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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MAY 2, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

1:00 P.M.

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1 APPEARANCES:

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

3

4 COMMITTEE MEMBERS:

5 Heather Asthagiri, MD

6 Lauren Carter-Smith

7 Charles Dillard, MD

8 Renee Garrett

9 James Giebfried

10 Lisa Katzman

11 Anne McDonnell

12 Donna Rotondo

13 Macon Sizemore

14

15 VDH/OEMS STAFF:

16 Wanda Street

17

18 ALSO PRESENT:

19 Tanya Trevilian

20 Pete Svoboda

21 Mike Aboutanos, MD
TAG, EMS Advisory Board

22

23

24

25

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A G E N D A

AGENDA ITEM PAGE

Call to Order

Affirmation of Liaison Members....................4

Approval of Previous Meeting Minutes.............7

Approval of Today's Agenda.......................8

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Review Data Collection Opportunities Researched by Team Members..................................20

Discuss Options for Best Approach to Coordinating Data Options....................................32

Review Proposed Goals for PAC and Determine Other Strategies Needed to Meet the Goals............77

Public Comment Period**

Unfinished Business**

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Adjourn

**Items on agenda not covered.

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1 (The Post-Acute Care Committee meeting
2 commenced at 1:00 p.m. A quorum was present and the
3 Committee's agenda commenced as follows:)
4
5 DR. GRIFFEN: So the first thing
6 that we have to do is -- hopefully everybody
7 looked at the minutes. And we just need to
8 approve the minutes from the last meeting.
9 Anyone have any suggestions for changes or
10 anything to this meeting?
11
12 COMMITTEE MEMBER: Very detailed
13 minutes. I think we should at least make
14 clear in the areas where people volunteered
15 to be liaisons to the -- it just says
16 committee member.
17 It doesn't identify who
18 volunteered for what. But I think we need
19 to, again, in this meeting to -- to say -- I
20 think it was Chad that volunteered for Acute
21 Care. Jim was going to be on Emergency
22 Preparedness and Response.
23
24 DR. GRIFFEN: So was Donna.
25

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1 COMMITTEE MEMBER: Donna?
2
3 MS. ROTONDO: Yeah. I believe it's
4 happening over two days in --
5
6 COMMITTEE MEMBER: Okay.
7
8 MS. ROTONDO: I think it's the same
9 as this committee.
10
11 COMMITTEE MEMBER: Anne was going
12 to be System Improvement.
13
14 MS. MCDONNELL: Mm-hmm.
15
16 COMMITTEE MEMBER: Is that correct
17 to people's memory? So if we can just --
18
19 DR. GRIFFEN: We'll add in those
20 names.
21
22 COMMITTEE MEMBER: Okay.
23
24 DR. GRIFFEN: So just on that note,
25 before we -- I've been given this note I

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1 have to read. All trauma system committee
2 meetings are audio recorded. So that's part
3 of why they're so detailed because they're
4 actually audio recording it.
5 Because not every meeting has
6 Wanda sitting here doing things. The record
7 -- these recordings are used for meeting
8 transcripts. Because of this, all
9 participants must do the following.
10 We were supposed to hang these
11 up. We don't have anywhere to hang them.
12 So speak clearly, identify yourself when
13 you're speaking and speak one at a time.
14 Okay.
15 So as much as you can, please
16 try to say who you are before you give us
17 your run down and speak as clearly as
18 possible.
19 The enthusiasm for
20 participation in the trauma system strategic
21 process is both understandable and welcome,
22 but following the above rules will assist in
23 accurate transcription. So if everyone can
24 please remember that, we'd appreciate it.
25 So I'm Maggie Griffen. I'm speaking. I'm

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1 asking for approval of the minutes from the
2 last meeting.
3
4 COMMITTEE MEMBER: So moved.
5
6 MS. GARRETT: I have a correction.
7
8 DR. GRIFFEN: Go ahead.
9
10 MS. GARRETT: Under my introduction
11 it says IVLR. It should say IPR.
12
13 DR. GRIFFEN: Okay.
14
15 MS. STREET: IPR.
16
17 DR. GRIFFEN: That's Renee Garrett
18 speaking. So under her introduction --
19
20 MS. GARRETT: It's me.
21
22 DR. GRIFFEN: Right. I know we got
23 to get used to it. I'm not used to it,
24 either.
25

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1 MS. GARRETT: Thank you.
2
3 DR. GRIFFEN: Anyone else with any
4 corrections? All right. Everyone in favor?
5
6 COMMITTEE MEMBERS: Aye.
7
8 DR. GRIFFEN: All opposed? The
9 minutes are carried. Very good. And then
10 the approval for the agenda for today's
11 meeting. Again, you all should have the
12 agenda in front of you with the nice green
13 banner up top.
14 Talks about our May 2nd agenda
15 meeting. Anyone with any questions or
16 corrections or additions for the agenda? If
17 not, I need a motion to approve.
18
19 MS. GARRETT: So moved. Renee
20 Garrett.
21
22 DR. GRIFFEN: Second?
23
24 COMMITTEE MEMBER: Second.
25

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1 DR. GRIFFEN: All right. All in
2 favor?
3
4 COMMITTEE MEMBERS: Aye.
5
6 DR. GRIFFEN: All right. No one's
7 opposed. We're -- agenda approved. Have to
8 do all this. Those are all those technical
9 things I have to do. All right. So did
10 everybody basically -- all right.
11 Before we start and dive in,
12 did I give this to you? I made copies of --
13 essentially, some people did some digging
14 and then sent me forward web site kind of --
15 I don't know what the technical computer
16 term is for those little thingies.
17 But addresses for various
18 places for data collection. So I made a
19 copy for -- I made 12 copies, so I'll get it
20 to whoever I can.
21 And then we can electronically
22 get it to anybody after that if need be.
23 And then James has sent me some other things
24 that are going to be easier for me to
25 electronically get to you all. So I will

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1 get them to you electronically as I can.
2 I'll either send them to Wanda and have
3 Wanda get them out to you all or I'll do it
4 at my office, which probably won't be 'till
5 -- I don't know when.
6 But I promise I'll get them to
7 you. So the first things that -- and
8 Wanda's going to send around the sign-in
9 sheet. So if you can sign in for today,
10 that would be great.
11 I don't have a whole lot to
12 report at this meeting because there hasn't
13 been -- we've done -- I appreciate
14 everybody's feedback with everything.
15 I apologize for the meeting in
16 between not being able to happen. I have no
17 idea -- are your offices still being worked
18 on --
19
20 MS. STREET: Yes. Still doing
21 renovations.
22
23 DR. GRIFFEN: I have no idea how
24 long the renovation issues is going to go at
25 OEMS. When -- when they're done renovating,

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1 we can -- if we're far enough ahead, we can
2 use their offices free of charge to come
3 have a meeting. Anywhere else, the Office
4 would have to pay for a meeting space.
5 And so that's kind of hard.
6 And I could probably get space at my place,
7 but I don't think everybody wants to drive
8 to Fairfax. I wouldn't. I don't like
9 driving in Fairfax, so I don't expect that
10 you guys all want to drive there.
11 So we may be a little bit
12 confined until then. And we'll try to do as
13 much as we can. And as I said, we do have
14 the limitations of the State laws as to how
15 we can communicate with each other.
16 That I basically can only send
17 it to one of you at a time. We can't do a
18 group thing. That isn't how the laws of
19 Virginia work. It's not allowed. It's
20 thought to be a meeting.
21 And that's not whatever the
22 rule is. So I'm following the rules this
23 time. Okay. So the first part of the
24 agenda after that was feedback from the
25 committee members for crossovers. I don't

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1 know whether everybody was able to go to the
2 crossover meeting. Because I think some of
3 them may have not happened yet, or they were
4 -- the last time we met, you were made the
5 crossover person and that meeting had
6 already happened.
7 So I'm not sure everybody's
8 been able to attend. But if you have, for
9 those people who went to the crossover
10 meeting, are there reports?
11
12 MS. MCDONNELL: So I did make the
13 Systems Improvement Committee meeting.
14
15 DR. GRIFFEN: So this is Anne
16 speaking.
17
18 MS. MCDONNELL: This is Anne
19 speaking. That was held the Friday morning
20 after the last meeting that we had. And we
21 had a -- a pretty good turnout.
22 There's some extensive
23 representation from both sort of -- you
24 know, intra-specific like burn center and
25 pediatric centers. But there's also a lot

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1 of, you know, data geeks on that committee
2 as well. So we had some fun talking about
3 that. The Committee has identified four --
4 five specific goals.
5 One is an integrated trauma
6 data system. How can we figure out who's
7 got the data, where is it, how can we get
8 our hands on it, what can we learn from it.
9 Another one is to -- where are
10 the institutions and providers to optimize
11 care, implement best practice, see what we
12 can do about preventing injury and
13 optimizing outcomes.
14 Another one is around
15 benchmarking within the trauma system as a
16 whole. Both regionally -- with a regional
17 focus as well as statewide.
18 Another goal is to see if all
19 this stuff that we're collecting, what of it
20 lends itself to research and publication and
21 best practice development.
22 And then another one is just
23 continuing to advise VDH on performance
24 improvement processes that need to happen.
25 It was a very geeky conversation.

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1 DR. GRIFFEN: And I think that ties
2 in -- sorry, this is Maggie Griffen talking.
3 This -- this ties in to what we talked about
4 last time is one of the biggest projects for
5 every committee is this whole data thing.
6 And we won't be the only one
7 bringing things to them saying, hey, we need
8 the data. And we know that even with
9 everything that everybody's sent -- and
10 we'll go -- we're going to go through all of
11 that and try to figure out some answers to
12 some questions.
13 But that's what, I think,
14 everybody's going to have to bring to the
15 data geeks is, hey, we can get this amount
16 of information here.
17 And we can get this amount of
18 information here. But then ultimately, roll
19 to the, well, okay -- that's a volunteer-y
20 [sp] thing. And if someone keeps it up,
21 that's great.
22 And that agency keeps it up,
23 that's great. But if that agency all of a
24 sudden decides that's not worth their time
25 and they drop it, then we're going to lose

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1 that whole host of information. And then,
2 how can that information be made to match to
3 a patient so we can actually follow the
4 patient.
5 So somewhere along the line
6 there's going to have to be a thought for
7 regulating the data. And -- and demanding
8 and making it a requirement. And that's
9 going to be a different focus altogether,
10 so...
11
12 MS. MCDONNELL: One of the things
13 that I'll add, Maggie -- this is Anne
14 again -- is that there was a discussion
15 about consumer representation of all of the
16 work groups.
17 So there were a few names that
18 were floated. They're looking for folks who
19 have received services through the trauma
20 system that feel like they have something
21 that they can offer and would be interested
22 in having these sorts of conversations. So
23 if you know somebody, the System Improvement
24 Committee, I think, is looking for
25 suggestions. And I don't know if that's

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1 something that's going to be suggested to
2 all of the committees eventually or not.
3
4 DR. GRIFFEN: Yeah, okay. Yeah, I
5 don't how that would -- I don't know how
6 that work with the consumer representation
7 with the State focus. I mean, I know a lot
8 of the centers and the hospitals collaborate
9 with consumer -- yeah, I don't know. We can
10 ask.
11
12 MS. MCDONNELL: Mm-hmm.
13
14 DR. GRIFFEN: We can certainly ask
15 about consumer representation. Okay. Good.
16 Was anyone else able to attend a meeting.
17 Oh, yes, sir.
18
19 MR. GIEBFRIED: This is Jim. I did
20 attend the Emergency Preparedness and
21 Response Committee. And was pleased to
22 hear all of the various regions in the State
23 and how they are preparing. The types of
24 resources that they have -- or actually, the
25 resources that they're planning on having.

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1 You may want to tell us more readily and
2 essential to the public communities. Some
3 particular areas, the western and the
4 southwestern, had more issues in response
5 time and the capabilities of having
6 equipment that they needed.
7 And we talked a great deal
8 about some of the unique needs in each of
9 the communities that exist there. Whether
10 it's a nuclear power plant or whether it's
11 the -- the hurricane, so whether it's the
12 tornadoes or mountains issues.
13 And that -- that was shared
14 among the group. So it was a -- basically
15 an overview of where we are and what we have
16 presently and what people are projecting
17 that may be.
18 And then looking at other
19 resources that may be out there, whether
20 it's Homeland Security, whether it's
21 military, whether it's Medical Reserve
22 Corps, other things -- other resources that
23 may be able to help us out [inaudible] if we
24 have a response.
25

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1 DR. GRIFFEN: I think -- sorry,
2 Maggie talking again. That's going to be --
3 that -- there's going to be so much
4 undertaking for that committee that's going
5 to go beyond just the system in -- in all
6 honesty.
7 But it's -- I think there is a
8 lot of potential for that across the
9 Commonwealth to help bring what people have
10 been doing in their pockets together.
11 Which is going to be a major
12 successes. We all know you can't plan for
13 the disaster that can come any way, any
14 time. So all right. Anyone else?
15 We had the Acute Care -- I
16 mean, what other one? There was one other
17 so I filled these on. There was another
18 rep. Sorry, Macon, what did you say?
19
20 MR. SIZEMORE: I was on Acute Care,
21 but I was not -- I was --
22
23 DR. GRIFFEN: Right, right, right.
24 Because they were meeting the same time we
25 were.

