COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: ACUTE CARE COMMITTEE MEETING

HEARD BEFORE: JEFF YOUNG, MD

CHAIR, ACUTE CARE COMMITTEE



MAY 2, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

3:00 P.M.

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APPEARANCES:

Jeff Young, MD, Presiding
Committee Chair

ACUTE CARE COMMITTEE MEMBERS:

Shelly Arnold

Beth Broering

Kelly Brown

Pier Ferguson

Terral Goode, MD

Tracey Jeffers

VDH/OEMS STAFF:

Cam Crittenden

Tim Erskine

ALSO PRESENT:

Mindy Carter

Dreama Chandler

Susan Union

Mark Day

Heather Davis

R. Jason Ferguson

Matt Lawler

Grace Eaton

Valerie Quick

Lou Ann Miller

ALSO PRESENT (con't.):

Charles Dillard

Tanya Trevilian

Kelly Rumsey

Michel Aboutanos, MD

A G E N D A

(The Acute Care Committee meeting commenced at approximately 3:00 p.m. A quorum was present and the Committee's agenda proceeded as follows:)

DR. YOUNG: All right. Let's call the meeting to order. I've been asked to read this statement regarding our audio recording. All trauma system committee meetings are audio-recorded. These recordings are used for meeting transcripts.

Because of this, all participants must do the following. Speak clearly. If not called on by name by the Chair, identify yourself before speaking and speak one at a time.

We appreciate the enthusiasm, participation in the trauma system process and welcome input. But following the above rules will assist in accurate transcription. So first of all, do you have a motion to approve the previous meeting? That was it?

COMMITTEE MEMBER: I'm -- second.

DR. YOUNG: Any opposed? Okay,

great. And any -- anything anybody wants to add to the agenda for today other than the public comment period? Okay, so we'll have that. All right.

So we had a little -- Cam, if you could say what each of the crossover assignments were and then -- we couldn't get it off the transcript. So we just have to confirm it. Beth, do you remember which one you were on? Yeah, that's -- we -- we need to know who was going where.



MR. ERSKINE: Yeah. Yeah, we need to know who was going where.

DR. YOUNG: Yeah, we designated it, but I didn't write it down.

MS. BROWN: I go to -- is it the one at 8:00 a.m., tomorrow morning. It's Kelly. Was it emergency --

DR. ABOUTANOS: Emergency Preparedness.

DR. YOUNG: Okay, so Kelly Brown is Emergency Preparedness. All right. What was -- what are the others?

MS. ARNOLD: Shelly Arnold is to the SIC.

DR. YOUNG: The what?

MS. ARNOLD: System Improvement.

DR. YOUNG: Okay.

MS. ARNOLD: S-I-C.

DR. YOUNG: Okay. What were the others?

COMMITTEE MEMBER: I think I'm supposed to be --

DR. YOUNG: You got -- you got assigned to something.

COMMITTEE MEMBER: I think it's

Post Acute Care.

DR. YOUNG: Okay. Post Acute, okay.

MR. ERSKINE: Oh, you missed that.

DR. ABOUTANOS: It was very good. That was the best.

COMMITTEE MEMBER: I just -- thanks for the reminder.

DR. ABOUTANOS: Yeah, what -- the last minute was two hours.

DR. YOUNG: Okay. Who else?

COMMITTEE MEMBER: I'll be -- I'll come --

DR. YOUNG: That's just three. Is that all there was?

MR. ERSKINE: I think that may be

it. Let me just check one thing here. Wait. You can interrupt.

DR. YOUNG: Yeah. So we're going to move off of it. So what we want to do is spend the majority of the meeting today talking about the designation process in the State.

The criterion and the current process that we use. And to speak about centers that are contemplating verification or contemplating it through the State or -- or BACS.

So first let's start a little bit out of order. Well, let's frame the issues. So right now, --

MR. ERSKINE: Oh, I'm sorry.

DR. YOUNG: Sorry.

MR. ERSKINE: If we could go around the room and --

DR. YOUNG: Okay.

MR. ERSKINE: -- introduce. So that way, the transcriptionist knows who's talking.

DR. YOUNG: Okay. Starting to the right.

MS. RUMSEY: My name is Kelly Rumsey. I'm the pediatric trauma program manager at VCU. I'm here today as the alternate crossover from Pre-Hospital. Your standing -- your standing rep had to leave today.



DR. YOUNG: All right.

DR. GOODE: I'm Terral Goode, the trauma medical director at Winchester Medical Center, a Level II center.

MS. BROERING: I'm Beth Broering. I'm the trauma program manager at VCU, which is a Level I.

DR. YOUNG: I'm Jeff Young. I'm

the Chair and I'm the trauma medical director at UVa, which is a Level I.

MR. ERSKINE: Tim Erskine, faceless bureaucrat.

DR. ABOUTANOS: Mike Aboutanos. I'm the Chair of the TAG and the Chair of VCU Trauma Services.

MS. JEFFERS: I'm Tracey Jeffers. I'm the trauma program manager at Southside Regional, a Level III.

MS. FERGUSON: Pier Ferguson, not designated.

MS. BROWN: I'm Kelly Brown. I'm the trauma program manager at Centra Lynchburg General. We're a Level II.

MS. ARNOLD: Shelly Arnold. ABP of trauma in the Capital Division. I am a representing trauma center administrator.

DR. YOUNG: All right, thank you. So we're going to spend the majority talking about the process and to frame the issue of a larger and larger number of trauma centers in the State have gone for ASC -- American College of Surgeons verification.

And there has been considerable discussion about what are the true differences between the criteria that the American College of Surgeons use, that the State uses, what -- what's -- what those differences are and what the value is in those differences.

And Beth and a group of others spent a great deal of time looking at this, and is going to start the discussion.

MS. BROERING: So -- yeah. So thanks a lot. So a number of us -- myself, Cathy Peterson, Shelly, Kelly Brown, Tracey. So sort of a broad representation of different centers or level, got together. Talked a lot about what we would look at. And we basically took the ACS criterion and the State criteria, and to the best of our

abilities, tried to sort of create a map or a crosswalk between the ACS and the State criteria, where they existed. And certainly, there is some State criteria that are unique to the state.

I'll use the example, particularly at the Annual Nursing Education requirements and sort of a -- a certification as it relates to like TNCC for your trauma nurses in the -- or the designated nurses in your emergency department.

Whereas there's others that are, for the most part, word for word right out of the ACS manual. And I think what we found as we started working through this and talking about it and trying to figure out, well, what standard -- this is a State standard, Chapter 6 point -- I'm just using numbers.

I'm just -- I'm not saying this exactly. But 6.24 maps here, you know, in -- into the ACS. And there is some grayness in the ACS. We agree to that, but they were also where we found some

interpretative guidance and -- that was in the ACS, that then became a standard for the state. Or there was interpretative guidance in the state that became a standard, but there really wasn't another standard.

So -- and you know, I think that that has sometimes maybe led to some confusion and some frustrations. And also, just where we need to go.

I'll use an example of, you know, the ACS says you have to have surgeon response times within 15 minutes. That's immediate. 30 minutes is prompt.

And your surgeon response time is 80% in -- in the state manual or -- as that's involved with ACS in our state manual back -- didn't evolve that metric of 80% of the time.

So we didn't -- we sort of follow it, but we don't. So what we did find, though, is -- and I think that we would agree upon -- is that for the most part, the Level I criteria -- it is almost exactly the same with the exception of the nursing -- the nursing education. And

certainly, if we adopt the -- the CME requirement or whatever, as the clarifications have changed.

And -- and for the most part, again, with the exception of -- with the exception of the nursing education requirements, the Level II and then research is almost exactly the same.

And so, designee -- who has to really -- as we start to revise and -- and develop a trauma -- a State trauma designation manual to sort of really kind of stick to the guidance of the ACS.

Or stick to the language of the ACS and not try to write further interpretive guidance or create more standards that are trying to be interpretive guidance that would lead to further confusion in the long run.

And I -- and I don't know the answer to that. But that's sort of where we sort of led. And that would it be -- is it the right thing for the patients of our State because -- because of what we should be providing at a Level I or a Level II

center to sort of emulate the ACS standards for the Level I's and the Level II's to the closest as possible. And then decide where there's differences or different standards.

Do we continue to accept those standards or not. And -- or do they need it -- do we need different additional standards.

And then we got that far and we're -- we still have some work to do with Level III's because there's a bigger variation with Level III's between the ACS and -- and the State.

And so I think Tracey can speak to that. But again, what's the right thing for our hospitals. But what's the right thing for our patients.

And where we currently have Level III's and where we might see Level III's develop in the future based on the needs of the State.

Are the ACS criteria versus State criteria -- are they practical, are they meet-able, are they, you know, what's -- and what's the best. So I -- I -- that's

where I'm going to leave it.

DR. ABOUTANOS: Can I ask a question?

DR. YOUNG: Of course. Mike Aboutanos speaking.

DR. ABOUTANOS: Right, oh, yeah. Yeah, sorry. Mike Aboutanos. The -- it sounds like we're jumping to ACS versus State. Which initially, it was what is going on with our designation manual.

Is it -- there's a lot of issues with discrepancies, issues with it. And is the fact of going to let's adopt the same language as the ACS a solution to that. Because that was identified as initial.

Instead of saying, hey, those two are not, you know -- and -- and I think that's got to be an important --

MS. BROERING: Sure.

