TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: May 26, 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) THA Representative	
GUESTS	(1) Christopher Alvarado (2) Rachel Appelbaum (3) Paula Bergon (4) Kathy Berrie (5) Alli Brogan (6) Helen Brooks (7) Van Bryant (8) Cristen Chaconas (9) Jim Christoffersen (10) Abby Cook (11) Dani Crowe (12) Theresa Day (13) Jenny Delong (14) Emily Drury (15) Josh Dugal (16) Nathanial Flinchbaugh (17) DaWanda Forester	(18) Kay Garrett (19) Jessica Holliday (20) Bre Hutton (21) Robert Jean (22) David Kerley (23) Mckenzie Karp (24) Natasha Kurth (25) Terrence Love (26) Eric Mace (27) Bryan Metzger (28) Michael Mixon (29) Erica Neisser (30) Michael Oakley (31) Andrea Palmer (32) Emily Parker (33) Anita Perry (34) Jennifer Porter	(35) Brian Reed (36) Angie Scissom (37) Rob Seesholtz (38) Eddie Small (39) Melissa Smith (40) Amber Thompson (41) Caroline Tippens (42) Kennedy Toban (43) Brandon Todd (44) Kenny Trent (45) Debi Tuggle (46) Stefanija Weaver (47) Jessica Weber (48) Lindsay Wilson (49) Melinda Wilson (50) Ben Voytas

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
I. Statute Rules/Roll Call	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	TCAC business including any council action will be conducted by roll call vote prior to adjournment. We are doing the best we can to acknowledge any questions or hands raised from the audience. We had almost 75 participants at February's meeting, so it is a little bit of lift to both convene the meeting as well as trying to get questions answered in a timely manner.		
II. 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.	
III. Old business Trauma Fund Report	R. Seesholtz	1st and 2nd quarters disbursement amounts have been given to the institutions. We received the Q3 disbursement numbers a couple of days ago. Once I received that final Excel spreadsheet of the amounts per institution, subsequent letters and you'll be receiving that disbursement amount within the next few weeks. One additional item, the commission voted to allow all site reviews being conducted in 2026 to be reviewed under current rules that was brought forth to the council. The council voted to accept that and to move it to the Commission for full approval, of which they approved it and centers undergoing reviews in 2027 and beyond will be reviewed under the new rules.		
IV. Subcommittee/Ad				

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
Hoc Committee Reports				
a. Registry	B. Dennis	Rob and I talked and sounds like Regional One has moved to ImageTrend, and so there's some data dictionary clarifications that they have requested that we make to help making import of data smoother. Rob, you want to show what we're talking about?		
	R. Seesholtz	As Dr. Dennis elaborated on Regional One had purchased ImageTrend for their abstraction software for their registry data from Tennessee, Mississippi, and Arkansas. There was a concern from ImageTrend on the language “current NTDB criteria”. They asked us to review and change that because while we all want, the most current NTDB criteria, we are not completely following the NTDB data set because we are wanting folks that have exclusionary criteria such as superficial injuries to the head neck et cetera. We still want that information if they are activated by your institutions. The only language change is, I highlighted inclusion criteria for submissions are different from the NTDS, excluding the following isolated injuries unless they meet institutional criteria for trauma team activation, and again Tennessee state registry inclusion criteria, current NTDB criteria except for superficial injury codes that are required if meeting institutional trauma team activation criteria. And there you have it. I think this was more for clarity because of our previous language that said current NTDB criteria. And I'll open the floor to any questions or concerns that folks may have.		
	B. Dennis	So I think my big question for Rob when we talked about it was, you know, will that will this result in any significant change for, you know, the centers? He says no that this is really just clarifying what we're actually currently doing.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Seesholtz	I think it was a fairly straight forward ask given the language that we had previously. If the council votes to approve this additional language, then I will take this to our next health facility commission meeting where they will weigh in and hopefully approve that as well. And then we will forward that to ImageTrend so they can clearly make sure they've got what they need.		
	A. Kerwin	Is anybody else in the state using ImageTrend?		
	B. Dennis	The state is using ImageTrend. That's the only one.		
	A. Kerwin	No other centers? Nope. So, no one else can be as unhappy as we are.		
	B. Dennis	That's correct, oh, we're unhappy for different reasons with our registry.		
	M. Campbell	Turkey Creek is switching to ImageTrend.		
	A. Kerwin	Well, we're, we're going see if we can undo that. I don't know, but we've not been happy with it. So if anyone, if any other institutions are considering, give us a call before switching.		
	B. Dennis	Alright, so Rob, we need a motion to approve that change.		
	R. Seesholtz	Yes, please.		
	B. Dennis	I formally make the motion to approve the changes outlined in Rob's document.		
	B. Burns	Second		
	R. Seesholtz	Role call vote to accept those changes in the data dictionary.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye	Unanimous aye votes – motion passes.

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
			Dr. Maxwell – aye Dr. Burns – aye Dr. Hunt – aye Dr. Campbell – aye Dr. Jensen – aye S. Hamby – 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	
	R. Williams	Excellent that passed. Did you want to give an update on data request?		
	R. Seesholtz	I know there were some concerns with data being requested from the state registry and the time that it takes to fulfill those requests, as you all know or you may not know the health facilities commission receives a crazy amount of data requests for information from the commission. Trauma being a small part of that as well. So when folks submit a data request, they're required to upload a copy of their driver's license to prove that they are a resident of the state of Tennessee and to go through a few more hurdles before that request is even put in the queue for folks to forward on. There has been some time delay. You can't request data one day expecting it the next day or maybe, maybe even the next week or weeks as it takes a significant amount of time. So that being said, Dr. Dennis, I'll turn the floor over to you sir.		
	B. Dennis	So, you know, I requested it with the intention of using it to help advocate, you know, for trauma registry funds, last month, two months ago, either way. My, real issue isn't, like I respect the		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		safety and, you know, that this feeds into the states, you know, whatever, like we fall into the same data request, you know, processes every organization within the state. My problem is that we're contributing this data and we still can't get it. We can't get access to it without showing a driver's license, I think that's idiotic. It doesn't make any sense at all. And so I think there has to be a way for participating centers to rapidly access that information. If I can do that quickly with my own data, I should be able to do that with the data that I'm giving to the state too. And, and again, it's all protected, right? Like we're not identifying centers. We're looking just for, you know, whole population data. Like we should be able to get that quickly.		
	R. Williams	I will reiterate what Brad just said in that I requested data maybe a month or so ago for a presentation at the annual COPEC meeting, and I do think there should be a different process for members of the council to request data rather than just what a regular citizen that the Tennessee would do. So I thought it was a little silly that I needed to upload my driver's license to prove that I was a resident of the state Tennessee when I chaired the council that oversees all of the data collections. And I agree with Brad in that it's aggregate data, so it's not identified but I think there should be a different process for members of the council to access the data. Nathaniel, do you have a thought?		