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1 MR. SIZEMORE: Right.
2
3 DR. GRIFFEN: Now do they meet
4 tomorrow?
5
6 MR. SIZEMORE: They meet today at
7 3:00.
8
9 MS. STREET: Today.
10
11 MR. SIZEMORE: So I was going to
12 go.
13
14 DR. GRIFFEN: Oh, today. Okay,
15 yeah. So that was the other thing. Tim --
16 when he was looking at like who went where,
17 he also realized that he made some
18 inabilities for that.
19 So they had to adjust
20 everything around so that people who were --
21 the committees didn't meet at the same time
22 so that they could get through that. So --
23 so that we -- good. Good. So we'll just
24 look for your report the next time around
25 kind of thing, which is --

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1 MR. GIEBFRIED: Madame Chair, if I
2 just may. I also understand that this is
3 what came out of -- as a liaison committee
4 report that was there. So I followed this.
5 But they are available online. And maybe
6 you could just indicate where.
7
8 MS. STREET: Yes. They're on the
9 Virginia Townhall. Virginia Regulatory
10 Townhall.
11
12 DR. GRIFFEN: All right. Great.
13 Okay. So everybody went back, I know, and
14 looked at a variety of things. And I
15 basically, like I said, I put together the
16 -- the -- people sent me lists of those
17 addresses.
18 And I think that the thing
19 that we have to figure out -- so again,
20 we're -- we want to -- in order for us to --
21 what our original issue -- one of our
22 original issues became is that we have no
23 way of knowing where anybody goes after
24 discharge, for the most part. We can get a
25 report from a registry out of our individual

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1 hospitals. But we can't get any data beyond
2 that for the most part in any consistent
3 manner. And so this is the black hole that
4 we're trying to figure out a way to fill.
5 And try to figure out what's
6 out there with the intent that in the long
7 term, we can provide back a plan to the data
8 committee, to the System planning committee
9 in general of the -- these are the bullet
10 points that we need -- that we would like.
11 These are places where we can
12 get some of them, but it's -- and it's
13 regulated. These are places where we can't
14 -- we can get some of them. And it's not
15 regulated, so it could go away at any time.
16 So this is a proposal for what
17 you're going to need to really track these
18 people. Now it's not going to be incumbent
19 upon us to say, so now you got to match and
20 tell us how you can follow them with that
21 particular patient.
22 That's -- that's going to be
23 the data committee people that -- that --
24 they got to figure out how they can make
25 them communicate to one another. But we've

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1 got to come up with what we think are the
2 basics of what we would need so that the
3 information can be useful for us to then be
4 able to do some sort of quality review on
5 where these patients go after the fact.
6 Because this truly is the
7 black hole of trauma across the country, is
8 really not knowing -- you know, we think we
9 all do a great job. I'm sure we do.
10 I got no proof that in the
11 long term, you know, and for these -- these
12 things that come out saying only this many
13 of the people go back to work ever and this,
14 that and the other thing.
15 We don't know the answer to
16 that either. Because we just don't have the
17 numbers and the data. So -- and ultimately,
18 someone's going to have to spend some money
19 somewhere along the line to -- to agree to
20 do this.
21 And agencies, particularly --
22 probably in my opinion, the nursing homes
23 who have never -- I don't know that it's not
24 wanted -- but never had the demand to do
25 this are going to have to be in some way

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1 encouraged to participate in this process.
2 So that we can truly have an assessment of
3 where do folks go and how they turn out,
4 depending on where they go.
5 And everybody gets a little
6 nervous when they start talking about that
7 because it's an assessment of their quality
8 of care and they get freaky.
9 And it has to do with money
10 and the government will get involved and who
11 knows. But anyway, you know --
12
13 MR. SIZEMORE: Maggie, this is
14 Macon. I'm just as -- following up on your
15 government and the money. CMS continues to
16 send a lot of messages out that they want to
17 continue to treat all post-acute care,
18 inpatient rehab, long term care, hospitals,
19 home health and -- who did I leave out?
20 It's four of them.
21
22 COMMITTEE MEMBER: Skilled nursing?
23
24 MR. SIZEMORE: Skilled nursing.
25 Thank you. That they are -- they want to

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1 try to bundle services. They want to have
2 similar data collection across those four
3 areas. They -- CMS put out its final rule
4 for inpatient rehab proposal for 2020 this
5 year.
6 And one of the things they
7 said is, well, we're thinking about
8 requiring all inpatient rehab facilities to
9 collect and submit data on all patients that
10 they treat regardless of payor source.
11 And most people do this
12 anyway. And most IRF's are 60% or more
13 Medicare anyway, but -- so the government is
14 continuing to take some efforts to -- in all
15 of the post-acute arena.
16 That won't get us outpatient
17 therapy. It won't go to that degree yet.
18 But it'll -- they're trying to standardize
19 and as bundling and other things become
20 possible, there might be some resources that
21 make that easier to --
22
23 DR. GRIFFEN: From a federal level.
24
25 MR. SIZEMORE: From a federal

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1 level.
2
3 DR. GRIFFEN: Okay.
4
5 DR. DILLARD: But again, that
6 wouldn't necessarily touch the pediatric
7 population.
8
9 DR. GRIFFEN: Correct.
10
11 MR. SIZEMORE: True, true.
12
13 DR. DILLARD: Because Medicare is
14 not a payor source for pediatrics. We're --
15 our inpatient rehab doesn't necessarily
16 follow the -- you know, we don't have the
17 WeeFIMS, or Pfizer [phonetic], you know,
18 earth pies or any of things. We're the only
19 pediatric rehab in the State.
20
21 DR. GRIFFEN: Right.
22
23 DR. DILLARD: And as far as skilled
24 nursing, you know, the -- the few pediatric
25 skilled nursing facilities around, they're

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1 all Medicaid --
2
3 DR. GRIFFEN: Right.
4
5 DR. DILLARD: -- not Medicare. So
6 --
7
8 DR. GRIFFEN: Right.
9
10 DR. DILLARD: -- that, you know,
11 would be a gap of the pediatric population.
12
13 COMMITTEE MEMBER: Yes.
14
15 DR. GRIFFEN: Whole reason why --
16 that was Charles talking. The whole reason
17 why --
18
19 DR. DILLARD: Sorry.
20
21 DR. GRIFFEN: That's okay. I know
22 we're all getting used to it. The whole
23 reason why -- that's the whole point of
24 having a pediatric representative on this is
25 that so many of us -- no, so many of us --

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1 DR. DILLARD: Just keep pointing
2 out where we -- where we are --
3
4 DR. GRIFFEN: No, we're thinking
5 adult. We -- so many of us all we work with
6 is adults, so we think adult all the time
7 and we don't recognize that.
8 So there may be some federal
9 help for all of that. So getting those --
10 making the CMS guidelines for that, you just
11 get off the CMS web site, I take it.
12
13 MR. SIZEMORE: Yeah.
14
15 COMMITTEE MEMBER: That's correct.
16
17 DR. GRIFFEN: Okay. Because that's
18 probably a good thing for us to get. And
19 then that'll at least give us some
20 guidelines as to what they think -- where
21 they think they might be going.
22 And where it might get us some
23 help for some portion of it. It's still
24 isn't necessarily -- I don't know that --
25 enough about it to know how we can marry

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1 that to a patient from our state --
2
3 COMMITTEE MEMBER: Right.
4
5 DR. GRIFFEN: -- kind of thing.
6 Yeah. This is where I just get nuts and
7 wish that like Amazon and FedEx could come
8 in and go, look, here's patient one. And
9 they go here.
10 And look, we can -- here's
11 your tracking number for patient 17. And --
12 but that's not what I'll get. So anyway --
13 all right.
14
15 COMMITTEE MEMBER: One question if
16 I may, mister -- Mrs. Chair in regards to
17 the federal government looking at bundling
18 and -- and those groups, I was just
19 wondering whether or not there was something
20 where they were also considering those
21 people that go to a psychiatric facilities
22 as well, that post-traumatic trauma that
23 exists. And whether or not, if we might
24 miss that if we -- we don't look at the
25 psychiatric units for children, but also for

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1 adults.
2
3 DR. GRIFFEN: Yeah.
4
5 COMMITTEE MEMBER: It's very hard
6 to find for children a psychiatric unit that
7 has any beds. And that's speaking for
8 adults.
9
10 DR. GRIFFEN: Yeah, I know. That's
11 true, because we have those -- unfortunately
12 in trauma is where we get some of these
13 folks that do bad things to themselves and
14 end up needing the psychiatric support for
15 ever or part time.
16 So if they got discharged
17 there, they may not get caught in that
18 global sort of thing. So that's true. So
19 anything -- the unusual, that's part of what
20 we have to think of is peds, psychiatric,
21 anything that's not something that's going
22 to fit in that acute rehab or nursing care
23 facility type umbrella, where we think we're
24 going go find these people go to.
25

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1 DR. DILLARD: And Macon, I'll --
2 this is Charles Dillard again. Macon, I'll
3 ask you. Is there a -- a population on the
4 Veterans military side where patients might
5 end up in the poly-trauma unit. Obviously
6 they're injured.
7 They're not -- there's no --
8 you know, they're not going to go to McGuire
9 for an ER. But if they end up needing rehab
10 and they do have Veterans' benefits, will
11 they end up on the poly-trauma units? And
12 that would again be sort of outside the --
13
14 MR. SIZEMORE: Yeah. That's
15 something we've considered in our realm of
16 all within the Commonwealth, whether it's a
17 federal or a -- or a public -- public
18 institution. That's something that -- it's
19 under the purview of this plan, I believe.
20
21 DR. GRIFFEN: Yeah. The
22 interesting thing about the -- sorry, it's
23 Maggie again. The interesting thing about
24 the Veterans is -- because we have a bunch
25 of facilities up by us. But when we try to

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1 get them in for rehab, they tell us they
2 ship them to the civilian centers for rehab.
3 The non -- the non-active duty. They can be
4 service connected and everything will be
5 paid for.
6 But if they're non-active
7 duty, they send -- they don't send it --
8 they don't send them to like Walter Reed
9 right there by us or -- or the -- or
10 Bethesda or any of that.
11 They don't -- they -- they
12 want them -- active duty, they ask for them
13 the second they arrive at the hospital. We
14 want them back. Get them up, transferred
15 over here or whatever.
16 And we'll do whatever. But if
17 they're non-active duty but service
18 connected, they send them to a civilian
19 center.
20
21 MR. GIEBFRIED: This -- this is Jim
22 again, just to follow up on that. I know
23 that when we get individuals who have
24 military service, the military does allow
25 for 60 days of skilled nursing facilities.

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1 And that's on top of what Medicare may
2 provide, they're covered for as well. And
3 again, there may be some information by the
4 nursing facilities that they'd have to
5 submit back in order to get -- for billing
6 purposes. It -- it might be a question to
7 ask.
8
9 DR. GRIFFEN: Okay. So I guess
10 maybe one of the things is figuring out
11 where we want to start. There's a lot of
12 things here, but do we think that we can
13 sort of identify those things that we think
14 would be important to know about an
15 individual who was leaving a hospital and
16 going to a facility.
17 What is it that we would want
18 to know back from that facility about that
19 person. Right? I mean --
20
21 COMMITTEE MEMBER: We're -- well,
22 how long their length of stay --
23
24 DR. GRIFFEN: Right. So I mean,
25 pretend that -- yeah.

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1 COMMITTEE MEMBER: Some sort of
2 record [inaudible].
3
4 DR. GRIFFEN: All right. So things
5 we would want to know. Because that's going
6 to allow us to do some sort of quality
7 review, right, to figure out. So their
8 length of stay at the facility.
9
10 COMMITTEE MEMBER: Where they left
11 and went after that facility.
12
13 MS. KATZMAN: Their medical -- if
14 they were -- had a medical re-admit while
15 they were at the facility.
16
17 DR. GRIFFEN: If they had what?
18
19 MS. KATZMAN: This is Lisa. If
20 they had a medical re-admission.
21
22 DR. GRIFFEN: Okay.
23
24 COMMITTEE MEMBER: Acute care
25 re-admit.

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1 DR. GRIFFEN: Yeah, that's it.
2 Yeah, that's good. Acute care re-admit.
3
4 COMMITTEE MEMBER: Glasgow.
5
6 DR. GRIFFEN: Okay. And so we want
7 it at admission and at discharge probably?
8
9 MS. MCDONNELL: But you would not
10 -- wouldn't get it necessarily at discharge.
11 You might get it from the field and on
12 admission.
13
14 DR. GRIFFEN: Yeah.
15
16 MS. MCDONNELL: But what that --
17
18 COMMITTEE MEMBER: Post -- post,
19 I'm sorry, Anne. The post-acute probably a
20 rancho level from a TBI.
21
22 MS. MCDONNELL: Well, that's true.
23
24 DR. GRIFFEN: So would you want
25 rancho rather than GCS probably? Maybe they

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1 can give us a more comprehensive --
2
3 COMMITTEE MEMBER: At the -- at the
4 post-acute, I think the rancho would --
5
6 DR. GRIFFEN: Is a nursing home
7 going to do a rancho?
8
9 COMMITTEE MEMBER: No, but it's the
10 rehab unit --
11
12 DR. GRIFFEN: Yeah, they'll --
13 right. So -- so ranchos for inpatient
14 rehab. But is there a surrogate that can
15 use for a nursing care facility, for --
16
17 COMMITTEE MEMBER: How about a
18 global functioning level --
19
20 DR. GRIFFEN: Okay.
21
22 COMMITTEE MEMBER: -- is what we're
23 really looking for.
24
25 COMMITTEE MEMBER: That's a good

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1 idea. Just word it that way.
2
3 MS. KATZMAN: New or worse -- this
4 is Lisa. New or worsening pressure ulcers.
5
6 DR. GRIFFEN: Yeah. Any hospital-
7 acquired -- oh, what do they call it?
8
9 COMMITTEE MEMBER: Not just
10 hospital-acquired any more.
11
12 COMMITTEE MEMBER: Not hospital-
13 acquired, yeah.
14
15 DR. GRIFFEN: Any -- I wonder what
16 they call them? Because I'm sure -- because
17 we would want to know more than pressure
18 ulcers. We'd want to know pneumonia, UTI --
19
20 COMMITTEE MEMBER: Absolutely.
21
22 DR. GRIFFEN: So what -- what are
23 they calling them, the facility-acquired --
24
25 COMMITTEE MEMBER: Acquired --

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1 COMMITTEE MEMBER: Is it acquired
2 -- complication --
3
4 COMMITTEE MEMBER: Complication at
5 the facility.
6
7 DR. GRIFFEN: Yeah.
8
9 COMMITTEE MEMBER: Falls. I think
10 somebody said falls. Meant to tell you also
11 about the facility.
12
13 COMMITTEE MEMBER: Payor source.
14
15 DR. GRIFFEN: Yeah. That would be
16 getting this -- that would be good.
17
18 COMMITTEE MEMBER: Support services
19 that are provided in the community.
20 Nursing, therapies, that sort of thing.
21
22 DR. GRIFFEN: So getting those in
23 -- for the individuals, or in other words,
24 this one went there and got an hour a day of
25 PT. And this individual went there and got

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1 nothing kind of thing.
2
3 COMMITTEE MEMBER: Or got it at
4 home.
5
6 COMMITTEE MEMBER: I'd want to know
7 what was the discharge plan. A succinct --
8 did they go to outpatient? Did they do
9 this? Did they --
10
11 COMMITTEE MEMBER: Maybe continuum
12 of care --
13
14 COMMITTEE MEMBER: Yeah.
15
16 COMMITTEE MEMBER: -- like at the
17 end. So what did it look like there.
18
19 DR. GRIFFEN: So a discharge status
20 plan, continuum of care sort of all
21 together? Because some of this stuff, I --
22 I have no idea what I'm talking about. Feel
23 like the -- I don't know what you're --
24
25 DR. DILLARD: From the pediatric

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1 perspective, what school looks like. So --
2
3 DR. GRIFFEN: Okay.
4
5 DR. DILLARD: -- special education,
6 return to school. And obviously, the flip
7 side of that or whatever the adult point
8 would be --
9
10 DR. GRIFFEN: Yeah.
11
12 DR. DILLARD: -- return to work for
13 the patient --
14
15 DR. GRIFFEN: School, work and --
16
17 DR. DILLARD: Yeah.
18
19 DR. GRIFFEN: Yeah, but -- but --
20
21 DR. DILLARD: But specifically -- I
22 -- I -- this is Dillard again. I think
23 there's a small chance that we might --
24 there's -- there might be a through line to
25 track. Kids who return get special -- would

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1 need special education services, AEP's,
2 504's that they will require after an
3 accident.
4 Because there is -- there --
5 that -- special education services is
6 tracked from -- in the school system at the
7 Department of Education, I -- you know, how
8 we're going to get a patient's name and then
9 a -- you know, a student's name.
10 I'm not sure how we're going
11 to do that. But I think there's a small
12 possibility there might be a throughput we
13 could track through that.
14
15 DR. GRIFFEN: Right. That if we
16 knew that they were coming out and they were
17 coming out of whatever special thing, that
18 would get them tracked then in the school
19 after that even.
20
21 DR. DILLARD: Yes.
22
23 DR. GRIFFEN: Okay.
24
25 DR. DILLARD: In -- in theory.