DR. ABOUTANOS: -- question. One

of the things that I've gotten a lot from is that we have adopted a -- a triage criteria equating clinically Level I to Level II in the State. But our designation manual does not equate clinically. Forget research.

MS. BROERING: Sure.

DR. ABOUTANOS: Does not equate clinically, Level I to Level II. The requirements are not the same --

MS. BROERING: Right.

DR. ABOUTANOS: -- for what you need. So that's a problem.

MS. BROERING: Correct.

DR. ABOUTANOS: If -- if we can not equate clinically Level I to Level II, then why are they different. And so -- that was one issue. That are other issues with it. You got medical issues, obligation-ness, you know. There were --

MS. BROERING: Yeah.

DR. ABOUTANOS: -- bunch of stuff that needed to be looked at. So my question is, do you jump into all of this or do you say, are the -- do the ACS criteria now solve most of the stuff.

And therefore, we're taking a very good shortcut. And the question that came in before, and we're skewed ourselves because we're with ACS a lot of ways.



MS. BROERING: Yeah.

DR. ABOUTANOS: Is ACS the standard for the -- for us or not? If it is --

MS. BROERING: Sure.

DR. ABOUTANOS: -- the standard, where does -- you know, [unintelligible].

MS. BROERING: Yeah.

DR. ABOUTANOS: I think that was

kind of just basic question I think this committee has to be able to answer to the trauma system plan.

DR. YOUNG: And -- and I think, Beth, the way we approached it was are there aspects of the current Virginia designation criteria that truly add value to the patient that should be preserved.

And the other side of that was are there criteria by the ACS that would firmly prevent a place that wants to be an ACS Level II -- or wants to be a Virginia Level II or I --

DR. ABOUTANOS: That's a good question.

MS. BROERING: Yeah.

DR. YOUNG: -- that would -- that would hurt it. And you know, I think our conclusion was, you know, there's some things such as nursing education in the Virginia that could certainly be preserved.

And it did not seem that there was things in the ACS, but that's where we have to open it up for comment. But I -- I'd just -- like I said, I do visits all over the country, so there's a lot of models to do this.

And North Carolina, they have the ACS team, the state OEMS director, the state medical director and then the state EMS director. They go to each visit together.

And the -- and the state people are there to look at whatever state criteria they may have and to determine if -- if the ACS does not verify the center, do they stay state-verified.

And that's why that team is there. Colorado does the same thing. West Virginia does a very similar thing. New Jersey does a very similar thing. So there are models where -- where you can preserve parts of each.

I do agree with Mike that we should try to create similar -- one set of criteria at least for the Level I's and Level II's. And then I think the discussion

was the Level III's may require a little bit more time to figure out.

DR. ABOUTANOS: This is Mike Aboutanos. I think the process of how you evaluate -- where you to two team, one team is a separate discussion.

MS. BROERING: Sure.

DR. YOUNG: Right.



MS. BROERING: We agree.

DR. ABOUTANOS: I think the discussion is really does the State designation manual and the quest that came from last time for this committee to take a look at it again.

You know, is the proposal now to compare it to the ACS? And I think this is such a touchy subject when it comes to the designation manual. And I think simply saying we think they're mostly similar -- I'm not saying simple. I know it's not

simple at all. But it took us, as you all remember, three years to come up with the first designation manual. And -- and it took literally looking at every -- and this what I will ask.

To get legitimacy and to get transparency is to just simply put one right next to each other and just say, this is the same, this is the same. And --

MS. BROERING: That's what we did.

DR. YOUNG: That's what they did.

DR. ABOUTANOS: But it needs to be shown --

MS. BROERING: Oh.

DR. ABOUTANOS: -- is what I'm saying. I'm just saying eventually from this --

MS. BROERING: Yeah.

DR. ABOUTANOS: -- it needs to come out that this is what we have seen for it to go forward, you know.

MS. BROERING: Okay.

DR. ABOUTANOS: And -- because it's -- and -- and does it answer the question I asked before. Does it solve some of the issues we've had with the -- I'm hoping it does.

It would be a lot easier to just have one -- one criteria. But we have to show it. That's most --

DR. YOUNG: Anything else -- comments? Just a conclusion from their group was for the Level I's and II's, there's a tremendous amount of similarity in those very few instances it seems that where there are differences that those differences are critical to the -- the survival of patients. Except for maybe a few things that -- that may be better that are in our criteria. But there aren't that many of

those.

DR. ABOUTANOS: Can I ask a question?

MS. BROERING: Sure.

DR. ABOUTANOS: Since you are also reviewer for the State of Pennsylvania, why is their state criteria much more stringent than the ACS? They don't even use the ACS criteria.



MS. BROERING: Their foundation, now. Yeah, I think that they are -- I'm just going to be honest. I think they're a little bit more evolved than we are at a state system perspective.

And I think that what I've seen over the years of being a reviewer from back in 2004 and 2005, all the way up to this year. Their standards have greatly evolved. Some of their standards, back in 2004 and 2005 -- again, I think their standards are very, very similar to the ACS.

And then there are some additional standards where the -- they're a little bit tight -- they are a little bit tighter. And I will use the example of nursing education. That is one of their standards that is -- is much more stringent.

I think that they've -- they've evolved as we are beginning to evolve with this. And that their -- and that's what they've made the decision.

What -- what Pennsylvania has also done is their standards that -- they have created standards that are just standards.

But then they create sort of interpretive processes that allow change without having to go through the general -- General Assembly.

So here's the minimum criteria. You must have a surgeon present 80% of the time or whatever, you know. I'm just using that as an example. But there's other parts of that like nuances of performance improvement, etcetera, that become like appendices that allow change and

reflect over time so that they can move the system and they can move patient care forward without having to be so exhaustive in a -- in a true Code mentality.

DR. ABOUTANOS: See that -- that would be one -- one part where we could learn from --

MS. BROERING: Yeah.

DR. ABOUTANOS: -- another avenue, you know, as far as putting -- adding something additional. And I'm not -- ask the question again. Again, this is Mike for the recorder.

So to Jeff, you've done so many of the ACS visits. Is there something in the ACS visit that -- and in their criteria -- that bothers you.

That you say, you know, for our own state maybe it's better to actually add this. If you were just speaking --

DR. YOUNG: Well, the biggest thing

is the ACS finally got rid of the CME requirement, which was the biggest problem. And now that that's gone, that's -- for the physicians, that's the biggest difference between the two criteria.

The ACS visit is -- is much more in depth on performance improvement as you all know if you've gone through it. The way that we look at charts and stuff is -- is a much deeper dive.

And -- but other than that, I think that's why we came to the conclusion the Level I and II criteria are not that different.

They're not appreciably different between the two, except for CME. So what -- any other comments or -- yes. Terral, good.

DR. GOODE: In your experience and when you're looking at these different states who have decided to adopt the ACS philosophy and those who have decided to retain their own, does it matter if you have a state that has an overwhelming -- say a

geography -- a demographic where there's the access to health care is pretty robust in all -- in all elements of the state, versus places where there are big gaps in care.

Such as a more -- a larger, more rural state where there are deserts in and around the places where the Level I and Level II.

DR. YOUNG: So there's a factor in that. So the more rural states usually do not have enough resources on the state EMS side to do their entire verification process.

So actually you find it more often in the very rural states that they want to farm the entire process out to the ACS. You know, the states that don't use the ACS are actually very urban states.

Illinois doesn't, although I've done visits in Illinois. No -- there have been no ACS visits in Pennsylvania as far as I know. Florida had their own system for a long time, but now they've gone to the ACS. Colorado, basically when you go --

when you finish the visit, they just hand you a checklist. And it basically goes, these are the ones that are different than the ACS. So you need to make sure that they're there.

New Jersey essentially uses the exact same criteria. So -- you know, I just haven't seen any state where they have us use their additional criteria where they were -- a lot of them has nursing education.

Because I think people do object to the vagueness of the nursing education requirements of the College. In fact, reviewers object to the vagueness of it.

But other than that, it's -- it's pretty similar. One issue that has come out nationally is a lot of places are Level II's and want to be Level I's.

And there's been a lot of gaming going on nationally to meet the research requirement. That there are places where, if you pay them a certain amount of money, they'll provide a certain amount of papers for you. And the VRC knows about

that and has tried to stop that. And then, the College requires for you to be a Level I -- and I am not entirely sure of the State requirement on this. That you have to have a continuous rotation in trauma surgery to PGY 4 or 5 level.

And so places that want to be Level I start making an affiliation with an academic center to have one resident come over five days a week so that they can do that.

And -- and I hope we would never do that kind of gaming here because it's a little bit destructive to the whole thing.

DR. ABOUTANOS: Can I add something? We're not talking -- I hope we're not talking, unless we're going to make another clarification.

It's simply adopting criteria, not adopting an organization. Those are very separate things because with the ACS comes a lot of additional finances and costs.

COMMITTEE MEMBER: Yeah. True that.

DR. ABOUTANOS: And so you know, we're simply looking at the criteria. Are we going to adopt some of their criteria? That's a different discussion from saying, are we going to become automatically ACS.

MS. BROERING: Right.

DR. ABOUTANOS: A state -- a -- at least maybe a proposal that this committee is putting together that a hospital can choose how they want to be state-verified.

I know these criteria are very similar to the ACS, but I don't want to be ACS verified. Let's put it that way. Right?

DR. YOUNG: And I think in our discussions, we never put forward that the whole system would be ACS.

MS. BROERING: Yeah.

