COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: ACUTE CARE COMMITTEE MEETING

HEARD BEFORE: JEFF YOUNG, MD

CHAIR OF THE ACUTE CARE COMMITTEE

FEBRUARY 7, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

3:00 P.M.

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APPEARANCES:

Jeff Young, MD, Presiding
Chair of the Acute Care Committee

ACUTE CARE COMMITTEE MEMBERS:

Shelly Arnold

Beth Broering

Kelly Brown

Brian Collier

Pier Ferguson

Tracey Jeffers

Cathy Peterson

Keith Stephenson

VDH/OEMS STAFF:

Tim Erskine

ALSO PRESENT:

Michel Aboutanos, MD
EMS Advisory Board

Heather Davis

Dallas Taylor
Reston Hospital

Paul Sharpe
Henrico Doctors

Mark Day
Beach General

ALSO PRESENT:

Kate Challis
Johnston-Willis

Jake O'Shea, MD
Chippenham Medical Center

Richard Szymcyk
Lifecare Medical Transport

Kelley Rumsey
VCU Children's Hospital

Dan Freeman
Roanoke Memorial Hospital

Lou Ann Miller
Riverside Regional

Beth Broering, MD
VCU Medical Center

AGENDA

**Items not listed on Draft Agenda

***Item on Agenda not Covered

(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: I'm a professor of surgery, director of the trauma center at the University of Virginia. Faceless bureaucrat.

MR. ERSKINE: I'm Tim Erskine, the faceless bureaucrat.

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

MS. FERGUSON: Pier Ferguson, non-designated hospital.

MS. PETERSON: Cathy Peterson, trauma program manager, pediatric, Level I.

MS. BROWN: I'm Kelly Brown. I'm the trauma program manager at Central Lynchburg General, Level II.

MS. ARNOLD: I'm Shelly Arnold. I'm the trauma center administration for HCA Capital Division.

DR. YOUNG: Why don't we go to the back, since we did that at the last committee.

COMMITTEE MEMBER: Introduce yourself.

MR. TAYLOR: Oh. Dallas Taylor, trauma director at Reston Hospital.

MR. SHARPE: Paul Sharpe, Henrico Doctors trauma program director.

MR. DAY: Mark Day, trauma program manager at Beach General, Level III.

MS. CHALLIS: Kate Challis. I'm a program manager at Johnston-Willis.

DR. O'SHEA: I'm Jake O'Shea, chief medical officer at Chippenham. Good to see

you.

DR. YOUNG: Hey, how you doing?

MS. DUNN: Governor's Advisory Board for Thomas Jefferson EMS Council.

MR. SZYMCYK: Richard Szymcyk, I'm a medic and safety officer through the Lifecare Medical Transport.

DR. YOUNG: Okay.

MS. RUMSEY: I'm Kelley Rumsey, I'm the pediatric trauma program manager at Children's Hospital of Richmond at VCU.

MR. FREEMAN: I'm Dan Freeman, trauma program director at Roanoke Memorial Hospital.

MS. MILLER: Lou Ann Miller. Trauma program -- not director, manager at Riverside Regional. I don't want to be director.

DR. YOUNG: Madame.

DR. BROERING: I'm Dr. Broering. I'm the VCU Medical Center, trauma and burn program.

DR. ABOUTANOS: I'm Mike Aboutanos. I'm the -- VCU chief of acute care and surgery, and Trauma System Committee coordinator.

DR. YOUNG: Great. So I -- some people may come in. I know Bryan Collier is not coming and Terral Goode's not coming. So next item is the Chair's report.

And I'd like to talk about something, it may be a little bit of an elephant in the room, which is why I'm sitting here.

The -- the simple reason is that Mike asked me and -- and I said I would do it. But there are other things I think I should bring up that people may not know. I -- I was chair of the critical care committee from 1996 to 2002 when it was --

also became the Trauma System Oversight and Management Committee. I was vice-chair EMS Advisory Board from 1996 to 2002. After that point, I began to do a lot more stuff nationally.

Forrest Calland became my partner. And the reason why Forest was here during the years after the Trauma System with you and I wasn't is because I wanted him to be.

And I covered for him at home while he came here to give him the experience to work with the State system as much as he could and gain that experience, which I thought was very important to me.

As to why -- Mike can speak for himself about why he may have asked me. The verification review committee in American College of Surgeons -- I hope y'all know what that is.

I've been the longest standing member of that committee. I've been on that committee since 2004. I've done 168 site visits across 30 states in the country, including 100 Level I centers. I was part

of the committee that did the first revision of the optimal document and I'm chair of the committee of two chapters that are in the current revision.

And you know, so I have a lot of national experience in looking at what works and what doesn't work with criteria for trauma centers pretty much all over the country.

And I just want to say that I completely respect the amazing amount of work you did. I certainly tried to do some of the stuff -- the trauma system -- a decade and a half ago, and you've -- you've succeeded.

And I want to enable you to do everything that you want to do. I think, just to say for many people who don't know me, my two pet peeves are that I think that when designing a trauma system, it's vitally important that the people that provide high level trauma care have a great influence on how rules are written. And that -- that for those people that dedicate themselves and their hospitals to providing high level

trauma care and going through designation that we have to listen to everybody. But those people are the people that do it every day and know what can go wrong after patients come, and what keeps patients from going home and going back to their lives.

And you know, I think that has to be heavily respected in how we draw up these criteria. So are there any questions about that? All right.

So now moving on to the agenda -- and I -- did everybody get what I passed out just recently? So in it, you have the charge of the committee. And one of the biggest things is going to be figuring out how we're to get -- I'm sorry.

COMMITTEE MEMBER: Did you want to get this passed out?

DR. YOUNG: Oh, sure.

COMMITTEE MEMBER: Okay.

DR. YOUNG: Yeah. How we're going

to get through all these things and how we're going to do it. Are we going to assign small sub-groups, etcetera. And so I want to open that up for discussion.

We'll go through them just quickly. To review and update the current standards, to evaluate for current visits between the State and the American College of Surgeons.

As far as the process for designation, how we do it -- look at the criteria and whether those criteria are continued to be used or whether any new criteria should be used.

Increased data sharing, statistical data analysis to identify the areas in need. And then to engage to create a real complete trauma system in this State. Review how to provide technical assistance and guidelines for treatment and transfer.

Bring to the administrative group for proposal to discuss inter-hospital triage criteria and form a work group to improve that, put it into action. Review the process to promote participating in

statewide trauma system performance improvement. And engage with non-designated acute care facilities for involvement in the system. So that's a lot to do.

Does anyone have any comments on what should be our first priority? Second priority? How you would like to do it? Start from one and go to 10?

DR. ABOUTANOS: So one -- one aspect if I could -- if I could talk to you, Jeff. For the past two and a half years as this -- as this sub-group, now committee, has evolved and has to present.

So one was -- was the development of these objectives for each goal. And that second was the development of the various -- I guess you'd call them indicators that we had following the -- the various different needs that this committee identified.

And so one of the objectives was to decide if you and the committee structures and everything that would roll out right now and functions. You view these

objectives, you have an -- these indicators say how they fit. And the overall plan is that where does this committee -- because this is an inaugural meeting.

We just started this, right? So just to bring everybody up to speed and this -- where does this committee now going to fit with the rest -- all of the other committees with regard to trauma system plan.

What does it mean to have a trauma system plan and why now the -- the function of this -- of this committee within that.

And the whole aspect of what are the, you know, the number one -- excuse me -- you know, mortality and morbidity, the cost of Virginia -- of the injured in Virginia.

And how does this committee going to have lessons within these goals. You know, in order for us to, you know, decrease everything. The second task that I -- that I've been asking all the committee chairs is that how do we present this

committee from being silent? And this would be right off the bat. How you don't simply work as the -- only as the trauma centers, but always see yourself as part of the trauma system.

And how are you going to relate to all the other committees what you're doing. So everything that happens here will eventually end up going to the TAG committee which you sit on and represent.

We're just going to give it a -- a background why this -- the objectives are and --

DR. YOUNG: Just ask you, Mike, are these drafts? Are these --

DR. ABOUTANOS: No, no. This is it.

DR. YOUNG: This is it. That's what I thought. Okay.

DR. ABOUTANOS: Yeah. But I'm not sure of every committee member's know where

they are in production and all this stuff. Hence the -- we just formed this since last meeting.

DR. YOUNG: Okay. So how many -- how many members of the committee have gone through a Virginia State site visit? Four, and how many have gone through an ACS? Okay. Yes. So -- all right.

So you know, as far as the first issue, from your -- your discussions of this or any of your thoughts in reviewing the standards and deciding -- I can tell you the background of the State ACS over the past 10 years.

I'm not sure if EBMS has had a visit, but the other four Level I's are all ACS-verified, I believe, at this point. VCU is a Level I peds, correct, for ACS?

DR. BROERING: Yes.

DR. YOUNG: Mary Washington, what is -- I believe -- an ACS --

COMMITTEE MEMBER: No.

DR. YOUNG: They're not any more?

COMMITTEE MEMBER: They haven't met it yet.

DR. YOUNG: Okay. Are there any ACS-verified Level II's?

COMMITTEE MEMBER: Chippenham.

DR. YOUNG: Chippenham. Okay.

DR. O'SHEA: We haven't made the level.

DR. YOUNG: But you're not verified yet?

COMMITTEE MEMBER: Chippenham is.

DR. YOUNG: Okay. And no III's correct? No ACS Level III's. Okay. So as far as looking at the standards, what

discussion has happened so far as far as -- was there any discussion of which standards should be looked at other than the proposal that I'll hand out on CME?

DR. ABOUTANOS: No, just the beginning.

DR. YOUNG: Okay. Let me hand this out now. This is a proposal that came for physician CME changes. And what -- since this is kind of very broad topic, why don't we get rid of some of the fairly simple things.

