TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: April 10, 2023

VOTING MEMBERS PRESENT	(1) Paula Bergon (2) Oseana Bratton, RN (3) Bracken Burns, MD (4) Brian Daley, MD (5) Brad Dennis, MD (6) Peter Fischer, MD	(7) Amber Greeno, RN (8) Nick Howald (9) Darrell Hunt, MD (10) David Kerley (11) Robert Maxwell, MD (12) Brian Reed, MD	(13) Sullivan Smith, MD (14) Regan Williams, MD
VOTING MEMBERS ABSENT	(1) Dave Bhattacharya, MD (2) Reagan Bollig, MD	(3) Willie Melvin, MD (4) Monica Warhaftig, MD	(5) Consumer of trauma care (6) Level IV Medical Director
GUESTS	(1) Carrie Austin (2) Jennifer Beecham (3) Kara Bernard (4) Kathy Berrie (5) Alli Brogan (6) Helen Brooks (7) Saskya Byerly (8) Jim Christofferson (9) Theresa Day (10) Josh Dugal	(11) Nathaniel Flinchbaugh (12) Kay Garrett (13) Alexis Hess (14) Andrew Hopper (15) Bre Huhrn (16) Natasha Kurth (17) Kallie Lawrence (18) Terry Love (19) Wanda McKnight (20) Brian Metzger	(21) Brent Nix (22) Andrea Palmer (23) Habeeba Park (24) Jennifer Richards (25) Rob Seesholtz (26) Melissa Smith (27) Stephanie Spain (28) Caroline Tippens (29) Pam Vanderberg
NEXT MEETING DATES:	**2023** Friday July 28th – Fall Creek Falls State Park Friday November 17th – Nashville		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
Statute Rules	B. Daley	Required to have majority voting members present to have a quorum.	Roll call – Quorum present	
I. Approval of Minutes	B. Daley	Minutes from the February 11, 2023, TCAC meeting were presented for approval.	Minutes approved	Motion: Dr. Maxwell Second: Dr. Burns
		Motion and second for items not captured via audio at last meeting.	Items on pg. 6 from 2/11 minutes	Motion: Dr. Dennis Second: Dr. Fischer
			Items on pg. 7 from 2/11 minutes	Motion: Dr. Dennis Second: Dr. Hunt
			Items on pg. 9 from 2/11 minutes	Motion: Dr. Dennis Second: Dr. Burns
			Items on pg. 10 from 2/11 minutes	Motion: Dr. Dennis Second: Dr. Fischer
			Items on pg. 11 from 2/11 minutes	Motion: Dr. Fischer Second: Dr. Hunt
II. Old Business a. Trauma Fund/Updates	R. Seesholtz	1st quarters disbursement letters for eligible facilities went out and were dated for 4-6-23. Utilization of 2020 data for fund calculations. • 1st qtr. Total: $1,568,860.76	The question was asked by Dr. Dennis if there was a timeline for the expenditure of the newly allocated funds from the General Assembly (use it or lose it) and when those monies will be populated in the trauma fund HFC fiscal advises that there were no time bound requirements for the expenditure of the allocated 5 million and funds will remain in the trauma fund and not revert back to the general fund.	R. Seesholtz

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III. Subcommittee/Ad Hoc Committee Reports				
a. Registry	B. Dennis	Rob reported that all facilities are submitting trauma registry data timely and with mid 90's validation scores. Australia vs. Alabama registry issues have been resolved. At the request of members, a survey was sent to facilities asking who has AIS 15 training. Of the 13 centers responding, 7 responded no & 6 responded yes. Regarding AIS 15 upgrades, Rob spoke with ImageTrend and was advised that since we do not have centers abstracting charts using direct entry (we import only), centers moving from AIS 08 to 15 will have no impact on the state registry.		
b. IP / Surveillance	T. Love	Overview of injury prevention efforts within the Department of Health, i.e. injury prevention core grant priorities: • Child safety seats • Checkpoints parent teen driving program • Safe Stars Initiative • Trauma informed workplace program		
c. System Development/ Outreach	B. Daley	Trauma symposium will occur at Fall Creek Falls State Park on Thursday July 27th and the TCAC meeting will commence the following day Friday July 28th.	Speakers for the symposium are being solicited and a draft agenda is being worked on. Dr. Daley presented on the speakers that are currently scheduled to	

