

**TRAUMA CARE ADVISORY COUNCIL  
MINUTES**

**Date: August 2, 2024**

<b>VOTING MEMBERS PRESENT</b>	(1) Reagan Bolig, MD (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) Darrell Hunt, MD	(9) David Kerley, RN (10) Robert Maxwell, MD (11) Natalie Whitmer (12) Regan Williams, MD
<b>VOTING MEMBERS ABSENT</b>	(1) Paula Bergon (2) Dave Bhattacharya, MD (3) Steve Hamby	(4) Willie Melvin, MD (5) Brian Reed, MD (6) Level IV Medical Director	(7) Consumer of trauma care
<b>GUESTS</b>	(1) Muyinea Adedokun (2) Jennifer Beecham (3) Kathleen Berrie (4) Sheree Bray (5) Helen Brooks (6) John Carr (7) Theresa Day (8) Jared Dooley (9) Josh Dugal (10) Amber Estes (11) Nathaniel Flinchbaugh (12) Lucas Flowers (13) Logan Grant	(14) Andrew Holt (15) Andrew Hopper (16) Bart Iddins (17) McKenzie Karup (18) Andy Kerwin (19) Kyle Lange (20) Jeff Levine (21) Bryan Metzger (22) Renee Mills (23) Erica Neisser (24) Brent Nix (25) Andrea Palmer (26) Habeeba Park	(27) Emily Parker (28) Mayur Patel (29) Sierra Preston (30) Keelin Roche (31) Angie Scissom (32) Stephanie Scott (33) Rob Seesholtz (34) Lou Smith (35) Melissa Smith (36) Stephanie Spain (37) Kennedy Toban (38) Debi Tuggle (39) Regina Young
<b>NEXT MEETING DATES:</b>	<b>2024</b> Friday November 8 <sup>th</sup> – Nashville		

TOPIC	SPEAKER	SUMMARY/DECISIONS	RECOMMENDATIONS/ ACTION	RESPONSIBLE PARTY
I. Statute Rules	B. Daley	Required to have majority voting members present to have a quorum.	Roll call – Quorum present	
New member on the council	R. Seesholtz	We have a new member on the council, Natalie Whitmer. She comes to us from Skyline Medical Center as the Chief Operating Officer and was recommended to the council from the Tennessee Hospital Association as the hospital administration rep. on the council.		
II. Approval of Minutes	B. Daley	Minutes from the April 2, 2024, Trauma Care Advisory Council (TCAC) meeting were presented for approval.	Minutes approved	
III. Legislative Update	L. Grant	<p>Appreciative of the council for allowing me to present on what we've done this year legislatively.</p> <ul style="list-style-type: none"> <li>• Changes were made with Council on Pediatric Emergency Care (CoPEC). They were previously a state entity and subject to open meeting rules. They were recognized in statute and are now an independent non-government agency and can now meet virtually.</li> <li>• The statute was silent previously on who made appointments to the TCAC. So, it was put in statute that they are appointed by me. We have no plans to make any changes with who's on the council and appreciate all the work that you all have done over the years.</li> <li>• We were hopeful that the folks lobbying in favor for additional money for the trauma fund would be successful however, as many of you may have heard, late last year the Lee administration learned that they had to make tax cuts for legal reasons, so no one received anything. It was a tough year budget wise. Our revenues are coming in at the projected levels and expect revenues to be pretty flat this year, with that being said we will still support those that are lobbying in favor of additional funds for the trauma fund. We really appreciated your efforts, especially those from</li> </ul>		

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IV. Finance Subcommittee Report	B. Burns	<p>the finance subcommittee on coming up with a plan on how to use these funds as efficiently as possible and we are here to support the good work you are doing. I would be happy to answer any questions.</p> <p>The finance subcommittee met prior to this meeting. Some background information, the state trauma fund currently has three buckets that money comes into, one bucket goes to providing the operational side of running the state trauma system, one bucket goes into a fund that is for readiness costs for trauma centers and one bucket goes into uncompensated care.</p> <p>The money that comes in comes from two sources, one established back in 2007 and is a 2-cent tax on every pack of cigarettes sold in the state of Tennessee. That has steadily declined over the years since its inception, originally being around \$12-\$13 million dollars, that's now down to roughly \$7million dollars as year. And the other, granted to us by the state a couple of years ago is a yearly appropriation of \$5 million dollars. So roughly we have a state trauma fund somewhere around \$12 million per year as our current state. With that as background, our discussion today was about how that money should be distributed compared to how it is currently distributed which is based on the decision that were made back in 2007. What we would like to put forward from the finance subcommittee for today is informational items. We will write this out as a one-page executive summary and everyone can take that back, look at it and discuss at their institutions. Our hope would be then at the next TCAC meeting we would put this forward as a proposal that could be voted upon if decided. So no proposed action, just taken on information today.</p> <p>So, what we discussed as a group is the operational side will always come out before the state trauma fund allocations are</p>		

