TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: February 11, 2026

VOTING MEMBERS PRESENT	(1) Dave Bhattacharya, MD (2) Reagan Bollig, MD (3) Oseana Bratton, RN (4) Bracken Burns, DO (5) Marc Campbell, MD (6) Anissa Cooper, RN	(7) Brad Dennis, MD (8) Amber Greeno, RN (9) Tyler Haines (10) Steve Hamby (11) Darrell Hunt, MD (12) Nicholas Jensen, MD	(13) Andy Kerwin, MD (14) Robert Maxwell, MD (15) Renee Mills, RN (16) William Nolan (17) Stephanie Spain, RN (18) Regan Williams, MD
VOTING MEMBERS ABSENT	(1) Jeff Levine, MD	(2) Natalie Whitmer	
GUESTS	(1) Rachel Appelbaum (2) Jennifer Beecham (3) Paula Bergon (4) Kathy Berrie (5) Oseana Bratton (6) Alli Brogan (7) Helen Brooks (8) Vicki Bryan (9) Saskya Byerly (10) Bill Campbell (11) Jim Christoffersen (12) Stephanie Coker (13) Abby Cook (14) Dani Crowe (15) Theresa Day (16) Jenny Delong (17) Josh Dugal (18) Nathanial Flinchbaugh	(19) Jack Fosbinder (20) Kay Garrett (21) Jameil Abou-Hanna (22) Andrew Hopper (23) Bre Hutton (24) Beth Jackson (25) Robert Jean (26) David Kerley (27) Sara Kucharski (28) Natasha Kurth (29) Jay Lea (30) Kim Lee (31) Terrence Love (32) Racheal McDowell (33) LaQuanita McGraw (34) Pam Minton (35) Erica Neisser (36) Brent Nix	(37) Andrea Palmer (38) Emily Parker (39) Missy Perkins (40) Anita Perry (41) Jennifer Porter (42) John Proctor (43) Brian Reed (44) Ben Scharfstein (45) Angie Scissom (46) Rob Seesholtz (47) Eddie Small (48) Melissa Smith (49) Caroline Tippens (50) Kennedy Toban (51) Debi Tuggle (52) Stefanija Weaver (53) Jennifer Webb (54) Regena Young

NEXT MEETING DATES:	**2026** Tuesday, May 26th – Virtual Friday, July 31st – In Person Friday, November 20th – Virtual

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
Statute Rules	R. Seesholtz	Good afternoon. My name is Rob Seesholtz, Trauma System Director for the Health Facilities Commission. Before I ask the chair to call the meeting to order, I would like to go through some procedural steps which are necessary to properly convene an electronic council meeting. Electronic meetings are recognized by Tennessee statute and are required to be conducted in accordance with applicable provisions in T.C.A statutes and with the Office of Health Facility Commission policies. Also, please note that a recording of this meeting is being maintained.	Roll call – Quorum present. All members voiced being able to hear and see other council members.	
Announcements	R. Seesholtz	Introductions of Stephanie Spain (Erlanger), who is the new TPM representative on the council and Tyler Haines (Sumner) who is the new Registry representative on the council. Ms. Natalie Whitner who currently serves as the Tennessee Hospital Associations administrator role on the council She will be leaving her position at Skyline for another opportunity. I've reached out to THA for another nominee, and they will get back to me as soon as they can. I will make sure council members are aware.		
I. Approval of Minutes	R. Williams	Good afternoon, everyone. I'm calling this February meeting of the Trauma Care Advisory Council, to order. The minutes were sent out by Rob for our last meeting. Did anybody have a chance to review them? And if so, is there a motion for approval?	Motion to approve and seconded.	
II. Old business Trauma Fund Report	R. Seesholtz	First quarters funding distribution utilizing the new funding formula has been completed. Most every institution should have received their email, letting them know what their disbursement amount is. Those emails get sent with corresponding letters typically to hospital CEOs. If there's any institution that would like to know what their amount is for this quarter, please wait till the meeting is over and send me an email and I'll be more than happy to provide you with that letter,		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
III. Subcommittee/Ad Hoc Committee Reports				
a. Registry	B. Dennis	Nothing new from the registry to report. I think there was some stuff that was more for the PI though, right Rob?		
	R. Seesholtz	Yes, one item Dr. Dennis, 25 participants attended the AAAM class and all passed the class except one. That person verbalized that they intend to retake the exam in the upcoming months.		
b. IP / Surveillance	T. Love	So just to remind everybody the core state's injury prevention project was funded by the CDC. Just a quick update to let you know that we have received an invitation to apply for a one-year extension on this funding, which is wonderful news. The purpose is to really strengthen the infrastructure of injury prevention in Tennessee and much of that involves working with your staff and focusing on ACEs, traumatic brain injury, transportation safety and suicide. These are the programs that we offer, but we do more than that. Checkpoints Tennessee, Safe Stars youth Sports initiative, and then of course the calm training, the counseling for access to lethal means and then the better workplaces Tennessee program. Those are our four main programs funded by this grant. I also wanted to share with you that we completed a special emphasis report for this year for the CDC and it's centered around traumatic brain injury. I can send a copy to Rob, and he can forward it with the minutes. But you can see that with this report firearms is a leading cause of traumatic brain injury death and falls are the leading cause of hospitalizations and ED visits. One thing I want to encourage your staff to do if you're not already, your prevention staff and everybody really is to take advantage of AI resources. We've been approved to use chat GPT	Encouraged council members to review and to reach out if any questions.	

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		in the Department of Health and I was one of the first lucky ones to get access to that to a state account and we have been learning how to use it.		
	R. Williams	I have some questions if everyone doesn't mind if I start. I'm really concerned about your second point, which was violence, and you listed homicide and suicide. Which one's higher? Are there more suicides death or more homicide deaths? So I really believe they're more homicide deaths than suicide deaths in our state, and I'm curious if that's true, why we focus so much on suicide prevention but never on homicide prevention.		