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			speak.	
d. PI/Outcomes		No Report		
e. CECA	N. Kurth	N. Kurth provided an update on CECA's activities: • Star of Life @ Farm Bureau Expo in Lebanon TN on May 4th, 2023 • Pediatric transport devices are being distributed. • Reminder council of educational offerings on the CECA website.		
f. Legislative	B. Daley	Helmet bill SB1450/HB0042 (Roberts/Reedy) has been withdrawn.		
	S. Smith	Update on the EMS Boards vacation and repopulation.		
g. Finance		Since the move to the HFC, it was recommended that the council vote again on the system development memo that was approved in 2015 by then Department of Health Commissioner John Dreyzehner.	The council voted that $300,000.00 of the trauma fund be allocated in the following manner: • $100,000.00 for strategic planning for the further/future development of Tennessee's trauma system • $100,000.00 for a multidisciplinary state trauma conference. This conference will provide continuing education units/CMEs • $100,000.00 for the education of medical professional responsible for providing care to traumatically injured Tennesseans and visitors to the state.	Motion: Dr. Fischer Second: Dr. Hunt
IV. New Business				

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a. Readiness Costs	R. Seesholtz	• This survey is not an audit. • Important for facilities to be engaged in providing requested data for survey. • Georgia's survey to be used as starting point. • Ad hoc committee for survey work. • In Georgia, surveys were accepted on what data the centers provided. • Survey will evaluate self-reported costs, will validate reported results via contracts, invoices etc. • Survey be based on, orange book, state criteria TBT. • Once survey is finalized, webinars are to be conducted for participants	Reminder of the requirements of needing to sunshine the ad hoc committee meeting.	C. Tippens
b. Rule Revision	Dr. Fischer	Inquired about previous discussions related to pediatric trauma centers and the concerns regarding CoPEC being disbanded as pediatric rules have not been through the rule making process. Who will own the responsibility of pediatric trauma care?	Jim Christoffersen spoke to this and advised that rules will go through normal process once decisions are made regarding the restructuring of CoPEC. The TCAC does not having the responsibility to weigh in on pediatric trauma. Nathaniel Flinchbaugh will reach out to the AG's office for an opinion. Dr. Smith reported on the EMS Boards membership endorsement of CoPEC.	
	B. Daley/R. Seesholtz	Language that remains the same is in green and any change/point for discussion is highlighted in yellow. (i) Programs for Quality Assurance (i) 1. Programs for Quality Assurance: Medical Care Education	No language change for #1	

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		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for all levels. The institution must provide resources to support the trauma process improvement program	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for all levels, the trauma PIPS program must be independent of the hospital or departmental PI program, but it must report to the hospital or departmental PI program	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for level I, II, & III's. Desired (D) for level IV's. All trauma centers must have a written PIPS plan that: • Outlines the organizational structure of the trauma PIPS process, with a clearly defined relationship to the hospital PI program • Specifies the processes for event identification. As an example, these events may be brought forth by a variety of sources, including but not limited to: individual personnel reporting, morning report or daily signouts, case abstraction, registry surveillance, use of clinical guideline variances, patient relations, or risk management. The scope for event review must extend from prehospital care to hospital discharge. • Includes a list of audit filters, event review, and report review that must include, at minimum, those listed in the **Resources section.** • Defines levels of review (primary, secondary, tertiary, and/or quaternary), with a listing for each level that clarifies:	

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			○ Which cases are to be reviewed ○ Who performs the review ○ When cases can be closed or must be advanced to the next level • Specifies the members and responsibilities of the trauma multidisciplinary PIPS committee • Outlines an annual process for identification of priority areas for PI, based on audit **Resources:** Audit filters, event or report reviews: • Surgeon arrival time for the highest level of activation • Delay in response for urgent assessment by the neurosurgery and orthopaedic specialists • Delayed recognition of or missed injuries • Compliance with prehospital triage criteria, as dictated by regional protocols • Delays or adverse events associated with prehospital trauma care • Compliance of trauma team activation, as dictated by program protocols • Accuracy of trauma team activation protocols • Delays in care due to the unavailability of emergency department physician (Level III) • Unanticipated return to the OR • Unanticipated transfer to the ICU or	

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			intermediate care • Transfers out of the facility for appropriateness and safety • All nonsurgical admissions (excludes isolated hip fractures) • Radiology interpretation errors or discrepancies between the preliminary and final reports • Delays in access to time-sensitive diagnostic or therapeutic interventions • Compliance with policies related to timely access to the OR for urgent surgical intervention • Delays in response to the ICU for patients with critical needs • Lack of availability of essential equipment for resuscitation or monitoring • MTP activations • Significant complications and adverse events • Transfers to hospice • All deaths: inpatient, died in emergency department (DIED), DOA • Inadequate or delayed blood product availability • Patient referral and organ procurement rates • Screening of eligible patients for psychological sequelae	

