TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: May 30, 2025

VOTING MEMBERS PRESENT	(1) Paula Bergon (2) Dave Bhattacharya, MD (3) Reagan Bollig, MD (4) Oseana Bratton, RN (5) Bracken Burns, DO	(6) Anissa Cooper, RN (7) Brad Dennis, MD (8) Amber Greeno, RN (9) Darrell Hunt, MD (10) Nicholas Jensen, MD	(11) David Kerley, RN (12) Andy Kerwin, MD (13) Jeff Levine, MD (14) William Nolan (15) Regan Williams, MD
VOTING MEMBERS ABSENT	(1) Marc Campbell, MD (2) Steve Hamby (3) Robert Maxwell, MD	(4) Natalie Whitmer	
GUESTS	(1) Jameil Abou-Hanna (2) Muyiwa Adedokun (3) Jennifer Beecham (4) Helen Brooks (5) Saskya Byerly (6) John Carr (7) Jim Christopherson (8) Theresa Day (9) Kristin Dury (10) Scott Faragher (11) Nathanial Flinchbaugh (12) Lucas Flowers	(13) Kay Garrett (14) Jeremy Gourley (15) Tyler Haines (16) Andrew Holt (17) Andrew Hopper (18) Matthew Jones (19) McKenzie Karp (20) Natasha Kurth (21) Kyle Lange (22) Kim Lee (23) Terrence Love (24) Willie Melvin	(25) Andrea Palmer (26) Emily Parker (27) Bryan Metzger (28) Renee Mills (29) Brent Nix (30) Anita Perry (31) Rob Seesholtz (32) Melissa Smith (33) Stephanie Spain (34) Caroline Tippens (35) Lindsey Wilson (36) James Zebley
NEXT MEETING DATES:	**2025** Friday May 30th – Nashville Friday August 8th – Paris Landing State Park Friday November 14th – Nashville		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
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 2-25-25 TCAC minutes.	Motion to approve with spelling corrections, Dennis, second Hunt.	
II. Old Business Trauma Fund Report	R. Seesholtz	2nd quarter disbursement calculations are complete with a disbursement total of $988,593.14. Letters and checks were sent on March 7th. 3rd quarter funding calculations are underway with the additional readiness costs as approved by the council for LeBonheur and Monroe Carell.		
	R. Seesholtz	I was asked to present a more detailed funding formula calculation to ensure that this is capture in minutes I would respectfully request the council to approve the Fischer funding formula as part of the trauma fund report.		
	B. Burns	My only comment is on item three, it has the current number of X's, if we want this document to live on, I recommend removing the 23.25 x's as this could change at any time with the addition or subtraction of centers.	Motion to approve Dennis, second Bollig.	
	R. Seesholtz	Voting on the Fischer funding formula as presented to the council.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton - aye	Unanimous aye votes – motion passes.

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			William Nolan – aye Paula Bergon – aye	
III. Subcommittee/Ad Hoc Committee Reports				
a. Registry	B. Dennis/R. Seesholtz	Two registry related items for the council today: 1. New rules require centers (I-III) to participate in a risk-adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registry data quality. Four centers currently do not participate in TQIP which provides that benchmarking platform. So, to those centers, just be aware of this requirement. 2. Sports related cause of injury was added to the trauma registry. However, that field was not activated when the schema was built. This was discovered after receiving communication from a center indicating this field was producing a null value.		
	R. Seesholtz	I spoke to ImageTrend who provided me 4 options for resolution, two of those options are more time intensive for centers and the other two less. I would recommend option #4 to keep the file structure as is as the sport field is already active and when 2026 is here, we don't have to worry about that field.		
	B. Dennis	I would agree with Rob and my recommendation would be the fourth option and we keep it as is for this year and include it in 2026.	Motion to approve, Burns, second Kerwin.	
	R. Seesholtz	Voting to keep the file structure as is and include the sport field in 2026.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye	Unanimous aye votes – motion passes.

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			Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton - aye William Nolan – aye Paula Bergon – aye	
	N. Jensen	Question, this requirement does not apply to level IV's, correct?		
	R. Seesholtz	Correct, this requirement does not apply to level IV's.		
	R. Williams	Question of council, do we need to a roll call vote every time?		
	N. Flinchbaugh	Yes.		
b. IP / Surveillance	T. Love	Terry provided updates to the CDC Core SIPP grant and presented the recently completed, 2025 annual report on suicide prevention in Tennessee.		
c. System Development/ Outreach	R. Williams	• Trauma symposium on Thursday August 7th at Paris Landing State Park. • TCAC meeting on Friday August 8th. • Please tell folks about the symposium.		
d. PI/Outcomes	R. Bollig	Presented on the spring 2025 TTACO collaborative report looking at: • Risk adjusted mortality • Hip Fractures • Risk adjusted hospital events • Odds ratios	Seeing improvements in changes made to address hospital events	

