**TRAUMA CARE ADVISORY COUNCIL**
**MINUTES**
**Date: November 8, 2024**

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| **VOTING MEMBERS PRESENT** | (1) Paula Bergon<br>(2) Oseana Bratton, RN<br>(3) Bracken Burns, MD<br>(4) Brad Dennis, MD<br>(5) Peter Fischer, MD | (6) Nicholas Jensen, MD<br>(7) David Kerley, RN<br>(8) Andy Kerwin, MD<br>(9) Robert Maxwell, MD<br>(10) Willie Melvin, MD | (11) William Nolan<br>(12) Brian Reed, MD<br>(13) Natalie Whitmer |
| **VOTING MEMBERS ABSENT** | (1) Dave Bhattacharya, MD<br>(2) Reagan Bolig, MD<br>(3) Amber Greeno, RN | (4) Steve Hamby<br>(5) Darrell Hunt, MD<br>(6) Anissa Revels, RN | (6) Regan Williams, MD |
| **GUESTS** | (1) Jennifer Beecham<br>(2) Alli Brogan<br>(3) Helen Brooks<br>(4) Saskya Byerly<br>(5) John Carr<br>(6) Amanda Cothran<br>(7) Theresa Day<br>(8) Christan Dury<br>(9) Scott Faragher<br>(10) Nathanial Flinchbaugh | (11) Britani Ford<br>(12) Kay Garrett<br>(13) Stephanie Hart<br>(14) Andrew Holt<br>(15) Andrew Hopper<br>(16) Bre Hutton<br>(17) Natasha Kurth<br>(18) Kim Lee<br>(19) Jeff Levine<br>(20) Bryan Metzger | (21) Tyler Haines<br>(22) Renee Mills<br>(23) Brent Nix<br>(24) Anita Perry<br>(25) Rob Seesholtz<br>(26) Melissa Smith<br>(27) Caroline Tippens<br>(28) Kennedy Toban<br>(29) Debi Tuggle<br>(30) Stefanija Weaver |
| **NEXT MEETING DATES:** | **2025**<br>TBD | | |

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| I. Statute Rules | P. Fischer | Required to have majority voting members present to have a quorum. | Roll call – Quorum present | |
| New members on the council | P. Fischer | Introductions of new and existing council membership and audience attendees. Membership and staff introduced:<br>• Dr. Nicholas Jensen, TMD, Maury Regional<br>• William Nolan, Consumer of trauma care<br>• Britani Ford, Asst. Trauma System Director | | |
| II. Approval of Minutes | P. Fischer | Approval of 8-2-24 TCAC minutes and finance subcommittee meeting minutes with corrections on pages 3 and 6. | Motion and second, both sets of minutes approved | |
| II. Trauma Fund Report | R. Seesholtz | 4th quarter disbursement calculations are complete with $1,249,714.90 being disbursed and letters were dated 11-4-24 for eligible facilities. Of note, we've had a $124,000.00 bump in trauma fund monies from cigarette tax collections in 2023, however, in 2024 those monies have been wiped away. | | |
| III. Subcommittee/Ad Hoc Committee Reports | | | | |
| a. Registry | B. Dennis | No report. Will move the registry superficial injury questions to the next meeting. | | |
| b. IP / Surveillance | T. Love | Expresses regrets. | | |
| c. System Development/ Outreach | R. Seesholtz | With Britani's arrival, there has been discussions on how to better the trauma programs involvement not only here within the state but also with our trauma center partners across the state.<br><br>A survey will be developed soon and distributed before the end of the year. These surveys will go out to trauma program managers, site review staff and other membership of the council. What we are looking for is how best this office can support all of you. The site review process, education for 2025, TPM meetings etc. will | | |

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| | | be part of these surveys. If there are any questions, please don't hesitate to let me know. | | |
| | P. Fischer | Just to confirm that the next trauma conference will be Thursday August 7th and will be held at Paris Landing? | R. Seesholtz – Correct | |
| d. PI/Outcomes | B. Dennis | Dr. Bolig was unable be here. He is reviewing the statewide collaborative TQIP data and there are some areas where we have worsened in the outcome data and he will be diving into this on a more granular level and will be probably sending emails to the program managers that are part of the collaborative for discussion at TQIP next week. | | |
| e. CECA | N. Kurth | Our education conference will be April 10th in Chattanooga at the Aquarium. The Star of Life awards ceremony that we host every year to recognize our EMS folks will be held April 30th at the MTSU student union building in Murfreesboro. A couple of projects that we are currently working on:<br>• Peds transport safety device is a still ongoing project, seeking additional funding, have given out over 300, still need approx. 100 more.<br>• We are doing sensory kits, these are for children with sensory disorders and includes headphones, sunglasses, etc. to help calm patient and can be utilized by EMS.<br>• We are in the process of creating a program called the "my hero cares" program. This will be for children with complex medical needs and will provide a care over plan to be provided to EMS so that gives them an idea of what is going on with the patient at baseline.<br>• Facility rules are currently under its third legal review and was signed by the Governor last legislative cycle and waiting for it to be posted. Once posted in will be effective 90 days after.<br>• CoPEC has created an EMS pediatric readiness recognition program and will be similar to the hospital program for pediatric readiness. That program has been approved by | | |

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| | | CoPEC and is going to the EMS Board for their review and input toward implementation. | | |
| f. Legislative | P. Fischer | No report | | |
| g. Finance | B. Burns | There's really three things that need to come before the council. For transparency, there has been no finance subcommittee meeting since our last meeting cause we were getting data together and so due to sunshine we weren't able to meet to discuss these three things. I'll put them up there and we can take them in the order of the preference of the chair.<br>1. The $5 million state appropriated line item and how we distribute the $5 million for this current year. For transparency, it is now no longer use it or loose it, so we don't have to do anything, but the conventional wisdom is if we let that money sit in the bank so to speak, efforts to seek additional funds might be limited.<br>2. Skyline Medical Center recently went from level II to level I status. That requires an adjustment in their readiness costs.<br>3. Finally, the discussion that is largely transcribed in your 28 pages of minutes from our last meeting where we came to this committee with a informational item discussing how a new process for potentially redistributing funds could be undertaken. Dr. Fischer, I'll leave it to you, if you want to take those in any particular order or, if you want to address funding in general first? | | |
| | P. Fischer | We've got a lot of work to do. What I would like to address first is Skyline. Skyline has gone from a level II to a level I and congrats to Skyline, fantastic work. Ideally, we would say that they are due level I readiness funding, but as you can see level I funding varies dramatically across the state. In all fairness, we don't remember how this was calculated. So we have to find some mechanism by which we can fairly fund Skylines readiness costs. We need to have some discussion on this as a council but my feeling would be that we average all of these amounts | | |

