COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: SYSTEM IMPROVEMENT COMMITTEE MEETING

HEARD BEFORE: VALERIA MITCHELL

SYSTEM IMPROVEMENT COMMITTEE

FEBRUARY 8, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

8:00 A.M.

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APPEARANCES:

Valeria Mitchell, Presiding
System Improvement Committee

SYSTEM IMPROVEMENT COMMITTEE MEMBERS:

Ann Kuhn

Anna Newcomb

Greg Neiman

Robin Pearce

Michelle Pomphrey

Narad Mishra

Sarah Beth Dinwiddie

Sherry Stanley

Shelly Arnold

VDH/OEMS STAFF:

Tim Erskine

Cam Crittenden

Robin Pearce

ALSO PRESENT:

Michel Aboutanos, MD
TAG & EMS Advisory Board

Rachel Bailey

Ann McDonald
Brain Injury Association of Virginia

Dan Freeman

A G E N D A

Items on Agenda not covered**
Items not on Agenda***

(The System Improvement Committee meeting commenced at approximately 8:00 a.m. A quorum was present and the Committee's agenda commenced as follows:)

MS. MITCHELL: I'd like to call this Systems Improvement Committee to order. Just a couple things before we get started. I need to make you aware that this meeting is being audio recorded for the purpose of creating an accurate meeting minutes.

When you speak, please introduce yourself. If the -- if for some reason, I don't call you -- say your name, please say who -- who you are before you speak. Thank you.

And the other thing that I'd just like to just remind everybody, the seats on this committee have been deliberately determined to provide some diversity of knowledge and -- and expertise to the committee.

However, we are not necessarily -- we are not representing our organization. We are representing the

Commonwealth. And so when you speak or when you're thinking about concepts or issues, think broadly, not just what -- what you would like to see for your institution.

You're really looking at care of trauma patients throughout the Commonwealth. Okay? And so you might want you kind of start around and let everybody go and introduce themselves.

Some of us know each other. I'll start. My name is Valeria Mitchell. And I am subbing for Shawn Safford, who is actually chair of this group. He's at a meeting in Houston today.

I'm the trauma program manager at Sentara Norfolk General Hospital in Norfolk, Virginia.

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

MS. KUHN: I'm Ann Kuhn. I'm the trauma director at CHPB in Norfolk.

MR. MISHRA: I'm Narad Mishra, the

epidemiologist at EMS.

MS. MCDONALD: I'm Ann McDonald. I'm the executive director of the Brain Injury Association of Virginia, and crossing over from the post-acute committee.

MS. POMPHREY: My name is Michelle Pomphrey. I am the trauma nurse registrar coordinator for the University of Virginia.

MS. ARNOLD: I'm Shelly Arnold. I'm the HCA trauma for the Capital Division. And I am the member that's crossing over from the Acute Care Committee.

MS. STANLEY: Sherry Stanley. I'm the trauma program manager at Carilion New River Valley Medical Center. And I am crossing over from the Pre-Hospital Committee.

MS. MITCHELL: Okay.

MS. DINWIDDIE: Sarah Beth

Dinwiddie. I'm the trauma outreach coordinator from Carilion Roanoke Memorial Hospital and crossing over from IVP.

MS. PEARCE: I'm Robin Pearce. I'm the trauma performance improvement manager at Henrico Doctors' Forest. And I am on this committee.

MR. ERSKINE: Yeah, PI coordinator.

MS. MITCHELL: PI coordinator.

MS. PEARCE: I'm supposed to be here.

MR. NEIMAN: I'm Greg Neiman. I'm the EMS community liaison for VCU Health. And I'm representing education.

MS. MITCHELL: What's your name again, sir?

MR. NEIMAN: Greg Neiman.

MS. MITCHELL: Greg, okay. All right, thanks.

DR. ABOUTANOS: And I'm Mike Aboutanos, I'm the trauma system coordinator.

MS. MITCHELL: Okay. So everybody has a copy of the agenda? Okay. So -- so this -- since this is our first meeting, I will -- Shawn had asked me -- there's a couple things that we can get to later.

But I really don't have a first report because this is really our first meeting. However, thank you all for being here and being willing to help us as we try to improve care for our trauma patients throughout the Commonwealth.

So the next thing on the agenda is to select a vice-chair. Hey, how are you? Want to tell us who you are?

MS. NEWCOMB: I'm Anna Newcomb. I'm the trauma research manager at Inova Fairfax.

MS. MITCHELL: Thank you. So the first agenda item is to select a vice-chair.

COMMITTEE MEMBER: I nominate Valeria Mitchell.

MS. MITCHELL: Oh, please.

DR. ABOUTANOS: I just want to tell you, so it's a -- really a nomination. It's the chair of this -- of the committee who picks a vice-chair.

MS. MITCHELL: Oh. So he does it, okay.

DR. ABOUTANOS: But -- but you can give suggestions.

MS. MITCHELL: Okay.

DR. ABOUTANOS: You can say, hey, we'd like to nominate this person. And so for the chair to make the selection.

MS. MITCHELL: Okay. So we'll pass that on to Shawn.

MR. ERSKINE: I think -- I think we -- you said --

DR. ABOUTANOS: So we put your name, so your name will be one of the things that can be fast forward.

MS. MITCHELL: Okay.

DR. ABOUTANOS: The function of the -- of the vice-chair is to preside over this committee when the chair can not do it. Function when any manner of the chair is needed.

And also present at the TAG the -- the report and the action items if any came out of this committee. But also, if the chair's not present at the Advisory Board to also present.

So today, you'll do the same thing, present the report and present an action item if the action item's been

approved by TAG.

MS. MITCHELL: Okay.

DR. ABOUTANOS: Okay. So if an action item comes out of this committee and goes to TAG at 10:30 when we meet. And it does go through -- TAG does approve it.

Then it comes back to the chair or the vice-chair of this committee to present at the Advisory Board.

MS. MITCHELL: Okay.

DR. ABOUTANOS: Okay. So that way the function be of the -- of the vice-chair.

MS. MITCHELL: Okay. So we have three positions that have not been filled. One is the non-trauma center representative and citizen representative.

And then we have a[n] epidemiologist spot, but we also have an epidemiologist from your office.

MR. MISHRA: That's the spot, right?

MS. MITCHELL: Yeah. So --

COMMITTEE MEMBER: So Narad is where people or data in the Office of EMS --

MS. MITCHELL: Yes.

COMMITTEE MEMBER: -- do data. But you still have an epidemiologist spot on the committee.

MS. MITCHELL: Right. So we could -- we would end up with two.

COMMITTEE MEMBER: Mm-hmm.

MS. MITCHELL: Okay.

COMMITTEE MEMBER: He's here as a resource.

MS. MITCHELL: Okay, thanks.

COMMITTEE MEMBER: He can interface with the data and the function of the Office.

MS. MITCHELL: Right. So do we have any suggestions for these empties?

MR. ERSKINE: For the non-trauma center when we -- we discussed this at Pre-Hospital Care yesterday. We've got a list of the truly rural non-trauma centers, and found the ones that are not affiliated with a health system that has a trauma center within that health system.

And I will be reaching out to a couple of them for members here, Pre-Hospital Care. One of them, the first one that I'm going to reach out to is Bath County because they are a critical access hospital.

They are not affiliated with any health care system. And the other one that stood out was Wythe County. There are a couple others that we can fall back on. But I mean, these -- these are facilities

that if you want the view of somebody who's not a trauma center, these are the places to get those -- to get those folks.

MS. MITCHELL: And where are these located? I'm sorry. You said Bath County. Where is that?

MR. ERSKINE: Hot Springs, Virginia.

MS. MITCHELL: Okay.

MR. ERSKINE: And Wythe County is in Wytheville, which is at the intersection of I-77 and I-81.

COMMITTEE MEMBER: South of Roanoke.

COMMITTEE MEMBER: Is there no, like in that big swathe at the bottom of the State of Virginia where we have --

MR. ERSKINE: There's a couple, but

most -- most of them are affiliated with a health care system. Let's see. What have I --

COMMITTEE MEMBER: We used to have a -- a lady that came -- that was with a hospital that was at Duke -- was affiliated with Duke.

MR. ERSKINE: Yeah.

COMMITTEE MEMBER: Like Danville, I think.

MR. ERSKINE: Well, Danville's not -- I -- I checked. Danville is one of the ones that's not affiliated. It's on the list of -- the list of non-affiliated hospitals.

COMMITTEE MEMBER: Maybe we stratified it to see who had the -- who might've had the highest amount of trauma patients.

MR. ERSKINE: Mm-hmm.

COMMITTEE MEMBER: What was the top -- one of those was the top one. Was it Bath County? Was it --

MR. ERSKINE: Bath County, yeah, was of -- was the top of the unaffiliated ones that -- you know, they don't have a large number. But they transfer 89% of them out to a trauma center.

We've got Southern Virginia Regional Medical Center, Buchanon General -- I'm probably pronouncing that wrong. I'm no -- it's spelled Buchanon. Okay.

Bath County, Southampton Memorial, Wythe County and Danville are the ones that are unaffiliated.

COMMITTEE MEMBER: And Danville should be -- Ann -- what is her last name -- and she left the organization. And they didn't fill that position for a really long time. I'm not sure who's taken the place now at this point.

COMMITTEE MEMBER: And this -- that facility was supportive of her coming to the meetings.

MR. ERSKINE: Okay.

COMMITTEE MEMBER: And so, she was very helpful.

COMMITTEE MEMBER: She was.

COMMITTEE MEMBER: That's a huge -- when you run the maps, that's a --

MR. ERSKINE: Oh, yeah.

COMMITTEE MEMBER: -- one of those areas that really falls out.

MR. ERSKINE: Okay. If -- if I can't get anybody from Bath, I'll go there second.

MS. MITCHELL: Okay.

MR. ERSKINE: And then to Wythe.

DR. ABOUTANOS: So we'll have one by the next -- the next meeting, hopefully.

MS. MITCHELL: Yeah.

MR. ERSKINE: Hopefully, that's -- there's the key word. Hopefully.

DR. ABOUTANOS: Have we sent out -- you said that the -- have we sent out a total request or you're just doing one individually or --

MR. ERSKINE: Have not sent -- I have not reached out to them yet.

DR. ABOUTANOS: Is that something that, also, VHHA can help with? I mean, they are -- as far as reaching out to all the hospitals and just say, you know --

COMMITTEE MEMBER: Sure.

DR. ABOUTANOS: -- so we could have a good -- especially if we identify -- if we identify where we'd like it to come from. It's been -- it's been going for a while now and we have not found this thing. It's been six months or more than that.

MR. ERSKINE: Okay.

MS. MITCHELL: Okay. So any suggestions for the citizen rep? Does it -- it's a little -- oh, okay.

COMMITTEE MEMBER: [unintelligible], the quality assurance coordinator for Chesterfield County's 911 center. She's a former paramedic and was a supervisor with Richmond Ambulance Authority. So she probably would be a good one.

MS. MITCHELL: Okay.

DR. ABOUTANOS: Does that fit the role?

MS. MITCHELL: I think so.

COMMITTEE MEMBER: I don't know if that is allowed because she was a 911 dispatcher for the -- I think the Pre-Hospital.

COMMITTEE MEMBER: Yeah, we're actually, I mean, except -- I'm not saying we can't consider her. But the true feeling behind it was a -- maybe someone who had vicarious interaction with a trauma system. A patient -- you know, that kind of --

MS. MITCHELL: A patient of the family or somebody like that.

COMMITTEE MEMBER: So that was a question I had.

MS. MITCHELL: Okay.

COMMITTEE MEMBER: Is -- is the preference to have somebody who has really no medical background or --

MS. MITCHELL: No medical background.

MR. ERSKINE: Yeah. We had a -- we had a couple -- we had a couple of nominations for that type of seat on a couple of the committees. And those people are now in health care.

And that's not the viewpoint we want to -- them to bring to the table. So we want somebody who's really not in health care to get the --

MS. MITCHELL: Right.

MR. ERSKINE: -- to get that -- that particular perspective.

DR. ABOUTANOS: So a family member would be the best?