DR. YOUNG: I think the philosophy was, number one, let's try to make as much of the criteria's that the same, the same. Try to look for those that actually add value.

For places that are already ACS verified and are already spending that money, that perhaps we could consider using their ACS verification with a State augment, like I said North Carolina does.

DR. ABOUTANOS: Mm-hmm.

DR. YOUNG: For places that don't ever want to be ACS, they could just have the same State visit they've always had, just using these criteria. And then I don't want to get into the weeds with this.

But it was something to discuss was if they go and the ACS does not verify them, but they would've passed by State criteria. And that's the reason why you have the State team go with them. Because -- and I've done this. I've done places where they didn't meet the ACS

criteria and we had a discussion with the state. And the State said, well, they do meet our criteria. And they will continue to be state verified.

DR. ABOUTANOS: And how does that work, they're using the same -- the same state --

DR. YOUNG: The -- the -- some of those states -- the states where this occurred, they do have five or six different criteria.

DR. ABOUTANOS: Oh.

DR. YOUNG: But actually, as you may know, the most common reason to -- to not be verified in an ACS site visit is performance improvement.

And so the states -- some of these states performance improvement bar may have been lower than the ACS. They looked at the charts with us. And the ACS reviewer would go, we're not going to pass them. And

the state reviewer who, you know, is an expert sector person, would go, no. This is good enough for us. And they would stay state verified.

And that happened in North Carolina and happened in Ohio when I was there. It does happen.

MS. ARNOLD: And -- this is Shelly Arnold. Kind of on that same note that we talked about, there may be things where the state would allow a corrective action plan where the ACS won't allow a corrective action plan if it's a Level I or Type I.

And you -- and you don't pass it, the ACS will just say you're not verified. You didn't pass. Whereas the state and the state team may say, we will allow you to continue with the state designation --

DR. YOUNG: That's a good point.

MS. ARNOLD: -- as long as you do this and you provide us this in three

months. And we'll come back in six months or whatever the state would say.

DR. YOUNG: Yeah, I --

MS. ARNOLD: To allow that -- that flexibility for your state to just not be not designated and done.

DR. YOUNG: And many states do that. And we -- we can certainly bite this off in chunks. And this -- the first chunk can just be what criteria are different, what are the same?

How should we merge them and should it be just ACS criteria we use, or ACS plus? And the other thing everyone needs to be aware of is there's big ACS revisions going in -- on right now.

And -- but the ACS in general -- and I'm in charge of the two of the chapters -- has, if I could say, has gotten more lenient. Has gotten away from those criteria that have never shown that they provide any value to the patient. And sent

down to all the centers to get feedback on every single criteria. And if the feedback from the centers were, this is a burden and we don't think we should do it. Then the -- the VRC is being very receptive to removing those criteria.

DR. ABOUTANOS: So this is -- this is Mike. Let me ask this other question because this one's important. So now there is a process also that's eventually being looked at.

Because so now you have another organization that has its own committees, its own people. And I'm sorry, from Pennsylvania. They have three exceptions.

Oh, I'm sorry, from Virginia. And they -- if they -- they need to change the criteria. Does that mean the State has to immediately change our criteria or -- it probably does not mean that.

DR. YOUNG: We can decide whatever we want. What many states do is they just

say -- they can say we follow every clarification document that comes from the ACS and we adopt it. Some have said, we're not going to change until an entire new optimal resources document comes out.

And you know, I think the way that states have done that is -- I think it's the way the Code is written here is that we will determine standards for trauma center designation, or Tim may know better what it says.

But the states that have regretted what they've done have said, our criteria for state verification are the current ACS criteria. And those states have regretted that because --

DR. ABOUTANOS: They're changing.

DR. YOUNG: Right. So you know, I think -- you know, we would still have a group. And you know, we can make a group that whenever new clarifications or actual changes in criteria come out. They don't -- the really, really big ones I don't think

come out more than three or four times a year. And we can just discuss them.

And you know, I think the Commonwealth can still have autonomy to say, you know, to make it -- I guess we have to decide whether it's going to be ACS plus or ACS minus a few things.

I think Beth and others have said one of the problems with the State criteria over the years is that we've tweaked things dependent on issues that came up. And it's left the criteria kind of gray. So --

DR. ABOUTANOS: But it just means that the State is -- sorry, it's Mike. That the state is responding to its need --

DR. YOUNG: Right.

DR. ABOUTANOS: -- in the criteria. And I think -- so this -- these are the -- you know, the committee can decide and obviously and you can -- eventually when the work is done it's got to be brought up to

the TAG. But the -- I -- I'm more into the language of ACS versus the labeling of ACS. And those two are not the same.

I'm just saying this is an ACS language that works fine. Instead of saying we're ACS plus, we'll just simply use the same language.

DR. YOUNG: I think -- don't we already say that now? Don't we already say, Tim or Cam --

MR. ERSKINE: No, we say --

DR. YOUNG: I thought we said it was -- doesn't it say somewhere it's fundamentally based on --

DR. ABOUTANOS: It does say that.

MS. CRITTENDEN: It says it's based on a national standard.

DR. YOUNG: Oh, that's all it says?

MR. ERSKINE: Mm-hmm.

DR. YOUNG: So I guess we could make that --

DR. ABOUTANOS: Be supported by. Which I --

DR. YOUNG: Although more --

MS. CRITTENDEN: Yeah.

DR. ABOUTANOS: How to avoid -- how to avoid some -- some things that, if -- if the criteria makes sense, you know, and it fits. Like I said, currently there are a lot of ambiguity needs to be solved, either way. So -- okay.

DR. YOUNG: And we also may have to go through a transition period. I -- I realize there may be many people that don't trust the ACS. But having been on the verification review committee for 22 years, I -- I -- it has tremendous representation

from all over the country. From Level I, II, III's and IV's. And people are not shy about speaking up if they think that there's an issue.

And for a long time, the executive committee stuck with criteria that a lot of people disagreed with. And the new executive committee has been very amenable to logical and reasonable changes in the criteria.

So -- so where do we want to go next with -- let's just take the first chunk of the criteria. And the question is to make a definitive assessment of what criteria we think should just be considered the same.

DR. ABOUTANOS: Mm-hmm.

DR. YOUNG: And then what that we think really need -- need additional Commonwealth of Virginia criteria, and for what levels. So Beth, what do you think?

MS. BROERING: I'll let somebody

else.

DR. YOUNG: What do you think, somebody else.

MS. BROERING: Anybody else is fine.

COMMITTEE MEMBER: If you're going to do kind of like the -- the areas where I have these 10 identified, and I'm only speaking for I's and II's.

We're kind of leaving III's over here because we know there's a significant variance between state and ACS that.

But for I's and II's, I mean, I think we need to look at nursing education and are we getting included or excluded. Physician CME's, are they in or are they out? Do we match the CME --

DR. YOUNG: They're on -- they're on their way out.

COMMITTEE MEMBER: But we're putting some other things in place.

DR. ABOUTANOS: We already voted on that, I think.

COMMITTEE MEMBER: The mid levels --

DR. YOUNG: It's -- it's working its way up.



COMMITTEE MEMBER: The mid levels are a higher standard than ACS. So they really are a higher standard than ACS with the new coming in's. But --

DR. YOUNG: In which -- in which way?

COMMITTEE MEMBER: The State of Virginia's going to have a higher requirement for mid level providers for CME's.

DR. YOUNG: Oh, for CME. Okay.

COMMITTEE MEMBER: So if -- we need to have discussion on CME. I do think there needs to be a discussion on the research component for Level I's.

There is pretty significant difference between ACS and State for the research requirements.

DR. YOUNG: Excuse me. Just for the group, what is the State research requirement?

COMMITTEE MEMBER: Five articles in three years.

DR. YOUNG: Yeah.

COMMITTEE MEMBER: Four adults, one peds. And one of the adults needs to be nursing by -- by -- there's a total of five article requirements for the State.

DR. YOUNG: Okay.

COMMITTEE MEMBER: So I think that's one. The neurosurgical in-house coverage is different with the State versus the ACS.

DR. YOUNG: And -- and the --

COMMITTEE MEMBER: For Level I's only.

DR. YOUNG: And the difference is what again? Who is what?

COMMITTEE MEMBER: The interpretation of the State guidelines says that there must be neurosurgical coverage in-house, 24 --

MS. CRITTENDEN: In person.

COMMITTEE MEMBER: -- in-house. Right.

COMMITTEE MEMBER: In person. I don't know if it says in person or in-house.

MS. CRITTENDEN: It says in-house.

DR. ABOUTANOS: It says in-house.

COMMITTEE MEMBER: A body has to be in-house where the ACS does not have in-house requirements. It has response time requirements, but not in-house.

MS. CRITTENDEN: But that can be filled by a PA or --



COMMITTEE MEMBER: Yeah.

(Several committee members starting speaking at once.)

COMMITTEE MEMBER: The neurosurgeon has to be --

DR. YOUNG: So -- so Cam Crittenden said that it -- it can be covered, not only by a neurosurgeon, but by a physician's assistant.

MS. CRITTENDEN: That is correct. But the ACS --

COMMITTEE MEMBER: Nurse practitioner, too?

DR. YOUNG: Yeah.

MS. CRITTENDEN: The ACS doesn't have a requirement on -- for the in-house piece.



DR. YOUNG: PTY, whatever.

MS. BROERING: What are the other big ones? I'm trying to think if there's anything else --

COMMITTEE MEMBER: Well, there's actually a volume requirement for Level I's --

MS. BROERING: Volume requirement, yeah.