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| | | together and give Skyline the average of what they are. With being a one-time amount as we redo the funding on the next item, that potentially changes again. Thoughts on that? | | |
| | B. Burns | My thought would be as the lowest funded on those that we either fix it for everybody or I don't know that an average is a fair thing. We've been a trauma center for a long time and we are on the lower side. | | |
| | R. Seesholtz | I will say the average calculated readiness costs amongst the level I's is $360,000.00. | | |
| | W. Melvin | One consideration is to look at volume. I know at least initially we won't give them a number based on that, but as we try to figure out how to calculate it, the volume that a facility takes should be compensated by the number they get. That's just a starting point. | | |
| | O. Bratton | So this would be just a one time payment because we've already discussed future algorithms for payment? | | |
| | P. Fischer | This is a one-time payment for this year, and then hopefully, in the next year we get to a point of having the new formula. | | |
| | A. Kerwin | How did we come up with the readiness costs? | | |
| | P. Fischer | UT Medical Center was highest because they do peds at the same time and we think that in talking with people that were on the council back then that the other stuff was based on volume. That's why there is a variation with level I funding. Its interesting that we see variation in level I readiness costs but see no variation in level III's readiness costs. In my opinion, we need to give Skyline something for going to a level I, the next discussion, how are we going to allocate the $5 million, then the third discussion, how do we redo our formula and when we redo the formula, one of the tenents of redoing the formula is that readiness costs will | | |

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| | | be the same regardless of volume secondarily to the fact that its such a small number in the amount of money to cap volume. | | |
| | B. Dennis | So, the first point, what are we going to give Skyline. It would seem inappropriate in my opinion for us to give them more than we give Johnson City. I would set it as no more than what Johnson City is getting. I'm happy to make that motion. $290,000.00. | | |
| | B. Burns | I'll second that. | | |
| | P. Fischer | Now open for discussion. | | |
| | W. Melvin | What's the basis for that? To bring them up to the minimum number? | | |
| | B. Dennis | Yes, we could get into the nitty gritty about readiness costs. There's a certain amount that you do have to have as your volume increases, so it seemed like a good starting off point for the conversation. | | |
| | W. Melvin | Is Skyline more like Erlanger, or Johnson City? The diversity of what they see, the volume that they see, the money they lose. It maybe too much in the weeds, maybe that's an answer for the second calculation. | | |
| | B. Burns | I think it's too much in the weeds and I'll say that because we did the survey and we know that it costs $20 million dollars, roughly to run a level I trauma center in the state of Tennessee. So, we are literally talking about table scraps in an all you can eat buffet. But in transparency and fairness, that volume was set for my center years before I got here, that is not the same center since I arrived 9 years ago. I don't think the calculation as we move forward should take that into account as much as it is what it takes to be a level I trauma center. | | |

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| | P. Fischer | Motion has been seconded, are we ok to vote on the motion after that discussion? | | |
| | R. Seesholtz | I do have a point of clarification for general council, we do have representation from Skyline sitting as a voting member, do they need to recuse themselves? | | |
| | N. Flinchbaugh | The best option is to have another member make that second just so the conflicts are clear. They all work for a medical center that's in one of these levels, so it is a minimal conflict, but it is a conflict. So if anyone else would like to substitute as a second. | W. Melvin raised hand as a second to the motion. | |
| | R. Seesholtz | Attempted roll call vote for Skyline Medical Cetner to receive a onetime payment of $290,000.00 for readiness costs from being a designated level I center. | | |
| | A. Kerwin | Can I ask a question first, to make sure that I understand? Where is the money coming from so that I am clear? | | |
| | P. Fischer | Don't worry about that yet. A very quick historical update, on where this money comes from. The trauma fund has always been funded by the cigarette tax. This tax has seen a significant decrease since these original calculations were made. The original fund was in the $10-$12-million-dollar range, and now wits in the $5 million dollar range. Last year we received a $5 million bolus, this year we've been lucky to receive the same $5 million bolus. We are hoping to get another $5 million dollar bolus next year. That's were the money will come from. Most of the money for this year has already been distributed except for the $5 million. This money is going to come out of that $5 million somehow and to figure out about how to redistribute the rest of the $5 million. | | |
| | R. Seesholtz | All readiness and uncompensated care costs for 2024 have already been distributed. Letters have been sent and facilities should be receiving 4th quarter monies soon and calculations for | | |

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| | | 2025 monies will begin soon. When that excel spreadsheet comes to me, I want to equitably distribute those monies based on trauma center designation. Skylines 4th quarter readiness cost disbursement amount was still at a level II as opposed to a level I which they should be funded at. | | |
| | C. Tippens | I have John Carr, our Director of Administration here and he can talk about the finances too, to give more context. | | |
| | J. Carr | As Rob explained, the way the funding works we've got the cigarette tax revenue and is an estimate based on what we actually get every quarter. We get those revenues from the Department of Revenue. We break out that revenue based on JAR data and whatever the formula is that we ultimately decide to vote on and we distribute that. In addition, we have a $5 million allocation from the general fund that needs to be distributed this year. | | |
| | R. Seesholtz | John, correct me, when you say this year, you mean fiscal year July 1st thru June 30th of 2025 correct? | | |
| | J. Carr | Correct. | | |
| | P. Fischer | So, the vote that's on the table, is that the readiness costs for Skyline Medical Center as a new level I center be equal to that of Johnson City's $290,000.00. Did I state your motion correctly? | | |
| | B. Dennis | Yes | | |
| | P. Fischer | Rob, roll the vote. | | |
| | R. Seesholtz | Roll call vote: Motion passes. | Dr. Kerwin – yes<br>Dr. Dennis – yes<br>Dr. Maxwell – yes<br>Dr. Burns – yes<br>Dr. Reed – yes | |

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| | | | Dr. Melvin – yes<br>Dr. Jensen – yes<br>David Kerley – yes<br>Oseana Bratton – yes<br>Mr. Nolan – yes<br>Paula Bergon – yes | |
| | P. Fischer | How to spend the $5 million. There are rules on how we spend the $5 million. | | |
| | J. Carr | There was some confusion last year with the allocation, but the bottom line is that what ever the board votes on how to spend it, as long as it doesn't exceed the $5 million then however the board wishes to expend. | | |
| | B. Burns | That's one of the clarifications that Rob put into the minutes, because I had the same understanding when we tried to spend the $5 million previously and it's been clarified that it is at our discretion up to $5 million. | | |
| | P. Fischer | I need proposals on how we think we should spend the $5 million. | | |
| | B. Burns | I think we should look discuss your formula and then potentially use the formula for the $5 million. | | |
| | W. Melvin | You're specifically saying the formula for readiness distribution? | | |
| | B. Burns | If you go through the meeting minutes, Dr. Fischer proposed a mathematical formula, that's the spreadsheet that council members have been given. He then applied that formula to see what that would reflect for calendar year 2024, its just an example of how that formula would work and I think if a group decided that that was the right way to go then I think that would also potentially work for the $5 million that is in discussion and it also sounds like we need to spend it this year, before June but the | | |