	T. Love	Part of the tradition and kind of the practice of the CDC and the funding mechanisms have been for unintentional injury. And so that drives some of that and in the case of our grant, you know it's unintentional injury that we get funded to do. So that drives some of that. Some of it is a difficult multi-layered problem. It's lends itself to very much of a coalition style like you're doing there in Memphis to try to address it and that's something with the infrastructure that we haven't traditionally statewide. That could be something we could create through trauma care advisory council or other means. I know that doesn't tell you what you necessarily want to hear, but that's the answer is that the funding is driving a lot of that. Perhaps we should be writing some grants for that specifically in the future.		
	R. Williams	Yeah, I was curious. I'm going to ask this of the council too, but is there an opportunity to request some funding focused on what's actually killing children? And maybe TCAC could help with that if the council was willing. What does the group think about looking at violence prevention rather than suicide and safe storage, which are not the huge drivers of childhood death?		
	O. Bratton	So I'm, I would like to second that because the other thing that we see that is a struggle is what you're seeing in West Tennessee is		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		not necessarily what we're seeing in East Tennessee and I've had multiple conversations with injury prevention and we're not able to look at the, the differences cause on our side of the state, gun violence is not killing kids, homicide is not.		
	R. Williams	You have more suicides.		
	O. Bratton	Correct. So, I think being able to differentiate and being able to isolate the different regions, even at a grand region, you know, East Middle and West would be incredibly helpful.		
	A. Greeno	Have you guys seen the new Tennessee child Fatality report that just came out? That report does list homicide over suicide for pediatric patients ages one to 17, but Oseana, if you look at the last few pages, it isolates the leading cause of death for each county. So, then you can look at your counties and see which ones are the leading cause per area if you want to isolate it that way. There's actually something I had just accidentally stumbled upon. Its at the last part of the report.		
	O. Bratton	I must have missed that page. I know that's been kind of an ongoing conversation with all of us, is that we have such different, different data when it comes to that across the state. So let me, I'll look at it.		
	R. Williams	What do the adult trauma centers see from a relation to, to firearm related death? Is it more homicide or more suicide or is it a mix or is it different based on the region? Does anybody have a feeling? Or.		
	B. Dennis	Yeah, well we see both, right? And, and not insignificant numbers of either. I mean, it's not heavily weighted in any direction it's probably more, you know, violence, but suicide is definitely a substantial amount of the gunshot mortality that we see.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	D. Bhattacharya	Is that, is that because who makes it to the hospital? Because some of the suicides are, I would predict a high proportion of the suicides by gun may not make it to the hospital.		
	B. Dennis	I think thats probably is a contributor.		
	A. Kerwin	Homicide too, right? You don't know how many people never show up because they're pronounced dead in the field.		
	D. Bhattacharya	Going back to Regan's original comment, I'm happy to help facilitate from both a violence and a suicide perspective and I understand that the state is different across regions and rural versus urban communities, but if there's something we can do to help Regan. We kind of sit in the middle, we're kind of both urban and rural so.		
	R. Williams	Is the council, was this something the council would like to work on as a group? Or do we think there are other things we want to work on?		
	R. Bollig	Can I throw a differing opinion out there? We kind of got our hands slapped by the ACS because we've done a lot of work with firearm prevention and safety, and that is a very minimal number of patients we actually see here. So, they're like, you guys have all these injuries from motor vehicles, falls and that stuff. So why is your injury prevention concentrating on something you really don't see? My take on that was because we were doing such a good job, but I don't think that's true, but you know, that's the perspective we got from our reviewers.		
	R. Williams	I think that's a really good point, Reagan.		
	A. Kerwin	Yeah, I mean, if you're doing ACS verification, they always want you to focus on whatever your most prevalent mechanism is. But this is a kind of a statewide initiative, right? And so why would we not approach both?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	T. Love	I would be glad to take any resources or direction from you guys to, you know, enhance the efforts. I think we, I think we can do more than one thing. We've been doing that but in terms of just having the bandwidth and staff capacity, you know, to satisfy the core SIPP grant which has you know paid very clear objectives and deliverables. And then, to perhaps work on a, another area of funding. If not, if not for the state, maybe, you know, maybe the, the region that needs it more, you know, and that and we know falls, fall prevention is probably, I don't know what the ACS had to say, but you know, that's probably one of your top, most of your top injuries that you see at in the ED, and there is another body, a safe body that works on that and there is a fall prevention coalition, and I could bring those people to the next meeting if you would like to have them present and share around resources around that area, I think to say that's one of the bigger problems in terms of, in the hospitals probably in one of your EDs. Am I correct on that?		
	R. Bollig	No, falls are by far what we see the most. You know, I don't want to put any words in anybody's mouth and I think I can say this keeping my TCAC hat on, but you know our Tennessee COT has a chair in injury prevention that could work with Terry and maybe organize this kind of stuff.		
	T. Love	Well, I'm just eager to do that if needed and also appreciative of the time here and the work that we are already doing. I just have to throw a shout out to Nick and in the intervention subcommittee from CoPEC, which many of those people that are on that group are in your institutions and they're doing wonderful things to support that. So, there's a lot of good work going on, but there's always going to be more work to do.		
	R. Williams	Yeah, I think that's great. And I would, I think I would love Terry for you to maybe talk about falls at our next TCAC meeting because I think that Reagan makes a good point. There are other mechanisms that we have more patients and so maybe we can		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		learn about some programs that the state has to offer. All right. My next question for Terry was you said that drownings was a leading cause of death in some regions, but what regions is it?		
	T. Love	Those areas I don't know off the top of my head for sure. I've had more feedback from people around lakes in Tennessee and the lake areas as a problem, but really anybody with a pools at risk if it's not managed well at home. While the numbers are not very high relative to other issues, it makes sense to do some prevention in that area. And there are some groups of kids that really simply don't learn how to swim because they're not taught how to swim, their parents may not even know how to swim. So that's part of what the no more unders addressing is those at risk groups.		
	O. Bratton	Dr. Williams, it looks like drowning's the top, in the top three for South central, Southeast, West, those three.		
	R. Williams	Thank you. Anybody else have any questions for Terry or any comments, thoughts about injury prevention and surveillance?		
	B. Dennis	Regan the only thing I want to mention is like, this is a committee or a subcommittee on TCAC, like maybe we ought to have that committee like get together and like come up with what we think TCACs priorities are and we can make some recommendations to Terry for the future, but we always sort of sit in here and make throw out comments or ask questions but you know like Terry sets his agenda way in advance and you know like has his budget limitation and all that stuff, but so we're not really able to accomplish a whole lot, you know, with this method.		