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		Seeing improvement in TTACO outcomes as a result of changes made as a collaborative. Data continues to improve.		
	R. Bollig	One more item. The collaborative has been meeting before this meeting which has caused some logistical problems with travel etc. I would like to ask council; we are not bound by sunshine statute for TTACO meetings, is that correct? TTACO is through the TN Chapter of the ACS-COT.		
	N. Flinchbaugh	That is correct since you are only giving updates to this council.		
	R. Bollig	Looking at geriatrics, TQIP and the collaboratives have parsed that out a little bit more for isolated hip fractures. Looking through this data I think we can find some trends and then take that back to our own institutions to see if we can make some changes.		
e. CECA	N. Kurth	We have three subcommittees in CoPEC: 1. Outreach and Injury Prevention: is working on monthly outreach categories to assist in injury prevention awareness in our communities. Also looking to assist schools with training in first aid seizure medication administration to comply with new law. 2. EMS: is working on a pediatric readiness recognition program. Approval received from the EMS Board and will be working on how to get that implemented. 3. Facilities standards: Update to rules yesterday, they have updated the process at the AG's office and rules are moving through that updated process. The HFC is working to help push those through. Interpretative guideline work continues. Projects update: • Star of life nominations are open. 2025 nominees only for next years awards ceremony. • Planning for pediatric conference next June and if you have a great talk in pediatrics that you are interested in sharing,		

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		we have those speaker applications on the website. • We received a grant for pediatric transport devices so we can order another 182 devices. • My Hero Cares program, connecting families who have children with complex medical needs with EMS teams. We have a grant for the Middle Tennessee region and are working as a pilot program getting agencies enrolled. At the meeting yesterday, we have a new CoPEC representative to recommend to the council. Renee Mills who is the Trauma Program Manager for Children's at Erlanger. My understanding is that there is an approval process for that?		
	R. Williams	Correct, Logan Grant has to approve all members of the council and since we just elected Renee yesterday, hopefully she will be approved soon. She will be a great addition to the council.		
	R. Seesholtz	Tasha, could you address the Broselow issue?		
	N. Kurth	Yes, for those who have not heard, the 2025 edition has three errors on it. The recommendation is if you haven't purchased them to please hold off and if you have already purchased them, you should have heard about the recall from the manufacturer. So please ensure that your colleagues are aware so that will use the 2019 version at this point.		
	R. Williams	The pediatric rules state that the Broselow must be part of the facility reviews, so we are going to send a letter to the state so that you know that the 2019 version are the most update ones. We don't want people to get dinged during a survey for having expired Broselow tapes when the new ones are not accurate. We are happy as pediatric champions to report on the next best available options for use.		
f. Legislative	R. Seesholtz	The only update for the council is that the legislative session is over, the vape bill has passed but I don't think trauma will be		

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		receiving any of those monies. It's not to early for the council COT to begin planning for next year's legislative session.		
	R. Williams	The COT will be working on that item separately to advocate for increased trauma funding.		
g. Finance	J. Carr	John Carr, Director of Administration for HFC. I wanted to bring the council up to date on where we are financially. Our budget for the trauma fund is currently $13.5M. That consists of two different funding sources, cigarette tax revenue estimate and the general fund reoccurring dollars. Of the 8.5M cigarette tax revenue estimate, we are nowhere close to reaching that estimate. That has been a static estimate for years dating back to 2014. I wanted to show revenues going back that far so you can see that we have not been anywhere close to reaching that estimate. I wanted to run it by the council and see if there was any appetite to consider changing the revenue estimate we currently have. There would be no change in how money is processed, we do not process any payments until we have money in hand from the department of revenue. So, there is no money that will be lost if we were to revise this estimate, it would be more in line with what we are seeing. Any questions?		
	B. Dennis	*Inaudible		
	J. Carr	Any number that we put in we would track on a regular basis and after a few years we might want to come back and revisit those numbers.		
	D. Bhattacharya	I see your point though; we could average it over the last three years. Then no one has to do this again.		
	J. Carr	We can do that.		
	B. Burns	What was the average for the last three years? Probable around 6		

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		to 6.5M?		
	D. Bhattacharya	I would like to make the motion that the cigarette tax estimate be the average over the last three years.	Motion to approve, Bhattacharya, second Dennis.	
	A. Kerwin	Just so we are clear on the wording, every year we take the last three years.		
	J. Carr	Yes		
	R. Seesholtz	Voting to approve the cigarette tax budget estimate as an average over the last three years.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton - aye William Nolan – aye Paula Bergon – aye	Unanimous aye votes – motion passes.
IV. New Business				
a. Data release, aggregate, individual, IRB.	R. Williams	Now we are going to move on to the bulk of our meeting as we have a lot of important things to talk about. The first is going to be the forms for data release from the state registry. This is a huge deal as we've been wanting to access our trauma registry data to learn from others across the state. Kudos to Rob for getting this together and for all the people who supported that effort.		