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| | | sooner the better. That is why my recommendation was to change the order. | | |
| | R. Maxwell | Can you just run back through your formula? | | |
| | B. Dennis | I had one question in regard to the allocation. There was no purposes or intents labeled with that allocation, like for the purpose of readiness, for the purposes of designated trauma centers. | | |
| | P. Fischer | As far as I'm aware, no. So, let's go through the formula. I'm going to go through it slowly as I'm the first to tell you that I've lived and breathed this for a while so for me it's like second nature, that doesn't mean that I haven't screwed something up.<br><br>A couple things about the formula that we talked about at the last finance subcommittee meeting. The goal of the new formula is multifold, one is to switch to 80% of the fund to readiness costs and 20% will go towards uncompensated care, that's tenet number one. Tenet number two was that the formula is dynamic, transparent, and could easily be adjusted with the addition or subtraction of more trauma centers of any level. Tenet number three was that overall distribution of readiness fund level was set in comparison to the data collected from the readiness cost survey. | | |
| | B. Burns | Can I add two things? One thing that is nice about the formula is that it adjusts based on the fund. It solves for "x" so if we were to somehow have more funds come in or the fund was to drop off, it would not take a motion or anything to change, those number would change accordingly to the formula. Another thing that I'll point out is there was discussion at the finance subcommittee when we met last that Rob clarified and are in the corrections, that there does have to be some component of uncompensated care per the statute, it does not say what percent that has to be. | | |

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| | P. Fischer | With that in mind, the reason we did this excel spreadsheet is that we came up with those tenets at the last finance subcommittee meeting. What we didn't have, is really the data to apply those tenets so that centers could see what would change, how it would look to them. Since you all represent individual facilities, I thought it was really important for us to actually go through and see, like don't vote for something until you know what it's actually going to do to your individual center. So that's why we did this.<br><br>I'm going to go through each column. So, our goal is to compare column E to column J, which is your total received approximately, please remember these are all approximates. Total received in 2024 compared to what your total received in 2024 would have been under the Fischer formula. Column B is readiness costs, this is what we discussed before, this is currently what readiness cost are. And if you look for 2024 again its $3.5 million of approximately the $5 million dollars is dedicated to readiness costs. Column C, again, uncompensated care. This is the uncompensated care and is based on a very complex uncompensated care formula that we are not planning on changing. If you notice, non-trauma centers are also included in that. The uncompensated care bucket totaled $1.7 million. Column D accounts for the $5 million onetime distribution that we had. And how it kind of added up, it's $4.1 million, in all actuality, there were a number of things, when that $5 million was allocated, it was allocated over a one quarter time period, but it really doesn't make a difference because my goal is that I wanted to give you some idea of how you're looking. | | |
| | R. Seesholtz | The $4.1 million one-time disbursement from the $5 million is listed here, the rest of the $5 million was distributed for readiness costs. That's how we account for the rest of that money totaling $5 million. We did not include that in column D because we included readiness costs already in column B for 2024. | | |

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| | P. Fischer | So Regional One, which is my hospital received approximately $2.4 million. So now, we get to the new formula. We talked about column F, we talked about that significantly in the finance subcommittee. When we looked at the readiness costs survey, which was completed under his term as chair, if you looked at readiness costs based on the survey, it costs a level I twice as much as a level II to be ready.<br><br>We set level II as the baseline, so these are X's. Each level I gets two X's, each level II gets one X, each level III gets one-half X, a level IV gets one-quarter X, CRPC's were equivalent to level II's. We also said in the finance subcommittee that if you have taken the time to undergo ACS verification, you get funding based on your level of designation. So LeBonheur and Vanderbilt, because they are level I's get two X's, similar to the other level I's. And again, nothing for non-trauma centers. That adds up to 23.25.<br><br>Column G, this is approximately what each hospital is getting based on the previous year of the uncompensated bucket. We a re going to have two buckets, a readiness bucket, and a uncompensated bucket. Column G is about how much your hospital is getting of the uncompensated bucket. For example, Regional One has a very high uncompensated costs, we are getting about 35% of the bucket, Erlanger, only gets about 5% of the uncompensated bucket and this is based on historical data. Under the Fischer formula, we are going to switch it where 80% of the fund goes into the readiness bucket. In the readiness bucket, we have $9.37 million, we multiply that by 0.8, that how much is in the total bucket for readiness costs, we divide that by the number of X's, again, that is 23.25 to give us a value of X. So, in this case, we would multiply it by two for level I's, so that's $644,999.94, so for level III's, they get one-half X so that's $161,249.98 and so forth, so now that becomes your total readiness fund. | | |

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| | | We now look at our uncompensated bucket, again, same math. So, assuming that Regional One still gets 35% of the uncompensated bucket, which is much smaller now, that 35% would be $672,851.03. Then you can look over here at your total funds for 2024 and ideally again, very rough estimate. And you look at this and column E is what we got, and column J is what we are getting under the new formula. Any questions from the council? | | |
| | R. Maxwell | I'm just curious, what was the rational to just flip them? | | |
| | P. Fischer | To the 80/20? | | |
| | R. Maxwell | Yes | | |
| | B. Burns | It was discussed at the last finance subcommittee meeting that once we determined how much it really costs for readiness and how this is only ever going to be a fraction of it, that we felt is was better to put the money towards readiness rather than uncompensated care, and not to be unfair to those folks that are not trauma centers, but the more its weighted toward uncompensated care, the more money that goes out of the fund and does not actually go to trauma centers. So, 80/20 was just a starting point and that's where we took the calculation from but that was the rational, that is costs $20 million to run a level I trauma center, that readiness cost is defined, we did that survey, we defined it, then the discussion became how to weight that and 80/20 is what, and again, its not a motion, that was just the discussion point and the things that Dr. Fischer has put together here is just showing you what if we used that formula in 2024 as opposed to that we already had in place. | | |
| | W. Melvin | Thank you all for the herculin effort is getting this together. So, with the formula, you can move the dial any way you want. So, the next question is why not 90/10, 70/30? I get it, flipping it toward readiness costs because that's what we need, just for | | |