I've discussed with Tara and I've discussed with Brian Collier there needs to be a vice-chair in case I can't make it, although I've mapped out my schedule for the next four meetings.

Brian Collier expressed interest in having that role and would hopefully eventually be the chair of the committee over time. And so I was going to appoint him to that. Is there any discussion, any problems with that or any

other people you think are appropriate? Okay.

COMMITTEE MEMBER: I second that nomination.

DR. YOUNG: Okay, good. And so we will -- he -- I will tell after this meeting. He said, you know, because of -- this meeting was difficult for him to attend but, I'm sure he'll try his best to attend going forward. Selection of a crossovers. You have a crossover sheet. Does everyone have it?

COMMITTEE MEMBER: No. That was -- that was just for you.

DR. YOUNG: Oh, okay. So the TS -- the TSC crossovers for our committee, I go to the TAG. We have a crossover from pre-hospital. There he is.

COMMITTEE MEMBER: You're supposed to be at the table.

DR. YOUNG: Come up to the table. And that was the only one from your committee? Anyone else from any other committees that appointed any crossovers? Yes.

COMMITTEE MEMBER: I'm the liaison from the post-acute.

COMMITTEE MEMBER: He's a crossover.

DR. YOUNG: Okay. You're a crossover, so you're --

DR. ABOUTANOS: You're a crossover.

DR. YOUNG: So you're a part of the --

COMMITTEE MEMBER: You're a member.

DR. YOUNG: Come on up. So System Improvement committee, a trauma center representative. Does anyone --

COMMITTEE MEMBER: It hasn't met yet, so --

DR. YOUNG: For the future.

DR. ABOUTANOS: They meet tomorrow and they'll provide one.

DR. YOUNG: Don't -- they -- they will choose them?

DR. ABOUTANOS: Yeah.

DR. YOUNG: Oh. Yes. So for us to send to others.

COMMITTEE MEMBER: Right.

DR. YOUNG: Who else? That's what I was going off of.

COMMITTEE MEMBER: Acute Care appoints members to System Improvement, Post-Acute Care and Emergency Preparedness.

DR. YOUNG: Oh, okay. I see.

COMMITTEE MEMBER: Yeah. You just -- you get to pick whoever wants --

DR. YOUNG: Rewind. So who wants to be on the System Improvement Committee, and it has to be a trauma center representative.

COMMITTEE MEMBER: I can be one.

DR. YOUNG: Okay, great.

COMMITTEE MEMBER: I have to -- sorry. I'm not on the other committee. I'm on another committee, not on this one. I'm just observing.

DR. YOUNG: That's okay. Well, whatever you'd like.

DR. ABOUTANOS: Yeah. You're on the -- you're on the Disaster Committee.

COMMITTEE MEMBER: Yeah.

DR. ABOUTANOS: Disaster Preparedness.

DR. YOUNG: And so we have that first -- second crossover. Post-Acute Care. Any of the committee members? I'll appoint someone who's not here. That's probably the easiest thing to do. When do they meet? Tomorrow?

COMMITTEE MEMBER: At 1:00 o'clock.

DR. YOUNG: They just --

COMMITTEE MEMBER: Two hours ago.

DR. YOUNG: All right. Excellent, all right. So we need to appoint someone to that. And then Emergency Preparedness and Response. When do they meet?

COMMITTEE MEMBER: They met today.

DR. YOUNG: They also met --

COMMITTEE MEMBER: Tomorrow.

DR. ABOUTANOS: Tomorrow?

DR. YOUNG: Tomorrow.

COMMITTEE MEMBER: Tomorrow morning at 8:00 o'clock.

DR. YOUNG: Okay. Anyone?

COMMITTEE MEMBER: There's no -- there's -- there's no expectation because of the last minute nature --

DR. YOUNG: Right.

COMMITTEE MEMBER: -- of this that you're going to be there --

DR. YOUNG: So any --

COMMITTEE MEMBER: -- tomorrow.

DR. YOUNG: Any --

COMMITTEE MEMBER: I'll do it. I'll do that.

DR. YOUNG: All right, great. You're writing this down there, too?

COMMITTEE MEMBER: I'm sorry, who -- who -- who was that?

MS. RUMSEY: Me. Kelley.

DR. YOUNG: All right. Well, we got that done.

COMMITTEE MEMBER: Dr. Young, I'll do the Post-Acute.

DR. YOUNG: Okay, great. All right. Okay. So now we have to go back. So the objectives. So what -- what discussion on how we're going to achieve these objectives, or how we should do it. Open the floor, the committee or anyone

else. I can tell you how it's done in other organizations. Would you like me to?

COMMITTEE MEMBER: That'll be good.

DR. YOUNG: Okay. So in the -- in the college, it's each chapter is -- or each set of criteria is given to a separate group. And that -- we would appoint a chair to that group.

And then they would pick content experts that they would want to help them. And I would think for this sort of thing, I would just pick two or three people because it's just incredibly complicated to get all this done.

And that -- those do not need to be committee members. And then I would -- I would have -- you know, give you the relevant criteria and then set a time line for you to look at it. Is -- we can do that. Is there --

COMMITTEE MEMBER: I'm going to -- if I can make a comment. I think that the

standards, the current State standards in Virginia are very, very similar to many of the ACS standards.

But because they have not probably stayed as up to date as the ACS standards in the way it's formatted, I actually think that it would be worthwhile -- several of us, whether we're committee members and non-committee members, whatever, working -- sort of dividing out the standards that are -- in the current -- before we jump into revision, dividing out the standards that are in the current designation manual.

And sort of, I'm going to say map them to the -- the correlating new ACS standards. So you know, standard criteria, 6.25 -- I'm just making that up -- maps to acute care criteria 10 -- 9 point something maps to something else. And then take those and start looking at it from a revision. Because it's sort of gotten jumbled over the --

DR. YOUNG: Yeah. I certainly wouldn't recommend we go over each chapter.

COMMITTEE MEMBER: Yeah.

DR. YOUNG: So I think -- I think that -- you know, I would just like to bring to the committee that that -- at that point in this -- since I have long experience with this, that would somewhat be taking the ACS standard as the benchmark.

And then -- instead of not taking the ACS and comparing it to us, we'd be taking us and comparing it to the ACS. I'm okay with that, but other -- other people would object to that, just to make sure. No. Okay. So I agree with that. So --

DR. ABOUTANOS: If it were built on the ACS standard, they --

DR. YOUNG: Okay. Originally, back in the old yellow book or whatever it was.

COMMITTEE MEMBER: Right.

DR. YOUNG: So there is a little

bit of a wild card, is that there is a bunch of revisions. The ACS document is a living document.

COMMITTEE MEMBER: Right.

DR. YOUNG: So there is a bunch of revisions that were accelerated to come out. And then something put a brake on it, and I don't know what it was. But I will -- why don't we go with what we have at this moment.

And I will work with the ACS executive committee to find out what major things have already been approved by the executive committee. And I don't think any of them were earth-shaking.

We all know about the CME change for the college, which I'm sure everybody would be anxious to have for our State. And so -- Beth, would you like to respond to this? Take a little bit of the lead?

DR. BROERING: Sure. What I would

--

DR. YOUNG: Okay.

DR. BROERING: What I would like to have is about four people of varying different centers. And what I'd really like to do with the first -- what I would first envision is we just go through the criteria and say what chapter does it map to, not what does the standard say.

And who does it apply to. So the first one is making sure that we get the standards aligned in the right -- I'm going to call it order for lack of a better term.

And then you go back to say, does it align with a Level I and a Level I, a Level II and a Level II, a Level III and a Level III, and a Level IV and a Level IV if we had some.

And decide -- then the next layer, does it -- does it apply to this state or does -- should it apply to this state or should it not.

DR. YOUNG: And to tell you the college process, at least for the last two revisions, they have asked all the designated centers what they thought of that criteria.

They had given the people doing the revisions what the people that were visited thought of the criteria, and whether they liked it or not. And what they felt -- whether it provided value or didn't provide value.

And then the people re-writing those criteria were expected to answer the objections from the people that are visited. So that should be incorporated.

DR. BROERING: Sure.

DR. YOUNG: So that -- that'll be pretty easy to work with. So I would like to help.

DR. BROERING: Okay.

COMMITTEE MEMBER: As a Level III,

I'd like to --

DR. YOUNG: Yeah, absolutely.

COMMITTEE MEMBER: Okay. I'd like to give you this.

DR. YOUNG: All right. You have more to fill. Okay.

COMMITTEE MEMBER: So your Level III and Level II -- Level III and Level II are peds. Level I --

DR. YOUNG: Well, I'll just kind of --

COMMITTEE MEMBER: Be in the background.

DR. YOUNG: -- be a liaison for the ACS stuff.

COMMITTEE MEMBER: Okay. All right.

MS. ARNOLD: Dr. Young?

DR. YOUNG: Yes.

MS. ARNOLD: Shelly Arnold. Just want to know, are we going to go with the new clarification document in the newest standards, or are we sticking with what's actually written in the orange book at our -- our --

DR. YOUNG: The clarification document is the new standard.

MS. ARNOLD: Right.

DR. YOUNG: So that's what we'd go off of.

COMMITTEE MEMBER: So we're going to go with that.

DR. YOUNG: But just to let you know, there is another thing floating.

MS. ARNOLD: Yeah.

COMMITTEE MEMBER: Is it going to be purple?

DR. YOUNG: They wanted to put it completely online.

COMMITTEE MEMBER: Oh. Interesting.

DR. YOUNG: So I -- that's a pipe dream. So -- okay. Anything else, Beth?

DR. BROERING: That's fine right now. We can pull it up if --

DR. YOUNG: Yeah.

COMMITTEE MEMBER: Does it have to be on the committee or can we in the -- in the room volunteer?

DR. YOUNG: I think --

DR. ABOUTANOS: Well, that's going to be -- I'll add to this. Let's go back to the process. Because we're -- this is a new -- newly formed, you know, and where -- where we are.

