TRAUMA CARE ADVISORY COUNCIL
MINUTES
Date: November 17, 2023

VOTING MEMBERS PRESENT	(1) Paula Bergon (2) Dave Bhattacharya, MD (3) Reagan Bollig, MD (4) Oseana Bratton, RN (5) Bracken Burns, MD (6) Brad Dennis, MD	(7) Brian Daley, MD (8) Peter Fischer, MD (9) Amber Greeno, RN (10) Nick Howald (11) Darrell Hunt, MD (12) David Kerley	(13) Brian Reed, MD (14) Regan Williams, MD
VOTING MEMBERS ABSENT	(1) Robert Maxwell, MD (2) Willie Melvin, MD	(3) Monica Warhaftig, MD (4) Consumer of trauma care	(5) Level IV Medical Director
GUESTS	(1) Jennifer Beecham (2) Kara Bernard (3) Lacy Blair (4) Alli Brogan (5) Jim Christofferson (6) Anissa Cooper (7) Theresa Day (8) Amber Ditmore	(9) Josh Dugal (10) Gina Felts (11) Nathanial Flinchbaugh (12) Lucas Flowers (13) Logan Grant (14) Wanda McKnight (15) Renee Mills (16) Brent Nix	(17) Anita Perry (18) Rob Seesholtz (19) Melissa Smith (20) Stephanie Spain (21) Caroline Tippens (22) Stefanija Weaver
NEXT MEETING DATES:	**2024** TBA		

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 July 28, 2023, TCAC meeting were presented for approval.	Minutes approved	Motion: Dr. Dennis Second: Dr. Hunt
II. Old Business a. Trauma Fund/Updates	R. Seesholtz	4th quarters disbursement calculations for eligible facilities are underway. • 1st qtr. letters dated 4/6 • 2nd qtr. letters dated 5/26 • 3rd qtr. letters dated 7/14 • Newly allocated $5 million reoccurring funds were distributed with letters dated 10/13		R. Seesholtz
	Logan Grant	Update on General Assembly's $5 million fund distribution: State Finance & Administration ruled that the unspent $5 million dollars allocated for the trauma fund would revert to the general fund due to a discrepancy in the statute that refers to revenues vs appropriations. Mr. Grant apologized for the oversight and informed the council that the existing $5 million has already been disbursed to eligible facilities.	Newly crafted legislative language to ensure that this does not happen again has been prepared and will be submitted during the next legislative session.	
	R. Seesholtz	Redetermining readiness costs	Dr. Fischer inquired about how the process of redetermining readiness costs would work, Rob informed the council that a Finance subcommittee of the council would meet post completion of the Readiness cost survey and determine new readiness cost amounts based on the readiness cost survey. These recommendations would be brought to the	

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			full council for discussion and approval and then be forwarded to the Executive Director of the Health Facilities Commission.	
III. Subcommittee/Ad Hoc Committee Reports				
a. Registry	B. Dennis	No report		
b. IP / Surveillance	T. Love	Terry expresses regret, unable to attend meeting.		
c. System Development/ Outreach	B. Daley	2024 Trauma symposium is scheduled for August 1, 2024, in Chattanooga. Dr. Daley asked members of the council for speakers, program topics.	Dr. Daley addressed the discussion from the last meeting about naming the trauma symposium after Dr. Oscar Guillamondegui.	Motion: Dr. Burns Second: Dr. Williams. Unanimously approved.
d. PI/Outcomes	R. Bolig	Discussed the recent report that came out from TQIP from the TTACO collaborative looking at mortality on major hospital events.	Discussion about ways to improve on these events. Plan to review data and formulate plans of action at the upcoming TQIP conference in Louisville.	
e. CECA	R. Williams	Pediatric rules were approved at rule making hearing at the last HCF Board meeting.		
		2024's pediatric emergency care conference and the Star of Life will be held on May 1st near Nashville.	Please submit any EMS saves to CECA so that they can address those at the Star of Life Awards.	CECA
f. Legislative	B. Daley	No report		