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| | | discussion. | | |
| | B. Dennis | I agree with Dr. Melvin on this, the concept makes sense, I like the idea, and I think the majority of it should be tilted toward readiness, but it seems like were not accounting for uncompensated care enough, I would be in favor of 70/30. I do have one clarifying question, in the finance subcommittee meeting minutes on page two, last year it was more 60/40 but just a minute ago you said it was 20/80? | | |
| | R. Seesholtz | It was 60/40. | | |
| | B. Dennis | So, 60% of last year went to readiness costs. We're not completely flipping this on its ear, were just shifting it more. To me this is more, we had a set amount vs. a sliding scale amount. It hurts us to bring on new trauma centers under this formula because it reduces out individual shares. | | |
| | P. Fischer | There is only so much amount of money, the pie gets smaller. | | |
| | B. Dennis | I get that, well actually it doesn't under other one, readiness amounts stay the same but your uncompensated care gets cut. But it probably hurst you more under this one. | | |
| | P. Fischer | So again, this is why I wanted to go through this. Under the current distribution, places that are getting a large amount of uncompensated care funds really get hurt by this new formula. I can tell you, I'm now the chair and do not represent my hospital, but I think that the person who represents my hospital now is going to be very upset at loosing a million dollars in a year. That's a significant budget hit. Your level III's are getting a huge bump out of this, they are almost tripling the amount they received in the past. | | |
| | B. Burns | I'm not a mathematician but I would point out that its probably not that much in actuality because we did the one-time | | |

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| | | distribution of the $5 million and since ethe readiness costs were already accounted for, a large portion of that went directly into uncompensated care. So, it weighted the uncompensated care heavier in the model that were looking at for actually happens, so I don't know that the loss would be that actual difference between those two numbers unless we decided to continue to do the same thing with the $5 million every year. I just point that out as a clarification. | | |
| | A. Kerwin | The percent uncompensated, where did that factor come from, is that each hospitals percentage of uncompensated care they provide? Or where did that come from? | | |
| | P. Fischer | That's roughly the estimate of each of the hospitals of the uncompensated bucket that they've taken in the past. It's just a rough estimate. | | |
| | A. Kerwin | So, it's a historical variable. | | |
| | P. Fischer | Yes, it a historical reference, and again, if the demographics of Memphis TN change dramatically and Chattanooga changes dramatically, it could switch the other way. | | |
| | A. Kerwin | Yes, it's a $1.1 million hit to Regional One and almost a million to Vanderbilt in the current example you've outlined here. | | |
| | R. Maxwell | So, Vanderbilt and Memphis take a bit hit and the rest of the level I's its kind of a wash and then the level III's look like they are making out the best. Has there been a cry out that there struggling or something? Certainly, the patients go up the line pretty quickly, least in our region. We don't have any level III's. | | |
| | P. Fischer | Again, this was purely based on the readiness survey, for a level III it was about a quarter of what a level I was, so that is where that distribution came in, and again these distributions were made before any of these calculations were made. Again, all of this is variable, you can change a level III, if the council wanted, you | | |

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| | | could change level III's to a 0.25 X and level I's to a 2.5 X. It could all be moved around depending on how you wanted to move it around.<br><br>Is it legal to give all the council members the electronic version so that council members can play with it? | | |
| | R. Maxwell | It's all kind of mind boggling, what you proposed is fine. | | |
| | P. Fischer | It would be nice to see, what if we applied the 70/30 to it. | | |
| | R. Maxwell | I would just say what I hear at this meeting over a few years is that Memphis struggles to keep its doors open and has to be salvaged by their local government, which is fine but, it seems particularly injurious to a place like that that has such a high level of indigent care, that they are getting stripped of frankly a third of what they've been receiving from the fund. It seems particularly injurious to a facility like that does so much good for so many underserved people in that region of the state. | | |
| | B. Reed | As a level III representative, I think that funding proposed is quite generous and could easily be redistributed to our level I centers considering that the bulk of trauma care, complex trauma care in the state is carried out by the level I centers. I mean, I'm not going to turn down, **inaudible**, but at the same time realistically I think those funds would be better served at the higher levels of care. | | |
| | A. Kerwin | I appreciate Dr. Maxwell's comments about Memphis, I think people have to understand the role we play and the impact that a million-dollar loss would be to Memphis. I don't have to explain that to you Dr. Fischer but that could be a devastating loss to Regional One. | | |
| | B. Burns | I'll say two things in order to move it along, Again, I'll point out that there was a one-time distribution there that is making this | | |

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| | | look like its more injurious than it probably is. I think we are getting some good feedback, what I would recommend is that we table this and then have the subcommittee come with a formal proposal to the next meeting that could then be beat up. Because it seems like we have too many things, level III's are saying we really don't need that much, there's still a lot of moving parts, this isn't a finished product, reading the room, we can take this, have the subcommittee have a sunshined meeting that discusses this and bring it for a more final proposal.<br><br>I don't want to take away from the tremendous amount of work that you've put into this. I feel that's kind of where we need to go. Everybody needs to take this home, mull it over send their thoughts to Rob or whatever and we can have a sunshined subcommittee meeting where everybody can weigh in want they want, but at the next meeting, you come with a proposal that will allow us to deal with how we fund going forward and allow us to deal with that $5 million before the end of the year. | | |
| | W. Melvin | Two things. When you come with a formal proposal, if you could have the previously distributed funds so that we can see what that really looks like, that Memphis got because everyone's concerned about the hit that the level I's are taking, but with that balance of what they actually got already, that may put it perspective. And the second thing is as a level III, were not just a throughput, we do a lot of work and we are constantly growing and so, a three fold increase is nice, the idea is that its well-received and used. | | |
| | A. Kerwin | I was just going to request time to take it back and review with our CEO, CFO, to see the impact on it and what would it mean. | | |
| | O. Bratton | To Dr. Burns point, would it make sense to have this document but take out the $5 million so we can just look at readiness costs? | | |
| | B. Burns | Essentially to your point, the only thing you have to do is ignore column three and then do the math and that's more representative of what it has been year after year after year. We did take a one- | | |

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| | | time $5 million and distributed out, so that got heavily weighted toward centers that had higher uncompensated care because the readiness costs were already accounted for. | | |
| | P. Fischer | So again, if you look at column G, we can easily change the percentages. To Dr. Burns point, that went from 35% down to 10% of the uncompensated care bucket. In the relative component to each other's facilities, it stays about the same. That's why I want to give this excel spreadsheet to all of you so you can do the exact same thing and rip this thing apart. You can adjust all of these things, it's a dynamic spreadsheet. You should be able to adjust all these things really easily and then look at the total. | | |
| | B. Dennis | Do we need a motion? | | |
| | P. Fischer | We need a motion to table it and to distribute the excel spreadsheet. We did this work not thing that there was going to be a motion for a vote today on this. Because there is a lot in this that still needs to be decided. | | |
| | W. Melvin | Motion to table and bring back. | | |
| | B. Dennis | Second | | |
| | A. Kerwin | Motion to table and allow each center to analyze it further in depth. | | |
| | P. Fischer | Now comes the $5 million that we need to discuss. With the new information that we have from council, when we discussed this at the last meeting, we thought that there were strict rules on how we could distribute that $5 million. We've now clarified that, and that's not necessarily the case. So this probably now needs a lot more discussion on how were going to do that because we thought that we were just going to say yeas and do it and it would go into the formula and flow through. Potentially more discussion | | |