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	R Seesholtz	We are starting with the aggregate data request form. A lot of the information contained was taken in part from a previously developed draft data release document that was not implemented. It's been reviewed by our legal counsel at the Commission and ff approved here, these documents will then by taken up by the Commission for review and hopeful approval. This document contains the 12 reports that are easily generated by the trauma office as we generate these reports annually for the legislative report. While not very time intensive, data requests will be based on staff schedule to abstract requested data. In addition, aggregate data release guidelines and reference guidelines contained are pretty straight forward. Are there any questions about the aggregated data request form?		
	A. Greeno	Can you remind me how much it costs to get this report?		
	R. Seesholtz	If it is one of those 12 aggregate reports, it will not cost anything. A report that requires ImageTrend technical assistance, ImageTrend charges $175.00 per hour.		
	N. Flinchbaugh	So, one caveat to that Rob. There are charges for the time spent fulfilling a public records request. They do waive 10 minutes of time for every public records requests. If you are requesting one report, we send the request to him, it's pretty quick, probably would not be a charge. If you do all 12 reports, it may take longer you could run into some charges, but it would be minimal. When you begin to look at IRB requests, it likely that those charges will go up.		
	R. Williams	Do you want to approve these individually or as a group?		
	R. Seesholtz	What's the will of the council?		
	R. Williams	We will try to move forward and approve all at the end but if we		

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		need to adjust we will.		
	A. Cooper	How long back can we ask for data?		
	R. Seesholtz	The cleanest data contained in the registry is from 2019 forward. We do have access to all previously submitted data, but data accuracy is a concern.		
	J. Levine	What steps does the state take at a 40,000-foot level to ensure non disparate data?		
	R. Seesholtz	All files submitted to the registry undergo validation checks that are completed against the national NTDS data set and out state extensions. Similar to the way TQIP and NTDS validate the records bring sent to them. Our average validation scores for submissions run around 94% to 97%.		
	R. Seesholtz	Next is the risk identification for aggregate data review. This document accompanies the previously discussed aggregate data request form and is a scoring tool that will be utilized to ensure that no PHI is released. This form is also utilized by the Tennessee Department of Health IRB.		
	O. Bratton	If we request a report for ages 1-10 years of age, the cumulative score is 15, which is an unacceptable risk?		
	R. Seesholtz	If that is the way the score is tabulated, then yes.		
	D. Hunt	In that case, you would have to aggregate the data in a different way to decrease the score. Either add a different region together or increase the number of years of your data. But you have to make your “n” or sample size higher.		
	O. Bratton	I just wanted to make sure that as pediatric facilities we can break down specific age categories.		

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	R. Seesholtz	I understand, trauma data is some of the most easily identifiable data and it is my view that we will do all that is necessary to ensure that no publicly identifiable data is released.		
	R. Williams	We also have to be able to use the information to improve public health. If we make it so hard that we can't use the aggregate data, then we can't learn from it and can't improve what we are doing.		
	O. Bratton	Mechanism of injury is different in all of those age categories, so we do to some extent need to be able to parse it out. According to this, we are going to run into a lot of difficulty.		
	B. Dennis	You will find the IRB unwavering on the protection of study subjects and that's appropriate, this document as least gives you the opportunity to drop the score by increasing the reporting period.		
	R. Williams	I think this is something that we will need to work through and if we find some barriers that are really limiting our ability the new can talk through that.		
	B. Burns	If you are trying to do research and you're looking at anybody over the age of 90, that is considered PHI. So, does that need to be something that's factored in? When I do retrospective studies, I literally have to exclude anyone over 90 to get it expedited through our IRB.		
	B. Dennis	This was a vetted list by the IRB. I don't see this as a negotiation.		
	B. Burns	I just want to ensure that what is protected remains protected.		
	R. Seesholtz	Thank you. Two other items, this is the individual data release form and policy for data release from the trauma registry. This outlines the request process and policy for those researchers wishing access to patient identifiable data. I would be happy to answer any questions that the council may have.		

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	J. Levine	Institutional variability of HAIH and I want to understand who is doing it best. Even that kind of request will need to go through the IFB at the state level?		
	R. Seesholtz	Most likely, yes.		
	J. Levine	That's a big cost for trying to identify best practice and to improve overall care at the state. After reviewing these documents I'm left with wanting to know who is doing it best so that we can develop best practice.		
	R. Bollig	That's what the TTACO is for.		
	R. Seesholtz	But, to Dr. Levine's point, level III centers in the state do not have that benchmarked comparison that level I centers do.		
	J. Levine	This is just something to think about moving forward, for at least the level III centers in trying to improve patient care.		
	R. Seesholtz	So, are thee any additional questions or concerns over the last two data release documents?		
	A. Kerwin	I'm going back to Dr. Williams point, we spend a whole lot of time to get data to the state to improve care, but it cost me $170.00 an hour to get it out?		
	D. Bhattacharya	It kind of goes to my comment earlier. What is Knoxville doing better, I would love to know what they are doing that we are not.		
	R. Williams	The purview of the chair. This is an attempt to start this process. I think we need to approve it and request data from the state and walk through the process as the trauma providers of the state and figure out how we can use it, and if we can use it. If we need to make changes then we need to make changes. I think the intent is for us to use this data to improve trauma care.		