	N. Flinchbaugh	So public records are controlled by the controller's offices, its in statute so in order to get access to any data in the state of Tennessee you have to show a driver's license or proof of the business that's operating here in Tennessee. There is no exception for that. So.once you create an account through our Granicus system and you upload that ID, we can mark your profile as verified and you go into that same profile and you should not have to upload the copy of your driver's license again once that or your business approved for your business that's registered in Tennessee. Once that's there and you're, you're verified,		

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		you can submit as many requests as you want. They are processed in the order they are received. So even though you're not asking for a lot of data, we do have significant amounts of data that are being asked for, and so there is no special treatment given to any, we don't even do that for, you know, members of the legislature. We process in the order that they come in so that no one is getting special treatment. We do have a full-time person. Miss Tippens and Miss Reed have given us additional staff to help process some of these because we were about ten months behind. Right now we're almost caught up to the current requests, so there's usually like two, two and a half month lag between what we're getting and what's being processed right now. As of last month I trained every attorney that is working for the commission, whether they were contracts, our rules attorney, both of my litigators, our general council and myself, and we are all processing those requests. So we're hoping that it is going to be quicker going forward but there is still a lag for that information to be processed. And I see some hands, so Dr. Kerwin?		
	A. Kerwin	So the Tennessee driver's license, so given the geography of Memphis it would not be out of the realm of possibilities that Dr. Williams or I would live in Arkansas or Mississippi. If we had as Arkansas or Mississippi driver's license, we'd not be able to access the data?		
	N. Flinchbaugh	That's correct.		
	R. Williams	What changed Nathaniel? This was not the process. The last five times I requested the exact same data.		
	N. Flinchbaugh	So the there's a Granicus system now which is what the health facilities commission put in place and so this is the process that uses the new system. And it's, it just digitized the steps, the steps		

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		are exactly the same. So that hasn't changed.		
	R. Williams	So was the trauma registry not under this until we came under the health facilities commission?		
	N. Flinchbaugh	Trauma has always been under the same rules and regs as the comptroller because they are an entity of the state.		
	R. Seesholtz	Dr. Williams that might have been my fault for not following the state comptroller's process for the release of some of the reports that were asked when we were with Health.		
	R. Williams	I think that this is being interpreted incorrectly and I'm going to kind of push back on that. But Brad, I'd like to hear what you have to say.		
	B. Dennis	Well I I guess I'm sort of going down the same lines is that like at this point the data is only used for the, you know, the report, the annual report. So Rob, are you pulling that data two and a half months before the end of the month or before the end of the year when you write the report? I mean, are you taking that lag time?		
	R. Seesholtz	June of this year at the end of June, all of 2025 data, minus probably one institution who is still dealing with some registry issues will be ready. It is our hope, with, and of course Abby's going to discuss a little bit of this later on that with our new dashboard, not only the public facing, but the private facing of which each designated trauma center will have access to will limit those asks potentially. You'll have that data available at your fingertips and you won't have to make those requests. But again, we're here to help satisfy what the council voted upon for, data request and trying to do things per statute and guidelines not to get any of us in trouble.		
	R. Williams	So if we voted on this process, can we vote to change it?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	N. Flinchbaugh	So the comptroller actually has a person on the commission. So I actually asked when we took over for Open Records Council come in and do training for all of us, which was done. So that could be part of why some of that process you saw change, but the actual Open Records Council came and did training for all the legal staff here.		
	C. Tippens	This is Caroline, Director of Licensure and Regulation and I would just say that this applies for all different provider types. Nathaniel didn't allude to the huge volume of work he and his team have done, but the reason that I made the decision to move some of our ASA's over to assisting with public records is we get a tremendous amount. So this commission in addition to having the trauma care registry, obviously we're the state survey agency for Tennessee, so we handle all FOI requests, all.state licensure requests, all look requests for litigation. We get subpoenas, we have to comply with law enforcement. We have to comply with Medicaid fraud units, the attorney general's office for public records requests. So the decision was made by leadership in this agency to move to one streamlined system, which is Granicus and treat all persons consistently. We are following the letter of the law for the comptroller's process, which I do believe that Nathaniel has put the requirements from the comptroller's office in the chat. So happy to answer any questions.		
	R. Williams	I think we appreciate all like all the steps that it takes and obviously y'all support us really well and are doing a lot of work. We just want to make it simpler, so this feels like really layered and a lot of bureaucracy, and I, again, I just wonder we don't have to deal with it right now but if there's some way to make the process simpler where only members of the council could directly request to Rob and Abby or whoever the trauma people are for that data so that it doesn't have to go through all that process because we aren't just lay people.		
	N.	So unfortunately with the way the las is in Tennessee we have to		

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	Flinchbaugh	log every request. So whether that comes in via, you know, an oral request, a written request via email or through our electronic system, it has to be logged. They don't care about the response, but they care about the initial request. So we're required to maintain that initial request for five years, so I can't have multiple, well what was happening under health multiple people were getting requests and then it wasn't being logged. So, I mean we didn't officially have a finding, thankfully from the comptroller's office because again all of that was happening under health. But in order to prevent that in the future, we make sure that everything goes through Granicus. Again, once you have that account and your ID has been verified, you'll be able to quickly go in and put those requests in, and then my public records people will quickly reassign that to Rob. They can get that back. And again, we have six or seven attorneys now all helping me, I was doing every check myself, so they're all helping get everything caught up and, and should decrease the amount of time it takes to get those answers.		
	R. Williams	It was not a terribly long process when I requested. I just didn't understand that all of those things were gonna be necessary. I think that I agree with you Rob, that our dashboards are going to help with a lot of information and I might suggest that the annual report include a lot more overview information of trauma in the state so that if people need representative data, it's already just there because it's part of our annual report and we're not having to pull it separate. Is there anybody, anyone else have any other discussion on this?		
	N. Flinchbaugh	And Dr. Williams, just to add something, so and Rob may know this or may not, this maybe something new for him. So there is a spot on our public records website, so if he does want us to publish that for you all, we can put it on the Granicus website, so you all will know to go in there and you can grab it from there without actually having to ask for it. So if it's a publicly available document I can create, a public forum basically is what it is,		

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		where you can go in and pull the same data so you don't have to request it from anyone. But it would have to be again a publicly available data bank.		
	R. Williams	Alright, good discussion. More to come. I'm going to read that attachment that Nathaniel sent and try to find a loophole, of course. But I like the idea of just maybe adding stuff to the annual report and then having that, that public facing document, Ethaniel I think that would be really great for anyone in the state that's wanting to talk about trauma care and what it looks like and what the numbers are and you know just representative data. So I think that would be an easy thing.		
	R. Maxwell	So, quick question. How long should we anticipate a data pull taking if we think we need the state data for some official purpose?		
	N. Flinchbaugh	So, I mean obviously you wouldn't want to try to get that in as soon as you know that you need it, but I can't guarantee any particular time we try to get them out as quick as possible. One of the reasons why we use Granicus now is to track how much time it takes from start to finish, and we use that as evidence-based budgeting when we go to request new positions, we were denied this year, of course. And again, Caroline and Ann kind of gave us some help with that. But the goal is to eventually be seven days. I don't know that that will ever happen with just the amount of requests that we've had and that we continue to receive and just the volume of each request. But we are trying different things to try to make it as quick as possible.		
	R. Maxwell	And is that just from the trauma database or are you fielding requests for all different sorts of data?		
	N. Flinchbaugh	Everything that comes through the commission.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Maxwell	And so expect at least a month right now.		
	N. Flinchbaugh	So if we can get, because there's a form that you all have to fill out when you request trauma data. So if you get that back very quickly, we can get that to Rob, it shouldn't take that long. If there's something that you all need, I mean we can try to get it out quicker, but we do process again in the order that we receive it in just so that, you know, we're not letting one sit for longer than it needs to.		