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1 DR. GRIFFEN: Right, right. Yeah,
2 I know. Everything -- this is all theory
3 right now.
4
5 MS. MCDONNELL: Well, you know,
6 it's not necessarily post-discharge, but it
7 sort of tracks what Chad is saying. And
8 this is Anne. You know, the model systems
9 program at VCU tracks individuals who are,
10 you know, in that program.
11 And a lot of them are trauma,
12 but they track them over 30 years. So you
13 know, that is another source of, you know,
14 long term data on what some of these folks
15 end up needing.
16 Whether or not we can attach
17 someone, you know, over the course of time
18 -- that probably happened through some of
19 the model systems data.
20 But it would also give us just
21 a -- just a set of individuals who've
22 experienced treatment in the trauma system
23 and what, you know, those individuals look
24 like later on.
25

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1 COMMITTEE MEMBER: Yeah.
2
3 DR. ASTHAGIRI: This is Heather
4 Asthagiri. That's only for TBI patients,
5 right?
6
7 COMMITTEE MEMBER: Right. We don't
8 have it --
9
10 MS. MCDONNELL: It's final.
11 They're going -- they're going to create
12 one, you know, with a -- with a joint
13 venture -- VCU is --
14
15 (At this time, several committee members
16 began speaking all at once.)
17
18 DR. GRIFFEN: Yeah.
19
20 COMMITTEE MEMBER: There's a new --
21
22 DR. GRIFFEN: But this is for your
23 patients at VCU.
24
25 DR. ASTHAGIRI: Right. So it's a

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1 small -- it's a small group, but it would
2 only contain some. But that is a long term
3 --
4
5 DR. GRIFFEN: Right.
6
7 DR. ASTHAGIRI: -- and they -- they
8 all track, you know, their patients for
9 quite some time.
10
11 COMMITTEE MEMBER: Right.
12
13 DR. ASTHAGIRI: And all the data
14 and over spinal cord injury goes back to
15 UAB. I'm not sure where the TBI data goes,
16 but --
17
18 DR. GRIFFEN: Craig. That's just
19 through the acute rehab.
20
21 DR. ASTHAGIRI: That's just through
22 model systems.
23
24 DR. DILLARD: Yeah. Specific model
25 systems, like VCU --

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1 DR. ASTHAGIRI: The problem is --
2 do you --
3
4 COMMITTEE MEMBER: It does --
5
6 DR. ASTHAGIRI: -- 14 spinal and
7 brain injury --
8
9 DR. GRIFFEN: Right, right. So
10 that --
11
12 MS. GARRETT: This is Renee. The
13 EOE tracks special education with a variety
14 of codes. So say, you know, autism is
15 pretty clear. But say you don't fall under
16 TBI, but it's still a trauma. There's other
17 health out --
18
19 DR. GRIFFEN: Right.
20
21 MS. GARRETT: -- which doesn't
22 identify --
23
24 DR. DILLARD: Right.
25

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1 MS. GARRETT: -- a specific -- you
2 know, if it's trauma.
3
4 DR. DILLARD: Yeah, that's what --
5 there's -- that's what I mean, small chance.
6
7 DR. GRIFFEN: Yeah.
8
9 DR. DILLARD: There -- there's a
10 lot of problems with trying to do it. But I
11 -- I -- you know.
12
13 COMMITTEE MEMBER: It's either
14 going to be classified, you know, under
15 emotional --
16
17 DR. DILLARD: Sure. But there's
18 also, from that perspective, if you don't --
19 if you've had a trauma, you don't
20 necessarily -- that -- you only get an IP if
21 it affects you academically.
22
23 COMMITTEE MEMBER: Right.
24
25 DR. DILLARD: So even if you have

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1 the need for accommodations and
2 modifications, you would have to get a 504
3 plan, which does not necessarily fall under
4 the -- so you can not have any of the 13
5 magic definitions that fall under an IP and
6 still get a 504. That's -- that's what I
7 mean. There's -- I -- yeah.
8
9 COMMITTEE MEMBER: This is -- this
10 is --
11
12 COMMITTEE MEMBER: I'm sorry.
13
14 COMMITTEE MEMBER: No, go ahead.
15
16 COMMITTEE MEMBER: No, you were
17 finishing --
18
19 COMMITTEE MEMBER: I was just
20 asking -- this is -- these are things we're
21 asking the facilities to report to us?
22
23 DR. GRIFFEN: Right. So this is
24 the idea to try to pull this off. So the
25 patient, right? So right now what we -- the

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1 way we're thinking this long. So we have a
2 patient. They get to EMS, they get to acute
3 care. Then they go up -- up -- post-acute
4 care, right?
5 They can go any number of
6 places. Right? Rehab in all of its stuff.
7 Skilled nursing facility, home with
8 outpatient -- I mean, they can go to all
9 these different places. I mean, jail --
10 we've talked about it. They can go to --
11
12 COMMITTEE MEMBER: State mental
13 hospital.
14
15 DR. GRIFFEN: -- the psych
16 facility. All these places they can go.
17 And -- I mean, our ultimate desire is that
18 we have EMS data stuff. We have a fair
19 amount of it.
20 It's pretty robust throughout
21 the state. But it doesn't -- we have no ER
22 databases, just so you know. There are --
23 the ER's are not required to, which boggles
24 my mind. But -- so we get this initial
25 stuff through trauma registries, right? So

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1 we get initial information about it. There
2 are EMS databases, and they're trying to get
3 them to work to communicate.
4 Sorry, the trauma registry
5 comes here, so we get a lot of our
6 information about the patients from the
7 trauma registry from all the acute care
8 hospitals.
9 Because that's what we have to
10 do is think trauma hospitals. We're
11 designated as these hospitals, we have to do
12 this. This is the black hole that we really
13 have.
14 And that's where those
15 addresses come from, is people just looking
16 out there, where in Virginia can we get
17 information? But there is no requirement
18 specifically for any information.
19 The hospitals get certain
20 information. Some of the rehabs provide
21 information. The nursing care facilities
22 provide information to Medicare. There are
23 some insurance companies that get -- but
24 it's like a jumble of crap everywhere that
25 doesn't talk to anybody and nothing. So the

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1 question is, these -- this patient that
2 comes to here and goes to one of these
3 places, if we're ultimately going to say
4 that all these places -- if they've been
5 involved with somebody here, we want them to
6 provide us with 'x' when that patient leaves
7 their facility.
8 So that we can then go back
9 and plug this information into that patient
10 to be able to say, guess what? 50% of
11 people who go to this and this, if they go
12 here and they get 'x', they do better and
13 become less a burden to society for the
14 finance people.
15 And have a greater quality of
16 life for the touchy-feely side of the world
17 or whatever it is we're trying to prove,
18 right? That -- that's what we want to be
19 able to do.
20 And in this day and age, like
21 I said, when Amazon knows which package is
22 70,000 miles away, I don't know why we can't
23 do this yet, but we can't. It's because it
24 requires money.
25

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1 DR. DILLARD: Well, it also is
2 HIPAA and --
3
4 COMMITTEE MEMBER: Yeah.
5
6 DR. GRIFFEN: I know.
7
8 COMMITTEE MEMBER: That's true.
9
10 DR. DILLARD: Jeff Bezos doesn't
11 have to play by those --
12
13 DR. GRIFFEN: Well, I know. He
14 doesn't have state taxes, either. So we can
15 start on that.
16
17 MS. KATZMAN: This is Lisa, again.
18 One of the other things, too, that needs to
19 be reported is when a patient discharges
20 from the acute care, how long does it take
21 them at home -- how many days lapse before
22 the home health agency comes in? Or how
23 many days does lapse -- does it lapse before
24 they are in to outpatient? Because that can
25 affect their --

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1 DR. GRIFFEN: So you mean for those
2 who go home?
3
4 MS. KATZMAN: Uh-huh. If they have
5 home health services, or if they go home and
6 have outpatient that -- how many days does
7 it take for -- for them to receive those
8 services?
9
10 COMMITTEE MEMBER: There have been
11 studies that -- where a discharge, say with
12 strokes. And like 50% discovered those
13 services.
14 For the stroke, we have -- and
15 I'm sure there's probably a lot of folks who
16 are prescribed, you know, for outpatient --
17 or services --
18
19 DR. GRIFFEN: And it never happens.
20
21 COMMITTEE MEMBER: Right.
22
23 MS. KATZMAN: But that can affect
24 their medical --
25

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1 DR. GRIFFEN: So we -- so we need
2 potentially two things. One, with those
3 that get discharged to -- better not write
4 -- no, this one. Better watch myself here.
5 I'm going to write the wrong
6 thing and get in trouble. Do we say that
7 something along the lines of these two where
8 it's a -- some sort of an inpatient type
9 discharge --
10
11 COMMITTEE MEMBER: And --
12
13 DR. GRIFFEN: Do we want
14 different --
15
16 COMMITTEE MEMBER: And LTAC.
17
18 COMMITTEE MEMBER: Oh, LTAC.
19
20 DR. GRIFFEN: Oh, yeah. That's
21 true. So that's the first -- you know, we
22 want different information that someone who
23 goes home. And I have no idea if there are
24 laws for somebody who goes to prison or jail
25 that they have to keep track of.

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1 COMMITTEE MEMBER: Well, I would
2 say they probably need -- I would like more
3 information from all the folks. For the --
4 for the folks that go home, I think we
5 probably need the same information as those
6 who we -- you know, post-discharge.
7 I think there's this pool of
8 information we need from everybody that --
9 for what we're requiring for the facilities
10 to give us, it's got to be -- they're not
11 going to know about half of this stuff that
12 we've listed.
13 They'll have length of stay.
14 They'll have, you know, the services they
15 received while there.
16
17 COMMITTEE MEMBER: Yeah.
18
19 COMMITTEE MEMBER: They'll have the
20 services that they set them up with. But
21 they probably won't know about work. And
22 they probably won't know about school
23 necessarily upon check out at the facility.
24 So I think there's like things we can ask
25 the facility and things that we want to know

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1 from them.
2
3 COMMITTEE MEMBER: Does that mean
4 --
5
6 DR. GRIFFEN: Yeah -- no. And that
7 -- that's what I mean. That -- that's what
8 I want to do is sort of -- because by making
9 this clear for us, then when we look at
10 these places that we've got all these
11 addresses for, it's a question of is the
12 data even in there that they want to -- you
13 know, that we want that we think is going to
14 be important or not.
15 And then, if we find places
16 that -- oh, this has the data. Can we do
17 our own little test to see if we can
18 actually find some things out about patients
19 and say, hey, this one's sort of -- sort of
20 not re-inventing the wheel.
21 Hey, these guys do it really
22 well. It has all the information. It's
23 voluntary. It's not something required, but
24 maybe we can borrow their -- what they do
25 and use that to create what we ultimately

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1 want to require from places.
2
3 DR. DILLARD: And just to throw
4 another wrinkle in there, there's a fair
5 amount of people that may -- who knows, who
6 are injured traveling on 95 who end up in
7 acute care at VCU. And then --
8
9 DR. GRIFFEN: Go to another state.
10
11 DR. DILLARD: Go wherever they're
12 going.
13
14 DR. GRIFFEN: Right.
15
16 DR. DILLARD: And so --
17
18 DR. GRIFFEN: Some of that we're
19 going to -- we have the same problem. But
20 --
21
22 MR. GIEBFRIED: This is Jim. With
23 phone therapy, there is a certain time span
24 that the individual is supposed to be seen
25 within 48 hours. Also, there's the OASIS,

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1 which is the Medicare requirement that you
2 have to fill out in order to obtain it. But
3 you'll indicate where the person was, why
4 they came, their diagnoses, will indicate
5 whether they had skin breakdowns, will
6 indicate medications that they were on.
7 There's a whole list of things
8 that will be there. And then during the
9 process that a person's under Medicare for
10 the 60 days before re-certification.
11 The -- when the
12 re-certification comes, you -- again -- have
13 to go through almost a full OASIS again and
14 get that information -- get the updates so
15 you have some information of how a patient
16 is progressing.
17 Whether it's a reduction in
18 medications, whether the skin ulcers have
19 changed. And then you have the status
20 functional test scores that are in there as
21 well. And you see the difference in the --
22 in the scores.
23
24 MS. CARTER-SMITH: That's -- that's
25 what I wanted to add. This is Lauren. So

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1 on top of this Glasgow coma scale, rancho,
2 global level function, we also need a
3 physical level of function. Because then
4 that's going to help, you know, refer to did
5 we decrease the burden of care.
6 You know, what is their
7 ability to return to work? So I also think
8 that, you know, whatever that looks like --
9 whether it's FIN scores --
10
11 COMMITTEE MEMBER: Yeah.
12
13 MS. CARTER-SMITH: -- but it will
14 -- and that's something.
15
16 DR. GRIFFEN: Yeah, I was figuring
17 out which one we think is the best one, you
18 know, kind of thing that's consistently
19 across agencies.
20 They -- you know, it's like --
21 and we don't want to invent a whole new
22 scale, and everybody's going, oh, God, yet
23 another one. No. We do this routinely.
24 This is routinely documented in there.
25 Because then if they have some crackerjack

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1 person at their facility that can dump this
2 stuff into a data sheet that they can then
3 -- if we can make it as simple as possible
4 for them to create a reporting data process
5 to give us the information.
6 That's going to make it much
7 more palatable for these places when we try
8 to push this.
9
10 MS. MCDONNELL: Well, and that --
11 this is -- this is Anne. And I think that,
12 you know, to some extent starting with the
13 end in mind can be very helpful.
14 What is it that we want --
15 what is it that we want to know about these
16 trauma patients after they leave post-acute.
17 What is it that we want to know?
18 Are they -- is their situation
19 improving or is it getting worse? You know,
20 so if it's improving, it's going to be
21 things like did -- were they able to go back
22 to work.
23
24 COMMITTEE MEMBER: Right.
25

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1 MS. MCDONNELL: Were they able to
2 drive. If it's getting worse, has the
3 burden of care increased? Are they now
4 require -- so you know, we can come up with
5 this great big old lost list of
6 possibilities.
7 But we need to -- we need to
8 know what it is we want to know so that we
9 can really drill down on the things.
10 Because we can't come at it with a list of
11 15 things that we need them to report
12 because that's not going to happen. They'll
13 buck and --
14
15 COMMITTEE MEMBER: Some of it's
16 reportable data, anyway.
17
18 DR. GRIFFEN: That's the thing.
19 Some of it -- Heather, sorry.
20
21 DR. ASTHAGIRI: So I guess in
22 October, there -- CMS is trying to get the
23 LTAC's, SNF's and the IRF's to kind of, I
24 guess, have functional measures. So just
25 speak of FIN. But now they're doing this

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1 IRF pie. It's a care tool.
2
3 DR. DILLARD: Care tool.
4
5 DR. ASTHAGIRI: Care tool, thank
6 you. And so then there's -- there are
7 overlaps like bladder function, physical
8 function that will be similar -- at least,
9 some aspects that may be similar across the
10 three types of facilities.
11 We could just look at that and
12 maybe ask them, you know, what -- what they
13 have. Because I think --
14
15 DR. GRIFFEN: So this is something
16 CMS is going to require all SNF's --
17
18 DR. ASTHAGIRI: In October.
19
20 DR. GRIFFEN: -- all IRF's and all
21 LTAC's to report back to them about only
22 Medicare patients or all patients?
23
24 MR. GIEBFRIED: Only Medicare
25 patients.