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			• Delays in providing rehab services • Screening of eligible patients for alcohol misuse • Pediatric admissions to nonpediatric trauma centers • Neurotrauma care at Level III trauma centers • Neurotrauma diversion	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for all levels. Must have a performance improvement coordinator dedicated to the trauma program. 0.5 FTE when annual volume exceeds 500 patients. 1 FTE when annual volume exceeds 1,000 pt. entries	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Must have a Trauma Performance Improvement Committee that meets at least quarterly and includes physician liaisons from the following services: Orthopedics, Radiology, Anesthesia, Emergency Medicine, Neurosurgery, Geriatric, and core Trauma surgeons as well as Nursing, pre-hospital personnel and other healthcare providers which review policies and procedures, system issues, and whose members or designees attend at least 50% of regular meetings. The Trauma Medical Director must attend at least 60 percent of regular Trauma Performance Improvement Committee meetings. Attendance cannot be delegated to the associate Trauma Medical Director The committee shall:	

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		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Delete the following language: • Identify discretionary and non-discretionary audit filters • Document and review times and reasons for trauma related diversion of patients from the scene or referral hospitals • Document and review response/consult times for trauma surgeons, neurosurgeons, anesthesia, and orthopedists, all of whom must demonstrate 80% compliance • Document and review response/consult times for trauma surgeons, anesthesia, and orthopedists, all of whom must demonstrate 80% compliance • Review pre-hospital trauma care to include patients dead on arrival • Review times and reasons for transfer of injured patients • The institution shall demonstrate that action taken as a result of issues identified in the Process Improvement Program created a measurable improvement. Documentation shall include where appropriate: 1) problem identification; 2) analysis; 3) preventability; 4) action plan; 5) implementation; and 6) reevaluation	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for level I & II's Desired (D) for level III's. Monitor team notification times. For highest level of activation trauma attending must be present within 15 minutes of patient arrival 80% of the time	

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			Essential (E) for level III's. Monitor team notification times. For highest level of activation trauma attending must be present within 30 minutes of patient arrival 80% of the time	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Delete the following language: The institution shall demonstrate that action taken as a result of issues identified in the Process Improvement Program created a measurable improvement. Documentation shall include where appropriate: 1) problem identification; 2) analysis; 3) preventability; 4) action plan; 5) implementation; and 6) reevaluation	
		(i) 2. Programs for Quality Assurance: Trauma Process Improvement (PI)	Essential (E) for level's I, II, & III, Desired (D) for level IV's. All trauma centers must have documented evidence of event identification; effective use of audit filters; demonstrated loop closure; attempts at corrective actions; and strategies for sustained improvement measured over time.	
		(i) 3. Programs for Quality Assurance: Operational Process Improvement (Evaluation of System Issues)	No language change for #3.	
		(i) 4. Programs for Quality Assurance: Trauma Bypass/Diversion Log	Delete the following language: Trauma bypass/diversion shall not exceed 5%. Trauma surgeons shall be involved in bypass/diversion decisions. All bypass/diversions shall be reviewed	

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		(i) 4. Programs for Quality Assurance: Trauma Bypass/Diversion Log	Essential (E) for all levels. All trauma centers must not exceed 400 hours of diversion during the reporting period (1 year - add reporting period in definitions)	
		(i) 5. Programs for Quality Assurance	Essential for levels I, II, & III, Desired (D) for level IV's. All trauma centers must have evidence-based clinical practice guidelines, protocols, or algorithms that are reviewed at least every three years	
		(i) 6. Programs for Quality Assurance	Essential (E) for level I & II centers, Desired (D) for level III centers. Level I and II trauma centers must have the following protocols for care of the injured older adult: • Identification of vulnerable geriatric patients • Identification of patients who will benefit from the input of a health care provider with geriatric expertise • Prevention, identification, and management of dementia, depression, and delirium • Process to capture and document what matters to patients, including preferences and goals of care, code status, advanced directives, and identification of a proxy decision maker • Medication reconciliation and avoidance of inappropriate medications • Screening for mobility limitations and assurance of early, frequent, and safe mobility • Implementation of safe transitions to	

