reports. When you look at your comorbidities, you can look to see ratios on how you kind of compare your age, some of the demographic, piece outside of that, it's not as substantial.		
	D. Hunt	What was your suggestion Rob?		

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	R Seesholtz	My question, the risk adjusted benchmarking programs requirement for all level III centers. My suggestion would then to make that as a desired for level IIIs. They don't have to participate in it, as all folks don't currently, and there's only probably, I think, three or four centers throughout the state that don't participate. But I just wanted to offer that up. We're about to ask the commission to move our current rules to rule making hearing. So I just wanted to throw that out there to the council and see whether or not that's appropriate prior to going through the long haul of rule revision, rulemaking, hearing, etc.		
	B. Burns	I'll motion to make desired for level IIIs.		
	J. Levine	Second		
	R. Williams	Has this come up at site reviews before?		
	R. Seesholtz	No.		
	R. Williams	So there are level threes that we approved that weren't compliant with the standards.		
	B. Burns	That wasn't a standard.		
	R. Williams	But that's just because this is a new standard.		
	B. Burns	Yes, it was going to be but what I'm hearing is value for money is maybe not there, and the possibility of a grassroots internal state aggregate, here's where you stand, which may be more helpful to people than $9312.00.		
	D. Kerley	You can take these complications de identify the center, break them out, and then that will allow, the level threes, to at least say, hey, whoever's got the lowest amount of AKIs please reach out to me.		

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	A. Greeno	Was the point to allow some version of TTACO to every trauma center? Or is this for level III centers. I'm not on TTACO.		
	R. Seesholtz	For this discussion, level IIIs.		
	R. Williams	Yeah, I don't think that. I don't think the point was for level IIIs to get TTACO. The point was that the level IIIs are looking through the rules, and there is a rule in there that they will not comply with as they go forward because they don't all do TQIP. Not everyone does risk adjusted benchmarking mandate, y		
	J. Levine	It was basically an unfunded mandate. Down the road, it could be a percent of total volume. I mean this all kinds of ways to manipulate the data. I think it's a great starting point.		
	R. Williams	I think it's a good starting point. Yes, Bracken.		
	B. Burns	I'd recommend that we stay on the motion. And then I think this can be developed by the nice folks at the level IIIs as to what they would see that would be beneficial to them and how to do it. What the motion is that we move it as desired for level IIIs for benchmarking.		
	R. Williams	Do you want to call the question?		
	B. Burns	Sure.		
	R. Seesholtz	Roll call vote for the participation in level III benchmarking to be desired in new rules.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye	Unanimous aye votes – motion passes.

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			Anissa Cooper – aye Amber Greeno – aye William Nolan – aye Paula Bergon – aye	
	R. Williams	Next, AIS training.		
	R. Seesholtz	During one of the previous trauma program manager meetings, the question regarding education came up, so we asked folks, hey, what kind of education do trauma centers need here in the state, the typical TNCCs and TOPICs some of those things, certainly, everybody was trained up enough on. AIS training is the primary area that trauma centers or trauma program managers mentioned that they could use assistance with. So I've reached out to AIS, and it is currently $750 per person, minimum of 15 attendees, maximum of 25 this is remote learning. So we do have the ability minimum, 15, maximum, 25 some dates that were thrown around September, November, as well as December too. If not, we need to look towards 2026 which is probably the case. So my question of the council, then, would there be enough information to generate a vote to approve expending the money to send maximum 25 folks to AIS training, and if any of the TPMS would like to talk about this of how important it is for their centers, primarily, I think it's college required, if I'm not mistaken.		
	E. Neisser	I'm Eric Neisser. I'm the TPM at Regional One Health, adult level I in Memphis. The triple AAAM does require that course. The college does require all of your trauma registry professionals to take this course once every five years. However, the triple AAAM only offers this course a handful of times a year, and literally, the registration will sell out before it goes live. They allot the seats and you will take a day from the college. Triple AAAM requires that your registrar be a registrar for six months prior to being eligible to take this course. However, if you do not get your registrar in a course in a timely manner and build		

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		something knowledgeable professionals **inaudible**, it is very hard to come by. We have 14 full time registry professionals. That's what the zero program is. It is extremely difficult to get our people through this course. And we had people all over the state ask us we were going to host a virtual course, because we do have our college visit coming up. We didn't have a choice. And we, had people from Chattanooga all over the state reached out like, Hey, do you have a seat? You have a seat?		
	B. Burns	Motion to approve		
	D. Hunt	Second		
	R. Williams	Any further discussion? Roll call vote.		
	R. Maxwell	What are we approving?		
	R. Williams	We're approving to pay for an AIS course for the registrars.		
	R. Maxwell	Do we have the money for that?		
	R. Williams	Yes.		
	R. Seesholtz	Roll call vote for the AAAM AIS 2015 class for trauma registrars.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye Anissa Cooper – aye Amber Greeno – aye William Nolan – aye Paula Bergon – aye	Unanimous aye votes – motion passes.

