Trauma System Advisory Committee
3760 South Highland Drive Salt Lake City, UT 84106
5th Floor Board Room
Meeting Minutes
Monday, September 12, 2016

Committee Members:	Craig Cook MD, Mark Thompson, Holly Burke, RN, Janet Cortez, RN, Jason Larson, MD,Hilary Hewes MD, Matt Birch, Rod McKinlay, MD, Grant Barraclough, Steve Anderson and Christopher Drucker
Excused:	Don Van Boerum, MD, Karen Glauser, RN and Mark Dalley
Absent:	
Guests:	Clay Mann, Kris Hansen and Shelly Arnold
Staff:	Peter Taillac MD, Bob Jex, Jolene Whitney, Allan Liu and Suzanne Barton
Presiding:	Craig Cook, MD

Agenda Topic	Discussion	Action
	Welcome	
Welcome	Craig welcomed the TSAC Committee members to the meeting and acknowledged guests present.	
	Action Items:	
Approval of Minutes	The March 14, 2016 Trauma System Advisory Committee meeting minutes were reviewed. Craig mentioned that he would like to change his recommendation entry on the bottom of page 11 in the paragraph referring to an ISS of 15 or 25 for level 3 and level 4 trauma centers to 15 instead of 25. Suzanne will make the appropriate changes to the draft minutes. The minutes were reviewed further and approved by the committee.	**Janet Cortez motioned to approve the March 14, 2016 meeting minutes. Grant Barraclough seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.**
	Informational Items:	
Status on Free Standing ED Role - Peter Taillac	Peter shared a power-point presentation that he used at a national meeting regarding free standing ED's. This concept is universally well known to people. He went over the following questions: 1. **What constitutes a freestanding ED?** A free standing ED is an emergency department not connected to an in-patient hospital. 2. **How are they different from a care clinic?** It does not typically have an in-patient capability. 3. **What can they do?** There is the University's free standing ED in South Jordan and in Daybreak and they actually have a ten bed observation unit so they have an overnight capacity for simpler patients and also used for recovery for out-patient surgery patients that require an overnight stay. Some ED's are stroke receiving facilities by state guidelines. They can care for a wide range of emergency patients and do everything that an emergency department does. They can provide pain medications, antibiotics and administer IV fluids. 4. **What should EMS know about what they can do?** The free standing ED's are generally fully staffed with emergency medicine docs and nurses and they have all the	**Peter will put some criteria together for guidelines for Free Standing ED's and bring it back to at the next meeting for the committee to look at.**

capabilities of a regular ED. They have a full pharmacy relative to treatment and they may not have a full out-patient pharmacy. They have a full laboratory, CT and Ultrasound are standard and MRI's are frequently available depending on the facility.

15% to 40% of the patients that are admitted to the ED can't be treated there and essentially have to be transferred to another facility. They are usually transported by EMS which means double billing for the transport.

5. **Which patients should be practically and functionally be brought to a free standing ED?**
   They have a full resuscitation and stabilization capability that any ED does which is very important with the "golden hour". If someone needs acute airway management and the airway is unstable, the free standing ED is as good as anywhere to get the patient there and stabilized and then transferred appropriately.

What the free standing ED's don't have:

- Inpatient beds
- They don't have consultants (Surgeons, neurologists, cardiologists) at hand that can come see the patient with the doctor and assist in their management and from the ACS trauma standpoint, it makes it unlikely to become any sort of a trauma center, level 5.
- There are no operating room or Cath labs.
- May not be open 24/7/365 and in Utah there are three free standing ED's that are open 24/7/365, but there is no law that says that have to open all the time.

The hospital associated free standing ED's which is the current law in rule in Utah states that a free standing has to have a "mother ship" and a recent rule was passed that each hospital can only have one free standing ED that it is associated with.