COMMITTEE MEMBER: -- by the ACS, but there is not actually -- and I was just looking again. I still have not been able to find the true volume requirement for an adult. There is peds, but there's not --

DR. YOUNG: For the State?

COMMITTEE MEMBER: Mm-hmm.

COMMITTEE MEMBER: -- a requirement for the State.



DR. YOUNG: There's not. Just from what I know, all of the current ACS verified Level I's in the State would meet -- meet the ACS volume criteria. So it's not -- there is no volume criteria for Level II's in the ACS.

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: I think that's

-- I think you spoke to it.

DR. YOUNG: So for an action plan --

COMMITTEE MEMBER: I think that -- I think that where we found it is that there's been some -- I'm going to use this example where the ACS says you must have a prompt response of surgical and surgical sub -- or you know, care of the patient in the emergency department.

The State has taken it to say there will be at least two board -- two physicians who are board-certified. So we've sort of taken that to a -- a level of higher specificity.

So -- and I -- some of that I think might -- might -- is actually pretty good. I'm not -- I'm not saying it's bad. But those are the types of nuances of how the standards in the State have been. The interpretive guidance have been turned into standards or -- in the State.

MS. CRITTENDEN: So can I say one thing?

DR. YOUNG: Mm-hmm. Cam.

MS. CRITTENDEN: So we keep saying the State. So for those of you that just -- just as some background.

DR. YOUNG: Uh-huh.

MS. CRITTENDEN: So the State didn't create this manual.

COMMITTEE MEMBER: Right. Yeah.

MS. CRITTENDEN: Just -- just so y'all know.

COMMITTEE MEMBER: Yeah.

MS. CRITTENDEN: We -- there's a lot of --

DR. ABOUTANOS: The TSOM -- the

TSOM.

MS. CRITTENDEN: Y'all did.

COMMITTEE MEMBER: Yeah.

MS. CRITTENDEN: I mean, it was 18 months of work from the TSOMC and that group. All the trauma program managers and all that.

So I'm looking at -- you know, we talk about nuances, but any of you that were on any of those work groups that came up with this criteria, I'm sure there were reasons and a ton -- knowing y'all and tons of discussions --

COMMITTEE MEMBER: Sure.

MS. CRITTENDEN: -- about all those nuances. So I think that, just from looking in this manual and living and breathing it and all these site visits, I -- the nuances are there. What we could benefit from, in some ways, is it may be a broader

interpretive guidance section. And into the manual, each section does have guidance wording. But if we help beef that up, some things -- I'm -- I don't know where -- how we got to some of these nuances --

COMMITTEE MEMBER: Yeah, you do.

MS. CRITTENDEN: -- because I wasn't there. But I mean, but I know that the brain trust came up with it. So I know that it wasn't just picked out of thin air. There was a ton of thought that went into it.

So if we move forward, that may be beefing that up a little more and providing more in-depth guidance or broader -- so that people 10 years from now, when we're all gone and retired forever, understand what we were talking about and why we're talking about it. I think that would be helpful.

DR. ABOUTANOS: Yeah.

DR. YOUNG: Terral.

DR. GOODE: I wasn't around when the -- the manual came out, either. I mean, I wasn't a part of the process. But I wonder is -- was some of the nuances, as well as the ambiguity that y'all referred to -- was it in some way in response to the idea that, at least from a Level II center, that all the Level II's are not exactly the same.

Do you know if you -- do you know what I'm saying? Like depending on -- on where you are --

DR. YOUNG: Yeah.

DR. GOODE: -- this Level II --

DR. YOUNG: But that -- that's very similar in the whole nation, though.

DR. GOODE: Right. This level --

DR. YOUNG: When you look at -- and

I said this to the group. Like when you look at the variability and performance of Level I's in the nation, they're like this.

When you look at the variation of Level II's, it's like this just because there are so many different institutions and such. And that's why the Level II criteria are kind of what they are.

They don't have the volume criteria. They don't have the research criteria. They don't have the educational criteria for the College of Surgeons. So that's -- you're correct.

That -- that's why the Level II criteria tend to be -- allow more entrance of centers to be in that -- to be in the Level II area. And -- so that's correct.

And now, as far as -- just give -- I don't know how many people have been dealing with this as long as I have. But the ACS was not a player in this state when I first started on this committee. Nobody was ACS verified. And so it wasn't even something we even talked about. So we

developed our criteria manual independently without really even thinking much about the ACS. And then -- then Inova and then VCU and then various places. And then some Level II's got verified.

And then that's what has had -- tried to make people realize why do we have to have two completely separate systems. And try to examine, you know, what value the differences really have.

DR. ABOUTANOS: I think the -- to answer your question. So the -- it was a long arduous process. Every line was debated, literally. That's why it took us three years.

And the short answer is yes. Because the difference -- when the TSOMC was in charge of this -- and this is what Cam's referring to -- you had every trauma center was on -- at that time, our committee was huge. But every center was basically represented. So -- and what happened was everyone brought their nuances to it. And everybody says, forget about this criteria.

I'm not going to vote for that. That's going to kill us. And the other one would just say, well, you know, I -- of course, you have to have this.

The ACS was used as a background because that -- we had something to go where -- that's why a lot of the criteria are very similar, almost the same in many, many ways, very much so.

So the -- that's why -- that's why -- like this is a process. It still has to go, you know, forward. We've made sure it's the same significantly, the fact that almost every Level I now is also ACS.

I wasn't -- before like Jeff was saying. And -- and I think almost every Level II now? No.

DR. YOUNG: No, not yet. But still, there were no Level II's ACS verified. Just, you know, a few years ago.

DR. ABOUTANOS: That's why my -- my -- as much as I am -- I am a fan of simplicity when it comes to criteria making

easier, especially when I see a trauma program manager going like, just do so many things all over again, different way, nuances.

So if we make it simpler and achieve the same outcome for our patients, I'll all for that, you know, from one aspect.

But I'm a little bit frustrated -- just to tell you, I'm a little bit hesitant of -- of labeling as in ACS because it's going to create some negativity.

Instead of saying, it's the same criteria and just allowing the State to continue to do what the State is doing, but it's very much similar to ACS. So I think there's a way to do both.

And that's my opinion, to gain -- to gain it appropriately. And -- because ultimately, we have to decide our own fate here. You know, and we can't -- you know, if you choose to be ACS, okay, fine. But for the State, this is what the State is requiring. But it sure makes it a lot

easier if it was the same criteria. Just a lot, lot easier.

COMMITTEE MEMBER: And this is to -- to what Cam said. And I -- I came back to the -- I -- I was very -- I was much less involved back in -- in the early 2000's, you know, peripherally just when I was up at Fairfax.

But when I came back here in 2013 and into '14, the -- the manual was essentially had been written, the drafts of it. So they were tweaking it in drafts and tweaking of the criteria.

And while the foundation as -- as Cam said and you've said has -- has always been the basis of -- of the ACS or national standards.

You know, whether it was the blue book or the white book, whatever, you know. And -- and we've evolved over that. There's -- I think that there's some -- there's some ambiguity in the standard of an ACS standard to allow for the interpretive

guidance to change and evolve as -- as we evolve. And so if we think about it that way, then the standard says there will be surgical commitment. That's the standard.

But the ACS says the surgical commitment is evidenced by x, y and z, versus in this state, we have the standard and x, y, z and three more as standards.

So how do you create an -- as Cam said, more robust interpretive guidance that can help us evolve that -- that doesn't have 13 -- you know? I -- I don't know. That's what I'm --

DR. ABOUTANOS: That's right. And I would say -- this is Mike, sorry. What you're talking about, it's going to happen no matter what.

COMMITTEE MEMBER: Sure.

DR. ABOUTANOS: But that number is a bit different. See, you made the guidelines. Then an issue come up and the committee votes to change it or to make an

amendment or to do something to bring it up. Once you say that this is ACS -- that's why I was talking about the process.

Does this committee continue that you will evolve based -- or you say, now I'm going to have to wait now for the ACS to change.

And all this -- you know, like these things will come up where this committee brought up its movement is not -- I'm only saying we think this criteria works for the State well, but just make same criteria. But also, what happens if a change is needed? But maybe --

COMMITTEE MEMBER: Sure.

DR. ABOUTANOS: Because those are -- those -- that's what changes you --

COMMITTEE MEMBER: Sure.

DR. ABOUTANOS: -- you know. So I think --

MS. CRITTENDEN: So we have a mechanism to update the manual. We don't have to wait and do major revisions to it. For example, by the CME change. You know, there is a way -- we've done it.

Just send a note over to the Commissioner to ask him to, you know -- the Board can do it or he can -- the Commissioner, whoever it might be -- can sign off on that.

And that's what we've asked for, for him to sign off on the CME change. And we'll make an addendum to the trauma manual. With everything that's been going on, all the other we've been doing, it's not really ever been a topic.

But if there are things, as we move forward -- talking about kind of being an agile document to reflect changes in the environment in this state, something we want to do better, there are ways that we can do that without having to do major revisions. So we can make this a living document versus every three or five years we have to do this major, you know, dozen tons of changes.

DR. ABOUTANOS: Sure.

MS. CRITTENDEN: And the only thing I would caution a little bit is that with four changes a year, if their major changes, you guys have to react to that four times a year.

And you're in mid-cycle or -- you know, I mean, those are -- those are from an operational perspective --

COMMITTEE MEMBER: Sure.