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g. Finance IV. New Business		Finance report was given under old business, trauma fund report.		
a. Readiness Cost Update	R. Seesholtz	Rob expressed his thanks to all institutions for their work on the submission of data for the readiness cost survey. Warren Averett advised that all institutions are registered on the Connect Portal for the submission of data and are on track for the submission deadline of November 21st.	If any institution needs additional time for submission of their data, please email Rob so that he can make Warren Averett aware.	Rob
b. Interpretative rule guidance – Trauma transfers	J. Christofferson (OGC)	Conflict of interest	Mr. Christofferson asked that any member of the council that works for who has a financial relationship with Vanderbilt or Tristar to recuse themselves from this matter.	
	Dr. Steven Russ	Dr. Russ presented on trauma transfers received from Tristar and is asking for clarification from the council in this matter. Vanderbilt is receiving an escalating number of transfer requests from HCA/Tristar hospitals and the physicians who are transferring these patients are saying that some of the surgical subspecialities that are listed as essential in rules are not on call at Skyline Medical Center. Most notable examples are in Otolaryngology and Ophthalmology. Transfer requests are a mix of trauma and medical diagnoses and most of the requests are for fundamental diagnoses such as peritonsillar abscess, epiglottitis, glaucoma, corneal abrasions/ulcers, and other		

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		ocular infections. Total number of transfer requests have gone up since Skyline became a provisional level I center. Asking clarity on what constitutes an essential service and do those physicians need to be on call.		
	Dr. Burns Dr. Russ	Was the data provided Tristar or Skyline? Data provided was both Tristar and & Skyline.		
	Dr. Bhattacharya R Seesholtz	Do we have the definition of what on-call means? Current rules do not define what on-call means. Only that there are response time requirements for certain specialties per rule.		
	Dr. Burns R Seesholtz	Site team visits either through the ACS or through the state site review process are required to provide coverage for these specialties being discussed, is this a correct statement? Yes		
	Dr. Fischer Dr. Russ	How many patients in your presentation met trauma registry inclusion criteria? I don't know.		
	Dr. Fischer Dr. Russ Dr. Fischer	So, what your asking is do we think that these services should be available 24/7? Yes Transfer out should be scrutinized during the site survey process as level I & II centers should be able to handle almost every single patient based on how the rules were written. My opinion is that when these rules were		

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		written we intended that these services should be available 24/7/.		
	Dr. Bolig	We also didn't say that there are times that those services don't need to be available.		
	Andrea Palmer	We have all those specialties covered and had CMS come in and do a EMTALA review and was cleared by CMS. Requests clarity of the injuries needing to be seen of every service.		
	R Seesholtz	Site reviews ensure that on-call schedules are reviewed to ensure that required specialties are available.		
	Dr. Daley	As a physician reviewer, they review transfer logs.		
	Dr. Fischer	This will be handled during the site survey of the designated hospital. This meeting our role is to determine the interpretative guidance behind this specific statement and not worry which hospital this applies to.		
	Dr. Fischer	For this council, the only thing that we can talk about is trauma patients and those that meet trauma inclusion criteria. If a patient meets trauma registry criteria, then the trauma center being reviewed is responsible for that said patient. The question to the council is when the rules were written, for patients that meet trauma registry criteria are these services available 24/7/365.		
	Dr. Bhattacharya	Just so that we understand our role, what are we being asked to do?		

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	Caroline Tippens	Interpretative guidance might be allowable here. You can go one of two ways; you can define on-call, or you can give interpretive guidance to this particular topic.		
	Dr. Bhattacharya	I think that we would presume that on-call goes back to the medical staff by-laws of every hospital as every hospital has their own on-call criteria and I don't believe that we as a council should be defining what on-call means to every hospital that participates as this would be cumbersome and site specific. From an interpretative guidance perspective, I would expect my E would be that the person who's listed for urologic surgery or neurosurgery would be on call for a level I trauma.		
	Dr. Burns	I'll throw interpretative guidance out there and we can decide if we like it or not. Based on evidence that during site visits you are required to have a call schedule that shows that you have the listed specialties 24/7, the interpretative guidance would be that yes, those services are required to be available 24/7, with or without the words on-call.		
	Dr. Bolig	I agree with that but is there more robust language in the gray book that we are trying to model?		
	Andrea Palmer	The gray book says that you have to have continuous coverage and it defines continues as 24/7/365 and it says sporadic gaps in coverage due to vacation, conference attendance etc. must be addressed with a contingency plan. So if the coverage wasn't there 24/7/365 there		