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		We haven't had this process in the past, and I agree that this is still cumbersome. But the state is protecting the people who live in Tennessee. Its not meant to be burdensome to us. If it's okay with everyone, we can work through the process and we can always make amendments and adjustments, but we have to start somewhere.		
	D. Bhattacharya	I understand if we are publishing as research, but how does this pertain to true quality improvement efforts at the system level?		
	R. Williams	Because there is no process for quality improvement at present.		
	D. Bhattacharya	Then why don't we call this a request for information instead of an IRB request?		
	R. Seesholtz	If anyone requests any identifiable data, I am bound by statute as I cannot not release that information. Requests will have to be vetted to make sure, the request is valid, the requestors are valid, and the study for which the data is requested meets the guidelines is this document which is to improved care in Tennessee.		
	B. Burns	I think the intent is that there has to be a gate keeper to protect this information, there may be that a pathway specific to quality improvement may open. I end with a motion to approve all documents presented.	Motion to approve, Burns, second Dennis.	
	R. Seesholtz	Voting to approve all data release documents before the council.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye	Unanimous aye votes – motion passes.

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			Amber Greeno – aye Oseana Bratton - aye William Nolan – aye Paula Bergon – aye	
	D. Bhattacharya	Is there any idea when an IRB request is made, to get an estimate on how long that request will take to be satisfied?		
	R. Seesholtz	No, since the IRB is through the department of health. I can reach out and see if I can get an estimated time frame.		
	R. Williams	These are all great questions. Please compile a list of those questions and send to Rob as we are unable to address some of these at present, and all of these questions are valuable, and we don't want them to get lost.		
	R. Seesholtz	Our next item is rule revision. I've done the best I can to organize our discussion of the document so that we can move through this process with minimal difficulty.		
	R. Seesholtz	First item, language added by legal to reflect the transfer of trauma rules from the Department of Health to the Commission. The rest of these items that are highlighted on pages one, two, and three are new definitions. I would like to thank Dr. Bollig for his work with these definitions. New definition of mid-levels (non-physician practioners) This was to align these rules with the Commissions definition of mid-level practioners. There is a considerable amount of level IV suggestions. Melissa, Britani and I went through the document and made our suggestions, especially since the addition of our high-volume level IV center. We felt that some of these items may need to be required for level IV's.		

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	B. Burns	The ACS has open for comment what their level IV rules are, is this our best guess for what they are gong to say or are we going to have to come back in six months and make changes, just asking the question.		
	R. Seesholtz	I've received correspondence from the ACS to weigh in about suggested level IV language. I submitted my comments for suggested changes to the ACS. Melissa, do you happen to know when the level IV requirements will be release by the ACS?		
	M. Smith	Fall of 2026.		
	R. Williams	Melissa, did you consider the colleges recommendations for the new level IV rules?		
	M. Smith	Yes.		
	R. Williams	Then this is our best guess on what the college will recommend.		
	R. Seesholtz	The next item for discussion is ICU equipment requirements for level IV's if they are admitting trauma patients to the ICU, except cardiac output monitoring. We've added this for discussion because of our newest level IV admits trauma patients to the ICU and there is no allowance for…		
	M. Smith	If you don't admit trauma patients to your ICU then you don't have to have this, if you do, then this is a requirement.		
	B. Dennis	End tidal CO2 is currently desired.		
	R. Seesholtz	Yes, this was desired, and we are recommending this to be essential for level IV's if admitting trauma patients. If there are any questions or concerns, I encourage everyone to		

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		weigh in, especially our level IV center in the state since this will be affecting them.		
	N. Jensen	No, this is appropriate.		
	B. Burns	Intracranial pressure monitoring device, it is desired for level III's but essential for level IV's?		
	R. Seesholtz	It should be desired for III's and IV's.		
	R. Seesholtz	The requirements for acute spinal cord/head injury management capabilities OR written transfer agreements should be essential for level IV centers. I believe that I've resolved the interventional radiology piece as the ACS does not require that capability except for bleeding control.		
	B. Burns	For interventional radiology, desired for level III centers, and nothing for level IV centers.		
	R. Seesholtz	For lab, level IV recommendations include essential for drug and alcohol screening, transfusion protocol developed collaboratively between trauma service and blood bank and must have adequate supply of blood products.		
	R. Bolig	If they have blood product, they should have a protocol. So, number 10 should be marked as essential.		
	A. Kerwin	There are things like type and cross, repeat blood draws, there is a patient safety component around transfusions, and it might be better defined for the intent, MTP vs transfusions.		
	R. Bolig	I would think whether or not its massive or just transfusion, if you're having blood, you need to have a protocol.		