	R. Maxwell	Yeah, so say we had something the state trauma funding that came up all of a sudden that we needed some data for. We could submit a request and then maybe somebody contact one of you guys and maybe get it expedited. Just want to know what reality is going to be if we ever want some data.		
	N. Flinchbaugh	No, I understand. I mean, again, we try to process everything so the system creates its own flow and we let the system tell us what needs to be done next and we go from oldest to newest. And again, we kind of round robin with the work to all of the attorneys now, so that should help alleviate some of that bottleneck that was happening too.		
	R. Seesholtz	Dr. Maxwell, I would say that also it's dependent on the workload within the trauma office, we can get on those data requests fairly quickly. It also depends on the amount of data that is requested. I mean, if there is an incredible amount of data that's been being requested, that's going to take certainly much more time. We provide that data in aggregate format, so if you're wanting it to, to be utilized for PowerPoint or some kind of graphical that you're using to present, we do not provide the data in that format. Just know that you'll need to take those numbers and put it whatever format you want to display it on so anyway, so there are certain things that can affect the time frame.		
	R. Maxwell	It goes to Granicus and then you have to process it. So your		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		processing time is part of how long it's going to take.		
	R. Seesholtz	Yes sir.		
	R. Williams	Alright, we're going to move on to injury prevention.		
	R. Maxwell	Yeah, sorry to belabor this, but do we need to make a motion to have a more detailed annual report so that gets done or do we, I guess we'd have to identify the details we want included, but, I think that's a great idea.		
	R. Williams	Yeah, I would I thought that maybe we could all marinate on all this information that's been presented to us and then we could ask Rob to send out what variables are in the annual report and then maybe we could send to Rob what else we would want and we could present it for, approval at the next meeting, if that's ok with people. I think it might be hard to do all that right now on this call.		
b. Injury Prevention	T. Love	I'm going to let you introduce since I'm moving and I'll let you introduce those folks and just to let folks know that we brought this presentation to you as a result of the questions from the last meeting about fall prevention and some resources from fall prevention. We were fortunate enough to find folks in our own state who are doing some innovative work and I'm anxious to have them share that with you.		
	R. Seesholtz	Fantastic, thank you Terry. Amber I have you unmuted making you a presenter. I'd like to introduce Amber Thompson, who is with UT Medical Center in here to give an overview of the good work that they are doing regarding fall prevention. Melinda Wilson is her partner in crime, but I believe she is also traveling today. But, I believe Amber's here to to give the presentation. Miss Thompson.		
	A. Thompson	So UT medical steps, is a fall prevention initiative that we're		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		doing here at UT Medical Center and steps is meaning stay active, take control and power movement, prevent falls, and sustain independence. And I believe Melinda is on the call as well. She is doing some traveling today, but I think she got, to the hotel in time to join us. And so the University of Tennessee Medical Center is an American College of Surgeons level one verified trauma center, and with that responsibility, of course, as you guys all know, we have the responsibility to only not only treat injuries, but to prevent them as well. So part of those standards requires us to focus on prevention efforts for our leading cause of mechanism and across our 21-county region for us that is historically falls in mvc's. And so when we looked at our data, the impact was pretty clear from 2023 through 2025. The medical center evaluated over 22,000 patients for fall related injuries, and that really just highlights how significant and ongoing issue this is within our community. To address this, we take a proactive approach, we focus on education, community outreach, and implementation of evidence based programs. And so as we looked at expanding our fall prevention efforts in 2026, it became clear that we needed a broader, more sustainable approach. Previously, a lot of our work around falls was centered around partnerships with a one specific agency, and while that was valuable, it really limited our reach. We also realized we weren't doing a great job at capturing our inpatient population through some of our earlier programs, and we know that our patients presenting with a fall are at a higher risk for a repeat fall. And then on top of that many of these initiatives depended heavily on support from other departments. And so as that support naturally shifted over time, the program started to lose momentum. So with this initiative, our goal has really been to build something more sustainable and something that doesn't rely on temporary resources or one specific. partnership but instead can continue to grow and serve our community long term and really leave a legacy program.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		And one opportunity that helped myself and Melinda move this forward was a grant through the administration for community living. We are currently in the process of applying for that grant when it comes open in the next few months through our nonprofit status. But I do want to emphasize that this work isn't dependent on grant funding and many of these efforts are already in place at the medical center, and we'll continue regardless of whether we receive the awarded money or not. What the grant really did for us was give us that structure and accountability that feet to the fire mentality while allowing us to extend what we're already doing to reach more people and just strengthen those efforts for a more coordinated sustainable approach. And so here is a pathway overview of our fall prevention initiative. It separates our patients into inpatients, outpatients, and then our community members as well. Once a patient is admitted to the hospital, they undergo a fall risk assessment. We currently use the John Hopkins fall risk assessment tool for all of our inpatients. This is a newer project that was implemented within the hospital, which has had great results, so we wanted to keep that in place. This tool uses a color coded system. For our patients that are not coded green on discharge, a role will fire in the system now for the nurse to add fall education to their discharge packet. And here is a snip of what that discharge education looks like. This starts with helping them understand why they're receiving this and some reasons that they maybe at risk for falls, as well as some QR codes are provided in the packet with local classes and then just more fall prevention resources as well. As far as our local classes go, we have chosen three evidence based programs to implement being cell, bingo size, and walk with ease. Our main goal with choosing these three was to really meet people where they are. We chose cell because it focuses on strength balance, and fall prevention in a structured progressive way. However, that program is a little bit of a commitment. They meet multiple times a week and for around twelve weeks. So we also		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		implemented bingo size became it brings a social and connective component into fall prevention as well as it is great for individuals with disabilities. It combines a lot exercise with health education and a fun, engaging format. And then we chose to walk with ease because it's highly adaptable and it's very easy to implement. It encourages regular movement, improves endurance, and can be done in both group settings or independently. Another advantage to all of these programs is the flexibility. Some components can be completely done remotely, and so that allows us to reach individuals who may have transportation barriers, live in more rural areas or simply prefer not to participate in person. And so together these programs really complement each other. They allow us to reach different populations, address multiple risk factors, and offer different options so that people are more likely to stick with the program. We also included a home safety checklist as part of this initiative. It was designed to give everyone something tangible that they can take home and act on right away, even if they're not interested in enrolling into a full program, this would empower individuals to identify and fix simple hazards in their home, so that they can take more meaningful steps towards fall prevention on their own. And then for our outpatient prevention pathway, so at UT, we're in a unique position because of the large number of outpatient clinics that we're connected to across our 21-county region, and so that gave us really a huge opportunity there to make an impact. Right now many of our clinics are already doing some level of a fall risk assessment on intake, but those tools and processes aren't standardized, and so of course that can lead to some inconsistencies in how patients are screened. So our main goal for our outpatient clinic was to start implementing steady screenings across all of our outpatient settings. And we're going to start with our primary care offices. And so a steady screening provides a standardized evidence based approach to identifying patients that		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		are at risk for falls with just three simple questions. Do you feel unsteady when you're standing or walking? Are you worried about falling and have you fallen in the last three or I'm sorry, in the last year? A yes to any of these would be considered positive and that outpatient personnel doing that screen would then provide them with a flyer with information about the program, and that flyer also has those QR codes and that home safety checklist as well. And then lastly, there is the community aspect of this initiative, so whether we're out participating in community education events or individuals are being identified through flyer distribution from our community partners, this pathway allows for self-identification, so someone may recognize their own risk through some steady based materials or education and then they could choose to take those next steps on their own. And so from there they can just directly access those evidence-based programs without needing to come into the health system first. This slide highlights the partners who have already provided letters of support and commitment for this initiative. We were very intentional about building this with both strong internal partnership and engaged community partners as well. So on the internal side you can see that we have support from key leadership across UT medical, including our primary care offices, our trauma medical director and executive leadership throughout the hospital as well. And then at the same time, we've partnered with a diverse network of community organizations that are already deeply imbedded in the populations that we're trying to reach. And so this collaboration allows us to extend our impact beyond the hospital and into those 21 counties that we serve. And some of our key partners with broad regional reach include the Tennessee Department of Health and the Tennessee Department of Disability on Aging both of which help us connect to vulnerable and un underserved populations across the state. And then we've also partnered with Ethra and the Knoxville East		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		Tennessee Healthcare coalition, their CMS 17 group. Both of those provide us access across 16 of our 21 counties and through this network we're able to engage a wide range of healthcare and community settings. The CMS 17 group includes in the 16 counties, any rehab centers, long term care facilities, assisted living facilities, surgery centers, home health organizations, outpatient rehab as well as dialysis clinics. And so our key objectives as we move this program forward, we're working to identify host sites and locations both within the healthcare system and within the community where these programs can be offered and easily accessible. We're focusing on engaging potential instructors. This includes both clinical staff and community partners, who can be trained to deliver these evidence-based programs and through the ACL grant, we would be able to pay for the upfront cost of becoming an instructor and renewing that anything that is required for a three year timeline as well. And then we're also prioritizing partnerships to help distribute information. We want to make sure that our patients and community members are aware of the resources that is available to them. And then of course lastly, we just want to ensure that we are sharing resources effectively across, all partners to have that more connected coordinated appropriate approach, and then I'll left this last few minutes here for any questions that you guys may have, and I will stop sharing my screen.		