	T. Love	And I'm certainly not the only subject matter expert on injury prevention in Tennessee. I mean we could bring in other people in other areas as we have done. And I'd be glad to work with		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		Regan to convene a committee of any, anybody who's interested and we can meet now virtually so it would be easily to do that subcommittee and we could talk more about priorities.		
	R. Williams	I like that idea. Abby, Rob, can you help us with that after the meeting?		
	R. Seesholtz	Absolutely.		
	A. Kerwin	This is Andy Kerwin. What about motor vehicle crashes?		
	T. Love	They are still and that's why we have the checkpoints program and I didn't mention this, but we actually are taking that online. It's for new teen drivers and that's where we focused our major resources, but new teen drivers are just the beginning of the deaths, you know, really the 25- to 34-year-olds is a high number you know of folks as well. So there's room for more prevention efforts in those, in those areas as well.		
	R. Seesholtz	I will say folks, in looking at our annual report, our top five fatalities in the state are falls, motor vehicle crashes, and assaults. Number four comes in at intentional self-harm. So that is also the same for top injury categories for the year as well.		
	T. Love	So there's some signs and some art to prevention, primary prevention and upstream prevention. So, but yeah, I'd be glad to work with Rob and Regan, Dr. Williams and try to get that meeting set up as soon as we can, so we'll be ready for the next quarterly meeting.		
	R. Williams	Excellent. All right, we're going move on to our next subcommittee report, which is system development and outreach. Are you giving that Rob or am I giving that?		
c. System Development/	R. Seesholtz	The only item that I have here, is just a reminder for the symposium save the date 30 July of this year at the Virgin Hotel		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
Outreach		Nashville. I believe Dr. McKnight is on the presenter committee and she's working diligently in getting presenters for the symposium. What I don't know, Dr. Williams is does she got a lot of presenters or does this council need to work their magic to bring up, get some other presenters for the symposium?		
	R. Williams	So, right now we have a pretty good agenda draft and based on the topics and the comments from last year, and we are working on getting volunteers to fill those spaces now. So if we don't get those filled in the next month or so, you'll certainly be hearing from us, for help. What we do want is for there to be at least one presenter from every trauma center in the state, so that we have wide representation. Our keynote speaker is going to be on rural trauma, that was something that was mentioned multiple times in the feedback from last year, so we think that that will be a great, topic and we're working on getting a speaker for that now that will come in from somewhere else in this state. Any questions or comments about that? We also, during that, not the trauma symposium, but the next day when we have our in person TCAC meeting, we'll have the Tennessee Department of Health that does emergency preparedness through the state.		
	R. Seesholtz	Th Tennessee Department of Health is ultimately responsible for preparedness within, you know, the health department or ESF eight, emergency support function eight.		
	R. Williams	Okay. So they're going to come and meet and greet with us during those few days in Nashville so we can learn more about emergency preparedness across the state and how our trauma centers interact with that. Hopefully helping develop our mocs or regional medical operations centers across the state in case there's a large-scale combat operation. So that will be during those few days as well. Questions, comments? Okay, next we'll move on to PI outcomes.		
d. PI/Outcomes	R. Seesholtz	I believe Dr. Bollig, if I'm not mistaken, there is no report from		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		TTACO Is that correct?		
	R. Bollig	No, not for this. don't have our spring report back yet. Just wanted to remind all the facilities we had discussed looking at ensuring obtainment of GCS, heart rates, and systolic blood pressure on all trauma patients within 30 min of arrival. I've found that somewhat difficult here, but we're making some progress. So, probably maybe at the, at the Tennessee ACS meeting, before that get some information from everybody and, and report what everybody's done and found. But I'll reach out to to folks before that. I'm going to use my own progress at my facility to see if it's even worthwhile to compile any data, but it looks promising so far. We only have two months.		
	R. Seesholtz	Thanks so much Dr. Bollig. If there's nothing further, I am going to turn the show over to Miss Cook who's been working very diligently on our power BI dashboard on how we're looking at hospital complications and other performance improvement related items over our last two meetings from our PI workgroup. I will now shut up and miss Cook, the floor is yours ma'am.		
	A. Cook	Well, hello everybody and happy 2026. At our last TCAC meeting, we talked about the need for meaningful level three benchmarking data and we talked about the formation of the PI workgroup. Since then we've started those PI workgroup meetings and have had excellent discussions around complication data, benchmarking and how we can better use our data to support performance improvement. During that last TCAC meeting, a static image of a dashboard was shown that displayed admission data and complication rates. So that was that, that PDF, that non interactive display that I showed. That image sparked an important conversation about performance improvement at the facility level, the designation level and in comparison to statewide data. From both that discussion and the work happening in our PI meetings, the idea emerged to move from a static image a static image or static dashboard to a more		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		interactive version, and that's what I'm going to show you today. So, before we begin, I just want to make mention that this is not the final iteration of this dashboard. There are still a few tweaks that we want to make that related to visual changes and they don't have anything to do with the data that's being shown or the intent of the dashboard, but just know that as you look at this and the next time you may see it, it could possibly look different. So what you're looking at currently is very similar to the static image or dashboard that was shown at our last TCAC meeting. But this one allows for you to interact with it. Right now, this is in state review mode, and it is comparing the data from a selected designation level, which you can see here is level three to statewide data. The 1st measure here across the top is where you would see the facility incident rate for a specific complication in a specific year. Of course, that's reading blank right now because we do not have a specific facility selected because we're in the state review mode. The next measure is that same complication type and year, but for centers of like designation levels, so right now that's looking at the rate of acute kidney injuries in 2025 for level three centers. This middle measure would show the variance between the facility rate and the peer group rate obviously showing blank because no facility selected. And then as you move across, it's the same type of setup, but comparing a facility versus all of the statewide data and then the difference there. So this chart, which says the complication rate visual comparison is those same measures along the top but in a visual representation. On the right side, you'll see the trend for the selected complication type over time and below that the trend for admitted volume. That admitted volume is what we use for the denominator when we calculated the rates for the facility, the peer group, and all statewide data. So currently, as you can see, this is showing the designation level versus statewide data, but if a facility were selected, that facility's data would also appear in these visuals.