In other states like Texas, any doctor and nurse can put up a free standing ED on any corner as an urgent care with a CT scan. Texas is unregulated and so they have 1/4 to1/3 of the free standing ED's in the country. Unfortunately the patient gets ED sized bills not urgent care sized bills which is often a big shock.

Currently, if they are unaffiliated they can't accept Medicare or Medicaid which is a big deal because that means they don't have to follow EMTALA which says you treat and stabilize everyone the same regardless of their insurance status or ability to pay. The only penalty from not doing that is you are excluded from Medicare and Medicaid programs.

The politics and economics of these free standing ED's is they can make a lot of money depending on the staffing, etc., ED prices and the turn of profit.

There have been discussions about replacing some critical access hospitals to get rid of the in-patient capability. Medicare is actively looking at this and they would replace them with free standing ED's. They would still have the emergency capabilities in the rural areas

but don't have the burden of trying to maintain patient accountability and OR costs.

Few are being built in rural areas because there is not enough volume to justify new construction. The problem with that is they directly compete with the hospitals that do take every patient and don't necessarily bill for every patient and they take Medicaid that doesn't really pay well.

Free standing ED's are popping up in affluent zip codes.

ACEP (American College of Emergency Physicians) has a policy on freestanding ED's that they recognize the limitations but they follow EMTALA and be available to the public 24/7/365.

The private places don't have policy agreements in place and so they make decisions on the fly for transfers, etc. The big advantage of having a "mother ship" is you tend to have a straight shot to that facility and that is why the free standing ED is there.

The TAFEC (Texas Association of Freestanding Emergency Centers) statement is that they believe freestanding emergency centers should treat all patients regardless of their ability to pay. In Texas they are required to do this because it is a state law. There are 400 – 500 of these nationwide; hospitals do it for market share purposes and encourage higher volume of the "mother ship". Some of them like Lone Peak here build with in-patient capability later which turns into a full scale hospital.

The trauma related recommendations from the journal of Free Standing Emergency Medicine for your consideration are:

1. If the patient's airway is unstable or they are in cardiac arrest etc. that they should go to the nearest hospital to become stabilized even if it is a free standing ED.
2. Any injury meeting the trauma field triage guidelines should not go to a free standing ED.
3. Patients with an angulated long bone fractures that are going to require surgery and will need acute orthopedic evaluation, anything open that is a fracture should not go to a free standing ED.
4. No emergent psychological consultation patients should go to a free standing ED.

You could argue that some of the step four things on the Utah Trauma Field Triage Guidelines might be able to go to a free standing ED.

Peter commented that the reason he brought this up to the committee is whether or not we want to establish some guidelines for freestanding ED's at the State level of what type of patients should be brought to the free standing ED's. Currently EMS in his opinion doesn't have a problem with free standing ED's and they know what to do and generally don't like to do double transfers. For the most part, EMS brings the right patients to free standings. Shelly Arnold commented that Taylorsville has had very few trauma patients come by EMS. She looks at ED logs every day since they opened and she has only seen 2 patients that had a higher motor vehicle rate that