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1 COMMITTEE MEMBER: But I think that
2 most facilities do it. Hard to say no to --
3
4 COMMITTEE MEMBER: Our -- our --
5 yeah. Our facility does all.
6
7 DR. GRIFFEN: So that's the thing.
8 It's just the only ones you're going to
9 report as of October when they make -- the
10 federal government makes it a requirement,
11 the only ones you're going to report are the
12 Medicare ones. But --
13
14 COMMITTEE MEMBER: But then you
15 probably report for everyone. And I think
16 part of that, especially when you're --
17
18 DR. GRIFFEN: Okay.
19
20 COMMITTEE MEMBER: -- is that if
21 people switch over to Medicare or something
22 while they're there, they want to make sure
23 they got everything there --
24
25 DR. GRIFFEN: Right.

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1 COMMITTEE MEMBER: -- because
2 Medicare will deny payment if there's
3 anything that's --
4
5 DR. GRIFFEN: So that may get the
6 adults, but it won't get the peds. Does
7 peds have any --
8
9 DR. DILLARD: There's a WeeFIM that
10 is a similar cousin of the --
11
12 DR. GRIFFEN: W-I-F-M?
13
14 DR. DILLARD: Yeah. W-E-E-F-I-M.
15 And we -- we have been trying to institute
16 that for about the last eight months, this
17 ability.
18
19 DR. GRIFFEN: Just for the -- for
20 any facility where a kid goes to?
21
22 DR. DILLARD: Well, the only
23 facility in the State to go to --
24
25 DR. GRIFFEN: Rehab.

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1 DR. DILLARD: -- is -- is for when
2 they only -- the CHKD, I'm sorry. Dillard,
3 CHKD from Norfolk. We're the only one in
4 the State. VCU will have kids that are 12
5 and above. But anybody below that comes to
6 --
7
8 DR. GRIFFEN: And what --
9
10 DR. DILLARD: -- CHKD.
11
12 DR. GRIFFEN: And what would you do
13 for a 12 and above? Would you just do the
14 --
15
16 DR. DILLARD: They would --
17
18 COMMITTEE MEMBER: Everybody --
19
20 DR. DILLARD: It would -- it would
21 still follow that -- even though they're not
22 Medicare, they would --
23
24 DR. GRIFFEN: No, no. That you
25 would do this.

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1 DR. DILLARD: Yes.
2
3 DR. GRIFFEN: 13, 14, 15, you would
4 do a care tool, not this WeeFIM.
5
6 DR. DILLARD: Yes.
7
8 DR. GRIFFEN: Okay. All right.
9
10 DR. DILLARD: Yeah.
11
12 DR. GRIFFEN: But we would have
13 something. There would be a -- some sort of
14 a discharge tool on this.
15
16 COMMITTEE MEMBER: Yes.
17
18 DR. GRIFFEN: So I guess maybe it's
19 a question of looking at what this care tool
20 encompasses to see whether we think that's
21 going to provide us with the information
22 that we want. And you know, that's the
23 other thing. We could potentially piggyback
24 on this. The -- that's going to be the
25 easiest and the most palatable for these

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1 institutions is going to be -- if we say,
2 look, you already have to do this for the
3 federal government. So we want you to do
4 the same thing and report it to the State
5 for all your patients as well.
6 And if they really are going
7 to require it from LTAC's, SNF's and IRF's,
8 then we're -- I mean, that -- that's huge.
9 That would be huge for us.
10 The question then is we would
11 have to figure out -- and that's, again, not
12 going to be necessarily for us to do, but
13 something that we would recommend to help
14 give the data people the enforcement to say
15 this is -- you now have to have it within
16 your track of patients.
17 Because somehow in the federal
18 government, they're looking -- they're not
19 getting that data just to get the data.
20 They're probably linking it to the patient
21 from acute care, don't you think or do you
22 know?
23
24 COMMITTEE MEMBER: I don't know.
25

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1 DR. GRIFFEN: Because that's the
2 other thing. If they're not at a federal
3 government level -- if they're just getting
4 general data from these facilities to see
5 what they do and not linking it to the
6 patient -- the Medicare patient that was in
7 the hospital somewhere, then they actually
8 --
9
10 DR. DILLARD: Well --
11
12 DR. GRIFFEN: They don't know.
13
14 DR. DILLARD: And another issue is
15 when they come into acute care, a lot of
16 times they have a trauma number. And then
17 when they come under rehab, they have a
18 name. They have their real name.
19
20 DR. GRIFFEN: Right.
21
22 DR. DILLARD: Sometimes there's --
23 there's a lot of --
24
25 DR. GRIFFEN: Right. The insurance

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1 or the Medicare -- that -- that's going to
2 be one of the hardest parts. And I -- I --
3 that's not something we're going to solve.
4 That's something really that the data team
5 is going to have to go after is linking.
6
7 MS. CARTER-SMITH: So this is
8 Lauren. So what I -- you know, I did some
9 interviews. I like to find out where the
10 data houses. And I spoke to people who like
11 did the satisfaction surveys, post-acute
12 care, post facilities.
13 But yes, the theme was that
14 they -- there is no -- and they don't know
15 if they're a trauma patient that there's no
16 identifier. They just ask these, you know,
17 very strategic questions.
18 And they're willing to, you
19 know, talk about, you know, adding a patient
20 identifier as well as what we want to know.
21 But they currently don't have that in place
22 or a way to track that. But with this --
23 with these patient satisfaction surveys,
24 they're going to -- could get this
25 information if we provided them --

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1 DR. GRIFFEN: There's just got to
2 be an easier way to do this. I just don't
3 --
4
5 COMMITTEE MEMBER: It's like a
6 daunting --
7
8 DR. DILLARD: Build a time machine
9 and go back.
10
11 DR. GRIFFEN: I mean, it just seems
12 so silly.
13
14 COMMITTEE MEMBER: You're right. I
15 think we can get a sampling. I don't know
16 how we can get everybody.
17
18 DR. GRIFFEN: It just seems so
19 crazy. It's like we -- and then everybody
20 believes they're doing all the right things.
21 We don't even know what we're doing yet.
22 Okay. So -- yeah. Okay. So
23 the bottom line is we -- we've got a lot of
24 ideas about what we would want. The
25 question is, I guess, pulling out this care

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1 tool. And then you have a copy of this
2 WeeFIM as well and what it -- what it
3 contains.
4 So we can get a copy of the
5 care tool and what it contains and the
6 WeeFIM and what it contains, so that we can
7 get everybody to be able to look at those
8 things and see what items are in those
9 various things.
10 And then we can decide whether
11 we think that that's enough, not enough, I
12 don't know. You don't have -- you can't
13 make copies, can you, Wanda, right here?
14
15 MS. STREET: I may be able to. I
16 may have to -- yeah.
17
18 DR. GRIFFEN: Okay. If anybody has
19 -- or if somebody has the -- the -- those
20 things, I can -- you can either email them
21 to me and I'll email them to everybody.
22
23 MS. KATZMAN: I think I can get
24 those free.
25

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1 DR. GRIFFEN: Okay.
2
3 MS. KATZMAN: This is Lisa.
4
5 DR. GRIFFEN: Yeah. That would be
6 great. And then -- because then I think we
7 can all look at that and have -- I just -- I
8 just don't know the answer to linking all of
9 this stuff, I'll be honest with you.
10 That's -- that's part of my
11 lack of knowledge with regards to what this
12 is all to do.
13
14 COMMITTEE MEMBER: I don't know if
15 anybody's interested. I have the -- what
16 they're asking for as far as documentation
17 from SNF, LTAC and IRF.
18
19 DR. GRIFFEN: That'd be great.
20
21 COMMITTEE MEMBER: -- as a slide.
22
23 DR. GRIFFEN: Can we project up
24 here? Where's the doohickey? Oh, wait.
25

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1 COMMITTEE MEMBER: I didn't think
2 you wanted to.
3
4 DR. GRIFFEN: No idea what I'm
5 doing. But we're going to try this.
6
7 COMMITTEE MEMBER: Just past Suter,
8 left, up, around.
9
10 COMMITTEE MEMBER: I just need two
11 EMS's.
12
13 DR. GRIFFEN: Well, I think I've
14 seen like actual stuff.
15
16 MS. STREET: It's coming, yeah.
17
18 COMMITTEE MEMBER: Maybe I should
19 just email this to you. Do you have --
20
21 DR. GRIFFEN: Yeah, email it to me.
22 And I can -- I've got my look-up for my
23 computer. And I can try --
24
25 MS. STREET: There it is. It's up

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1 there.
2
3 DR. GRIFFEN: If you'd just send it
4 -- but sent it to this one. Send it to mgri
5 -- yeah, because I don't have -- I'm not on
6 that work thingie here.
7
8 COMMITTEE MEMBER: Mg --
9
10 DR. GRIFFEN: Mgriff, L as in
11 little, B as in bit @gmail.com.
12
13 COMMITTEE MEMBER: I'm sorry. Say
14 it again.
15
16 DR. GRIFFEN: Mgriff, L as in
17 little, B as in bit @gmail -- most of the
18 stuff I'll get at work, but --
19
20 COMMITTEE MEMBER: Maggie, you just
21 put your personal email out there for the
22 entire State of Virginia to have access --
23
24 DR. GRIFFEN: Sorry.
25

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1 (Several committee members began talking all
2 at once.)
3
4 DR. GRIFFEN: Good luck with that
5 one. You and a thousand other silly emails
6 that I -- yeah, it's amazing. If I get one
7 more call about my student loans.
8 My 90-year-old father gets the
9 phone calls about his student loans, and
10 then we laugh. It's like, really? It's
11 going to bounce off a thousand things.
12
13 COMMITTEE MEMBER: There are hot
14 pretzels out there.
15
16 DR. GRIFFEN: Oh, that's what you
17 went for. Did you know?
18
19 COMMITTEE MEMBER: It was a phone
20 call about my car insurance that took me
21 outside of the room.
22
23 COMMITTEE MEMBER: For a hot
24 pretzel?
25

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1 COMMITTEE MEMBER: I had a call.
2
3 COMMITTEE MEMBER: Tried to send it
4 to you from my work email and that didn't
5 work very well. Is it mgriffbl?
6
7 DR. GRIFFEN: L-B.
8
9 COMMITTEE MEMBER: L-B, okay.
10
11 DR. GRIFFEN: Little bit.
12
13 COMMITTEE MEMBER: Okay.
14
15 DR. GRIFFEN: Two and a half pint
16 Chihuahua with a lot of attitude. I don't
17 know if it's going to let us do this or not,
18 but we'll see.
19
20 COMMITTEE MEMBER: Okay. I think
21 we may be able to continue on with the
22 talking about what we would require from --
23
24 COMMITTEE MEMBER: So the care
25 discharge tool is 25 pages long.

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1 COMMITTEE MEMBER: Yes, it is.
2
3 DR. GRIFFEN: 25 pages?
4
5 COMMITTEE MEMBER: Yep.
6
7 DR. GRIFFEN: That sounds bad.
8
9 COMMITTEE MEMBER: What's 25 pages?
10
11 COMMITTEE MEMBER: The care tool
12 discharge document. Current medical
13 information, allergies, adverse drug
14 reactions, skin integrity, number of major
15 wounds, physiologic factors, cognitive
16 status, mood, pain.
17 The whole -- and then bowel,
18 bladder, impairments swallowing, impairments
19 hearing, vision, communication. Grip
20 strength, endurance, mobility devices and
21 aids.
22
23 COMMITTEE MEMBER: So at the -- at
24 the -- they just collect so much data on
25 these patients --

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1 COMMITTEE MEMBER: Yeah. But there
2 is some subsets that they're not going to
3 have that, you know, all the facilities will
4 do this --
5
6 COMMITTEE MEMBER: This gets down
7 to the ability to make her answer or place a
8 phone call.
9
10 DR. GRIFFEN: We'll see if this is
11 going to work. I don't know if it's going
12 to work or not. Right. So what you have is
13 like just -- what you're saying is just like
14 a snapshot, right? Is that what --
15
16 COMMITTEE MEMBER: Yeah, it's just
17 a little --
18
19 DR. GRIFFEN: Yeah, I don't know if
20 it's going to work or not. I mean, I
21 switched it over to my thing. But it's not
22 going to -- it keeps telling me that there's
23 no input. I don't know how to hook into
24 this thing. Huh? I know. And I don't know
25 what --

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1 (A committee member is speaking, but she is
2 beyond the mic's ability to pick her up clearly.)
3
4 DR. GRIFFEN: See if that makes a
5 difference. In the mean -- okay. Let me
6 see. In the meantime -- let's see. It says
7 you'll have signal. I don't know that it's
8 going to work. Okay.
9 So the bottom line is -- it's
10 not that one. If we want to -- if we --
11 regardless of what this post -- this therapy
12 or one of the rancho level is. If we want
13 to decide what we think and clarify that.
14 It may only be a portion of
15 the 25 pages that they're going to give us,
16 obviously. But if the components that we
17 want are all in there, then --
18
19 COMMITTEE MEMBER: Right.
20
21 DR. GRIFFEN: -- that -- that's
22 fine. And if there's a way that those 10
23 components we can pull from there and they
24 can get it to where it's, you know, the kind
25 of thing that's downloaded into a file that

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1 they send to the State or whatever, then
2 that's okay. So -- so that's good. All
3 right. So all these things then -- and so
4 we're going to say that we need to have two
5 separate things.
6 We need to have the rehab and
7 the SNF and the LTAC as one sort of area
8 that we need information from. So sort of a
9 inpatient-y kind of a thing. And then we've
10 got to have an outpatient component.
11 And then we've got to have the
12 other places. And then within this, we have
13 to have peds and adult. And same here, we
14 need peds and adult really for everywhere.
15 Not so much jail, hopefully.
16
17 COMMITTEE MEMBER: Juvenile
18 detention.
19
20 DR. GRIFFEN: Okay.
21
22 MR. SIZEMORE: Maggie, this is
23 Macon. One of the things I still try to
24 wrap my head around is the data system
25 improvement with this. How do we capture

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1 the trauma? What diagnoses, what conditions
2 will trigger -- do you want to track all of
3 this? Because we --
4
5 COMMITTEE MEMBER: Yeah, it's --
6
7 MR. SIZEMORE: -- we're looking at
8 something very broad. And I don't -- how do
9 you just ask that we want this on trauma and
10 not other conceivable --
11
12 MS. GARRETT: So this is Renee.
13 Defining what trauma is?
14
15 MR. SIZEMORE: Right.
16
17 DR. GRIFFEN: So do we say that
18 it's anyone contained in a registry? In a
19 trauma registry. I mean, that -- that's
20 going to give you -- I mean, the thing about
21 Virginia is that there's a whole bunch of
22 trauma patients that get in the registry
23 that a trauma team never sees. But it
24 doesn't mean it's any less, you know,
25 because that whole component of that is the

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1 elderly falls and breaks her hip. Which we
2 never take care of on our team. They're
3 always on the medicine team or the
4 orthopedic consultation.
5 But would we see that as a
6 major component of the population that we
7 ought to know what the heck happens to them.
8 Yeah, I would think that we all think that's
9 a component of the population that we ought
10 to have some say on. So --
11
12 COMMITTEE MEMBER: What about the
13 ICU 10 codes that --
14
15 DR. GRIFFEN: And that's what the
16 registry uses.
17
18 COMMITTEE MEMBER: I mean, I know
19 there's --
20
21 COMMITTEE MEMBER: There's 300 at
22 least for brain injury alone. So...
23
24 DR. GRIFFEN: Well that -- and that
25 -- that's -- but that's what the trauma

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1 registries use to define the trauma patient
2 is they -- anybody who fits within a certain
3 ICD-10 code is put in the registry. If
4 they're outside that ICD-10, they don't go
5 in the registry.
6 If they don't meet one of
7 those, they don't go in the registry. I get
8 it. It's you know, thousands of patients a
9 year that this is going to equate to. But
10 -- so we could say that we want to identify
11 the population by saying it's anybody in the
12 trauma registry.
13 The -- the question is then,
14 when they go to the nursing home or they go
15 to the rehab and they go to whatever, it's
16 probably more likely at the rehab they're
17 going to know that they were a trauma
18 patient.
19 At the nursing home, they may
20 have no idea what was their inpatient
21 hospitalization for.
22
23 COMMITTEE MEMBER: And there's a
24 ton of people that are brought in and
25 monitored for a few days and then sent home

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1 that are going to fall outside of all the --
2 you know, the bundling of the LTAC's, the
3 inpatient rehabs and --
4
5 DR. GRIFFEN: Well, that's what I
6 mean.
7
8 COMMITTEE MEMBER: Yeah.
9
10 DR. GRIFFEN: Those would be our
11 outpatient people. And the only -- so we
12 would then have to recognize -- we'd have to
13 -- you know, as it is now from a registry,
14 you can run a report and have who gets
15 discharged home and who gets discharged to a
16 facility.
17 I can get my people to run
18 that in a day. That's easy. Give me, for
19 the last year, everybody that got discharged
20 home.
21 The issue then is I have to be
22 able to go, okay, they got discharged home
23 with services. And then I got to be able to
24 go into something and say, okay, these
25 people with these injuries got this service.