So there are committee members. And it's going to be up to the -- I guess up to the chair to see the committee members are fulfilling their function of what the committee is. But our number one task is the citizen[s] of Virginia.

What does that citizen need? So what does that mean? That means that Jeff can draw on -- on anybody to form a task group, to form a liaison to an organization. He just can not have a committee member make that. So absolutely, you're --

DR. YOUNG: I see what you're saying.

DR. ABOUTANOS: You could --

DR. YOUNG: We'll add you on.

DR. ABOUTANOS: -- any help, any sub-group. You know --

DR. YOUNG: Any one you think that would be --

COMMITTEE MEMBER: Okay.

DR. YOUNG: -- good.

COMMITTEE MEMBER: I'm interested if you want me?

DR. BROERING: Huh?

COMMITTEE MEMBER: I said I'm interested if you want me.

DR. BROERING: Okay, that's fine. I think it would be helpful to have -- I know that eventually it would be helpful to either bring Valeria or somebody from Norfolk General in --

DR. YOUNG: Uh-huh.

DR. BROERING: -- as it pertains to review of the ADA criteria.

DR. YOUNG: Yeah. Yeah.

DR. BROERING: And the -- and the aspects of the AD -- of burn criteria that are in the ACS manual. And then where that fits in so we can pull somebody from Norfolk General -- and I -- because our -- the burn coordinator for VCU is starting next week.

So I would not put that person in to a hot spot. But we can get somebody from Norfolk General as we get to that point.

But I think that to get it into alignment first and then start thinking about next steps. So...

DR. YOUNG: Great. Any other discussion on that? That moved that along well. All right. The next is the concurrent visit between State and ACS. And I can certainly talk about this. But how many people have been State site visitors?

Just raise your hand. Well obviously, Paul. Okay.

COMMITTEE MEMBER: Not in this state.

DR. YOUNG: Okay. So you know, I -- I can easily, since we have time, tell the committee the differences with an ACS visit.

For those of you that've been through ACS visits, I can also give you the background of being a senior reviewer. The PRQ is much different than the document that we create.

And it's -- as far as being respectful of TPM's time and their lives, having a similar PRQ and a -- would be something that should seriously be considered.

And I -- would you mind? Well, I guess that can be part of this next objective.

DR. BROERING: That could be --

let's get the standard and the other --

DR. YOUNG: Okay. All right. So --

DR. BROERING: Let's keep --

DR. YOUNG: I would be happy to try to find some people to work on that. Because the PRQ, while for the ACS is not nearly perfect and certainly can be made less onerous, it is somewhat easier to put together having done both.

And then -- so the -- the team gets that slight differences in the component. And this would be something we would all have to decide as a state.

The usual ACS component for a Level I adult is two trauma surgeons. For a Level I peds it's two trauma surgeons and a pediatric trauma surgeon.

For a Level II peds, it's a pediatric surgeon and a trauma surgeon. In Colorado, Florida, West Virginia and North Carolina, I believe, it's two trauma

surgeons, and emergency physician and a trauma program manager. So -- and as you know what it is here, surgeon, emergency medicine, administrative component, ER and obviously, a trauma program manager-type component.

So one thing for us all think about in that group is what would be -- and I would also like to also bring in the Office for how difficult it is to schedule and -- and to take that into effect. And we should really look at what value is brought by different things.

And you know, I feel having -- from doing ACS visits, when we have to do visits where a lot of work has to be done with the program, the TPM person is invaluable for working with the TPM at a program and showing them PI and showing them how to document things. For a mature program, it usually is okay. Were you going to say something?

DR. ABOUTANOS: No, no.

DR. YOUNG: So for that, I am happy to take some lead on that, if anyone has another idea, and to find some people who will be interested.

You know, I would ask for people that have been through several State and several ACS, so -- because those I think would be the best people to compare.

If I was -- had to say, the biggest difference is the entire ACS visit essentially focuses on PI. I -- without a doubt. I get the tour done in 10 minutes because I've seen a lot of trauma centers.

So -- but you know, we spend a lot of time looking at the PI, have a specific template for how those cases have to be written out, a specific standards for how we have to write about the program's PI response.

And the -- as you may or may not know -- some of you may know, the most common criteria deficiency issued by the college is performance improvement. So I -- I would see that as somewhat -- the major difference I've seen having done both

reviews. Are there any other comments on that?

DR. ABOUTANOS: I need to make on other comment if you step back for it, is a little bit of the -- initially just to evaluate where this can come with it. Is that something that should be done. Is that -- I think that was the question that would've been asked initially. And --

DR. YOUNG: Yeah. I think the people visited by the ACS would say yes, and the people no.

DR. ABOUTANOS: What's the pro's, what's the negative. Where does the Office of EMS stand with --

DR. YOUNG: Right.

DR. ABOUTANOS: -- through that. And I think this is -- this is our job as a process of fact, to just say is this something that is beneficial for -- for all

of us. Is that -- is the -- as you know, you have some -- you have Level I's, Level II's, but also Level III's. And then -- are we talking across the board on every level that would be ACS or not.

Is it going to be only if you choose to, so I think those are specific nuances that we need to solve before jumping into how it would be done. But I agree with you. Evaluate, think it out.

First of all, it's a difference. And many people know before they meet -- they go, oh, I don't want the ACS. Well, hold up for a second. Find out what we're talking about here.

And -- and I think this is kind of what was part of the -- known as to be one of the objectives that this committee needs to handle.

DR. YOUNG: Yeah, I think we have to -- whatever we decide. If we did decide to have more synergy, it would have to be a lot of education and discussion with centers that are designated by Virginia but have not

been visited by the ACS. I can tell you that in Colorado, West Virginia, Florida and Jersey, the Offices of EMS in those states do the visit with us.

They are there the entire time. Did I say North Carolina? North Carolina as well. North Carolina, you can't look at the charts to a -- until a member of North Carolina EMS is there.

And they supervise the entire thing. So there's ways of doing it. Certain states, Ohio designates the entire authority to the ACS. And whereas other states, it is absolutely a joint, nationally in some states.

The ACS report is reviewed by an OEMS committee, and they decide. Obviously, the ACS does not designate, we just verify. So --

DR. ABOUTANOS: I -- just one thing. So let me give -- I think this is really incredible. You bring in lot of the -- the knowledge base. And just when restructuring the plan, that's why we did

the -- we actually benchmarked a lot of various places to see how the plan, as you know, gets formed or -- or not.

So I think the -- the biggest -- the biggest aspect as -- as you mentioned is that, you know, what -- is there -- what does the committee feel with regard to just the whole -- joint process or not?

You know, it would be nice to see what other -- that list and you just right off the bat. You mail off one, two or three to see what they want, what kind of model would -- would work and what's the implication.

I can handle it as just relate -- especially in all the other centers that are also ACS and state where it continues to be evaluated, either by one or the other. It's just a huge amount of resources.

And that's how we push this as, can you streamline it, just can we do it at same time. But it has to be --

DR. YOUNG: As -- as far as I know the only two states in the United States

that do not have the ACS come in at all are Maryland and Pennsylvania. So Pennsylvania has the PTSF, Pennsylvania Trauma System Foundation.

They have their own site visit process. I don't believe any hospital in Pennsylvania has ever been visited by the ACS. And Maryland, you can do it, but it's not binding.

You -- you can have them come in for giggles. But the -- Maryland has its own system that OEMS has. And Carol Mays runs it. And she can be a good resource for that.

DR. ABOUTANOS: And I mean, on the other hand, also you can speak with yours, so do an evaluation in Pennsylvania.

COMMITTEE MEMBER: Yes.

DR. ABOUTANOS: Or a more regular --

DR. YOUNG: They won't let me in.

DR. ABOUTANOS: -- than the ACS. It's very regulated. That's why they don't --

COMMITTEE MEMBER: They're too tough. No. They're not tough, no. It's very rigorous. And actually other states -- Oregon, Washington State -- have pretty structured site visit processes as well.

Pennsylvania certainly is -- is probably as rigorous or more rigorous than -- than the ACS with some of their structure and standards.

Because their standards and -- and what their sub -- I'm going to call process standards -- that are not written into Code are -- are probably why it -- its people went to trouble with respect to PI and things like that.

But I think that the more we can move to an alignment of -- of a -- I'm going to call it a combined-joint, whatever, for those of us that choose that direction, it would be -- I think it would be healthy for the State.

DR. YOUNG: Great. And -- and -- go ahead.

COMMITTEE MEMBER: And I definitely speak to the state of --

DR. YOUNG: I'm sorry. Just one second. When you speak -- I guess this was said the previous meeting. Since it's recorded, if you could just say who you are.

MS. ARNOLD: I'm sorry. Shelly Arnold. I can certainly speak to the State of North Dakota. Was there as a trauma program director for 10 years and also as a state trauma coordinator for 10 years.

And they do do a bit of a joint. And the vast majority is ACS. And I can certainly speak to some of the challenges that we've seen when we went with the ACS for Level I's and II's.

III's we would allow to do either, ACS or state. So we had in-state teams. And we did provisional by the state for when there were gaps for the Level I's

and II's if they didn't ask for visits or if they had challenges or needed a fix. So I can certainly speak to all the different processes that we put into place in the State of North Dakota in comparison to that.

DR. YOUNG: Great. So I'd love for you to help with that.

MS. ARNOLD: Yep.

DR. YOUNG: And just to say one other thing from having done these 170 reviews. When you do a review for the ACS, other than PI, I view it as there's very little leeway.

I have people going, yeah, you're really going to fail me on that? I'd go, I got nothing to do with it. I -- I do the standard. I -- if I don't catch it, the committee will catch it.

And it's not going to help you in the long run. So I -- I do think another thing when you do look at it. Especially -- I -- I don't know the Pennsylvania

standards. But there are definitely things that don't need to be in the standards, absolutely.

