COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY SERVICES

IN RE: SYSTEM IMPROVEMENT COMMITTEE MEETING

HEARD BEFORE: SHAWN SAFFORD, MD

CHAIR, SYSTEM IMPROVEMENT COMMITTEE

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MAY 3, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

8:00 A.M.

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APPEARANCES:

Shawn Safford, MD, Presiding
Chair, System Improvement Committee

COMMITTEE MEMBERS:

Shelly Arnold

Sara Beth Dinwiddie

Valeria Mitchell

Anna Newcomb

Greg Nieman

Jessica Rosner

Anne McDonnell

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VDH/OEMS STAFF:

Tim Erskine

Cam Crittenden

ALSO PRESENT:

Narad Mishra

Maureen McCusker

Valerie Quick

Mindy Carter

Dreama Chandler

Lou Ann Miller

Michel Aboutanos, MD

A G E N D A

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

DR. SAFFORD: Good morning. So I call to order the Systems Improvement Committee. Before we continue, notice for all TSE attendees. All trauma systems committee meetings are audio recorded.

These recordings are used for meeting transcripts. Because of this, all participants must do the following. Number one, speak clearly.

Number two, if not called on by name by the Chair, identify themselves before speaking, and then speak at one time. The enthusiasm for participation in trauma systems strategic process is both understandable and welcome.

But following the above rules will assist in accurate transcription. Looking at the -- looking at the guest list, we have a quorum to on go with absence of Ann Kuhn, Robin Pierce, Michelle Pomphrey, Sherry Stanley. And then a few other

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members are still being identified. And we'll talk about that later. So Chair report. So we actually need to first approve the previous minutes. Do we have the -- can we --

MR. ERSKINE: Working on that right now.

DR. SAFFORD: Those are sent out to the members. Did everyone have a chance to review those? Yes. If we can get that up. That would be my wife. Knows to call the exact appropriate time. And she said she loves me.

COMMITTEE MEMBER: Tell her we love her.

DR. SAFFORD: 20 years. All right. And then we will -- in the meantime, while we're getting that up, we've seen today's agenda. So can we just approve today's agenda while we're waiting. Everyone say yes -- aye.

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COMMITTEE MEMBERS: Aye.

DR. SAFFORD: And all opposed? So we're approving today's agenda. And the previous minutes will be above 164 pages.

MR. ERSKINE: That's why I don't have copies.

DR. ABOUTANOS: No, no. He said can you go to the -- to the minutes for this?

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MR. ERSKINE: We only have a transcription. Just like the Advisory Board. We don't have, right now, the administrative ability to do seven committees with the -- with minutes. So like the Board, we do a transcription.

DR. ABOUTANOS: And where's the transcription?

MR. ERSKINE: That's it.

DR. SAFFORD: It's the 164 pages.

DR. ABOUTANOS: Yeah, this transcription is on everything.

MR. ERSKINE: No. This is just this meeting.

DR. ABOUTANOS: It is? I'm sorry. Okay, I thought it was on everything.

COMMITTEE MEMBER: Just condense them so that --

DR. ABOUTANOS: All right. Go ahead. So it's there. It's just a matter of --

MR. ERSKINE: Yeah. And everybody --

DR. SAFFORD: Everybody was sent a copy.

COMMITTEE MEMBER: I don't believe

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those of us who were crossover members received it. I don't recall --

MR. ERSKINE: That -- that -- you probably -- you probably didn't. Again, this went out during our network outage. So I apologize for that.

DR. SAFFORD: But I think we should have that as part of the future to the -- to the cross pollinating members.

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MR. ERSKINE: Yes. That was my intent. The construction had other plans. We'll blame Cam.

MS. CRITTENDEN: I blew up the system.

DR. SAFFORD: To that question, if -- if someone is happy to take minutes for the meeting, are we allowed to use those as minutes then?

MS. CRITTENDEN: If you'd like.

There are some pretty -- some committees that minutes have to be done in a format that we can see by -- by -- and available 10 days. And there's some parameters we have to meet.

And honestly, we're going to continue to do these any how. We don't -- can't have staff in every meeting sometimes. And so we just need to be able to go back if somebody has a question.

And we've had people over the last three years just sort of question what's happening. And we're able to go through and pull out the recordings.

And -- and so, the Advisory Board, we do a transcription also because that's -- that's a lot of information.

DR. ABOUTANOS: Yeah, my -- I mean, my take, I think this is extremely important. We need to have this. But I do think the minutes are functional for the committee to work. The actual --

MS. CRITTENDEN: So we're still --

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we're working on a plan. You know, we've incorporated seven new committees to --

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: -- an already existing system. And we don't have a ton of administrative support. We are looking at some wage positions and having administrative, so we'll have staff member in each committee.