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		would need to be a contingency plan as to how to take care of the patient. For example, at my center because we have neurosurgeons that cover the adult and kids center, if we don't have a neurosurgeon available, we have a written agreement with another hospital where those patients would go if we don't have those service available. So, I think that would be the gray book definition.		
	Dr. Fischer	So, the interpretative guidance to add on to yours and again to match the language that we are trying to match, in this section here we interpreted E to mean that the service is continuously available 24/7/365 and any gaps must be addressed both in your PI plan as well as with a specified contingency plan.		
	Amber Greeno	How often can the contingency plan be used?		
	Dr. Daley	Trauma bypass says 5% and that must be reviewed by the institution.		
	Dr. Burns	And again, we are already going above and beyond what we already do if were saying that you can have a contingency plan or whatever. 24/7 means 24/7 and the two site visits that I've had where I had to provide call schedules to Rob to review required someone to be on call for those specialties 24/7. Their clinical competencies, their willingness to be a participant, all those things were not subject to interpretation, the only thing that was required was whether or not somebody was on call. I think that is the starting point and I think if that's the question we are being asked to		

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		answer then the answer is 24/7 required as is in evidence by current practice during site visits at any level center where it's essential.		
	Dr. Fischer	And again, to your point, any site survey should include a very robust review of transfers out especially at the level I or II trauma centers.		
	R. Seesholtz	The council has ruled about this previously. In 2021 the question was asked are all surgical specialty availability from inside or outside the hospital, is this a 24/7 call need or can the nonemergent subspecialities be available during certain hours. Examples, Dentistry not OMFS. Psych., ENT, etc. The answer and interpretation from the council was subspecialties do not have to be onsite but must be available 24/7.		
	Dr. Russ	So, if a patient has a diagnosis of eye pain and gets transferred out then gets the diagnosis of a corneal abrasion how does that hit the trauma registry?		
	Amber Greeno	Those patients would be included because they were transferred from an outside facility. Mostly likely they would be sent home but are in the registry because of that.		
	Dr. Russ	But when you are looking at the patient who gets transferred to Vanderbilt who gets a diagnosis of corneal abrasion, and they came from Skyline how do they hit the trauma registry?		

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	Dr. Fischer	They probably wouldn't. At Skylines trauma registry. But that's the limitation of what we have.		
	Amber Greeno	The only way Skyline could get it is if they get loop closure on their transfer. Sometimes hospitals request information about the patients they send us as far as diagnosis, treatment, etc.		
	Dr. Fischer	Some of the patients you presented earlier, like a peritonsillar abscess, this council has no role in the transfers of a peritonsillar abscess.		
	Dr. Russ	I do find it problematic if we are heading down a road where a Cardiologist says I can do STEMIs, but I don't do A-fib, or an Orthopedist says I don't do joint infections, that's not me, but I'll do other things. Or a Neurologist will do strokes, you can have a stroke center, but you don't do seizures. That's not part of it. Maybe we can think about a way to get loop closure for those trauma registry patients that might show up at one facility.		
	Dr. Fischer	I do think that your point is well taken and as we look to how to use this council better to develop a trauma system this is why it is so important for us actually able to use our registry data. But currently the rules don't even allow us really to use our data in any sort of effective way to track this. I can't look at all the transfers out from level I trauma centers in West Tennessee because its potentially identifiable. There is a state to our south that specifically has a PI committee looking at the state registry also run by the state who very		