MS. MITCHELL: Right, or --

DR. ABOUTANOS: Or someone --

MS. MITCHELL: -- or a former trauma patient.

DR. ABOUTANOS: -- someone who can work as an advocate. That's the biggest part of the citizen. Someone that can hear us, understand and gives us a perspective of a citizen, not someone who's in the health system.

And also, can help with all level -- either with this committee or also at the -- with the -- you know, any type of, you know, government approach. Whichever way, somebody that can be an advocate for us with the system.

COMMITTEE MEMBER: There is a young lady, Kelly Sydnor, whose son was a spinal cord injured --

COMMITTEE MEMBER: Nicole.

COMMITTEE MEMBER: -- was a spinal cord injury. They were at VCU. They also went down to Shepherd. The whole family has

become a huge advocates for individuals with spinal cord injuries.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: They do a lot of work with those community rehab organizations.

MR. ERSKINE: If you can get me their contact information --

COMMITTEE MEMBER: Either -- either Nicole or Kelly, either one, would probably be very good.

MR. ERSKINE: Can you get me their contact information?

COMMITTEE MEMBER: I can try. You might --

DR. ABOUTANOS: I know -- I know them very, very well.

MR. ERSKINE: Oh.

DR. ABOUTANOS: So unless you want to.

MS. MITCHELL: Right.

DR. ABOUTANOS: So either way, so either Nicole or Kelly. They also serve on our -- our gala committee. And they -- I'm not sure why I didn't think of them. That's a great idea.

MS. MITCHELL: Yeah. That's a --

DR. ABOUTANOS: They're very active in -- so that's one name.

MS. MITCHELL: I have a --

MR. ERSKINE: Dan -- his name is --

MS. MITCHELL: Dan, I'm sorry.

MR. FREEMAN: There's another one,

very similar. Norma Meyers in the Roanoke region. Had one son killed, another one had a significant brain injury. Went down to Shepherd's.

Very active, writes newsletters for the Brain Injury organization. And I can easily get you her contact information.

MR. ERSKINE: Okay. That'd be great, thank you.

DR. ABOUTANOS: This is also very important because we have a citizen representative also on TAG and -- who is -- one of the things that would be kind of helpful is put together a whole ensemble of citizen representatives.

Even though they're on different committees, they become also a -- a voice together. So the more names, the better. Even if you don't serve --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- if we pick one, we don't want to lose the other ones. So the more names people come up with that consent -- we've been working on how we put this together.

They want to create a web site, they want to do a lot of stuff. And this would be great.

COMMITTEE MEMBER: I think the committee needs a citizen representative, too. So maybe one of them will serve on one and the other on another.

DR. ABOUTANOS: Perfect.

MS. MITCHELL: Right.

MR. ERSKINE: Yeah.

MS. MITCHELL: Yeah. I have a -- a name as well that I'll submit. We have a young girl that was involved in a motor vehicle crash. Her friend died and her mother -- she ended up with a brain injury.

And her mother has started a brain injury support group locally. And -- and the young girl is now -- I think she's a freshman at Virginia Tech.

COMMITTEE MEMBER: Mm-hmm.

MS. MITCHELL: And so her mom might -- would be willing to --

DR. ABOUTANOS: What's her name?

COMMITTEE MEMBER: Debbie.

MS. MITCHELL: Last name is Munder -- Mundor.

COMMITTEE MEMBER: Well, we must -- we might be thinking about two different --

MS. MITCHELL: Sabrina is the patient.

COMMITTEE MEMBER: That seems to be --

MS. MITCHELL: Yeah, Sabrina --

COMMITTEE MEMBER: Sabrina's the daughter.

MS. MITCHELL: Daughter.

COMMITTEE MEMBER: Mom is Debbie.

MS. MITCHELL: Yeah, I don't know her mom's name.

COMMITTEE MEMBER: Ybarra, Y-B-A-R-R-A, hyphen, Ledger, L-E-D-G-E-R. She's on our board. She just recently joined the board.

MS. MITCHELL: Oh, okay.

COMMITTEE MEMBER: So I can contact her easily.

DR. ABOUTANOS: Okay.

COMMITTEE MEMBER: There's another

woman that I thought of who was in an accident with her daughter. The daughter sustained a significant brain injury, mom sustained a brain injury. And they're from Northern Virginia. Her name is Kelly Lange[sp].

DR. ABOUTANOS: See, this is great. Because the three different areas.

MS. MITCHELL: Different people, yeah.

DR. ABOUTANOS: This -- so we already came up with four names besides Susan who is also on the TAG. That's five people.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: That would be great. So --

MS. MITCHELL: For sure we'll get somebody.

COMMITTEE MEMBER: Who do you want the names and contact information to go to?

MR. ERSKINE: To me.

DR. ABOUTANOS: Yeah, I would send it to Tim.

COMMITTEE MEMBER: Okay.

DR. ABOUTANOS: And then Tim will get in touch with Susan and we'll get all this [unintelligible]. Right? Her name is Kelly what?

COMMITTEE MEMBER: Lange.

DR. ABOUTANOS: Lange. Okay.

COMMITTEE MEMBER: She's doing a lot of work for us at Fairfax. So I mean, I see her every other week. So she might be booked for that some months, but then after that she may be --

MS. MITCHELL: Mm-hmm.

MR. ERSKINE: Well, that's one of the -- one of the things with -- with all of these committees as they're starting up. And you know, any time there's a new appointment for, you know, just about any position, that first meeting -- even if it is three months away, that first meeting they may not be able to make it. That's why Dr. Safford's not here.

COMMITTEE MEMBER: Okay.

MS. MITCHELL: Okay. So any suggestions for the epidemiologist? Can you remember the young lady's name -- Ann -- that was on --

DR. ABOUTANOS: Yeah, Ann's at VDH.

MS. MITCHELL: -- the original committee with us? Is she --

COMMITTEE MEMBER: I think there

was a -- isn't there a problem with her grant or something?

COMMITTEE MEMBER: She's somewhere else now. She left the --

DR. ABOUTANOS: She left the --

COMMITTEE MEMBER: -- and she's the epidemiologist at EMS, yes.

DR. ABOUTANOS: I suggest we go back to the Office -- we can reach the Office -- VDH office.

COMMITTEE MEMBER: They haven't filled that position yet. I'm not sure who --

DR. ABOUTANOS: This would be the strategic -- for this committee is to have someone from -- from VDH. Because we're talking about State epidemiology to come work with the Office here, work with you. So we'll have synergy in doing this.

MS. MITCHELL: Yeah, she's really good. Because she talked about -- I mean, there is a lot of data that she worked with every day that she thought would've been very helpful for us. So --

DR. ABOUTANOS: Yeah. She's -- she's an educated epidemiologist.

MS. MITCHELL: Yes. Yeah, definitely. So -- okay. So we'll reach out to VDH for a rep for this group. Okay.

DR. ABOUTANOS: VDH epidemiologist.

MS. MITCHELL: Yeah. So it looks like we've -- well, on the road to being able to fill these positions. So I would think that's -- we meet again in May? That's right?

So we should certainly find some people before our next big meeting. Okay. The next item on the agenda is to define our meeting frequency. Should we -- this group would meet again -- the big group

would meet again in May. We follow that same schedule. And -- so I don't know if we want to talk about that today or that we want Shawn to be a part of that discussion.

DR. ABOUTANOS: Well, Shawn should definitely be a part of that discussion.

MS. MITCHELL: Part of that discussion.

DR. ABOUTANOS: I think the -- the -- you don't want to meet to meet. You want to meet because you have to meet.

MS. MITCHELL: Mm-hmm, right.

DR. ABOUTANOS: So the function of the committee is going to be most important part. So I would actually venture that we should -- need to find what's the function of this committee, what we're here to do. And then, once you -- I would leave how often we're going to meet be the last thing on this committee. Because then once you

look at the work, you decide can we do this in two months or do we need to meet? Or --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- should only part of this committee meet if there's something that only if it was cross on the floor that we start talking about it before at a different time.

MS. MITCHELL: Mm-hmm. Okay.

MR. ERSKINE: Okay. Everybody should have the goals and objectives.

MS. MITCHELL: So these are the goals that we identified in our sub-group that we were creating in this whole process. So I guess we can go through these and see if there's any other things we want to add.

DR. ABOUTANOS: Well, there was something very important yesterday at the Post-Acute Committee --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- that you guys informed us of the Governor's Task Force. And did -- do you want to talk about it, because that fits in the very first one. And that's system --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- entry print their systems.

MS. MCDONNELL: I'm very happy to do that. I'm Ann McDonnell, Brain Injury Association of Virginia. And we were discussing yesterday in the Post-Acute Care group that one of the early executive orders that Governor Northam signed -- and I had the Code citation yesterday, but I don't have my lap top this morning, created a secretarial level data-sharing task force, data analysis, trying to figure out what we had and how we could better share it. The HHR reps, the Department of Health and Human

Services reps to the committee are Gina Berger [sp] and Martin Figueroa [sp], who are both deputy secretaries in HHR to the -- to the State -- State level task force.

The chief data officer, which is a new position in the Commonwealth of Virginia, is a gentleman named Carlos Ribero [sp]. And so they're just now starting to get work.

There's a couple of meeting minutes on the web that you can find. But their whole -- their whole thing is how we -- how we share data. So we're paying attention.

We have a federal grant related to data-sharing, you know, on -- on brain injury data. So we're paying attention to that and we'll keep folks updated as we learn more.

But if you're really geeky and you -- you search out data dissemination and analysis in Virginia, Google it. You'll, you know, they click there eventually. There's an interim -- there's an interim study report that's due sometime in the next

couple of months to the General Assembly. So that should have some recommendations going forward for what the next steps are.

MS. MITCHELL: Okay. So if you want to look at the -- the various goals we have here, we can start with goal one and see if there's anything that we feel like needs to be added or -- or to clarify what's here.

So I know that one of the things that Shawn had sent me is that he thought that we needed to -- and I don't know if we can do that today.

We'll maybe start the conversation about -- he wanted to -- us to identify the list of databases that we have or we have access to.

MS. MITCHELL: Yeah.

DR. ABOUTANOS: This is key. Let's start it where we -- there's a reason why there's so many different representatives.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: And crossovers from the various -- from the various committees because -- so the system -- so let's -- if we step back a little bit.

So the System Improvement Committee is -- is one of the infrastructure committees, not an operational committee in that -- in that sense.

And so, the -- the function of this committee is to serve every other committee. That's like the most important function, especially the TAG.

So this is where the -- the data is. This is where we -- we look at it and find out how does the data impact with what we do.

And give that feedback to the other committees. So this -- the reason why during the task force -- when it was a -- when it was a task force prior to becoming a committee, this became number one objective. And you notice in all of you guys committees, everyone -- we don't -- we don't

know what's out there. Everybody's cycled within their own committee. So that's why this was put out -- out there.

We need to know what exists at every level of the trauma system. We take the patient pathway from the pre-injury, so injury prevention such as -- and that was one part.

And then you go into the pre-hospital, then the hospital, then the post-acute. Those are the four big phases of the patient pathway in the trauma system.

And so the -- this is also -- I mean, the -- the additional databases, etcetera, also with the other aspect of a trauma system, including legislative, finance, etcetera.

So there are many, many ways. So the first thing that we put together is really what's out there. Because we mainly have the trauma registry, right?

And we have the State registry. And then we also have the pre-hospital registry. Those are kind of -- and there's a lot more than those two that

exist, especially when you look at whether -- you know, for example, brain.

MS. MITCHELL: The brain injury, yeah.

DR. ABOUTANOS: Brain injury, orthopedic, we -- I mean, there's so much. And so the whole idea was, can we put all these together, find out what data elements exist, what -- what -- so it -- that's why I asked that you talk about the data-sharing task force.

I wonder if they're doing the same thing, if they have -- except theirs will not be limited to injury work goal.

MS. MCDONNELL: Yeah, it's statewide. They're, you know, different secretarial level representatives. So I think they're assessing everybody's, you know, data capacity including the Department of Medical Assistant Services and, you know, all of that. So --

DR. ABOUTANOS: Tim, what do you think? Can we -- can we own the part of our injury in-depth task force by only contribute to it and say, hey, we want to be involved in all these databases.