	were very stable and not lost consciousness that came by ambulance to the hospital. From what she sees they are doing a great job making determinations on what patients are appropriate there and which ones are not. Holly commented that EMS knows where to take the more critical patients to a regular ER. She hates to create more work but with the turn-over of new people coming in that when new medics and advanced EMT's; make sure they are aware of that from an educational standpoint of what can go to those ED's or should we set specific guidelines to what type of patient they take to those facilities especially in Salt Lake where there is a hospital everywhere. She continued that it would be different in a rural area. Jolene asked about pediatrics and if EMS had brought any kids to a free standing. Hilary commented that they have had kids brought them by private vehicle, not EMS. Peter commented that the EMS seems to be doing a good job as far as he can see and we can watch it as a committee and if it does become an issue we could write some guidelines. The "mothership" takes care of things and we could in lieu of making guidelines make it an educational outreach thing and share the criteria with those folks at different conferences and let them know what the real pros and cons are. Holly commented that there may be problems with the free standing ED's advertising to EMS to bring them their stemi and stroke patients and they should not be getting these or trauma patients. Janet commented that we need guidelines and she feels like if we wait we are behind the 8 ball and why wait to have a problem and be like Texas. If she were EMS and something happened and she didn't have any written document to support her and she feels like as a state we are better than that and we need to provide EMS with what is appropriate and what is not and then it is crystal clear. She feels like it is unfair to the patient and the hospital. Peter commented that maybe she is right. Craig also agreed. Stroke and other situations might be a gray zone. It would be nice to have something that is similar to the field triage guidelines we already have and make it more specific and follow the protocol guidelines. Chris made comments about Texas and by catching it early in Utah it will be a positive thing. Peter will put some criteria together and will bring it back to the next meeting for the committee to look at.	
Audit Filter Discussion – Janet Cortez	Janet referenced the older PI Guide (page 15) audit filter #1 trauma patients with more than one inter-hospital transfer prior to definitive care (definitive care is defined as the final discharge hospital). One thing she remembers about that being a definitive care facility, she was looking at some data and a lot of them fell out because they would come to them for definitive care and then they would go to the VA or they may go to UV which is not the final discharge hospital. They fell out because there was more than one transfer. The intention was to transfer for critical care not transfer in general. When she looked through the data, 95% would have fallen out of this filter if you would have defined it by acute care status versus being stable enough to transfer to the VA or UV which are also hospitals. Is there a better way to wordsmith this like this is the final trauma center and we can't use VA or UV, so what could we use? Craig mentioned to use acute definitive care. Janet agreed that something like that would work better and you would get more meaningful data. We talked about the other one with trauma patients with an ISS and	**Hilary Hewes motioned to approve the changes Janet Cortez recommended and add acute definitive care and change to greater than or equal to 15 from 25. Mark Thompson seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.** **Changes will be brought back to the next meeting**

	non-trauma centers. We have a more robust trauma center system than we used to and so it is important to see the types of patients that are being treated at other places and if they are doing a great job which most of them probably are. And just to encourage them to meet their requirements to be a trauma center so they fit in with all the rest in the meetings, feedback and discussions. We talked about the deaths at level 3's or 4's sick patients and we know that sometimes patients just go in and they are sick and they are going to die regardless of what hospital they are at. We still need to look at those and review them and make sure that is the case or see how we can support those hospitals. Peter commented that those are hard because if they need an airway or arrested and they got vitals back and the EMS wants to unload to a doctor or a nurse appropriately as soon as possible and then they are at the ED and if they are really that unstable you can't really throw them back on the ambulance and tell them to drive them somewhere else. Sometimes they don't get stabilized and they die. Janet added and how do you support them in that! Janet stated that she thinks the information could be cleaned and if you look at our triage criteria and followed the criteria and took them to the highest center within that region (which is Janet's proposal) then that would help eliminate some of this because they would not be at a lower level hospital (3 or 4) with those issues unless EMS made a judgement that they would not make it to a level I or a level II in the region which is justifiable. At least you would have another filter that would capture those. You are reviewing them at some level and then you can continue to refine your criteria. Those were a couple of thoughts she had on some of them. It allows us to help support these facilities. Peter commented that these are just some cases that needed review and it doesn't necessarily mean they did something wrong and Janet commented absolutely and that it allows us to help support the facilities because right now we really don't know what they are getting and maybe they need education or they need support from us to encourage them to be a trauma center. Mark Thompson made comments on the capabilities of that hospital because they had an incident that came up. It worked out well and when he explained to EMS why that person could not go to a certain facility because of the weight and requirements to handle that patient they understood. It would be nice if all the EMS agencies knew the capabilities and weight limits each hospital has that could also determine where they can take patients like this. Hilary commented on #6 in PI guide. Jolene said they haven't been updated yet. It should be less than 13 instead of 15. Jolene said it will be changed on the final version. Shelly asked if these cases involved with the audit filters are going to be reviewed at the state or regional meetings. Jolene commented that the plan is to review them at the state performance improvement PIPS group we are developing and they will review them there and get in to the details and bring back a report to TSAC to let them know what has been found and make recommendations and the kinds of things that need to be done. We want to have regional performance improvement do the same kind of thing too with a lead center. Clay asked Janet about the revisions. Both of the changes for these two audit filters are looking at patients that go to non-trauma centers	**for the TSAC Committee to review.**

