COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: POST-ACUTE CARE COMMITTEE MEETING

HEARD BEFORE: MARGARET GRIFFEN, MD

CHAIR, POST-ACUTE CARE COMMITTEE

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FEBRUARY 7, 2019

CONFERENCE ROOM

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

1:00 P.M.

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APPEARANCES:

Margaret Griffen, MD, Presiding
Chair, Post-Acute Care Committee

POST-ACUTE CARE COMMITTEE MEMBERS:

Lauren Carter-Smith

Charles Dillard, MD

Renee Garrett

James Giebfried

Patti Goodall

Anne McDonnell

Donna Rotondo

Macon Sizemore

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VDH/OEMS STAFF:

Wanda Street

Tim Erskine

Cam Crittenden

ALSO PRESENT:

Dan Freeman

Valeria Mitchell

Rachel Bailey

Heather Asthagiri

Tanya Trevilian

Jill Lucas

ALSO PRESENT (con't.)

Sarah Beth Dinwiddie

Michel Aboutanos, MD
TAG & EMS Advisory Board

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(The Post-Acute Care Committee meeting commenced at 1:00 p.m. A quorum was present and the Committee's agenda proceeded as follows:)

DR. GRIFFEN: And I come representing basically the trauma centers. And a variety of things across the state. So I'll tell you a little bit more about what we've done in the last two years to prepare for what we're about to do now.

For those of you who are wondering, why am I here and what am I doing here? I think there's some housekeeping stuff that I have to remember to do that I'm not used to remembering to do.

And Wanda's going to keep me in line over here, I'm sure. I will let you know the meeting is being audio recorded basically so we can get accurate minutes. Because I can't take accurate minutes.

So for the first meeting at least, if you guys would at least say who you are when you're making a comment. Because I'm not going to know who everybody is and we'll all get to know each other over

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the next many, many months and years. Maybe not years, but -- so -- just so that they know on the minutes, they can say who -- who was talking and who was making a point kind of thing. That would be very helpful to us.

And then at first, I just -- I'm going to pass around the sign-in sheet. But if everybody can go around and just introduce yourself.

Who you are and what organization you're representing and that kind of thing. I've got papers that I'm going to pass out to you ultimately. But this is the sign-in sheet.

And so, we can just -- you all can sign in. But if we can just go around the room and if you want to say a fun fact about yourself, that's fine. My name is Maggie Griffen. Like I said, I'm the chief of the trauma program.

I'm from Kentucky originally, although I was born in Minneapolis. I have two 90-year-old parents and I have six siblings. So a whole lot of people in my family that thankfully I've been able to

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hang out with. So I appreciate y'all taking your time and joining us.

DR. DILLARD: I'm Chad Dillard. I'm a pediatric rehab doc down at CHKD Norfolk.

DR. GRIFFEN: Great.

MS. BAILEY: Rachel Bailey. I am trauma educator and injury prevention at Johnston-Willis.

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MS. GARRETT: I'm Renee Garrett. I am a speech pathologist with both IVLR acute care and then some outpatient experience. And I'm representing the Speech Hearing and Language Association of Virginia.

MS. GOODALL: I'm Patti Goodall. I'm director of brain injury services for the Department for Aging and Rehabilitative Services. And the interesting fact about me, actually I have to share this regardless, is I'm retiring April 1st. So

-- yeah.

DR. DILLARD: What have you done that at?

DR. GRIFFEN: Yeah. We're going to have a -- still [unintelligible]. No, we're kidding.

MS. GOODALL: But I did let people know that I -- I didn't accept this under false pretenses. But I want to come and get the lay of the land. Kind of find out more about it and see if my replacement would be the appropriate person or another person.

DR. GRIFFEN: Great. Thank you.

MS. MCDONNELL: I'm Anne McDonnell. I'm the executive director of the Brain Injury Association of Virginia. And I am the -- good morning, Patti's heard of me.

MS. GOODALL: She's never worked with anyone else at DARS but me.

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DR. GRIFFEN: Oh, wow.

MS. MCDONNELL: Yeah.

DR. GRIFFEN: The transition.

MS. MCDONNELL: Yeah.

DR. GRIFFEN: Wow.

MS. CARTER-SMITH: I'm Lauren Carter-Smith. I'm an occupational therapist for Bon Secours Mercy Health and representing the Virginia Occupational Therapy Association.

DR. GRIFFEN: Good.

MR. GIEBFRIED: My name is Jim Giebfried. I'm a physical therapist representing the Virginia Physical Therapy Association. Presently with Sentara Home Care. I'm here to share and to learn. Certainly learn more than share. And I appreciate the opportunity to serve.

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DR. GRIFFEN: Great. Welcome.

MR. SIZEMORE: Good afternoon. Macon Sizemore from VCU Health. Maggie and I have been on this journey together from task force to now committee for a couple of years.

So welcome -- welcome all of you. And -- and look forward to working with you to help us move this trauma -- part of the trauma plan along.

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MS. ROTONDO: I'm Donna Rotondo. I'm a social worker, case manager Inova Health System at Fairfax Hospital up in Falls Church.

And I've been in trauma ER work for many years. But the whole gamut for trauma patients from ER to discharge.

MS. STREET: Hi, I'm Wanda Street. Office of EMS. I've been with the Office for 12 years last month. And it's been quite a journey.

DR. GRIFFEN: That is an understatement. All right, great. Well, we appreciate -- why don't you folks tell us where you came from and what you're here for.

MS. ASTHAGIRI: I'm Heather Asthagiri. I'm from UVa. I'm a [unintelligible] for the adults. I handle the interesting.

DR. GRIFFEN: Yeah, great.

MS. TREVILIAN: I'm Tanya Trevilian. I'm the pediatric trauma program coordinator at Carilion Children's Roanoke.

DR. GRIFFEN: Oh, great.

MS. LUCAS: I'm Jill Lucas. And I'm the coalition coordinator and trauma and injury prevention for Carilion Children's in Roanoke.

DR. GRIFFEN: Great.

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MS. LUCAS: And my boys live in Minneapolis.

DR. GRIFFEN: All right. Very good. Nice place. Little cold last week.

MS. LUCAS: Oh, my gosh.

DR. GRIFFEN: 37 below, I heard.

MS. DINWIDDIE: I'm Sarah Beth Dinwiddie. I'm the trauma outreach coordinator for Carilion Roanoke Memorial.

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DR. GRIFFEN: Great. Yeah, you guys came a long way to hang out, I guess. When you come this far, you just hang out for a couple days, right? Yeah, okay. Awesome. All right.

So you guys all have the agenda for today. And we kind of have to approve that agenda and make sure everybody's comfortable with it. If you can just look at it. If anybody can -- I guess that can be the motion and all that good

stuff. If anyone has any questions or concerns about the agenda. Motion to approve?

COMMITTEE MEMBER: Motion to approve.

DR. GRIFFEN: Second?

COMMITTEE MEMBER: Second.

DR. GRIFFEN: Everyone in favor of the agenda, say aye.

COMMITTEE MEMBERS: Aye.

DR. GRIFFEN: Anyone opposed? All right, excellent. So we have -- and I'm going to pass around. There just some standard operating procedures that is sure to go on for the systems for these committee meetings. All right, there you go. I know, we're doing a lot of who's here. All right. So we sort of have to go through this so everybody's comfortable that this is the

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standard way that -- sort of the committee's going to go. And everybody understands all of the chairs discussed all of this.

And we all felt sort of that this was the way in which we should -- we should go. So you see the initial structure there. And I'm going to kind of weave in and out some of this stuff, because it's -- if you don't know what's going on.

Essentially the state -- not the -- the State of Virginia asked for the American College of Surgeons to review our trauma system plan for the State in 2015.

Apparently, they've been asking for it for quite some time. In 2015, they came and, they said great. You guys have some really good parts, but you don't have a system. And we went, what?

Basically we all thought we had a great system. So the American College of Surgeons is the governing body for a lot of trauma stuff across the country and across the world. They put out ATLS, which is a course and all kinds of other things. But essentially, for those of us that are

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trauma centers, we usually -- in the State of Virginia, there's a designation. It isn't true in every state.

Some states have no designations for their trauma centers at all. They have no system, they have no anything. It's not federally mandated. It's not state mandated.

Your state doesn't have you choose. The State of Virginia has been fairly involved and they've had a state mandated process for many, many years. And you, as a center, fill out all kinds of paperwork and apply.

And every three years, they come to you as the State and they say, oh, let us look in for this and let us look at your patients and let us look at this. Oh, you do great.

Oh, awesome, you can be a designated center. And then for some centers, if you choose, you get the American College of Surgeons to come see you every three years. And you're a designated center as well. Or they verify that your center is

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good. So the College, for years, has offered to come around and look at State trauma systems in hopes of getting it to the point where every state has a system.

And Virginia asked for it. In 2015 when they came, when they gave us the report they said, you don't really have a system. You have a lot of trauma centers that sit in silos.

You have a very robust EMS program. But you don't have what we would consider a system. So the trauma site management oversight committee, which many of us have been parts of for many years and years said, you know what?

We need to do something about this. So we began a two-year process of having meetings. And the task force -- the task force that were created were basically very similar to these committees that you see now that we've created to do this part. And we've spent two years in a lot of meetings because the State of Virginia -- and you guys, you are more involved from the state level than I am -- understand it. You

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can not meet online. You can not pass emails. You know, no note passing. It's a little bit crazy in my opinion.

But that's my opinion. So you have to meet in person. So it was a challenge. We had to all meet in person and get together on a -- as regular a basis as we could with the TSOMC only meeting quarterly.

So a lot of us found ways to go and meet and get quorum and go through a lot of things. But a lot of people put a lot of effort in to getting this organized to the point where, finally, in 2018 we came up with a plan.