So instead of having somebody else look at all that and we're also looking at it, this would be kind of a combined effort. This is part of the integrative process of the trauma system and to the rest of the VDH systems. What do you think?

MR. ERSKINE: Can look into where they are in the process. And if we can assist or participate in some way.

MS. MCDONNELL: And it's probably a little too early. They've only met just a couple of times and they're -- they're deciding it for the whole state.

But I think that, you know, Dr. Oliver talking to whichever -- Berger or Figueroa -- has jurisdiction, if you will, over VDH would probably be the way to go. Just to drop a little thing in there, hey,

have you heard about this? And we've got a lot of interest. And keep us in mind.

DR. ABOUTANOS: Yeah, because they keep the --

MS. MCDONNELL: Yeah.

DR. ABOUTANOS: -- the big -- the big thing is that, see I'm happy that they're starting -- they're starting early. You don't want to come in at a late stage.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: You want to come in early and just say, by the way, this is what we're starting to look at. And -- and therefore, we may actually be able to walk very early with them into having one representative from here help on that task force eventually.

MS. MCDONNELL: So yeah, it is -- and -- and Gina Berger and Figueroa are the

mirror. We're aware of that and that was Carlos and Pam are updated as being -- we're a part of that, what we can do when kind of integrating and I'll say, yeah, this -- it's a great thing.

We're really excited about it. It ties in with who's in the Cloud. And it's a lot -- a new day. Yes. So at OEMS, we do our part of that in some ways. But it is really high level right now. And just in the early stages of --

MS. MITCHELL: Yeah.

MS. MCDONNELL: -- even figuring out who the right people are and what we're looking at.

DR. ABOUTANOS: Okay.

COMMITTEE MEMBER: Have you guys looked into maybe tapping in to the emergency department care coordination program that just was implemented last year?

DR. ABOUTANOS: What is that?

MS. MITCHELL: What -- yeah.

COMMITTEE MEMBER: It's a platform that governor -- they received a federal grant from the High Tech Ops funds to create the emergency department care coordination to allow for interoperability, real time data between the emergency departments throughout the state.

The first one in the nation to do it actually. It's updated with all your transfer patients for all of your emergency rooms who can receive real time data instead of waiting for certain things to come with the patient effort of getting transferred in.

So there -- I don't know if there's going to be a trauma component to that. But I know that they just, last year, finally got committee members going. And they're starting the first steps, the stage one steps this year. They started them last year, excuse me.

MR. ERSKINE: Has she got the contact information for that so we --

COMMITTEE MEMBER: Debbie Condrey is the --

COMMITTEE MEMBER: It's Debbie Condrey.

MR. ERSKINE: Oh, okay.

COMMITTEE MEMBER: -- chief information officer.

COMMITTEE MEMBER: Yeah. It's greater -- they're really kind of at this point -- or the beginning meetings of opioids. They're really kind of focusing on that data-sharing on the opioid crisis.

EMS is part of the phase two. They actually incorporate the EMS medical records and that information into the platform. So that's being -- phase one is how we implement it and that's part of phase two from that end. Yeah, it's fantastic.

COMMITTEE MEMBER: Phase one is -- phase one is what? What's phase one?

COMMITTEE MEMBER: Is getting it up and running. It's actually getting the hospitals on and -- and --

COMMITTEE MEMBER: Yeah, providing local contracts between all the ER's --

COMMITTEE MEMBER: But it's just ER's. It's limited to ER's.

COMMITTEE MEMBER: Right. But I don't know if it could be a trauma component to [inaudible] or injury.

DR. ABOUTANOS: See, just imagine that because that's -- that's the missing link for us, right? We have the Pre-Hospital. We have with the trauma registry, the ER [unintelligible] and trauma. And I was wondering is there a database for the ER's specifically. Because we don't include those in the data. It's

only admitted patients. Okay? So this is an opportunity --

COMMITTEE MEMBER: Yeah, and these -- and these are not -- it's not mandatory. It's voluntary participation. So again, it's only probably four months now that they've actually been --

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: So it's coming. It's been worked on. And then the goal will be, in the phase two, to actually take that EMS medical record, which has all that pre-injury info and put that in there.

So I mean, it's -- it's building that database. But we're really new into it, but it's amazing.

COMMITTEE MEMBER: So that -- so now might be a good time to maybe get somebody --

COMMITTEE MEMBER: Well and Debbie

-- Debbie is our CIO. And I helped with the database, so we work with her. She's very familiar with it and is trying to move -- yeah, she's the only colleague we know. We said we want to be a part of it, too. So...

DR. ABOUTANOS: Okay, great. So what do you think, we go down and see if anybody knows a list? And then have everybody send you and Shawn the list and the --

MS. MITCHELL: List of databases?

DR. ABOUTANOS: Yeah.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: Because you mentioned all four it sounds like. And you mentioned the -- you mentioned the -- we have our Pre-Hospital database already.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: And we have our data -- the Hospital database. And mention the possibility of -- I'm not sure how to do this and how -- if there's anything there that, in the emergency --

COMMITTEE MEMBER: VDH has access to the VHI. It's not in real time. It's behind, but we do have access to that.

DR. ABOUTANOS: Well, we -- that was discussed in the Post-Acute meeting, sorry, committee meeting. And the big discussion was there's a cost associated with it. You have to pay to get the data.

COMMITTEE MEMBER: I -- I don't --

DR. ABOUTANOS: Do we, or we don't? Does the Office of EMS have --

COMMITTEE MEMBER: We don't -- VDH, the epidemiology, that department does have that data. We share it with us -- looked like the opening dashboard. They have

access to it. I don't know what that would cost. I'm not sure.

DR. ABOUTANOS: But if they share with you, they're not sharing with you at any cost. If we ask for the information, you get it.

COMMITTEE MEMBER: I do not ask --

COMMITTEE MEMBER: Yes, but the data that -- I say share. We are -- we send data to the opioid dashboard and some of the VHI data goes into opioid dashboard.

DR. ABOUTANOS: Oh, I see.

COMMITTEE MEMBER: As far as the cost, I don't know that. There is the essence database, too. But I think that's mainly -- that's the main ER information. But it's not trauma-specific. OCME is part of VDH. And Rosie Hobron is their epidemiologist. And they have, obviously, the medical examiner data.

DR. ABOUTANOS: So with OCME is medical examiner data?

COMMITTEE MEMBER: Mm-hmm.

DR. ABOUTANOS: Okay.

MS. MITCHELL: So the -- the information from the brain injury -- office of -- do you all have -- you have data as well. Correct?

MS. MCDONNELL: No, we don't.

MS. MITCHELL: You don't.

MS. MCDONNELL: I mean, we have -- we have what we're able to get from a variety of state -- state agencies.

MS. MITCHELL: Okay. Right.

MS. MCDONNELL: But we have -- right now, we have a federal grant trying to determine where all our brain injury data

sources are.

MS. MITCHELL: Yeah.

MS. MCDONNELL: So that's why we've been looking into it and digging around and sending letters and --

MS. MITCHELL: Okay.

MS. MCDONNELL: -- things like that.

MS. MITCHELL: So you pull -- and I've been in this a long time. But it seems like years ago when I first started, we used to submit data to the brain injury --

MS. MCDONNELL: We used to have a central registry --

MS. MITCHELL: Yeah, right.

MS. MCDONNELL: -- and it's maintained by the Department of Rehab

Services.

MS. MITCHELL: Okay.

MS. MCDONNELL: But in 2007, JLARC suggested, and it was followed through on, that that registry be eliminated.

MS. MITCHELL: Okay.

MS. MCDONNELL: And we report -- we get reports from the trauma registry, which meant -- at that point -- that we lost all ER level data.

So we're not getting any ER level data on individuals who sustain a brain injury, only if they're admitted.

MS. MITCHELL: Admitted. Okay.

MS. MCDONNELL: And -- and we do work with the Department of Rehab Services's outreach efforts to those individuals who are reported.

MS. MITCHELL: Okay. So any other databases? Sounds like one of the opportunities to figure out how we can get data on people that -- we seem to have a lot of data, or potential data, on inpatients.

But it's the people that, you know, sustain an injury and -- or are discharged from the ED that we have limited or not a lot of data.

MS. MCDONNELL: And I -- and you know, I think that there are a number of community-based programs that do have some long term data. There's the model systems program at VCU which is tracking people over 30 years.

But the issue, as we discussed yesterday, is actually attaching a unique patient identifier that lets us track someone all the way through the system.

You know, we can't -- we can't do that. And that's going to take a tremendous amount of work --

MS. MITCHELL: Mm-hmm.

MS. MCDONNELL: -- if it ever, you know, gets done.

DR. ABOUTANOS: Yeah. I mean, something that the doctors -- what it is they think is, you know [unintelligible] just as a basic familiar, I think just having all -- everything that's mentioned here. But then having -- if everybody else can just send in anything they could think of as far as --

MS. MITCHELL: Right.

DR. ABOUTANOS: -- data list. And then deciding, what you said, what exists at every level would be good.

MS. MITCHELL: Right.

DR. ABOUTANOS: If it be injury or other databases. Of course, what are the databases, the Pre-Hospital -- and then maybe we should just put it here once we have those done and try to figure out -- you

know, at the end our objective, obviously, is to figure out what happened to the -- what happened to our average Virginian who gets injured in our system.

And which database can tell us what, so we could have a clear picture of whether -- whether our system of care is having an impact.

MS. MITCHELL: All right.

MS. MCDONNELL: Well the -- the GBI model system's database is something that you might want to look into. So VCU has had a -- a federally designated model system of care for probably 30-40 some years now.

And they -- they're tracking long term outcomes in individuals who are seen, you know, some at VCU, some at other Virginia hospitals.

But they've all been through some sort of traumatic episode and are being followed many years post. So there may be some -- some information that we can glean from that. They're working on a report now

for our federal grant on, you know, all the -- the data that they have on 30 years worth of Virginia residents.

Who's still struggling to get a job, who's living where, how many people went home, how many people went to a nursing home. So that may -- that may have something that you'd like to see in there.

MS. MITCHELL: And where did -- is there -- I'm just wondering, is there a database that -- or some database we could pull information by where -- what happens to people. Do they go back to work or do they --

MS. MCDONNELL: Well, they would -- they would have some of that information --

MS. MITCHELL: That would -- that --

MS. MCDONNELL: -- in their -- in their model systems database.

MS. MITCHELL: And it's just their patients.

DR. ABOUTANOS: Is it just VCU.

MS. MITCHELL: Is it just VCU? They don't have any --

MS. MCDONNELL: It's people who end up at VCU at some point --

MS. MITCHELL: Point, okay.

MS. MCDONNELL: -- not necessarily for the trauma. They may have sustained trauma and been seen at UVa, but are getting follow up care through this model systems program at VCU.

So individuals may have been seen at any Virginia hospital or even their hospital out of state. But they would have some long term --

MS. MITCHELL: Okay.

MS. MCDONNELL: -- and I imagine that they have a -- a method of unique identifiers for the ones that they're following.

DR. ABOUTANOS: Okay.

MS. MITCHELL: Okay.

MS. MCDONNELL: The bio-statistician -- I mean, if you had some interest in talking to him, I could put you in touch with the bio-statistician.

MS. MITCHELL: Okay. That would be good to send to Tim.

MS. MCDONNELL: Okay.

DR. ABOUTANOS: Anything else on objective -- this is a database as [unintelligible]. This is -- the second one. Just for that -- that list we're projecting. And then we can start talking about all of them without -- and it's going

to be most useful for us to use. Okay?

MS. MITCHELL: Michelle Pomphrey, did you have something to -- because you were --

MS. POMPHREY: Oh, I was just --

MS. MITCHELL: Listening, okay. I didn't know whether you needed to be recognized. Okay. Thank you. All righty, so -- so we're -- we're going to send any list of database and -- and then contact information to Tim. Correct? Okay, that's what we decided. Okay.

DR. ABOUTANOS: And -- and I would include Shawn also.