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		This has the potential to be a great tool, especially for our level three centers. I'm not going to put it on facility mode because we don't want to share other facilities data with anybody, but we do have that capability. And when we move into the facility review mode, the dashboard keeps the designation level and statewide comparisons as you see them and adds the facility rates into it. When a facility is selected, the designation level automatically updates to match the facility so the comparison is always being made to the correct peer group. At that point, a facility can see how they compare to other facilities of their same designation level and to statewide data overall. Prior to this, level three centers did not really have a practical way to benchmark their complication data against peers unless they were participating in TQIP. This dashboard allows us to benchmark like facilities to like facilities in a way that's not been readily available from the state before. It shifts the conversation from reviewing numbers in isolation to understanding performance within the peer group, and it can be done in seconds without multiple reports or manual calculations. Another major difference from the static version is the ability to interact with the data in more real time. Using the slicers or filters across the top, we can select a complication type in a year and the entire dashboard updates instantly based on the most recent registry quarter submitted. So currently through September of 2025. So as you can see right now, it's showing the complication type of acute kidney injury for 2025, but say we wanted to look at something else and we pull up unplanned admission to the ICU. So this is showing unplanned admission to the ICU so far in 2025 for level three centers as it compares to statewide data. What previously took significant amounts of time can now be done in seconds. This allows us to isolate complication types, look at trends over time, and relate those trends to admitted volume. This is the type of tool we hope to begin using during our PI workgroups, site reviews, and any		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		other time we want to take a look at the data in context instead of relying on static reports. Why does this matter? Because we're moving from a static image of data to an interactive dashboard that allows us to actually work with the data. It helps facilities understand their data and context instead of isolation. I do want to point out that this is raw data and it is not risk adjusted. But recently during an ACS review, a center was encouraged to look more closely at their raw data in addition to risk adjusted data because it can provide a more accurate picture of what is truly happening within the facility. Presenting the data this way has also led us to begin reviewing complication definitions with facilities to make sure we're all capturing complications consistently across the state. It supports site review preparation for level three centers especially, and it provides a benchmarking visibility that hasn't previously been available outside of TQIP. This can change how facilities use their data. It lets us use our registry data for more than just reports. We can actually use it to guide discussion and make improvements. Right now, you're just seeing the state review side, but this was built with row level security in mind. So that means that we can control what someone sees based on who they are when they log in. A facility would be able to see only their own data compared to their designation level and the state. They would not be able to see any other facilities information. This allows centers to use this as a PI tool while keeping data of privacy exactly where we want it. This dashboard is really just the starting point and using this structure, this framework could be expanded to include additional dashboards, including things like fatalities, volumes, trends over time, and a million other key trauma metrics. This is pulled directly from our registry data. It can be updated each quarter without needing to recreate reports, and we're also seeing other states move towards this type of interactive trauma data review. For example, here's Montana. Looking ahead, this does open up the possibility for a public facing deidentified view of		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		trauma data that shows Tennessee's commitment to quality improvement without exposing facility specific data. So as you can see this is Montana's, it's pretty impressive. We do have the capabilities to be able to do that if we so desire. So what started as just that PDF screenshot of a quote unquote dashboard has now become a tool that can truly change how we look at our data. This is where we stop looking at reports and truly use the data. That's all I got.		
	D. Hunt	That's fantastic.		
	R. Williams	Great job, Abby, great job.		
	B. Dennis	Yeah, Abby I just wanted to say this is great work and I think a really nice evolution from the, as I was telling Rob, I loved the printout and calling the dashboard. So this is actually a dashboard, so thank you for that. Is this homegrown, like have you built this or is this using like our vendor existing tools?		
	A. Cook	No. I made all of this.		
	B. Dennis	Do we then have the ability like if we want to add, you know, if we if we see areas that, hey, this would be a cool way to look at this data like.		
	A. Cook	100 %. Anything you all want, that's and that's ultimately why I wanted to show everybody this. We can make it whatever we want. You know I've started to play a little bit more. Another area outside of complications that's a little bit more cut and dry and easy to pull data and metrics on was our fatalities report. So I have started to kind of develop a dashboard based on that as well, but this can just open up to a million opportunities, and we can make it whatever we want.		
	R. Seesholtz	It is no secret, I mean the work that she's done and completed with this is just fantastic. Her subject matter expertise of getting		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		this up and running has been nothing short of amazing. However, there is a caveat as there is with about everything. For us to fully develop this out meaning interactivity, that can be forwarded to each trauma center so they can review their own data, do comparative analysis with like centers or the state. There is a cost associated with that. Currently, Abby is working on a trial version which is due to expire at the end of this month. We will still be able to work with that data, but some of that row level security and the functionality of having each trauma center being able to look and compare their own data, at their own house, at their own center that and please Abby if I'm misspeaking, let me know.		
	A. Cook	Ultimately, I can still use it on my end, even if we don't move to fully incorporating this into our trauma system. I can still use this on my end and build these dashboards, which makes the usability very easy for me to then grab screenshots and send them off as a PDF. But that gets us back to where we were before at the last TCAC meeting where it was just a static image.		
	R. Seesholtz	So in, in discussing with our fiscal office, the state of Tennessee does have a Microsoft contract, which power BI is a Microsoft software product. We do get a significant discount because we are under contract. However, that cost is to the.tune of about $20000 per year for us to do this. So I would inquire of the council, it has already demonstrated its value to me and the ability to use data different ways as well as each individual center. We've been getting nothing short of rave reviews from centers that are seeing the data, seeing their own data, how they can compare their data with like trauma centers designations as, as well as state data as well. And it's also been a great tool from a, data quality perspective here at the state. We're with these PI workgroup meetings that we are conducting we're ensuring everybody is following the same data dictionary definitions, and it's already paid off dividends from institutions realizing, hey, that's not, that's not our data. We need to take a look at that and		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		resubmit again. So, it's already, it's already paid off as far as I'm concerned. But I would ask of the council, if this is…		
	B. Dennis	Is that an annual $20,000?		
	R. Seesholtz	It is sir.		
	B. Dennis	And our readiness allocation from the trauma fund is, is how much? The system administration allocation.		
	R. Seesholtz	A hundred thousand dollars a year, sir. So I would ask the council for any questions, comments, concerns. I would ask for approval for the council to expend this, but I'd be more than willing to, or Abby is more than willing to answer any questions that any of you guys may have.		