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| | | after you've had the adjusted formula. I'll let the council decide. | | |
| | B. Burns | I say we hold onto it until we can figure out how the right way to distribute the funds, if we go too many meetings then yes, were going to have to figure out to pull the trigger on that, but if at the next meeting, we are able to come to some agreement, we can roll that $5 million in to that new formula and then were moving on. You can see when we did it the last time, we threw it in there as a one-time thing, its creating a skew that is now causing confusion I think in the formula that your proposing. That would be my recommendation. | | |
| | B. Dennis | My question would be are we going to hurt ourselves in fiscal year 2025 by waiting three more months. Meaning with the next legislative session. | | |
| | P. Fischer | When is the next legislative session? | | |
| | C. Tippens | January | | |
| | B. Dennis | I think we should do it now. | | |
| | A. Kerwin | When is our next meeting? | | |
| | B. Dennis | February. I think it makes sense to do it now, were going to have a hard time, they may decide in the next legislative session to not even allocate it if we've haven't spent 2023 funds by 2025. I would strongly favor. | | |
| | R. Seesholtz | Dr. Dennis, for this $5 million distribution, those calculations were pushed through based on one quarter worth of data. If this is the decision of the council, the recommendation would be since all of 2024 is in to use a full year's worth of data, plug the $5 million into that and it would seem to be a more equable distribution. Especially for institutions like Regional One and Vanderbilt where they won't have that much of uncompensated | | |

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| | | care but it still would be more than what was distributed in 2024. | | |
| | R. Maxwell | I think that's a great idea. I think our numbers looks skewed, I don't know how Erlanger got so low on that. | | |
| | A. Kerwin | So, you're saying to use the current formula, Rob? | | |
| | B. Dennis | Or this formula, (pointing to video screen) | | |
| | R. Seesholtz | No, the current formula, but instead of using one quarter worth of data we use the entire 2024. | | |
| | R. Maxwell | The uncompensated care formula was for one quarter, so if we get the wholes year's worth it might look different. | | |
| | B. Dennis | I would motion then that we use a full year's worth of data under the current existing formula and distribute it. | | |
| | W. Melvin | Second. | | |
| | B. Burns | You have a motion and a second so now you are on discussion. | | |
| | P. Fischer | The only thing that I would add to that is since we have funded Skyline to that level that we bring them up to a level, that we use a tiny amount of that $5 million to bring them up to the $290,000.00 level, since they are now a level I, for readiness costs. | | |
| | B. Burns | I'll make that an amendment to the current motion. | | |
| | W. Melvin | Second. | | |
| | P. Fischer | Any further discussion on that? | | |
| | R. Maxwell | When did they become a level I? | | |

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| | R. Seesholtz | At the last Commission meeting, August. | | |
| | R. Maxwell | So, should we prorate it? | | |
| | B. Burns | So, we have a motion and discussion and since were on discussion and to Dr. Maxwells point we are fighting for table scraps at an all you can eat buffet. | | |
| | A. Kerwin | So just to be clear, the motion is we take the $5 million apply the current formula. | | |
| | R. Seesholtz | With the addition of Skylines readiness costs. | | |
| | B. Burns | We need to vote on the amendment first, and then the motion. | | |
| | P. Fischer | This is on the amendment to provide Skyline updated readiness funds for being a level I. | | |
| | R. Seesholtz | Roll call vote. Amendment passes. | Dr. Kerwin – yes<br>Dr. Dennis – yes<br>Dr. Maxwell – yes<br>Dr. Burns – yes<br>Dr. Reed – yes<br>Dr. Melvin – yes<br>Dr. Jensen – yes<br>David Kerley – yes<br>Oseana Bratton – yes<br>Mr. Nolan – yes<br>Paula Bergon – yes | |
| | B. Burns | Mr. Chairman, what you now have is a motion to distribute the $5 million per the current formula with the amended amount for Skyline. | | |
| | P. Fischer | That's been motioned and seconded already, correct? | | |

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| | B. Burns | Yes, but you have the amended motion so now we are voting on the motion as amended. | | |
| | R. Maxwell | Quick question, how do you get the uncompensated costs Rob? Do you call each hospital? | | |
| | R. Seesholtz | Uncompensated care is based on that formula and is based on data two years in arrears from the joint annual report and hospital discharge data. | | |
| | B. Dennis | That data gets sent to the state from THA or, and it's from two years ago. | | |
| | R. Maxwell. | So is that something that my hospital has already sent in. | | |
| | R. Seesholtz | Yes. | | |
| | P. Fischer | I've got another amendment, but I can't make amendments. | | |
| | B. Burns | We are still in discussion so you can discuss. | | |
| | P. Fischer | You may want to consider since this is the trauma fund, that in this $5 million that you are about to spend, that it does not go to non-trauma centers, it only goes to trauma centers. | | |
| | R. Maxwell | Sure, if we can do that. | | |
| | P. Fischer | According to council, yes. | | |
| | R. Maxwell | Is that for just this $5 million? | | |
| | P. Fischer | This is just for this $5 million. | | |
| | A. Kerwin | So do we need to make a motion? | | |
| | B. Burns | You would make an amendment. | | |

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| | A. Kerwin | I would like to make an amendment that the funding for uncompensated trauma care goes to trauma centers only. For this $5 million only. | | |
| | R. Maxwell | Second. | | |
| | B. Burns | So you have an amendment that's been motioned and seconded, now you have to see if there is any discussion. | | |
| | O. Bratton | So it will only go to trauma centers meaning that East TN Childrens and Erlanger Childrens won't not get any? | | |
| | P. Fischer | No sorry, trauma centers and CRPC's. | | |
| | A. Kerwin | I'll except that as a friendly amendment. | | |
| | P. Fischer | Any further discussion? So we have to vote on the amendment. | | |
| | R. Seesholtz | So, uncompensated care for trauma centers and CRPC's only. Roll call vote: Amendment passes. | Dr. Kerwin – yes<br>Dr. Dennis – yes<br>Dr. Maxwell – yes<br>Dr. Burns – yes<br>Dr. Reed – yes<br>Dr. Melvin – yes<br>Dr. Jensen – yes<br>David Kerley – yes<br>Oseana Bratton – yes<br>Natalie Whitmer – yes<br>Mr. Nolan – yes<br>Paula Bergon – yes | |
| | B. Burns | Mr. Chairman, you have a twice amended motion on the floor that's been seconded and now you are on discussion. | | |
| | P. Fischer | Any further discussion? Again, what we are discussing, the | | |