MS. MITCHELL: Shawn, okay.

DR. ABOUTANOS: Yes.

MS. MITCHELL: Yeah. Right. Goal two is -- the second goal is to promote

education, empower institutions and providers to reduce the burden of preventable deaths and suffering as a result of injury through optimized care, implementation of best practice, development of clinical practice guidelines and engagement of our populace and their trauma system through training advocacy and understanding.

I know that when Forrest was part of this group, one of his goals for this group was that we would eventually have risk adjusted mortality reports by institution. And that was one of the things that he had talked a lot about.

DR. ABOUTANOS: What we had is a --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- is a couple of things, you know. So the -- the committee with that -- where this committee came from. Most of what we used to discuss was all Pre-Hospital data. And we're very limited

in -- and that still needs to happen. We still need to look at all the pre-hospital data and the triage and presentation. And then --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: What we have not done is start looking at the actual hospital data being presented. That's going to -- that was where this committee needs to move the system forward.

And as a help with that, we need to drive all -- lock down the data as far as this is what happened, patients come out of the hospital and then we could look in the post-acute.

What happened before, we look at the pre-hospital. And -- and so the -- and this is where we need the Office of EMS help. And to -- what would -- what kind of report can come out of the trauma registry and not as we have. Because we don't have a report from the trauma registry currently.

COMMITTEE MEMBER: Narad's been working on one. He's been looking at what the other -- the trauma triage report was, which was so heavily focused on just -- just -- on the vital signs --

MS. MITCHELL: Yeah, right.

COMMITTEE MEMBER: -- in pre-hospital. And we have got him working on -- he's working on pulling in -- looking at the patients that didn't go trauma centers, pulling in where they -- registry data where they transferred.

Looking at bound for trauma center, were they discharged, were they admitted, what time, you know. Anything we can get.

So he is in the process of that, to get inside a little bit, to even understand how it -- how and if we can link it to the pre-hospital --

DR. ABOUTANOS: Yeah. And even -- even if we can start have an -- Tim has a

good example from the Ohio. But the report that VDH used to have a while back on injured-emiology [phonetic], you know, this -- they stopped because they ran out of claims.

You know, I used -- that was very useful to the folks in the hospital. And before looking at who goes where, it was at least a basic demographics were there.

So if you understand, what is the state of the injury in Virginia? So you know, how many we have that are -- what is the basic databases, you know. What's the demographic, male, female.

What jurisdiction, what are the highest mortality for which mechanism and where. Because the -- the most important part of this committee is to drive all the other committees.

So we have to, as a committee here, get this report. And then generate what is the issues in the -- in the trauma system indicated in Virginia. And then start on that to the various committees. And this work -- all of the crossovers will

end up working with of saying, yeah, you know, I -- I know we're talking about how to present raccoon bites. But the most important part is the falls. That's number one -- that's an example.

Or the second is traumatic brain injury or whatever -- whatever -- those are the three big things that are killing our citizens. And therefore, everything that we do in the committee must address this overarching thing.

And so this is what we need from those -- from the database. We need that basic report that's helpful. So I think -- correct me if I'm wrong, Cam, that they ran -- the grant ran out. That's why -- that's why we stopped having that report.

MS. CRITTENDEN: That's years before my time. I don't know. I've been here three years and -- I mean, the last one that I -- are you talking about the one that was sort of published in the --

MS. MITCHELL: Yeah. I think

that's the one.

MS. CRITTENDEN: I am not -- I am not -- Robin, you were there a year before I was. Do you know --

DR. ABOUTANOS: Was it the year before --

MS. MITCHELL: That was before you, Robin.

MS. PEARCE: It was -- it wasn't through us. It was --

DR. ABOUTANOS: Was it from VDH, right? Maybe it was epidemiology.

MS. PEARCE: It was the -- epidemiology had it. They printed it out. It wasn't -- it wasn't --

DR. ABOUTANOS: No, it wasn't through us, but it was provided --

MS. PEARCE: They gave it to us --

MS. MITCHELL: Yes.

DR. ABOUTANOS: Yeah.

MS. PEARCE: -- and we used it for quite a bit of work.

DR. ABOUTANOS: And so -- but they stopped because it was -- the biggest problem with it wasn't hardwired, it was grant-based. That's the problem with all our grant-based as well.

And then grant had also stopped. But I just heard that VDH, again, have gotten some funds with regard to restarting it.

So I think this will be very important to link with them and find out who in the -- in mediation part epidemiology working on injury data. All of it.

And they still, you know, work -- that's why we need their epidemiologist. That's why I was advocating that be from

that department. So then -- then we look at what is -- are they still doing this report or not, you know. What we don't want to do is for us come out -- we're coming out with a report and they're coming out with a separate --

MS. CRITTENDEN: So the Violence and Injury Prevention program web page on VDH actually has a 2016 -- it's a dashboard, it's a tabloid dashboard. But it's injury hospitalization rate trend number. It's got deaths and it's got all kind of stuff. So --

DR. ABOUTANOS: Yeah. So do -- do we share our trauma registry data with them?

MS. CRITTENDEN: If they ask, I'm sure we do.

DR. ABOUTANOS: Do they ask for it.

MS. CRITTENDEN: They haven't asked for it.

DR. ABOUTANOS: So how do they come up with this report? What is their database source?

MS. CRITTENDEN: Death would be at the offices of the OCME. I mean, that would come from them, the death, purely from OCME. And then the -- the hospital admission trends would come from, I guess, VHI or -- don't know. I'd have to check. Yeah, but this is 2016, so this is the latest information.

DR. ABOUTANOS: Yeah.

COMMITTEE MEMBER: Do all the deaths go through the medical examiner?

MS. CRITTENDEN: We have a vital records department. I -- I'm speaking from my other state. But do -- do you have a vital records department that tracks all births and deaths in the entire state?

COMMITTEE MEMBER: Yes.

MS. CRITTENDEN: I would assume -- and I would think you could certainly get death data from there. I mean, it's only as clean as what -- as what was filled out on the form by the physician that declared the death, you know, how people miss --

MR. ERSKINE: Cause of death, cardiopulmonary arrest.

MS. MITCHELL: Right, mm-hmm.

MS. CRITTENDEN: You should be able to get injury deaths from that.

MR. ERSKINE: Secondary to intense cranial --

MS. MITCHELL: Right.

DR. ABOUTANOS: Yeah, so what I'm asking is does the office of epidemiology get us one of its source or not. It may be. So this is -- this is why this committee is here, that's why we formed it. Because of

all these ambiguities which for some is not a -- because they know what they're doing. They just need to be part of us here.

And so, we definitely have to reach out to the office of epidemiology at VDH, find out where this report's coming from, why did it stop in 2016.

And if they say no, we have infrastructure to continue it, that's great. So we don't exhaust resources.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: And then how can we combine now to either they share data with us or we augment this report that we need to use to drive our trauma system. This is probably the most important part right now.

Even though we're getting the list of the big -- so somebody asked me already if we have this -- this list, and is getting all that information. And if we're not -- if we didn't contribute the data registry to them, I mean, they don't have any of the -- the hospital -- I mean, all of

us know from our own hospital the -- if you look at EMR and if you look at your own data, you have to abstract it to your registry.

It's totally different in terms of the accuracy, the regularity, the type of -- of what you need. So our data registry has a lot of information that -- we just have to combine it.

MR. ERSKINE: Okay.

MS. MITCHELL: Okay.

MR. ERSKINE: Another potential source --

DR. ABOUTANOS: So who's going to do that -- sorry, Tim. Who's going to do that. Who's going to reach out to -- is that -- our office going to do it or --

MS. CRITTENDEN: There's a -- vdh.virginia.gov has a database which lists all of the data resources of VDH by subject

and then again by sources. So that's a good place to start it.

MS. MITCHELL: Oh, great.

DR. ABOUTANOS: So that list what we need for the next meeting. That needs to come in along -- so next meeting, we really should have a presentation on, this is what we know so far from all these lists.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: And we definitely have to have somebody from that office.

MS. MITCHELL: Yeah.

MS. CRITTENDEN: Yeah, so this is all different offices, so -- so I mean, these data are all different. It's just a big master list. So for your injury you got -- the available reports for data are injured death rates, injury hospitalization rates. And then the sources are school

reporting, immunization surveys, the health opportunity index -- just some different required disease reporting. Virginia Cancer Registry -- VOIRS, that's the one that was the -- the grant-related one.

Vital statistics and then -- it's a whole bunch of different places, people, systems. I'll look into that and we'll get it.

MS. CRITTENDEN: Another potential source is the Department of Motor Vehicles. And they have what is federally required traffic records coordinating committee.

And one of the big things that they will have that would be of interest to this group is the crash records. There's a lot of people that die at the scene that just aren't known to the clinicians.

MS. MITCHELL: Mm-hmm.

MS. CRITTENDEN: And that -- that will have, you know, the majority of what they do is engineering and enforcement.

They're big into roadways and traffic engineering and seat belts, speed limits, etcetera. But they do -- they will be the source for those crash records.

DR. ABOUTANOS: Okay.

COMMITTEE MEMBER: I can reach --

MS. CRITTENDEN: We submit our EMS data to them for -- wholly for that. And actually OEMS -- like I sit on their quarterly committee, too, [inaudible] health system.

All of that, we're getting ready to [inaudible], and I'm on that, too. We'll come from -- Tim and I will come next month with everything and anything that we'll have access to from VDH, just a listing.

And send information on [inaudible] just as a starting place that we -- we could --

COMMITTEE MEMBER: Yeah.

MS. CRITTENDEN: -- work with.

COMMITTEE MEMBER: In Virginia, do you have a child's fatality review panel, and do they collect data at the source?

MS. CRITTENDEN: We do.

MR. ERSKINE: Yes.

MS. CRITTENDEN: All states do.

DR. ABOUTANOS: It's another source.

MS. CRITTENDEN: Another source of data.

MS. PEARCE: In emergency management during -- I don't know if they have anything -- deaths related to natural causes and things -- anything of that source.

COMMITTEE MEMBER: Law enforcement

because, again, that would be deaths as -- at the scene. They're still -- include law enforcement there, wherever, the gun shot wound --

COMMITTEE MEMBER: That -- and that would go back to OCME, yeah.

COMMITTEE MEMBER: Usually some [unintelligible] will also have them.

MS. MITCHELL: Okay. Okay so, I guess we can look -- anything else for that goal or anything else anybody wants to add? So if we look at the next goal, goal three.

DR. ABOUTANOS: Sorry, I just want to --

MS. MITCHELL: Sorry.

DR. ABOUTANOS: Sorry, I have a statement on --

MS. MITCHELL: Okay.

DR. ABOUTANOS: So the -- the three sound like, when you heard me said conduct educational gap analysis of --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: So this -- so this goal has -- there's something else. So one -- so one part is just finding out the data.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: Which was one of the function of this System Improvement, and the system from -- we've added an educational component to it just for this. Which is really will be based on this educational gap analysis.

You know, so if you look at your second objection, second goal -- I'm sorry, second goal and the second objective in the goal -- in that goal. It says conduct educational gap analysis of institutions, populace and providers regarding the role of the trauma system in

the community, etcetera. So I think the -- the big part will be once we have this data system and -- and find out which data we're going to use, even though -- that might take a long time even though we could right off the bat look at the two databases that we actually own.

Look at the thermal registry that we have and look at the -- the Pre-Hospital registry that we have. And get the report on those initially.

Okay, meanwhile a separate part is getting the rest of other databases that should augment what these two big databases are doing.

Because I'm -- I have a fear that we're -- the educational gap analysis and then develop regional benchmarking and all this stuff.

We can't do any of that if we don't know -- if we don't have the basic first. So like goal number three, goal number -- we aren't even going to get to those -- four or five -- if we -- if we don't concentrate first on objective number

one and objective number two.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: So I think it may behooves us to kind of spend some time to look at -- I see that Tim has a report here with him. You have a sample report.

MR. ERSKINE: Mm-hmm.

MS. MITCHELL: Yeah, we have that.