	R. Seesholtz	Thank you so very much, Amber, very strong work coming out of UT given that falls is the number one cause of traumatic injury here in our state. It is certainly great to hear some good work going on here in the state. I do have a quick question Amber. How's the response been so far? Not only from in hospital but from your community partners as well?		
	A. Thompson	So we're very early on in this, so we don't have as much going on as right now as far as the classes. But as far as our internal and		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		external partners, it has been wonderful. Everyone has been very willing to help and excited about this coming down their way as well.		
	R. Seesholtz	Thanks so much. Anybody have any additional questions or thoughts?		
	R. Williams	Is this something that we can implement across the state?		
	M. Wilson	Yeah, so that was actually a big of what we wanted to do as we have been building this is we wanted to be able to be replicated. A lot of these classes and the partnerships that we have worked on getting and obtaining are easily accessible to anybody that has the organizational support to get them. And, and that Amber I'll echo what Amber said. We have been very lucky that as we have talked to our administrators, our executive leaders, everybody has been fully supportive and the limitation is current us and what our brain can comprehend doing because our organization is fully behind us.		
c. System Development	R. Williams	Awesome work. Alright, thank you for being here. We appreciate you. Alright, now we're going to move on to system development outreach.		
	R. Seesholtz	Well, the only item that I have, Dr. Williams is just to remind folks that our symposium save the date is July 30 of this year, at the Virgin Hotel in Nashville. I believe 30 July is a Thursday. We will then have our Trauma Care Advisory Council meeting that next day on Friday. I didn't know if there's any new information or concerns regarding presenters that you needed to let the council know, Dr. Williams.		
	R. Williams	I think that we are set, for our symposium with a good representation across the state and as part of our TCAC meeting the next day, we are going to have the Tennessee Department of Health come and talk about preparedness and the regional		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		medical communication centers that's set up across the state so we can better understand and integrate our trauma system into the emergency preparedness system in case there is a large scale combat operation as is feared. So I encourage everyone to come both on Thursday for the symposium and on Friday for our TCAC meeting. Any other questions? Comments?		
d. PI/Outcomes	R. Williams	Great. Next, we'll move on to PI and outcomes. Reagan, do you have an update on TTACO?		
	R. Seesholtz	Dr. Bollig did have, but he had to abscond due to another commitment, so I think what we are up for next is, a little bit of show and tell of the good work that's been ongoing regarding our state dashboard as well as our new website. We would hopefully like the council's approval to place a public facing portion of our dashboard onto the website, and of course Abby will show you where that will go. She will also tell you within that public facing dashboard, there is a secure link or secure button where each institution then can log on to the dashboard to see their individual data for their institution only and how they how they compare with other institutions of like designation. So, without further ado miss Cook, the show is yours ma'am.		
	A. Cook	Alright everybody. Good afternoon. It's good to virtually see all of you. For those of you who have visited the Tennessee trauma system website before, it does look a little bit different now. We wanted to give it kind of a fresher look and make things a little bit more easily accessible. So right from the start, you get a little snippet about the Tennessee trauma system and some fun icons to click on as opposed to just kind of some of those linear links that used to exist here. And you do have the menu over here to the left that you can go through. So we do have our trauma center locations, which is maps that show where our trauma facilities are located. Of course, our rules, some resources. This trauma registry is where ultimately as I do a bit more of show and tell here, as Rob said. This is where we would like to embed our		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		public-facing trauma registry dashboard, and that is all information that would be gleaned from our existing trauma reports. So there's also a section here that shows our trauma report. You can click on them very easily. So here's an example of some of the items that show up in our current annual reports. So registering counts, distribution, who's seeing, you know, patients from a level perspective, what kind of payers, just it contains quite a bit of information, but it's just static, right? It's a, it's a report with one snapshot of that graph ultimately what we would like to do again in this trauma registry section of our website is embed this. This is our potentially public facing dashboard for folks who are interested in what the trauma system of the state of Tennessee is doing. So I'm going to walk you through this one and the facility dashboard. This one again is for the public. It's built off the same information that we have in the annual report, but in a format that is easier to explore and interact with. So from a data standpoint, there's nothing new. It's the same high level aggregate system wide data that we pull for the annual report. This is not something that is unique to Tennessee. Other states around the nation are doing something similar. E.g., this right here is what, well, I don't know what I just clicked on, but you got saw a little glimpse of what Montana's dashboard looks like. So they too, are putting some of their high level system data out there to track overall trends and patterns. So our goal was to build something similar to that that corresponds and correlates with how we, as the state of Tennessee are already looking at our data. At a very high level, this is letting us look at different things like volume, patient demographics, injury patterns, outcomes. The nice thing is, is with these dashboards you can also do fun things like hover over a specific part of different visuals and it'll give you just a little bit more information. So on this map, that is the Tennessee trauma volume by county. So this is representative of our grand divisions certainly, and then as you hover over individual counties, you can see that county's name, what grand division they're in, the time frame that you've selected and how		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		many patients from this county have been treated in our trauma facilities. So again, you can change the time frame, so I've changed it from 2020 to 2026 and decreased it so it's only 2020 to 2023. And you can see that that information now changes. Well, it's supposed to, but for whatever reason it did not, let me change this. Well, apparently it's being stubborn because, of course, it is because I wanted to demonstrate it. But anyway, you can see some information there. Again, you can come over. This is looking at volume, we can see where our patients are coming from across the nation. You can see males, females. We also included a snippet in here to cover some of our other genders that folks do identify themselves as. Here's payer mixes, so you can see the number of those types of cases that we've had and what percentage that makes up of our total trauma volume. We also look at injury patterns coming off that falls presentation, you can look here and see that falls in our elderly and this heat map is clearly our number one incidence of trauma injury across the state. Also breaks down how many in each month for a specific kind of overarching top mechanism. Our outcomes speak to where our patients are going. Are they going home? Are they receiving some type of care after they leave our facilities? What is our fatality rate across the board? So this is all again at the system level. There's no facility specific data in here. All of the data is aggregated and additionally protected so that folks wouldn't even be able to download the data and look at it if they wanted to. So we made sure to put extra safety measures in place to protect that. So again, at the end of this presentation, Rob mentioned the possibility of taking a vote to embed this in our website. We're not going to do that right now because there are a couple other things that I do want to show you. So we talked about the public facing dashboard. Now I'd like to show you our facility dashboard. Again, my computer is being a bit of a pain, so I'll go in this way. Alright, so what I'm showing you now is the facility level dashboard, and this is designed for a