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		<p>available to trauma centers. What we are recommending is a defined split in the remainder of those funds with 80 percent going to readiness cost and 20 percent going to uncompensated care. As a point of information, there is no defined number as to how that split is percentage wise previously, but if you look at the allocations last year, it was roughly 60 percent in readiness costs and 40 percent in uncompensated care. So, it's shifting the needle towards readiness cost side of things. The state of Tennessee undertook a readiness survey of all the trauma centers to figure out how much it costs to be a trauma center in the state of Tennessee. We fashioned this off of a study that was done in the state of Georgia a number of years ago and those numbers are quite staggering with soon to be six level I trauma centers and an estimated readiness cost of over \$20 million dollars a year. Just to fund six level I trauma centers would be over \$120 million dollars a year and the state trauma fund is \$12 million. When we start talking about these numbers, it's only going to be a fraction of the cost of what we all do in providing care to the citizens of Tennessee.</p> <p>What we put forward is a new formula for readiness costs of which I'll speak to in a minute, for the uncompensated care formula, that formula was put in place in 2007 and that formula would stay as is for the 20 percent of available funds. For the other 80 percent of the funds, Dr. Fischer has created the "Fischer Formula" which was discussed in detail. The way the formula works, is that 80 percent that goes into readiness costs would be divided by the number of trauma centers that are in the state based on a formula where a level II trauma center equals X. X is a variable number depending on how many dollars go into that 80 percent. Along those lines, a level I trauma center would get 2 times X, a level II trauma center would get X, a level III center would get one-half of X, a level IV center would get one-quarter of X, and a CRPC would get X.</p>		

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	<p>P. Smith</p> <p>B. Burns</p> <p>L. Grant</p>	<p>As part of that discussion, we felt that being a level I trauma center was being a level I trauma center, so whether that is state designated or ACS verified and whether that is pediatric or whether that's adult, those centers would be factored in, basically, a level I center is a level I center. So that is our informational report as to what we are going to propose to maybe bring back the next time, we will probably have a finance subcommittee before the next TCAC meeting to see if there are any revisions and then see if we can move it forward.</p> <p>I remember last year that there was some discussion of the collection of tax money on vaping and understand that vaping products are going down.</p> <p>We discussed this as part of the finance subcommittee. The purview of the finance subcommittee and the TCAC is to utilize and dispense the funds that are available to us. We do have an opportunity as a Tennessee Committee on Trauma (COT) to discuss and perhaps use the data available to try to appeal to the legislature for more money, but that is not the purview of what we can do as the TCAC. So, I would expect the COT to have some discussion.</p> <p>I can tell you in speaking to some of the lobbyists who are working on securing more funding, that is something that they are working on, they are having those conversations with the administration and the Department of Revenue on how they can go about that. I haven't had an update from them in the past several months on how that's looking, I think right now a lot of folks are kind of in election mode, but once the elections are over I think that that's, I can tell you that's ongoing and it hasn't been forgotten, its just sometimes it takes a little time to get everybody on the same page with <b>inaudible</b> increases. So, I just wanted everyone to know that people are still working on that.</p>		