And it -- it takes a long -- this is a great opportunity for us to really have a clear assessment of what adds value and what doesn't add value. There are absolutely things that add a lot of value.

And if I had to say more than integration with EMS and air medical throughout the country, would add a great deal of value. CME just did -- there's never been literature to show that it -- that it adds value.

And so, I think we should definitely look at it, that let's do things that are known to make better care of the patient. And get rid of the things that just drive us nuts. So -- okay.

COMMITTEE MEMBER: Yeah. I think that what you just said is really important. Because Amy from the PTSF and I have had several conversations about this. And at times, Shelly, you may probably can allude

to this as well. Sometimes if you -- if you write standards, the standards are the Code. But if you write things like your process measures, like you know, you're monitoring your -- your length of stay in the ED or you're monitoring your time to operative fixation of open fractures or your elongate [phonetic] fractures or whatever it is. Time to antibiotics.

If you write down those process measures and process improvement initiatives in -- in descriptors, it gives you the ability to change that over time.

So that if it's no longer necessary to monitor time to antibiotics, you can change that versus having to go through general code to change it.

So figure out the structure and the criterion in the -- in the verification process where process measures and process improvement can be changed over time as new trials or new research allows it. And the standards are things that really are you're, you know, the things that have to be written into Code.

DR. YOUNG: And the other important thing -- we haven't talked about this yet -- is if you're in the MCAS visit, you have to have TQIP.

COMMITTEE MEMBER: Right.

DR. YOUNG: So that is a cost. It -- the college is trying to make it reasonable by making it a joint amount of money. But you still have to hire the FTE to put things in TQIP.

From -- we are now mandated to look at the TQIP results when we do a site visit, but not use it to determine whether a center should be verified or not.

We do mandate that centers look at their report and determine a PI project based on what their report has shown.

But I've seen places that are stellar with regard to the criteria and are horrible in TQIP. And I've seen places that look like they can barely hold together, but do a fantastic job in saving lives. So you

know, I -- everybody just needs to be mindful and TQIP is certainly part of it if we decide to have the ACS.

DR. ABOUTANOS: I think that -- this is what I was talking about earlier. The decision is not whether -- the decision is only if -- if the Level II trauma center state-designated also wants to be ACS.

That's -- then they have to fulfill these criteria. But a Level II can choose not to be ACS. This is what I think the whole decision is not --

DR. YOUNG: Right. That hasn't been decided, right?

DR. ABOUTANOS: Because it's also -- it's also a decision that involves also the hospitals --

DR. YOUNG: Right.

DR. ABOUTANOS: I mean, it's more than -- than us that just said, you know, I

don't want TQIP. I think it's a conflict of interest, you know. I don't want this, I don't want -- so there's a lot of -- a lot of issues.

I think the idea was that if we are going to -- if a hospital is going to be both, can the site visit be done together and how would that be done.

And leaving it open, even though we all would love to kind of push it more, then every hospital becomes -- becomes ACS. On the other hand, if we get to the process where our evaluation process is very close --

DR. YOUNG: Right. And that's what the --

DR. ABOUTANOS: -- then you can just say, hey, you might as well be both. But there is a cost, like you said, associated with it.

DR. YOUNG: And there's no question if we did that, it would have to evolve over

probably two cycles. So -- but all I was really getting at was the ACS does not have a bargain discount package. If you're going to be verified with the ACS, you have to do the things the ACS asks.

DR. ABOUTANOS: Only bargain is do it now because it can get higher next time.

DR. YOUNG: Yeah, well.

DR. ABOUTANOS: Just kidding.

DR. YOUNG: The VRC doesn't decide that, so -- okay. Anything else on goal one. That was a great discussion, and we made a good plan on that.

COMMITTEE MEMBER: May I ask a clarifying question?

DR. YOUNG: Sure.

COMMITTEE MEMBER: Tim or, you know, or anybody else from the -- I guess,

Tim, you have to provide the guidance. When we -- when these committees that are meeting today and tomorrow, these formal committees of the Trauma System are meeting.

When we form these sub-groups or work groups, are they also required to follow the same sort of meeting guidelines? Or are they considered work groups that can meet off-line by telephone, by email, etcetera?

MR. ERSKINE: We'll have to double check with this, but I'm pretty sure that it still has to be -- you know, if work is being done on behalf of the citizens, it still has to be an open meeting.

But I will get clarification on that as far as -- as far as that goes. But I am pretty sure that it's still open meeting.

COMMITTEE MEMBER: Okay, thanks.

DR. YOUNG: Okay. So I need a little guidance from Mike and Tim on goal

number two. This is specifically for adding a trauma center. Because it says, evaluating process designation of additional trauma center.

DR. ABOUTANOS: Mm-hmm, yeah. This was the fact that, you know, what are the -- what are good standards and -- for that. And it's --

DR. YOUNG: And did you mean this more as a needs assessment type --

DR. ABOUTANOS: By whatever way this committee assess -- we state from that -- that word is a buzz word that everybody jumped up and down at when it comes to need. Because it has a lot of --

DR. YOUNG: We'll make a different word.

DR. ABOUTANOS: -- lot of -- lot of implication for it. So what -- for this -- for us to decide, what are our plans, what

should be our process that we can take back to the -- eventually to TAG and to the Advisory Board. And -- so this warrants a lot of -- lot of discussion.

Not sure this needs to be tackled immediately now in this first kind of meeting because there's a lot. Or if you want to assign somebody to start looking at it, look in the background what's available.

But it doesn't necessarily only have to be me. Whichever way we decide whether it is -- you know, what are the various criteria, you know, that should be put into place to guide this process.

DR. YOUNG: And -- and just to go back, I don't remember the whole consultation report. The -- the items in the consultation report that prompted this was areas that weren't well covered.

DR. ABOUTANOS: Yeah. They -- they mentioned this specifically. Just to kind of give it a background, the past two and a half years, one of the biggest things we

have made sure of that those were simply ACS recommendations. Because a lot of stuff came about which we were able to put to rest and at ease that we would begin our own way. And so -- and that we will take the ACS recommendation simply as recommendations.

DR. YOUNG: Okay.

DR. ABOUTANOS: And so -- but this was one of them that there is no standard whatsoever with regard to having a -- any trauma center of any level.

And should the State -- should we together look around and just say, you know, do -- should we have criteria? Have others done criteria with a benchmark?

Are they helpful or not? What is our need in the State with regard to trauma centers? Or the -- and if there is one, should there be any criteria for one?

DR. YOUNG: So what I will do, and I don't know if you got this in the report, is I will contact Bob Winchell, who's the

trauma system guru for the ACS, and would very likely have a variety of --

DR. ABOUTANOS: So he did outside visit --

DR. YOUNG: I know. But -- but did he -- but he may -- that was a while ago. So he may have what some states have done. I know that Florida has -- I won't say needs assessment -- but has a needs assessment process.

And so maybe what we do -- so what I might do with that, if the committee doesn't object, is to ask two of the people who aren't here -- which is Tara and Collier -- if they would like to help with this.

MR. ERSKINE: I think that's smart.

DR. ABOUTANOS: Yeah, there was a -- as you know, the ACS trauma system committee also came up and their standards have changed.

DR. YOUNG: Yeah. And they're in the middle of it.

DR. ABOUTANOS: So --

DR. YOUNG: It's a highly politically charged issue. So --

DR. ABOUTANOS: Sure.

DR. YOUNG: And -- so -- okay. So that's basically all three of these objectives interrelate. So how to decide whether a place has too many or too few trauma centers, etcetera. Okay. Any other discussion on goal two from anyone? Did North Dakota do anything with this?

MS. ARNOLD: They actually were an inclusive trauma system. And their goal was that every hospital --

DR. YOUNG: Had to --

MS. ARNOLD: -- had to be a trauma

center. And by the time I left, 40 -- 45 or 46 hospitals were trauma centers. Yeah, everybody was because to provide the best care that we could, those systems in North Dakota -- no matter where you landed, no matter where you were, you were at a trauma center of the level that you were able to provide. Whole different concept.

DR. YOUNG: Well, West Virginia --

MS. ARNOLD: That was great.

DR. YOUNG: West Virginia had it for a while. I don't know if they got away from it.

COMMITTEE MEMBER: Iowa's got it as well.

DR. ABOUTANOS: So I think as -- yeah, as you know, Dr. Safford can look at the whole standard. I mean, what kind of goes into this one aspect. That's why you're going to assign a separate group --

DR. YOUNG: Well, I was going to talk to Tara and Brian about it --

DR. ABOUTANOS: See what they --

DR. YOUNG: See if they're interested. I mean, I'd have to ask you and Tim -- our ability to get statewide accurate data on motor vehicle crashes and -- and other stuff from every county would help that.

DR. ABOUTANOS: Yeah. So that's what -- so -- so this part is the objective three of goal two is basically speaks about working with the System Improvement Committee with regard to the adequate data that we would need. You know, what is the data. And so --

DR. YOUNG: I'll talk to them both and see if one of them will -- it'd probably be a good thing for Brian. Well, actually Tara's in an area that has been talked about. So...

DR. ABOUTANOS: Yeah, that would be great.

DR. YOUNG: Any other -- Terral, I'm sorry. Any other questions on that? Okay. Next, which is also somehow related is what you just said.

How do we make a statewide trauma system no matter somebody gets hurt, that everybody knows to do A, B, C, and D to get them where they need to go.

You know, I think for this, it's important -- like I don't think Charlottesville's a big city. But we have to have real rural involvement in this to -- to really know the problems.

And you know, I think EMS and -- and aeromedical transport and all that is incredibly important in this -- you know, give me the background.

DR. ABOUTANOS: So the big thing with this is that -- so this is probably one of the most important part one of that we've never functioned this way. You go to a

different part -- our state designation is based on process. It's not -- it's not truly based on outcome, right?