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1 And they did this. These people got injury
2 with this service and didn't get any. Well,
3 guess what? If they get these services,
4 they do better kind of -- you know, that --
5 that's the thing.
6 So if you're saying defining
7 the trauma patient, do we say it's everybody
8 who's in a trauma registry across the State
9 of Virginia. I -- I don't know another way
10 --
11
12 COMMITTEE MEMBER: It's starting --
13
14 DR. GRIFFEN: I don't know another
15 way to define the population.
16
17 COMMITTEE MEMBER: I think you got
18 to start somewhere, and that's as good a
19 place as any.
20
21 DR. GRIFFEN: Okay. So that's a --
22 so we are the -- we -- we feel like the
23 population should be defined as any patient
24 in -- in a registry. And then, obviously,
25 that's going to give the acute care -- like

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1 I said, they're going to retroactively go
2 through how do they get it to EMS and all.
3 And then -- which is going to be -- I mean,
4 that's easily -- I mean, the five Level I --
5 between the five Level I's, it's 12,000 or
6 13,000 patients right there.
7 That's just the five Level I's
8 will be 12,000 or 13,000 patients a year.
9 So with all the Level II's and III's
10 involved, you know, you're going to talk --
11 25,000 or 30,000 patients a year.
12 But think about the
13 opportunities if we had 30,000 patients a
14 year that we could follow how they
15 recovered. What -- what sort of grounds we
16 could make and improvements we could make in
17 efficiency and effectiveness of services.
18
19 COMMITTEE MEMBER: Right.
20
21 MS. MCDONNELL: This is Anne. And
22 it maybe that, you know, beginning that
23 30,000 patient list when you add in all of
24 the hospitals, that you start with a -- with
25 a group that we feel like we might be able

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1 to track. You know, someone with a spinal
2 cord injury, for example. But we start
3 small and we see sort of how it works and --
4 and take what we learn and then grow it.
5 You know, if we wanted to
6 start with major trauma, you know -- I mean,
7 it's all pretty major. Just eating the
8 apple a bite at a time.
9 Getting our brain wrapped
10 around where it all comes from, how we use
11 it. And then taking what we learn and
12 expanding it to the rest of -- of all of the
13 patients.
14
15 DR. GRIFFEN: Well, exact -- and
16 that may be a way of starting down a pathway
17 for -- and looking at the consumer -- what
18 you were talking about --
19
20 MS. MCDONNELL: Mm-hmm.
21
22 DR. GRIFFEN: -- the consumer-wise.
23
24 MS. MCDONNELL: Mm-hmm.
25

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1 DR. GRIFFEN: If you look at the
2 spinal cord injury or the traumatic brain
3 injury patient --
4
5 MS. MCDONNELL: Well, what I'm
6 thinking is that there's almost -- there are
7 so few spinal cord injury patients that
8 would not have extensive medical follow up.
9 But there are a lot of brain injury patients
10 who don't get that at all.
11
12 DR. GRIFFEN: Well, I know.
13
14 MS. MCDONNELL: You know, I mean
15 the modern --
16
17 DR. GRIFFEN: The modern brain
18 injury is the --
19
20 MS. MCDONNELL: Right.
21
22 DR. GRIFFEN: -- black hole of the
23 world right now --
24
25 MS. MCDONNELL: Yeah.

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1 DR. GRIFFEN: -- as far as I'm
2 concerned.
3
4 MS. MCDONNELL: Yeah. And even
5 moderate to some extent. But you know,
6 spinal cord injury patients might be, you
7 know, a group that would be, you know, maybe
8 easier.
9 And I know that VCU and
10 Sheltering Arms -- as a part of this joint
11 institute -- are going to create a model
12 systems program. So there's getting ready
13 to be a spinal cord injury registry set up
14 here in Virginia. We already --
15
16 DR. GRIFFEN: For anybody in the
17 state?
18
19 MS. MCDONNELL: For -- for anybody
20 that's reported to the trauma registry with
21 an ICD-9 code related to spinal cord injury.
22
23 DR. GRIFFEN: Mm-hmm.
24
25 MS. MCDONNELL: We already have

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1 that for brain injury. And we do outreach
2 to those. So each year we get, you know,
3 thousands of letters sent out. And we get,
4 you know, a number of calls back from people
5 who've been reported to a trauma registry.
6 We have information on a
7 couple hundred of them every year, what
8 their long term needs are, you know. But
9 spinal cord is just getting ready to sort of
10 be, you know, developed.
11 And that may present an
12 opportunity. There are researchers at VCU
13 who are working on this right now. Getting
14 the spinal cord injury registry up and
15 running.
16
17 DR. GRIFFEN: Yeah. I know. It's
18 just a huge -- every time I have
19 conversations about this, it just gets
20 bigger in my brain and hurts it more.
21 That -- that's the problem.
22 It's -- because you want to be able to have
23 -- I mean, we want -- the thing is we want
24 it to be global so everyone's included. And
25 there are going to be portions of it that

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1 are going to be more study than others.
2 There's no way around it. Because of the
3 burden to society as a whole, and the
4 quality of life for the patient.
5 There's going to be groups of
6 individuals that when we can get this data,
7 we're going to be more intensely wanting to
8 look at.
9 Like what does work for the
10 brain injured patient, what does work for
11 the spinal cord injured patient, what does
12 work for the elderly, you know, whatever.
13 There's going to be areas that
14 are going to certainly be more focused on.
15 But the idea is so that we get -- can catch
16 everybody. So that we can do really a
17 global quality review of our trauma system
18 as a whole.
19 Are we -- do we really think
20 we're doing -- are we really doing as well
21 as we think we are when we're taking care of
22 these patients when they're getting picked
23 up. Is there something that happens in EMS
24 that impacts their recovery? Is there
25 something we do in the acute care that harms

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1 them in their recovery or helps them in
2 their recovery? In order to -- as
3 efficiently and as effectively put resources
4 where they need to be. I mean, that --
5 that's really the long term goal.
6
7 COMMITTEE MEMBER: Right.
8
9 DR. GRIFFEN: So it's a question of
10 trying to figure out -- if we look at this
11 care tool and this WeeFIM and we pull out --
12 or we decide what we want and look in these
13 tools, and everything that we want is there,
14 then that may help us a lot with this long
15 term idea.
16 We're not going to be asking
17 any more of them that what CMS is starting
18 to ask of them. And how can we parlay that
19 into us getting what we want with the least
20 amount of cost to the facilities.
21 And thus, that'll be the least
22 amount of pain and agony for all of us. So
23 I guess the question is, of these things
24 that we've written up here, truly which --
25 which are -- we -- when -- when someone's

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1 leaving discharge to try to figure out how
2 we want them to be, or what -- what we need
3 to know in order to do a full quality
4 assessment.
5 Just for the -- just doing
6 inpatient, not the outpatient stuff yet and
7 that kind of thing. Is it important that we
8 know how long they stayed at that facility?
9 I think we would all agree
10 that's important because it's going to be a
11 measure, I suspect, of the -- the degree of
12 their injuries. Although payor-wise --
13
14 COMMITTEE MEMBER: This says where
15 the --
16
17 DR. GRIFFEN: Right. This is the
18 thing. And I only know this because Macon
19 and I spend a lot of time listening to a lot
20 of people talk to us.
21 The rehabs are going to turn
22 them over pretty fast. They're going to
23 want to get them out so they can get the
24 next patient in. My understanding is that's
25 not so much the goal here. Am I wrong?

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1 COMMITTEE MEMBER: Well, there's so
2 many --
3
4 COMMITTEE MEMBER: It's the --
5
6 COMMITTEE MEMBER: I agree.
7
8 COMMITTEE MEMBER: Number of days
9 covered for Medicare patients, so they can
10 -- the standard Medicare, they have 20 days.
11
12 DR. GRIFFEN: In a rehab?
13
14 COMMITTEE MEMBER: In a
15 [unintelligible].
16
17 DR. GRIFFEN: That's -- but if
18 they're ready to go in 10 days, my
19 understanding is they make keep them 10
20 more.
21
22 COMMITTEE MEMBER: Potentially.
23 But I think with a lot of the -- I don't
24 know. There's a push content.
25

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1 COMMITTEE MEMBER: That's right.
2
3 COMMITTEE MEMBER: Think about the
4 -- the ends.
5
6 DR. GRIFFEN: No, and I get that.
7 And I think that -- so, again --
8
9 COMMITTEE MEMBER: The pace is
10 definitely slower at a SNF. There's less
11 intensity of services, so --
12
13 DR. GRIFFEN: Well -- and some of
14 it may be the pace is slower because the
15 patients aren't as well and they can't
16 tolerate the rehab. So they need it for a
17 longer period of time.
18
19 COMMITTEE MEMBER: Correct.
20
21 DR. GRIFFEN: But again, it may
22 highlight abuses of a system that isn't
23 perfect as well in the process of all this.
24
25 COMMITTEE MEMBER: Well -- and you

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1 -- you may have an insurance -- patient with
2 insurance and they're pushing to get them
3 out when sometimes they're not appropriate
4 yet to --
5
6 DR. GRIFFEN: To leave.
7
8 COMMITTEE MEMBER: -- so you have
9 that side.
10
11 COMMITTEE MEMBER: Well, that
12 happens in rehab all the time.
13
14 COMMITTEE MEMBER: We know.
15
16 COMMITTEE MEMBER: And that's --
17 but they get bumped down oftentimes to -- to
18 a --
19
20 COMMITTEE MEMBER: Right.
21
22 COMMITTEE MEMBER: Yeah.
23
24 DR. GRIFFEN: Okay. So length of
25 stay is definitely something we want.

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1 Discharge status. So let's define that a
2 little more. We want to know -- I mean, not
3 everybody gets discharged home, right? Some
4 of them get discharged to a SNF or some from
5 the SNF on -- very rarely get discharged to
6 an acute rehab, I guess.
7
8 COMMITTEE MEMBER: So discharge
9 disposition. Where are they going?
10
11 DR. GRIFFEN: Okay.
12
13 COMMITTEE MEMBER: Yeah. And --
14 and then there would need to be some sort of
15 measure about the request working with the
16 payor, you know. What that is I'm not sure,
17 but how much support do they get?
18 Are they getting home health
19 and are they getting, you know, eight hours
20 of -- you know, not exactly sure how to word
21 that.
22
23 DR. GRIFFEN: And I've learned more
24 about home health and all that in the last
25 two weeks than I ever care to learn in my

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1 life. All right, length of stay is enough.
2 Discharge disposition --
3
4 COMMITTEE MEMBER: Mm-hmm.
5
6 DR. GRIFFEN: -- is definitely
7 something we want.
8
9 COMMITTEE MEMBER: Well -- and
10 level of functioning may take care of
11 further care, you know --
12
13 COMMITTEE MEMBER: Well certainly
14 -- it wouldn't necessarily trigger -- be a
15 trigger.
16
17 DR. GRIFFEN: So we're at discharge
18 disposition and then if it's home, we want
19 to know services. Is that -- or should we
20 just say discharge disposition and then with
21 or without services. Do we care what
22 services or we just want to know with or
23 without continued --
24
25 MS. KATZMAN: No.

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1 DR. GRIFFEN: -- service?
2
3 MS. KATZMAN: Type of services are
4 important.
5
6 DR. GRIFFEN: Okay.
7
8 MS. KATZMAN: I'm sorry speaking
9 for myself This is Lisa.
10
11 DR. GRIFFEN: No, no. That's --
12 this is the whole point of this. It's for
13 everybody to say what they think. And then
14 we can decide as a team sort of what we
15 want.
16 Okay. We also have under
17 discharge status, plan continuum of care.
18 Does that answer all those questions? DC,
19 disposition and if home, type of service.
20 Is that good?
21
22 COMMITTEE MEMBER: That's good.
23
24 DR. GRIFFEN: Okay.
25

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1 MR. GIEBFRIED: This is -- this is
2 Jim. It misses the equipment that needs to
3 go with that patient, so that they are
4 functional or that family members or
5 whatever team goes in can do the services as
6 quickly as possible.
7
8 COMMITTEE MEMBER: DME --
9
10 COMMITTEE MEMBER: DME sort of
11 speaks to that.
12
13 DR. GRIFFEN: I get -- we could say
14 DME's.
15
16 COMMITTEE MEMBER: Right. Durable
17 medical equipment, yeah. But functional
18 care stuff would speak to, you know, would
19 include if they need a bath chair, you know,
20 or a walker for ambulation --
21
22 DR. GRIFFEN: So if we said global
23 functional level on discharge, we should
24 then be able to get --
25

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1 COMMITTEE MEMBER: Hopefully, it
2 would --
3
4 COMMITTEE MEMBER: Yes.
5
6 DR. GRIFFEN: It would give us an
7 idea of what DME's.
8
9 COMMITTEE MEMBER: Right.
10
11 DR. GRIFFEN: Okay. So --
12
13 MR. GIEBFRIED: It may be discharge
14 -- this is Jim again. It may be using
15 something in the facility, but it may not
16 readily be at home. Or they need it --
17 whether it's a hospital bed, whether it's a
18 wheelchair.
19 They may have been using that
20 in the facility, but they may not have one
21 delivered at the appropriate time when that
22 person's going to be home. Or all of it.
23 Or whether they --
24
25 DR. GRIFFEN: Well, I think that'll

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1 go to some of this, where we then -- if they
2 are discharged home -- will catch them
3 hopefully then here. And -- and we get into
4 part of this was how long until services
5 were rendered.
6
7 MS. GARRETT: This is Renee, again.
8 Speaking along that same line, discharge
9 diet and if they have a PEG tube or an
10 alternative source of feeding, that would be
11 another --
12
13 DR. GRIFFEN: Does that go with --
14 it might be --
15
16 COMMITTEE MEMBER: Sure.
17
18 DR. GRIFFEN: When you do a global
19 function -- I'm sorry. This is my --
20
21 COMMITTEE MEMBER: It swallows --
22
23 DR. GRIFFEN: -- lack of knowledge.
24 It has their feeding habits, their bathing
25 habits, their --