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V. Trauma Fund Report  VI. Subcommittee/Ad Hoc Committee Reports  a. Registry	Unknown speaker	Is there a requirement to have the uncompensated care in with this?		
	B. Burns	We did not think that it is in statute that there is a requirement that was put in place at the time of the initial funding disbursement it was put there and we looked to make sure that there wasn't a set percent or anything like that and what we've seen over the years that it has decreased because as we've said readiness costs have been a fixed number, as the fund has decreased uncompensated care has decreased, and so, we decided as a group to put this information forward to recommend an 80/20 split.		
	R. Seesholtz	Uncompensated care is mentioned in state statute or state law. And to piggyback onto Dr. Burns statements, in approx. 2 week I will create a single information page based on the discussion on the Fischer formula.		
	P. Fischer	Rob, I'm happy to help you with this but I do think that in that report it would be, based on that last full year of data if we looked at each hospital what they received in readiness costs and uncompensated care and what they would receive under the new formula in readiness costs and uncompensated care so that you can take to your administrators.		
	R. Seesholtz	3 <sup>rd</sup> quarter disbursement calculations are complete with 1,292,866.59 being disbursed and letters dated for 5-31-24.		
	B. Dennis	A couple of items that need to be discussed regarding the state registry. The first one is the additional of a mechanism of injury classification for "sports" related injury, the second is which patient identifiers that we need and don't need and I		

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	<p>R. Seesholtz</p> <p>R. Bolig</p> <p>R. Seesholtz</p> <p>B. Dennis</p> <p>R. Seesholtz</p> <p>B. Dennis</p> <p>R. Seesholtz</p>	<p>think the big one is social security number which is being submitted for each patient, and we wanted to have a discussion on being more deidentified.</p> <p>The's correct, most of the patient demographics are capture in the registry to include full social security number. The purpose being that was the potential to link data sets, the injury surveillance system, and others. That has not come to fruition and with the increase in data breaches within healthcare systems I felt that this was a great opportunity to discuss with the council to either remove the social security number in its entirety or to allow the last four of the social security to be allowed for submissions.</p> <p>Does that add any value to anything we do with that information?</p> <p>No</p> <p>Physician office/urgent care was an injury location that was retired by ESO.</p> <p>On of the registrars had reached out and advised that ESO had removed that field. That doesn't mean that we can't require it, however I was unable to generate a registry report that showed how patients centers received from a physician's office/urgent care. I would assume that number would be relatively small or non-existent for some institutions but wanted to offer that up for any discussion.</p> <p>I guess my question related to that would be free standing ER's and if that is a separate category, Melissa is telling me yes.</p> <p>The data dictionary was forwarded to TCAC voting members as well as participants on the TCAC. I put together the draft</p>		

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<p>b. IP / Surveillance</p> <p>c. System Development/ Outreach</p> <p>d. PI/Outcomes</p>		<p>data dictionary without all the definitions associated with the NTDS data set. A hyperlink was put in for those wanting to see definition specifics for the NTDS data set. I would respectfully request the approval of this document in addition to the removal of the social security number in its entirety, the addition of sports as an injury mechanism field element and the potential removal of the physician office/urgent care as a injury location field element.</p>	<p>Ayes heard in the room, no nays to the motion heard. Motion approved.</p>	
	B. Dennis	That is my motion.		
	B. Burns	Second		
	B. Daley	Any further discussion? All in favor? Any opposed?		
	P. Fischer	I'm out of order, I have to leave but wanted to thank Rob and Dr. Daley for all of their hard work with the trauma symposium yesterday.		
	B. Daley	Also out of order, I will be leaving as chair of the TCAC Committee on Trauma and Dr. Fischer will be the new chair.		
	T. Love	Expresses regrets.		
B. Daley	<p>I think Dr. Fischer provided great insight, over 140 attendees, a robust demonstration of the great trauma care and research that's occurring in our state at both the prehospital and hospital level. Some insightful comments on the next phase of care from Dr. Zarzaur from Wisconsin, a former TCAC/COT chair. A robust program, if anyone has ideas on how to demonstrate what they are doing at their centers please contact the new TCAC/COT chair.</p>			
R. Bolig	Historically we've been relying a lot on our TQIP			

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e. CECA	R. Williams	<p>collaborative/TTACO data for outcomes, for those of you that are not familiar with it, there are three big categories to look at risk adjusted mortality, risk adjusted hospital events, and then those are combined into a risk adjusted hospital events that include death. We have been relatively stable ever since we started the collaborative with a high mortality overall but relatively few complications.</p> <p>This last report from the spring, while we aren't high outliers, per se, we are towing the line on some of those especially with penetrating and now hip fracture mortality, which historically has been pretty low, the last two reports there is a 30-40% increase in that since 2022 with a 15-20% in penetrating over the last year, so that's driving our risk adjusted, major hospital events and to include death right at being a high outlier for those two cohorts. I'm going to be in touch with some facilities, I think we can drill into that. I'm not sure the reason for that data anomaly, with these reports it takes a couple cycles to really make sure its valid. That's the bad news. On the good side, for the last couple of years we've been having discussions at our TTACO meetings regarding CAUTI's. I'm happy to say that since 2022 when we had an odds ratio of almost 2.1, it has dropped below 60% and is now below 1 at 0.8. We are doing a good job with that.</p> <p>There was a fireside chat about a week ago with Dr. Giles and we discussed cerebral vascular injury and what the different centers do for that and at that time I made a request for folks to send in their guidelines/protocols on how they work those patients up and identify who's at risk, so I am going to send out a formal request for that information shortly.</p> <p>Our legislative change went through, and I think that it is pretty much approved where we are no longer a state organization, but rather an organization that is mandated in statute but supported by a non-profit. We will be able to do</p>		