	D. Hunt	I think this is fantastic. I think we should move forward.		
	R. Williams	Would that be a motion to approve Darrell?		
	D. Hunt	Yes ma'am, that's a motion to approve for me. Okay.		
	R. Williams	Think I got some seconds. Great. Do you want to roll call vote that?		
	A. Kerwin	No, I have a question. So what, so if we did it for one year and then we say, ok, this is not what we thought it was going to be. What happens? We're out and we lose the data or?		
	A. Cook	No, the data would still be ours, it would still be owned within powered BI desktop, which is where I build everything. It would just become then back to that static imagery rather than being able to send it out to each individual facility and letting them interact with it.		
	R. Williams	Any other questions?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	A. Cooper	Data is only accessible by Abby or is it am I understanding that correct?		
	A. Cook	All of the data that I use to build these reports is from our ImageTrend registry. So it's what all of you are submitting to the state's registry. And then what would happen is as I am able to build whatever dashboards we so desire, so for right now we do have this complications dashboard. I would be able to send that out to the TPMs TMDs, whoever at your facility would want access to your facilities data, I would add you to the list or what's called the row level security for that specific facilities data. And then when you would want to access it, you would just put in your email. It would say, oh, this is Anissa, she's from LeBonheur she can only see LeBonheur's data versus the state data. So it would all be accessible to you, your facilities data, and the comparison to peer level and state level. It's you just wouldn't have access to any other facilities, and all of the data is from our ImageTrend registry.		
	R. Maxwell	One other question, this maybe down the road details, but say someone had a question that they wound up abstracting data and like wanted to present something at a meeting, is there going to be some sort of permission process that you have to go through or if you're given access, can you just do whatever you see fit with what you see?		
	R. Seesholtz	You know Dr. Maxwell, I think since it is comparative aggregate data from the state, you are really only looking at your own institution. I wouldn't think unless the office legal services had another comment. I wouldn't think that there would be any permissions necessary because it is your data and its all deidentified.		
	A. Kerwin	How, how far back would you be able to go or is it only going forward from when we start building or you started building?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	A. Cook	Yeah, so whatever is present in the ImageTrend registry, I'm sure that there is data that exists outside of that. It's a matter of getting my hands on that, that would be the tricky part, but certainly from the point of inception of using the ImageTrend registry data, which I have pretty clear and clean data back to 2020 and then ultimately going forward, I have access to all that data as well.		
	R. Williams	All right, we'll call the question.		
	R. Seesholtz	I have a motion to approve by Dr. Hunt, seconded by Dr. Dennis for the expenditure of trauma fund monies for the purchase of PowerBi license.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Maxwell – aye Dr. Bolig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Campbell – aye Dr. Jensen – aye D. Kerley – aye Stephanie Spain – aye Renee Mills – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Tyler Haines – aye	Unanimous aye votes – motion passes.
	R. Williams	Excellent. Great job, Abby. Super excited about the opportunity to learn from each other and help make our care better. So thank you for all of the work on that. Next we're going to have our children's emergency care alliance/CoPEC update from Renee Mills.		
	R. Mills	Guys I don't have an update today. Our CoPEC meeting is actually tomorrow, so we've not had an update since our last		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		TCAC meeting, so, more to come and I'll send that to Rob tomorrow as we finish up, our CoPEC meeting.		
	R. Williams	Any questions for CoPEC? Okay, we are moving on to Legislative.		
f. Legislative	R. Seesholtz	The only item I have is that previous years the tnpath group convened to present to the General Assembly their thoughts and concerns regarding trauma funding. I would just encourage if that group decides to meet again this year to approach the General Assembly, just know that the health facilities commission specifically trauma is certainly ready and willing to help that group with any data or any information that the group may need for presentation to the General Assembly.		
	R. Williams	Brad, do you have any update on tnpath? Were you able to talk to your people?		
	B. Dennis	I talked to them, but we have the email, thread where we're gonna have the meeting next week.		
g. Finance	R. Williams	Excellent. Yep, Rob we'll let you know, and we will include you in anything we do. Okay, finance subcommittee, any updates?		
	R. Seesholtz	No ma'am, other than the trauma fund news.		
IV. New Business	R. Williams	Now we're going to move on to new business. I think Rob is going to give us an update on the emergency medicine physician attendance in the ED 24/7/365. He did send out a little blurb about this this morning, so that we would be prepared to discuss.		
a. EM physician attendance in the ED 24/7/365	R. Seesholtz	Absolutely, and I believe the two individuals that expressed some concern with this new role language was certainly President Elect, Dr. John Proctor through the Tennessee chapter of the College of Emergency Physicians and I believe their lobbyist		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		Jack Foss Binder is on the call and in attendance today as well. I'm going to share my screen with a couple items. I forwarded you guys the interpretive guidance as well as the subsequent email from Dr. Proctor. Their concern was, as I stated previously, all physicians must be physically present in the ED 24/7/365. I used to work in a small community emergency department and certainly understand what resources are there or not there and have responded to multiple different resuscitations, respiratory arrest in the hospital when I was functioning as an ED nurse and the emergency room physician, we had to go up to whatever floor to ensure any resuscitative needs or airway needs were taken care of. And this was really the biggest concern for, I believe, Dr. Proctor. Having physicians remain physically present in the ED 24 hrs. a day is unattainable. While the college has similar language, specifically in level one and two trauma centers, the board-certified board eligible emergency physician must be present in the ED at all times. And they go on to further clarify at all times is defined as 24/7/365 and implies that there are no gaps in coverage. And I believe that is the intent of the council, in accepting this college rule, however, to address some of Dr. Proctors concerns, this is what we felt was appropriate moving forward. So, the rules, the language contained is certainly draft. This can be reviewed, altered, or however the council sees fit since those new rules have not been promulgated yet. The red underlying area is where, our legal department said, hey, we need to put this in here because if we want this to go into effect once rules are fully promulgated, we need to add this here. So I was interested in hearing any thoughts or concerns from the council and whether or not the language that is currently contained is appropriate or not.		