DR. ABOUTANOS: You know, that maybe in the future take a look at it, even see is this the kind of data we want, etcetera.

And then -- then move into this -- like the education gap analysis of institution, we need to know what institution need to know first before we can figure out what the gap, right? If we have come up and just say, these are the various solution what -- and this is the knowledge base that we want all the citizens to know.

That we want all the hospitals to know. We don't know what it is --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: -- unless -- like if I ask any member here what are the top 10 causes of mortality in Virginia, do we know, do we have a table? We can't even start.

MS. MITCHELL: Mm-hmm, no.

DR. ABOUTANOS: So that's --

MS. MITCHELL: We have thoughts, but we don't really specifically know.

DR. ABOUTANOS: Well you know, we can find it. None of us have this brain. We just say, let me go find it. You going to go to the same web site you just had.

MS. CRITTENDEN: You -- you can pull it from the CDC web site.

DR. ABOUTANOS: Yeah. Where is the CDC getting their data from?

MS. CRITTENDEN: Required reporting from the states. We -- we -- you know, our EMS data goes to NEMSIS and that's put out nationally -- level.

Trauma data, you know, we've all -- entities, TBB standard and you guys were all submitting your data. And so that's --

MS. MITCHELL: Mm-hmm.

MS. CRITTENDEN: -- that's -- it's coming from this organization for submitting data, too. So...

DR. ABOUTANOS: So can we have -- and make sure we are going to discuss this with Shawn --

MS. MITCHELL: Yeah, mm-hmm.

DR. ABOUTANOS: Can we have for

next time or even if you send all the committee, just the basic report of -- of what I just mentioned, whether it's CDC or our data registry. Something that gets us started.

I think maybe -- maybe a good way to be able to look at what Tim has from his -- or how you sample that. I think Shawn sent everybody --

MS. MITCHELL: Mm-hmm. Yeah.

DR. ABOUTANOS: Even a sample registry. If you that -- I'm going to take a look at it.

MR. ERSKINE: Well, I thought maybe -- I -- I was waiting until we were finished with the -- going over the goals and objectives. But yeah, we can do that.

MS. MITCHELL: Yes, Michelle.

MS. POMPHREY: From a data standpoint, I just have a lot of alarm bells

going off in my head because we just spent the last couple meetings talking about all of the data and what the data needs to do --

MS. MITCHELL: Mm-hmm.

MS. POMPHREY: -- for our state. But I think we need to put on our docket to address a fundamental question is how good is the data that we have.

MS. MITCHELL: That we happen to have, right.

MS. POMPHREY: Because if we make a trend based on the data to go forward because of what we have now, and then we find that we have an inter-rated liability of 60% or 50% on our data, then we are implementing tremendous change based on bad data.

MS. MITCHELL: Mm-hmm.

MS. POMPHREY: So I think that

needs to be part of our foundation as we do the education, the graph analysis to actually look at the validity of the data that's being reported.

MS. MITCHELL: Right. Okay, thank you.

DR. ABOUTANOS: So that's a --

MS. MITCHELL: Good point.

DR. ABOUTANOS: So just to let you know, so the -- the Trauma Performance Improvement Committee, which is what this committee came from, that's what we've been doing for the past two and a half years, three years.

It was all on the pre-hospital part. So what we had done, we looked at the pre-hospital data and we find out it's just -- it's not complete, it's not adequate. When -- when we had to give the report to Advisory Board, which we have to do today, our report essentially was, hey, the data's

not -- you know, more than 60% of -- the vital signs not present, you know. And then we started an improvement system, the pre-hospital then.

But that limited to that one part. I do think we need to bring this back so that we want the function to bring back that -- that same reporting we have right now.

But now we have to add the hospital to it. Then every registry that we have exact to look at the various -- what's missing and how valid is this data.

MS. POMPHREY: Because even with the -- the trauma registry systems that we have in each individual hospital and their trauma registrar, there's some national education that's out there.

But that's not a mandate that everyone take the monthly TQIP quizzes. It's kind of a, it's here for you. As TQIP reports rolled out, that was one of the first feedback is realizing how institutional-level data was not up to par.

That it wasn't a true reflection of their cases. And so there -- there definitely -- things in place for the hospital-level trauma registry and data validity that we -- we should look at.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: During the last meeting that we had for the TAG, the whole concept of the -- the trauma registrar work group, had -- does that exist currently? Isn't there a trauma registrar group?

MS. MITCHELL: Yeah, there is a work group. Right.

COMMITTEE MEMBER: Is it meeting?

MS. MITCHELL: Is it meeting?

COMMITTEE MEMBER: They -- they -- we have a quarterly meeting.

DR. ABOUTANOS: Who heads that, or

is that 600?

MR. ERSKINE: That is -- it's an independent organization.

DR. ABOUTANOS: It's independent organization?

MR. ERSKINE: Yes. It is not part of -- of the government structure.

COMMITTEE MEMBER: What are they called? They have a name. If we can --

MR. ERSKINE: Avatar. The Association of Virginia Trauma Registrars.

DR. ABOUTANOS: So it's a trauma registrars, I thought he said outside of the trauma system plan. How does that work?

COMMITTEE MEMBER: It's the group that they want to, you know --

MR. ERSKINE: It's like the program

managers. They are an independent organization.

MS. MITCHELL: Yeah.

MR. ERSKINE: It's like the College of Surgeons.

DR. ABOUTANOS: Yeah, but -- okay. The trauma program manager, where do they meet?

COMMITTEE MEMBER: Maybe -- sometimes they'll get office space and they'll have it at the office. And they'll come and get that --

MS. MITCHELL: Yeah. I think that's where --

COMMITTEE MEMBER: It quarterly and the registrars typically meet the same day.

DR. ABOUTANOS: Yeah. But what kind of -- what was reported to the -- the

TSOMC as part of their report? That was an official report that was given.

MS. MITCHELL: Yeah, but I think that what has happened with the registrars group and the trauma program managers group, the plan is that we're going to meet off-cycle.

We used to meet as part of this -- these meetings. We'd meet the day before the meetings and now we're having two -- two days of meetings. So now, we're going to meet at a different time.

Because that would mean that we would meet three days, be away from work three days. So -- and then we've kind of gotten away from having the registrars and the program managers meet at the same time.

Because there was an issue with submitting data. We -- we met near the time that you had to submit TQIP data and state data so that people didn't really want to try to do it then. So the registrars are now meeting at a different time.

DR. ABOUTANOS: Because the last time -- what we've -- what we discussed came about that the trauma registrars should have along with them a -- one trauma program manager to be involved so they won't be -- and -- and that they will report, you know, have a report.

And it should be this committee that should be asking for it. And they will report either to this committee. We decided trauma program managers should report to TAG as a form of reporting --

MS. CRITTENDEN: This is the trauma program managers and the -- when they started the registrar. But they're not -- they were not official staff committees by OEMS. And the trauma program managers, all of them meet -- how many -- a long time, right?

MS. MITCHELL: Mm-hmm. They've been meeting for years.

DR. ABOUTANOS: They don't have to

be -- they don't have to be staff OEMS to report to here.

MS. CRITTENDEN: And that's -- and so what I'm just saying, though, is that we don't -- we don't staff -- we don't keep meeting minutes. We don't do any of that. They use public meeting space.

So if they want -- yeah, that's just kind of -- it's not been -- so it's not been subject to all of the things that --

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: Yeah, just what Michelle said, that kind of remind me. So -- so this is a huge resource. Right? And this resource should be part of this.

So for example, like for TAG, we're going to be asking the trauma program managers to report if they continue to meet as a work group. The same thing as we -- you know, we could ask -- we ask anyone to report. You know, the -- the -- you know,

and so this would be something that we should really consider, whether the registrar for the trauma registry for the hospitals who meet and have the input.

And whether they should report on issues, report on what -- report on what's missing and how this is -- you know, this would be a huge asset to -- to us.

So I -- I'm not a member of this committee, but if somebody wants to make a motion to have them report and then just see how that work. Would somebody contact them?

Then you have to approach them, I think. Reach out and just say, where do they fit now? What is their voice, what is that outlet? If they don't have an outlet then they're not part of trauma system plan. And that's a problem.

They have to be part of trauma system plan. You can not say they're separate entity, they live somewhere else. That doesn't exist. That's why we created the trauma system plan.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: We're done with this stuff. We really have to be able to say, who are you? Do you serve the citizen? Please come. Report, tell us what's the problem so we can fix it.

MR. FREEMAN: Well, there are also --

MS. MITCHELL: Dan.

MR. FREEMAN: -- performance improvement committee there. It was short-lived, but it was kind of tagged on to the trauma program managers meeting and the registrar meetings.

And then there's currently their outreach committee, which I'm not sure that's accurate in those type ways or not. But I mean, really, we got four committees essentially that could be a work group, if that's what you're talking about, from those areas of the trauma world if that's what you

want to do is report all of those or have members from each one. Or just a couple of those that just don't think about that. There's other groups out there that exist.

DR. ABOUTANOS: For the -- for the -- so what are the groups, can you name them?

MR. FREEMAN: Trauma program managers, registrar group, outreach and the performance improvement group met briefly. And I'm not sure what happened in the group, but --

DR. ABOUTANOS: What's the performance improvement group?

MS. CRITTENDEN: That was the PI --

MS. MITCHELL: The PI group that ran --

MS. CRITTENDEN: -- the managers and coordinators for each of the trauma

centers. And we met at the same time that the trauma registrars were meeting. And we talked about glue closures and documentations and process --

MR. FREEMAN: It was really a brain storming meeting. It really wasn't work --

COMMITTEE MEMBER: It -- it was -- it was a way for us to -- to share like what we were doing to help educate our trauma registrars to help with our data validity concerns. What our interpretations of various parts of the State and ACS guidelines were.

COMMITTEE MEMBER: It really is just all your components of your trauma program in your hospital that are your people that are meeting in their groups of their respective jobs, of what they do. And sharing information.

COMMITTEE MEMBER: It was more of a support, slash, education meeting and not a

formal reporting thing. So it was -- it was very helpful to those because a lot of us were very new in the worlds at the time that we were meeting.

And so it was nice for us to be able to throw ideas back and forth. I think we stole a couple documents from each other and that kind of stuff.

MR. ERSKINE: And that's the -- that's the strength of those organizations is the networking.

MS. MITCHELL: Mm-hmm.

MR. ERSKINE: You know --

COMMITTEE MEMBER: And not being tied to the -- all the rules that go with these formal --

MR. ERSKINE: Right.

COMMITTEE MEMBER: -- committees. But they can share emails back and forth,

meet in groups, discuss whatever --

MS. MITCHELL: Have conference calls and stuff like that.

DR. ABOUTANOS: I -- I mean, that's fine. We need to do that.

COMMITTEE MEMBER: Yes.

DR. ABOUTANOS: That's been one of the -- that's one of the issues. You know, we have the same thing as, you know, the -- you think about the committee on trauma, all the trauma surgeons get together and we're -- we're talking, you know, what happened, some separate organization.

I just think if this committee is a performance improvement committee and you just mentioned the actual work of this committee, those four separate things.

This is the meat of this committee. So this is a wonderful opportunity. We already have the work group. You're already working together.

And -- but the idea that they're -- so this committee is not dictating when you would meet, not dictating to the public, none of that. You're your own group.

But is asking that the idea of somebody representing here. So I'm asking whether this should be something that we want to have.

The coordinators, the representative, you know, before [unintelligible]. You -- you always have a chance to report what's going on here. So -- so this will become a source -- plan.

You know, of -- so they -- there's a reason why we've added education to this part, an education representative. Kind of silly to have an education representative but -- who's not tied in to what all the education role. I mean, you got to identify together.

So that's what the whole point is. How can we start bringing all this to work together? It's a constraint that we can not meet -- I mean, it has to be public. So we won't put any constraint of -- of the

various work group. But there's got to be a way to bring it here --

MS. CRITTENDEN: And invite them to come in for public comment or for -- I don't know if they'd come. I mean, we can extend an invitation. They're no longer open, so anybody can come forward.