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		much looks at the report on all the transfers out from level I and level II trauma centers and why is this occurring. And they have really been able to develop their system because of that, and that's where I would urge this council to go. Again, based on the interpretative guidance I think we have said it, especially in this graph, where you see an E, we expect the interpretative guidance of the council that these specialties are available continuously 24/7/365 for care of the trauma patient.		
	Dr. Burns	I would second the comment just made for 24/7 coverage on all specialties listed as essential.		
	Nathanial Flinchbaugh (OGC)	Can I ask for a friendly amendment since you guys are already in the process of redoing your rules while you vote for this interpretative guidance can you also vote to have that continues language added to your rule packet?		
	Dr. Daley	Any further discussion? Council members please vote, all in favor say aye. Any oppose? No opposition heard.	Roll call vote for 24/7 interpretative guidance: Dr. Daley – aye Dr. Fischer – aye Dr. Dennis – abstain Dr. Bolig – aye Dr. Burns – aye Dr. Hunt – abstain Dr. Reed – aye David Kerley – aye Dr. Williams – aye Dr. Bhattacharya – aye Amber Greeno – abstain Oseana Bratton – aye	
	J. Christofferson (OGC)	Abstentions do not affect a quorum.		
	R Seesholtz	Motion passes		

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			Nicholas Howald – abstain Paula Bergon – abstain	
b. Interpretative rule guidance – TMD requirements for level IV centers	Dr. Daley	What does the council think the requirements need to be for a trauma medical director for a level IV center in trauma rules?		
	Dr. Dennis	It seems to me that it should be the same as a level III.		
	Dr. Fischer	The level III trauma medical director needs to be a surgeon. I think that you can have a level IV trauma center with no surgical capability. The goal of a level IV is to be a very highly prepared first stop.		
	Dr. Dennis	So, is the only question related to their medical practice? There are educational/CME/ATLS requirements that are required.		
	Dr. Fischer	No, you still have to do all of that other stuff.		
	Dr. Hunt	So, level IV's can exist without surgeons at all? So, the TMD doesn't need to be a surgeon?		
	Dr. Fischer R. Seesholtz	Who brought this before the council? Bre Hutton, AVP for clinical excellence for Tristar and Dr. Hunt wanted this brought before the council, received request via email.		
	Dr. Fischer	So, if you are asking for interpretative guidance, I think that you need to be here to ask the question and not through an email before we vote on this. Rules says that they don't have to be a general surgeon and it doesn't say they have to be a member of the		

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		COT only that they must participate. By participating, they show up when we are taking COT issues. The COT meeting is immediately following the TCAC meeting, and I would hope that they would stay around the meeting, and I would count that as participating. They are not a voting member, and they need to retain current ATLS.		
b. Interpretative rule guidance – ATLS requirements for level IV EM physicians.	Dr. Daley	The other request for interpretative guidance was "can board certification (ABEM) serve as ongoing certification on the management of the traumatically injured patient. In November of 2022 the council approved this for level III centers.		
	R. Seesholtz	I would respectfully ask the council to weight in as it reflects on level IV centers since we've had our first provisionally designated level IV here in the state. To use that interpretative guidance that was put before the board previously but now for level IV's.		
	Dr. Burns	I would point out that this is in a different section then when we were talking about emergency medicine personnel and their board certification, so this is for an individual that is going to be designated as a trauma medical director and the way it is written currently is they must maintain current ATLS certification because it is currently listed as essential the same way that it is listed as essential that they participate in the TN COT.		
	Dr. Fischer	To piggyback on Bracken, it is an "and" not an "or". So, 13 is retain a current ATLS		