different purpose, of course than what our public facing		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		dashboard would look like. So this dashboard is secured but from a different way. So while the public facing dashboard has the extra aggregates in place to make sure that no one can download and look at facility specific data, this one was intended to have facility data but protect it so that only individuals from the designated facility can see that facility's data. So that is what we call row level security. The dashboard is secured and access is set up so that each facility only sees their own data. I'm not going to display any specific facility today, of course, but I do want to kind of show you how this works. So from right here, because I am a employee of the state of Tennessee, when I log in, it shows Tennessee trauma system. So I'm seeing the designation level, so on and so forth. And you're seeing mine in Rob's names. Now, if Stephanie Spain were to log in, she would see all the information based on Erlanger, her facility or David Kerly, if he logged in, he's going to see Sumners. So it's specific to you and your facility. At a very high level, everything in this dashboard is built around three perspectives, the facility, the peer group, and then the state. So when I click in here and I can zoom in so you guys can see this a little bit better, I have some options here. Now, when I click on this, I get all the facilities. If an individual from a specific facility were to log in, only their facility would be listed in the facility with what we call slicer. From a designation level, they too would see the designation level for their facility. I have access, of course, to all the facilities and all of the designation levels. So what you can see is there's a spot here that would show facility volume. There's a spot here that would show peer volume and then the state total. So if I wanted to I could just say, ok, let's look at our level one centers and see how they compare to the state. So again, not showing any specific facility today, but we can look at this from a level one perspective and how it compares to the state regarding volume. So as you kind of slice through things, these visuals will change and show you what you've selected. You can also adjust the time frame here. So if you		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		wanted to look at a specific year or a quarter you could go in and you could start to determine all of those different things. One of the areas that this is really cool is, our hospital events. So we have actually been using this quite a bit in our PI workgroup in talking about different things. It has allowed us to review definitions of the different events and make sure everybody understands how to use them in the the how to apply the audit filters. So e.g., right now we're looking at all facilities and all designation levels, but we could say, you know what, we want to look at our level ones and we wanna see what kind of acute kidney injuries are happening. So you can see we've had across our level one organizations across the state from 2020 to 2026. There's been 910 acute kidney injuries specific to level one. Now of course you can change that, right? And put it on level three. So you can see how that changed and adjusted when we went from comparing level ones to the state and then level three to the state for the same type of hospital event. From we include fatalities in here and look at mechanisms of injury and rates and counts. Same thing with demographics, lots of information here where are your patients coming from? You know, we see, as we develop and grow in our trauma system and we see facilities open, we see where patients come from for each facility kind of change. Again, gender payer method, and then we look at injury patterns. So overall both the public facing dashboard and the facility dashboard are meant to support transparency at the system level and provide meaningful insight at the facility level. They make it easier to explore the data, we've already have an answer questions more quickly especially when it involves our registry data. We've also put together a user guide that walks you through how to use it, so that will be very helpful. So some of the asks will be if there are individuals who have not yet sent me, the folks that they would like to have access to their facility dashboard, if you could please email that to me with their names, what role they play in your trauma program and their email addresses because again that's a row level security, so		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		they have to be added in a very specific way and be built into the report in order to access it. We are asking that we limit it to three people per facility just to help maintain the security of the data. And of course if down the road you have folks turnover in their roles and staffing changes that you let us know immediately so we can make sure to remove them from the report build so they will not have access. Rob, is there anything else you would like me to cover?		
	R. Seesholtz	No, just that last piece regarding security and data access. I mean, we typically find out folks are no longer employed at institutions when I get an email bounce back from something. So, I get it, people come and go, and it's difficult to get folks added. However, we have had multiple folks having access to the trauma registry, meaning your institution's data for five years, ten years, and they have never logged on to the registry. I think that's a huge security concern in my personal opinion. But this is also along those same lines. I would not give anyone access just because, if they stand to realistically look at it, realistically dive into it, that's another matter. But just because I don't think is certainly good enough, given that all your institutions data, well not all of it, but a considerable amount of your institutional data is provided here.		
	A. Cook	Just another thing Rob, as you were talking about that, you had mentioned the link from the public dashboard to the facility dashboard. So this is when, it would be embedded into the website what it would look like. And so there would be a link here right now, of course that is not hooked up, but when this would be present on the website, if we so choose to do that, facility folks would be able to click on this and it would bring them to their facility specific dashboard. If someone else were to click on this that did not have their built in access to a facility dashboard, this would kick them over and say, I'm sorry you do not have access to this. If you are seeking access, please reach out to and it would list my email address for folks to reach out, which of course I would then say, I'm sorry unless you are a		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		member of one of our trauma centers, and then I would confirm through, you know, our trauma program managers and directors if that person is appropriate to have access and again we're asking that more than three people. But I also, once those facility dashboards go live, I would share the specific link with everyone so that way you could just click on that and bookmark it and you would be able to click on that. And again, it would only bring up your facilities data.		
	O. Bratton	So first of all, great work Abby, this, this is great. I did have a question about the divisions. So all of the other state sanctioned, healthcare databases regions follow kind of the, the eight region format, so EMS, healthcare coalitions, even the child fatality report. So is there a reason we went with three grand divisions as opposed to doing a little bit more granular to look at, you know, northeast, east, so on and so forth?		
	R. Seesholtz	I don't have an answer other than both Abby and I talked just felt that this was the best way to split the state up. Certainly if the suggestion is to have it split up into those other regions we can potentially work towards accomplishing something like that.		
	A. Cook	Also, I think from a, more of a public facing, I think the folks of Tennessee understand the three grand divisions kind of East Tennessee, middle Tennessee, West Tennessee more so than they would that granular level Oseanna, but certainly like Rob said, we can look at breaking that up even further if, if that's the decision that's made. Absolutely.		
	R. Williams	Aren't there two different ways to divide into eight regions? Didn't we find that Rob? They're like the EMS regions and then there's like a different way of dividing and they don't overlap with each other.		
	R. Seesholtz	I believe there are some counties that are different depending on which region you're, you're, you're speaking about. But yes, if		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		there was something that the council felt that was hey, this is the way to go, we can certainly look at that.		