It involved components from all of these task force. And that went to the State. And the State said, we like your idea. Great. We'll give you approval.

Perfect. Now we got to figure out how we're going to implement what needs to go first, all that type of thing. So that's -- this is sort of the beginning of that. And in the process of making this --

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COMMITTEE MEMBER: You said go to the State. I mean, who -- who at the State? We're talking the Department of Health, we're talking the -- okay, the Department of Health.

DR. GRIFFEN: And that's who -- Dr. Aboutanos, for those of you who don't know him is the -- essentially been the chair of the TSOMC, which is now converted to the Trauma System -- he is the chair over all of this. He's the one that basically --

COMMITTEE MEMBER: Gotcha.

DR. GRIFFEN: -- runs it now. And because it involved some change in the TSOMC no longer exists, we now all get to go to the -- all of us that are chairs are expected to attend the EMS council meeting and give reports and all this kind of stuff. So it changed some hierarchy. And it created the ability for us to continue all of this. So now, we can figure out how to implement the plan that we've created,

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knowing it may need some adjustments because you all weren't involved in those two years at all.

And a lot of people that are now -- have been pulled in and asked for assistance didn't have anything to do with those first two years.

Because we felt that you all were stakeholders and that you needed to be involved. So that's how that all came about. Macon and I were on the Post-Acute Care from the beginning.

We also had two other people, Cathy Butler and Stephanie Basie [sp] who are both trauma program managers around the state, who assisted with that. That we were the four committee members and we had a lot of other people that came to the meetings.

But we were the four. And we went through sort of line by line this ACS, American College of Surgeons, document. And then the HRSA document which has to do with a lot of, do you want your state's plan to be sort of public type based. So there was a lot of work. So we're beginning the next

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phase of it. So these seven committees here are the -- were the initial committees that we came up with. And then now, these seven committees are going to be run by various people, different input.

And we're going to talk a little bit later about there's some of these committees that we think someone from this group -- we think, someone from this group needs to be attending those meetings as well.

So one of the committee members here is going to be asked about being willing to attend one of those as well. Because we feel like the crossover is such that we need the input from their committee.

We also need to have our committee have input on their committee. All right? So that's the first part of it. The membership just talks about the committee chairs, how the nominations went about. The crossovers is what I've been talking about as far as the -- who goes over to another committee. And specifically for

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us, we need to have a -- I have to go to the Trauma Advisory Council, which is tomorrow. The System Improvement Committee, the -- the hope -- the expectation is that we will have someone from our committee go to the System Improvement Committee.

It's also that we will have someone go to the Acute Care Committee. And it's that we will have one of our members go to the Emergency Preparedness and Response Committee.

So -- and we can -- as we talk about going to those committees, we can talk a little bit more about why it is that when we were coming up with our initial decisions, we thought that those committees were ones that would be helpful for us to be -- it just seemed there was enough crossover that opinions could be shared in a big way. And then maybe solve things a little easier.

This standard operating talks about the duties of the chair, we are also going to have to come up with someone willing to be a vice-chair. So we'll -- we'll talk about that here. That's on the

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agenda. Someone who can fill in if I can't be here for some reason and facilitate meetings and discussion and those types of things.

And then, basically how the process moves forward and how we get our data and what we report to the EMS council meeting. What quorum is, so one half plus one. So we have 12 members.

So we have to have six plus one, which we have today, so we do have a quorum. What the action -- how each member has one vote and that proxys are not allowed. Again, this is Virginia State law.

I didn't make any of this up. And then essentially meetings, we'll work to do them in a manner that doesn't conflict with another committee.

So Tim is trying to juggle things so that when he schedules these two days, which we will have another two days in May where we do a similar thing. Whether we need to meet before then, that's something that we can discuss today as well. We didn't -- just saying that it would be

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quarterly is not necessarily going to get it all done depending on the work that we have. In which case, we'll try to be -- location and time-wise, as friendly to everyone that we can meet, for the committee members to be able to be there.

It -- I realize everyone's schedule is crazy. And I know it's very difficult sometimes to organize all of that. But we will do -- I've -- I've -- Macon and I've been managing for two years. So I'm confident we can manage it again. So we will work on it.

COMMITTEE MEMBER: Does that mean we will have crossover members from other committees on the committee?

DR. GRIFFEN: We have -- I don't remember the answer to that. But I wouldn't be surprised and the answer's probably yes. Let me see here. I know --

COMMITTEE MEMBER: We think things like --

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DR. GRIFFEN: The Acute Care -- the Acute Care Committee will have someone in here. So the Acute Care Committee, they'll be deciding today about having someone in there.

Soon as we know who that is, we'll -- we'll make them aware of any other meetings. That's the only other one that will be in here with us.

The -- and I can talk about the committees a little bit and as to why -- some of them have huge tasks that are going to be -- I just can't even imagine how they're going to get it -- get around to it to be perfectly honest.

But we will get there. Everybody's motivated and dedicated to having -- get this done and completed. But does anybody have any questions about the standard operating procedure?

I know it's the first time you've seen it. Take it back and certainly if you have any questions or concerns, let me know. I can let Wanda know. We can include any concerns in the -- in the

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minutes and those types of things. Okay. So as I said, for our committee of Post-Acute is sort of exactly what it -- we were given the task.

And we felt like what needed to happen after the patients left the hospital was just as important. Because we realize trauma goes across the entire spectrum.

Some of us seeing our patients, you know, that we took care of 10 years ago when the initial event occurred.

COMMITTEE MEMBER: It's technically leaving the acute care hospital.

DR. GRIFFEN: Right.

COMMITTEE MEMBER: Those -- those places that -- that patient rehab units are still in the hospital that -- that it's leaving the acute care beds.

DR. GRIFFEN: And I don't know that any of us knew exactly what that meant when

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we started this. Because I think a lot of you are sort of all, oh, it means this and it means this and it means this. And then we realize there's this whole gamut of things.

So as we know, we have a whole lot of patients who go home. And we may never see them again. We may, we may not. But we have a whole huge amount that go home.

We're not going to get data from those patients. We have a whole bunch that go home that might get PT, OT, whatever services at their home. We can't get anything back from them, either. So it -- this clearly becomes a common theme.

We have a whole group of people that go to rehabs, acute care rehabs -- whether they be affiliated with the hospital or free-standing.

Guess what? We can get really limited information about what happens to those patients because there's only so much requirement for -- for information feedback to the State with regards to those patients.

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It took us a tremendous amount of time just to figure that out. And then there's a whole group of patients that go to skilled nursing facilities. We can get basically no information about those people.

So if you see where a huge gap for us is in Post-Acute Care and -- we can work on any idea about outcomes and the system and how it's functioning and what our quality is.

How much is sort of a screeching halt, because we can get no feedback from a lot of these folks right off the bat.

And finding out who these folks are and what service they provide, again, extremely difficult for us to figure out.

So we went through a lot of our time just trying to figure out what information can we get. And what information we would think we would want to need -- that we felt like we would need. The System Improvement Committee, which is on a bunch of things and has a lot of people

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that will interact in crossover. Them to other committees, other committees to them is because that is their task.

And their -- their major task really has to do with information and how we can create the ability to get information about all of our trauma patients.

Not just from EMS and arrival to the hospital and through their acute care. But after they leave the hospital -- where they go, how they do, what their outcomes are so that we can get a patient from when they get picked up in wherever until they start their job six months later when they've recovered.

Whenever it is that that patient goes through, that's our ultimate goal is to be able to follow them through the entire system.

So we can truly do a quality review of our system and whether it's actually working the way we want it to. That is going to be a very major task. And it involves money. So everyone is -- you know, we'll see how that goes. So, and

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having said that, when we -- when we break it down, we essentially went through -- there were -- I don't know how many items on this -- on the college thing about, what about this, what about this, what about this?

And we essentially went through and looked at every one of those items that involved post-acute care. And looked at it and tried to figure out how we could fit in with it or not fit in with it.

Work through it, whatever. These are sort of -- these were the goals and objectives for this committee going forward that we are going to have to try and come up with a plan and a process of how do we answer. How are you, ma'am?

COMMITTEE MEMBER: [inaudible].

DR. GRIFFEN: All these -- that's why you're here for all that knowledge.

COMMITTEE MEMBER: Well, I think it's a perfect time to ask the Virginia

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government for money because the money is the last thing they're worrying about right now.

DR. GRIFFEN: Right. Exactly. I'm just not sure anybody's going to be able to give the okay for that.

COMMITTEE MEMBER: Good luck with that.

DR. GRIFFEN: Right? That will be the problem.

COMMITTEE MEMBER: Well -- so this can be an exclusive problem in Virginia, correct?

DR. GRIFFEN: Which part?

COMMITTEE MEMBER: The part of tracking post-acute outpatients.

DR. GRIFFEN: It -- it is not. As I said, the systems -- trauma systems across

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the country vary greatly.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: So some have very well developed ones, some don't. We did exactly what you're talking about and looked at other systems across the country that had very good systems.

Tennessee, Pennsylvania have fairly good information-sharing. But I'll be honest with you. For the post-discharge, not any of them are really good.

A lot of the stuff you see that comes out literature-wise quality, literature-wise for Tennessee and Pennsylvania really has to do more with EMS. And -- and we have some of these databases in Virginia.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: But EMS to a hospital and then the hospital to discharge, and that's where it ends. It ends at how many

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-- so it's mortality and, you know, did they go home, did they go to a skilled nursing, did they go to a rehab? And that's sort of where it comes to a screeching halt.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: So no, you're right. It -- it's not -- and then other places have nothing.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: Not a thing.