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	R. Seesholtz	Regarding, the trauma medical director for level IV centers. Other than the CME piece and coordinating PI and peer review, there are no other requirements for who the level IV TMD can be. The council has previously deliberated to allow an EM physician to function as the TMD for level IV centers, but I want to ensure that this is want the council wants and is appropriate for the requirements for a level IV TMD.		
	M. Smith	In the gray book, the new level IV language, an APP can be the trauma medical director. I would say at least emergency medicine.		
	J. Levine	I would think, especially at level IV's where you may not have a surgeon as your medical director, it's probably more or as essential to have 12 hrs of CME a year because its something that they don't do that often.		
	B. Burns	Do we need to add something what the qualifications are beyond the CME? It doesn't have to be a surgeon, but nowhere in the guidelines does it say what it does have to be. Maybe their needs to be a line below board certification saying for level IV centers, must be whatever we feel that it should be, and then it would be essential under that category.		
	A Greeno	Or could say a special interest in trauma for level IV.		
	B. Burns	But who with a special interest? It could be an APP, does it have to be EM person, EM boarded? You have people in my region who are family medicine and IM boarded who work in emergency departments. I feel that it needs a definition as to who qualifies to be the medical director. If the gray book does not provide guidance, then we may have to seek interpretative guidance.		
	R. Seesholtz	It certainly is up to the council but as Melissa said, at some smaller centers APP's and PA's serve as their trauma medical		

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		director. Since this is our first foray into level IV centers, I think it would be appropriate to the have the trauma medical director be boarded in emergency medicine if the council feels a physician is appropriate.		
	M. Smith	This is what the college says, "in level IV's there must be a trauma medical director who is a physician or who is an advanced practice provider and has at a minimum the following responsibilities and authorities". It goes on to read basically that they oversee the PI program, they they must be active in the provision of trauma care, current in ATLS, and have 24 hours of CME every three years.		
	B. Burns	So, we leave the CME off since its already in there and put other verbiage under board certified in general surgery and make it an E for IV. I will make that a motion.		
	R. Seesholtz	Below number one, correct?		
	B. Burns	Below number one, now to become number two, the language that Melissa just read from the gray book with the exception of the CME's hours, which are now covered under number three. And that would be an E for level IV centers only.		
	R. Williams	I have a clarification, you would agree that it could be an APP as trauma medical director?		
	B. Burns	If that's what the gray book says.		
	R. Seesholtz	The council has the authority to recommend what its feels is appropriate.		
	B. Burns	Yes, but in answering the question, I don't know what the right answer is, so if that's the only guidance that we have out there then I'm ok with as its worded.		

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	A. Kerwin	Why would we make it more stringent than the ACS?		
	M. Smith	**Inaudible.**		
	A. Kerwin	I was going to say physician, board certified in general surgery, and make it a desired for a level IVs, not essential. Then, the physician could be EM, anesthesia, or whomever they pick. But it would be clear that we want a physician.		
	B. Burns	I withdraw my motion. I'll go with Dr. Kerwin's motion.		
	R. Williams	It is the purview of the council of what we think is necessary for a level IV, we have been trying to align with the gray book, but those are not approved yet. We also do not have independent practice for APPs in the state of Tennessee and this may be different in other states and why it is worded as such.		
	R. Seesholtz	So would it be appropriate in level IV trauma centers, there must be a trauma medical director who is a physician.		
	A. Kerwin	I'll make that motion, a physician board certified in general surgery, essential for level's I, II, & III and desired for level IVs.		
	J. Levine	Having come from a state with a number of level IV centers, general surgeons at level IVs are not the norm, we have orthopedics, etc. D is ok but it may send a message that a lot of level IVs aren't able to **inaudible**.		
	A. Greeno	Another alternative is that you can make another row and then have that address what level IVs are.		
	R. Seesholtz	I'm certainly amenable to adding desired to level IVs but I would prefer the addition of another line indicating the requirements for a level IV trauma medical director as a physician.		
	R. Williams	Do we have a motion to add a line under board certified in		

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		general surgery that specific that the trauma medical director must be a physician for level IV centers.		
	A. Kerwin	Do I have to withdraw my motion?		
	R. Williams	Your motion was never seconded so it wasn't an actual motion.		
	B. Burns	I'll make that motion, and I think it should have minus the CME, the other verbiage that Melissa read and can read again into the record if necessary, but a second line that says it must be a physician, plus the other verbiage minus the CME hrs.		
	R. Williams	Is there a second on this motion to open it up for discussion.		
	R. Bollig	Second		
	R. Williams	Melissa, can you stand up and read the verbiage please?		
	M. Smith	In level IV centers, there must be a Trauma Medica Director who is a physician and has, at minimum, the following authority and responsibilities. It goes over more things, ensuring clinicians meet all requirements, adhere to institutional standards etc. The trauma medical director must fulfill the following requirements, be active in the provision of trauma care in the trauma center, be current in ATLS, and provide evidence of 24 hours of trauma related continuing education (CME/CE) per 3 years.		
	A. Greeno	Can we do another row and for level IVs say 24 instead of 36? I think CME is important for the trauma medica directors.		
	R. Williams	The current motion which we need to discuss and vote on, then your welcome to make your motion after that as it is a second motion.		