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		certification, that's nonnegotiable and participate in the provision of trauma related instruction to other healthcare personal that can be satisfied by the board certification.		
	R. Seesholtz	These are two separate things, the first item up for discussion relates to Dr. Hunt and the Tristar question in regard to level IV requirements for Trauma Medical Director, the council weighed in to keep rules as written.		
	C. Tippens	I think that you are going to need interpretative guidance. It has to be in writing, or these issues will keep coming up. You can have the discussion and have it in the meeting minutes but it's not actual interpretation by the advisory council until it is in interpretative guidance format and posted on the website for everyone to view and approved by the board.		
	Dr. Dennis	So, where essentials are, that doesn't look to require interpretative guidance as it is pretty clear cut, its where there's no letters at all. Do we need to address every single thing?		
	Dr. Fischer	No, because we don't do it in other places. I think the question to us is quite clear., for others, it is not quite clear as they have brought it to us for interpretation. Since is not clear, the question before us does the person specifically need to be a surgeon. And my interpretative guidance based on our rules, is that the rules are as written, and that person does not necessarily need to be a surgeon because there is no place where it says they are required to be a surgeon, however it does require them to		

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		"*participate*" with the TN chapter of the American College of Surgeons, Committee on Trauma and retain current certification of ATLS.		
	A. Greeno	With this and the ATLS requirement, if we do…**inaudible**…would it not be reasonable…**inaudible**.		
	C. Tippens	I think you have a motion on the table, and you have a second. So, you need to vote on the motion and then we can address your question unless your question is considered to be discussion and pertinent to the motion on the table.		
	Amber Greeno	I was just adding it to ATLS and all the other stuff, that they need to… I can add it separately. But that's part of the TMD requirements.		
	Dr. Daley	But not for level IV.		
	Dr. Fischer	But not for level IV as written. Number 3 clearly states that its E, E, E, and not there.		
	A. Greeno	So, they don't have to have any CME stuff? Ok.		
	Dr. Fischer	To address that in the new rules, right? 100%, but the rules as written.		
	A. Greeno	**Inaudible.**		
	Dr. Fischer	I don't disagree with you but that would require changing the rules.		

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	Dr. Burns	Your motion would be to change the rules, what we are doing here is interpretative guidance of the rules as they already exist. And as they already exist, Dr. Fischer's motion was to say that it clearly says that you do not need to be a surgeon, it clearly says that you do need to participate in the TN COT, clearly says you do need to maintain ATLS.		
	Dr. Daley	So, the motion has been seconded.		
	Dr. Burns	I seconded the motion.		
	Dr. Daley	And we are having discussion. So, is there any further discussion?		
	O. Bratton	Is there anything written in the body of the rules regarding this? Cause this is just the chart, right?		
	R. Seesholtz	There is not.		
	Dr. Daley	Call the question. All in favor of the motion say aye. Any apposed? Hearing non, motion carries.		
	C. Tippens	Has anyone recused themselves from this motion? I don't believe that I heard any recusals.		
	Dr. Daley	None apposed, motion carries for interpretative guidance, rules as written.	The council approved interpretative guidance for rules as written for level IV requirements for Trauma Medical Director.	
	R. Seesholtz	As the council may remember, on 11-18-22 Dr. Matt Tincture from Tristar Emergency		

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		Medicine Group approached the council asking that the American Board of Emergency Medicine (ABEM) serve as ongoing certification in the management of the traumatically injured patient. This council voted to approve that interpretative guidance and subsequently the board voted to accept that interpretative guidance. The question before the council now is using that same language but instead of being applicable to level III centers, this will apply to level IV centers as well. ABEM certification for Emergency Medicine Physicians can be used as proof of ongoing certification in the management of the traumatically injured patient.		
	Dr. Fischer	The interpretative guidance that we said for level III's also applies to level IV's. I would say yes.		
	Dr. Burns	I second it.		
	Dr. Daley	So, the motion is to carry that to level IV's. It's been proposed and seconded. I call the question, all in favor say aye, any opposed? None heard.	The council approved interpretative guidance that the American Board of Emergency Medicine (ABEM) certification can serve as ongoing certification in the management of the traumatically injured patient for level IV centers.	
	Dr. Fischer	So, who is becoming a level IV? That's great news.		
	R. Seesholtz	Maury Regional, they expressed regrets in not being able to attend the council meeting.		