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VII. New Business	M. Smith	<p>our work a little bit easier and continue the great work that were doing. A couple of updates:</p> <ul style="list-style-type: none"> <li>• Our pediatric facility rules that outline pediatric trauma centers have been signed by the Governor and are going through a final Attorney General review. Once that is finished, they'll be posted on their website for 90 days and then they'll come back to us and then we can move forward with how were going to verify pediatric trauma centers in the state.</li> <li>• Our CECA conference will be on April 10<sup>th</sup> here in Chattanooga at the Tennessee Aquarium and invite everyone to come. If you are interested in giving a talk, visit the CECA website, these a form to fill out and we welcome anyone to come talk and share their pediatric knowledge with EMS and other providers across the state.</li> <li>• Last, we have a pediatric safety transport device project so if you were here yesterday for the symposium, I talked about pediatric readiness and the importance of having a PECC which is a pediatric emergency care coordinator. If you know anyone who wants to have a PECC and doesn't have one, we are happy to help with that. If EMS agencies have a PECC, then we are providing pediatric transport devices for their ambulances, and if anybody is aware of any funding to help us continue to allow that program to grow please let us know.</li> </ul> <p>As some of you may or may not know, we have been missing a voting member of the council, the consumer of trauma care for approx. 3 years now and I wanted to bring forth a potential candidate who was a former trauma patient and was seriously injured when a tree fell, he had pelvic injuries, a brachial plexus injury etc. In 2022 he became an active member of our trauma survivors network. I reached out to see if this was something that he would be interested in, and he whole heartedly said yes. I wanted to bring him before the committee.</p>		

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	B. Daley	So, as our director has just told us, we can make a recommendation. So, if there is a motion, we can as a council vote on that and pass that on to our director for appointment.	Motion in favor: B. Burns & seconded. None apposed	
A. Greeno	I recently received a response to one of my ME (medical examiner) requests from the ME's office, and apparently there is a bill that was signed by Governor Lee that says any pediatric patient or minor that is a victim of violence, and the suspect is a caregiver or legal guardian, then we cannot get access to that ME report. So, I was hoping that the council would advocate to have an amendment to that to where we as trauma centers can still receive ME reports on minors, that are victims of death by a legal guardian.			
R. Seesholtz	Why do you need this information?			
A. Greeno	One, it's one of the requirements for ACS for you to have your ME reports, two, its good for our loop closure to know exactly how that child died. If they present to our ED and they die when they arrive there, they don't get scanned, we have no idea what their injuries were, could we have done something differently. Its more about learning from the patients. It also affects your registry and TQIP numbers with a death and no associated ISS score. I think that as a council for the state we could advocate for that, Its not that were pursuing anything with it or passing this information on.			
L. Grant	I think a great way to proceed, to get some questions answered as to why the bill was passed, what the intent was, whether or not this conflicts with that, If I could get a quick summary of what you need the information for and how it would benefit patients then I can talk to administration, figuring where the bill came from and do some front end work to see if this is something that we can fix.			
A. Greeno	It's house bill 1695			

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VIII. Adjourn	R. Seesholtz	Amber, can you forward me some of those recommendations, rational for needing this information so I can pass that information on to Mr. Grant?		
	L. Grant	Yes, and then I can run this up the flagpole through the General Assembly and see what the reception is and report back to you all on what I've heard.		
	B. Daley	And I think independent of TCAC, the COT can be requested to act on this as well.		
	R. Seesholtz	Rob presented Dr. Daley with a certificate of appreciation for his work in serving as the TCAC chair.		
		Meeting was adjourned		