MS. CRITTENDEN: -- in your program. Those are big deals. And so, we -- by maintaining control ourselves, we can time that. And we can put in effective dates and things.

So we do have mechanisms to make this a living document, versus we have to re-do it totally every time.

DR. YOUNG: So let's try to learn from what the ACS has done wrong. So six years ago, there was a big deal about making

a living document. They gave up on it after four years because it was a disaster. Because people -- new criteria would come up.

You would go visit someone. Oh, I didn't know that was the new criteria. Well, we sent it to you in an email three -- you know. So we can't -- so ACS --

MS. CRITTENDEN: Every triennial, we would say effective with this -- you know, that --

DR. YOUNG: That's a semi-living document.

MS. CRITTENDEN: For us -- we're controlling ours to date. I mean --

DR. YOUNG: No, no, no. I agree with that. I'm just saying, they were -- their idea was that as science happened, as things they would revise. And it was a disaster.

MS. CRITTENDEN: I mean, four times a year -- what you just said for major -- for changes. And you -- I mean, that's a big deal to implement.

MR. ERSKINE: Yeah, that's a lot.

DR. YOUNG: I actually thought this would be the smaller chunk. But maybe -- maybe the smaller chunk is actually having a discussion of what we should do with people that are already ACS verified.

Do they have to do two visits? Can they have a combined visit? I mean, maybe that's a[n] easier discussion. And we can still keep all the criteria exactly the same and they could just have a combined visit.

MS. CRITTENDEN: We're back to Code change to do that --

MR. ERSKINE: Right.

MS. CRITTENDEN: -- in some ways.

Well, let me back up. We have tried to do that with ACS, but our speed -- when we were asked by two other facilities, we sent that -- met with the trauma program -- trauma surgeons site team leaders about that who would have to train in two different ways to a review.

DR. YOUNG: Oh, no, no, no. No, I meant having the State people do State -- you would have --



MS. CRITTENDEN: Like in current reviews.

DR. YOUNG: Yes.

MS. CRITTENDEN: So we -- we tried to do that, but we would have to then conduct our visits in different ways. Y'all do it differently than we do.

The trauma surgeons that do our site review, our team leaders really didn't want to do that. I mean, we had somebody requesting, you know, we got an ACS

visit coming up. Can you just do the same medical records for ACS? I --

DR. YOUNG: Well, we could.

MR. ERSKINE: No. Absolutely not because that is not even across the board. There are only five ACS centers in the state.

DR. YOUNG: No, I'm saying --

MR. ERSKINE: The other 14 --

DR. YOUNG: -- what is the matter with the way the ACS pulls their charts?

MS. CRITTENDEN: We have our own formula that we --

MR. ERSKINE: We have our own --

MS. CRITTENDEN: -- that we have to follow.

MR. ERSKINE: We have our own randomization formula. And it has been applied evenly across the State. And to then say, well, if you're ACS we'll give you special treatment.

MS. CRITTENDEN: Different treatment.

MR. ERSKINE: One could argue the ACS criteria are much harder to get through the visit than the State criteria are. The failure rate is certainly much higher.

DR. ABOUTANOS: I think the question is not -- I think that -- if you're saying as far as what can we do to have, you know, the site visit done at the same time -- even just arguing that, there's going to be some -- not necessarily combined, you know, kind of one aspect.

I think maybe we get this through steps. Step one. Like for us, we're continuously in preparation. We don't even have time to work on QI's because

you're always at preparation. Whether State, ACS. It is -- it is not -- has not allowed time to change -- to happen because you're always working it. So --

DR. YOUNG: And also doesn't add value.

DR. ABOUTANOS: Yeah.

DR. YOUNG: It doesn't add value to do it that way. There is no -- I mean, I've done 170 ACS visits. So we'll have a dinner -- which you don't have to come to. You guys don't have a dinner.

And then the next morning, we have a tour and we look at charts. So you could have different set of charts. You know, possibly we would look at the way Virginia randomizes charts and we would say, do it that way.

That's not written in stone for the ACS. So it's quite possible that the ACS -- since I've been on that committee for a long time -- could probably -- could

probably adjust to those things that we think are essential. Because we do do that in other states.

COMMITTEE MEMBER: And like do you believe that the ACS is looking at a new process for chart selection? There was some pilot projects going on when we were at the last TQIP conference --

DR. YOUNG: Yeah, that's --

COMMITTEE MEMBER: -- which maybe would match what the State wants as well. I don't know. But they are continuing --

DR. YOUNG: Yeah, I wouldn't -- I wouldn't say out of bounds the ACS wouldn't adopt it. Because I think we're all trying to figure out what the right charts are to pull.

All the ACS cares about is we want to see every -- every mortality with OFI and every unanticipated mortality. Beyond that --

COMMITTEE MEMBER: And then it's a matter --

DR. YOUNG: And for Level II's we want to see every patient you transfer out, because we want to make sure you're not transferring out stuff you should keep. Other than that, that's -- that's pretty much the core.

COMMITTEE MEMBER: And we'd got to do that, wouldn't you agree?

MS. CRITTENDEN: Yeah, I think the core -- yeah, I think -- I mean, I -- yeah. It gives us the -- we -- it's much -- I think there's more -- it's more [unintelligible].

DR. ABOUTANOS: Well, that's what I was talking about, sorry. It's Mike. I'm talking about different -- different -- distinguish the process from the tool. So first, we thought about talking about the tool. You know, is the tool adequate?

Should we adopt the same tool? And that's why I said at very beginning, that's a different discussion --

MS. CRITTENDEN: It is.

DR. ABOUTANOS: -- from the process. No matter what tool we -- whether we adopt our tool or whether we set ACS plus or just, hey, it's the State. We just have to do very much the exact same thing just to make it easier.

I think that's one process committee in charge of. The second is a total ask for, you know, whether you want to combine. How do you combine?

Do you distinguish now a process for Level I, Level II that's separate from Level III. What does that do to the -- to a state process together? I mean, so those -- I think those are bigger questions.

DR. YOUNG: Knowing the -- knowing the criteria for the College very well, if

the state is eliminating CME then it's easily do-able. You could even have the state team come the day of the dinner. And you'd have the charts there.

We could probably make the charts as similar as possible. And then the ACS would just stay the next day.

DR. ABOUTANOS: See, but you could actually do that now without even -- I mean, you could do --

DR. YOUNG: Well, it depends on -- it depends on your cycle. I mean, you'd have to get it --

DR. ABOUTANOS: Yeah.

DR. YOUNG: So a lot of us are in a different ACS versus State cycle.

DR. ABOUTANOS: Yeah, but I'm just saying you could have the State come in, take a look, review the -- the chart. Then the ACS review the same chart when it's its

turn.

DR. YOUNG: Yeah.

DR. ABOUTANOS: But it --

MS. CRITTENDEN: Actually, that's what we offered to do --

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: -- that, but we won't do it in the same week. You know, we'll -- you know, we're triennial date, Code of Virginia, what we follow.

So if they want to try to schedule it the day after or two days after -- I mean, we could work with the -- the schedule.

DR. YOUNG: Yeah. Well, that might be a solution. It would just be a two-day visit. One and a half for the ACS and one for the State.

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: Yeah, I mean, that was our -- we said we would do that. But nobody has taken -- well, y'all haven't done it yet. But they haven't taken us up on it yet.

DR. ABOUTANOS: No matter how we look at this, I -- I do think going back to the fact that there are certain things in the designation manual that needs to be changed. So we -- we -- with -- that has to be addressed.

COMMITTEE MEMBER: Yeah, and I think that to -- just to clarify. When we said we would, quote -- I'm going to use the term that was sort of thrown out -- adopt and I even used sort of adopt.

It wouldn't be -- here's the ACS standards, we're going to follow them. We would literally take every single standard. We would have a designation manual. And if standard 1.1 and 1.2 and 1.3

that talks about involving in regional trauma from the ACS. If we have that standard when you think it meets, then that becomes for a Level I. This is the standard, it's the Level I.

So there wouldn't be a literal manual. It wouldn't be -- you know, we can do it that way so that you have a -- so if a center did not want to be ACS, there's still a State manual. And if there needs to be a change --



DR. YOUNG: Yeah.

COMMITTEE MEMBER: -- but it would allow sort of -- I don't know, to some -- to some degree, it might be a little bit of a reset to some of the stuff that we've evolved and changed. But sort of more to make it live-able.

DR. YOUNG: Yeah. I guess -- my only comment would be, I -- I think -- I wasn't on this committee for 12 years. I did it for 12 years before that. Back 12

years ago, many of the criteria were changed because one person objected. Not a lot of you were here. And it would be a single person from a single center who would say this is going to hurt us.

And therefore, we changed all the criteria for the state. And I think what -- having it in some way fits to the ACS is -- I don't think that's a good idea, for a State trauma system, for us to do that. And I mean, perhaps it's never happened in the last 12 years.

DR. ABOUTANOS: To do what?

DR. YOUNG: To have a single --

DR. ABOUTANOS: Point.

DR. YOUNG: -- veto of a criteria.

MS. RUMSEY: Yeah, this is Kelly Rumsey. Doesn't that take us back to how we established our mission for the school system?

COMMITTEE MEMBER: Yeah.

MS. RUMSEY: That we're here in -- on behalf of the citizens of the Commonwealth, not the individual institution.

DR. YOUNG: Yeah.