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	Dr. Dennis	As a procedural item, shouldn't that be in the system development report when we have new centers come aboard?		
	R. Seesholtz	I would like to extend kudos to Melissa Smith who conducted her first site review as lead reviewer for the state with Maury Regionals visit.		
c. Discussion on establishing a timeframe for level I & II centers to become ACS verified	Dr. Fischer	There are currently two level I centers and two CRPC's that are not ACS verified. So, from the adult side, I think this is an appropriate thing to discuss and for the state to move forward with the discussion of transitioning for adult level I & II centers a timeframe by which we would go to an ACS verification state. I think that this is something that needs to start being discussed, and I'm not talking about January 1, 2024.		
	Dr. Daley	Peter, what would you say your timeline is?		
	Dr. Fischer	I would say January 1, 2027.		
	Dr. Daley	Bracken?		
	Dr. Bhattacharya	**Inaudible**		
	Dr. Fischer	I think that the ACS standard is more appropriate standard, I think that as centers are already going toward ACS that the role of the state designation process probably is not necessary, I think the fact that we have to go through this rule revision every year where we consistently just redefine based on the ACS rules is not appropriate and I think that the gold		

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		standard quite frankly is still the ACS.		
	Dr. Dennis	The ACS process has more agility than the state process to.		
	Dr. Bolig	Think about the time spent discussing items that have been already decided in other documents.		
	Dr. Daley	Bracken, what would you say your timeline is?		
	Dr. Burns	Five years conservative.		
	N. Flinchbaugh (OGC)	I would warn this council there are other boards that have used outside guidance's for in state control and it is not looked upon favorably by the legislature. They gave you all the authority to make these decisions and that's what they want you to do. If you do adopt something from outside, it needs to be a specific version and it still has to go through the rule making process. So, you would have to pick a version, if you are going to use ACS a year, and then as those standards change, you would not be able to say ACS standards as they exist because at any time they could change, they disfavor that. You'll have to pick a version and its basically going to be the same thing you are already doing. So, it's not going to be just as easy as saying were adopting ACS standards.		
	Dr. Fischer	But couldn't our rules say, level I and level II trauma centers you must present to the council an ACS verification certificate, yes or no.		

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	N. Flinchbaugh (OGC)	Your rules can state whatever you want but getting past government ops is a different story.		
	Dr. Fischer	I would urge the legal team that there are many states who have done this already, very similar state with similar rules, Ohio, South Carolina, North Carolina, all of these have transitioned, gone through this very process with the very objections that you've stated, and have found ways around them. I think that we should also, not ways around them, ways to integrate them.		
	N. Flinchbaugh (OGC)	My suggestion would be to have outside lobbing agencies to get the temperature of the legislature to see if you could get a bill and have it put in statute. If you all are saying as the council that you want this that's one thing, coming from the legislature they'll make ACS certification binding then you don't have to worry about any of the rule's year after year. So, if it comes from them and they put it in statute, then it can change year after year and you won't have to go through the rule making process every time it changes. So, if that is your desire, it would be my suggestion that you all find lobbying outside your positions as the council and have that done through legislation, not through rule making. You run the risk of getting your rules and all of the work that you've put into that would be for naught cause they'll deny them.		
	C. Tippens	And there is a public chapter that was passed a few years ago that requires boards to adopt specific editions. So that is the reason for Mr.		

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		Flinchbaugh s statements.		
	Dr. Daley	Can I ask what is the usual timeline to get something like that through the legislature? Would that be 2028?		
	N. Flinchbaugh (OGC)	I can't speak to that, you would have to find a legislature that has a spot open and would be willing to support your bill and it has to go through the House and Senate. It could be a cumbersome process, but I would do it outside the council if that's your desire and you want those standards to be applicable as they evolve that's the way to do it. If you're going to do it on this side, even if you put it into rule, you will still have to pick a version and you're going to be right back to doing rules every year anyway. If you want them to be ACS standards as they evolve it needs to be in statute and it needs to be very clear, it doesn't have the same restrictions.		
	J. Christofferson (OGC)	And the answer to the question about how quickly it can be done that depends entirely on how quickly you can get somebody to sponsor it.		
	Dr. Burns	I'll just say I don't like the thought of it not being in our control due to the possibility of unforeseen circumstances, it's not the most fun part of what we do but it does give us the ability, not just present company in this room but if other centers try to come on board that are in an underserved area and are trying to work their way through a process, this gives us a mechanism to help them get there whereas		