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			home or other health care facility	
		(i) 7. Programs for Quality Assurance:	Essential (E) for all levels. All trauma centers must have a process in place to assess children for nonaccidental trauma	
		(i) 8. Programs for Quality Assurance:	Essential (E) for all levels. All trauma centers must have a rapid reversal protocol in place for patients on anticoagulants	
		(i) 9. Programs for Quality Assurance:	Essential (E) for all levels. In all trauma centers, the emergency department must evaluate its pediatric readiness and have a plan to address any deficiencies	
		(i) 10. Programs for Quality Assurance:	Essential (E) for levels I, II, & III. Trauma centers must have treatment guidelines for, at minimum, the following orthopedic injuries: • Patients who are hemodynamically unstable attributable to pelvic ring injuries • Long bone fractures in patients with multiple injuries (e.g., time to fixation, order of fixation, and damage control versus definitive fixation strategies) • Open extremity fractures (e.g., time to antibiotics, time to OR for operative debridement, and time to wound coverage for open fractures) • Hip fractures in geriatric patients (e.g., expected time to OR)	
		(i) 11. Programs for Quality Assurance:	Essential (E) for levels I, II, & III. In trauma centers, an orthopedic surgeon (resident, APP, trauma surgeon with ortho	

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			privileges) must be at bedside within 30 minutes of request for the following: • hemodynamically unstable, secondary to pelvic fracture • suspected extremity compartment syndrome • fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus) • vascular compromise related to a fracture or dislocation • trauma surgeon discretion The orthopedic surgeon must be involved in the clinical decision-making for care of these patients Move #11 up to page 2 (ortho). In addition, add this sentence to neurosurgery as well. Add: Neurosurgery attending must be involved in the clinical decision making. at beginning to neuro.	
		(i) 12. Programs for Quality Assurance:	Essential (E) for levels I, II, & III. Trauma centers must meet the rehabilitation needs of trauma patients by: • Developing protocols that identify which patients will require rehabilitation services during their acute inpatient stay • Establishing processes that determine the rehabilitation care, needs, and services required during the acute inpatient stay • Ensuring that the required services during acute inpatient stay are provided in a timely manner	

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		(i) 13. Programs for Quality Assurance:	Essential (E) for levels I, II, & III. Rehabilitation and discharge planning. Trauma centers must have a process to determine the level of care patients require after trauma center discharge, as well as the specific rehabilitation care services required at the next level of care. The level of care and services required must be documented in the medical record	
		(i) 14. Programs for Quality Assurance:	Essential (E) for levels I & II. Trauma centers must meet the mental health needs of trauma patients by having: • A protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider Essential (E) for level III's. Trauma centers must meet the mental health needs of trauma patients by having: • A process for referral to a mental health provider when required	
		(i) 15. Programs for Quality Assurance:	Essential (E) for level's I, II, & III. Desired (D) for level IV. Alcohol misuse screening. Trauma centers must screen all admitted trauma patients greater than 12 years old for alcohol misuse with a validated tool or routine blood alcohol content testing. Programs must achieve a screening rate of at least 80 percent Essential (E) for level's I, II, & III. Desired (D) for level IV. Alcohol misuse intervention. In trauma centers, at least 80	

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			percent of patients who have screened positive for alcohol misuse must receive a brief intervention by appropriately trained staff prior to discharge. This intervention must be documented. Level III trauma centers must have a mechanism for referral if brief intervention is not available as an inpatient	
		(i) 16. Programs for Quality Assurance:	Essential (E) for level's I, II, & III. Trauma centers must have a written data quality plan and demonstrate compliance with that plan. At minimum, the plan must require quarterly review of data quality	
		(i) 17. Programs for Quality Assurance:	Essential (E) for level's I, II, & III. Desired (D) for level IV. Trauma centers must participate in a risk-adjusted benchmarking program and use the results to determine whether there are opportunities for improvement in patient care and registry data quality	
		(i) 18. Programs for Quality Assurance:	Essential (E) for level's I, II, & III. Desired (D) for level IV. In trauma centers, all nonsurgical trauma admissions must be reviewed by the trauma program. Nonsurgical admissions (NSA) without trauma or other surgical consultation, with ISS > 9, or with identified opportunities for improvement must, at a minimum, be reviewed by the TMD in secondary review	
		(j) System Development	No language change for #1 thru #4. Essential (E) for level's I, II, & III, Desired (D) for level IV.	