Every meeting has a public comment period. We can send an invitation to come report. I don't know if they will --

COMMITTEE MEMBER: I don't think -- inform me -- correct me if I'm wrong, but I don't think the Performance Improvement -- I mean, we have not gotten together in probably two years.

COMMITTEE MEMBER: Yeah, it -- it dissolved probably about a year and a half ago. But I think there's probably still interest --

COMMITTEE MEMBER: Sure.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: -- for the group and program managers, I think, we can probably facilitate that.

MS. MITCHELL: Right. We probably should, yeah.

COMMITTEE MEMBER: And if the Office of EMS would help with space, especially since we're meeting next month. And it sounds like we want to move forward with quarterly meetings on the next month ahead with these orders.

We can certainly get those groups together and help facilitate that as program managers.

DR. ABOUTANOS: Because a program manager used to report all the time. And actually they were on every agenda every since I work with TSOMC, there was a trauma program managers report. That was part of TSOMC.

COMMITTEE MEMBER: I'm a program manager who was on the committee and reported out.

DR. ABOUTANOS: Yeah, which we do have now also. And so -- but that was, you know, instead of official representation, you know, of this is what we decided for me to do, we want everybody to know about this. And then -- that was very important. And I think we need -- this has to continue.

MS. MITCHELL: Right.

DR. ABOUTANOS: For this -- for this committee specifically, that's what I was thinking about the registrar would be more -- makes more sense registrars report also to here, at least have a representative. We have a registrar here, right? It says registrar representative.

MS. MITCHELL: Yes, Michelle.

MR. ERSKINE: It's Michelle.

MS. MITCHELL: It's Michelle Pomphrey.

DR. ABOUTANOS: So Michelle, that would be your part, I would say to say, this is what -- you are the voice. And that's why -- that's why that function is put on here, to report as the registrar.

MS. MITCHELL: Yeah.

MS. POMPHREY: We have a -- I'll speak to them and I can coordinate with Jennifer for an official report.

DR. ABOUTANOS: Yeah. So -- so what I'm saying is that I would reach out to Shawn and Shawn decided Valeria will be the vice-president to both of the -- to be included on the agenda.

So the agenda will have a registrar. This is a voice that needs to come in and say, this is issue.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: You know, this -- this will extend more when we start talking about other registries and how their -- what their registrars are doing.

Because they may have done some things and gained insight to some things that -- that would be very helpful for everyone.

You know, or -- or vice versa, they have a[n] issue with some kind of definition. We say, well, this is how we solved it and this is how we -- or this is work we need to bring it up forth.

MS. MITCHELL: And they kind of do some of that now. But I think Michelle brings up a really good point about knowing what -- how valid and accurate our data is that we are putting into our registry.

And one of the things that with -- that was very helpful for us as a center with part of TQIP, Michelle came to our facility and did an audit of some of our charts. And it was nice to have an outside person come and look at them. And she gave

us some really good recommendations that we took to heart and tried to make some changes. And I think about how we don't really do that at State level.

That would be really helpful, just to figure out a way that from -- that we -- we'd have someone come in and look at -- you know, look at our data in our different institutions.

And just -- just check to see if the data is valid. I mean, there are things that she picked up that I was -- we were able to teach our registrars and the changes to their practice and how they abstract the data just based on that input.

So I think that if we could identify some things that we want to look at and then figure out how we can go to each other facilities.

Because sometimes when you look at it all the time, you see something very different than some -- when fresh eyes look at it and say, why are you doing it that way? And sometimes our registrars, you know, will have difficulty making changes

because they see it as more work and -- and it's just easier to not deal with it. And it's nice sometimes to have someone come in.

DR. ABOUTANOS: Okay, so -- so my question though --

MS. MITCHELL: Yeah.

DR. ABOUTANOS: Okay. So how do you take this and make it more into something that's useful, so it does not -- it's more useful, what I meant, for everyone.

Show the system improvement committee, for example, and say that from the registrars, we would need a -- a reporting in this one aspect. But other part is that the, you know, what should everyone shall have?

What are the -- there is -- is there a -- is there anything that will -- that is attributed to the function of -- of the registrar, the educational level, what they need to do. And --

COMMITTEE MEMBER: That's in your State designation criteria.

COMMITTEE MEMBER: And that -- those are out there. There is national guidelines for education in the ACS manual. There's two classes that they need to have within the first two years.

There's no mandate for certification nationally. Different hospitals will put that in their implementation. But the problem that we see on a national level is the individual hospitals support of the registrar.

So in other words, the college can give you an FTE guideline and hospitals don't necessarily follow that. The State can make a recommendation that there needs to be a staffing or x,y,z.

The hospital sometimes doesn't follow that. So there is guidelines, but there's sometimes implementation barriers as well.

DR. ABOUTANOS: Yeah, so -- so this

what I'm talking -- so this is actually very important information that should be filtered out.

Because -- so the Acute Care surgery committee, they're looking at now -- one of the -- one of the -- the work group that was just formed yesterday was the development of the group's going to work on the manual, right?

So -- so what would be -- see if the registrars don't have a voice -- this goes to back what I was just saying earlier -- then you're not going to contribute to that manual. It's going to be top down instead of bottom up. You need both.

MS. MITCHELL: Mm-hmm.

DR. ABOUTANOS: And so, this is when you formalize yourself and you just say, hey, we want to present here. This is what's -- what's important to us. So that will -- you need to contribute to that manual. This is what you just said. This is very important, what can we do -- look at

the criteria and just say, this is why we think should be important. And so -- so that's one thing. I will -- I will encourage the talk.

I think Beth was -- was put in charge of that manual -- of the -- of the manual. She put together a small work group. You're able to reach out to her and just say, this is -- let's look at -- let's look at -- what I'm just saying.

So this is what happened when you bring in these issues that have been talk only about in one session. Bring in more out to -- so everybody can hear.

And what -- what you have stated about was reading which was very important was all the -- all the ways that we can improve our system. What you just said, that's an educational aspect of learning, going, benchmarking, you know.

Those are the part that will come into it. I guess that -- that can be moved into that -- that goal three. Even though we are not yet discuss it yet. It sounds like where they were benchmarking,

seeing other people do -- improve our -- our system.

COMMITTEE MEMBER: So Tim, would it be possible to do -- like run out of Image Trend a validity per EMS region for the EMS data and the -- a validity report for the -- like how many errors or whatever that's hitting for the hospital submissions?

MR. ERSKINE: Perhaps.

COMMITTEE MEMBER: Is it something that we could see?

COMMITTEE MEMBER: I was going to say, I want -- I want to kind of -- before we -- as registrars, before we can report data to the State, any hospital individual, we have to run what's called a validator report.

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: That is only

schematic errors. So in other words, it will check our data from a hospital perspective and see that my blood pressure is 180. It's a three-digit blood pressure.

It's above zero and it's below 300. So it says, okay, this is the right format. Therefore, you can submit your data to the State.

But that -- that validator has no way of checking, is that -- should it have been 80/108 or 180. And so, when we report data to the State --

MR. ERSKINE: We can check validity, but not accuracy.

COMMITTEE MEMBER: Exactly. They can check and make sure that everything has a blood pressure, but we don't know if the blood pressure's right.

It can check and make sure that there's an 'e' code there, but there is no validity to, is that 'e' code actually what happened to the patient.

COMMITTEE MEMBER: When -- when I was there, we ran -- we did 10 spot check on charts for different ones.

COMMITTEE MEMBER: Mm-hmm.

COMMITTEE MEMBER: And there was a guy who got hit by a car on the side -- walking on the sidewalk. And he was entered by the EMS agency as an overdose.

So I -- I know that -- that that is a problem that -- I was just wondering if there was any way that we can like look to see if things aren't matching up to what they were.

COMMITTEE MEMBER: You can. And I think -- I don't know too much because I -- I mean, I'm very new. But with Pre-Hospital, we -- we regularly do the Pre-Hospital validity thing.

And it's improving a lot. And recently started doing the trauma as well, so -- but we can do the validity. And like she said, you don't know about the accuracy.

COMMITTEE MEMBER: And with part of the trauma registry, unfortunately, that -- and we go -- the Pre-Hospital side has more robust reporting than the validity and more tracking on it.

The trauma registry program is not -- they didn't -- it seems to not -- it's not in yet and it's horrible. It doesn't have the same tools that the Elite does.

We're working with them on really tightening up the validity and trying to improve it. But it's just not -- the vendor doesn't appear to have committed as much.

EMS is their bailiwick, I think, of anyone. And so the trauma registry is -- is improving. They're working on it, but it's catching up.

COMMITTEE MEMBER: I also think that with the trauma centers, the validity is probably a lot better than your non-trauma centers. Because your non-trauma centers are just putting -- they're really

not -- they're -- they're taking probably information from the coders who are coding for -- for billing versus trauma. So that -- that data is not as valid as your trauma center data. So that's --

COMMITTEE MEMBER: It's a lot less data.

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: And a lot of the trauma centers are doing some inter-rater reliability of multiple levels. In fact --

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: -- if you are a higher level trauma center, you should be doing that.

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: You know, you're -- you're one check of how this is

billed out is one thing. But there's higher levels.

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: And most of them are probably doing that. So the higher the level of trauma center, you know, should have more valid data.

COMMITTEE MEMBER: Your -- your non-trauma centers --

COMMITTEE MEMBER: I was going to -- your non-trauma centers are just putting in -- and it's probably somebody who is not even trained in doing a registry.

COMMITTEE MEMBER: Correct.

COMMITTEE MEMBER: It's the ER nurse at 3:00 in the morning, because it happens to be quiet. That's one incident and it's probably 10 or 12 different people at a facility doing it, not one or two that

are trained.

COMMITTEE MEMBER: And they're not capturing all the data that they need to catch. But --

COMMITTEE MEMBER: But that's the issue.

COMMITTEE MEMBER: Right. But we do have a sample for the State that we can look at. It may not be a complete sample, but it is there.

MS. MITCHELL: But I think that if we're going to try to use this data to make decisions, we need to really back up and make sure that we've got accurate data. And -- and we -- yeah.

COMMITTEE MEMBER: To at least then look if it's accurate, what we're dealing with and what's not so we can say, we're pretty sure -- and this is an assumption. Yeah.

MS. MITCHELL: Yeah. So we just need to figure that out. So I guess -- okay, where are we now? Let's see. So we are going to now look at this report.

I know that Shawn wanted us to look at this, but I don't know that we can look through it today, or just that he wants us to have it.

And look at it and think about -- he -- he would like to have some type of trauma report produced by the end of the year. And you know, he thinks some of the fields in here are things that we would want to look at.

But then, of course, it kind of raises a question. We could put together a report, but we want to make sure our data is accurate, too, that we're going to put in this report.

COMMITTEE MEMBER: So -- so I did my training in Ohio. So I'm very familiar with this -- this report from years and years ago. But they -- they've actually improved upon it since I was there.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Ohio State -- the State of Ohio, I should say, has a fairly robust trauma program. And their -- their trauma programs are heavily funded by the state. So there's a lot of interest in having this data available to them. Yeah, but --

MR. ERSKINE: Whoa. There's -- not a dime --

COMMITTEE MEMBER: No.

MR. ERSKINE: -- goes from the state to the trauma programs. I was -- was --

MS. CRITTENDEN: Tim was the trauma --

MR. ERSKINE: I was -- I was Cam for 10 years.

COMMITTEE MEMBER: Oh, okay. Back in the -- back in the day, they were heavily funded by the state. So they've changed that?

MR. ERSKINE: There was a federal grant from 2000 to 2003 or '05.

COMMITTEE MEMBER: Okay.

MR. ERSKINE: But that was to the tune of about $100,000.00 for the whole state that went to the Division of EMS. And they used that for system level activities.

COMMITTEE MEMBER: Okay.

MR. ERSKINE: The trauma registry, the staffing for the trauma registry, that's all carved out of the Division of Emergency Medical Services. It doesn't have its own separate funding. None of the trauma centers, you know, and the system started out with 14 Level I's and II's. It's now up to 53.

COMMITTEE MEMBER: Right.

MR. ERSKINE: Nobody received a dime.