COMMITTEE MEMBER: And as we looked -- the difference we had in the system, Virginia has a trauma system. But we didn't necessarily have a[n] articulated plan.

So that -- that's -- so a lot of states have trauma plans that may or may not have data collection within that.

DR. GRIFFEN: Or in front of it.

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COMMITTEE MEMBER: So part of our challenge was the work of all these committees to help Virginia develop a plan. And -- and those that have been working on it say, well, we need data to feed the plan to a degree.

DR. GRIFFEN: They may have ideas about plan, but is it really the right thing? We don't know. How do we know if we don't have data to feed -- feedback to be able to say, hey, look, when we do it this way, you know, 50% of the people end up back at work and this, that and the other thing. We -- we don't even know the answers to those questions at this point.

COMMITTEE MEMBER: I did a little bit of homework and asked our national organization whether or not they knew of any governor -- I mean, trauma advisory councils or creating trauma plans, statewide plan. They came up with four. None of which, except for Virginia, that they knew had a therapy component involved. And it's

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Kansas, Texas, Florida and New Hampshire. And I have their web site information if you're interested. I don't know how they're -- yeah, I didn't -- I didn't go into it.

DR. GRIFFEN: Yeah. I -- I cam from Florida and they have had a plan for a long time, for a -- they have a system. So I know what goes on there.

As far as sharing of data between the various centers and -- and the data at a statewide, there's been a lot of advocates for that.

They still don't have -- I'm not sure at this point, to be honest, in whether they even have the trauma centers themselves sharing the data.

It gets into a state repository, but whether you -- as an individual -- can get that data back and compare yourself to the other centers in the state, I'm not even sure they've gotten to that point yet. So there is a lot of data that's being collected. But the cooperativeness of that data tends to be the

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problem in almost every state. But I don't know about the others, so -- and be glad they're -- yeah, if we can -- if you can give that to Wanda and we'll include that in our prime minutes kind of thing.

And that way, we'll have the -- the details for contacting or looking them up or something. So these are basically the -- the things that we came up with.

And -- and believe me, this is -- this is the short list. I did it. But when you read them, you'll go, yeah, sure. But -- right. Other groups have about 20 of these things.

And some of theirs aren't as daunting to figure out. So the first objective having to do with the complete -- to complete a comprehensive system status inventory that identifies the availability and distribution of current capabilities and resources. It sounds vague. The bottom line is, we don't even know where anything -- everything is. So when we went -- case in point, we went to look for rehabs across

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-- we tried to look and find all the rehabs in the State of Virginia. Well, what's a rehab? Because I can tell you, there is a definition out there.

But there's a whole lot of people who use rehab in their name and they wouldn't fit the definition of a rehab. And so it becomes very, very difficult to figure out all the rehabs across the Commonwealth.

And then to define apples to apples and not apples and oranges because of the way something is defined. And then I learned way more than I thought I -- I would ever know about skilled nursing facilities and what bed means what?

Trust -- trust me on this. I -- it was a lot of information. And I'm not sure I still understand it. So -- and there is no reference for how many nursing care facilities we have across the Commonwealth.

And then to even get to that point we tried to figure out, okay, if we had this 'x' number of trauma patients, how many of those trauma patients really should be getting a rehab. I don't know the answer

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to that because I don't know the denominator and I don't know a numerator and I don't know -- most of our rehabs that we identified had -- were full most of the time.

They were definitely churning it and working it hard and all that kind of stuff. But could the State benefit from another 15 acute care rehab facilities because that would serve our population.

We -- we don't even have the data to say something like that. So that's where this whole thing became a -- there's this black hole that we don't quite know how to -- and it's very difficult to say.

And if we want information from all of these places, we've got to identify where those places are and what they do and that kind of thing.

COMMITTEE MEMBER: It was a lot of subjective feedback at -- when the trauma surgeons did their survey. And there were public forums -- concerns that we can't get -- there's no place for brain injury.

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There's no place for behavioral brain injury. So the -- no place for pediatric. So we heard that a lot and that's why this current committee has some of the composition it had, just because we heard that all over and over again from the State.

So the data, but just hearing that repeatedly from folks. We felt we had the capabilities of looking at all the accreditation groups that are out there, the Joint Commission.

Looking at therapy, who does the rehab centers, also the skilled nursings. Then we have the capabilities of getting into Medicare because they rank or rate hospitals or skilled nursing facilities, indicate, you know, what their standard is and what they found when they went in to review them.

So there's -- there's some information out there. And there's something that we're -- if there's a standard for -- they meet that standard and are accredited by that agency.

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DR. GRIFFEN: So there are standards that define an acute rehab versus a skilled nursing facility. But my understanding is that there is no -- you don't have to get certified. Correct? Is that --

COMMITTEE MEMBER: Nursing home -- yeah, we -- we'll --

COMMITTEE MEMBER: Yeah.

COMMITTEE MEMBER: 30 years ago, we -- we'd always refer to CARP. And CARP is only -- there's only one public hospital in Virginia, National -- National in DC area. National -- what's it called?

COMMITTEE MEMBER: National Rehab Hospital.

COMMITTEE MEMBER: National -- no, it's not that one. I don't know.

COMMITTEE MEMBER: Children's

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Hospital?

COMMITTEE MEMBER: It used to be National Orthopedic. National Hospital.

COMMITTEE MEMBER: National Rehab facility?

DR. GRIFFEN: NRH in DC --

COMMITTEE MEMBER: It's not NRH. That's --

COMMITTEE MEMBER: Virginia Hospital?

COMMITTEE MEMBER: Virginia -- I knew it was -- Virginia. Virginia Hospital is the only inpatient rehab program in the state currently that has CARP -- it's elective, but it doesn't mean that much. It's not valuated any more. So -- but that -- the licensed in our state for inpatient rehab beds doesn't give you any information due to brains, cords, peds.

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There's no standardization for that. Joint Commission, you can have elective stroke or elective others, but it doesn't drill down to tell you -- to help you with data and the like.

It is -- so there are about 25 inpatient rehab units in free-standing hospitals in the State. And -- but finding a list of them on the State site as well as the nursing, it's buried. It's buried.

We -- we tried to work with VDH to say, here's the list. Make it available. But it's -- it's still hard.

DR. GRIFFEN: Yeah.

COMMITTEE MEMBER: Can I -- I also wanted to make a point. When you're looking at resources statewide, what we find from this, there -- there are a lot of private places.

But our folks don't have private insurance. And some of the really good site boundaries post a few rehabs, they don't take Medicaid. So when you talk about

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what are the resources, what's the access to the resources.

DR. GRIFFEN: And that's the other component. That's part of -- now once we find them all, then it's what -- what are they willing to accept.

And then -- because by having quality data, then can we work on -- I mean, this is -- this is the pipe dream in the long term.

But saying, you know, as opposed to someone not being accepted to rehab to get this, that and the other thing, that would then allow them to go back to work.

Which would then allow them to get off federal assistance or state assistance, which will, in the long run, save everybody money. Which we know is what certain people want to hear.

That may be the only way for us to push certain things as far as getting these patients what they really need, as opposed to, well, you don't have that --

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funding for that, so we can't make that happen. So that -- the long term goal is that we create it so that we have all the -- all the data we need, so we can go somewhere and say, look, the system's not working for the patients.

And the patients are the ones that need to have this. And so we need to come up with a way that even the one that doesn't want to accept everybody is incentivized [sp] to take them.

Because we know, in the long term, it's going to be better for the patient. But oh, for you books, it's going to be better for them -- for you financially. So let's make it happen.

So the reason for including the folks that we have is we don't know all the answers to where this data -- you all may have lists of data somewhere that we just don't know -- we've looked.

We read the VHHA. We read the VDH. We read -- we went and we tried to go -- we had a conference call meeting with several people just trying to say what data

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do you have? What State data do you have that we would have access to? Even the insurance -- there's the one insurance data thing that comes out, but it's mainly just Medicare.

So it doesn't -- it's -- the private insurers aren't part of it. It's all piecemeal. And it's going to be trying to figure out about what -- where we can get data, where we can try to get a list of all these folks.

How we can push forward with it being exactly what you're talking about. That someone has to go somewhere and say, hey, this facility has been inspected by x, y and z, and they meet these criteria.

And they can be put on this list as far as that's concerned. And we get it. We know it's going to be a whole bunch of push back. Nobody's going to want to do this.

It's going to cost them more money to provide feedback. And ultimately, we want them to provide feedback to the State so that we can get to that ultimate

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goal of someone getting picked up by an ambulance here. And we know where they ended up. And we know how they came out after they ended up there.

COMMITTEE MEMBER: Maybe one other thought is, I know the -- the VA and -- and its ability to help service members stay -- are allowed to go into a skilled nursing facility for up to six months.

Separate from Medicare or anything else. They go in and certify that that facility is a facility that meets their standards to handle the military personnel. They may be a -- a resource.

Again, if we had a list of those and what standards they use to accredit those particular skilled nursing facilities to handle servicemen. There's that as another point.

DR. GRIFFEN: Yeah. That's part of -- that's the whole idea. The idea is for us to sort of get it -- ultimately figure this out. Heather, did you --

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MS. ASTHAGIRI: I was going to say in the Medicare web site, you can look and see all the, you know, acute patient rehab facilities that take Medicare patients and all the skilled nursing facilities.

They do have some data, but that's just Medicare patients. Does Medicaid -- did you find anything with Medicaid patients?

DR. GRIFFEN: This is -- this is the -- this is where it all becomes this black hole of stuff.

COMMITTEE MEMBER: Yeah. Medicaid is -- is very well known for being incredibly stingy with their data. And when you ask for it, they'll tell you you have a file FOIA request. And then they will bill you 300 hours worth of research to -- you know.