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		they may not be able to just jump right in to the ACS process. The center I took over 8 years ago would not have been an ACS center and we are still fine-tuning some things.		
	Dr. Fischer	I would highly agree with you that we keep level III's within the council, the level III rules within the council. With that very thought that I agree with you, the way to step in is as a level III or level IV then work your way up to a level II or level I.		
	Dr. Burns	Interpretative guidance. Would they have issues, because again, we oversee trauma care level I's, II's, III's & IV's, if we try to introduce something that only covered half of those by a guideline and then the other, we just said we are going to make our own rules? I'm just asking.		
	C. Tippens	Basically, two different standards, your right Dr. Burns, you basically have, you'd be following ACS standards for level I and level II, you'd have separate state standards for level III and level IV. There's an argument that perhaps it could be disparate treatment. That's one thing that you need to think of. And I will also humbly submit to you the belt and suspenders approach which is different from interpretative guidance essentially you could pass a policy before you change your rules, that allows the policy to go into effect while the rules are pending. So, in other words, you could adopt a specific edition of ACS, you could say that we are going to adopt the 2023 ACS version, were going to put that in policy		

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		and while Nathaniel and the legal team are working on developing the rules, that will take effect, all the centers will be aware that we've adopted this edition until the rules are finalized. So that may be another option, we use that approach quite frequently with the board for licensing health care facilities.		
	Dr. Daley	I'll just say, our current rule, revised rules which do contain some language from the ACS is still under review by the ACS for permission to use said language.		
	C. Tippens	So, Dr. Daley, that poses a good question, so what edition are you using in the current rules?		
	Dr. Daley	We are using the gray book, which is the most current version.		
	R. Seesholtz	We are not using ACS language in the current state rules.		
	Dr. Daley	No, our proposed rules that are waiting ACS approval.		
	C. Tippens	The rules that are currently in effect now.		
	Dr. Burns	They were modeled after a previous edition. But they are not the same as that previous edition whereas the latest version we have submitted is very parallel to the current version of the ACS rules.		
	C. Tippens Dr. Burns	Do you know which edition it was previously? The Orange book.		

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	Dr. Fischer	It was before orange, it would probably be yellow.		
	C. Tippens	2014 edition? Ok. That's pertinent in case we ever have to go to government operations.		
	Dr. Fischer	There is nothing that says though that we couldn't right, when we look at our rules are we in our rules now Rob? Scroll up to where it has E's across it. There is nothing that says that we couldn't at the very top say, let's put it in system development, verification by the American College of Surgeons at the same level as the state E, E, D, for I's, II's, and III's.		
	Dr. Burns	I think their saying that we can put whatever we want but it has to be approved.		
	Dr. Fischer	If we threw that line in there, E, E, D then still have the rest of the rules there.		
	Dr. Burns	But then your copying language that we are having a hard time getting approved currently with our current revision.		
	Dr. Fischer	I agree, that's not the way to do it. Again, this has been overcome in other legislatures in other states, so let's do some research as to how this has been overcome in other areas. I will do some research and report back to the council.		
	R. Seesholtz	I'll email my state counterparts as well.		
	Dr. Fischer	The people that have done it most recently have been South Carolina, or potentially		