COMMITTEE MEMBER: Got it. So I'm mistaken on where the money came from. But they had -- they had a fairly -- at least when I was a resident there, they had a fairly robust financial reward for doing trauma. Where that came from, I have no idea. But --

MR. ERSKINE: Well, because you can make money doing trauma.

COMMITTEE MEMBER: Yeah. So they -- they did very well. However, I think that what we have to do is take -- and I think this is what Shawn's intent was with this report -- is to take the data that's contained in this report, compare it to what we do in Virginia, and then what works for us and what doesn't. So a lot of this is just population data and trauma data, which

is probably stuff that we already collect.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And we can organize it in whatever fashion works the best for our system. I mean, I think a lot of the information is probably what we already have. Is that correct, Tim?

MR. ERSKINE: Yeah. This is -- this is all out of National Trauma Databank --

COMMITTEE MEMBER: Right.

MR. ERSKINE: -- data, which we also collect.

COMMITTEE MEMBER: So I think -- and I don't know, do -- do we have -- because that's the one thing, do we have a formal report like this?

MR. ERSKINE: No.

MS. MITCHELL: No, mm-mm.

COMMITTEE MEMBER: So basically, just take our data and put it into a formal report.

MS. MITCHELL: Mm-hmm. I -- I think that's his intent.

COMMITTEE MEMBER: Yeah.

MS. MITCHELL: Yeah, is to put together some type of report. And this was what he considered a good example of what it could be. Whether --

COMMITTEE MEMBER: Right.

MS. MITCHELL: -- we have it -- one exactly like this. I don't think that's his intent, but certainly, wanted us to see what, you know, the possible data points are.

COMMITTEE MEMBER: It depends what

you want to know. If you want to know the total numbers of what happens -- what kind of trauma throughout the state, this is really good one.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: If you want to know about whether trauma patient is going to write or not, you have different like what --

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: -- that they used to produce with -- that which is -- what I'm -- I was working on.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And we can definitely do this. This just shows more of like numbers, what -- what is happening type thing.

MS. MITCHELL: Mm-hmm. Okay.

COMMITTEE MEMBER: I mean, it's a good report.

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: It has a lot of data in it. And it's --

MS. MITCHELL: Right.

COMMITTEE MEMBER: And -- and again, for anybody who just wants to know what is happening in the State, this is a good one resource. Pull it up and you've got all that data.

Where -- and again, correct me if I'm wrong, you sort of have to search around for it a little bit in different sites. Is that the way we are right now?

MS. MITCHELL: No, I think this would come from our registry.

MR. ERSKINE: This is all from trauma registry, yeah.

DR. ABOUTANOS: Trauma registry.

MR. ERSKINE: Yeah.

MS. MITCHELL: We have a lot of stuff --

MR. ERSKINE: And you know, there -- but there is a lot -- there are a lot of different resources depending on what you're looking for.

COMMITTEE MEMBER: Right.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: So that's what I'm saying. I think that -- I think Shawn's intent was pick what we really wanted --

MS. MITCHELL: Wanted to know.

COMMITTEE MEMBER: -- in one location. And then gather that into one report.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Because each -- I guess it's eight.

MS. MITCHELL: Date of the report?

COMMITTEE MEMBER: It's table one, duration of hospital stay by mechanism of injury.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: If we were to do something like this -- personally, I would like to see it like broken out, trauma center versus non-trauma center.

And even maybe by trauma center level, like Level I, Level II, Level III. And -- and ISS IV put to it like the ISS of this to this stays this many days in

the hospital. I think a prior level of control would be very helpful. And you would -- because it would be all Level I's, all Level II's, all Level III's.

And it could say, you know, Norfolk General's doing better than Roanoke. It would be -- if you have an ISS for -- of 30 and you survive, you're in the hospital for 25 to 30 days no matter which hospital you're in. I think that would be very useful information for us as --

COMMITTEE MEMBER: It would be very interesting to compare this to the CDC web site and their mechanisms of injury. And it may be a way to kind of check up with the -- the --

COMMITTEE MEMBER: People leaving.

COMMITTEE MEMBER: Thank you. And just where are those numbers coming from and are we --

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Are we producing the same numbers.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And they've -- they've got it over here in table two, it says number of hospital days by injury, severity score.

But I -- I think being able to look at it at a higher or a little bit slightly more granular level would be very helpful.

MS. MITCHELL: And some of this data would be helpful even to the Post-Acute Care committee in terms of looking at length of stay for certain injuries. And then, you know --

COMMITTEE MEMBER: Discharge disposition.

MS. MITCHELL: Yeah. And then figuring out whether --

COMMITTEE MEMBER: Continuing care maybe add do they go to a nursing home, do they go to back home. I mean, that would be huge to know, you know, as a state.

We're keeping you alive and we're going to rehab as opposed to we're keeping you alive and you're -- yeah.

COMMITTEE MEMBER: The point is to know.

COMMITTEE MEMBER: Yeah. The point is to know.

COMMITTEE MEMBER: Or even whether the -- you know, yeah. Yeah.

COMMITTEE MEMBER: Like what are the outcomes, what the long terms outcomes are for those individuals, yeah.

COMMITTEE MEMBER: So you know, you have an ISS IV greater than 25. They're in the hospital for more than 30 days. And they're all going to nursing homes, then

maybe we need to look at what we're doing that's keeping people alive for over 30 days. Could this reduce scores and then they're still ending up in a nursing home.

MS. MITCHELL: We're looking at, you know, maybe help us to see whether we have the -- enough -- we have beds for patients that go to and where -- and why are they staying in the hospital so long before they go to rehab.

Because sometimes that's a real issue that people, you know, stay. And -- and that's me trying to look at what things we need in our community to support our trauma service to try to get a sense of where the barriers are to disposition from the hospital would certainly help us as well.

COMMITTEE MEMBER: This is also information that's one of our goals as the IVP group.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: So -- so we aren't duplicating efforts --

MS. MITCHELL: Right.

COMMITTEE MEMBER: -- and we could be working on together.

MS. MITCHELL: Right, right. I do think that one of the really good things about reorganizing our trauma meetings and bringing in more people is I think we do have an opportunity to look broader and look at where we're really going.

Because I think, prior to now -- at this point, we've all been looking at care from our hospital standpoint. And we even realize that there's opportunity -- I, for example, Lou Ann is in our region and we -- we talk a lot.

But we don't really get together and really plan and look at care. And we've got three centers right there together, two in the Sentara system and -- and Lou Ann's system. And we really should

probably be looking at regional things that we could be working on. You know, rather than Lou Ann doing all the work by herself and I'm doing it by myself.

And then -- and then Mark is doing it. Certainly, we could make some impact just regionally that we could share and replicate other places. Because we all are, you know, together somewhere.

You know, you have a sister trauma center, whether it's part of your system or not or a neighbor. And you know, we -- we tend to work together whether we're in the same system or not because we're all doing the same thing.

Working together, trying to take care of injured patients. So I think this is good. We're going to -- so I know that he wanted us to look at this.

And I think they probably -- I don't know whether he wants -- I guess we could certainly think about what data points we'd like to collect. What we would like -- what we would like -- how a report reflecting the Virginia trauma service --

trauma injuries would look. What it would look like, what it would contain. And so, I think we could share that with Shawn. And then we could talk about that at a future meeting.

Maybe our next meeting if his goal is to try to have something like this at the end of year. We probably need to know a little bit more about what it's going to be.

MR. ERSKINE: The first thing that we would need --

MS. MITCHELL: Mm-hmm.

MR. ERSKINE: -- and this is something that -- that just helps to focus it is a table of contents.

MS. MITCHELL: Okay.

MR. ERSKINE: You know, don't worry about what it's going to look like --

MS. MITCHELL: Mm-hmm.

MR. ERSKINE: -- whether it's going to be a table or a pie chart or anything like that.

MS. MITCHELL: Mm-hmm.

MR. ERSKINE: Just tell us what you want to see. And we can work on it from there.

MS. MITCHELL: Okay.

COMMITTEE MEMBER: Well, the only thing I printed out was the table of contents. I just kind of wanted to know what we might do.

And if you read down this table of contents, I -- I don't know -- do you draft considerations? I don't know that I would have --

MR. ERSKINE: That's a -- that's a -- that's an Ohio political thing.

COMMITTEE MEMBER: Yeah. I -- I don't know that that would be something. Injury characteristics, when you go back and you start looking at it, it does talk about intent.

Was there intentional, unintentional, which I think would be very helpful to our peers in the Pre-Hospital and in Injury Prevention.

MS. MITCHELL: Prevention.

COMMITTEE MEMBER: I think that would be huge for them.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Outcome measures, it looks like in here that they talk about whether they died or whether they went to rehab, which would be a huge benefit to our rehab colleagues. So I -- I think that's really good. Their registry inclusion criteria and data dictionary, I don't know about that part.

MR. ERSKINE: The appendices, that's just -- that's --

MS. MITCHELL: Definitions.

MR. ERSKINE: Yeah, that's definitions and information.

COMMITTEE MEMBER: The maps are very helpful if you're looking at the audience that's going to look at this. But it would be really great if those maps were kept on that OEMS web site and kept updated constantly.

Because we're always asked to give presentations and things to our different groups. And it would be really nice to have real maps.

MS. MITCHELL: And even some of the outcome data, if it could be separated by injury type. So if we had some information for the section on traumatic brain injuries, spinal cord injuries. Some of those patients that are challenging for us to

manage or challenging from a resource standpoint. But if we could look at some of the data, you know, age spread, you know, how they got injured.

That could -- may have some implications for Injury Prevention opportunities. And then also could help focus some of the -- the care or resources that we need for them.

But if you put them all together, they kind of get all mixed in. But if you look at -- because we all know that, you know, our -- I know from us, traumatic brain injury patients are a real challenge in terms of what we're able to do with them.

And if you roll them up with everybody else, they kind of -- it looks better. But the reality is is that group, you still -- that's a pod of people that --

COMMITTEE MEMBER: What about insurance? As -- I mean, our uninsured population, especially with TBI's, we have a horrible, horrible time with placement for

those patients.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Yes, they just expanded Medicaid. But what -- what does it really --

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: What is the impact of that on our patient population?

COMMITTEE MEMBER: That goes back to Robin's point earlier. I think all of these, you know, do it for the whole registry. But then do it for the Level I's, the Level II's, the Level III's.

MS. MITCHELL: II's, the Level III's.

COMMITTEE MEMBER: And the non-trauma centers.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Because I think we'll see some very interesting data come out. It'll help you with your validity when you run these reports.

Because even when you look at this, you go why are there so many not reported fields in here? Why is it that way?

It'll at least be a smidge above -- of a glean as to how good is your statewide trauma registry, you know. And you can start looking at -- at least a little bit of some of the validity to the data fields.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: I mean, I don't know what the current numbers are, but at one point in time, 50% of the people who met step one trauma triage in Virginia were not going to a trauma center. So if we broke it down by, as you say, the non-trauma centers

and the trauma centers, it would -- I think it would be able to give us some ammunition to be able to say, yes, we need to bring up either -- we're doing the -- what's the -- rural trauma team development programs --

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: -- just for hospitals. But what do we need to do to help get those people --

COMMITTEE MEMBER: But that's where your geographic data used to -- you know, you said we don't probably need that. But that's where your geographic data actually helps you a little bit.

Because then you can show in this area where there's no trauma center, here's how many deaths there were.

COMMITTEE MEMBER: I would --

COMMITTEE MEMBER: I was looking at that as being under the -- the maps of the

trauma centers --

COMMITTEE MEMBER: Right. Yeah, but I think that -- I think it does help -- the geographic stuff does help you. Because it kind of convinces -- like when you look at that data, it convinces you, hey, we -- we have an area here that needs something.

COMMITTEE MEMBER: Yeah. But I mean, I think we need to -- to drill it down a little further than what they did in here.

MS. MITCHELL: Okay. It's a good discussion. Okay, so we'll look at the table of contents in this report and -- and try to identify that -- that we think we -- you know, we'd like to see in a report. Share that back with Shawn and then we can -- I guess, I think one of the things he will need to decide is how often we'll meet because some of this stuff we -- we need to talk about. Let's see, done that. Okay. So do we want to go through the -- these other goals or you just want to

stop with this -- the first two and --

COMMITTEE MEMBER: I think until we find out about all of this -- about how this stuff is connected and where we can get data from, I think that --

MS. MITCHELL: Right.