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		So, our current motion is to add under board certified in general surgery an additional row that says the trauma medical director must be a physician with the following things, authority, takes care of trauma patients etc. That's what's on the floor, does anyone have any more comments or questions?		
	R. Bollig	Just essential for level IV?		
	R. Williams	Yes.		
	A. Kerwin	Question, I think Melissa said ATLS certified?		
	M. Smith	Current in ATLS.		
	R. Seesholtz	I will add what's not contained in current rule for level IV trauma medical Director.		
	R. Williams	Can we all agree on this as we will be taking a motion for all of these changes at the end. All in favor? Any in opposition?	Ayes present. no nays heard.	
	A, Greeno	I would like to make a motion to add an additional row under three, which will be in the future number four, that says 24 hours CME, and this only applies to level IV centers.		
	R. Williams	Is there a second for her motion?		
	A. Cooper	Second.		
	R. Williams	Any discussion?		
	R. Bollig	Is this 24 hours ever three years?		
	A. Greeno	Yes.		
	R. Williams	Does everyone agree with that? All in favor?	Ayes present, no nays heard.	Numnber

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	R. Seesholtz	Still in the TMD requirements, number 15 was blank for level IV's, however the language says "in all trauma centers" and I wanted to be sure that level IV is needed to be added here or I can adjust the nomenclature to read "in level I, II, & III trauma centers".		
	A. Greeno	I think it need to have level IV added, when you are resuscitating a patient, you need to have defined roles and responsibilities.		
	B. Dennis	I just think the point thought made about surgeons means we can't do that.		
	B. Burns	If they don't have surgeons, how do they coordinate that?		
	R. Williams	It just says that it needs to be approved and defined by the trauma medical director, so I think it can be different for each center.		
	A. Greeno	You can say and/or.		
	R. Seesholtz	So, what's the main concern with this?		
	B. Dennis	Fours always won't have surgeons.		
	R. Bollig	Can we add a superscript, and says if trauma surgeons are present…		
	B. Dennis	The point is, if they don't have a surgeon, they don't have shared roles. Then the roles and responsibility of resuscitation *is* the emergency medicine physician, by default. You need to define and approve that as a trauma medical director if you have no surgeon		
	N. Jensen.	I see the points but don't know the correct way to formalize that, other than an asterisk if surgeons are available then to define those roles. I'm not sure the best way to capture that.		

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	A. Kerwin	Could you make a sub row, just for level IV's, where it says responsibilities of trauma surgeons and emergency medicine physicians replace it with "all physicians responding to trauma". Because you could have emergency department staffed by family medicine or internist. No one board certified or trained in emergency medicine.		
	B. Burns	Are we getting off the task on what the intent was when we borrowed this from the ACS, so that the ED docs and the trauma surgeons aren't butting heads as to who's in charge or who's doing what.		
	R. Williams	May I suggest that we leave this field blank?		
	A. Greeno	You could also just take out shared roles and responsibilities for trauma resuscitation must be defined and approved by the trauma medical director, so if you remove the surgeon and the EM, your just saying that whomever is in the room..		
	R. Bollig	Just put desired for level IV's.		
	R. Seesholtz	Put desired for level IV's?		
	A. Greeno	Yes.		
	R. Williams	Everyone good with that?		
	R. Seesholtz	Attending general surgeons on the trauma service.		
	B. Burns	There not required to have surgeons but if they do, should they be board certified or board eligible, I say the answer is yes, then you stay with the E. If they don't have surgeons, then they don't have to be board certified or board eligible. If they do have them, then they need to be.		
	R. Seesholtz	The next line, trauma specific CME and is meant to mark a new		

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		superscript indicating that CME certificate or maintenance or certification are measures of this item. This was meant more for an fyi than for a decision.		
	R. Williams	Is that the part that went away with the college?		
	A. Greeno	No, because right now you have to be board eligible and as long as they have their certification, as long as they are current. They don't do anything. That's per the gray book, there's no CME requirements for all the other surgeons, they just have to be current in their board status.		
	R. Williams	What does the council think about CME requirements? For your trauma surgeons?		
	A. Kerwin	So, we said for the TMD we need 36 hrs. every three years, for the general surgeons were saying 48. Why are we making it more stringent?		
	A. Greeno	It went away. It used to higher for the trauma medical director when that rule was in effect.		
	R. Williams	I see your point, and we can address that, if we want to consider changing number three to be inline with the gray book which is that the general surgeons on the trauma service have to be board certified or board eligible and current in their board eligibility and then they do not have to have CME's.		
	D. Bhattacharya	I agree with that.		
	R. Williams	Can someone make that into a motion?		
	B. Dennis	So, we are motioning to eliminate number three?		
	R. Williams	Yes		

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	D. Bhattacharya	I motion that we eliminate number three.		
	B. Burns	But do you have to change one to be in the maintenance of certification pathway? Because if not, you could be board certified once and never..		
	R. Williams	We could add current to number one?		
	D. Bhattacharya	I would like to make two motions, the first is for number one, "must be currently board certified or board eligible in general surgery", then the second motion would be to remove number three.		
	B. Burns	Second.		
	R. Williams	Any discussion?		
	R. Seesholtz	So, number three is eliminated?		
	R. Williams	Correct. And we are adding current to number one.		
	R. Seesholtz	Next is trauma program manager. We added a few things for level IV's, requirements for experience in critical care nursing, and job description including the reporting structure that includes the TMD and shall attend a national meeting within the three-year designation cycle. Are there any questions?		
	M. Smith	The national one for a level IV, it should be regional. It's just one regional meeting.		
	R. Williams	Current membership in a regional organization or attending a regional meeting?		
	R. Seesholtz	How many regional meetings do TPMs attend?		