COMMITTEE MEMBER: I -- I was thinking, I know in home care we do with the Oasis, which is a survey, use information at

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the beginning and at the end of that patient's time where we provide care. Also the American Physical Therapy Association has reached out to its various members and started an outcome registry indicating what -- what is the outcome.

We see these patients in the hospital or wherever you see them. We want you to gather that data and give it to us so that we can have something that supports the benefit of therapy, how long it took, what were the changes in the individual. So that's in the --

DR. GRIFFEN: That's great.

COMMITTEE MEMBER: -- process of being built. And it's been probably about two years now. So I might -- might be able to get some of that data for the group.

DR. GRIFFEN: Well, I -- I think the biggest thing -- obviously we're not going to answer the question. We're going to have to meet. And this was just so you

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guys get a taste of what we're looking at. But I see every one of you going, oh, man. So -- but the point is to now -- now you know what the task is.

And you can think about all of those places where you know of you've gotten data at some point or another. Just write it down.

And what we'll do is we're -- we're going to have -- I -- I just don't think that we're going to be able to meet quarterly.

I think we're going to have to work on a meeting sometime between now and the early May meeting. And we can work on dates and trying to figure out that type of thing.

I'm -- I'm allowed, right, to email the committee members individually about dates, right, Michael?

DR. ABOUTANOS: You can. I mean, when you have some of the -- so, this --

DR. GRIFFEN: This is

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Dr. Aboutanos, for those who don't know.

DR. ABOUTANOS: So it's impressive --

DR. GRIFFEN: He's our boss. Our boss.

DR. ABOUTANOS: It's impressive seeing the members of all the committees. And you probably have the hardest task of the entire system. That's why Maggie's in charge. I'll just throw that in there.

DR. GRIFFEN: Thanks.

DR. ABOUTANOS: But seriously, though. What we -- this is a huge amount of work that's now being done. But the only thing I was going to say is that that came up at the executive meeting that we just had. And a lot of committees who are choosing to meet half way, so that when they come to this meeting, there is a -- something to work on. Three months is too

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long. So if this committee decided that you want to meet at a different time, what the Office of EMS is asking is that the target of being the central time a lot of other committees are meeting together.

So they can provide best location, accommodation, etcetera, all of these -- these things. So I would say, yes, you can email everybody. But work with -- with Tim and Cam on seeing where that --

DR. GRIFFEN: Okay. If they're going to maybe work on a proof of -- a variety of the committees meeting a similar day.

DR. ABOUTANOS: Yes.

DR. GRIFFEN: Okay, all right. Well, we'll stay in touch with them and let -- but that's why I just don't think we can wait three months to meet again. But between now and then, the task that we can work on is everybody coming up with any -- anything you can think of that might be a

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source of information for us in order to try and get a list, create a list as comprehensive as possible.

And then the thought process of how it -- to have a comprehensive list, we can work on it being routinely available for everyone and not, you know, everyone having to pull things out of their own database to send somewhere.

But building it to the point where it can be the -- there can be -- we can work towards, this is the agency that should take ownership of this. And it may require contribution from here and here and here.

But regular expected contributions from those various places to that keeper of the list, so that we can -- we can all become confident that you, as a provider of support for trauma patients when you go to that particular agency -- state agency and you pull up that list, you can feel comfortable it's accurate. It's the data that you're going to need in order to get whatever you need. And then, like I

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said, down the line or long term, it's going to be what we require of those people on that list as far as feedback to us.

So that we can show that our patients are getting actually what they need. And we can have some quality -- true quality review about what our patients are getting.

COMMITTEE MEMBER: And VHI web site, Virginia Health Information, is a whole -- a long --

DR. GRIFFEN: We know.

COMMITTEE MEMBER: -- list.

DR. GRIFFEN: And that's one of the conference calls we had with them, that the VHI, it was cost to get it.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: You have to request what you want them to pull --

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COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: -- and it isn't complete because there are certain groups that don't have to -- only certain groups have to send them the information.

COMMITTEE MEMBER: Correct, it is voluntary.

DR. GRIFFEN: Right. So that's the problem. There's always that voluntary component. And unfortunately, we're going to have to get away from a voluntary component if we're going to have people build trust in the list.

It can't be voluntary. Or it's not going to be a trusted, capable list of doing what we want. And so that was our problem with them. They probably have some of the best information --

COMMITTEE MEMBER: Right.

DR. GRIFFEN: -- and I'll be honest

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with you. We never went beyond it because it was going to cost us money. They were happy to talk to us and tell us the kind of stuff they had.

But for us to actually get a list, we were going to have to cough up money to send to them, this is what we would like. And then they would, for the amount -- for whatever.

I don't even remember what it was. I don't know if we even got to the point of asking them.

COMMITTEE MEMBER: Yeah. I think -- if I remember, inpatient rehab unit data was included because their acute care hospitals were required to. But free-standing rehab hospitals did not have to. So they -- they could, but --

DR. GRIFFEN: They didn't have to.

COMMITTEE MEMBER: -- many were choosing not to.

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DR. GRIFFEN: It wasn't a mandatory thing. So right -- so right off the bat, we're potentially having things that should be included that aren't there.

COMMITTEE MEMBER: Yeah.

DR. GRIFFEN: Michael?

DR. ABOUTANOS: Sorry. Just shows our ignorance on these lines. What is VHI, what does it stand for? And is that then a part of the --

COMMITTEE MEMBER: Virginia Hospital Information.

DR. ABOUTANOS: Is it a State agency?

DR. GRIFFEN: It's a private agency, isn't it?

COMMITTEE MEMBER: It is a private -- it's a private contractor to the

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Department of Health. And it is an all claims payor database. So private insurers and public insurers report their stats to VHI. But it is voluntary for everybody but, I think, the acute care trauma hospitals.

Military hospitals don't have to report to it. And I don't know that Medicaid is required, but I think they do it.

DR. ABOUTANOS: But how do we -- how do we bypass the cost requirement?

DR. GRIFFEN: Well, this is -- and this is the thing, we didn't know the answers to these things. So this is -- this may ultimately be the place where we say, hey, this would be the great place to do it.

But then we'd have to get into the cost. And we have to make sure that it's not voluntary for everyone, it has to be required for everyone which costs everybody else that didn't volunteer to do it before to now have someone designated to do that.

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COMMITTEE MEMBER: And is that going to have to be a Code of Virginia change?

DR. GRIFFEN: Well, that's -- I don't know the -- I don't know the answer to that.

COMMITTEE MEMBER: People are going to fight it.

DR. GRIFFEN: Well, this is --

COMMITTEE MEMBER: Yeah.

DR. GRIFFEN: This is the -- this is, you know, we're talking the top off -- the lid's coming off the can here. And now you understand what we're talking about. So it's a -- it's very difficult.

MR. GIEBFRIED: I think, you know, well, if I can talk about transparency. And I think that is what we're faced with, we're not getting it. I want to point out

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something that I was involved with a while ago. I worked for Blue Cross Blue Shield, and I was a liaison between them and working with the -- with the State and the Department of Health in Rhode Island, as well as non-profit organizations.

And our job was to find out ways -- looking at our data, we knew the outcomes. We wanted to go out and get research grant money to cut down on costs.

And drawing in with other groups so that we could get that money through various -- either with National Institute of Health or -- or from other agencies.

And we -- so the data is there. And one of our selling points in -- in getting the grants was saying to the people, we have the data.

We can tell you how much it costs, how long we have those and what would be the outcome with those people. So I raise it as a sense that if we knock on some doors with some of the insurance companies, whether or not they would be willing to

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share some of that data that we're looking for. We can't find it other ways. But somebody always wants the money.

And the money is coming from the insurance companies. And the insurance companies want to know, and they do know where all those pennies are going.

And if it's not being spent correctly, they will change how they're reimbursing you or not reimburse you at all. So it's -- it's another source.

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DR. GRIFFEN: Yeah.

MS. MCDONNELL: And I'm just -- you were talking about the class through Virginia Health Information. Donors made a request -- this has been a number of years back.

But if you're a State agency making a request, it's a lot cheaper. I think I paid maybe -- somewhere between $500.00 and $1500.00 for the brain injury data. So it -- it's not -- I don't think for a State agency to the State agency --

well, they're quasi. It's not going to be that expensive.

DR. GRIFFEN: And it may work. And it may ultimately be a -- if we feel like VHI is the place to have it, great. And that State agencies pay for it because it's a State agency -- as long as we work out the details that it's not, you know, onerous.

But that we have to get rid of the volunteer side of it. It has to be mandatory because then the list will be complete.

And the agencies, as you say, we -- we have to have the quality data to prove it to these insurance companies to say, we have this and that type of thing. Then we've got to match patient to patient.

And so, that's the -- that's the next component of it. But even being able right now, we get the quality data to tell an insurance company, hey, if you do this, it -- it does better and it saves you money. We -- we can't even do that yet until we have all this. But it's a great

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idea because in the long term, if doing some of that review -- that quality review or research or whatever it turns out to be in order to get that information, to get a grant from somewhere, heck, yeah.

I mean, we'll take money from Blue Cross Blue Shield. We'll take money from anyone if they can help us. So you're right, transparency is what we're really trying to work for.

And I don't think that there's any -- it's not that I think people are purposefully trying to keep data away from people. It's that every place is trying to collect their data.

Okay, so some people might be, I don't -- I try not to be pessimistic. But that -- each pocket has their stuff. We just don't know where it all is.

COMMITTEE MEMBER: So as we're coming up with this list, would you like us to add a little context about what we know either a problem to be existing --

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DR. GRIFFEN: Absolutely.

COMMITTEE MEMBER: -- or what we know worked?