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| | | motion that's been on the table and has subsequently been amended, twice, that we spend the $5 million based on the uncompensated care formula over an entire year, gets Skylines up to their appropriate readiness costs for a level I, and of that $5 million dollars, it would not go to any non-trauma center or non-CRPC. Any further discussion. | | |
| | R. Seesholtz | Roll call vote: Motion and amendments pass. | Dr. Kerwin – yes<br>Dr. Dennis – yes<br>Dr. Maxwell – yes<br>Dr. Burns – yes<br>Dr. Reed – yes<br>Dr. Melvin – yes<br>Dr. Jensen – yes<br>David Kerley – yes<br>Oseana Bratton – yes<br>Natalie Whitmer – yes<br>Mr. Nolan – yes<br>Paula Bergon – yes | |
| | O. Bratton | Just a side question on this document, Monroe Carrel and Erlanger Childrens had zero uncompensated care? | | |
| | R. Seesholtz | If you would scroll up Dr. Fischer. The two boxes that are highlighted in yellow, Vanderbilt University and Erlanger Medical Centers uncompensated care monies are linked together. Those institutions get paid for both centers. Meaning Vanderbilt adult and children's and Erlanger adult and children's uncompensated care costs are not separated. | | |
| | N. Jensen | Question, to better understand the impact of "x", changing the way its disbursed, do we get data from 2022, 2023, to better see how the $5 million bolus impacted distributions? | | |
| | P. Fischer | We've only had one $5 million bolus. | | |

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| | B. Dennis | 2022 data is in the trauma care in Tennessee report and that's publicly available. | | |
| | P. Fischer | We can get you a copy of it. So Rob, homework is we are going to distribute the trauma care report to everybody, distribute the excel spreadsheet to everybody. | | |
| | R. Seesholtz | Readiness costs have stayed the same since 2007, so nothing changes there. The only thing that has changed is the uncompensated care piece based on the amount in the fund, and what those calculations show. But I'll be more than happy to provide anything to council members. | | |
| | R. Maxwell | So who does those calculations, do you do them? | | |
| | R. Seesholtz | No, the Office of Occupational Health and Injury Surveillance Program. An epidemiologist does those calculations. | | |
| | R. Maxwell | So you just call him up and tell him to redo it? | | |
| | R. Seesholtz | I do not call him up. Our finance and administrative director John Carr.. | | |
| | R. Maxwell | So you don't call him up, I gotcha. I'm just curious on how it all works. | | |
| | P. Fischer | The formula is public, it's very complex. | | |
| | R. Maxwell | I looked at it before, I'm just curious how were going to get this new number to change this table. | | |
| VII. New Business | | | | |
| a. Rule revision and process | M. Smith | Recently Rob, Britani and myself conducted a level IV site visit for Maury Regional. It was not what we expected as they are a very high functioning level IV trauma center. I think when we | | |

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| | | wrote the rules years ago, we underestimated what a level IV could potentially do. We were surprised by how much they were doing in their facility. If level IV centers were going to function at a higher level, almost a 3.5, then they need to have additional things according to the rules. A lot of what you see here we have no requirements for and wanted to go down through these, get some thoughts and hopefully get a motion to get these approved.<br><br>So, for ICU equipment list, I don't know if there needs to be a caveat in the references, but this should be for centers, for level IV's that are admitting patients. I do know that down the road, we have another level IV that opens up they may not be as high functioning as Maury Regional so I think there does need to be a caveat for a lot of these for if they are admitting trauma patients to their facility. ICU equipment list, they need to have some sort of end tidal CO2 carbon dioxide monitoring. Right now we have nothing for a level IV. Even if it's on their code cart, not all monitors need to have that. I do think that need to be essential.<br><br>Lab requirements, drug and alcohol screening should be essential for them. Must have transfusion protocol developed, that's desired. Some of these level IV's have a lot of blood products and it's not listed as either essential or desired that they need to have blood products. So it would be nice if they had some sort of adequate supply, I don't care if it's five units, but something that they could send with the patient if they are sending them out. They had some sick patients at this level IV that they sent out, so having blood products should be essential. Adequate supply could be low because obviously they don't need a whole bunch at a level IV.<br><br>TMD requirements, if they are admitting these patients and are seeing these patients, then they need to have the CME's, that should be essential. TPM, if they are admitting, currently there are no requirements for a level IV but they should have some sort of emergency medicine or critical care nursing expertise. | | |

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| | | Trauma registrar. Currently they don't have to have a registrar for a level IV facility in the rules. So, if their admitting trauma patients you have to have this this isn't even just a state rules it's an NTDB rule as well. Anything that applies for the registrars and the registry, that has to be essential if you're admitting these patients.<br><br>The PIPS program. Basically, everything that falls under that, if your admitting patients at a level IV, even if you're not admitting at a level IV, you have to monitor things, delays, how are you transferring these patients out. As far as having performance improvement it should be essential and it could be a smaller subgroup for a level IV but if they are admitting patients, they need to have a performance improvement program, including 6, 7, and 8 and 9, all of that has to do with their performance improvement. 10 and 11, this could be desired, but they are actually doing a lot in their own communities because it is so small they are out there trying to do injury prevention, so as a smaller community I think it's even more important to get out there because you are the face of facilities that people rely on in smaller community hospitals.<br><br>These are just some of the items found doing the first level IV review and designation. I would like to hear any comments. | | |
| | P. Fischer | I have a couple of points. We've worked really hard to mirror our rules with the American College of Surgeons Committee on Traumas rules, which the level IV standards will be coming out quite soon. So, my question would be is, should we be deciding this now or do we wait till the ACS standards come out and see how close we are and how quickly needed is this? So, Maury Regional is good for three years? Do we have any other level IV's that are in the pipeline that this needs to be expedited for? | | |
| | R. Seesholtz | No | | |