COMMITTEE MEMBER: -- we can do this other stuff another time.

MS. MITCHELL: Right. I know that Forrest had a real vision for some things that I think we're just not ready for. He had this vision that, you know, patients didn't have vital signs -- we were -- because he was focused a lot on vital signs in the -- in the last couple years.

But you know, there were -- and actually, the EM -- the Pre-Hospital providers really showed some -- a lot of improvement. Because in the beginning, we had lots of patients that didn't have complete vital signs. And so, that improved

over time. One of the things I think we really want to make sure we are able to do is some of the -- the data that Dwight would put together, which is now -- what's the gentleman's name that just --

MR. ERSKINE: Narad.

MS. MITCHELL: Narad, will put together. I think it needs to be close to as real time as possible. Because we -- when we would take that information and try to talk about it in our regional PI committees, he's like the hero.

And so -- you know, it's kind of hard to get the EMS providers engaged in trying to make things better when they're sensing that it's not -- it is better already and you -- what you're showing me doesn't make any sense.

Or it's very old. So we need to really see how we can make that as real time as possible. You know, because --

COMMITTEE MEMBER: I have a

question. We get ME reports on our patients that die.

MS. MITCHELL: You get what reports?

COMMITTEE MEMBER: The medical examiner reports --

MS. MITCHELL: Uh-huh.

COMMITTEE MEMBER: -- on our traumatic deaths. And we get, I would say probably 90 plus percent of them are view only's. And we don't really get any detailed exams.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: Would there be any way like to get that kind of information statewide to see if -- how -- what the percentages are, view only's versus exams?

COMMITTEE MEMBER: That's up to

medical examiner. That's -- it's very frustrating because you can ask for a complete exam and they can say, no, sorry. We're not going to do it. Yeah, it's very frustrating.

COMMITTEE MEMBER: What about a single -- a 17-year-old with not a mark on him --

COMMITTEE MEMBER: Yes, it's very frustrating.

COMMITTEE MEMBER: -- is dead in a car.

COMMITTEE MEMBER: It's very frustrating.

COMMITTEE MEMBER: You know, it's -- when you have out of state reviewers come and look at your information and they're like, why don't you know why these people died? And we have no --

COMMITTEE MEMBER: Right.

MS. MITCHELL: Mm-hmm. Yeah, that would be -- so one of the things that we realized -- you know, for a while we weren't getting anything from the medical examiners because they were just looking at people and just, you know, saying no suspicious injury.

And then I actually called and talked to the medical examiner's office because we had all these -- our penetrating trauma when we'd code it and send it in to TQIP, you know, they'd have like a one.

And -- but they died. So then they had all these people with low ISS scores that are dying. I talked to the medical examiner and realized that they actually did autopsies on all penetrating trauma.

And we worked out a way for it -- they said you just have to request it. Well, we thought they didn't -- they weren't doing them. So now, we request -- request a report on all our penetrating traumas. And it lists out all the injuries. And we've

been able to really get better ISS scores out of these patients and our numbers look better and benchmark. And -- but for years we thought that we couldn't get anything.

So for penetrating, I'd recommend that you reach out and ask them because I was pleasantly surprised. And now we just -- we send a -- we send a request and they send it back to us.

COMMITTEE MEMBER: I've got the penetrating head mark -- head wound.

MS. MITCHELL: Right.

COMMITTEE MEMBER: Been very detailed and very pretty. But like I get some that are view only and they don't even roll them over. Patient too big to turn. And that's on like three --

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: -- or four of the ones I've gotten recently. So -- okay.

MS. MITCHELL: So we've been really good --

COMMITTEE MEMBER: And they impact our -- could improve our data if we knew what they really -- what's wrong with them.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: It seems to be related mostly to the motor vehicle -- what they consider motor vehicle. They -- they just do external, which doesn't make any sense.

COMMITTEE MEMBER: We've had the fall patients and we've had elderly falls that broke all the pieces. It would be lovely to know.

MS. MITCHELL: Well, but that -- it may be an opportunity if -- I could talk to Shawn about. Maybe you know, reaching out to the Office of the Medical Examiners and talk to them about what we're trying to do.

Maybe there's -- I don't know, sometimes it doesn't hurt to talk to people and find out -- I mean, they'd understand what you're trying to do because there maybe a willingness to help us in the ways that we just assumed that wouldn't occur.

COMMITTEE MEMBER: I will.

MS. MITCHELL: It would be worth asking.

COMMITTEE MEMBER: We're going to work on our data through --

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: If that would work, that would -- if either of us could say this had not.

COMMITTEE MEMBER: I think that would be huge.

MS. MITCHELL: Yeah. Okay, thank

you.

COMMITTEE MEMBER: Yeah, we talked to our medical examiner in the Roanoke region. And it came down -- we asked them these same questions. It came down to resource allocation --

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: -- and the ability to do these extensive exams on patients. And -- and at least, they expressed some frustration with really not being able to do some of that work that we would think that they would do because of it. It's just manpower, really.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: We're actually lucky enough in Roanoke at the medical examiner's office that they've got a CT Scanner. And so they're able to actually do some post-mortem scans on folks --

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: -- which have gotten us some information related to injuries that we weren't -- you know, somebody comes in dead and stays dead in the ER.

And they're in there for 10 minutes and they get pronounced. So they don't get a scan, you know, because they're dead.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And so the hospital's not going to pay for us to do post-mortem scans. But at least the Roanoke office occasionally will pull that trigger and they'll do a post-mortem scan. But it's a -- it's a challenge and they -- they have some reasons.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And it all comes

down to manpower. But --

MS. MITCHELL: Yeah. I think they're workload is pretty high. And I think that's --

COMMITTEE MEMBER: At a state level committee is requesting the information, maybe they give you the leverage that could help them get the manpower. I mean, I don't know.

COMMITTEE MEMBER: Or the CT Scanners to do more of them.

COMMITTEE MEMBER: Some can --

COMMITTEE MEMBER: You know --

COMMITTEE MEMBER: Yes, that mistake, it's actually supposed to be in Richmond. But for whatever reason, the -- that building that was there, it couldn't house a CT Scanner. So the Roanoke office actually ended up getting it. It was a

great mistake for our region.

MS. MITCHELL: Okay. All righty. So you passed out this report. Did you want to talk to us about it, or just --

MR. MISHRA: This is quarterly trauma report that EMS used to produce and hasn't been producing it because of the [inaudible].

MS. MITCHELL: Right.

MR. MISHRA: This will give you an idea of what Robin was saying about, you know, who goes to the trauma center, who doesn't go to -- and those numbers. And I added a map of Virginia with all the trauma centers with the 30-minute drive time.

To -- so what part of the -- of this status has to at least to exist to the trauma centers? And why -- why are we getting -- why are -- why are the EMS taking the patient that needed to go to a certain level of trauma not going to their -- the --

that could be -- that's a factor.

MS. CRITTENDEN: This -- Dwight -- this was -- [inaudible] to his report and kind of massaged it a little bit. And maybe there were some redundancies. He kind of streamlined it a bit.

It's just a starting point. The next phase would be -- I mentioned a little earlier. And I'll look and see if we can try it.

The patients at the non-trauma centers, if we can get in the trauma registry and -- and again, where they end up getting transferred to, if they got transferred, if they got discharged, if they -- you know.

Kind of a little bit more of the story. But he's had some great ideas on it. But again, this is just a -- massaging it is what we call it. And so, we can continue on with it. Do y'all want to make changes to it? Just letting you know he's been working on it since then.

MS. MITCHELL: Okay.

COMMITTEE MEMBER: Is that -- or is it at least 50% --

MS. CRITTENDEN: Yeah, it's a lot. That [inaudible] really getting the original parties involved and talking about it and the medical directors about what -- a lot of them are documenting stuff, you know, in the wrong place.

And we're able to get them to put it in the drop down fields of the narrative. We've got richer data. So it's -- yeah, a lot of work on how we get it.

COMMITTEE MEMBER: That's kind of a lot.

MS. MITCHELL: Mm-hmm.

MR. MISHRA: This figure the -- the vital signs recording has got a lot better, Tim, you wouldn't believe.

MS. MITCHELL: Mm-hmm. Yeah, it is better.

COMMITTEE MEMBER: Did we get a -- I know this is fourth quarter, 2018. I know we got the first two quarters. Did we get the third quarter?

MS. CRITTENDEN: We haven't --

MR. MISHRA: I -- I don't even know if you got the first two quarters. The last one I -- I saw in the computer that I used now is of quarter 2, 2017.

COMMITTEE MEMBER: Okay.

MR. MISHRA: I don't see anything close to that.

COMMITTEE MEMBER: Okay.

MS. MITCHELL: Yeah.

MR. MISHRA: It could be not saved

in there, I don't know.

COMMITTEE MEMBER: Okay.

MS. MITCHELL: I don't remember getting it.

COMMITTEE MEMBER: Maybe -- maybe it might be missing years.

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: So --

MS. MITCHELL: It could be.

COMMITTEE MEMBER: It'll take -- they take away 2017 instead of '18. But I -- I know we got -- you're probably right.

MS. MITCHELL: Mm-hmm.

COMMITTEE MEMBER: And we can share this --

MR. ERSKINE: Yes.

COMMITTEE MEMBER: -- with our --

MS. MITCHELL: With -- it says -- okay.

MS. CRITTENDEN: We wanted to show it to y'all before we distributed it. But if you guys are okay, we can send it out to the councils and it'll be on the web site.

MS. MITCHELL: Okay. All righty, so. Let me see, so --

COMMITTEE MEMBER: Thank you for letting us [inaudible].

MS. MITCHELL: That's nice. So do we have any public comments? I think we've kind of all been talking all the way through this, so -- which is fine. It just -- make sure that -- okay. Can you think of anything that we're leaving off?

MR. ERSKINE: I think we covered it all.

MS. MITCHELL: Okay.

MR. ERSKINE: And then some.

MS. MITCHELL: Okay. Does anybody have anything else they would like to add or say before we adjourn the meeting?

(At this time, several committee members started speaking at once.)

MS. MITCHELL: Yeah, I guess we -- kind of -- I'm not real sure without Shawn here to do that. That's why I'm thinking I will --

COMMITTEE MEMBER: Because they probably would --

MR. ERSKINE: Yeah.

COMMITTEE MEMBER: So I don't know

if they had a special grant.

MS. MITCHELL: Yeah.

COMMITTEE MEMBER: Do you think they had a special --

MS. MITCHELL: So I was going to --

(At this time, the committee members began talking and laughing all together.)

MS. MITCHELL: Okay. So one of the -- the question that was asked is whether we would determine the frequency of meetings. And I -- I think probably I'd like to pass that information on to Shawn and let Shawn -- I don't know whether he'll -- we have everybody's email addresses, right?

MR. ERSKINE: Yes.

MS. MITCHELL: So if Shawn wants to -- can he email them and ask them -- like can we deal with that, how frequency via

email?

MR. ERSKINE: That would be meeting planning, so that would be okay.

MS. MITCHELL: Okay, okay. So Shawn will disseminate something informational, poll people and figure out how we want to do that. Anything else anybody has?

Well, I'd like to thank you for coming and participating. I -- actually last night I was thinking, oh, my God. I have to see if I can -- you know, we had all this time this morning.

I thought, I hope we don't finish in 15 minutes, and then I don't know what to do. So luckily as -- as, you know, when you get people that are passionate about what we're doing and you get us in a room, we find something to talk -- something to talk about for sure. So seeing nothing further, we'll adjourn the meeting. Thank you.

(The System Improvement Committee meeting concluded.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing SYSTEM IMPROVEMENT COMMITTEE MEETING heard on February 8, 2019, from digital media, and that the foregoing is a full and complete transcript of the said System Improvement committee meeting to the best of my ability.

Given under my hand this 16th day of March 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2019.

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