DR. GRIFFEN: Absolutely. What I would say is everybody come up with all the places you can think of where you have data. And whatever issues you see might be a hindrance to us being able to get access to that data.

And then hopefully, with our next meeting, what we can ultimately do is we can meet to come up with, hey, these are all the places where we can get data. Okay?

And how do we want it to be structured and how is it going to support what we want to do. And do we think we have -- is there anything missing.

So we can get this here, this here, this here, this here. Where -- where are we missing -- what -- what patient population are we missing.

COMMITTEE MEMBER: So we're okay

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with the segmentations, sort of, approach as well as --

DR. GRIFFEN: Absolutely. I -- I just want to -- that's why -- because we just have no way of getting data. And when one of the biggest things for this committee came to -- we got to figure out how we can find all the places across the State that people actually go to and where the data is related to those patients.

And then -- then this may grow into whatever else. Hey, we want to create this across the State for post-acute care. We don't even know where that's going to go because our problem is we don't even know what we have yet.

So until we know what we have and whether it's enough and whether it's quality, it's very difficult for us to say, you know what?

We don't have enough of 'x' in order to get our patients into it, in order for them to recover the way we need them to recover. We haven't even gotten to that

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point yet. So it's going to be an evolving process. This is just -- we don't even have a beginning. We don't even know where we're starting from.

COMMITTEE MEMBER: And also, I would imagine that everybody's familiar with the governor's task force commission on data -- State-level data sharing.

DR. GRIFFEN: No.

MS. MCDONNELL: Oh, yeah, yeah.

COMMITTEE MEMBER: And I'm sure that there has to be a VDH representative on that. I would think --

DR. GRIFFEN: That's why you're all here. Governor's task force?

MS. MCDONNELL: Yeah. So the governor's second executive order, I think it was.

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MS. MCDONNELL: Yeah, it's -- and it's -- I think the first meeting is not until October. I can send -- I'll send you the -- the Code language and stuff. But I mean, that's what we're kind of looking at.

DR. GRIFFEN: Right.

MS. MCDONNELL: We're in the same boat just with brain injury data. But we have the same obstacles, the same issues. And we have kind of been down all these little paths, too. And it's -- it is very -- it's frustrating and overwhelming.

DR. GRIFFEN: Right.

MS. MCDONNELL: But -- but someone will need to --

COMMITTEE MEMBER: Your experiences will help this group, yeah.

MS. MCDONNELL: We need to key into that, you know, State-level group. Maybe

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not to serve on it or do this or that, but they need to know what you're working on, what Doris is working on because we're working on a plan for sharing State-level TBI data.

DR. GRIFFEN: Well, I presume --

MS. MCDONNELL: We are doing this.

DR. GRIFFEN: Yeah. There are people on the task force. And then if it's like everything else in Virginia, it's got to be a public meeting.

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: I would presume. We can find out. Because if it's a public meeting, then anybody can attend and raise whatever questions they want.

COMMITTEE MEMBER: As far as databases, I mean, trauma centers -- we have data registry which if the patients

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abstracted correctly, it'll tell you exactly where they went. It'll be very regional.

DR. GRIFFEN: But that -- and we get -- and that's our -- we all have that. And that's why a person from this committee -- so we can segue into that, a person of this committee being a crossover to the Acute Care Committee.

So the Acute Care Committee is the inpatients, in the hospital, getting their care for trauma. And there is all the data about the registry.

But we felt like we needed to have someone sit in on that committee and see what they were talking about. They have a whole bunch of tasks, not all of which are just with data.

But when there is a conversation about data, having the input from us to be able to stay -- because you're right. We can pull from the registry. I can go home and I can say, hey, tell me everybody in the last year that went to rehab versus home versus this, versus that.

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They can give me that data. And then it's a -- poof. Then it ends. And I have no idea how to say come back and see us.

MS. MCDONNELL: Well, sort of we're getting it. The district doesn't capture -- or do they? Do they report names and -- because we had to get a special arrangement to get mailing label information on people with brain injury out of the State registry.

COMMITTEE MEMBER: The trauma registries are -- are all -- they're all trauma numbers, right? They're not tied to a specific --

MS. MCDONNELL: But there's also a different neuro base. So you have like a trauma base and then there's a neuro base. So it's --

DR. GRIFFEN: Yeah, so we all put the -- we put the data into the State. But we haven't gotten to the point where the State -- like I can't make a request for the

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State data. But I -- I -- as a trauma center, I can't say I want all my people that you know who went to this. We -- we -- we're working on it.

That's been in the works for a while. The EMS database is extremely strong in the State of Virginia. Although there is no ED data. There is no ED database, just so you know.

Which is another big -- which is -- there's something they're going to work on. But EMS and knowing which EMS patient is which trauma registry patient, we don't even have that fully work.

So we can't even -- that's not even from EMS, the trauma registry. The trauma registry database is extremely strong. EMS database extremely strong. Communication between the two, not so much yet.

COMMITTEE MEMBER: Well, you know, the -- the visitor stuff is -- is quite often incomplete. You know, we can't -- we did a data pull over a 12-month period. We

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had to take 70% of the names off the top because they had no addresses. And so, we're supposed to be, by Code, reaching out to these people.

COMMITTEE MEMBER: Right, right.

DR. GRIFFEN: And there you go right there.

COMMITTEE MEMBER: But there's 70% of names off the top. And I'm telling you who the biggest offender is.

DR. GRIFFEN: But then -- but then the question becomes how does that information that we get back -- how does that get back? You know, how -- we're not -- it's again, data in, data out.

And so then, where is the expectation and the accountability? Because that's the next phase of it ultimately.

COMMITTEE MEMBER: We're working on that.

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COMMITTEE MEMBER: Yeah. And -- and we have some information on some of those folks that contact us. But we can't track them back to their trauma registry number.

DR. GRIFFEN: Correct.

COMMITTEE MEMBER: So, yeah. Even though we might have data we can give back to you, we can't connect it.

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DR. GRIFFEN: Right.

COMMITTEE MEMBER: I have another wrench I'd like to throw in here --

DR. GRIFFEN: Great, yes.

COMMITTEE MEMBER: -- as the we gotcha representative. We talk about -- you know, talk about when did it -- when does everybody go back to work after trauma. You know, we need to get the -- 100% of these kids that are injured go back to school.

DR. GRIFFEN: Or should.

COMMITTEE MEMBER: In some capacity. It might be homebound. It might be in school with accommodations or IEP or something. So I -- I don't think that data is available -- well --

DR. GRIFFEN: Again, I don't know.

COMMITTEE MEMBER: Right.

DR. GRIFFEN: So beside your list of where you know you get data, things like that on the list. How do I find the data.

COMMITTEE MEMBER: Pardon my education, I would not be --

DR. GRIFFEN: Again, exactly.

COMMITTEE MEMBER: Yeah. So it's not so I guess in the list, not only include where you know you can get data, but what data we would want that isn't related to the

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working folks. The data related to the elderly who are retired or the pediatric patient who doesn't go to work but goes to school. Where are there other gaps that we foresee that we would like to have information.

COMMITTEE MEMBER: What are the sources in the school system -- another thing I did in the past. I was the mayor of my town.

And one of the problems we had in the schools were we were bringing in people who required OT, PT, speech in order to work with people in the school system.

And I -- and they looked at their budget and they said, it costs us this amount of money. And I said, how come you're not billing Medicaid, Medicare for this? Uh.

So then they started billing and we started recouping some of the cost. So there should be some information, and again, billing process of how we -- how the schools are billing --

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COMMITTEE MEMBER: I'm not sure the schools bill Medicaid or --

COMMITTEE MEMBER: Maybe they --

COMMITTEE MEMBER: Maybe.

COMMITTEE MEMBER: It depends on what the specific -- yeah.

COMMITTEE MEMBER: Yeah, but it's something. Because at least you get something then.

COMMITTEE MEMBER: But that's if -- that's if the kid goes back and requires therapy.

COMMITTEE MEMBER: Yes. Yeah.

COMMITTEE MEMBER: If they still -- if they require accommodations or, you know, non-therapeutic interventions, that technically should be recorded somewhere. Whether -- you know.

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DR. GRIFFEN: Right.

COMMITTEE MEMBER: It might be you can contact the school and they have a nurse. And the nurse -- the nurse says in the school, the school nurse has notification that the individual can come back to school.

COMMITTEE MEMBER: Sure.

COMMITTEE MEMBER: Or go back into intramural sports.

COMMITTEE MEMBER: Sure. But not every school has a school nurse. Some of our schools share a nurse among 10 elementary schools. One nurse that's only there on Thursdays.

COMMITTEE MEMBER: And what do they do with that data that comes in?

COMMITTEE MEMBER: Right.

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COMMITTEE MEMBER: I don't even know that their data is complete as far as they give out recognition of diagnosis of -- that it was trauma. It may be that they now have a language of a paramedic or they need another --

COMMITTEE MEMBER: By the time they get to school, it's another health-impaired.

COMMITTEE MEMBER: Right, absolutely. Another health-impaired or -- or non-disclosed because people, you know, parents are very sensitive to not disclosing that information because they don't want their child treated differently.

So they try to, you know, support them without an IEP, without a 504, without anybody knowing. And so that's never data that gets -- that gets captured.

COMMITTEE MEMBER: And then they move to a different locality and that just creates --

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COMMITTEE MEMBER: You know, and I don't know what sort of -- I don't know what sort of pipeline there might be between VDH and DOE on special education.

DR. GRIFFEN: We can add it to the list. Yeah. And we can do that -- we can -- there's no rule that says we can't, I don't think. I may be -- I don't know. Rules and me don't always get along.

But I don't think there's any rule that says we can't bring in like stakeholders, right? So if we wanted to get someone from the school system kind of thing, right?