	B. Dennis	I mean I think the key phrase is second part of what you were showing on the ACS rules that it implies gaps in coverage, and that would be what I, you know, I mean, I think obviously people are fine with people leaving the unit to go to the bathroom or get		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		lunch or dinner, and I think recognizing the clinical scenario you described where the ED physician maybe required to help, you know, resuscitations on the units. I think that's completely appropriate too. In fact, our rules for other areas for the ICU actually say that exact thing. So, I think from an interpretive guidance standpoint, if we outline that we're talking about gaps in coverage like staffing the shift, that I think would probably address this.		
	A. Kerwin	Yeah, I agree with Dr. Dennis about the bathroom and the cafeteria. Leaving the emergency department to go run a code on the 6th floor though, I think that's where there could be problems, right? You could be gone for 30 min running a code and then the ED is left un uncovered, right? So, I think that's the piece that's really the question of this and I thought the American College of Emergency Physicians even had something in their on their website or something about this because it was always a question my last hospital about them responding to codes up on the on the floor. So I don't know and maybe Dr. Proctor can clarify what ACEP's stance on this is.		
	B. Burns	Yeah, I think the key to the language going into the world of interpretive guidance is that it's availability to the trauma patient at the time that the trauma patient needs the availability. So I don't have any strong angst about the wording, the way that it is. I think it would be fine if it said within the facility, but then somebody would say well now you're saying I can't go out to the car to have my smoke break. I mean at some level you don't want to nuance every little thing when you're really trying to just get the point across that patient care is the priority and you have to be physically present. So I would be fine changing the word ED to facility or immediately available or something like that, but I mean we pretty much took the language from the American College of surgeons. So, if I went to a place and I saw there were no gaps in coverage while doing a site visit, I'm not gonna then say, ok, show me the camera footage for 24/7		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		that shows the ED physician never went the bathroom, right? Like, so there's a difference between what the words say and what the intent is and I'm open to changing a word or two, but I don't think I'm open to changing the intent.		
	R. Seesholtz	I'm going to stop sharing my screen for a minute. Dr. Proctor, I believe is on this meeting. I'm going to see about unmuting his mic and, having him speak.		
	J. Proctor	Yes, thank you for allowing me the opportunity to speak. The language that was projected a moment ago as amended we would certainly support. It preserves let me speak to the resuscitation piece. Many emergency contractual agreements that include provisions that we will respond to in-house codes. That is generally intended for us to initiate a resuscitation such as airway management and then hand off the resuscitation to the next available, most appropriate provider. It is true that we can get trapped, so to speak, for 30 min or uncommonly even longer, but what is typical is that we initiate resuscitation and then return to the emergency department. I'll also note that the comments about visiting the position lounge or cafeteria briefly to have a private bathroom break or to obtain food, this is very true and very customary of what occurs most particularly in what would be the equivalent of level three and level four centers. I'll stop there for now.		
	N. Jensen	So I'm the only other emergency physician on the call. I agree with all the sentiments, the only issue would be prolonged resuscitations which would rarely happen, but I agree with the modification of the wording. The intent is that the emergency physician is immediately available this formalizes the practice of most ER physicians, which is to be immediately available. If you're leaving the department, most docs will have a phone on them that allows them to be called back in a few minutes at most.		
	R. Bollig	I was just going to echo what was just said. We went through this		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		wording vernacular hootenanny with our private group and one thing what we ended up landing on was immediately available within the facility to respond to trauma. I mean that's, you know, we're, we're the trauma care advisory council. We understand you gotta respond, but we got to take care of our own first and so being immediately available to respond to traumas, with the immediately available within the facility to respond to traumas catches all of that.		
	A. Kerwin	I like that. I think that's a good way to handle this.		
	M. Smith	Okay, so I agree with a lot of what people are saying and as an ACS nurse reviewer, this has never come up. The only thing we've ever checked for is just ensuring there were no gaps in coverage. And that's clearly stated in the orange book for standard 4.8. We expect them to attend to any house emergencies if anesthesia's not available and they're the only ones, but it doesn't mean that somebody has to physically be present 24/7, it's just we're looking for gaps in coverage on their call schedules.		
	R. Seesholtz	I would echo that statement from Melissa when we go to do site reviews as well. That's what we are looking at. Any gaps in call schedules and certainly any delays or gaps in care. So for what's projected on the screen for all levels of trauma centers, this was Rob's 1st attempt at this language. All physicians must be physically present in ED 24 hrs a day is meant to confirm that the ED physician is to be present in the hospital so they can respond quickly to a trauma and to confirm that no gaps in coverage occur. Is that language appropriate?		
	R. Bollig	What, about, I mean if people are getting hung up on the verbiage to be present just immediately available.		
	R. Williams	That the ED physician is immediately available so they can respond quickly to a trauma changes that.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	C. Tippens	I think Dr. Burns mentioned immediately available within the facility to respond to trauma.		
	R. Bollig	Yeah. I'd say at the facility because then you don't split hairs. Oh, they were out of their car.		
	R. Seesholtz	All physicians must be physically present in the ED 24 hrs a day is meant to confirm that the ED physician is immediately available in the facility so they can respond quickly to a trauma and to confirm that no gaps in coverage occur.		
	A. Kerwin	Say at the facility, that way if you are…		
	R. Seesholtz	At the facility		
	R. Bollig	Or on site		
	A. Kerwin	That way if you go to your car or you go outside to sit down the…		
	R. Bollig	The American Academy of Emergency Medicine uses the words on site.		
	J. Proctor	I'm not an attorney, but I'm concerned that phrase one that states clearly must be physically present in the ED 24 hrs a day. A reference later in this statement to the facility could be misinterpreted as the ED being the facility since it was referenced earlier in the statement. I prefer the language as it's written currently. Thank you.		
	N. Flinchbaugh	Rob, correct me if I'm wrong, but that in the ED that's coming directly from the rule and you're just giving your interpretation of that, correct?		