DR. ABOUTANOS: And that's why there's -- you know, I mean, one could object. It doesn't matter. It's going through -- first it's got to come out of this committee.

MS. RUMSEY: Mm-hmm.

DR. ABOUTANOS: Then it's got to go out of the -- the TAG. And then -- so I mean, so we created different aspect for it to be vetted very well and looked at very well, you know. And so -- and none of us -- I think that the nuances have been also is that everybody understood that -- and got to understand more and more in the past --

whatever -- six years at least were the difficulties in every center, and what they were facing locally.

And -- which was -- that allowed to a lot of aspect of the political things that came in -- into, you know, this center really should function as a Level II.

Is this really an issue? Can everybody live with that? And that's kind of what -- what it was. It's a little bit different if we -- that by itself can lead to a lot of issues eventually, if the system does not evolve.

If it doesn't evolve, we're -- then you end up saying, you know -- you know, I'm sorry. We eventually did evolve and we said, for example -- I'm not sure if you guys remember with CKD and all that stuff. These are the criteria.

DR. YOUNG: Yeah.

DR. ABOUTANOS: Everybody, no matter how much it was pushed and how much people were that we love or respect, you

know, the -- the system. We still, as a committee said sorry. We are going to adopt these criteria because that's what -- that's for everybody overall.

Not the best for each institution. And so, that's just an example. It was a very touchy example. It was fought at every level.

I'm just saying it's -- it's -- I think we are able to do that and not allow one institution to say, this is what's best for us and everybody say, okay, now we're going to have to change.

And this will come no matter what it is. I just -- I just -- why I think if -- we just need to look at our tools and say, does it still serve us or not? It's been three years.

It's a new committee. And then if the ACS is an example, can we use it? Can we in any way match? Then we talk about the processes next.

DR. YOUNG: Lou Ann Miller.

MS. MILLER: Yeah. Lou Ann Miller, Riverside.

DR. YOUNG: I just introduced --

MS. MILLER: As probably one of the only persons or people that were here during the last designation manual -- well, maybe Kelly.

Revision -- I would like to say that we did not take -- I mean, we did have a lot of people say, oh, that's not going to work at our facility. However, we looked at what was best for the patient as a whole.

DR. ABOUTANOS: True.

MS. MILLER: And that's what we made the -- the criteria regarding. I mean, one of the things -- an example is Level III said that they couldn't have -- you know, they wouldn't be able to hire a half FTE as a -- with the full time trauma coordinator. And we said, well, that's -- that's the

criteria. If you can't meet that, then you won't be a Level III. And that was, you know, we adopted that. And lo and behold, the -- you know, Level III's were able to come up with that half FTE.

DR. ABOUTANOS: After we changed the trauma fund to give them --

MS. MILLER: Same thing with the Level II's. Huh?



DR. ABOUTANOS: Well, we also changed the trauma fund to be able to also help. So we --

MS. MILLER: Right.

DR. ABOUTANOS: -- we were cognizant of what -- what was needed.

MS. MILLER: Absolutely. So --

DR. YOUNG: And still is needed.

MS. MILLER: So I think that -- you know, I just want to say that, you know, when we -- when we made the criteria, we did not look at each center as to what their needs were.

We looked at the Commonwealth as a whole and what the needs were for the Commonwealth --

DR. ABOUTANOS: Absolutely.

MS. MILLER: -- and for -- for the patients.

DR. YOUNG: Yes. Tracey Jeffers.

MS. JEFFERS: I'd just like to add as not -- as a Level III and as a non-designated ACS. I want to come out of the weeds of the ACS.

Looking at the ACS document and the updates that they have done, it's more of an evidence-based practice and standard that we were able to kind of say, are we at the standard? Are we -- or can

we, as a commonwealth, is that beneficial to our -- our -- our trauma system. And so, I think that it's gotten kind of convoluted a little bit that this is -- it's -- it's ACS-driven.

And we want to become just like the ACS. The ACS came into the State and evaluated our state. But we spent a very hard three years of our lives comparing, is this going to work for the State of Virginia?

Is this going to benefit the patients of the Commonwealth? And some of the things, no, it's not. And that's kind of what we're doing in -- in trying to say, okay, well the State -- we live by this. ACS suggests or ACS lives by this.

Is that something that would benefit our patients? Is it going to benefit our centers and is it going to benefit our growth?

And can we bring in more centers in those deserts to assist the -- the trauma centers that are not able or that -- the non-designated facilities that we

have in these areas that are rural areas. Because we don't have that concentration of trauma centers. So I don't -- I -- I kind of wanted to back out of the weeds and the ACS part of that.

Other than the fact that we've used this document as evidence-based as proven and as a national guideline is how we're using it.

And that's what we're trying to work towards. The -- the designation manual, if -- if you've lived in and been through a designation, I -- most trauma program managers have -- then yes, there are places you're going, what the heck did they come up with that at?

How -- where did that come from? How am I supposed to live up to that? But that's where it gave us a little bit of backbone for that half FTE, for going to these committees with trauma surgeons -- sorry. And arguing, yes, you have to be there in 30 minutes because it says so. And we're going to lose our designation. We're going to lose our -- we're going to lose

everything. So I don't think the -- it's that we want to become a -- everybody has to become ACS, because we can't all afford that. So -- but we can afford to use that -- that guide and criteria to help us become better.

DR. YOUNG: Yeah, we have to separate those two things. I don't think anyone is suggesting here we want to be ACS. I -- I'm not.



MS. JEFFERS: No, I didn't make --

DR. YOUNG: I am -- I am consent -- I think -- I -- we're saying -- I think what Mike was just saying the -- the ACS criteria as a foundation --

COMMITTEE MEMBER: It's a frame work --

DR. YOUNG: -- for how we move --

MS. JEFFERS: I just want to make

sure that the perception --

DR. ABOUTANOS: Because that's what counts.

MS. JEFFERS: Because -- because that's what counts. Perception is what counts. And if it looks like -- because in my perception sometimes, I feel like Level III's -- oh, here's I's and II's, but you're over here.

So you know -- but we're going to have to do special things because you're a Level III. So -- but instead of being inclusive --

DR. ABOUTANOS: Mm-hmm.

MS. JEFFERS: -- I feel like there's some separation. And I felt like that may have been a perception that needed clarification.

DR. ABOUTANOS: I think this is important to learn from our own history.

That's what we struggled with the first three years after the ACS site visits. That just that word can cause so much problems. And I don't know why, but it did.

And we have to face reality and we said that we - we need to determine and make our own destiny. The State can decide for itself.

So that's what I was warning is that -- that's -- we could use the ACS, but we don't have to say it's ACS plus or ACS.

It's just -- here's a guideline that's -- and if it matches and we have two different organizations that have very similar guidelines and very similar criteria, it's easier on everybody, you know. That's all.

DR. YOUNG: So then, what's the suggestion for the process? We have a State designation manual right now.

MS. BROWN: And we just about -- I'm sorry, it's Kelly. We've just about

cross-walked all of it. Right? Isn't that the intention --

COMMITTEE MEMBER: Yeah, I think we have --

DR. YOUNG: Cross-walk with the current --

COMMITTEE MEMBER: State.

DR. YOUNG: -- ACS.

COMMITTEE MEMBER: Not --

DR. YOUNG: The current state with the current ACS as a cross-walk.

COMMITTEE MEMBER: Yes.

MS. BROWN: Yeah.

DR. YOUNG: So -- so where do we go from here?

DR. ABOUTANOS: Can I make a suggestion? Sorry.

DR. YOUNG: I'm hoping.

DR. ABOUTANOS: That -- see what -- what I'm -- like this, right? I'll just give you what I'm interested in. I'm interested in looking at here there's a designation manual. Here's a highlight.

Here's the issues we've had with it that need to have changed. Here's the ACS manual. And where it -- and kind of achieve both.

And then bring that as a proposal out of this committee to the TAG, eventually saying this is the proposal of fixing these criteria. That's it. I mean --

COMMITTEE MEMBER: I think that was the first thing you said.

DR. YOUNG: And we just look at the ones who are different.

DR. ABOUTANOS: And -- and -- but fixing the issues we've had with it. See, that was the whole point that drove this thing is fixing some of those.

MS. JEFFERS: I think -- I think it's -- sorry, Tracey. I think is to taking a step further and we've cross-walked. Now we need to go back to the designation manual and look at where our problems are within that and how that aligns what we've cross-walked.



MS. BROWN: Yeah, I would agree with that.

DR. ABOUTANOS: Okay. That's what I'm --

MS. JEFFERS: Different way to say it. Is that better?

DR. ABOUTANOS: It's a different way of saying it.

DR. YOUNG: So let's just make -- so --

MS. JEFFERS: That's the nurses' explanation.

DR. YOUNG: So at the next meeting -- obviously we're not going to do that now.

MS. JEFFERS: No.

DR. YOUNG: So that -- we're saying we are now going to -- but didn't you cross-walk?

COMMITTEE MEMBER: We cross-walked --

MS. BROWN: With the exception of a few chapters, we just ran out of time. We've done a majority of it. We can get it done, just within a couple --

DR. YOUNG: So we're pretty much saying finish the cross-walk?

MS. BROWN: Finish the cross-walk.

DR. YOUNG: And then make recommendation --

MS. BROWN: I mean, we can highlight -- we can highlight the differences. But it -- it's not the differences, it's the -- it's the problem, if that's what you're --

DR. ABOUTANOS: Yeah. My -- my interest is not -- is not the difference between ACS and -- I said from very beginning, it shouldn't be what's the difference between ACS. It should be these are the -- the things that should've been fixed.