And so this is a big difference here, is the management of logistics something simple we see all the time are the fractures. Can it be the same in one -- our center versus another center?

If my daughter got injured in Roanoke, is she going to get the same way she can be treated if she's in Norfolk or VCU, etcetera, or -- or Fairfax or any of -- any of our trauma centers.

And so the -- the whole concept was can we -- this is part of our evolution. Can we evolve that we say this is the standard of care that we have? Can we come together at various different facilities and say this is what we're doing.

And there's various ways to do this. As you know, one -- one way is that if we look at using that again, what are our top mortality. And then break that down and just say, well, how do you treat this disease that's causing the most number of --

number of injuries. And then -- and if we did this at the regional meeting, just between your center and our center with regard -- just the -- at a [unintelligible] protocol, we'd learn tremendously. We found out that -- for example, UVa, your protocol that -- I think it was the better --

COMMITTEE MEMBER: The Battle score.

DR. ABOUTANOS: Yeah. So we use the Battle score and looked at what you guys have. And we compared to what we have and that prompted us to be involved in changing our protocol and significantly minimized the number of our ICU admissions just by learning from each other.

Eventually, that needs to be studied together, but it just was one example of can we say what is the standard of care in Virginia. Can we eventually get to that level. And that involves sharing, you know, what we need to do to create the ability to share protocols and to debate

pro's and con's. Look at our own data and -- why is mortality different in one center versus another center but -- for the same exact disease. Is that protocol better than ours, essentially. So...

DR. YOUNG: That's pretty wide ranging --

DR. ABOUTANOS: Yeah.

DR. YOUNG: -- objectives, okay. So part of this was also standardizing, in some way, best practice.

DR. ABOUTANOS: Absolutely.

DR. YOUNG: I guess, is what that means.

DR. ABOUTANOS: Data-driven, experience-driven from the various centers. Ability to share those aspect that now we speak as -- as one trauma system.

DR. YOUNG: Would you mind being --

COMMITTEE MEMBER: Tim, can I ask a -- sorry for the interruption. Can I ask a question, Tim? Do you have -- can you verify that the non-designated centers in the state are actually submitting the minimum data set for their trauma-related admissions and discharges? That we would even be able to take that data set and look at some of that --

MR. ERSKINE: Yes.

COMMITTEE MEMBER: -- and compare it?

MR. ERSKINE: Yes. And that's something that, you know, we check on a regular basis after, you know, submission deadlines are up is to make sure that everybody has submitted their data. And we've had a -- a bit of a fall off because of personnel changes. But we're now getting back to the point where we can start riding

herd on the people who haven't. In the small hospitals where you're only missing a few records, you know, those are the places that we need to call.

And you know, riding herd is -- is very strong -- strong language. Because it's really just a gentle reminder. Most of the time, they have a change in their personnel and the ball got dropped.

Then nobody knew that, you know, it had to be picked up. This is common across the country. But yeah, we do collect from the non-trauma centers. They do submit on a regular basis.

And it is -- it's actually -- there's -- there's no minimum data set. It is the same data set. It's just that most of it doesn't apply. You know, they don't -- they don't have to worry about operative procedures and things along those lines.

COMMITTEE MEMBER: Right, right.

MR. ERSKINE: But it's -- so it's the same data set for -- for all hospitals.

Yeah, it's -- it's as reliable as it's going to get without having some large program to go in and audit.

COMMITTEE MEMBER: Okay. Can I also ask, is there -- are there checks and balances so that patients are double counted? Let's say they started in a real small hospital.

They got transferred up to a III and then they ended up in a I. Is that same patient counted three times within your data system --

MR. ERSKINE: Yes. But that's easy to pick out based on -- hospital one, they will arrive from the scene with a transfer out as the disposition. Hospital two transfer in, transfer out.

COMMITTEE MEMBER: Right, but I was looking at that and thinking that data when --

MR. ERSKINE: We need to know all

of that. You know, that's the whole thing. We need to know from moment of injury to the moment of discharge. So we do need to have all of that data.

COMMITTEE MEMBER: But what's to say we didn't need to do it?

MR. ERSKINE: Right.

COMMITTEE MEMBER: That would be -- okay.

MR. ERSKINE: You know, it's a -- it's a -- you know, if it's a counting issue, I don't -- haven't looked at Virginia's. In Ohio, it was a very small percentage. You know, we knew how many single transfers there were, how many double transfers there were.

DR. YOUNG: I've been gone for 17 years and we argued about this in 1996.

MR. ERSKINE: Level III

representatives, I think you should both play a significant role in this discussion, and are not designated as well, to talk about that.

So afterwards -- for all these people that have raised their hands for things, let's just come down here so we can get it all written down.

You know, another -- another very important issue that I think -- some Level I representation is really important -- is that at least for us, we develop systems that work great when it's sunny.

And when it gets cloudy and the choppers can't fly, it turns into a disaster because places are used to simply turning people out of their ED in 25 minutes.

And all of a sudden, they got to figure out a way to get them to us with a two-hour ride. And so I think that has to be part of it as well. It has to be contingent on things. The second thing that I already talked to the chair of pre-hospital about this is -- and I think --

I'm happy to share it with us as well is that my son and I did a study of all of our air medical transfers for the past 20 years. And compared it to the -- this -- all of the national criteria for air medical transport.

And found that something like 10,000 helicopter flights, 70% of them did not meet any of the criteria for air medical transport.

And we provided absolutely no value to those patients by having them come by air. However, in the 30% that did meet the air medical criteria, we provided tremendous value to those patients by having them come to air.

So that's a big problem. And it -- it has not gotten published because EM doc's don't like the results of that. So the -- so -- but I'm happy to show people the data, or the people on that committee.

Because I think -- I think it's an important thing and I think all of the Level I's and Level II's have -- have seen patients come by air that didn't need to come by air. Has anyone seen any --

isn't there a law now that -- or is it a suggestion -- that you have to tell them how much it's going to cost? Is that --

COMMITTEE MEMBER: It's still in committee.

MR. ERSKINE: It's in --

COMMITTEE MEMBER: You've seen one --

COMMITTEE MEMBER: It's crossed over.

COMMITTEE MEMBER: -- denying that.

MR. ERSKINE: Well, that'd be tough to do it on the scene.

DR. YOUNG: Well, they'll make -- they'll make it a law anyway.

MR. ERSKINE: Okay, all right.

DR. YOUNG: All right. I think we have a -- a plan on that as well. Anything else on that, Mike, that you wanted to --

DR. ABOUTANOS: No, that's good.

DR. YOUNG: Okay. Let me look at the agenda again. We did the crossovers, we did the vice-chair. I don't think we can yet really discuss the process for meeting these objective -- well, I guess we could do the process.

But I'm -- I'm not sure at this meeting. I think what we'll do is do some communication by email, or even conference call in between now and the next meeting.

For the people that are leading up some of these things, once you get your head around it to decide, you know, when maybe we can do a deliverable on it or -- or just some ideas from your committee about where we should go. As always, with these committees just waiting every three months to do something doesn't work. So

now, we can do all kinds of stuff. You join me or whatever online and we can have those meetings.

DR. ABOUTANOS: You can't.

MR. ERSKINE: You can't.

DR. YOUNG: Oh. Wait, wait. No, you can't.

MR. ERSKINE: You can --

DR. YOUNG: Can I use email?

MR. ERSKINE: No.

COMMITTEE MEMBER: No.

DR. ABOUTANOS: You can use email only if you go to one person. And only one person talk to you, that's it. You can not --

COMMITTEE MEMBER: You can not

reply all.

DR. YOUNG: All right. Well, don't do anything I just said. I'm going to do it -- do -- do whatever -- do whatever Mike says.

DR. ABOUTANOS: And let me tell you what's happening.

COMMITTEE MEMBER: Carrier pigeons.

DR. YOUNG: Can we make it Disney characters?

DR. ABOUTANOS: I like the pigeons idea. I think the -- what -- this has been the biggest problem. And that's why it took us this long to come up with a trauma system plan, instead of having it done in one year.

But about this one decision that you -- you need to make with everybody else here is that now two others committees that I've stopped by is that they -- the

committee members have decided there's a lot to do. And waiting for three months, it's just not going to happen. So the decision whether you're going to need one more time in between.

Only I ask if this becomes a decision for this -- for this to happen is work with the Office of EMS because there's some cost. And whether everybody needs to meet at the same time.

This was discussed at the Executive Committee and asked if they -- if there's one day that all the committees can be present. This has both advantage in one sense that some people are on more than one committee.

So you're on -- you're ask -- especially the other crossovers. The other advantage is that you -- you add more to the integration with the other --

DR. YOUNG: So we may be able to discuss this at TAG, I guess.

DR. ABOUTANOS: Discuss it, but

this is also the -- you are the chair in this committee. You could say, I want us to also meet midway within the three months.

DR. YOUNG: So there is absolutely not secure conference call thing that we can use that -- the State government does not have a secure --

MR. ERSKINE: No, it -- it's -- the law states that you have to meet in person.

DR. YOUNG: Excellent.

MR. ERSKINE: You know, it's --

COMMITTEE MEMBER: And that's for all work groups, even smaller work groups of this committee --

MR. ERSKINE: Yes. If you are -- if you are doing work for the citizens, it must be held in the open. You know, there are -- there's some minor like meeting planning, if you want to call and discuss

how you're going to lay out the agenda. But you can't make any decisions about what's going to happen beyond here's what we're going to discuss and the order in which we're going to --

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: So you could email --

DR. YOUNG: Oh, so we could do that?

DR. ABOUTANOS: Yeah, you could talk about --

MR. ERSKINE: Yeah.

DR. ABOUTANOS: -- planning for the -- for the committee. But no -- no discussion that involves any kind of content.

COMMITTEE MEMBER: Like a really

detailed plan.