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		Georgia, I think that both of those we can look at.		
	Dr. Daley	Any other new business?		
	C. Tippens	Do you have a legislative subcommittee?		
	Dr. Daley	We have a legislative subcommittee; it's not convened in recent times.		
	C. Tippens	That might be a good place for discussions to occur I guess is my point to Mr. Flinchbaughs earlier statements.		
	Dr. Fischer	We're not allowed. **Inaudible**, right?		
	C. Tippens	The Trauma Care Advisory Council itself cannot but as Mr. Flinchbaugh stated, outside entities can. And you have various associations attached to you all.		
	Dr. Reed	A point of clarification. What you're asking for is for level I and level II's designation from the American College of Surgeons. You're not asking the American College of Surgeons rules to supplant our rules. Because let's be honest we are building our state rules to mirror that, **inaudible.**		
	Dr. Fischer	I'm more than anything else requesting that we move towards that in 2028, if you want to be a level I or level II designated adult trauma center in the state of Tennessee, one of the requirements would be verification at the same level by the American College of Surgeons. Does this make sense?		

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	Dr. Reed	It does, but my confusion comes in why are we discussing giving up our power as a council because it's not going to change the fact that we still need to work on rules. I guess I'm not understanding why we have to go before the legislature to make that happen.		
	N. Flinchbaugh (OGC)	I don't want to speak for you so if I misspeak, I think the idea was the ACS standards are continually evolving and the rule process is taking much longer than anticipated, so having ACS standards continually updated and then having to wait to redo the rules and then they are already on another version of the ACS rules. So, if you all want to adopt the ACS rules, you have to get their permission first as its intellectual property.		
	Dr. Fischer	So that's where it gets sticky is let's say we added that box for ACS, if we got down to the point where an ACS rule was contradictory to a state rule because the state rules are eight years behind the ACS rules then it would get really dirty and muddy.		
	B. Daley	Besides Dr. Fischer, any other members willing to join the legislative committee?	Dr. Fischer, Dr. Burns, Dr. Williams, & Dr. Hunt volunteered to be part of the Legislative Subcommittee.	
d. Level IV rules	M. Smith	Being the lead reviewer for the level IV trauma center, I identified some areas in our rules it was hard for me to do their review because of audit filters, we don't have anything in rules, and this should definitely be essential. They have to identify times to CT, times to transfer,		

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		etc. So, I would like that to be essential, review prehospital trauma care to include patients dead on arrival.		
	Dr. Dennis	Are you asking for guidance for current or for rules for the future? Because they are provisional, so they are under these rules.		
	Dr. Burns	I don't want to put words in your mouth, I think your asking to change the current rules because the guidance is not clear as someone who's done a site visit at a level IV center.		
	M. Smith	Yes sir.		
	Dr. Daley	So, this would be a policy?		
	N. Flinchbaugh (OGC)	You're not going to want to do a policy on something like this to create a requirement for a license type that's already in process. What I would suggest to you is that when we have the rule making hearing, that would be the appropriate time to bring it back to the committee to adjust what is already in process and they can make changes at that time and that will allow public comments to be made on your suggestions. So, not that they will ignore you today its going to be postponed to the rule making hearing and then it will go through the formal process then they can make the changes at that time without any additional votes or interpretative guidance.		
	Dr. Daley M. Smith	So, will you forward those recommendations? There's a lot, yes.		

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	N. Flinchbaugh (OGC)	For the rule making hearing if you want to prepare a summary for the council, it will have to go to the council and it will have to go, depending on when it gets either to the board or the new Commission as of July 1 to have all that where they can read it ahead of time will also be beneficial to rule making so that its not an all day thing.		
	Dr. Daley	Any other new business?		
	R. Seesholtz	Discussed potential meeting dates for 2024. Of the prospective dates, there were a few conflicts that surrounded national meetings, Rob will send doodle poll to voting members for date availability.		
	Dr. Fischer	There's no virtual meeting, right?		
	J. Christofferson (OGC)	Much as we would love to be able to have virtual meetings, state law, and folks at the comptroller's office disapprove of having those. It is strongly discouraged, and I would have hoped it would change after COVID where we saw the technology is caught up in a way that folks are able to participate remotely, even citizens, but we are not there yet, as far as the law changing.		
V. Adjourn		Meeting was adjourned		