DR. YOUNG: Should've been fixed in the State?

DR. ABOUTANOS: That -- that -- let's just -- let's just say if ACS doesn't exist. Let's just say it doesn't exist.

DR. YOUNG: Right.

DR. ABOUTANOS: These are our current guidelines. These are the things that we've been wanting to change. Let's highlight them. But then you could add -- since you've already done it in a cross-walk of saying, this cross-walk would actually solve this.

MR. ERSKINE: So who -- who has a list of those problems?



DR. ABOUTANOS: We do.

DR. YOUNG: I do.

MR. ERSKINE: Okay. Can you send it to me?

DR. YOUNG: Yeah.

DR. ABOUTANOS: We've been working on it for a while.

DR. YOUNG: It was one of the first things I did.

MR. ERSKINE: So we'll take a -- take a look at those problems --

COMMITTEE MEMBER: You're going to read criteria --

MR. ERSKINE: Yeah, look at that.

DR. YOUNG: Pretty much, you know. And it's -- it's --

DR. ABOUTANOS: It's a good question.

DR. YOUNG: It's not clinical. It's three pages of grammar typo's and logic.

MR. ERSKINE: Oh.

COMMITTEE MEMBER: Well, that's not -- that's not -- that's not what we're --

no, we're worried about. Grammar typo's and logic are -- are spell checks that --

DR. YOUNG: Well, logic that -- logic enters in into quite a bit of it. The --

DR. ABOUTANOS: Yeah, logic may be a problem.

COMMITTEE MEMBER: Okay.

DR. GOODE: This is Terral. You don't mean like syntax logic. You mean the -- the thought process, the way its written, it's too ambiguous? Let me -- wait. Who --

DR. YOUNG: Yeah, this --

DR. GOODE: Who said it's a problem? Like now.

COMMITTEE MEMBER: Yeah, yeah. Who said it's a problem?

DR. GOODE: Who -- who is -- who are the people that -- that came together and said, hey, you got a problem here, you got a problem here.

Or is this like a -- a historical gathering of problems that people, as we've gone through meetings, just written out on a piece of paper somewhere.

MR. ERSKINE: Yes.

DR. YOUNG: Heather.

MS. DAVIS: This is Heather Davis from Chippenham. I can tell you that leading up to a site visit we had just this week, there was a lot of interpretation that I pinged Cam and Tim to death about.

And I'm sure that they see repeat patterns in the types of things they get pinged about.

DR. YOUNG: And -- I mean, there's -- when -- when there's -- when I read it in coordinating the site visits --

MS. DAVIS: Yeah.

DR. YOUNG: -- you know, I look at it and think, how are we going to hold them to this standard? It says, you've got to be really good at surgery. You know, something as vague as that.

MS. DAVIS: No, they're qualifying.

DR. YOUNG: You know, how -- how are we going to do that? You know, diversion can't be more than five percent. Five percent of what?

It's 72 minutes of the day or 18 days of the year. You know, there's -- there's a lot of stuff that is not clear.

MR. ERSKINE: I'm going to let you speak in a second, but let me just say something. A lot of this is people not being terribly familiar with what goes on at the College level.

DR. YOUNG: Because the College --

MR. ERSKINE: But -- but there's one person at this table that's very familiar with the College process. And they are very -- a lot of these things that you just talked about, five percent, 10% -- blah, blah, blah -- they are getting rid of.

Because they -- if -- when we did this revision, we said, where is the evidence to support that you need to be there 10% of the time. There is no evidence. We're not going to do it any more.

So you know, I'm not saying it's perfect. But they are very amenable to that. Now we have -- I'm sorry. We have a really good test case here. You've been ACS visited in the past year?

MS. DAVIS: No. Our ACS was in 2017.

MR. ERSKINE: Okay.

MS. DAVIS: Our verification. We had a consultative in '16 and a verification

in '17.

MR. ERSKINE: So can I just ask, what are your comments about the differences between --

MS. DAVIS: So it's slightly different for -- for Chippenham because we were Level II, designated by the State. Provisional for a year, and then fully designated.

Then went for ACS designation. So that seemed like a pretty solid process between the two. We obviously chose -- whichever way it went -- the higher standard.

So if ACS had the higher standard, we went the ACS route. If the State standard was the higher standard, we went the State route.

With this recent visit, it was working towards going -- building up to the next designation level. So it was -- it was very different in interpretation between the College and the State.

DR. YOUNG: Yeah, I would say the way you still have to do that would make it very confusing going forward, which I guess is the basis of the whole issue that we're talking about. You, yes.

COMMITTEE MEMBER: I did. So -- and this might be a little bit further thinking than we're ready for. But the changes that you're referring to that ACS is getting ready to make, is that because of the overall ACS philosophy of moving towards outcomes --

DR. YOUNG: Yeah.

COMMITTEE MEMBER: -- and TQIP data and -- and less focus on the resources?

DR. YOUNG: It's -- it's -- it's more focused on being more evidence-based and getting rid of arbitrary criteria that just five people sitting around the room decide what we needed to do, like CME. Which has no evidentiary basis. So -- you

know, so it's that sort of thing. And there are a lot of them that are being revised. Radiology, response time, IR response time. It's going to go more towards, did you have any delays in getting rapid angiography?

Did you have any delays in getting a neurosurgery patient for a craniotomy? And I think that's the right way to do it. It's -- you know, the only problem with that is, at least for us, we only look at 20 charts.

So you could know which is where -- why the State way of pulling charts might be better is that you can -- you can hide a lot of damage when you only looking at 20 charts.

MS. DAVIS: Yeah. Because they send us MRN's and --

DR. YOUNG: Yeah. So that's a -- so that makes -- you know, I'm -- it may be a better system. It may be a better system to tell me it's a yet.

DR. ABOUTANOS: But it's not -- this is Mike. This is not TQIP-based.

COMMITTEE MEMBER: Oh, yeah. That sort of -- that direction now.

DR. YOUNG: Yeah. The latest TQIP report have obviated us using TQIP as a way of designated centers.

COMMITTEE MEMBER: Okay. All right.



DR. YOUNG: That's not happening.

COMMITTEE MEMBER: Okay. I mean, I think that -- I don't want to harp on ACS. I think that the ACS process of selecting charts and the State -- the difference is ACS says you need to have all your deaths.

You know, you need to have, you know, your deaths with opportunity, your unanticipated. And then they say you got to have your -- you got to have 20 major pelvis, lower extremity.

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: You got to have major chest. You got to have major head, and non-surgical admissions. And they want to see which is -- you've got to have immediate surgical care [inaudible].

That's how you demonstrate that versus you have an IR response time of 30 minutes. And so, you know, I don't know what the formula for the State is.

But I do think that the ACS gives -- affords centers the opportunity to highlight -- you can hide a lot.

But you can also highlight good care, too. So it's a -- it's two ways, you know. And then whatever formula you have for the State, I'm not 100% sure.

COMMITTEE MEMBER: It's random.

COMMITTEE MEMBER: Yeah.

DR. YOUNG: It's -- it's -- we have categories.

COMMITTEE MEMBER: But if it gets off center you could -- you could get nothing at all, you know. You could get really good cases to look at from performance improvement and operative management.

COMMITTEE MEMBER: Get a good mix of --

COMMITTEE MEMBER: Or you could get -- you could get nothing at all. So...

DR. YOUNG: All right. So do we think the next step is to finish --

COMMITTEE MEMBER: I think we'll keep working on -- it actually might -- Terral, it might be really good to have you maybe weigh in a little bit from a surgical -- from a non-ACS verified, you know, kind of philosophy of looking at it and giving some ideas. And certainly, I can bounce some things off Dr. Aboutanos -- you know, bounce some things off Dr. Aboutanos and

Dr. Young. Just to kind of think through, you know, a different perspective of, think about it this way instead of that. And --

DR. GOODE: Sure.

MS. CRITTENDEN: And when you all schedule that meeting, you need to alert the Office --

COMMITTEE MEMBER: Okay.



MS. CRITTENDEN: -- and we need to follow all of our meeting requirements --

COMMITTEE MEMBER: Okay.

MS. CRITTENDEN: -- announcements --

DR. YOUNG: Yeah.

MS. CRITTENDEN: -- all that stuff that you're doing work on behalf of an Advisory Board committee now. These are

official meetings, so --

COMMITTEE MEMBER: Okay.

DR. YOUNG: Yeah.

MS. CRITTENDEN: -- I believe that's what y'all are --

DR. YOUNG: So can I ask you, what is the warning? Like let's say they wanted to do this tomorrow.

MS. CRITTENDEN: You have to have 10-day notice --

DR. YOUNG: 10 days, okay.

MS. CRITTENDEN: -- on the Townhall, yeah. And we have to get space and all that. So -- I mean, there's -- and we'll support you administratively, but we just have to be able to work it in. It is a --

COMMITTEE MEMBER: Okay.

MS. CRITTENDEN: It is a real meeting now.

COMMITTEE MEMBER: If we formally, okay. All right.

DR. YOUNG: So that was the action plan. That was 3-D. Anything else -- I think we've beaten this. Public comment period. There's been a lot of public comments. Any hopes? Okay. Unfinished business.

MR. ERSKINE: Item and item.