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	R. Williams	Injury prevention collaborative.		
	R. Seesholtz	Injury prevention collaborative is mentioned in rules. Balled health approached me probably about a month ago, asked me about this injury prevention collaborative. We don't have one, if you will. We've typically hung our hat on Terry love with the Department of Health, who does a quarterly injury prevention update, which is really isolated to what he's required to report on and work on for the CDC grant, suicide, years past, safe sleep, etcetera, et cetera, but nothing specific to ongoing issues that every trauma center is seeing here, top three mechanisms. Dr hunt said he falls yesterday, MVCs assaults is our third leading cause of registry entry in the state trauma registry. So I guess my question is, is there of interest to create a trauma specific injury prevention collaborative. If that is the case, my first call would be to Terry Love to see if there's anything that we potentially can piggyback on. If not and that is created just by the council, then it's going to take partnerships from each center to identify some of these injury trends that they're seeing and, more importantly, step up, provide information om, hey, these are the things that we're doing to help mitigate these things that we're seeing in our center.		
	C. Tippens	Is this going to be a subcommittee of the council, or is this going to be voluntary?		
	R. Williams	How can it meet virtual?		
	C. Tippens	Well, it's fun that you answer that. Ask me that next meeting. Okay, no, really, I'm serious. Ask me about that next weekend, next time talk about that later, not today, not ready to talk about it today, but we can talk about, we can talk about, if you want to do a subcommittee, the only thing I would say about the subcommittee is you got to provide notice. Even if you're doing it in some other form or fashion, you're still going to have to Sunshine it so that, especially if you're going to have council		

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		members. So that was the only thing I was going to say, it's fine to do it as a subcommittee. Just wanted to give that caveat.		
	R. Williams	If you did it as a subcommittee, but there were actually no council members on it. So say like we each submitted our injury prevention professional from our center, would it still have to be sunshine?		
	C. Tippens	Nope, if there's no council members on it doesn't have to be sunshined.		
	R. Williams	But it can still be like a subcommittee of this, and they could still come and present to the council with our quarterly meetings.		
	R. Bollig	Are you looking for a formal recommendation?		
	C. Tippens	Are you looking for formal recommendations from this Committee? If they're going to make a formal recommendation regarding rules or potential policies, then yes, they would need, still need to be sunshine. But if they're not, and they just needing to have discussions about like those top issues, you know that are not going to be used for rulemaking purposes that, no, it does not need to be sunshine.		
	R. Seesholtz	The question regarding rule, participate in statewide Trauma Center collaborative injury prevention efforts focused on common needs throughout the state. This is a requirement for all levels, ones, twos, threes and fours. So this of what we're looking to develop will satisfy this rule, correct?		
	Inaudible	Yes		
	R. Seesholtz	Thank you.		
	R. Williams	Summarizing Rob is going to work on putting together an injury prevention collaborative across the state that looks at how, how		

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		people are injured, and what we can do across the state on how to collaborate. And it will be a subcommittee of the council. One more to go.		
	R. Seesholtz	Our fiscal office notified me four days ago, maybe five days ago. of the data use agreement for the patient registry, as you guys well know, my position was moved to the commission, taken from the Department of Health. However, our trauma registry, as well as the EMS EPCR system, hospital hub and data mart still ride resides with the Department of Health. So they've come up with a one year contract for us to have access to the patient registry, which is by saying access this is meaning the maintenance cost that ImageTrend provides for the next year. So that is to a tune of $40,800 to continue to have access to the state registry. That is for the maintenance cost for 2000 for the next year. What's going to be even more of a significant discussion is when that year is up, of how this council feels, how to move forward regarding our state registry. Trauma hasn't been responsible for paying for it. Yes, we've had these maintenance costs paid. It just wasn't paid by trauma. For example, I wrote a $100,000 grant for Tennessee Highway Safety Office that deferred some of those maintenance costs for several years. Hospital preparedness provided money for the EMS side of the house to get that system up and developed and maintenance cost. Now all of that's coming back. There's no additional funding sources that I'm aware of that pays those maintenance costs. So now EMS is responsible for their side maintenance cost. EMS, epcrs, hospital hub, data, etc. And now trauma is responsible for the patient registry side of things. This is, this is ImageTrends amount to provide maintenance cost for the following year. That's what their cost is.		
	R. Maxwell	**Inaudible…**		
	R. Seesholtz	I don't know that that's correct. Dr Maxwell, but we would certainly have to go back to the drawing board if the council says,		