DR. ABOUTANOS: The way -- so, I guess that the way we start is from very beginning. It is we put the citizen first, right? What do we need to solve this issue?

And so, yes, we have committee members and it takes a while to add the committee members because we just got this approved. So what I'm asking all the chairs and all the -- is you can create -- you can

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bring anybody to create liaison to various organizations to serve on this committee as liaison. So they're non-voting member but they're liaison. So that -- for the school system, that could be perfect thing to do.

And I think when -- when you ask everybody here to -- to bring information, there -- there is a -- there is something that we're missing.

An organization that needs to be at the table, maybe not as far as the liaison and eventually as the committee member.

So yeah, I think you -- you just need to do what we need to do to get the information. This is -- we can not be rigid.

DR. GRIFFEN: No. And I think it's going to take us a few meetings to where we even get, you know, sort of gel to figure out exactly what it is -- where -- where it is we're going with this and everybody that needs to be involved. But we can ask the liaison and I already got a name here for

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someone to contact with regards to someone that could be a liaison to come and help us with all this.

Because I mean, if we're going to do it, we might as well -- as I tell the residents all the time -- we're going to do it, let's do it right the first time and not have to do it again.

COMMITTEE MEMBER: Right.

DR. GRIFFEN: So we'll -- we'll work on that part. So -- yeah. And you guys are -- I appreciate all the -- you guys obviously have taken this on and those types of things.

And -- and so there's going to be a lot of work to do. And I appreciate everyone's enthusiasm for it all. We've been an hour doing this. We do have to make some decisions about some things.

And so, let's try to make those decisions as best we can so that we aren't here all day long. And -- and then we'll -- I'll -- I guess I'll communicate.

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So Cam and Tim -- Tim -- I don't know if you guys know Tim. He's walking around here in his white beard. He and Cam work at the Office of EMS with Wanda.

I'll communicate with them if the meetings have all sort of suggested they'd like to get an interim meeting between the two.

And then I'll make sure I do it the way I'm supposed to, to get that information to all of you so that we hopefully can work on a location and -- or whatever to meet again before the meetings in May, just so everybody can attend.

And at that meeting, I would say everybody bring whatever list they come up with, whatever thoughts they have to where it may still be an issue. Whatever other people you think we may need in here long term.

And so that maybe we can come together with that, so that by May we can be talking about how we're going to reach out to these various people. And I'm sure everything will evolve sort of as it is. In

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the meantime, as I said, there are there committees that we have to have someone from this committee willing to crossover to attend.

And those -- those committees are -- that we need someone to the Acute Care Committee. And none of the expectation is today or tomorrow. But if you're available and you want to, that's great.

But one is the Acute Care Committee. So the Acute Care Committee is the one that's taking the lead in the patients in the hospitals -- at that time in the hospital.

And the reason for us feeling like we needed to be a part of that was just the information process, what we already talked about. The registry exists. How is that going to sort of coordinate with us.

And -- and that -- Post-Acute is a huge part of where those patients go and how do they get there. And do we have enough and that kind of thing. So we really felt like we needed to have someone on that. That's one, the other one is Emergency

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Preparedness and Response. And the reason that we felt the Emergency Preparedness was -- it's essentially basically being prepared for the worst.

We all know that thing -- bad things happen. Those of us close to me get worried about the place 12 miles down the road on a regular basis. So there is the potential for a major problem and a disaster across the State in some way, shape or form.

And having facilities that might be able to help in some way, we felt like we should -- as a trauma system plan -- that we should be part of that emergency preparedness, if and when the time came that we actually had to empty out a nursing care facility or a rehab to help with the acutely injured because of some major disaster.

So that was the other reason -- that was one of the reasons there. And then the other is the System Improvement Committee because so much of their task is going to be related to data. And knowing what ultimately we're going to want, we wanted a voice at that meeting. So I don't

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know if there are people willing to say, hey, that sounds really interesting to me, and I'd like to do that. But if you do, I would be happy to have you let me know that you'd like to do that.

And be a part of one of these other committees because we do have to send work on identifying someone. If no one wants to do those types of things, then I will work to make some decisions, I guess. Yes, ma'am.

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MS. MCDONNELL: We have a federal grant that's specifically looking at data and data-sharing for brain injury. So I feel like I got to do that.

DR. GRIFFEN: The System Improvement? Awesome. Thank you very much. All right. Can you tell me your name one more time?

MS. MCDONNELL: Anne McDonnell.

DR. GRIFFEN: All right. Awesome.

COMMITTEE MEMBER: Thank you.

COMMITTEE MEMBER: Since -- since the voting members are specifically approved at Patti's, we would love to have you into retirement. But --

MS. GOODALL: Yeah, I can just sit and kick my feet up.

COMMITTEE MEMBER: I mean, she's DARS point by name that if -- if she retires in April, do we need to go to DARS and say, give us someone else or -- or will she make a recommendation to someone else, or can she continue -- I'm putting you on the spot, sorry.

MS. GOODALL: That's fine.

DR. ABOUTANOS: Yeah. So the -- okay. The whole aspect is how functional this committee can -- not just the information, but also in its ability to eventually exert its influence, okay? And

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so -- so that would be the conversation. And again, it goes back to the chair -- or Maggie -- to come up to the committee members to say that what would be your function as representative of that organization.

I -- you still have -- and the organization acknowledges that. It's up to them. So this -- this is the aspect. Or do you stay function here as a non-voting member, but injury member?

I mean, there's a lot of possibilities. We don't know enough, I think what you just said. So we don't know enough, you know, what does -- what does it mean when you retire in April?

The most important thing is not to lose the -- the importance of who you are, your contribution and how -- how are we going to help in this. Because --

COMMITTEE MEMBER: In all respects.

DR. ABOUTANOS: -- like I said, this is a difficult committee. Again, if

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this existed before and we'd all come together and --

MS. GOODALL: Well, one thing I would say about that, seems pretty clear. I mean, if you -- you need a representative from that agency, we're working on similar, you know, really interconnected goals ourselves.

So if you need somebody who's still an employee of DARS who can exert the influence and whatever for the agency to bear, then that will no longer be me.

So I think it should be somebody who's a current State employee, honestly. But if you want to put me in another place --

COMMITTEE MEMBER: Well, you can always -- the other roles, but sort of -- so we can keep our quorum and like, I'll just make a recommendation that after a meeting or two, you can make a recommendation, a name to -- to Maggie. And Maggie will get it --

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DR. GRIFFEN: To Mike.

COMMITTEE MEMBER: -- to Mike for approval.

DR. ABOUTANOS: But what we have not explored yet, also -- in all honesty -- is the reverse. Is having this committee now having liaison on these organizations.

Also, we want a representative from here on the various committees where we have -- this is an act for more people to be involved. And this may be something for -- that also works the other way, you know.

MS. GOODALL: And I also wanted to point out that we, actually attend the Injury and Violence Prevention Committee. And so my staff person who goes to that may -- this may be a perfect -- then you've actually got -- she's doing double duty.

DR. GRIFFEN: Okay.

MS. GOODALL: Anyway, we'll -- I'll

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-- I'll --

DR. GRIFFEN: Yeah, that's fine.

MS. GOODALL: Thank you all for bringing that.

COMMITTEE MEMBER: Can you just clarify what a liaison person would actually be expected to do?

DR. GRIFFEN: The expectation is that you will attend their committee meeting. So in other words, like today the Acute Care Committee meets at 3:00 o'clock.

So if someone was the crossover for them, then what you would do is leave this meeting -- we would finish this meeting. The expectation would be that that person would attend that meeting.

Like I said, not necessarily today. We're throwing all this at you. But in the future, that you would attend their meetings. So Tim is organizing the meetings in such a way that where the crossovers are,

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your meeting will not be happening the same time as the other meeting. And so you would be attending whichever committee you're the crossover for.

COMMITTEE MEMBER: Okay.

DR. GRIFFEN: You're not a voting member. But you're attending because we feel like it's a benefit to have our committee discussion input into that committee should that topic come up.

And it may not. It may be a day where the topic related to what we're talking about doesn't come up. But if it does, we want to have some say in sort of what we've been talking about.

COMMITTEE MEMBER: I'll do Acute Care. [inaudible].

DR. GRIFFEN: I won't tell you what.

COMMITTEE MEMBER: Which one did

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you say?

DR. GRIFFEN: Acute Care.

MR. GIEBFRIED: I've always had an interest in the emergency preparedness. I -- I was in Medical Reserve Corps and took a lot of courses with Homeland when I was up in Boston as part of our region for it. And also, I was police commissioner. So --

DR. GRIFFEN: Which stuff didn't you do?

COMMITTEE MEMBER: Mayor.

DR. GRIFFEN: I've -- I've just getting the feeling you haven't -- what job you haven't had.

MR. GIEBFRIED: Well you have to realize, I'm really one of the oldest -- yeah, I've been in health care for about 50 years.

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COMMITTEE MEMBER: Have you considered 2020? I mean --

MR. GIEBFRIED: So I -- I never like to stay in one place too long because I always enjoy all the different opportunities that I've met. So if no one else is interested in that, I have a -- an interest in it.

DR. GRIFFEN: All right, good.

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MR. GIEBFRIED: I think it's also something that's -- in the therapies too, we're involved in the special services corps as the military.

And many of our people who serve in the Guard or Reservists learn how to do things very differently. And everyone that can do in the military is what they can do civilian.

And they have a lot to offer in Medical Reserve Corps, etcetera, when they -- when they serve in that capacity. Yeah, if there's nobody -- if there's

nobody else.

DR. GRIFFEN: All right.

COMMITTEE MEMBER: Can we have two? I'd be interested in it as well. It's something that I've been working on --

COMMITTEE MEMBER: That'd be great. If one of you can't make it, the other one --

DR. GRIFFEN: Yeah. I don't know why we can't.