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	A. Greeno	That's not in the gray book.		
	R. Seesholtz	Ok, that's desired for number seven for level IVs.		
	R. Williams	Correct.		
	R. Seesholtz	On to trauma registrars, at least one registrar must be a current CAISS specialist, staff members that have a registry role must fulfill the following requirements as listed below, and 24 hours of CE for the designation cycle. Are there any questions or concerns?		
	R. Seesholtz	Written PIPS plan. This is fairly extensive and contains a lot of information. It was listed as desired, but after discussion it was felt that this needed to be a requirement for level IVs.		
	A. Greeno	Yes, if you are receiving trauma patients, they need to evaluate their care.		
	R. Seesholtz	Must have a trauma performance improvement committee, evidence of loop closure, multidisciplinary conference presided over by the trauma medical director for level IVs. Are there any questions related to these items under PI?		
	R. Seesholtz	A process for referral to a mental health provider. Should this be desired or essential for level IVs?		
	A. Greeno	Yes, they should.		
	R. Williams	Is it expected for Is and IIs?		
	R. Seesholtz	Yes.		
	A. Greeno	I would put an E for 14.		
	J. Levine	In theory it should be E, but the reality is that might not be		

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		practical in some really rural areas of the state.		
	R. Seesholtz	The mental health provider referral?		
	J. Levine	Yes, it just might not be practical.		
	N. Jensen	The weird reality that the only level IV in the state is not a typical level IV and has a lot of resources available. I can see where a lot of rural facilities may not have the ability to provide a mental health referral, and this could be challenging.		
	R. Williams	We do want to encourage level IVs and not discourage them.		
	B. Burns	Essential only says that you have to have the process, it doesn't say it has to work.		
	R. Seesholtz	We are leaving it as D or desired?		
	R. Williams	Yes		
	R. Seesholtz	The next item comes back from our previous discussion on risk adjusted bench marking. I wanted to show the council where this requirement is located in rule and it is required for levels I, II, and IIIs.		
	R. Seesholtz	The next item, the trauma center shall be involved in community awareness of trauma and the trauma system we made essential for level IVs.		
	R. Seesholtz	We made essential, the participation in statewide trauma center collaborative injury prevention efforts. Terry Love convenes a quarterly meeting and highlights injury prevention efforts and of course, the important outreach that all of your centers are doing.		
	R. Seesholtz	On to the superscripts, this is the level IV ICU equipment requirement. There is a subscript related MOC or maintenance of		

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		certification.		
	R. Seesholtz	The final item with rules dovetails with the discussion on the site review team document.		
	B. Burns	Rather than a motion, can I open a discussion on this?		
	R. Williams	Yes		
	B. Burns	I emailed Rob yesterday and he felt that we needed to discuss it and to get that ball rolling, as a state and as someone who is a site visitor, we always want programs to succeed and give them the benefit of the doubt, and whereas the ACS will give you a yes or a no, and then there's a little bit of gray, I think we're are a little more in favor of the gray in order to support the growth and development of the trauma system in the state. That's my opinion for background. The way the document that was sent out was written, if you have less than three type II deficiencies, you are provisional then we come back in a year either in person or through desk review. If you have greater than three. It says the exact same thing. It also says if you have a type I. I want to go through something out there, so I want to have a discussion. I would like to recommend a discussion on a point system, where a type I deficiency would be one point, and a type II deficiency would be three points. If you have three points or higher, then you would be provisional and have either the desk review or an in-person site visit. If you have less than three points or up to two type II deficiencies, you could be fully designated, but you would have to correct those actions within that one-year time period. I would like to add something, because again, its not the intent, but there also has to be a point at which the site visit team says that maybe, provisional designation is not right for this place,		

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		maybe its not safe, maybe its not appropriate. So my proposal would be language that says above five points, the site visit team may determine that provisional status is not appropriate. It would then go through the vetting process at the Commission meeting as we don't hold any final decisions, but beyond five points, we could make that recommendation, and so the problem has always been, its too gray, but at least this would put numbers associated with, so if you get seven type II deficiencies, they may say you know what, its okay, we'll come back in a year, if you have four type I deficiencies, then they may say, I'm not sure care is safe here, and we need to make the recommendation to no longer be a center. I welcome any comments or edits as the way this document was written needs some additional work. If I may Dr. Burns, what is on the screen now are the changes in rule that are also referenced in this site review policy. This language is to update the process. New language replacing the 60-day requirement for deficiency resolution to a 30-day corrective action plan and a focused review in one year. We've realized that to correct deficiencies within a 30- or 60-day timeframe is virtually impossible since most of the deficiencies identified surround performance improvement, loop closure. Changes to the length of time from 30 days to one year before having to appear before the Commission if deficiencies have not been corrected. So, all three of these items add new language, changes to time requirements. It dove tails into the policy indicting the way site review are conducted, presentation of findings etc. This is where Melissa, Britani and I attempted to assign a weighted value on deficiencies indicating either type I or type II if found at the institution, and finally, everything above the line is what was sent to council members. Below that line is additional language that		
	R. Seesholtz			