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| | D. Dennis | How soon are the rules coming out? | | |
| | P. Fischer | At TQIP, it's supposed to be somewhat discussed, we should know more at the TQIP meeting next week. | | |
| | W. Melvin | Just in talking around the community there is a hospital in the area that's considering level IV, they haven't submitted obviously, and so, I appreciate your efforts and your input, if we're going to do this, it's really a level IV-A for admit, verses a level IV not, because as you point out, if your admitting patients, that's a different level of care, that the level IV needs to provide. Or, if you have the capacity to admit then perhaps you should go for a level III instead of a IV. There a lot of working, moving parts here but, I agree, I don't think there is any rush following up with the ACS recommendations then revisiting this would be appropriate. | | |
| | B. Burns | My comments/question goes along with Dr. Melvin I guess, to me what was the intention of a level IV center? It seems to me that the admitting part was an add on after the fact. My recollection was we were talking about places that would not be admitting patients, they basically would be a triage station and moving people on, so I don't anything about the ACS rules and what they may or may not say about admitting and everything. I think that your points are very salient if they are admitting patients, I think that all the things your recommending are important but to Dr. Melvin's point aren't they really supposed to be a level III instead of saying they are a level IV. | | |
| | R. Seesholtz | Certainly, the intent of level IV designation was based on those institutions that were more rural. Rapid identification, treatment, stabilization, and move them to a higher level of care. There are no current requirements that require institutions to designate at a certain level. If an institution likes to be a level IV regardless of whether they have a 700-bed capacity or a 3-bed capacity, they | | |

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| | | can make application and undergo a survey as a level IV center. | | |
| | B. Dennis | But our interpretative guidance said that they did have to have the ability to admit, that precluded free standing ER's from being level IV's. | | |
| | M. Smith | It just makes it difficult for reviewers, doing this for the first time. Especially them being high functioning. It's great what there doing there, don't get me wrong. It put us in a harder place as reviewers because we had no essentials or desired for half of what they had there. | | |
| | W. Melvin | It might be necessary for a carve out, a caveat saying that if you have the resources, and you are admitting, then these are the extra things that you have to do as a level IV plus. | | |
| | D. Kerley | I know it's an individual center, but can you share with us something that they didn't have that a level III would have? | | |
| | N. Jensen | I can provide some context. I'm the ER doc, not a surgeon. The hospital wants to provide trauma care in the community, the surgical staff is not particular interested in trauma care. Traumatic injuries get shipped up to Nashville. | | |
| | M. Smith | They have orthopedic and neurosurgical admissions mostly. | | |
| | B. Dennis | We can discuss this now or we can discuss this when the rules come out. The fundamental thing about a trauma center is to optimize patient outcomes, so if you don't have a registry, or a quality improvement program, I think its difficult to call yourselves a trauma center. It should be an essential requirement is what I'm trying to say. All the other things I think are negotiable, but those two to me are essential. | | |
| | M. Smith | I guess we can wait for the level IV ACS rules to come out, I just don't know when they are coming out. | | |

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| | P. Fischer | I would consider getting some clarification on when those rules are going to come out, since we are not under any particular rush. Nothing is pushing us to get this done quickly so let's figure when those level IV rules are going to come out and then we can compare. | | |
| | B. Dennis | Motion to table this until a later date. | | |
| | B. Burns | Second | | |
| | R. Seesholtz | There are a couple of additional items that Melissa, myself, and Britani have talked about, certainly this is one of them. The designation process in rule we were hopeful to have that information for the IV's by February that we might be able to get through all the existing rules and make our rules available for a rule making hearing, but the other item Melissa was, | | |
| | M. Smith | The number of deficiencies | | |
| | R. Seesholtz | That's correct. We've struggled with what deficiencies identified in individual institutions should require a focus visit a year later. Its still fairly subjective, we do our best to take subjectivity out of it but the site review team and the process really needs some finer guidelines on how we do that. | | |
| | M. Smith | We need to kind of mirror what the ACS does, if you get one level one deficiency you have a focus visit. We have no way as reviewers for the state to say ok, you had three level twos, we have to have a focus visit. Or if you have two level one's, you fail. | | |
| | B. Dennis | As I read the rules, we really don't have the ability to do a focused visit. If you have one deficiency, you fail the site visit. That's how the rules currently read. I'm in support of this, I agree. | | |

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| | R. Seesholtz | And that was the other item Dr. Dennis, "the institution shall have 60 days to correct their deficiencies", the overwhelming deficiencies for folks that are required to undergo a focus visit is regarding PI to a large degree, or gaps in surgical call schedules, so you cannot correct some of this in 60 days. It takes a tremendous amount of time for folks to get on board to be really reviewing their audit filters and what they have going on regarding PI. | | |
| | B. Dennis | So, do they have language? It would require us to separate our rules into type ones and type two's. Noted for our rule revision discussion in the future. | | |
| | P. Fischer | So, it sounds like were tabling this, and while you're up their congratulations to Vanderbilt, to you and Dr. Dennis on passing your ACS reverification review. | | |
| b. Pediatric trauma care improvement study/project. | O. Bratton | So, as the only pediatric person who's here, I was designated as the person to ask this question. Through CoPEC, the four CRPC's have been looking at a study that was done out of Arizona, it was an eight-year study that looked at about 21,000 pediatric patients with head injuries. And what they did was really intense education for EMS agencies doing education on proper ventilation and avoidance of hypoperfusion of head injury patients to see if that would change outcomes. What they found with that education with interventions they were able to increase out of hospital survivability by, it doubled with sever injuries and tripled with sever injuries with intubation. So, significant lives saved in the pediatric population. It didn't change moderate or critical outcomes, it was the middle ground that changed. So the ask of the group is we are looking at implementing this here in our state and focus on pediatric deaths.<br><br>So, what we are hoping for is support from this group as we push forward in this endeavor, and the biggest support that we are | | |

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| | | going to need is looking at the trauma database information about survivability and outcomes with these kids. So we are hoping this group and the trauma database will be able to partner with us to provide that data. | | |
| | P. Fischer | Any discussion, especially you Dr. Dennis and the registry? | | |
| | R. Seesholtz | So, what does that support look like? How many data fields, how many patients? Statutorily, there are things that we can, but more importantly things we can't give, or identify. | | |
| | O. Bratton | Everything would be deidentified. I don't think we know specific data fields now but just having the conversation of what would that look like. | | |
| | B. Dennis | This is a conversation that we really haven't had on how to utilize the state registry other than with the trauma care report. And this is exactly what this is, IRB process, etc. | | |
| | R. Seesholtz | One of the things as we are currently undergoing rule revision, one of those items to be addressed is the registry. I certainly don't mean to misspeak but we don't have to release any data other than what we currently put forth in the trauma care in Tennessee report. However, there was a movement serval months ago to address the Institutional Review Board again. We are looking with the help of Scott our rules attorney who has been instrumental in meeting with the Department of Health utilizing their IRB instead of the Commission creating their own. So, as these discussions continue, its my hope that we will have language February of 2025 that includes the registry and the IRB process. | | |
| | B. Dennis | So, what your saying is that there is currently not process that exists. | | |
| | R. Seesholtz | Not with the Commission, but with the Department of Health has | | |