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1 COMMITTEE MEMBER: Cognitive
2 status.
3
4 COMMITTEE MEMBER: Cognitive, yes.
5
6 COMMITTEE MEMBER: Bowel, bladder,
7 continence.
8
9 DR. GRIFFEN: Okay.
10
11 COMMITTEE MEMBER: Need of
12 equipment.
13
14 COMMITTEE MEMBER: Ambulation.
15
16 COMMITTEE MEMBER: All of that sort
17 of stuff.
18
19 DR. GRIFFEN: Okay. So that's a
20 good -- that is a good way to call it, then.
21 Global functional level, because that should
22 give us cognitive, bowel, bladder, DME, all
23 that stuff.
24
25 COMMITTEE MEMBER: Ambulation,

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1 ability to transfer --
2
3 COMMITTEE MEMBER: Mobility.
4
5 MS. KATZMAN: To -- it's John. I'm
6 sorry, I don't know.
7
8 MR. GIEBFRIED: Jim.
9
10 MS. KATZMAN: Jim. To Jim's point,
11 this is Lisa. The DME is so important
12 because if -- if there's a piece of
13 equipment that the patient's supposed to
14 have and for some reason they don't, that
15 can change their whole, you know --
16
17 COMMITTEE MEMBER: You don't have a
18 wheelchair, you're not getting out of your
19 house.
20
21 MS. KATZMAN: That is true. Or --
22
23 COMMITTEE MEMBER: Or a ramp.
24
25 MS. KATZMAN: -- if you don't have

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1 a walker, you could fall. So you know, all
2 of that is effecting --
3
4 COMMITTEE MEMBER: They shouldn't
5 if they're going to a facility. I think
6 it's -- what she's saying is that if it
7 captured -- it's almost like we have two
8 points for people to go to another facility.
9 Like we want to ask the
10 facility these questions. But then if, you
11 know, for folks that go straight home from
12 acute care and folks that come home from --
13
14 COMMITTEE MEMBER: The post post-
15 acute.
16
17 COMMITTEE MEMBER: Right.
18
19 COMMITTEE MEMBER: We'd be having
20 the same set of questions for those people,
21 right? So --
22
23 DR. GRIFFEN: Yeah, so this is just
24 for those people who go to an inpatient.
25 What is it that we want to know when they're

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1 getting discharged from an inpatient.
2
3 COMMITTEE MEMBER: Okay.
4
5 DR. GRIFFEN: And if global
6 functional level at discharge, if we get --
7 if that's something that most facilities do
8 --
9
10 COMMITTEE MEMBER: They do.
11
12 COMMITTEE MEMBER: Yes.
13
14 COMMITTEE MEMBER: They do.
15
16 DR. GRIFFEN: Right. If that's a
17 requirement, then we should be able to get
18 cognitive, bowel, bladder, DME, mobility --
19 we should be able to parse out that they are
20 going to be getting 'x, y, and z' to go with
21 their cognitive and functional level.
22 Now -- then we then will
23 hopefully pick them up when they get to that
24 outpatient. And we'll do another set of --
25

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1 COMMITTEE MEMBER: Yeah.
2
3 DR. GRIFFEN: -- whatever we want
4 to know from there.
5
6 MS. MCDONNELL: It's -- it's --
7 this is Anne. It's almost like thinking
8 about it points in time. Because you're
9 going to want to know something about, you
10 know, a trauma patient at -- at the end of
11 the inpatient setting.
12 But did you want to know six
13 months, maybe 12 months down the road. So
14 the question's at that point would be very,
15 very different --
16
17 DR. GRIFFEN: Right.
18
19 MS. MCDONNELL: -- than they would
20 be upon -- upon discharge for an inpatient
21 facility.
22
23 DR. GRIFFEN: Right. Yeah. Yeah,
24 and I -- I had a kid come back. He got
25 shot. We sent him home. I don't know where

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1 Tappahannock is.
2
3 COMMITTEE MEMBER: On the --
4
5 DR. GRIFFEN: Somewhere out --
6
7 COMMITTEE MEMBER: -- eastern side
8 of the state.
9
10 DR. GRIFFEN: Somewhere out in
11 nowhere is what I figured out. Because when
12 he came back -- we sent him home with a
13 trach because he shot himself in the mouth.
14 And he comes in to see me in clinic to tell
15 me he can't breathe.
16 I said, you can't breathe. He
17 goes, no, I can't breathe. So home health
18 had never come. Took us forever to even
19 find home health it would seem.
20 So I pulled out his inner
21 cannula, which was full of stuff. Cleaned
22 it out for him, put it back in. He goes,
23 man, I feel much better.
24
25 COMMITTEE MEMBER: He's lucky --

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1 DR. GRIFFEN: He didn't -- the kid
2 didn't -- he didn't die. Cute kid. Anyway.
3 All right. Okay. So that's -- any facility
4 acquired complications, we have that.
5 Do we -- do we want to know
6 that, if there was a -- a -- and I don't
7 know a way to -- I mean, just -- hospitals
8 have to report hospital-acquired events or
9 infections or whatever. I'm presuming
10 there's the same type of thing that you have
11 to --
12
13 COMMITTEE MEMBER: It's part of the
14 care tool, is it not?
15
16 COMMITTEE MEMBER: Yeah.
17
18 COMMITTEE MEMBER: So that should
19 be on there as well.
20
21 DR. GRIFFEN: So what is it -- that
22 a global name? Facility-acquired --
23
24 COMMITTEE MEMBER: So --
25

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1 DR. GRIFFEN: Because I -- yeah, I
2 mean, I can't believe they're --
3
4 COMMITTEE MEMBER: I mean, they
5 have to report like worsening pressure
6 ulcers.
7
8 DR. GRIFFEN: Or -- and the UTI or
9 -- so I would think all of that stuff. Just
10 like we have to do line infections,
11 [unintelligible], all that.
12
13 COMMITTEE MEMBER: Yeah.
14
15 COMMITTEE MEMBER: If you get -- if
16 you get re-admitted to acute care, that's
17 part of it.
18
19 DR. GRIFFEN: Well -- and we said
20 that, re-admit. That we would want to know
21 if someone was re-admitted. So -- I guess
22 trans -- re-admission to acute care. But if
23 there's more of a global term for any -- I
24 guess, facility-based events. I'll just
25 call it that. We'll figure out how to --

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1 COMMITTEE MEMBER: They've got
2 adverse drug reactions, but that's not --
3
4 (A committee member is speaking, but the
5 words are spoken too low to reach the recorder
6 clearly.)
7
8 COMMITTEE MEMBER: Yeah. It's
9 pressure ulcers. They're like --
10
11 DR. GRIFFEN: They don't -- they
12 don't do UTI, pneumonia and all that stuff.
13 You don't have to report any of that?
14
15 COMMITTEE MEMBER: Those are
16 quality indicators that may be not
17 necessarily traced to individual patients.
18
19 DR. GRIFFEN: That's really
20 interesting.
21
22 COMMITTEE MEMBER: In OASIS it's in
23 there. If you go to your GI's within the
24 last 14 days and you're going to discharge
25 somebody within that time period from home

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1 care.

2

3 DR. GRIFFEN: That's at the home

4 care level, though.

5

6 COMMITTEE MEMBER: Right.

7

8 DR. GRIFFEN: Not at the inpatient.

9 It's interesting. So we'll -- we'll want

10 that for -- that's the other thing for this.

11 There's the OASIS and what you can get

12 through that.

13 Okay. Well, I just put

14 facility-based events. So whatever facility

15 -- whatever reported events have to be done.

16

17 COMMITTEE MEMBER: Okay.

18

19 DR. GRIFFEN: The pressure ulcers

20 --

21

22 COMMITTEE MEMBER: Falls.

23

24 DR. GRIFFEN: Falls.

25

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1 COMMITTEE MEMBER: That would be --
2 that would again be included in that one.
3
4 DR. GRIFFEN: So falls or pressure
5 ulcers are the two big ones at the -- at an
6 inpatient facility.
7
8 COMMITTEE MEMBER: Right.
9
10 DR. GRIFFEN: Whether it be a
11 rehab, a nursing care facility or an LTAC.
12 It's all the same. Because I --
13
14 COMMITTEE MEMBER: It's amazing
15 that they don't have them when y'all report
16 UTI's.
17
18 MR. GIEBFRIED: A side note. One
19 of the things that we come across is that
20 some of the surgeons will not send a person
21 to a SNF level facility because of the
22 research data showing infections that are
23 higher incidents, if a person goes to a SNF
24 than if they go home, you know. So
25 therefore, the -- the individual may certain

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1 -- best being in a SNF level and all those
2 services and all the things that would've
3 made a difference as far as length of time
4 that will have to be taken in home care.
5
6 DR. GRIFFEN: Well, and that -- and
7 that's one of the things that, long term-
8 wise, would be the goal is, you know, Joe
9 Schmoe has this set of injuries and the
10 recommendation was home.
11 And this Joe Schmoe has the
12 same injuries and the recommendation was a
13 nursing care facility. Then they both go,
14 this one gets this, this one gets this.
15 This person is better and
16 back, you know, to a more returning to life
17 and a job in seven weeks. And this one, it
18 takes three -- you know, three months or six
19 months.
20 That -- that's the idea in the
21 long term to be able to look at it and say,
22 what have we done differently? Okay. This
23 one did better. And then it's like, well,
24 why did this one get the facility and this
25 one get the home? Oh, this one got home

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1 because this one didn't have insurance. Or
2 this one got the facility because they have
3 really great insurance, or whatever it is
4 for the reason. So that hopefully we can
5 come back and say, you know what?
6 People with this constellation
7 of symptoms and injuries, they do better --
8 even if -- as a State, we pay for them to go
9 to a facility, a rehab facility or a --
10 whatever for three weeks to get more
11 intensive care.
12 They do better in the long
13 term and come off of Disability and Social
14 Security and whatever else and have a
15 greater quality of life if we actually
16 provide that for them.
17 So that in the long run, we're
18 costing less to everybody by actually making
19 this happen as opposed to telling them they
20 go to go home.
21 So those are the pipe dreams
22 that are, you know, 100 years from now and
23 I'll be long dead. But that -- that's the
24 pipe dream --
25

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1 MS. MCDONNELL: Well --
2
3 DR. GRIFFEN: -- to do that very
4 thing.
5
6 MS. MCDONNELL: This is Anne. And
7 you know, one of the things I'm thinking of
8 as I listen to you, Maggie, is this whole
9 issue of pre-morbid level of function.
10 Which, you know, is -- is an unknown factor
11 in all of this, as is family support.
12
13 DR. GRIFFEN: And we're not going
14 to have --
15
16 MS. MCDONNELL: Yeah, I don't even
17 know --
18
19 DR. GRIFFEN: We're not -- we're
20 not going to be able to get into that. All
21 we're going to be able -- they -- I -- I
22 will think -- I would think, then I will
23 tell you. Through the acute care component
24 of all of this, in the world of trauma,
25 frailty and the frailty index with the age

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1 of our individuals --
2
3 MS. MCDONNELL: Mm-hmm. Yep.
4
5 DR. GRIFFEN: -- in the geriatric
6 trauma.
7
8 MS. MCDONNELL: Yeah.
9
10 DR. GRIFFEN: We're working really
11 hard on trying to figure out a way to do
12 that. The problem right now is every
13 frailty index that exists out there is 17
14 pages long for the most part.
15
16 MS. MCDONNELL: Yeah.
17
18 DR. GRIFFEN: And it asks a lot of
19 questions that we can't often get the
20 answers to. So there's a lot of us who've
21 been trying to figure out if we can come up
22 with an -- as objective possible frailty
23 index that's a little more down and dirty
24 and easier for us to fill out on patients.
25 And I would bet you that ultimately, with

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1 all their push with the geriatric trauma
2 stuff, that within the next five years,
3 there is probably going to be some sort of
4 -- as best as possible, simple, objective
5 sort of frailty criteria that everybody over
6 65 is going to get filled out at their acute
7 care facility, as a trauma patient.
8 I really believe that's going
9 to happen. It's very frustrating right now
10 because we have very -- what we do a lot of
11 times at our facility is we do a -- we have
12 our dieticians come up and do malnutrition
13 on the patients as a way of figuring out
14 it's -- putting something in the chart to
15 show pre -- pre their injury that they had
16 some difficulties with maintaining their
17 normal body life thing.
18 Because they're moderate
19 eaters severely malnourished because they
20 just couldn't get it done. So I -- I think
21 that will get some of that --
22
23 MS. MCDONNELL: Yeah.
24
25 DR. GRIFFEN: -- to be honest with

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1 you.
2
3 MS. KATZMAN: Where -- which --
4 this is Lisa. Where patients go after acute
5 care -- in Mississippi, we had criteria that
6 they had to meet and it's -- and the same
7 for LTAC's and, you know, SNF's. So --
8
9 DR. GRIFFEN: Well, and this is --
10
11 MS. KATZMAN: -- and that
12 determines --
13
14 COMMITTEE MEMBER: But a lot of
15 that is determined by insurance.
16
17 MS. KATZMAN: Yeah.
18
19 COMMITTEE MEMBER: A lot of times,
20 it's not necessarily --
21
22 MS. KATZMAN: But CMS guidelines, I
23 know for acute rehab. But --
24
25 COMMITTEE MEMBER: Sure. But again

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1 --
2
3 MS. KATZMAN: Yeah.
4
5 COMMITTEE MEMBER: -- you know, a
6 lot of times, it's --
7
8 MS. KATZMAN: Well, yeah. Sure.
9
10 COMMITTEE MEMBER: -- insurance
11 dictates who's going to rehab and who's
12 going to SNF.
13
14 MS. KATZMAN: That is true.
15
16 DR. GRIFFEN: Well, and the other
17 -- the other component that we learned in --
18 when Macon and I are -- and Stephanie was
19 going to be here. And she -- you'll know
20 her when she comes.
21 It's -- but she's going to
22 start coming. She and Cathy Butler, who are
23 trauma program managers that work with us
24 for the couple of years that we were
25 organizing all this. One of the other

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1 things we figured out is it's -- even in the
2 front end trying to figure out how many
3 people get rehab, it's really only about
4 eight or nine percent.
5 Which -- if you have 30,000
6 people in this state in a year -- if you're
7 just guessing that number that are involved
8 in a trauma.
9 And only eight percent --
10 that's less than 3,000 a year that get
11 rehab. We can all think in our brain that
12 seems kind of minor.
13 Well, it's defined by, as you
14 say, what an insurance company says it --
15 for someone to be able to do rehab. And
16 then in the back end, we have no way of
17 saying, well, could another 20% have
18 benefited from rehab?
19 We don't know that because we
20 never looked at the -- at the program. So
21 again, we get back to being able to say,
22 hey, all these guys with workman's comp and
23 rehab jumps all over it. And they want to
24 do it because they get the cash for it.
25 They -- guess what, they have this

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1 constellation of injuries. And there's this
2 whole group of people here that have the
3 same constellation of injuries. And they
4 never get rehab because they either don't
5 have funding or they're under-funded.
6 And guess what, these folks
7 that got the workman's comp and got to go to
8 a rehab, they're back up and functional and
9 hitting it hard at two months.
10 And these other folks are six
11 months, eight months or never. And again,
12 we get back to looking at the finances.
13 We're only looking at it one way right now.
14 And so realizing that even the
15 patient population -- so then you get to
16 where you can say, okay, not eight percent
17 need rehab but 25% need rehab.
18 So if you're state's going to
19 have 100,000 people, then you need to have
20 25 -- the opportunity for 25,000 to get a
21 rehab in here.
22 We don't even come close to
23 having 25,000 rehab beds available for
24 people. I mean, that -- that's what's so
25 crazy. We don't even know what we need.