DR. YOUNG: Yeah. Item and item. Any new business? Anyone wants to bring up -- so let me just tell you what I -- my idea of this, of all the things that this committee is supposed to do. The way we're set up with only being able to meet -- you know, that our meetings are restricted, I think it was probably better to not get five

percent done of 10 things. To try to get 30% done of one thing. So -- I mean, that's my idea unless anybody wants to make a more varied agenda.

But we figured -- I mean, the next meeting we may have to do this thing at phase two of this discussion. And I think that's just what we have to do.

MS. CRITTENDEN: I mean, these meetings -- this is your work for 50 years from now. The Advisory Board committee -- I was talking to Dr. Aboutanos last night.

The Advisory Board committee has a need for 30 years. So I'll be left -- dead and gone and I'll still be working on the work. So yeah, I mean, it's always going to be there.

Pulling through, there's always stuff to work on. And so I know we want to as, you know, physicians and nurses, you want to get it done and get it done. And -- but this is ongoing work --

DR. YOUNG: Set a trauma series.

DR. ABOUTANOS: All right. So here's -- here's my comment. My comment is that what I -- what I am suggesting for this committee to do is because we're short. We're going to be asking from every committee to do is step back.

You say now we have a trauma system plan. What does it mean, you know, into overall -- you know, from a system aspect. What's getting Virginians from trauma? What are we at?

What is this committee in this trauma system plan? What kind of data does it need to figure out where to go forward? What are the -- the three [unintelligible] we need to be at?

And not be stuck into a -- what we were before, which was the number one criticism of the TSOMC, this triage designation manual. Those are the two things.

And then we said, that that's not a trauma -- that's not a system. And -- so my -- my only recommendation is -- I'm speaking as a -- kind of a -- from the TAG

and from driving the system with everybody else, is that we wanted really Acute Care, not simply to be a substitution for TSOMC.

But truly to kind of look at the other committees, the other systems as a -- as a committee representing the Acute Care phase. How do we interact with the other thing?

Did we hear what happened from the Post Acute? Did we hear what happened from the Pre-Hospital? What are the system, what are the data management? We're -- this is very important for us to kind of re-jump right into the -- into the weeds of this.

And then I think this is going to be one aspect -- and I will bring it up tomorrow -- is for the TAG, especially with the Chairs, to bring back and just say, okay.

As a system, where are we and redirect every committee toward us. At the end of a year, where are we going to be at? What are the main things so that the committee can still work on important aspect, but can also be cognizant of what

everybody else is working on. So we could, as a system, get somewhere. So I think that's -- that's a big challenge for us, to be able to do that.

DR. YOUNG: We've been -- we've been trying to look at inner hospital versus direct scene transfer, major trauma patients for quite a while.

I mean, to me, there's in some ways no better indication of the proper functioning of your system than to know whether that is harming patients or not.

DR. ABOUTANOS: Sure.

DR. YOUNG: And so, at the -- do we have data robust enough --

DR. ABOUTANOS: Pre-hospital --

DR. YOUNG: -- from the State to look at that? Because the problem with TQIP is it's only going to be from six hospitals.

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: Every hospital in Virginia, it's going to state --

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: -- on a registry. Not the smaller data set for the non-trauma centers, but we have transfer data.



DR. YOUNG: So we could --

MR. ERSKINE: We can -- we can look at, you know, how long did they stay at that non-designated facility before they got sent over. And --

DR. YOUNG: But we don't have risk stratification.

MR. ERSKINE: Not yet.

MS. CRITTENDEN: Right now, we're

just starting baseline on some data now and looking at the patients that didn't -- that met step one, step two triage criteria.

DR. YOUNG: Oh, okay. That's a good start.

MS. CRITTENDEN: Taken to a non-trauma center, what happened to them? How many of them were discharged from the ED? How many of them were admitted at that hospital? If they were at that hospital, were they admitted home?

DR. YOUNG: So in the data set, if we got a query, it would have a column that said met step one, met step two?

DR. ABOUTANOS: Yeah.

DR. YOUNG: Oh, okay.

MS. CRITTENDEN: I mean, we -- we can do all this quickly looking at -- out of those hospice patients that got taken to

non-trauma center, how many of them were transferred to a trauma center? How many didn't get transferred? And the ones that didn't get transferred, did they live or they die? So I'm going to look at --

MR. ERSKINE: All right. Here's the --

DR. YOUNG: And how many of the transfers in got sent home?

MS. CRITTENDEN: You link them from the first hospital to the second hospital, so you can get a --

DR. YOUNG: This was the problem we discussed 20 years ago.

MR. ERSKINE: Actually it is -- it's -- it is -- it has -- we have the potential to do that. It's the -- the problem will be the -- the personnel and the time. That is an extraordinarily time-consuming process. We did it in Ohio a

couple of times and that's just park that person over in the corner for a couple weeks. So we'll have to, you know, there's -- there's plenty of software out there that can do that.

DR. YOUNG: Let me ask another question. So Cam and Tim, so with the rules about what we can do, one person on this committee could not get that data set and work on it --



MR. ERSKINE: Sure.

DR. YOUNG: -- in preparation for a meeting.

DR. ABOUTANOS: Yes, they can.

DR. YOUNG: They can or they can't?

MS. CRITTENDEN: Well, I know one or two epidemiologists, so you could just give us -- send us a request and we could pull the data and work on it that way, too,

and then share it. But no, one person -- I mean, any person sitting right there could request data and we get do it. I mean, that's --

DR. YOUNG: Oh.

DR. ABOUTANOS: You could assign to each -- each person, say, okay. I want you to work on this. I want you to work on this, work on that.

And then they send it to you as the Chair. As long as they're not meeting as a group. And you could redirect back.

MR. ERSKINE: All right. Let me talk to you afterwards about what the -- the output of those files are and what are the -- all right.

MS. CRITTENDEN: All right.

MR. ERSKINE: Any other questions?

DR. ABOUTANOS: I think that was kind of the one -- one aspect was is that so is the care -- is the care in our trauma centers, no matter whether it's the same or not, are the protocols the same?

Is that -- those, I think, are kind of the bigger picture we want to addressed yet. You know, eventually we have to be able to address those.

DR. YOUNG: Okay.



DR. ABOUTANOS: Because that was one of the -- that was one of the criticism of the trauma system plan. If -- if I am -- I have no idea what the care is in Norfolk. I have no idea what the care is in UVa.

And you have no idea what the care is at VCU, except we trust each other's care is very good. But are the policies the same?

Is a person that goes to UVa with this injury get admitted to the ICU, but not at VCU. Why? And they -- so a -- there were a lot of -- there were like small

nuances, but the whole idea of policies and protocol. So the designation was one aspect to guarantee the minimum resources that you need. But the management is not dictated in a designation manual.

Designation manual does not talk about -- it only talks processes and resources. And assumes -- all it wants to know do you have a protocol for this.

Because -- so this is one thing that was going to identify -- because we're not outcome-driven, that -- at least, not the State was.

DR. GOODE: This is Terral. I may be -- could be, you know, it needs a little bit here with this. But that's -- the answer's yes, obviously. I mean, it's inherently yes.

Especially in a place like Virginia where our -- our -- our system -- our regions are so absolutely different. Living in Richmond is nothing like living in Fairfax. It's nothing like living in Winchester. You know, our mechanisms for

transfer and moving patients, it's -- each one of us has our own set of challenges. For example, when we're talking about transfers and how long it takes to transfer somebody.

You know, I often have to transfer somebody by ground because I can not transfer them by air. It happens all the time.

DR. ABOUTANOS: Sure.

DR. GOODE: And there is going to be a delay. And that could actually lead to -- to a decreased outcome. Do we have the -- the capability to really dive down into that -- into those kind of situations, really.

DR. YOUNG: So we do, but I -- I do not know the state of the State Registry at this point. I just don't know. I mean, I know what it was 20 years ago. So we -- we probably could with our own registries to do a collaborative, to look at it.

COMMITTEE MEMBER: Yeah.

DR. YOUNG: Because I think with probability of survival, it's not the greatest thing on Earth. But it would give us something that you would have two patients with roughly the same GCS-ISS and physiologic signs, and one had to go by ground and one can go out by air.

And you'd probably have a bunch of those. And we can probably compare them. I don't know if the State registry has that capability.

DR. ABOUTANOS: The whole point was that we don't work in silos. So -- so tomorrow, the System Improvement Committee is going be meeting. Their whole aspect is what do other committees need to drive their processes?

And so, for us to -- to look and just say, okay, do we have the data on this? How robust is the data? But we identify what we need, and then ask these questions, you know. So I think that that's

the -- the whole -- you know, like -- you know, the -- so transfer was one -- one aspect, mortality's not. I mean, just -- we just haven't asked in those manners yet. We'll get there. I mean, this is --

DR. YOUNG: So what time is that meeting?

DR. ABOUTANOS: Tomorrow at -- what, first meeting?



MR. ERSKINE: First meeting is 8:00 o'clock.

DR. ABOUTANOS: 8:00 o'clock.

DR. YOUNG: All right.

DR. ABOUTANOS: Who is the liaison? Is there a liaison for the System -- from this committee or no?

MS. ARNOLD: It's me.

DR. YOUNG: Shelly. All right. Anything else? All right, thank you. And we're adjourned.

(The Acute Care Committee meeting concluded.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing ACUTE CARE COMMITTEE MEETING heard on May 2, 2019, from digital media, and that the foregoing is a full and complete transcript of the said ACUTE CARE COMMITTEE MEETING to the best of my ability.

Given under my hand this 16th day of June, 2019.



Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.