	A. Kerwin	Are, are they populations of the three regions similar? I would guess the central as far more than the rest or no?		
	A. Cook	Specifically, I cannot answer that question, Dr. Kerwin. I just from a geographical standpoint, this is how Tennessee gets split up. It's certainly long priorities to me, but again, I can investigate this and break it out however we so choose.		
	R. Seesholtz	You can see Dr. Kerwin in the grand division numbers itself for the time period that's 21 to 26. Middle Tennessee is just slightly beating East Tennessee with 81,870 records versus 79,141 in east. And now this is not population. This is patients that received care at a trauma center.		
	A. Kerwin	That's why I asked.		
	A. Cook	But that's also there's only one trauma facility located in the West Grant division as it's broken up kind of geographically, so I'd say, I mean that's pretty kudos to y'all out there definitely taking care of some business in West Tennessee.		
	R. Seesholtz	That includes LeBonheur also.		
	R. Williams	This is so awesome, Abby I think this is really going to help all of us better understand what's in the registry and we can utilize this information to try to make improvements in our own centers. So I really look forward to this. I think that we need a couple motions. One, we need to decide if we want there to be a public facing dashboard. So does anybody, I can't really make a motion but does anybody want to make a motion that we have a public facing dashboard?		
	A. Kerwin	Motion for a public facing dashboard.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	B. Dennis	Second.		
	R. Williams	Thank you, is there any other specifics, any discussion on the public facing dashboard as presented by Abby?		
	B. Burns	Sorry, it's and if nobody cares then it's fine, but if we have a public facing dashboard that only has the three areas, and there's only two trauma centers that represent one of those areas, doesn't that by nature take away some of the anonymity factor? So in the east, we have multiple level ones, level threes, all that sort of thing. But when you look in the west, there's one adult, one pediatric. Is that a concern? I'm not concerned, but does anyone have a concern?		
	O. Bratton	Yeah, I mean. The only other similar report I have to go off of is the child fatality and inventing fatality reports that are all public facing, and like I said, they break it down to more granular, so you can even look at those and be like, you know, there's only one children's hospital in that area. So, I, I don't think it's an issue. I would even say it's worth breaking it down so that it matches the other health reporting regions. So it's consistent across different specialties.		
	R. Williams	I think that you can, Bracken just to your question, that the data that's going to be part of the public facing is what's already publicly available anyway in our annual report. It's just split up in a different way. So I don't think that there's going to be such specific information that it would be harmful to any of the centers, in the smaller regions or the regions with less trauma centers. Alright, any other discussion? I'm going to call the question. Do you want to go ahead and do roll call Rob?		
	R. Seesholtz	Yes, everyone's voting for permission to include the public facing dashboard onto the health facilities Commission website.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Maxwell – aye	Unanimous aye votes – motion passes.

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
			Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – aye Dr. Campbell – aye Dr. Jensen – aye Steve Hamby – 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	
	R. Seesholtz	Fantastic motion passes. Thank you very much council members. I just want to have one follow up item before Dr. Bollig gives his PI report. As most of you know, we are convening a PI workgroup meeting monthly. I want to thank Abby for stirring my memory in that that we've been gradually working through hospital complications or hospital event list to ensure folks are speaking the same language. This dashboard certainly was a big part of that, being able to see, what data we show at the commission and comparatively what you guys are submitting. So, we are nearing the end. We probably have another couple of months of reviewing those hospital complications. We did send out a survey for participants of that to say, hey, how's this meeting going? Would you like to see it continued? And there was a overarching yes on allowing this meeting to continue beyond our hospital complication review. So more information to come and Dr. Williams, is it ok for Dr. Bollig to do his TTACO report?		
	R. Bollig	Our report is as bad as it has been since we've been doing this. Brad Dennis and I emailed back and forth and there's a couple of things we can do, but I think the, the, the big thing and Brad		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		correct me if I'm misspeaking, but the, the data quality aspect, I know at least for ours our facility has been, it's been, I don't want to say difficult to ensure, but there there's, there's so many little details that if they're not right, it can make your data in your morbidity and mortality, well, hospital events and mortality not really reflect what's going on. There's a Brad since I, we spoke I I've looked into a couple of different ways to go about assessing that. It's not really applicable as a, like across the collaborative as a whole, but each each center is going to have to take a dig at their, their data and their processes. And so hopefully before our next meeting, I'll get something out that's a little more formulaic to to assess that stuff, send it out to the centers and then we can share. Number one what we find wrong, how we fixed it or what we're, what we think we can do. And I think that'll be a better, better use of our report other than saying, look, the, there's still as much red as there has been correct.		
	B. Dennis	Yeah, I think, you know, when you look at it and just to give you like this, the super high level, you know, summary, we are high outliers for most of the mortality or for mortality for most of the cohorts, but we're low outliers for many of the complications in in hospital events for all cohorts, which to me strongly suggests a data reporting issue. Exactly I mean it's kind of hard to fake the deaths, but it's really easy to underreport, you know, the complications and so I suspect that's probably a lot of what we're saying, it's not probably not all the whole picture, but I think that's just a fair bit of it and I think you know in the context of the collaborative. I think what it does to, you know, it gives us things to take back to our individual centers to work on or to look at. And I think that's probably like the 1st step is like looking at, you know, doing some audits and, and sort of quality control on our data submission and making sure that we are capturing the things that, that we're, that we need to be capturing or rather submitting, you know, the things that need to get submitted so that they're, they are reflected in the report. And so I think, you know, that maybe a good opportunity for us to at least sort of		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		share, how individual centers go about doing that and and so that we can identify some best practices or common threats that that might be helpful to the whole collaborative.		
	R. Williams	Any questions about the TTACO report? Alright, hearing none. We will move on to our CECA updates.		
e. CECA	R. Mills	Currently Copec is seeking a new vice chair. They are restructuring some meetings with Copec to better facilitate the subcommittees that are meeting prior. Copec is very excited this week for TCAC to review the interpretive guidelines for Tennessee pediatric trauma centers today. They had a successful conference in April. Planning next year will begin in June. If anyone's interested, please reach out. The conference will be in Memphis this in 2027 and applications are open on the CECA website. They are also continuing to grow the my hero cares program. If anyone is interested, please reach out to the CECA website or myself or Dr. Williams or Natasha I think Natasha's on. Thank you.		
	R. Williams	Thanks Renee. Anybody have any questions for CECA? Rob, what's next on the agenda.		
f. Legislative	R. Seesholtz	I have one item just for legislative. I sent an email out, I believe last week but attended our government operations meeting a few weeks ago and the good news, those members of the government operations committee did not have many questions related to our new trauma rule set and subsequently it was recommended for approval and as of May 6th of this year the new trauma rules were approved. I am extremely thankful for Dr. Daly and his work on those rules and all of you for your work as well.		
g. Finance	R. Seesholtz	For finance, Dr. Williams, I have no items other than what I, explained to the council regarding our trauma fund report earlier.		
V. New Business	R. Williams	Great, thank you. Now we'll move on to new business. The		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		pediatric interpretive guidelines were sent out twice now and then a reminder was sent again this morning, so I'm hopeful that everybody has had a chance to look through those interpretive guidelines. And please, this is your time to bring forth any questions or concerns you may have.		