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		no, we won't fund this		
	B. Burns	Can you expound on what you were saying that is a bigger concern after this year?		
	R. Seesholtz	The council is going to have to take into consideration of maintenance costs year by year by year by year. And either approved that or not, and knowing that, should this come out of the council's trauma fund and should it come from another funding source. I don't know that's going to be up to council members to debate and discuss. But as for right now, I am merely asking for the approval to expend $40,800.00 for next year's maintenance cost for ImageTrend patient registry.		
	R. Maxwell	So if we don't pay it we can't access our own data for like we were just talking about, for level threes to get a report?		
	R. Seesholtz	And truthfully, I don't know the answer to that. If, if I went back Monday morning, said the council denied payment. I don't know what the next step is. I really don't I'd have to reach out to Caroline, legal counsel and figure out what the next steps are. Every institution has access to their own data.		
	R. Williams	I think what we maybe need to do is approve for now, for this year, and then before we get to next year, we look at the options, I think. And Rob, please, Rob and Carolyn, please tell me if I'm wrong is that the Tennessee Department of Health paid these maintenance fees, but now that we are under the Commission and not under the Tennessee Department of Health, they now say we're not paying your fees anymore, because you don't, you don't belong to us, right? Correct?		
	C. Tippens	You got it. And so right now, you're basically paying for us as the health facilities commission to provide you this data for your injury prevention collaborative, the other data requests for stuff that are going to come for IRB, for us to have access to use that		

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TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		system. And you know, this has been a contract that we have done on a yearly basis, but at some point in time, we might need to consider procuring our own system. Don't panic. We're not there yet. But so right now, were just voting for us to have the approval for the maintenance fees for us to continue to have access because we don't own the system.		
	J. Levine	Can we plan to have quarterly reports, like at the next meeting, a more robust discussion of where we're heading for the next year?		
	R. Williams	We'll gather some information.		
	B. Burns	If we have a registry subcommittee that could investigate that.		
	R. Williams	We do.		
	B. Burns	I'll make a motion to pay the fee but commission the subcommittee to further evaluate, to make sure that it's the most prudent option going forward.		
	J. Levine	Second		
	R. Williams	Wonderful, any discussion? All right, roll call vote on paying the $40,000 and requesting that the registry get us some extra information so we can discuss further in the future.		
	R. Seesholtz	Roll call vote approving maintenance fees for the registry.	Roll call vote: Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Renee Mills – aye Anissa Cooper – aye	Unanimous aye votes – motion passes.

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TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
			Amber Greeno – aye William Nolan – aye Paula Bergon – aye	
	R. Williams	Last is dates.		
	R. Seesholtz	Yes. Suggested dates for 2026 meeting dates. I initially forwarded some information to Dr Williams, and that got rapidly blown out of the water because of other meetings. So i'm going back to the drawing board. We're hopeful to meet at 665, mainstream drive, where there's plenty of parking. The health department said, hey, yeah, you can still use it. Well, we'll see how that goes. But are there any national meetings that you guys need to respectfully stay away from so you guys can attend our council meeting. This is for 2026 and I can receive those by email.		
	R. Williams	For this meeting next year, it will be in Nashville but they have not confirmed a spot yet. I think we go back to Fall Creek Falls after that.		
	C. Tippens	There may be changes so were working on that.		
	D. Hunt	I thought that we spent too much money in Nashville last time?		
	R. Williams	We did spend too much money in Nashville, but they said that if we had bigger space, we could have more exhibitors, and then the exhibitors could pay the money. So I think that's what they're trying to do. There was talk about moving to like Franklin, or somewhere outside of Nashville. So it's like Nashville, but easier to get to. But they didn't like that idea, for some reason, there wasn't enough things down there would be hard to find places to eat and entertain was the comment. It ultimately is up to the President for next year to make that decision, and so we don't, we can get feedback, but we don't have a lot of choice. I'm just curious where we meet. Donna is the president of the Tennessee		

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V. Adjourn		ACS for next year, so she will ultimately make the decision. Okay I don't think we have anything else. Anyone like to adjourn? Motion to adjourn and seconded. Meeting was adjourned		

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