DR. YOUNG: Absurd question, can we email about deciding whether we're going to do this?

DR. ABOUTANOS: Like you could email as the chair telling everybody else what you want to do. They could send you -- or we could send you their comments. You just can't reply to all. You can send one to all, but no one can reply back to you.

DR. YOUNG: All right. We'll go over this --

COMMITTEE MEMBER: A one-sided conversation.

DR. YOUNG: Okay. I just -- all right.

MR. ERSKINE: It's -- this is -- this is --

DR. YOUNG: Can't fight city hall. This is real common across the country.

DR. ABOUTANOS: Well, I think you've done that for 17 years. Didn't you just say --

DR. YOUNG: Yeah, that's why I took a vacation for another 10 years from it. All right. We'll talk about some -- okay. We'll, I'm not sure everybody wants to -- I mean, I would say if we're going to get this done in any kind of reasonable time period, probably four meetings a year is not going to do it.

But let's -- let me talk -- I didn't quite understand the email, call and response thing. But we'll -- we'll figure out what that is.

COMMITTEE MEMBER: That's why I never responded to you when you sent an email the other day.

DR. YOUNG: Okay. The --

DR. ABOUTANOS: And you could do that. You could just say, don't respond back to all. Here is my question. Just email me directly. You could --

DR. YOUNG: Oh, okay. Now I -- okay.

MR. ERSKINE: Yeah, because if -- if you hit a reply all, that's technically a meeting. I'm not sure how that became a -- a legal interpretation, but it is.

DR. YOUNG: Okay. I'll ask you a question off-line -- well, I guess I can't do that.

MR. ERSKINE: When you -- when you send out to the committee, send it as blind copies to everybody. That way, they can't reply all.

DR. YOUNG: I'm not sure if I can say this. What -- what if VCU and UVa got ideas from this and made work groups to look

at some of this, and it wasn't a state thing.

DR. ABOUTANOS: This is different, so --

DR. YOUNG: What if I just said as trauma director at UVa, I'd like us to look at --

DR. ABOUTANOS: Well, let me -- let me put it this way. So what has happened is that we've got to work hand in hand with the -- with the -- a lot of the COT and the Level I.

And they -- they met -- even at some time -- even had the same -- Office of EMS provided space for the COT meeting to meet --

MR. ERSKINE: Right.

DR. ABOUTANOS: -- together at the same time. But you know, the -- you could have -- well, I --

DR. YOUNG: Let's just -- right.

COMMITTEE MEMBER: If I could just say --

DR. YOUNG: If you have a solution, please.

COMMITTEE MEMBER: Well, so sometimes that VHHA can help coordinate things. And I think some of those -- if the VHHA coordinated it, it would be a meeting of the VHHA not, of the State.

DR. YOUNG: Okay. Yeah, let me ask another question, Tim. A share point type thing where you can -- is there any secure document storage that we could put --

MR. ERSKINE: That I would have to look into. That actually --

DR. YOUNG: Can I get you to check that?

MR. ERSKINE: Yeah.

DR. YOUNG: Because then people --

MR. ERSKINE: That is -- that is -- that is a possibility.

DR. YOUNG: Okay.

MR. ERSKINE: You know, as long as it's just -- okay, here's the document that we will be discussing at the next meeting, something along those lines.

DR. YOUNG: Well, that may be all we need, like for the people in these groups to just say, this is what we want to discuss --

DR. ABOUTANOS: As long -- I think as long as everybody in the public has access to it.

MR. ERSKINE: Yeah. And the other -- the other thing is --

DR. ABOUTANOS: It should just be transparent.

MR. ERSKINE: It is the -- the -- the thing -- the thing to remember -- the very base of this is if what you are doing is working on behalf of the citizens of the -- of the Commonwealth, then it has to be in the open. So --

DR. YOUNG: All right, well -- let's figure -- it sounds like it may just be easier for us to try to figure out a way to meet every six weeks. I -- I think that's what I'm hearing for the most part.

DR. ABOUTANOS: And then -- and so -- then you -- we'll work it out. If that starts happening more, it sounds like -- or maybe I should push into TAG to do the same thing, is probably what I would be doing.

And we would be changing that -- and we have to take a look whether Thursday and Friday of both can become or it maybe that you don't meet on Thursday --

DR. YOUNG: Right.

DR. ABOUTANOS: You meet only for half an hour --

DR. YOUNG: Yeah. I think it would have to be one day.

DR. ABOUTANOS: So you cut -- you cut out everybody's obligation to be here two days you're making every six weeks, and -- and see how it goes.

DR. YOUNG: Yeah. That would be a good solution if we -- if we could make it as streamlined as possible at that six-week meeting. So it's not two days.

DR. ABOUTANOS: Because you could make a long meeting for the -- for the six weeks, like at the Office of EMS or some other place. And during this meeting, you can make it only half an hour to catch up and make sure you have an action item, whichever way. There's ways to be

innovative and cut out one day in one place and put in another place. But it really sounded, across the board -- I guess that even at the Executive Meeting this morning -- was the same thing.

Hey, we need to meet much more often. This is not -- three months is just not doing it. Especially with how much or how big an agenda we have. It would take us 10 years.

DR. YOUNG: Okay. All right. We'll work on it. Public comment period. That's essentially what this meeting has been. Anyone? Okay. First meeting, so I don't think we have unfinished business. Do we?

DR. ABOUTANOS: The only thing I have -- so we -- this was -- so the way the system works, everybody else to -- to understand the way we have it is that if the committee decides on an action plan -- the committee here follows on the action. And if it -- and if decided that, yeah, we're

going to carry this action forward, then it goes to the TAG. So the TAG has basic kind of three -- three choices. Number one, say I think this needs further discussion, like what happened here with this one.

And this is additional input. We've got to send it back to the committee. Okay? Or the TAG may decide, I'm going to actually send this to a different committee.

And that's why we've got to make it a cohesive plan, not be [unintelligible]. And those different committees can review what one committee has done and add -- and add to it.

Then it has to come out of that committee again and come back to the TAG. And only when it comes out of the TAG does it go to the -- to the Advisory Board for -- as -- as an action item.

And so this is what happened here in this process. This was discussed at TAG and was not enough information was sent back to this committee. Should have been in the minute of -- of what they want.

DR. YOUNG: So there's a possibility we could vote on this?

DR. ABOUTANOS: It was voted on here first -- last -- last meeting. But the TAG was voted to bring it back to here.

DR. YOUNG: Okay. All right. Does everyone -- did we pass it here? Does everyone have the proposal for CME changes?

DR. ABOUTANOS: Do you have one more copy?

COMMITTEE MEMBER: Here's -- found one. Here's an extra one.

DR. ABOUTANOS: Thank you.

DR. YOUNG: So I -- I -- this is the first I've seen it. I would just say if -- if we're looking at the college criteria, I think you have it in here about board eligibility at the bottom. But we say that the -- the trauma director needs to be

currently board-certified. But really, everyone else can be board-eligible as long as they're within their eligibility period. So I don't know if in your discussion you wanted to make it stricter than that.

The college, for instance, does not require the neurosurgeon liaison be board-certified. They can be board-eligible.

DR. ABOUTANOS: Yeah. That was not discussed that way. That was done initially.

DR. YOUNG: So should we just -- I mean I would just propose that other than the trauma director, you could change everything else to current or board-eligible. Is that --

MR. ERSKINE: Well --

COMMITTEE MEMBER: Clarification. I'm not quite sure I understood what he said.

DR. YOUNG: So for the ACS, the trauma medical director needs to be board-certified, but we do allow everyone else to be within their eligibility period.

I've seen -- I've seen neurosurgery liaisons, actually EDM doc's one year out of residency. They -- they're still -- they're -- it's not a CE. So I --

COMMITTEE MEMBER: I do think if -- and somebody else help me out. Because we did go around in a circle a little bit in our own groups with this, is I think that we did discuss that in meetings prior to bringing it to the former TSOMC and back from a work group.

That -- should we just make it everybody that's board-certified or board-eligible and follow every strict -- very clearly what the ACS was saying?

Or do we separate out that individual physician, particularly -- it's -- it's really a state criteria pertaining to your emergency medicine physicians, which I think is where it's not -- it is not --

for -- what row or the last -- the second to last in the last row, which is a little bit -- I think -- still unclear.

DR. YOUNG: Well it says not EM board-certified --

COMMITTEE MEMBER: Yeah.

DR. YOUNG: -- but then it says, current board certification.

COMMITTEE MEMBER: So I think that -- I think that what the current state criteria says that if an EM physician is not board-certified in emergency medicine, they have to maintain current ATLS.

And there's no -- there's no -- this is where the ACS says, if you're board-certified or board-eligible. It's all lumped together.

DR. YOUNG: Right. The only time you have to be current in ATLS for an EM position is if you're not -- if you are

boarded in a specialty other than emergency medicine.

COMMITTEE MEMBER: Right. That's the -- that's --

COMMITTEE MEMBER: It's board-eligible.

COMMITTEE MEMBER: Board-eligible.

DR. ABOUTANOS: That didn't change.

DR. YOUNG: Okay.

DR. ABOUTANOS: I think the biggest thing why this came back was actually the bottom statements was with regard to -- it wasn't the top criteria. In the document are mandated for both of -- you have the trauma center, then the whole burn center.

DR. BROERING: Right.

DR. ABOUTANOS: Is this, Tim, the

modified from -- or the exact same one?

MR. ERSKINE: This is the modified.

DR. ABOUTANOS: Okay. So this was the modification with regard to after the discussion that happened with TAG, Tim?

MR. ERSKINE: Yes.

COMMITTEE MEMBER: I think it also was the fact that the State criteria -- the State criteria lumps in acute care -- not acute care, advanced practice providers into this whole lump sum.