	B. Burns	Yeah, minor minor things, but under the ED under the physician part, it was talking about nursing schedules as well as physician schedules and at least on the adult side, we've never, asked facilities to provide nursing schedules for the emergency department. And there was a section and maybe it's covered in another place where it mentioned the surgeons response within 15 min and it also said monitoring neurosurgery and orthopedics, but that's not within the 15 min requirement, not that it doesn't need to be tracked, but it's not tracked under that requirement. So those were the two things on my review.		
	R. Williams	Anissa and Oseana and Amber, do you have any responses to that? I know Anissa is on the committee for CECA.		
	B. Dennis	One thing that I would suggest is they used TPM and trauma program leader interchangeably, and I think those are A inaccurate and B confusing. And I would suggest that everywhere it says trauma program leader, that that'd be changed back to manager. So I think that's what they're, that's who they're seem to be referred.		
	O. Bratton	That one I can answer off the top of my head is because some facilities call them program managers and some people are directors. So I think that they wanted Amber, help me out here. You might remember that, but I think the plan was to change them all to leader.		
	A. Greeno	Do you think that it was also depending on the hospital they didn't have a specific, they wanted to use a role that was different, so they would just working on point the leader is what I		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		was told.		
	B. Dennis	I sort of fall back to what the ACS says about trauma and trauma is a surgical disease and it's led by the surgeon, and so by calling the trauma program manager, the trauma program leader, we're confusing that, and that's why I would suggest a different term than leader.		
	A. Greeno	That's a good point, and I don't see why we can't have manager and then just let it be loose cause there's coordinators, there's managers and Directors and so it all works.		
	R. Seesholtz	Now trauma program leader is mentioned in rule, that specific nomenclature.		
	B. Dennis	In what rules?		
	R. Seesholtz	Pediatric rules.		
	O. Bratton	So I have the document pulled up. If someone can tell me what page the question is, I can pull it up and look at it. In Jennifer Porter I don't know Rob, if we're allowed to unmute Jennifer Porter. This is actually her she's kind of the leader of this, so I don't know if we can have her available for questions as a representative of CoPEC please.		
	A. Cooper	Dr. Burns, you don't happen to have the page of what your, where your questions is coming from?		
	B. Burns	No, I can only tell you it's amongst the parts that were highlighted. Is that helpful? No, the, the one section was talking about the emergency medicine physicians and it says something about on the far right about where you provide proof for documentation, it says physician and nursing schedules and nursing doesn't fit in under there.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	B. Dennis	I think that was on like page 35, like it was one of the first things.		
	O. Bratton	Yeah, so it says evidence may may include and that's the important part is this is just recommendations for documentation. It's not a hard and fast that this is how you must. ED on call roster for MD and RN demonstrating coverage is the verbiage there?		
	B. Burns	The rule doesn't require anything about nurses, it requires physicians, and as a DO, just saying MD is also not correct. And this is interpretive guidance, which is what we were asked to provide which is different than interpretive dance which I've been studying separately.		
	J. Porter	From what I'm hearing is you're just the verbiage of trauma program leader, trauma program manager, you guys would prefer that be trauma program manager?		
	B. Dennis	Yes		
	R. Seesholtz	I'm sorry Jennifer. My concern would be with legal more so than anybody else. It's mentioned in rule trauma program leader. If you have trauma program director/manager or never mind, legal has weighed in.		
	N. Flinchbaugh	So it has all three nomenclatures under that trauma program leader definition.		
	O. Bratton	So that would, so since it's written into rule, that's something we can't change. We'll have to bring that back to the group for our next round of edits.		
	J. Porter	So these, the nurse like the nurses schedules and from what I'm understanding, and I apologize I'm also mobile today, what I'm understanding is it's in the suggested documents of evidence that speaks of the nursing schedules or is that in the rule?		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Williams	Its in the interpretative part, not in rule.		
	J. Porter	Yeah, I think that was just saying this is a suggestion of something you may provide to show compliance with this particular rule. It's not saying they have to have that. A lot of that is just they need record to show that they had appropriate staffing at all times in the emergency departments, is kind of how it is throughout the document in regards to the different sections of the rule.		
	R. Seesholtz	And Jennifer, I will say that when we do site reviews, we do look at those schedules as well. We look at on call surgeons. We look on call all subspecialties to include emergency department staff, nursing as well as physicians.		
	R. Williams	I think the question is this rule just talks about physician coverage, but you put in RNs as part of it. And so I don't think that, that the American College of surgeons nor do the Tennessee rules specify the RN coverage, it's specifying physician coverage.		
	J. Porter	Okay, I can definitely review that rule in particular. Do you, because it's not up on the screen, could you tell me the rule number or the TAG number?		
	R. Williams	Yeah, it's 72031.05.		
	O. Bratton	Is it helpful if I share this? Am I allowed to share it? Is that not helpful?		
	R. Williams	I think you can share it. I do want to encourage us not to go line by line through these things. Like we, it sounds like this is not something that's going to be approved today because there are multiple different questions that I'm assuming Jennifer and Oseana and Anissa you're going to have to take back to Copec and then answer them and then bring it back to us. So I think we make a list of what our questions and concerns are and then y'all		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		can bring it back to us at the next meeting. Unless you're able to make those changes right now.		
	O. Bratton	Well, I think here, can I just, I'm going to share this.		
	B. Burns	I personally don't care if you want to leave that in and make it part of what it is that you look at when you do pediatric reviews. I'm just giving quite literally interpretive guidance that that's not what we do on the adult side and it's under a section that's talking about physician requirements, so to require nursing schedules doesn't make sense, just like I said. The only other area that I raised is under the trauma surgeon, the pediatric trauma surgeon response within 15 min the highest level of activation, it mentions two other disciplines that are not held to that same rule in that same section.		
	O. Bratton	So two parts just so everyone kind of like just so we're all on the same board as our same page as far as timelines. So this is due to go in front of healthcare facilities commission for approval tomorrow. Is that correct order?		
	J. Porter	That was our understanding. We received an email this morning that it might be pushed to the June meeting, but I think it's supposed to go prior to the next meeting that you guys are having with this committee because it it was pushed from the last meeting also.		
	O. Bratton	So to the best of our abilities, I think we're trying to answer all these questions today so we don't miss the next healthcare facilities.		
	R. Williams	My question for the three of you would be, can you change anything in this documentation based on our feedback or do you have to take that back to the greater group?		
	J. Porter	Alright, I think it it depends on what the change is. If we're		

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		changing the intention of what the group agreed on as far as verbiage and things like that, you know, that would be something we would have to take back. If we're just changing a word here, word there. I don't think that the subcommittee would have a problem with us at at the desire to get these approved since it has been going on for so long. I don't feel that the committee would subcommittee would have a problem with us going ahead and making those small wordsmithing changes. The rules themselves we can't touch of course it's just simply the actual interpretive guideline.		
	O. Bratton	So I have the note to change MD to physicians so we include our DOs and to remove RN, and then help me out with what page was the next.		
	R. Williams	Is it the 15-minute time thing?		
	S. Spain	TAG 474.		
	O. Bratton	Okay, so I see, I see that there, so I think for simplicity's sake, we had merged those two cells, so I think what we can do is just unmerge them and clarify the language So that it matches up with the line by line because I think the inclusion, I believe, the inclusion of neurosurgeons and orthopedics was for 473, which looks at their response time and their 80 % compliance. The 15 min was specific to the trauma surgeon and so we just need to split those and clarify. Which should be an easy fix. I don't think we need to go back to the committee for that. Thank you for pointing that out.		