	so are you only wanting to look at deaths with an ISS greater than 25 at a non-designated center? The last one you are looking at those that are treated with an ISS greater than 15? Craig said that it was a discussion we had at the last meeting to change it to greater than or equal to 15. Janet will make the appropriate change. Motion made by Hilary Hewes to make these two specific changes that Janet recommended and add acute definitive care and change to greater than or equal to 15 from 25. Motion was seconded by Mark Thompson. All in favor and none opposed. Changes will be brought back to the next meeting and be a specific agenda item.	
Trauma Center Needs Assessment Rule Change – Bob Jex	In your packet you have two documents; one of them is the recommendation from the American College of Surgeons Committee on the needs assessment of trauma system tools. We had a discussion 18 months ago in TSAC regarding the necessity to develop needs based criteria for the designation of level I and level II hospitals in the state. We crafted a rule and we sent it to the EMS Committee and there was significant push-back from some of the committee members, so we put it on hold until we were able to work through the problems that were identified in that meeting. Later that year Bob was fortunate to be invited back to Chicago to discuss with the National Advisory Board the potential items for our needs assessment that regulatory agencies could use to craft rules to determine whether or not additional definitive care was needed in the service area. We brought that back and reviewed it and adopted it in to potential rules and another part of the document began. In the ACS document they used trauma system carriers and we changed that to MSA's which is metropolitan statistical area. This is the fine guide for GSA for government purposes and it fits and works well in Utah because we have nine MSA's. We incorporated that into the proposed rule that we have with that and the guidelines closely follow the assessment parameters in that are set up in Florida. Have been adjudicated and are confident they are sound in their approach. Met with St. Mark's and reviewed it with them. St. Mark's expressed the desire to work towards a level II designated trauma center. We would support towards a level II and going forward would recommend that the rules be adopted to apply a needs assessment for all level I and II in the state. We feel like it is a reasonable move for the State to support St. Mark's and they would support it as well. The rule in the handout states that the needs assessment will be applied to any hospital seeking designation as a level I or level II trauma center and will apply for that after December 31, 2016 and will be considered for designation following the point system. This is a tool we can use. Later on they will apply it on the West side of the county and other geographical areas and apply it and use it for their determination and if they are denied we will supply the justification for our decision. Janet asked if they used other determinations to come up with the date, December 31, 2016. Bob commented that the other determination was that down the road they will look at St. Mark's progress. Craig commented that this could also be applied to the same situation with points for the hospital in St George. This only applies to level I and level II facilities only. Bob commented that this document is much more objective than the one they passed 18	**Bob will add that the data source would be the Statewide Trauma Registry.** **Dr. Rod McKinlay made the motion to approve the proposed trauma center needs. Jason Larson seconded the motion. All present members voted in favor of the motion. No one opposed; Janet Cortez abstained from voting. Motion carried.**