DR. ABOUTANOS: This is -- the importance of this is try to -- what you said Maggie, is not only emergency response. The biggest thing in disaster preparedness and medical is the recovery.

And this is where -- once this committee involved in -- you get to the level of, you know, what kind of recovery is going to become obligated and with that response. So the more expertise that comes

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from this committee, the better for that -- for the people who are only thinking in the acute setting, what would I do not knowing that the recovery is the most expensive and most important part of this process.

DR. GRIFFEN: Yeah.

MR. GIEBFRIED: I just want to paraphrase something. Like you said, we're -- you'll be serving 12 miles away. When I was with Blue Cross, I had the opportunity to be with Homeland Security people that came to class and had a discussion.

And they said, well, what are you most concerned about for emergencies and so forth. Everybody went around and said what they were concerned about and how they would manage.

And he stopped and he paused and he said, I'll tell you what we're concerned about. And he says, when the Soviet Union broke -- broke away and broke down, they reported at least 28 nuclear suitcase bombs that are missing. They have

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no idea where they are. And he said, we're -- we're concerned that if one of them gets in the country and detonated for whatever reason, who are you going to respond to those types of things.

Not a power plant because you're all thinking about and -- and your states, etcetera. But we're talking about this because the reality exists.

So it kind of just, you know, really took me back to realize how vulnerable we can be and how disasters can happen. These are man-made, not natural.

DR. GRIFFEN: Yeah. And -- and this, the idea behind this committee is really -- the emergency preparedness is really to make it so that it's, again, the State system plan.

And we have to, as trauma -- as the trauma system, we know that we should be the -- at the forefront of the disaster, I think. Not that the flu isn't a disaster when it happens in the middle of the winter, because we all have been there and seen

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every bed taken up by the flu patient. But if something should happen on a grander scale of some sort, the -- we don't have a system necessary -- we have regions and we have this. And I don't even know all the outreach they're going to have to do.

Because I know every region has a system. But it -- it -- we need to have something where we can all come together as a -- as a Commonwealth to help out wherever the -- the problem happens.

So -- great. Well, I appreciate -- I don't think I have to make a motion. I think as long as you guys all volunteered, I can just forward your names to Mike.

And -- and I don't think, since he was sitting here, he's going to have an issue. We also have to select a vice-chair. Someone who basically will be attending these meetings.

And then should I not be available, takes on the responsibilities of running the meeting and following up and all that kind of thing. And if it -- goes as a

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voting member for the Trauma Administration and Governance Committee thing, which then goes to the EMS Advisory Board. So we do need a vice-chair.

They act in my absence and that type of thing. I don't know if there's anyone in particular who would like to be the vice-chair. If not, I will pick someone at some point.

COMMITTEE MEMBER: Duck, duck, goose.

DR. GRIFFEN: I may not -- I get the sense that you attend this meeting. I -- I think the attendance at the trauma advisory -- at the Trauma Administrative and Governance Committee is if I can't be there.

I don't know that it's an -- an attendance -- like if I'm going, you don't have to go. I think it's just if I can not be there, then the expectation would be that you would be there. So it sounds like the -- the real commitment is to this meeting. And then if I, for some reason,

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can not be available, the vice-chair would go to the trauma -- the TAG meeting, which is usually the next day and that type of thing.

But otherwise, it's -- it's attending this meeting and maybe assisting me with some duties if need be. So -- it can be Macon. All right.

MR. SIZEMORE: Unless Jim needs something else on his resume. He's already put --

MR. GIEBFRIED: I was going to nominate you.

DR. GRIFFEN: Macon will be the vice-chair. And we have all our members. Awesome. Wow, that was -- I have to say -- easier than I thought it was going to be. So thank you very much. All right.

So this -- this -- the thing was sort of open-ended. It said 1:00 o'clock, and I know it says the next meetings are at 3:00 o'clock. But there's

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no rules for us. As an inaugural meeting, I think it was great and it helped us. We need more sort of data and things before we can move forward to some degree.

So I would say look for some information with regards to a meeting between now and the next one is -- the next one of these is May 2nd and 3rd or something like that, right?

MS. STREET: Mm-hmm.

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DR. GRIFFEN: I realize it's right before the dirt again, lady. So -- yes.

COMMITTEE MEMBER: So the -- the Code chapter in Virginia for the data exchange, because it's already in Code, is 2.2-3800.

DR. GRIFFEN: Okay.

COMMITTEE MEMBER: The representatives for --

COMMITTEE MEMBER: Did you know that off the top of your head?

COMMITTEE MEMBER: No -- yes. I've got it right here. Because I had it up last week. The representatives from HHR are Martin Figueroa and Gina Berger, who are the deputy secretaries for HHS.

There's no one at this point listed from VDH or the actual task force. So it's secretary level or higher.

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COMMITTEE MEMBER: What's her name, Gina?

COMMITTEE MEMBER: Gina Berger, B-E-R-G-E-R, or Martin Figueroa. And this gets into all of the data that the Commonwealth is sort of collecting.

But there are specific representatives from HHR and, you know, I'm imagining Dr. Oliver may have had some conversations with them about it. But I don't want to make that assumption without knowing.

DR. GRIFFEN: Right. Okay. We can certainly look into that. Is there any public comments you guys want to make or -- we -- we appreciate your participation. We hope you will come again and participate in any way you would like.

If there's specific things that you've heard today and you can think of something that would help your workplace, let us know.

We know out west, it can often be very difficult to find rehab, in particular pediatric rehab. We have heard that loud and clear from the various -- the various individuals who did attend our prior meetings.

We know that that's very hard. Andy, our friend Andy at Roanoke has shared with us extensively about that. So we know that is a problem.

So we -- and -- and one of our -- one of our goals in attempting some of the committee stuff, although we knew we needed State representative, was trying to make sure we were geographically

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representing all parts of the Commonwealth. Because it isn't the same. I mean, where Donna and I are up in Fairfax, there's a whole lot of stuff around.

Folks in Richmond have a bit more resource-type stuff than some other places. You get out west, and it's a whole different ball game. And we understand that. You get down south and the same thing.

So there's areas that have many more resources available to them than other areas. And the goal of the committee is not just to make it for the areas with all the resources, but for the folks that maybe don't have as much. Luana [phonetic].

COMMITTEE MEMBER: So I think that one of the things that -- that came up a little bit late. But for us -- I'm down in Virginia -- in Norfolk, Hampton Roads area.

One of the real challenges for us is that head injured patient that only needs cognitive rehab. And because you really can't go to rehab inpatient unless

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you have --

DR. GRIFFEN: Right.

COMMITTEE MEMBER: -- need more than one skill -- I mean, more than one service. So the head injured patient that does need cognitive rehab that -- that will not go to a rehab facility, we need to go to look at outpatient services as well.

That we've updated rehab centers, but it's really hard for people to get back and forth to those. So that -- that I think is real important.

And then, you know, the -- the connection for the pediatric -- or we take care of young kids that are 15 or older. So if you have a 15-, 16- or 17-year-old that's in school -- because, you know, we have quite a few that haven't been to school in years.

But we do have the kids that are in school. And just being able to identify those resources to connect parents. I mean, I had a -- my son had special

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education needs, so I learned the system to help him. He did not have a head injury or anything, but learning difficulties. But as a parent, I learned what those resources are and could really teach my patients and families.

But a lot of people don't realize the things that are in the public schools that you -- that's part of -- we pay taxes for it. So your kids can get a lot of the services during the daytime while they're at school.

So that kind of information we need to really identify and figure out, so that we can actually communicate that to families. Because that's a resource that doesn't require a lot of money.

And the day I found -- when my son was school, they would ask about insurance information. I don't know if they ever billed my insurance for the PT and OT that -- that he got at school, or speech that he got at school.

DR. GRIFFEN: Yeah, schools

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obviously become the thing. And we realize we really need to --

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: -- have a liaison.

COMMITTEE MEMBER: Yeah. And you know by law, they have to provide access to those kids. So it's not like other places where they say, well, we can't take them because they got this or that.

And the school, part of their -- their mission is to provide access. And as a savvy parent that knows that, you can just say things like, it sounds like you're denying my child access.

And all of a sudden, people are throwing so many resources at you, you don't know what to do.

COMMITTEE MEMBER: Well -- and you bring up a good point. And I deal with kids with a lot of trauma -- traumatic injuries, but also general injuries.

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COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: And -- so parents that are, and have grown up in the Special Ed system, they speak the language.

COMMITTEE MEMBER: Mm-hmm.

COMMITTEE MEMBER: You know, they know how to go into an activity and say the magic words to get it done.

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COMMITTEE MEMBER: Mm-hmm.

COMMITTEE MEMBER: So if you're 15 years old and you've always had an honor student, you never had to go through that. And then all of a sudden, there's a crash course.

And as Charlie Brown's teacher, while you're at an IED conference and -- and again, if you don't know the magic words, you don't know what's going to come out of that. So you're absolutely right that it -- you know, but there's -- the

access has to be provided. But there's a lot of gray areas in -- in -- there's a lot -- there's just a ton of -- I really think we -- you know --

DR. GRIFFEN: Yeah. And that's somebody we'll look at.

COMMITTEE MEMBER: Well, as far as the data we have program, the only one that I know about -- I'm in Hampton Roads as well -- is Sentara's day rehab --

COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: And they do provide -- they do provide transportation for the patient. That's included.

COMMITTEE MEMBER: Oh, I thought it was limited by the -- how -- it's certain mile radius and they won't go --

COMMITTEE MEMBER: Yes, it is a certain mile radius. You're right about

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that. I mean, they wouldn't come to Richmond. They would turn them down. But locally, they do provide that transportation.