	R. Williams	Perfect. Any other questions?		
	R. Seesholtz	I just have a few quick ones. Tag 410 and Tag 441 both mentioned that's here, 410 EM medical directors board certified board eligible blah blah blah. Suggested documents I would only include proof of board certification. That's the same		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
		thing with Tag 441.		
	O. Bratton	So I think the board certification, are you Rob, do you mean in repli in lieu of the CV? Cause the law, the rule specifically calls out that they have to have a record of appointment and acceptance.		
	R. Seesholtz	Okay, since you mentioned in the regulation board certified or board eligible? I don't, well, I I'm not gonna say that anymore, but, I'm assuming then the CV would then contain evidence of current board certification or board eligibility. If not.		
	A. Greeno	The ACS requires your, just a proof of board like cert, and then they also require a letter saying that you've been appointed. So I think that you just add the three things that ACS asked for and the CV doesn't need to be there.		
	O. Bratton	Yeah, I think that's easy enough. So under 410 we need to have, so just to clarify under 410 we need to have, take out the CV and just change that to proof of board certification or board eligibility and then leave record of appointment.		
	R. Seesholtz	I personally would leave CV but an ad board, but that's up to that's up, up to the group. I know we look at CVs of department chairs when we do site visits.		
	A. Greeno	So is this for the chair or just for all of them?		
	O. Bratton	I can look. That was 410. What was your other tag number?		
	R. Seesholtz	441 ma'am.		
	O. Bratton	You want me to just copy paste what's in 410 to 441?		
	R. Seesholtz	Yeah, I think that'd be great. Okay, and two final ones, tag 446 and 466. These are just typos that say exemplers and I believe it		

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		was meant as examples..		
	J. Porter	Thank you for catching that.		
	R. Williams	Anybody else have any comments or concerns?		
	O. Bratton	What was the other one Rob? 446 and..		
	R. Seesholtz	466.		
	A. Greeno	For the emergency department director, ACS requires the roles and responsibilities document and then the evidence of board certification. Those are the two things that they asked for.		
	O. Bratton	Okay, hold on a second. For, the surgeon or for the emergency department, sorry.		
	A. Greeno	Emergency department, and then I can tell you what for the is it for the trauma medical director? The other one?		
	O. Bratton	Hold on. I'm still here. You're going faster than I can. Ok, so for the emergency director, they require, say it one more time, what?		
	A. Greeno	There needs to be a document that lists the roles and responsibilities of the emergency department director and then evidence of board certification are the two things that ACS request. And then you're wanting the TMD. Is that the other one?		
	O. Bratton	So ok and then what's next for?		
	A. Greeno	What is that the trauma medical director?		
	O. Bratton	Yeah, we were just going to copy paste from what was at the emergency department?		
	A. Greeno	So for that one, I can tell you they want the board certification,		

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		they want, the ATLS because they have to be current. I don't know if we make that a rule, and then the CME requirements, which I don't know if we made that a rule. And then finally the roles and responsibilities, same as the medical director of the ED.		
	O. Bratton	Yeah, so I think what my recommendation will be is just to copy paste 410 into 441 which calls for the CV, the job description or the roles and responsibilities.		
	A. Greeno	And then the credentialing		
	O. Bratton	And then the trauma medical and the board certification board eligibility because the CMEs and continuing education has called out in a different timeline.		
	A. Greeno	Is the credentialing, the trauma medical director has to have a credentialing letter.		
	R. Seesholtz	Now, is that what's currently contained in pediatric rule or is that what the college requires?		
	A. Greeno	I was just saying that the college requires and so I didn't know what was in ours, but I didn't know, for the guidelines, this is what the interpretive guidelines, this is what would be the, I guess the version of the PRQ. I can just copy the PRQ request into the chat if that's helpful or can I?		
	O. Bratton	You can, we just got to make sure that it's not an extra requirement it's not all that is not written into, you know what I mean? All we're able to recommend is supporting documents to show what is already required.		
	A. Greeno	Yeah, then just match them.		
	O. Bratton	If that is something that we need to add into the next one we can definitely take note of it though.		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
	R. Williams	All right. All right. Any other comments, concerns about the interpretive? Go Rob, go.		
	R. Seesholtz	Tag 464. Administration shall provide resources to support the trauma process improvement program. So it's got on the left, it's got CRPC. It looks like it should be CRPC and PTC. Yeah maybe left out of that. I'm not sure. Is everything above it or not everything, but quite a quite a few things say CRPC.		
	O. Bratton	I do believe you're correct.		
	R. Seesholtz	My work here is done.		
	R. Williams	Good job. Any other council members have any questions or concerns about the interpretive guidance? Okay, is there a motion to accept these with the additions that were identified today?		
	A. Kerwin	Motion.		
	R. Williams	Thank you, Andy. Is there a second?		
	A. Cooper	Second		
	R. Williams	Ok roll call vote.		
	R. Seesholtz	Voting to accept the pediatric interpretive guidance with the additions identified today for the pediatric emergency care facility rules.	Roll call vote: Dr. Kerwin – aye Dr. Dennis – aye Dr. Maxwell – aye Dr. Bollig – aye Dr. Burns – aye Dr. Hunt – absent Dr. Campbell – aye Dr. Jensen – aye Steve Hamby – aye Stephanie Spain – aye	Unanimous aye votes – motion passes.

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			Renee Mills – aye Anissa Cooper – aye Dr. Bhattacharya – absent Amber Greeno – aye Oseana Bratton – aye William Nolan – aye Tyler Haines – aye	
	O. Bratton	I have, just sent that document over to our CoPEC, Tasha Kurth and Jennifer Porter as well as Rob and Dr. Williams.		
	R. Williams	Wonderful. Great job. Thanks to the people for getting that together and pushed through. And thank you to the council for reviewing everything so that this could happen in a better fashion. Ok, next does anybody from the public have a comment? Anyone? Questions concerns, public commenting time?		
	R. Seesholtz	Any public comments on the website Ms. Cook?		
	A. Cook	No public comments on the website. I did just want to quickly, if I may, I have folks signed up for dashboard access from every facility except for these ones. LeBonheur, StoneCrest, Maury Regional, VUMC Wilson County and UT Medical Center. So if you guys want access to the dashboard, if you can please get me over the folks that you want to be able to do that because I, again, have to make sure that they are built into the system in order to have that access. So that's all I have.		
	R. Williams	Can I have access to LeBonheur?		
	A. Cook	Absolutely.		
	R. Williams	Thank you. Alright, anything else for the greater good? Okay, with that, I will make a motion to adjourn the meeting. Our next meeting is going to be on July 31 or 1 August 1? 31 July 31 is our next TCAC meeting. The symposium is on the 30th, it is in		

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		Nashville. Remember, we have to meet in person once a year and it's going to be on July 31 so please go ahead and take off for that morning. We will, it'll be a lunch meeting, right? We get lunch and eat and then meet. Is that correct Rob?		
	R. Seesholtz	Yes ma'am.		
	R. Williams	I believe that is the same schedule that I have seen from the group. But be looking for a calendar invite, but just go ahead and block it off. July 30, July 31, we will see you all in Nashville. Thanks everybody.		
V. Adjourn	R. Williams			