	months ago. Level 3 and level 4 facility's mission is primarily to take care of the low ISS trauma patients. Bob commented that they spent the better part of 2 days discussing this and they compared it with ACS recommended guidelines and it is pretty much down the line the same. They did change the TSA to MSA. The population parameters are 1.2 million people in Salt Lake Valley and for level 1 centers, including Primary's, there were about 850 ISS's greater than 15 in the last year. Level I and Level II facilities need to take care of sick patients. Steven asked how for the Salt Lake Valley how is the TSA defined; is it more than one and Bob commented they are using MSA and they only use one area. They would compare it with Utah County to see the population for the South end and also compare Davis County for the North end population. Clay made a suggestion to add that the data source would be the statewide trauma registry. Everyone agreed this would be a good idea and Bob will make that change. With your approval we will move forward with this. Craig commented that this is a decision we need to make because we need to have objective criteria and his opinion is that we accept this because this is the best objective measure we have right now. Craig asked if St. Mark's or St. George failed to get their designation are they grandfathered in once they have initiated the process. Bob says once they have received the application and initiated the process they are in. This doesn't apply to St. George because of the geography. The intent of the needs assessment is not only to control, but to encourage and verify the need. Motion to approve proposed trauma center needs was made by Rod McKinlay. Jason Larson seconded the motion. Janet abstained from voting.	
2017 Registry Inclusion Criteria – Bob Jex	The handout in your packet is a flowchart that represents the Registry Inclusion Criteria that was presented to the Rules Task Force Committee last December. The rule is in place and will stay in place until ICD-11 comes out or some other issue comes out. They had a discussion with the trauma managers last week. Janet commented that everyone saw the spreadsheet that we sent out at our last meeting about the volume that would increase in their hospitals and the level 1 trauma centers are hit the most severely with the addition of about 200 patients per year which takes resources to enter the data. Of course the questions come up as to whether the data we are seeking is going to benefit the trauma system or is it going to muddy the water or fill it with non-pertinent types of cases. Most people felt like the numbers were not dramatic enough but the larger centers will be impacted the most. Level 1 Centers will have an addition of 100 or more cases per year. They are wondering if the information the state will clean is worth the resource investment. There were not any obvious objections from the trauma managers; just questions of what the hope was to bring by doing this. Peter commented that the benefit reaped is not missing potentially a group of patients that are relatively severely injured but don't spend more than 24 hours in the hospital. The consensus was that was the group we wanted to know about and that would be the benefit of this	**Bob Jex will change the definition in the Registry Inclusion Criteria to read "hospital arrival".**

	information. The burden would be on two or three people in this room to actually make that happen. Peter asked how long it would take to do one input times 200? Janet commented it depends, if someone that goes home in 24 hours it doesn't take too long and is fairly simple if their injury list is small. Kris Hansen suggested that where you have listed the patient being admitted to the hospital is a definition of start time for the measurement you discussed at the last meeting from the time they hit in-patient admission for 12 hours. If you want to change that definition from the time they hit the door in the ER you need to call that out specifically. They consider ER outpatient and has nothing to do with admission time. It would need to say something like ED arrival time versus hospital arrival time. If they had a time line "general rule criteria" when a kid hits the door with a broken arm and it's a compound fracture and sits in ED waiting room for over 1 hour or 2 before being seen. When the child is seen and it's determined the break needs to be fixed, if the kid doesn't live in Panguitch or somewhere, the child would be splinted and sent home and come back for a scheduled out-patient surgery in a day or two. They would become an outpatient to get it fixed. This particular scenario happens all the time when a child is observed for a while in the observation area and Ortho would look for a time when they can add them on because it is convenient for the child and fix the arm and go home from the OR. It is just a matter of circumstance whether or not the child will be considered an out-patient surgery or an in-patient surgery. They have always considered those out-patient events seen in the ED discharged for an out-patient procedure. Peter commented that part of using the registry is looking to identify the severely injured patient, but also to look for over-triage and is that an issue and if anywhere it's an issue at Primary's and essentially could by capturing these we have a better sense of over-triage and can target strategies for that and the head injuries at Primary's, the U of U and IMC get the dinky head injuries where they are scanned and watched for 24 hours or less and sent home. Craig mentioned that is a big part of the population they were trying to capture that they were missing with head injuries. They are in for 18 hours and then go home and they wouldn't necessarily be in the registry. Kris commented if those patients are transferred from one hospital to another hospital by EMS without regard to the length of stay, even if they are discharged from the ED, they would be in the registry. That is how they know how many inter-facility transfers there are. They do not capture the ones that walk in from the street with a minor traumatic injury that we would watch for 6 hours and then release them after 24 hours and these patients would not be in the registry. Peter said is it important to get this sub-group of data. Look at the sub-group over a year and see if it is of value and worth it. It would take approximately 200 hours to capture 200 patients for this information. Craig said he would propose we make the change and see how it works over the next year and then review it to see if it is of value and if not change back. Hilary commented that we could ask the trauma program managers to keep a general idea across the country and keep an abstract on it and maybe quantify it. Bob will make the change to	