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1 And so we do what we do within what we have.
2 But we're not even -- there's a whole
3 patient population that we're certainly not
4 even serving appropriately.
5 And -- and that's what we're
6 trying to -- to -- it's -- it is. It's a
7 big black hole that we're trying to figure
8 out. Okay.
9
10 DR. ABOUTANOS: Maggie, I think we
11 -- what you were saying before -- and I'm --
12 I'm Mike. Sorry. On the TAG Committee.
13 But you were saying for -- you don't know --
14 so what's the impact, especially the
15 financial impact. Okay.
16 And so -- so we need that --
17 those calculations in order to -- to drive
18 the legislative system. Because what you're
19 talking about system inequality. But -- so
20 we think they half are getting better.
21 And the half are not. But we
22 don't know. But if we show that the half
23 are actually paying for those who are not.
24 See that's the trick, to move beyond the
25 [inaudible]. And I've got to say so, we

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1 have not gone to that level, but eventually
2 we're going to need to, to have a cost
3 analysis of all those that did not get the
4 rehab, did not go there.
5 What happened to them? And
6 they -- if they're not returning back to
7 society and if they're costing us a lot
8 more, then this committee would be in a
9 different position of driving a legislative
10 aspect.
11 So this -- this is how you
12 vote that over the course of this year, for
13 us to get to the point of, you know, having
14 an impact.
15
16 DR. GRIFFEN: Right. And we have
17 to -- and that's where it all came in.
18 We're trying to find out the places. So
19 initially what we're going to have to do is
20 figure out what we want.
21 We -- yes, it sounds like EMS
22 is going to do some of this stuff or require
23 some of this stuff in October and all. But
24 whether we're going to have access to that,
25 probably not right away. So then the

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1 question becomes, all these things that
2 everybody's looked at is us starting to
3 review those things to figure out where can
4 we get this data so that essentially, we're
5 pulling the data to create this ourselves.
6 So that we can then show this
7 is the impact. I mean, when you're talking
8 about trauma across the United States, the
9 number one health care problem $16M a year.
10 And we -- yet we have no idea
11 which -- the injury side, the prevention
12 side we work really hard on it. We've tried
13 seat belts save lives, I won't get into
14 guns.
15 But -- but there's so much
16 stuff that we can do that we're not doing on
17 the prevention side at this point that we
18 can't continue to do.
19 But then we have all these
20 people that have it, and then we have all
21 these people that get discharged from the
22 hospital and continue to have problems with
23 it. And that's a black hole that we don't
24 even know. So if we can help everybody
25 understand that it -- it can't just end here

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1 and it can't -- that we have to provide --
2 some of this is going to happen no matter
3 what.
4 Doesn't matter what we do
5 prevention-wise, it's going to happen. And
6 if we can't figure out how we can help them
7 after that -- to be back in society, to be
8 back in -- to a quality of life.
9 To be back to functional,
10 we're just being silly. We're just wasting
11 money. I -- I mean, it's just a waste. And
12 it's a waste of life. And that's not what
13 our -- our job is.
14 So anyway -- so we're going to
15 have to use these databases to create what
16 we think we need in order to then be able to
17 push our agenda saying, no, you really need
18 to do this.
19 And this is why because we're
20 going to show you and -- you know, those
21 guys. You always got to show them how
22 you're going to save them money. That's
23 what they want to know.
24
25 DR. ASTHAGIRI: Heather again. I

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1 would like to know all the diagnoses that
2 they are going to -- I just --
3
4 DR. GRIFFEN: Okay.
5
6 DR. ASTHAGIRI: Because they'll
7 have that.
8
9 DR. GRIFFEN: So admission
10 diagnoses.
11
12 DR. ASTHAGIRI: Well, even if they
13 have --
14
15 COMMITTEE MEMBER: I think that's
16 part of the care tool, isn't it?
17
18 COMMITTEE MEMBER: Yeah, it is.
19
20 DR. ASTHAGIRI: So again, I guess
21 I'm just trying to pick apart what we want
22 from the care tool. Is that what we're
23 doing kind of like --
24
25 DR. GRIFFEN: Yeah, so we want a

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1 say. So if we come up with a group of
2 these, then what we -- what I try to do -- I
3 know we only have like a half an hour left.
4 But if we can get a list of
5 sort of what we want -- that's going to be
6 the big question. That's why I gave every
7 one of you a piece of these things. And
8 then some of them may be overlap.
9 And like I said, Jim sent me
10 some other ones that I'll email to you. And
11 there's a bunch of sites. And it's a
12 question of every -- some people are more
13 savvy than others at looking at these places
14 and seeing if the data's there.
15 But a question of us trying to
16 take some time and each of us -- you know,
17 we can either break them up or whatever so
18 everybody only has two or three sites to go
19 to, to try to see what data is at that site.
20 What data can we get from
21 there that will answer some of these
22 questions. There's one of them got --
23 because we may have to go to 25 sites and
24 still not be able to find everything that
25 we're trying to get on -- on patients or get

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1 the answers that we want. So --
2
3 MS. MCDONNELL: Yeah, some of these
4 sites are -- if you're looking at them for
5 data, I can take a couple of them right off
6 the list right now. Because they're not
7 going to have data, they're going to have
8 information about the services they offer.
9
10 DR. GRIFFEN: And that's good.
11 What I would say is don't -- if you'll send
12 me those ones --
13
14 MS. MCDONNELL: Yeah.
15
16 DR. GRIFFEN: -- as an email.
17 Anne, if you would send me those, then I can
18 just take them off the list for us
19 altogether.
20
21 MS. MCDONNELL: I can also send you
22 some information on state registries. We're
23 currently working with 19 other states on
24 their state registries. So I can tell you
25 who's got a surveillance registry, who's got

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1 an outreach registry, who's developing one.
2 And I'll send that to you in a separate
3 email as well, Maggie.
4
5 DR. GRIFFEN: That'd be great.
6 That'd be great. All right. So length of
7 stay, discharge disposition, the global
8 functional level. If they were re-admitted,
9 the facility-based events and we'll see what
10 we can get.
11 Whether that's only skin and
12 -- skin breakdown and -- and falls versus
13 UTI's, whatever. And admission diagnosis --
14
15 MS. CARTER-SMITH: This is Lauren.
16 Maybe discharge with that admission
17 diagnosis if they're different. Because
18 sometimes --
19
20 DR. GRIFFEN: Okay.
21
22 MS. CARTER-SMITH: -- once they're
23 admit -- like their admission diagnoses is
24 not anything to do with why they're really
25 there.

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1 DR. GRIFFEN: Okay, good. Yeah.
2 And then the other things that we had on our
3 original thing were payor source. Do we
4 really care? Yes, no?
5
6 COMMITTEE MEMBER: I think -- yeah.
7
8 DR. GRIFFEN: I think that's going
9 to -- I think initially that's going to be a
10 very important thing. Because it's going to
11 let us know, maybe, why someone went there
12 as opposed to somewhere else.
13 And then work/school we talked
14 about. But do we think we're going to get
15 information specifically from these guys
16 about that. Probably not. They're just
17 saying -- going to say they discharged to
18 home or they discharged them somewhere.
19 Right?
20
21 COMMITTEE MEMBER: Correct.
22
23 DR. GRIFFEN: Okay. That is what
24 we have on this. So there are other things
25 that we want to know about specifically when

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1 they're discharged from the inpatient rehab.
2 If they're discharged from any of these
3 places, do we think to do some sort of
4 quality review?
5 Do we need to know? Because
6 it -- I mean, I -- this would be more home
7 -- you know, it would be all of that. So we
8 would get a -- we'd be able to pull out
9 mortality.
10
11 COMMITTEE MEMBER: Well, there'd
12 also be filtered. I mean, sometimes in your
13 discharge or your admission, we have twists
14 in.
15
16 DR. GRIFFEN: Right.
17
18 COMMITTEE MEMBER: And so we have
19 the --
20
21 DR. GRIFFEN: We have that. And
22 then we could -- right. And we -- we --
23 again, we could follow them in the SNF
24 again. I mean, that's only one, two, three,
25 four, five -- it's really only -- it's less

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1 than 10 things that we would be asking for
2 from these facilities. That doesn't seem
3 like too much I wouldn't think.
4
5 COMMITTEE MEMBER: Well, and I
6 think it's already what they're doing.
7
8 DR. GRIFFEN: Well, that's what I
9 think. And this is --
10
11 COMMITTEE MEMBER: Yes, right.
12
13 DR. GRIFFEN: This is the part that
14 we're going to have to convince them of, is
15 that this is really what we need to be in a
16 trauma post-discharge registry would be
17 these things.
18 And that would allow us to do
19 a quality review of their entire care within
20 a trauma system.
21
22 COMMITTEE MEMBER: I mean, I think
23 this is at least a good starting point. But
24 we may -- you know, as we go find more stuff
25 that we want to include. But I mean, I

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1 think this is -- that this is a good, you
2 know, starting point as any.
3
4 COMMITTEE MEMBER: I don't know if
5 this is the right place to say this, but if
6 like ask them if they're like a rehab as a
7 part of the -- I guess there would be best
8 to have a SNF and acute beds.
9 Like is it part of a hospital
10 or is it a stand-alone? Most SNF's are
11 going to be stand-alone. But --
12
13 COMMITTEE MEMBER: Do you know how
14 many beds? Do you think that that would
15 have any --
16
17 DR. GRIFFEN: Yeah. Well, I know
18 there's a little bit of a difference because
19 you can go to a SNF and you can be in a --
20 there's two kinds of beds.
21
22 COMMITTEE MEMBER: Right. It's
23 like you're literally -- where you're on one
24 side of the place here in the SNF. And on
25 the other side, you're -- yeah.

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1 COMMITTEE MEMBER: Long term care
2 or --
3
4 DR. GRIFFEN: Would they have -- or
5 sub-acute rehab versus --
6
7 COMMITTEE MEMBER: It's -- it's
8 long term care, right?
9
10 COMMITTEE MEMBER: Long term,
11 right.
12
13 COMMITTEE MEMBER: And then skilled
14 --
15
16 DR. GRIFFEN: And then skilled
17 nursing. So do we say types -- type for the
18 -- for the SNF's so that they tell us
19 whether they were put in long term or the --
20 or the skilled?
21
22 COMMITTEE MEMBER: Yes. That's --
23
24 COMMITTEE MEMBER: But there's a --
25 there's a difference between SNF and long

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1 term -- I mean, there's a --
2
3 DR. GRIFFEN: But within the SNF's
4 they have some patients who come in for a
5 long term bed and some they get the skilled
6 nursing beds. And there are two different
7 beds within the SNF, right? Again, I know
8 too much about --
9
10 COMMITTEE MEMBER: The level of
11 service is different in a SNF.
12
13 COMMITTEE MEMBER: But I think that
14 the -- like if they're admitted at SNF,
15 they'd be discharged from SNF to the long
16 term or nursing home. I think with that one
17 --
18
19 COMMITTEE MEMBER: Are the
20 definitions consistent is what --
21
22 COMMITTEE MEMBER: I mean, I'm just
23 saying like, you know, if -- there's a
24 switch because SNF beds are often covered by
25 insurance. Long term care is self-pay for

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1 the most part, unless you have --
2
3 COMMITTEE MEMBER: Medicaid.
4
5 COMMITTEE MEMBER: Medicaid.
6
7 COMMITTEE MEMBER: So I mean, this
8 is like kind of a big difference in the
9 facility. So --
10
11 DR. GRIFFEN: So how would we ask
12 the question to get what it is we want?
13 Because you're right. We want to know the
14 difference between whether the patient --
15
16 COMMITTEE MEMBER: Well, they're
17 going to -- they'll bill at a level of
18 service. So inpatient --
19
20 DR. GRIFFEN: Well, we're not going
21 to get their billing.
22
23 COMMITTEE MEMBER: So -- but I just
24 think that -- I guess if somebody is sent to
25 a skilled nursing facility and they don't go

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1 home. And they, you know, switch over to
2 long term care, they may not report that.
3 But they may not.
4
5 DR. GRIFFEN: I don't know if they
6 have to.
7
8 COMMITTEE MEMBER: We -- okay. I
9 guess that's something we definitely have to
10 --
11
12 DR. GRIFFEN: Right. So do we want
13 to ask type of -- type of bed.
14
15 COMMITTEE MEMBER: Mm-hmm.
16
17 DR. GRIFFEN: Is that the way --
18 some -- somehow --
19
20 COMMITTEE MEMBER: Yeah.
21
22 COMMITTEE MEMBER: Yeah, skilled
23 versus long term.
24
25 DR. GRIFFEN: So -- so their

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1 admission type. Admission type -- type of
2 bed. Yeah. There's probably a way to say
3 that. I just don't know what it is.
4
5 COMMITTEE MEMBER: I guess some
6 have assisted living, too.
7
8 DR. GRIFFEN: Well, that -- that's
9 the thing is -- is -- and then -- yeah, and
10 I don't know how that -- like I don't know
11 if you get admission information. We have a
12 lot of people up IS that run into
13 [unintelligible] places.
14
15 COMMITTEE MEMBER: Yeah.
16
17 DR. GRIFFEN: And they are in
18 independent living, but we may send them
19 back to their tiered facility. But they go
20 to the skilled nursing.
21 I had no idea we know that
22 they went to the skilled nurse -- even --
23 come up that we're just at, oh, we sent them
24 back to the Virginian.
25

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1 MS. CARTER-SMITH: Maybe instead of
2 type of bed -- this is Lauren -- under that
3 discharge disposition, like take out the
4 home and just write services provided.
5 Because what -- doesn't matter
6 where they go. What services are they going
7 to get? So if they go to inpatient rehab,
8 we know they're going to get three hours of
9 therapy.
10 If they go to a nursing
11 facility, is it going to be skilled? Like
12 you know, just defined as what are they
13 receiving.
14
15 DR. GRIFFEN: This is where
16 discharge starts disposition from the
17 inpatient bed.
18
19 MS. CARTER-SMITH: Yes.
20
21 DR. GRIFFEN: This is our request
22 of what kind of bed did they get sent to at
23 the inpatient.
24
25 COMMITTEE MEMBER: After acute

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1 care.

2

3 DR. GRIFFEN: After acute care. So

4 this is like did they go from acute care to

5 a skilled nursing bed, to a long term bed,

6 to a rehab bed. This is when they're

7 leaving the acute -- the post-acute care,

8 where did they go?

9

10 COMMITTEE MEMBER: Actually -- so

11 the -- the bed is continuum of care, not

12 disposition at time of discharge from acute

13 care.

14

15 DR. GRIFFEN: Correct.

16

17 COMMITTEE MEMBER: Okay.

18

19 DR. GRIFFEN: Right. Yeah, because

20 that may be something to know.