And -- so I think that the groups that worked on this and the individuals that worked on this tried to break it out a little bit more specific so that an individual level of provider, we were more clear. Because it was just all lumped together. So --

DR. YOUNG: Yeah, the college doesn't care about it --

COMMITTEE MEMBER: I know.

DR. YOUNG: -- the CPE's that don't respond --

COMMITTEE MEMBER: Correct.

DR. YOUNG: -- to trauma activation.

COMMITTEE MEMBER: Correct.

DR. YOUNG: So was the general gist when this was discussed that it should be more stringent than the college?

COMMITTEE MEMBER: Yeah.

MR. ERSKINE: Yes.

DR. ABOUTANOS: Yeah, definitely. There was a discussion about that.

DR. YOUNG: Well. Every site visit I've ever seen, if we didn't let board-

eligible people be on the panel, it would reduce the panel by 25 to 30% in every place.

MR. ERSKINE: This has -- this has only been an issue with one -- I mean, in the last 18 months. I've been to all but three of the trauma centers at this point. It was an issue for one physician.

DR. YOUNG: Being board --

COMMITTEE MEMBER: Does he have to be board-certified in order to --

MR. ERSKINE: He was board-eligible, but didn't have ATLS.

COMMITTEE MEMBER: And -- and you can be board-eligible and still sit. But you have to have that current ATLS.

MR. ERSKINE: Yeah. And that was -- that was it. And that was --

COMMITTEE MEMBER: That's -- that's -- that's the depth of it.

DR. ABOUTANOS: I don't think that was as much of an issue --

DR. BROERING: As the burn stuff.

DR. ABOUTANOS: -- with this. It's more of the -- the advanced practitioners was one. And then, again, the -- the modifications are already done here in the bottom. So I think if this --

COMMITTEE MEMBER: The two -- excuse me.

DR. ABOUTANOS: Go ahead.

COMMITTEE MEMBER: The two -- the clarification that I -- the question that I have now, though, is that I actually think that we've -- the statement at the -- in the very last row concerns me, is that it says board-eligible MD, DO. And then it says

eligibility documentation, and then ATLS must be current. And then the CME requirements would be 10 per year --

DR. ABOUTANOS: Yeah, we weren't not --

COMMITTEE MEMBER: -- per three years.

DR. YOUNG: We don't require it.

COMMITTEE MEMBER: And you're -- you're saying -- are you saying any board-eligible MD? So are -- is that any specialty? So that clarification probably needs to be --

DR. YOUNG: One thing --

COMMITTEE MEMBER: -- exactly what it says.

DR. YOUNG: I think one thing that's -- that needs to be done here, and I

had done this initially and was -- was voted down. But I put these, not in a table form, but wrote them out as if they were a criterion.

COMMITTEE MEMBER: Correct.

DR. YOUNG: That will make it a lot clearer what exactly is being said. And I can -- I can do that to help clarify this.

DR. ABOUTANOS: Let me -- let me put this one -- I think that's helpful what -- what you're saying. But one -- one aspect is that if we go with what Jeff was talking about earlier at very beginning, if you exclude -- just from this for now -- the medical director, which has to be board-certified.

And if we are using -- if we exclude the advanced practice practitioners -- advanced practice providers, excuse me -- take everybody else and just say board-certified or -eligible. And you can eliminate that last -- that last row.

Because the last row now is very different, because you're saying board-eligible --

DR. YOUNG: But you can also -- you can eliminate the last two rows.

DR. ABOUTANOS: EM board-certified --

DR. YOUNG: Yeah, because you have EM physicians above. You said current -- you said current or board-eligible. You can take out the last two rows.

DR. ABOUTANOS: Yeah. And then -- so you only leave the ED director and the trauma director that they have to be board-certified. Everybody else, certified or eligible. And then you take away the CME part. That -- that's --

DR. YOUNG: The medical director still has to have CME.

DR. ABOUTANOS: Yeah, yeah. I

know. I'm just saying we have to exclude those two and have --

DR. YOUNG: Yeah.

COMMITTEE MEMBER: And emergency medicine that is not board-certified in emergency medicine.

COMMITTEE MEMBER: Emergency medicine, so like I'd have to be current in ATLS.

DR. YOUNG: Yeah, right. So the family practice guy working in the ED still has to have ATLS.

DR. ABOUTANOS: So eliminate the last one, not the last two.

COMMITTEE MEMBER: Yeah. Not the last two.

COMMITTEE MEMBER: Correct, right.

DR. ABOUTANOS: And keep -- and keep --

DR. YOUNG: Oh, I see. I didn't realize that. Okay.

COMMITTEE MEMBER: And then if you keep --

DR. YOUNG: So it's not EM --

DR. ABOUTANOS: Not EM board-certified.

COMMITTEE MEMBER: Not EM board.

COMMITTEE MEMBER: It's an emergency medicine --

DR. YOUNG: If you all understand it, that's fine.

COMMITTEE MEMBER: -- in some states.

DR. YOUNG: Yes.

COMMITTEE MEMBER: What I understand is that the EM physicians can change, but it's only for board-certified physicians who are participating in MOC, the recent changes.

They no longer have to complete CME, that's what ACS said. But that only applies to certified. So board-eligible who are not certified would still need to get CME every year.

DR. YOUNG: We don't check with CME on -- we consider, really -- if you're in the eligibility period, you have the same criteria as a board-certified person. Unless you're not boarded in emergency medicine. That's a different criteria.

DR. ABOUTANOS: And that's what this says. It says if you're not EM board-certified you still have to have CME. That's the second -- that's second to last row. You know what I'm saying?

DR. YOUNG: Mm-hmm.

DR. ABOUTANOS: So that -- we decide that's the --

COMMITTEE MEMBER: Yeah, that's the only part --

COMMITTEE MEMBER: Yeah.

DR. ABOUTANOS: We keep that as a -- yeah.

DR. YOUNG: Yeah. So the only reason why that confused me would be -- just the board-certified and we've been talking about board certified. Just like -- just considered not EM-boarded, or boarded in another specialty.

COMMITTEE MEMBER: Another specialty, right.

DR. YOUNG: Yeah, so --

COMMITTEE MEMBER: And then if we take out the -- if we take out the very last row, it --

DR. ABOUTANOS: That's it.

DR. YOUNG: And for current and board-eligible next to everything except for --

DR. ABOUTANOS: Except the medical data part.

COMMITTEE MEMBER: Just change the language for EM physicians and say not boarded in EM.

DR. YOUNG: Right, that's what I would say.

COMMITTEE MEMBER: Emergency -- yeah.

DR. YOUNG: Because there's a --

DR. ABOUTANOS: A question also. I thought the ACS said medical director in the ED still has to have CME's, but you were saying no.

DR. YOUNG: That was -- that was the last -- that was the last change that was made was that if the following the ACS where if you're -- if you're an MOC --

MR. ERSKINE: The latest thing is only the TMD if people meeting the alternate pathway need to have CME.

COMMITTEE MEMBER: Correct.

DR. ABOUTANOS: Not the ED.

COMMITTEE MEMBER: No. The -- the ED is only state. The ED one is only state.

COMMITTEE MEMBER: Well, let's have this whole conversation that initiated, it was about CME, not board-eligibility.

DR. ABOUTANOS: Yeah, yeah.

DR. YOUNG: Yeah.

DR. ABOUTANOS: All CME. Everybody was happy with all the other stuff, which is --

DR. YOUNG: Well, you're killing two birds with one stone.

DR. ABOUTANOS: So -- so right now --

DR. YOUNG: Just to make sure, everyone's okay with the ACP's having had to --

DR. ABOUTANOS: Yeah.

DR. YOUNG: Like all the TPM's are cool with collecting 30 hours of CME documentation on their ACP's? All right.

COMMITTEE MEMBER: In a way, 55 --

DR. YOUNG: It's up to you guys.

COMMITTEE MEMBER: -- issues. So I'm unhappy with it.

DR. YOUNG: I might -- I might tell them they just need to put orders in in EPIC and go stand around the bed.

COMMITTEE MEMBER: I think that there is a lot of discussion because of variability in training, variability in practice.

How they practice, the response and everything that we thought felt that it would be important to make it happen.

DR. YOUNG: I am agnostic on that issue. If the TPM's want to do it --

DR. ABOUTANOS: So if you eliminate just the last one, keep everything the same. Add eligibility --

DR. YOUNG: I think I have it here.

DR. ABOUTANOS: -- to the provider.

COMMITTEE MEMBER: Yeah.

DR. YOUNG: And current and board-eligible to all of these.

MR. ERSKINE: Mm-hmm.

DR. YOUNG: Leave that one. So you guys are saying you want the medical director of the ER can not be board-eligible. That's what you've decided.

MR. ERSKINE: Right. The --

DR. ABOUTANOS: That's what they said.

DR. YOUNG: Okay, all right. So those two stay current and the rest go to that. All right. So we can make a motion, right? Our only motion of the day at 4:15.

DR. BROERING: The only -- to also make it that the American Burn Association does not board-certify any physician. It's the American Board of Plastic Surgery or the American Board of Surgery. So --

DR. ABOUTANOS: That was discussed, too.

DR. BROERING: -- the ABA --

DR. ABOUTANOS: That was modified, this was not.

DR. YOUNG: I'm sorry that that didn't get struck.

DR. BROERING: So from the -- from the American Burn Association should be taken out.

MR. ERSKINE: All right. I think I have all the corrections.

COMMITTEE MEMBER: Can I just ask a

question?

MR. ERSKINE: And it's the Board of Surgery was the other one?

DR. YOUNG: Yeah, I have it. I -- I think what we'll do is I'll read what I think the changes are and then we can vote.

COMMITTEE MEMBER: So for your board-eligible physicians, it says you have to have current ATLS. So it --

DR. YOUNG: For your --

COMMITTEE MEMBER: For your board-eligible EM physicians, you have to have current ATLS.

DR. YOUNG: In all reasonableness, I can't say. I think because usually they're within their five years, they almost all are current.