	clarify the definition to hospital arrival and we will move forward with it and look at it in a year.	
Trauma Protocol Revisions – Peter Taillac	As requested, required and recommended the State EMS Protocol Guidelines are under review and they were 2 years old at the beginning of this year. They have a committee working on them through the year. There are 4 sections; medical, general, trauma and cardiac. The handout you have is essentially the final draft and we have one more meeting in a month to clean-up and tie up loose ends. Peter would like everyone to take the handout and look it over and if you have questions or concerns, let him know. He would like to put the protocols on the website officially around January 1st. The changes involved are we took a couple items out. There was a crush injury protocol that really didn't say much so we incorporated it in to general and the extremity injury protocols both. We put tooth avulsions with amputations. The biggest thing we did was on page 7 on general trauma management and the goal of this review was to look at them from the basis of is there new evidence, new protocols and any medications we should be using based on everybody's experience. Also we did a detailed comparison of our guidelines to the recently published national guidelines and incorporated portions that we thought made sense for us in Utah and also left out some as well that seemed inappropriate for us. The general trauma management is almost verbatim from the national guidelines and Eileen Volder with the ACSCOT actually wrote this as a general assessment approach to the traumatized patient that involves the tension pneumothorax issues. The head injury guideline didn't change very much and the one change that is being made relative to head injury is in general in the guidelines we are allowing agencies to either use GCS in their documentation or the AVPU which is an assessment of consciousness; is the patient alert, are they responsive to verbal stimuli, are their only responses to a painful stimuli or are they unresponsive. There is substantial data in an article that was published specific for kids last month that shows if a patient is between the "V" and the "P" that they are a GSC of 8 or less. So for EMS purposes if they are only responsive to painful stimuli or unresponsive, then that is a critically ill patient with a bad head injury and consider airway management and transfer the patient to a trauma center. If a patient is alert they are a 13 to 15 statistically speaking. If they are only responsive to verbal stimuli there is a wider range of a 6 to 14. This was done at the national level too and GCS is hard to do with kids and it is hard to do for adults with any real inter-rater reliability so this is simpler for EMS to make quick assessments and make decisions on that basis. We will introduce Ketamine into the pre-hospital environment in Utah and very beneficial to our providers. It is in the State Protocols Guidelines and be introduced for the management of the psycho adult patients. Right now EMS doesn't have any good drugs to manage them quickly and safely. They have Haldol and Versed and both of those take a long time to take effect which helps him in the ED but does not help the providers bringing in a patient that is unruly and could possibly hurt themselves or others. Ketamine has been around a long time since the 1930's and it is remarkably safe and effective. It is a human tranquilizer and it makes an adult compliant in 5 minutes which is a huge difference. It does not affect your airway reflex protection or your respiratory rate so it is super safe. There will be some agencies that will be asking their medical	**Everyone will review the trauma protocol revisions and at the next meeting in December the committee will vote on them.**