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		plugs rule directly into this document. To Dr. Burns point, there site review document does need additional work, but as it relates to disciplinary actions, it was really important for me that everyone is aware of the discussion and is in the same page.		
	R. Williams	What I hear you saying is the type I and type II deficiencies is in the policy for doing a site review and not part of the rules themselves.		
	R. Seesholtz	That's correct.		
	R. Williams	Do we want to put it into the rules, or do we want to keep this separate as I think want you want to address Bracken now is not part of the rule document.		
	B. Burns	Correct.		
	R. Williams	If we want to put it in., we should talk about it now. If not, we could complete the rules and then address this policy.		
	B. Burns	I'll go a step further recommend we complete the rules and approve them, and I'm happy to go offline and work one on one with Rob between now and the next meeting to put that together for everyone to look at, as far as the type Is and type IIs and what that would look like for a process. Then we can debate numbers, etc. That way the rules can move forward.		
	R. Seesholtz	I have no issue with this, the only concern is that the last half of the year its busy for reviews, and the potential for two new trauma centers to come online. The bottom line is that I would like to have the policy complete and approved by the council prior to the next site review sometime in August because if we wait for rule promulgation, that will take some time. I have no issues with forward with the rules.		
	R. Williams	So can we do that in August, and they will be okay with you.		

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		Once we suggest this then the Commission must approve it?		
	R. Seesholtz	Yes.		
	R. Williams	The Commission meets quarterly?		
	R. Seesholtz	Monthly		
	B. Burns	But to be the devils advocate, it wouldn't change anything from the way things are currently being done, and it would buy us sometime to put a system in place that is reproducible as we go forward. The way it was written, you could have 47 type II deficiencies and have the same outcome as if you had one. There's always subjectivity, just ask anyone whose conducted a review or has been reviewed. We are trying to limit that and so if you have a document, scorecard that says that if you get more than one type I your going to be at six points, then you are in jeopardy of not being able to continue as a trauma center, people know that going in and will be a better system.		
	R. Williams	I think we should finish the rules and if time allows, we will talk about the site review policy. So, what's everyone think about a, b, & c, on disciplinary action? Which changes the timeframe from 60 days to one year with plan submitted in 30 days and deficiencies need to be corrected within one year		
	R. Seesholtz	It does give the site review team the purview to make a decision on what type of site visit is required to address deficiencies, either desk review, or in person onsite.		
	R. Williams	Everyone good with that? Good. Let move on.		
	R. Seesholtz	Actually, that's it.		
	R. Williams	Can we get a motion to accept these rules in their entirety with		

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		the recommendations we've made through out.		
	B. Dennis	Motion to approve		
	B. Burns	Second.		
	R. Seesholtz	Voting on accepting rules in their entirety with the recommendations we've made throughout.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye Dr. Levine – aye Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Paula Bergon – aye	Unanimous aye votes – motion passes.
	R. Seesholtz	My thanks to the council as this was a lot of work.		
	R. Williams	Let's move on to the site review policy, I like Bracken's idea, its up to the council if we want to try to decide what to do today or if we would like word smith and think about that more and discuss again in August. We meet early in August, so I think that the Commission will meet after us.		
	B. Dennis	Motion to table.		
	R. Williams	I have a motion to table the site review policy until next meeting, do I hear a second?		
	A. Kerwin	Second.		
	R. Williams	All those in favor say aye.	Ayes heard, none dissented.	

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	R. Williams	I added something brief, as I want to be a site reviewer for the state but I'm a pediatric trauma surgeon and not an adult trauma surgeon, and we felt that the council should decide or not.		
	B. Dennis	I make a motion to approve you as a site reviewer.		
	A. Greeno	Second.		
	A. Kerwin	Question, so as a pediatric surgeon, you come to review an adult center, vice versa, I should be able to review a pediatric center?		
	R. Williams	Correct. But those are different rules.		
	B. Dennis	Yes, we've not done reviews on pediatric centers.		
	R. Williams	Once, rules are passed, the Commission will be able to review pediatric centers.		
	R. Bollig	Are we voted just for you or for any pediatric surgeons?		
	R. Williams	For any pediatric surgeon.		
	B. Burns	To be clear, it should be a trauma medical director at a CRPC or a level I center. Just to be consistent with the language.		
	R. Williams	Yes, Brad do you accept that friendly amendment?		
	B. Dennis	I do, yes		
	R. Seesholtz	Voting on allowing a pediatric trauma surgeon who is also a trauma medical director at a CRPC or a level I trauma center to function as a site reviewer for trauma center reviews.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Bolig – aye Dr. Burns – aye Dr. Levine – aye	Unanimous aye votes – motion passes.

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			Dr. Jensen – aye David Kerley – aye Anissa Cooper – aye Dr. Bhattacharya – aye Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Paula Bergon – aye	
	R. Williams	The next item on the agenda was about regional advisory committee buts we will talk about late later and table until next time.		
	R. Seesholtz	Just a reminder that the Commission is moving to downtown and the ability to use this room will be non-existent for calendar year 2026. Any suggestions for meeting locations are appreciated.		
V. Adjourn		Motion to adjourn and seconded. Meeting was adjourned		