And as far as the cognitive rehab piece, the -- the thing that I've always run into and this will not be a surprise to anyone, is insurance.

They're going to approve a certain number of visits. They don't necessarily think cognitive rehab as a benefit. They look at the -- unfortunately mostly the physical part.

Can they charge us for it, can they take themselves for the development. Beyond that, they don't really care. If they get lost, we can pick up at school.

DR. GRIFFEN: Well, we didn't get into it. We talked briefly about the outpatient side of things, and we couldn't even get into that because the inpatient side was so overwhelming. And again, we get back to data being able to point to somebody. You think that cognitive may not

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be as important, but as best as we can from the information we have, the reports that are out there is that a third of trauma patients never go back to work.

That has to be a drain. I mean, it has to be. $16M a year. It's the number one health care problem. I will continue to say that until someone believes me.

COMMITTEE MEMBER: And not just the cognitive aspect, the emotional aspect of the trauma is --

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: -- vastly under-served.

DR. GRIFFEN: I will not talk about the summer, regular race.

MR. GIEBFRIED: And you have a real

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good point. This -- one of the things that we're getting involved now is the compact for licensure. And you have to treat across state lines, and talking about losing data.

COMMITTEE MEMBER: Yeah, we're just --

MR. GIEBFRIED: So one of the things now we're not sure. So somebody comes out of an acute hospital and lives x, y, z in another state.

And then you're going to see those people as an outpatient, I mean, the other -- other state, we're not listening to that data. So I think that's -- that's also an issue that I haven't heard.

And really brought that up to mind when I heard that. The other thing that I found was difficult for people going to get outpatient services to the therapies is that driver's license. Physician makes the decision. It's only the physician in Virginia that makes that decision. In other states, it's the other health providers.

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And a lot of these people don't ask the question. If I don't ask, no one tells me I can't. And they go and drive. They're unsafe.

Or they may only be able to drive a certain distance. Again, over -- not over the state line or whatever to get back to where they really should be going for the services and to gather the data.

But DMV may have some sources of those people who applied for handicapped. And what's the reason why the physician has given them for that. So maybe -- maybe -- I'm just saying, if you keep pulling straws --

DR. GRIFFEN: Absolutely.

MR. GIEBFRIED: -- maybe we can build a house.

DR. GRIFFEN: Yep.

MR. GIEBFRIED: And that might be another source to go in and look at.

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DR. GRIFFEN: Yeah.

MR. FREEMAN: Yeah, hi. I'm Dan Freeman with Roanoke. I took Annie's spot. But --

DR. GRIFFEN: Haw-haw.

COMMITTEE MEMBER: That's all right.

MR. FREEMAN: Yeah, exactly. We have challenges with people from other states. I'm glad he actually mentioned that with all those state line folks, like West Virginia's very challenged for rehabs.

So we get traumatic patients from West Virginia attempting to coordinate care across state lines because they've got West Virginia Medicaid. It's now extremely challenging for us.

And so along with the pediatric piece in our portion of the state as well, I'd say from our perspective, those are two really big issues for us. That if

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we could at least look at it in dregs to some extent, I'll keep coming back to the public -- to this section -- so we can get some information.

DR. GRIFFEN: Yeah.

MR. FREEMAN: We looked at inpatient pediatric rehab discharges maybe 10 years back. And -- and wondered about what is squiggling across state lines because we -- we looked when Charlottesville closed.

And nobody else in the State went up -- we're only talking 50 or 70 admissions here. But nobody else in the State went up when Charlottesville closed or when King's Daughter shut down for a little bit to change some programming for a year.

Nobody else went up. So whether they just went to outpatient or went across state borders, we just kind of like, we don't know. We don't know where they went.

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COMMITTEE MEMBER: Looking at some of things that show up on the Vista reports are people who are treated in out of -- Virginia hospitals who are out of state. And so that's, you know, that's a whole 'nother layer to what sort of follow up and care, you know.

It speaks to what you were just talking about when the trauma happens in this state but they actually live someplace.

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MR. FREEMAN: Right.

COMMITTEE MEMBER: Not actually when they're coming into the -- trauma happened in West Virginia. They come to Virginia.

So it's a sort of a two-way -- and -- and we see an increasing number of discharge dispositions that are listed as jail. It's a number that's definitely increasing for us.

DR. GRIFFEN: Yeah. I mean, that's

the thing. This is what I mean. They -- they go to so many places and we have no way of putting it in one location when it's a huge task.

And it's going to require some ingenuity and some -- we're going to break down the ball -- the walls and get at the -- that it's transparent.

Because only by knowing where everybody goes and then being able to link them all -- and everybody's so afraid of giving up whatever it is they think they got. I'm not really sure what that is. But it scares everybody, trust me.

COMMITTEE MEMBER: Yeah, it does. And it -- it -- in my mind, it seems like the low hanging fruit that everybody could agree on is just to increase accuracy and compliance with registries. If we could just get that --

COMMITTEE MEMBER: It's required already.

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DR. GRIFFEN: Yeah.

COMMITTEE MEMBER: Yeah, but there's not -- we're talking about Tennessee. Tennessee has like a 93% compliance rate with their trauma hospitals reporting to their registry.

So they -- they've licked a huge piece of this, but that -- there -- there are consequences for non-reporting. And we have no stick in Virginia Code.

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DR. GRIFFEN: Right. And that's one of the things. And --

COMMITTEE MEMBER: Yeah.

DR. GRIFFEN: -- you know that the -- for those of you who don't know, the -- the fact that Virginia has a state fund for trauma is an unusual thing. Not --

COMMITTEE MEMBER: Mm-hmm.

DR. GRIFFEN: -- most states do not

have any money that goes to trauma for trauma. 2004, a large study was done and basically found that 40% of Virginians are not within an hour of a trauma center. And that scared everybody enough to say we need to create a trauma fund so that we can support hospitals' readiness.

And literally, you have to -- I mean, there -- I have a surgeon 24/7 that is in the hospital along with the ICU and the ED and the respiratory therapist and the -- however many other people.

And 24/7 we're there ready to take care of whoever comes in. And every trauma center that's designated in the Commonwealth gets a certain portion of money from the State fund to do exactly the same thing.

Because there's going to be a percentage of patients who can not pay for it. And the hospital, frankly, makes the commitment to providing those resources with some support. And we did it even without the support. But it's a huge thing to have the support. So having the State fund is an

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amazing thing and we don't want it to go away. And we work very hard to make sure they understand why it shouldn't go away and all that.

But you're right. We don't have a stick attached to that in any way, shape or form because it's never -- the money's there.

The State takes it -- some of it back when they want it. But for the most part, it's still there and we're still getting the money.

And so the maturation of that fund and where that ultimately goes is potentially going to be something that we have to use as part of that for the accuracy and that type of thing.

So I -- there's a lot of options going forward. So, any other comments from anybody?

MR. GIEBFRIED: One more from me.

DR. GRIFFEN: Yeah.

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MR. GIEBFRIED: Trauma medicine and -- and actually recording the outcomes from that on some of the [inaudible] because some of the people can not get to the centers. They're not close enough to centers.

If we're using more of the tele-medicine and we're going across lines with tele-medicine, I'm not sure what -- how that data is being collected.

DR. GRIFFEN: Yeah. And that's only going to become a bigger thing. And I suspect in your emergency preparedness, that will be something they talk about potentially use in -- because I know regionally, people talk about tele-medicine related to a -- some sort of major disaster.

And needing for patients to stay in certain areas, but have the video capability to communicate with those elsewhere.

So that's going to become a bigger thing, I would suspect. Okay. For anybody who didn't sign in because you were -- came in after we had sent this around,

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please come up and sign in so that Wanda will have your name and all that type of stuff so we can include it in the minutes. And then everybody will get minutes -- copy of the minutes before the next one.

And then I will work -- Tim is in the back of the room for those of you who have not met Tim before. And we will work with Tim to figure out the meeting in between somewhere.

Now if you agreed to be a crossover and you think you can attend that crossover meeting --

COMMITTEE MEMBER: Go ahead and do it.

DR. GRIFFEN: Go ahead and do it.

COMMITTEE MEMBER: Okay.

DR. GRIFFEN: Absolutely fine.

COMMITTEE MEMBER: I should've looked at the schedule before I volunteered.

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DR. GRIFFEN: I would tell you, but I don't know. But if you -- if you -- yeah. If you can, that would be great to go ahead and attend the crossover meeting if you can.

But I think a lot of it's going to be similar to what we did today, just getting the members up to speed. I will tell you, some of the committees have more members familiar with the initial process than this one.

This -- the only people in this room that -- were Macon and I, basically. Everybody else is brand new, just getting to know the -- the system. So I appreciate -- again, I can not thank you enough for your time.

I -- in the last few years, I have learned what it means to take the time out of your day, come down and do this. And I can not thank you enough for the -- the support.

And we're going to do really cool things. So I thank you and everybody drive careful home if you're going home. All righty, thanks. We will adjourn the

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meeting.

COMMITTEE MEMBER: Before you adjourn, when do you want us to submit -- what's the --

DR. GRIFFEN: Just bring -- just bring it with you. Bring it to the next meeting.

COMMITTEE MEMBER: Okay.

DR. GRIFFEN: Yeah, just bring whatever list to the next meeting.

(The Post-Acute Care Committee meeting adjourned.)

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CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing POST-ACUTE CARE COMMITTEE MEETING heard on February 7th, 2019, from digital media, and that the foregoing is a full and complete transcript of the said Post-Acute Care Committee meeting to the best of my ability.

Given under my hand this 30th day of March, 2019.

CERTIFIED COPY

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2019.