	directors to use this for pain in a lower dosage which is good data, but we won't put that in the state guidelines for now; too much and too fast at the State level. The only issue in some of the studies where they have done this; patients are really out, mentally out and they are breathing fine, blood pressure is fine and they're stable but they have a GCS under 5, they are responsive to pain stimuli and they are unresponsive to confrontation, but they do not have to be intubated. It will be an educational process. In some of the studies 3 to 4 of these patients out of 100 got incubated at the ED because the doctor said he was unresponsive and needed to protect his airway but you don't with Ketamine. Grant asked if there was hyper salivation with it? Peter answered no because if you use your GCS criteria which is less than 8 it gets their airway protected. He doesn't believe it has been an issue with adults, but he will research that back a little bit and see. Everybody take a look at this and we can look at them again at the next meeting and vote on them.	
Trauma System PI Guide – Bob Jex	We developed the Trauma System PI Guide the better part of last year. We changed the direction of it a little bit. In your spare time before our next meeting in December, please review the performance improvement guide and if you have any recommendations, let him know. We would like to finalize it and start on it next year. One thing that is a big change is incorporating the local PI categories into our State PI guide so that the ownership is not on the State and will be transferred over to the regions. There are 6 regions and we will be developing a lead in each of the regions usually centered around a level II or level II trauma center in the region. Holly asked for them to change the name of Pioneer Valley to Jordan Valley West; Bob will make that change. Janet asked what if you had a case that you are concerned about that needs to be reviewed external to your region by unbiased providers because the care happened in the same region and they need an outside prospective. Craig commented that the State PI Committee would be perfect for that, but it's not set up yet. Bob commented that we would like to have the state and the regions set in place by next year. Peter commented that the committee could act as a neutral third party when appropriate and also that the big benefit of this committee and the regional advisory councils will be encouraging and enhancing communication within in each region and even if you agree or disagree that's really good communication and it is really good PI. Bob commented on an example they had happen at their last meeting in the South Central region. There were representatives from 13 hospitals down there and we asked the question if they wanted to change and be departmentalized so these smaller hospitals that are outside of Utah County who are meeting separately could be involved with them in that process. The timing is right and there was some enthusiasm for it and we intend to have it in place as a major goal by the Bureau by 2017. Janet asked if there is a role for the COT in the Utah PI. Craig commented that the thought was that the COT takes the lead for each region. Page 9 shows the role of the COT and it says that Level I or Level II representative would consult for the regional trauma network. The role in our minds is the COT would take the lead in the region because they should have representation on the state COT. Craig commented that the next COT meeting is next week on	**Bob will change Pioneer Valley to Jordan Valley on the map that shows the regions.**

	Monday and he is hopeful that some of the COT members that haven't really been involved are getting the message and are going to be present from the Northern part of the state as well as the Southern part of the state and that would be really good representation. Janet asked if it is okay to share this document and Bob said yes. This document hasn't been adopted yet so if you have any comments or editing, make him aware of them. Peter commented that it is a real emphasis to engage the COT in this process because it is a great resource that has been under-used at the State level and certainly at the regional level in the past and to use their expertise and input in this process is a great opportunity and they do not have a statutory role per law, but they can always advise through their participation. Bob commented that they thought it was important to articulate them in the PI document as a role. Janet commented that the State COT meetings will be closed for the business part of the meeting (invitation only) and the informative meeting is open to the public. Peter commented that members will have to have data sharing agreements with the State and the hospitals will have to have data sharing agreements because some of the information being potentially identifiable within that region. We will make every effort to comply with appropriate guidelines for patient confidentiality which may require part of those meetings not to be open. Craig commented that it will be a new process for a lot of people to go through this and some of these ground rules and it will be important that all members understand what the purpose of PI is and what legal structure around it is and essentially this will improve our patient care as a region.	
2017 Schedule	Craig commented on the upcoming potluck in December. We will start at 12:00 pm and we will have the Open Meetings training while we are eating.	
2017 Meeting Schedule	March 13, 2017, June 12, 2017, September 11, 2017, December 11, 2017 - (Mondays at 1pm)	
End of Meeting	Next Meeting: December 12, 2016	**Meeting Adjourned**