	R. Seesholtz	That is correct sir.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	N. Flinchbaugh	We wouldn't be able to change that because that's how it's currently written in the rule. So this interpretive guidance is just the trauma council's interpretation of what they meant by that. And of course later iterations of these rules we can modify that so that the meeting is clear without any need for interpretive guidance. But these rules are going into effect May 6th and there's no time to make modifications before that occurs. So this will allow us to make this adjustment until the rules can be updated to appropriately reflect some improved language.		
	N. Jensen	How about immediately available at the hospital that address everyone's concerns and clarify the language?		
	R. Bollig	What if it's not a full hospital? What if it's just a care center for a facility?		
	R. Williams	Would they be considered a trauma center then?		
	R. Bollig	If we're, we're splitting hairs on vernacular, like it can be a box, a shack, a shed. I gotta say on site clarifies all of those, just on site.		
	B. Dennis	Just to be clear, the very beginning of the trauma center rules, we have definitions which include what facility means and it refers to some other TCA guidelines.		
	R. Seesholtz	So I'm I am certainly willing to entertain any additional language Dr. Proctor is fine with the way the language is currently depicted here. There are some that have mentioned all physicians must be here is meant to confirm that the ED physician is immediately available on site so they can respond quickly.		
	R. Bollig	Like what Brad said, whatever, whatever definition we use for, for that, if it is facility or hospital or care unit.		
	R. Williams	Do we have the definitions that we use in the rules?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	B. Dennis	Nathanial might be able to give it to us because it's a reference to a different statute within TCA, the Tennessee code. So it's not within our trauma rules.		
	C. Tippens	Nathanial, I believe, correct me if I'm wrong, but it's the definition of healthcare facility under Tennessee code annotated 68-11-201.		
	N. Flinchbaugh	I'm double checking, So facility in the statute is defined as any institution, place or building providing healthcare services that is required to be licensed under this chapter. So it's a pretty broad statutory definition.		
	R. Bollig	So there you go. Use that word. Do we need a motion for this?		
	R. Seesholtz	I need to confirm the language.		
	R. Willams	Okay, we do need a motion. And we want him to say immediately available, not present.		
	B. Burns	No, we can't change that part.		
	R. Williams	We can.		
	B. Burns	Sorry, I was looking at the part that was in quotes.	.	
	R. Seesholtz	So, is meant to confirm that the ED physician is to be immediately available in the facility, so they can respond quickly to a trauma and to confirm that no gaps in coverage occur.		
	R. Bollig	I make a motion that we change it to that.		
	A. Kerwin	Second.		
	R. Williams	Okay. Any discussion, any further discussion on the motion on the table? All right, hearing none, we'll take a vote.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Seesholtz	Vote on interpretative guidance. For all levels of trauma centers, "all physicians must be physically present in the ED 24 hours a day" is meant to confirm that the ED physician is to be immediately available in the facility, so they can respond quickly to a trauma and to confirm that no gaps in coverage occur.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – ??? Dr. Campbell – aye Dr. Jensen – aye Stephanie Spain – aye Renee Mills – aye Anissa Cooper – aye Dr. Bhattacharya – ??? Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Tyler Haines – aye	Unanimous aye votes – motion passes.
b. Pediatric emergency care facilities licensure survey	R. Seesholtz	We reached out to some folks to ask about their participation as a site reviewer for pediatric trauma center site reviews, we received interest from two individuals, one of those a physician, one of those a nurse that have volunteered to step up to provide that. If there are any additional pediatric trauma surgeons or pediatric nurses that are interested in performing as a site team member for pediatric traumas center site reviews, please reach out to myself and Abby and we will get them hooked up and trained up within this process.		
c. Pediatric interpretative guidelines	R. Seesholtz	The council has been asked to look over the pediatric interpretive guidelines, so this document can be moved forward to the commission for full approval. I certainly understand that a considerable amount of these interpretive guidelines are not under the council's purview, but, I was asked to send this out to get this body's, view on the matter, any thoughts and concerns, and hopefully a vote to move this to the full Commission for ratification.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Williams	Do we have the interpretive guidelines to look at?		
	R. Seesholtz	They have been sent to all council members about a week and a half ago.		
	R. Bollig	Sent on 1-29-26		
	O. Bratton	At 10:39 EST.		
	R. Seesholtz	Thank you. It is a very lengthy document, so that's why I wanted to give the council enough time to review or at least leaf through to see if you had any questions or concerns.		
	B. Dennis	I have concerns about the length of the document.		
	B. Burns	Does it have to be decided today because it seems the majority of people have not had the chance to review it. So if it does not need to be decided today, I would put forth a motion to table.		
	R. Bollig	Can I bring up one quick little point? One issue that we have with the way we have things set up here in Knoxville is the designation and so we, you know, we get pediatric trauma patients here, and then we have a PICU to open up to take care of them before they get transferred over across the river to ETCH. And so we're, we're going back and forth with guidance on since we can have a PICU, do we have to designate as a general with the PICU or because we have that, it's, it's a messy situation for us. So that's the only thing I have, I don't think that comes up in the actual wording. It's just with us with the state. So tabling this, I would second that. That's a long-winded way to say that.		
	B. Dennis	So I, mean this is an 87 page document and I can't see anything that's like easily identifiable as like targeted for us, so I would recommend we send this back to them and say, can you just tell us what you actually need the TCAC to weigh in on? Because also, if you're wanting me to weigh in on all 87		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		pages I would say it's too long. Start over.		
	O. Bratton	There is a trauma section that you can scroll down to. I will tell you by us not approving this today, we're further delaying a document that's very, very important for pushing this out.		
	R. Williams	So Rob and maybe Caroline and Nathaniel can help with this. We really don't need to approve this whole document because we're the trauma council, we just need to look at the trauma part and make sure that it makes sense. Is that a true statement? Can that be a true statement?		
	C. Tippens	This is Caroline Tippens, wanting to make sure that it jives with what essentially you have under the trauma care rules, and also since you're the trauma care advisory council, everyone answers at this point to the health facilities commission. So your ratification of interpretive guides would then be put on Rob's trauma report which is then put on the agenda for the commission to ratify. So it's the first step in the process and that's why it's being brought here. We want to make sure that all standards align. Nathaniel, anything you want to add to that?		