21

22 MR. GIEBFRIED: This is Jim. Just

23 something came to me about -- I don't have

24 the answer. But as we all know, medical --

25 the capability of that individual to be able

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1 to understand what's going on, where they're
2 going. What's -- what's their
3 responsibilities, etcetera. Makes a
4 difference at that time of disposition how
5 they're going to better themselves.
6 So I -- I don't know -- I know
7 it's -- the OASIS bed, as an example. They
8 have an educational level for the persons.
9 They have an -- information regarding what
10 language -- does the person need an
11 interpreter, etcetera.
12 Because very often, things are
13 missed by the individual or the families in
14 understanding. And where it'd help that
15 individual progress and move further
16 forward.
17 So I'm not sure where in that
18 process -- whether it's known initially that
19 this is a -- this is an issue. But like I
20 said, they're being transferred.
21 That person then will be set
22 up so that person is going to get that
23 service. And the service is going to be
24 designed to meet the inadequacies that
25 person has to benefit most from at getting

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1 what they have.
2
3 DR. GRIFFEN: Yeah. I -- there
4 will -- I mean, I think you're going to get
5 -- again, ultimately, really can link
6 patients, the educational level or the
7 language barrier type things, you're going
8 to get from acute care.
9 Because I think that's where
10 you're going to identify that. Because we
11 have to identify that in every patient who
12 comes into the acute care hospital whether
13 they need language services and that kind of
14 thing.
15 So I think once the patients
16 are linked, we should be able to follow and
17 know that they would have a language problem
18 or an educational problem.
19 Or as we want to know, the
20 admission diagnosis -- whether they have a
21 dementia problem or things like that. So I
22 think we'll -- once we can link the patients
23 rather than having -- getting this
24 information from them. Because I don't know
25 whether they do that or not. We would, I

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1 think, get that from the acute care hospital
2 once the patient can be linked.
3
4 COMMITTEE MEMBER: I think -- is
5 that one of the things that's happening on
6 the IRF bed? For -- for rehab. It's --
7 it's cap -- it's one of the artists that's
8 captured --
9
10 DR. GRIFFEN: I have no idea if
11 it's captured. What about at a nursing care
12 facility?
13
14 COMMITTEE MEMBER: I'm going to
15 find out --
16
17 DR. GRIFFEN: We can --
18
19 COMMITTEE MEMBER: -- if they're
20 actually supposed to. But I don't think
21 that they'll do the -- half of the stuff.
22
23 MR. GIEBFRIED: And it's after the
24 fact sometimes unless they've done some
25 cognitive testing at the hospitals. It

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1 would be better discovered there or with a
2 psychiatrist -- psychologist got in there to
3 do the -- the -- probably the best thing to
4 do [inaudible].
5
6 DR. GRIFFEN: Yeah.
7
8 MR. GIEBFRIED: You see more severe
9 side of stroke, you know, injury or
10 something that they can't communicate or
11 they -- they see the deficits right there.
12 But it's the mild stuff that you're going to
13 miss.
14
15 DR. GRIFFEN: Yeah. Like I said,
16 that's where moderate brain injury people
17 that, you know --
18
19 (At this time, something near the recorder
20 interferes with audio clarity.)
21
22 COMMITTEE MEMBER: Do you even want
23 to open a can of worms?
24
25 COMMITTEE MEMBER: I was going to

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1 say -- I actually determine a source --
2
3 DR. GRIFFEN: Well, I think once we
4 talk about peds, we may be asking different
5 questions.
6
7 COMMITTEE MEMBER: Yeah.
8
9 DR. GRIFFEN: So I -- I would say
10 that this is in general for adults. And we
11 can make -- I think the -- don't you think
12 the admission diagnosis for a pediatric
13 patient -- wouldn't it say non-accidental
14 trauma --
15
16 COMMITTEE MEMBER: Not necessarily.
17
18 DR. GRIFFEN: Coming from a
19 facility, you don't think it would
20 necessarily say that?
21
22 COMMITTEE MEMBER: I see -- you
23 know, I -- I see kids all the time that come
24 in -- maybe it's not a part of -- it's --
25

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1 DR. GRIFFEN: And we may have to
2 have a different component of -- of things.
3 If -- so we -- we have like 20 minutes. So
4 if we -- if we're happy that this, for the
5 patients going to an inpatient facility --
6 one of these three places -- that this will
7 give us, if we had our perfect thing.
8 And this data could be dumped
9 in from these types of facilities on every
10 patient that met -- was in a trauma
11 registry.
12 And if all these could be
13 dumped into a database that we could then
14 link to the patient at the facility and link
15 to their trauma, and link to everything.
16 Would this be enough data --
17 would this be what -- all that we wanted in
18 order to be able to then say, hey, doing
19 this, this and this got our patients to 'x,
20 y and z'.
21 Because if I think -- I think
22 -- like I said, this is only -- this is less
23 than 10 things. And if it comes out that
24 this is part of the care -- that every one
25 of these is part of care tool, that is in

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1 the long term going to benefit us greatly.
2 Because they will already be collecting the
3 data. And then it'll be a question of
4 figuring out how we can make -- help them
5 make that data available to us.
6 But then, the -- the component
7 that we need to do before the next meeting
8 is if we're going to agree -- we're going to
9 -- we're going to work on a mini-product.
10 If this is what we believe we
11 need to have, then as best we can with all
12 of these potential data sources for us, what
13 we're going to need to do is we're going to
14 have to try to see can we really get these
15 things for a set of patients.
16 And do we feel like it answers
17 all those questions that we think we're
18 going to want from a quality perspective.
19
20 COMMITTEE MEMBER: I think literacy
21 needs to be captured. Health literacy needs
22 to be captured.
23
24 DR. GRIFFEN: And is that something
25 in the care tool that they --

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1 COMMITTEE MEMBER: Not in a care
2 tool. It's -- I just feel like it's such a
3 -- you know, if -- if we don't capture the
4 fact that they are not literate, then it
5 really affects their recovery.
6 They're not -- like your
7 perfect example. Your gentleman that came
8 in with the trach.
9
10 DR. GRIFFEN: So did they --
11
12 COMMITTEE MEMBER: You know, I
13 mean, they --
14
15 DR. GRIFFEN: -- capture that in
16 the acute care? Do they ask every patient
17 who gets -- I mean, --
18
19 MS. GARRETT: This is Renee. We
20 have to do an education assessment that we
21 fill out that talks about who -- who did we
22 educate? Is it the patient, is it the
23 family, is it both, is it someone else? And
24 that's typically where I put this patient
25 has -- is unable to read. That would be

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1 where I would put that. So we capture it in
2 acute care, but I don't know where -- where
3 it goes after that.
4
5 MR. GIEBFRIED: Is that the same as
6 health literacy that you're addressing?
7
8 MS. GARRETT: Yeah.
9
10 COMMITTEE MEMBER: Because we -- we
11 talk about educational level and it's part
12 of our assessment. In IBR, it's part of the
13 assessment.
14
15 COMMITTEE MEMBER: Yeah, that's
16 patient level and --
17
18 COMMITTEE MEMBER: Well, also what
19 he's saying is different -- yeah.
20
21 MR. GIEBFRIED: Yeah.
22
23 COMMITTEE MEMBER: I mean, you can
24 -- I have plenty of patients that are -- you
25 know, that might have a graduate degree that

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1 don't -- can't take their medicine.
2
3 DR. GRIFFEN: Right.
4
5 COMMITTEE MEMBER: You know, so
6 that health literacy and education level, I
7 think, can be very different.
8
9 DR. GRIFFEN: Well, and the -- and
10 the thing is -- yeah.
11
12 COMMITTEE MEMBER: Well, where I'm
13 at is in the country. So when we talk about
14 health literacy, we do have a large
15 component of patients who can't read. So
16 that was where that point was triggered.
17
18 DR. GRIFFEN: I think it's going to
19 be inconsistent across -- it's going to be
20 inconsistent is the problem. And we could
21 say a whole bunch of other things that we
22 want to be included in this that right now
23 isn't -- we don't think we can get the
24 information any other way. But again, you
25 got to think about the -- the final product

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1 is -- the ideal is that they're going to be
2 linked through their entire hospitalization.
3 So we're going to have access to the
4 information that was obtained in an acute
5 care hospitalization.
6 We're going to have access to
7 the EMS database and those kinds of things.
8 So I'm fairly certain that every acute care
9 hospital asks -- on that face sheet, it has
10 someone's -- something about their
11 educational level.
12 I'm almost positive it does.
13 Now it doesn't mean their -- they have
14 literacy in health, yes, obviously. But we
15 would get a -- a potential -- at least a[n]
16 educational level for the patients to -- as
17 you say, not necessarily use as a surrogate
18 because they're -- we've all met the very
19 smart person who can't get out of a paper
20 bag.
21 But I -- I don't know that --
22 I guess we have to decide how strongly we
23 feel about that, that we're going to require
24 these facilities to do an entire extra
25 evaluation of a patient to be included on

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1 something there on the report. When 99% of
2 what they have to report, they're already
3 being asked to do. I think we'll -- I think
4 that will be left blank so frequently that
5 it may not be worth it, that's the only
6 thing. Okay.
7 So if we say that this is what
8 -- what we want, then what we've got to do
9 is -- we got to figure out a way to do our
10 mini-thing to say, hey, these are the things
11 that we think are important to know from the
12 inpatient facilities patients go to.
13 And we've done a little look
14 through the databases that are out there in
15 the State of Virginia right now. And we
16 found on these -- if we go to these six
17 different places, we can actually get this
18 data.
19 And when we do have this data,
20 although it probably won't be linked to
21 anybody at this point. But that there's --
22 right now, there's six different places to
23 get this data. And we want to get this all
24 from one place. And if we look at the --
25 the care tool and realize that that's going

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1 to answer this for us, then we can work
2 toward the day -- we as a State, when you --
3 when CMS starts this care tool, we want to
4 have dibs on it to be able to get this
5 information on the people in the State of
6 Virginia and not just the Medicare patients,
7 but everybody.
8 And so we'll have to figure
9 out whether, as you say, it's reported on
10 everybody kind of. And then in the process
11 of looking through some of this stuff, we
12 may realize, you know what?
13 It'd be really good for us to
14 have this information, too, that we didn't
15 talk about. Okay? So going forward then,
16 what -- what we'll do is I'll send everybody
17 out this.
18 That these are the things we
19 decided. Okay? That these are the things
20 we want to do. I'll see what Anne sends
21 back that says that's just a -- you know,
22 advertisement web site. You're not going to
23 find any data there. Okay? And then I will
24 -- if there's -- databases you're really
25 familiar with, send me those and say, look,

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1 I'll check this one and this one because I
2 know the database really well. And I go in
3 it all the time to look for stuff with my
4 patients.
5 And whatever ones are left,
6 I'll divide them up and send two or three to
7 everybody to try to -- and so our job will
8 be can we find any of this data on those
9 particular web sites for patients.
10 So that we can see if we can
11 even -- if it's even feasible to find this
12 stuff anywhere right now. And then I'll --
13 I'll try to look at this care tool thing
14 that I know nothing about.
15 And familiarize myself with it
16 and see what it does. And I may be able to
17 -- yeah, if you can send it to. Yeah, if
18 you can send it to me and I'll send it to
19 everybody so everybody can read it and see
20 what it says.
21 And -- and we'll kind of go
22 from there. Next time, then, we'll talk
23 about peds a little bit more and get it sort
24 of defined for peds and outpatient as far as
25 this stuff. Now, if for some reason, again,

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1 it looks like things are a lot and we think
2 we want to meet in between, I'll stay in
3 touch with Wanda and the Office of OEMS and
4 when they're going to be finally done and
5 whatever.
6 And -- so I'll keep you
7 informed of that if the Office isn't going
8 to be renovated and open before our next
9 meeting, then we won't meet until August.
10 Which I know is a bad time of the year, but
11 it's --
12
13 COMMITTEE MEMBER: Do we know when
14 that is yet?
15
16 DR. GRIFFEN: August -- it's that
17 2nd and 3rd or 1st and 2nd or whatever.
18 It's that weekend, which is -- or that
19 couple days, which I don't know what I'm
20 going to do yet. I'll let you know.
21
22 COMMITTEE MEMBER: The 1st and 2nd.
23
24 DR. GRIFFEN: 1st and 2nd. And --
25 and then we can go from there. And if it

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1 looks -- if everything seems to be going
2 crazy, y'all let me know. Because if it
3 looks like people are -- I know August is a
4 terrible time of year. If it looks like
5 it's a lot of vacation type issue, then let
6 me know.
7 Because if we have to do
8 something at some other time that we can
9 meet because people are -- we're not going
10 to make quorum, then we can potentially
11 adjust ourselves around so we can meet.
12 And then it would just be a
13 question of the availability to come to the
14 -- the Friday meeting for the TAG or
15 something like that. So we can -- we can
16 discuss that if you guys have individual
17 things.
18 Just send me an email and if I
19 realize that we're not going to quorum or
20 whatever, I will -- will work to organize a
21 little different. Okay?
22
23 MR. GIEBFRIED: Maggie, can you
24 include that one-page sheet that Heather was
25 trying to --

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1 DR. GRIFFEN: Yeah.
2
3 MR. GIEBFRIED: -- put out earlier.
4
5 DR. GRIFFEN: If you -- Heather, if
6 you -- let me see if it came. If it didn't
7 come through, then just send it to the email
8 at work. Oh, I got it. Okay. I have it
9 here, so -- and I -- I got that.
10 So I will send those to myself
11 at work. And I will send it to everybody so
12 everybody has all the data that we need.
13 Okay?
14 So next time, we'll talk more
15 about peds and more about outpatient and
16 trying to do define what our goals are going
17 to be for getting the information. We'll
18 see how much information we can actually get
19 from what's out there now.
20 So that we feel comfortable
21 whether these are all the data points that
22 we want. And then we can sort of move
23 forward from there. Anne'll take,
24 obviously, some of the stuff that we've
25 talked about back to the data stuff. You

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1 were going to go to the Acute Care tomorrow.
2 Disaster meets tomorrow or --
3
4 DR. ABOUTANOS: No. Acute Care is
5 today, yeah.
6
7 DR. GRIFFEN: Oh, Acute Care is
8 today.
9
10 COMMITTEE MEMBER: That's tomorrow.
11
12 DR. GRIFFEN: It's tomorrow. So
13 yours is tomorrow and yours is today. Okay.
14 And then we'll kind of go from there. So
15 we'll hear from y'all again when we meet
16 next time. Does anybody have anything else
17 for the Committee for today?
18
19 DR. ABOUTANOS: Have you heard
20 anything from System Improvement? That's
21 tomorrow, also. That's the data also.
22
23 DR. GRIFFEN: Anne goes to that.
24
25 DR. ABOUTANOS: Anne goes.

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1 DR. GRIFFEN: And she reported on
2 what they talked about last time. So I'm
3 sure she'll take the stuff that we talked
4 about today to them tomorrow. I really
5 appreciate everybody taking the time in
6 coming and all.
7 And so like I said, let's just
8 stay in touch for the next thing. If we
9 need to adjust stuff, we can. And then I'll
10 get stuff out to you.
11 It's probably -- will be
12 honest with you, it's going to be a week
13 from Tuesday before I can probably see
14 anything above my head. But I will get it
15 to you. All right. Thanks.
16
17 (The Post-Acute Care Committee meeting
18 concluded.)
19
20
21
22
23
24
25

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1 CERTIFICATE OF THE COURT REPORTER

2

3 I, Debroah Carter, do hereby certify that I

4 transcribed the foregoing POST-ACUTE CARE COMMITTEE

5 MEETING heard on May 2nd, 2019, from digital media,

6 and that the foregoing is a full and complete

7 transcript of the said Post-Acute Care Committee

8 Meeting to the best of my ability.

9 Given under my hand this 31st day of July,

10 2019.

11

12

13

14

15 Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

16

17

18 My certification expires June 30, 2020.

19

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