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| | | an IRB. | | |
| | P. Fischer | As you know, we've been severely hamstringed on what we can actually use our registry for. The PI committee in the past has been, we can't compare outcomes from the east side of the state to the west side of the state secondarily to the fact that there's not that many trauma centers on the west side of the state, so you don't even know. I can't imagine anyone on the council will argue against kids doing better after a head injury. So, I think that you have our support, from that, I think that we have some significant work to do and this brings it forward, how we can actually use our data. Because again, I don't think anyone would be against our data to say, in 2023 we did a statewide initiative and in 2025 this is how we did. But we don't have any mechanism in which to do that at this time. Is there anything that I misspoke on, does that sound correct. But we are actively investigating ways to get that done. | | |
| | S. Faragher | So, right now the process is almost completely in place and essentially what will happen when new get a request we will review, obviously the privacy portion of it, we are still working on the schematics of this but essentially it will comes before you all and you'll discuss it and from that information we will go to their IRB which will include specifically for these requests related to us we will have someone like myself or Rob or someone will sit on that IRB review board to make sure part of that conversation is on how that works, after looking at everything when I was initially reviewing this possibility, I went through and discussed with the IRB for health what that looks like, what setting up one looks like, what the cost is. It just didn't make sense on the amount of requests, it would be overly laborious and cost inefficient, so it was a good way to do it, I think it will work out well for us and gives us that added layer of scrutiny to be able to have that protection in the IRB for the process itself. So anyway, we are working to get that done, we are at the conclusion of that to have that going forward. | | |

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| | W. Melvin | Is there a cost associated with sharing this data? | | |
| | R. Seesholtz | Just the time it takes to abstract that data. | | |
| | N. Flinchbaugh | Just to dovetail what Scott has told you, once we have the IRB interagency agreement in place we will create a policy. This council will have to approve that policy and it will also have to be approved by the full Commission. So, its not going to be an immediate process but we obviously didn't want to make a policy not to have an IRB in place with Health, so we are waiting on that final agreement to be signed. It has been transmitted to the general council over at the Department of Health. Once we get that back, the policy will be finalized and will be brought hopefully at the next meeting. I have our contract attorney checking on it now. Hopefully at your next meeting we will have a policy ready for you to approve and then it will be presented to the Commission for approval at the meeting after that. | | |
| | O. Bratton | When you talk about costs associated with obtaining the data, are you talking about the costs associated with us putting in the data to be reviewed or on the back end of pulling it? | | |
| | R. Seesholtz | If that request comes to our office and is not currently one of the reports that we generate currently and if we have difficulty abstracting that data the registry and have to enlist ImageTrend's assistance there would be costs associate with it, I think $175.00 per hour is the cost I believe. I know that when we were in discussions with Scott, what about the reports that you don't have created, and how easy or difficult is it, if we have to reach out there may be an additional cost. There may not be though, our agreement with ImageTrend is based on how many help tickets do you ask for in a calendar year. And at this point, when weve approached ImageTrend, they've said were good. That really doesn't do me any good as it doesn't give me an idea on how many help tickets to we have for the rest of the calendar year but, | | |

| TOPIC | SPEAKER | SUMMARY/DECISIONS | RECOMMENDATIONS/ ACTION | RESPONSIBLE PARTY |
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| | | we will see if we can nail that down a little bit firmer.<br><br>I would ask, if you have any idea of what data you are asking for, if its outside of the NTDB data set, we don't have that data. | | |
| | O. Bratton | We are at the very early planning stages of this. Trying to figure what our costs are, what do we already have in place, that were going to seek help for, so I think a lot of it is stuff that we already collect as trauma centers. We are hoping that it's a fairly easy, more conversation to be had. | | |
| | D. Kerley | I would say that it probably needs to be fixed at the level we are talking about so we can use statewide data, but at the same time do you think it would be possible that you could reach out to certain centers and collect data from them if they were in agreement with that? | | |
| | O. Bratton | I think the problem with that is everyone then has to do their own IRB's and overlapping and a lot of difficulty in sharing data as opposed as it coming out completely blinded as state data, cause our intent is to improve the state, not just one hospital or compare one hospital together, we are endeavoring this together. | | |
| | P. Fischer | I think this sounds like a perfect first project. We are also talking about our funding, and if we need to potentially carve out $10,000.00 per year to research budget, that may be something that we need to do. | | |
| | O. Bratton | We've already meet with the gentleman that spearheaded this in Arizona and they were very forthcoming in sharing their data points and how back in 2007 how they had to abstract everything manually and didn't have a database to pull from. | | |
| | N. Flinchbaugh | Good news from the contract attorney, Health has sent back a fully executed version of the IAA so you will have a policy to look at your next meeting. | | |

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| | P. Fischer | In terms of the shortest TCAC Chair in the history of the TCAC. This is my one and only meeting as TCAC Chair I will be leaving the state effective in January so thank you all, I've been on this council close to eight years probably. I want to thank the council and their time with me. It been my please and I apologize for serving only one session. I would like to congratulate Dr. Regan Williams who is the new TN COT Chair and TCAC Chair. She will be taking over as the TCAC Chair at the February meeting. | | |
| | B. Dennis | I have a question, does Dr. Williams pick up the duration of your term, is that how that works? Does hers reset, gets pushed back a quarter? | | |
| | P. Fischer | I don't know. We've never done this before, I think that it's the duration of my term. | | |
| | B. Dennis | Is that the same for others who fill in, who replace someone on the committee too? | | |
| b. Level III reps on the council | R. Seesholtz | The level III representatives on the council, their three years terms are expiring at this meeting. So, Dr. Reed and Dr. Melvin, I will be sending out an email to all of the level III Trauma Medical Directors for them to vote on who in that medical directors list will take over as level III voting members on the council for the next three years. | | |
| | P. Fischer | Yes, obviously we like to thank Dr. Reed and Dr. Melvin who have been integral and to the success of this committee. | | |
| c. 2025 TCAC Meeting Dates | R. Seesholtz | Tuesday February 18th<br>Friday May 30th<br>Friday August 8th in conjunction with the state trauma symposium at Paris Landing State Park<br>Friday November 14th | | |

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| | | I will investigate another date in February and will bet back to Dr. Burns by Monday, to the council by Tuesday. | | |
| | A. Kerwin | I would like for the council to recognize Dr. Fischer's tenure here as chair and his contributions to West Tennessee and at Regional One, UT and the tristate area for everything he's done in the last 8-9 years. | | |
| VIII. Adjourn | | Meeting was adjourned | | |