DR. ABOUTANOS: No, we've had --

COMMITTEE MEMBER: No.

DR. YOUNG: So all right. This is funny. After 170 reviews. Do we actually require board --

COMMITTEE MEMBER: The current -- the current state criteria --

DR. YOUNG: No, no, I meant the ACS.

COMMITTEE MEMBER: The ACS does not have --

COMMITTEE MEMBER: I don't know.

COMMITTEE MEMBER: The ACS does not take a stand on board eligibility in --

DR. YOUNG: No, I think we were talking about ATLS, current for people that are board-eligible.

COMMITTEE MEMBER: That's -- that's

what I was -- board-certified.

COMMITTEE MEMBER: It's only a state criteria.

DR. YOUNG: That's what I thought. Okay.

COMMITTEE MEMBER: It's not an ACS.

DR. YOUNG: It's not an ACS, okay.

COMMITTEE MEMBER: Well, see, here's the -- here's where it comes up. If you've got say if somebody takes ATLS as a second-year resident. So they're good through the remainder of their residency. Then they go out into practice, they're board-eligible for the first year. But maybe their ATLS --

DR. ABOUTANOS: Has expired.

COMMITTEE MEMBER: -- has expired.

DR. ABOUTANOS: Sure.

COMMITTEE MEMBER: Yes.

DR. YOUNG: That was the one -- that was the one guy where this became an issue.

COMMITTEE MEMBER: I was just have to ask that it go away.

COMMITTEE MEMBER: I think you -- I think you could -- EM physicians that are board-certified are board-eligible.

DR. YOUNG: And leave it taken once.

COMMITTEE MEMBER: Taken once.

DR. YOUNG: Okay. All right. Let me --

DR. ABOUTANOS: Just make it simple.

DR. YOUNG: Let me try to -- if people have their own notes. Let me try to say what I think we said. So starting from the beginning, the first line -- medical director trauma -- stays the way it is. The second line stays the way it is.

COMMITTEE MEMBER: Correct.

DR. YOUNG: The third line under board-certification box changes to current or board-eligible.

COMMITTEE MEMBER: Yeah.

DR. YOUNG: The fourth line -- and the rest of it stays the way it is. The fourth line, board certification changes to current or board-eligible. Everything else stays the same as it is. ACP line --

COMMITTEE MEMBER: Stays the same.

DR. YOUNG: So we're getting -- there's no board eligibility for ACP's?

DR. ABOUTANOS: No.

DR. YOUNG: Okay. I have no idea. All right.

DR. ABOUTANOS: They have to get one from the state.

DR. YOUNG: Okay. And then the ACP providing care on unit and clinics, we are actually going to order that? The ACS doesn't even look at that. That's what you all wanted?

DR. ABOUTANOS: Mm-hmm.

COMMITTEE MEMBER: The ACS does it.

COMMITTEE MEMBER: In this -- yeah. It says in this state.

DR. YOUNG: All right. I guess Mike's saying like we can actually decide this. So like what do people think --

DR. ABOUTANOS: Well, this -- that email's been a big thing. This is -- ACS is just the recommending body.

COMMITTEE MEMBER: Right.

DR. ABOUTANOS: But we are -- assist us.

DR. YOUNG: But we can actually take this out or keep it, and recommend it to the TAG, right?

DR. ABOUTANOS: Exactly.

DR. YOUNG: What if people want to say for ACP's providing care --

COMMITTEE MEMBER: Providers that are in the [inaudible].

DR. YOUNG: I don't. But -- all right. Let's -- someone make -- let's do this real. So someone make a motion. I don't think I can.

COMMITTEE MEMBER: I would make a motion that ATLS is not required that taken once. Because a person -- I think it would be very difficult for trauma program managers or anybody else to track some of our providers who have been around with us for five or 10 or 25 years.

DR. YOUNG: And which box were you --

DR. ABOUTANOS: Which one are you talking about?

DR. YOUNG: We were talking about ACP --

COMMITTEE MEMBER: ACP's providing care on units, slash clinic, their board-certification or licensure stays current. Take out ATLS, they're taken once. Say not applicable, but they maintain the CEU's or CME.

DR. YOUNG: Okay.

DR. ABOUTANOS: So you don't want to take ATLS to take care of the patient on the floor or the ICU?

DR. YOUNG: So let me just -- like -- does anyone, I would say another motion, I don't believe I can make one, is to take that whole line out. So this is the motion. So is there a second?

DR. ABOUTANOS: Is that --

COMMITTEE MEMBER: Because there's a stake in a line that says that if you're involved in the care of trauma -- I'm just asking.

COMMITTEE MEMBER: Is there a clarification? If we change it here, it's not going to change --

DR. ABOUTANOS: It's not.

COMMITTEE MEMBER: -- that guideline. So if I'm going to be designated

next year, I'm still going to have to --

DR. ABOUTANOS: I think you're right, especially because you have not changed the -- the manual yet.

COMMITTEE MEMBER: Right.

DR. ABOUTANOS: You can not change what's not in the manual yet based on this vote.

COMMITTEE MEMBER: You can't make it less.

DR. YOUNG: Can I just ask if anyone knows? Do the ACP's just -- do ACP's just have to have the CME to keep their license?

COMMITTEE MEMBER: Yes.

DR. YOUNG: Or is this extra CME?

COMMITTEE MEMBER: This started as

a discussion with -- correct me if I'm wrong -- with the physicians on trauma oversight, specifically about the practitioner --

DR. ABOUTANOS: It was the ED physicians.

DR. YOUNG: Well, this --

DR. ABOUTANOS: Go ahead.

COMMITTEE MEMBER: Each surgeon, emergency physician, nurse practitioner or physician's assistant participates, slash, taking call in the program or could possibly be caring for adult trauma -- I'm sorry, for trauma alert patients in the ED shall complete 30 Category I CME in trauma critical care across a three-year [inaudible] patient period.

DR. YOUNG: All right. That's not this.

COMMITTEE MEMBER: That's in the

ED.

DR. YOUNG: That's --

COMMITTEE MEMBER: Taking call in the program?

DR. YOUNG: No, it says taking call in trauma activations, right?

COMMITTEE MEMBER: It says taking call in the program more than half of the --

DR. YOUNG: Oh, my gosh.

COMMITTEE MEMBER: -- or caring for a --

COMMITTEE MEMBER: That's --

DR. YOUNG: I would not change this.

DR. ABOUTANOS: I would not change this.

DR. YOUNG: Just -- so you -- so we can't even change what that said?

COMMITTEE MEMBER: We can't take away this.

DR. YOUNG: All right. All right. Leave it the way it is. And for the next line, EM physicians. We're changing what's in the parentheses to not boarded in emergency medicine.

DR. ABOUTANOS: Yeah.

DR. YOUNG: And leaving the rest the same. Correct?

DR. ABOUTANOS: Yeah.

DR. YOUNG: We're eliminating the final row.

COMMITTEE MEMBER: Correct.

DR. YOUNG: Correct? And then,

under -- we're leaving the requirements are mandated for both adult and pediatric the same.

COMMITTEE MEMBER: Correct.

DR. YOUNG: And for the next thing, we're replacing Burn Association with Board of Surgery.

COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: Yes.

DR. YOUNG: Okay.

COMMITTEE MEMBER: ACP's required to providing care, exactly as specified, to trauma patients.

MR. ERSKINE: I guess.

DR. YOUNG: Yes. So that's -- that's the -- that's the intent. This was -- this was sort of short-cutting and short-

handing that is --

COMMITTEE MEMBER: It's your emergency medicine and your --

DR. YOUNG: Right.

COMMITTEE MEMBER: -- surgery ACP's. So that's --

DR. YOUNG: Okay. All right. Blah, blah, blah, blah, blah. All right.

COMMITTEE MEMBER: I'm making a motion for what we just talked about.

DR. YOUNG: Okay. Is there a second?

COMMITTEE MEMBER: I second.

DR. YOUNG: All in favor?

COMMITTEE MEMBERS: Aye.

DR. YOUNG: Any opposed?

DR. YOUNG: All right. We -- we did something.

COMMITTEE MEMBER: Can I make a clarification question?

DR. YOUNG: Who seconded, by the way?

COMMITTEE MEMBER: I did.

DR. YOUNG: Okay.

COMMITTEE MEMBER: So my understanding -- my understanding of this is that now that this has been voted upon again by this committee, that it can go back to TAG tomorrow.

DR. YOUNG: Yep.

DR. YOUNG: If TAG votes in favor of this, then it goes to the Advisory group.

If the Advisory group votes in favor of it, it goes to the DOH. Is that right? Or to --

DR. ABOUTANOS: Board of Health.

DR. YOUNG: Board of Health.

COMMITTEE MEMBER: Board of Health, sorry.

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: And if it is approved then that way, that's where it gets shifted into Code. Is that correct, into the standards?

MR. ERSKINE: It'll -- it'll -- at this point, it'll be in a -- like an appendix to the current designation manual. Our own version of a clarification document.

COMMITTEE MEMBER: Okay, that's great. I just think that we all have to be

able to articulate that process because we have individuals in our own centers that are asking for follow up on this process. So -- and we want to be able to communicate it accurately.

DR. YOUNG: Yes.

COMMITTEE MEMBER: Can I ask one more clarification on it? And I know we've --

DR. YOUNG: We already voted on it.

COMMITTEE MEMBER: I know, I know. But I want to go back to Dr. O'Shea's question of the providing care in the units and clinics.

Is that -- is that your -- is that your ABP's for ortho and for neurosurgery because they're providing care in the clinics? I'm just -- I'm just asking --

DR. YOUNG: I guess one thing we

could do with this line --

(Recording stopped.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing ACUTE CARE COMMITTEE MEETING of the EMS ADVISORY BOARD heard on February 8, 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 28th day of February, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2019.

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