	N. Flinchbaugh	No ma'am, you got it.		
	R. Williams	Oseana, what pages are we supposed to look at?		
	O. Bratton	So, pediatric trauma care guidelines start on page 60 and they go through page 66. There is no surveyor guidance for the pediatric trauma rules because this group to the best of our understanding is the surveyors, so there was no specific survey or guidance put into those line items.		
	R. Williams	So there is nothing for us to approve there.		
	R. Bollig	So alright explain to this to me like I'm a six year old, so why is		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		this coming to us? If we don't have to.		
	O. Bratton	I retract my previous statement. There is another section that we did put stuff in. I mean. Page 45 thru 60 has surveyor guidance on it. See we need to look at 45 thru 60.		
	C. Tippens	And, and I might add, so obviously the surveyors for the Health Facilities Commission also look at this when we were on hospital survey. So reviewing that surveyor guidance would, would be helpful. I believe Mr. Trent came to one of your prior meetings and it and explained some of this because our acute and continuing care hospital surveyors do look at this as well, so it would be important to have you all review this to ensure again that we are, you know, consistent within your regulation and the spirit and intent of the law.		
	R. Bollig	Well, I kind of agree with Brad. I mean we can't do that, we can't do 15 pages right now. I mean, I understand there's a push to get this done, but you want to, I'd rather do it right.		
	B. Dennis	Isn't our next meeting in April?		
	R. Seesholtz	May sir.		
	R. Williams	Can we, do we have any stipulations for voting by email? No?		
	C. Tippens	Sunshine law. Unfortunately, you cannot execute a vote via email. All your votes must be deliberated and done in public.		
	N. Flinchbaugh	So the statute that allows you all to have electronic meetings does not contemplate the use of email because that doesn't allow for meaningful participation by any member of the public. So you could schedule another meeting earlier than May. Rob, do you know when the next Commission's meeting in May. Usually that 4th Wednesday, so as long as you all meet before May 27th, you should be able to, to make any recommendations to the		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		Commission and get on that agenda.		
	R. Seesholtz	Our meeting is scheduled for May 26th.		
	N. Flinchbaugh	So what I would do is tentatively put it on the agenda Rob, and then once you get that final recommendation, just send that out to the Commission members as soon as it's ratified.		
	R. Seesholtz	I will do it. So, is it the will of the council to punt this for further review, deliberation, and comment at the next Trauma Care Advisory Council meeting?		
	A. Kerwin	So if we meet on May 26 and we want to make three changes, there's no way for that to be made by May 27 right?		
	R. Seesholtz	Good point, Dr. Kerwin. I would assume that if the council met, had recommended changes that could be done that Afternoon, now I would be under the assumption that that would need to go back to the pediatric folks for subsequent approval through CECA or CoPEC, but I'm not sure that that's the case or not.		
	B. Burns	With all due respect, there is a motion in a second on the table to table this already. These rules were started in either 2017 or 2018 to the best of my knowledge for driving to Nashville once a month every month while they were being initially put together. I don't see an urgency for a bunch of people who clearly have not read them to therefore ratify them. I don't think that's in the spirit of what the request is. So I stand by my motion.		
	R. Williams	Any more discussion on this motion? Alright, vote.		
	R. Seesholtz	Vote to table, pediatric interpretive guidance until our next meeting.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye	Motion passes.

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
			Dr. Maxwell – aye Dr. Bolig – aye Dr. Burns – aye Dr. Campbell – aye Dr. Jensen – aye Stephanie Spain – aye Anissa Cooper – aye Amber Greeno – aye Oseana Bratton – nay William Nolan – aye Tyler Haines – aye	
	R. Seesholtz	Thank you, council members, motion passes. I have one final item for the council, but unfortunately, I believe Mr. Flinchbaugh had stole my thunder. Rules are to be promulgated in May. So May 6th I believe is due for rule promulgation. The only request that I have from the council, considering that these new rules are a great deal more than what's currently contained in rule. For those institutions that are due redesignation visits for 2026, I would respectfully ask the council to allow those facilities that are due reviews this year to be reviewed under the old rules. And any institution having a redesignation or new site review for 2027 be reviewed under the new rules. Would that be appropriate?		
	R. Williams	Yes, do you want a motion?		
	R. Seesholtz	I do please ma'am.		
	R. Williams	Would someone make a motion that all reviews for 2026 will be under the old rules, and the new rules will actually go into effect for site reviews in 2027?		
	B. Burns	So moved		
	B. Dennis	Second		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Seesholtz	Voting that all site reviews for 2026 will be conducted under the old rules, and the new rules will go into effect for site reviews in 2027.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Maxwell – aye Dr. Bolig – aye Dr. Burns – aye Dr. Campbell – aye Dr. Jensen – aye Stephanie Spain – aye Anissa Cooper – aye Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Tyler Haines – aye	Unanimous aye votes – motion passes.
	R. Seesholtz	And the only other final item that I have, I will ask Miss Cook. Miss Cook, has there been anyone online to log any public comments for today's council meeting?		
	A. Cook	No, there has not.		
	R. Seesholtz	Thank you very much Ms. Cook.		
	C. Tippens	Hey Rob, one thing, if it would be possible since you had the commission vote on that, let's make sure or the council vote on that, let's make sure it gets on the commission's agenda, and then also since you do have a vote on that, let's turn that into a policy as well. If the council members are comfortable with that because we need to have documentation that can be produced in case we're audited.		
	R. Williams	I think that's a great idea. Thanks Rob. Big thanks to everyone. I appreciate the conversation that we had today and the work we got done and I think the roll call votes are slightly annoying, but it's still better than driving all that distance. And so if you see me roll my eyes, just ignore it Rob. But it does make us feel like		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		we're in COVID again because we had to roll call vote everything, but this is a great meeting, appreciate everyone. Apologize, we did not read the part about the pediatric interpretive guidance. We will definitely get that done and hopefully approved, at our May meeting. Okay, Anybody have anything for the greater good? Rob, Abby Thanks for getting this together.		
	R. Seesholtz	Our pleasure.		
	R. Maxwell	Yeah, thanks Rob and Abby this meeting is definitely a win.		
V. Adjourn	R. Williams			