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		(k) 1. Injury Prevention	No language change for #1. Essential (E) for level's I, II, & III. Desired (D) for level IV.	
		(k) 2. Injury Prevention	Essential (E) for level's I & II. Desired (D) for level III. Perform studies in injury control while monitoring the effects of prevention programs Implement at least 2 activities over the course of the designation cycle with specific objectives and deliverables that address separate major causes of injury in the community (define designation cycle)	
		(k) 3. Injury Prevention	No language change for #3. Essential (E) for level's I & II. Desired (D) for level III & IV.	
		(i) 1. Institutional Commitment	No language change for #1.	
		(i) 2. Institutional Commitment	No language change for #2.	
		(i) 3. Institutional Commitment	No language change for #3.	
		(i) 4. Institutional Commitment	Essential (E) for level I. Desired (D) for level II. Hospital administration must demonstrate support for research efforts of the Trauma Service	
		(i) 5. Institutional Commitment	Delete existing language. Essential (E) for level I. Must demonstrate the following scholarly activities during the designation cycle: • At least 10 trauma-related research articles	

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			• Participation by at least one trauma program faculty member as a visiting professor, invited lecturer, or speaker at a regional, national, or international trauma conference • Support of residents or fellows in any of the following scholarly activities: laboratory experience; clinical trials; resident trauma paper competition at the state, regional, or national level; and other resident trauma research presentations	
		(m) 1. Activation Criteria	Essential (E) for level's I & II. Each center shall have clearly defined graded activation criteria. For the highest level of activation, the trauma team (trauma Chief resident: PGY4/5 or ED attending) shall be immediately available and the trauma attending available with 15 minutes of patient arrival	
		(m) 2. Activation Criteria	Essential (E) for level III. For the highest level of activation for level III centers, the trauma attending shall be available within 30 minutes of patient arrival, unless the patient is immediately being transferred to a higher level of care	
		(n) Disaster Preparedness	No language change for #1	
		(n) Disaster Preparedness	Essential (E) for level I, II & III. A trauma surgeon from the trauma panel must be a part of the disaster planning committee	
		(n) Disaster Preparedness	Essential (E) for level I. Ortho trauma	

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			surgeon from the trauma panel must be a part of the disaster planning committee	
		(n) Disaster Preparedness	Essential (E) for level I, II & III. All trauma programs must participate in 2 hospital drills/exercise per year	
		(n) Disaster Preparedness	Essential (E) for level I. Surgeon liaison to disaster committee must complete DMEP course at least once	
		(3)(a) 1. References	In Level I and Level II trauma centers, if cardiopulmonary bypass equipment is not immediately available, a contingency plan, including immediate transfer to an appropriate center and 100 percent performance improvement review of all patients transferred, must be in place.	
		(3)(a) 2. References	This requirement may be substituted by a department or division capable of treating maxillofacial trauma as demonstrated by staff privileges	
		(3)(a) 3. References	This requirement may be substituted by a current signed transfer agreement with an institution having a Pediatric Surgery Service.	
		(3)(a) 4 thru 18 References	No language change for #4 thru #18	
		(4)(a) Designation	No language change	
		(4)(b) 2 Designation	Replace Department of Health language with Commission language	

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		(4)(b) 3 thru 5 Designation	No language change #3 thru #5	
		(4)(c) 1 thru 3 Designation	No language change #1 thru #3	
		(4)(c) 4 Designation	Replace state trauma program manager/EMS director with state trauma system Director/Asst. Director	
		(4)(d) 1 & 2 Designation	No language change #1 and #2	
		(4)(d) 3 Designation	Replace state trauma program manager/EMS director with state trauma system Director/Asst. Director	
		(4)(e) 1 & 3 Designation	No language change #1 and #3	
		(4)(e) 2 Designation	Replace state trauma program manager/EMS director with state trauma system Director/Asst. Director	
		(4)(f) 1 & 2 Designation	Replace state trauma program manager/EMS director with state trauma system Director/Asst. Director	
		(4)(g thru q) Designation	No language change g thru q	
		(5)(a thru i) Verification	No language change a thru i	
		(6)(a & b) Disciplinary Action	No language change a & b	
		(7)(a thru c) Prohibitions	No language change a thru c	
		Site review team for level I & II centers	The review team (for level I & II centers) must consist of one out-of-state surgeon, one in-state surgeon (one of which must be a TMD) and TPM from a level I center. If	

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			the out of state surgeon is not available, he/she may be substituted by an in-state surgeon from a level I or II center from a different grand division at the discretion of the center being reviewed.	
		Site review team for level I & II centers	Level III site review team shall consist of TMD from an in-state level I or II center and TPM from a level I center.	
		Rob asked for guidance on during site reviews how many essential items need to be identified as deficient before a focused visit is required? Reviewer discretion per the council with consultation with Trauma System Director.	C. Tippens recommended to look at defining deficiencies and to look at prior board president.in where essential items were deficient. Then create interpretative guidance to help guide site reviewers.	
		Rob asked if the addition of nurse reviewer for ACS verification visits should be required for Tennessee.	No per the council.	
			Motion to accept all rules as discussed.	Motion: Dr. Hunt Second: Dr. Dennis
V. Adjourn		Meeting was adjourned		