You got to give us a little time to work on that. And once we get a staff member in each committee, then we can -- that can do minutes -- we will have the minutes plus the transcript.

DR. ABOUTANOS: Because what Shawn is asking, can a member of each committee simply do the minutes?

MS. CRITTENDEN: Sure, if they'd like.

DR. SAFFORD: And is it --

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DR. ABOUTANOS: And it would help your staff. Then it could go to your staff, it could be put -- if you want. You'll have somebody come do the whole thing.

MS. CRITTENDEN: The only -- you know, we would still -- we would still record these. The only thing is that if we -- if we're not there, we don't know what happened.

And for us -- if people call and ask questions about where did -- you know, what the minutes were --

DR. SAFFORD: No, I just want to make sure that --

MS. CRITTENDEN: If you want to, absolutely, you can.

DR. SAFFORD: I just want to make sure what -- what -- I just want to make sure the process is intact. That as we submit the minutes, that they're done -- I -- I understand we have to do this if we

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can't have staff. But if we do this, is that -- I just want to make sure we're staying within regulations --

MS. CRITTENDEN: Sure.

DR. SAFFORD: -- of -- of that.

MS. CRITTENDEN: That would -- we're fine with it if you want to do minutes. Yeah, absolutely. I mean, if you want us to have somebody -- I mean, we would just have to have them pretty quickly. They have to be posted or completed within 10 days of the meeting.

DR. SAFFORD: Okay. And Valeria, you okay with that?

MS. MITCHELL: Yeah, I can do that.

DR. SAFFORD: Okay.

MS. MITCHELL: I'll do that.

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DR. SAFFORD: If you can actually just send us the -- the criteria, what we need for that, that'd be helpful. Just making notes for myself. So can we vote on the approval of previous meeting minutes. All in favor, aye.

COMMITTEE MEMBERS: Aye.

DR. SAFFORD: All opposed. Okay. Chair report. Unfortunately, I was not at the last Chair -- I mean, the last chair -- and last meeting is the vice-chair for our group -- co-chair. Vice-chair.

And the -- the ongoings -- going forward, which is trying to identify those things that we're going to go forward with, with identifiable criteria.

I'm going to go through that in a second with the NQF criteria. Tim, can you give us an update on those quarterly report of trauma incidents? Is that on here? I don't --

MR. ERSKINE: No. That -- but that

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is something that has been --

DR. ABOUTANOS: Go ahead.

MR. ERSKINE: It's a regular component. Narad put this together as we're required to do on a quarterly basis.

DR. ABOUTANOS: Can this get projected at all?

MR. ERSKINE: I do not have it electronically.

MS. CRITTENDEN: You know, this was -- former TQIP committee worked on format and what we wanted to use over the last couple of years. So this -- this is what kind of morphed from that out of that.

We could do -- whatever part is part of the update. And if I -- if I update to the Advisory Board on annual basis. So we just do this quarterly, maintain where the previous TQIP is on the --

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DR. ABOUTANOS: So this -- yeah. I just -- I mean, looking at this. So just to -- one aspect as a reminder. So this was a big advancement in labor to be able to provide to the -- I guess the Advisory Board what are the numbers, how come we don't have adequate numbers?

And if you even look at -- and the whole idea was the beginning of the -- if you just show them where the numbers are, the number would improve.

And the numbers as far as the vital signs recorded when someone arrives and -- and -- I just -- so this -- and then it became a quarterly report.

The first time -- actually, in my position, I get that report the first time when they presented it at EMS. And then we said, we're going to -- Cam and the whole group worked very hard to start doing this on a -- on a regular basis.

And now it's kind of part of the regular aspect. And so the -- so that was a -- a big push to improve the data at every level, you know, with regard to it.

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And if you look now -- like I was -- was glancing at it. It's pretty impressive in a lot of ways. We went from much lower numbers --

MS. CRITTENDEN: The GCS was the biggest one.

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: And now since we started, we have more effects. We're looking at -- you know, people -- the EMS providers were putting it in the narrative, as opposed to the narrative.

We can't -- we want it out of the narrative. So we started sending out communication, you know, with the DCS and sending -- posting these reports.

And we -- our previous statistician had been reporting. And the Medical Director and the QA people at the agencies saw the results and she where they stood. So even by us talking about it and reaching out, you know -- first of all,

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discovery was an issue. Talking about reaching out, letting them know them working on it at their agency level and now they're documenting GCSon the dropdown menu.

DR. ABOUTANOS: Yeah. And the big -- the big aspect was providing this report to the -- to the various regions. And then mostly we thought about saying, hey, you have to meet.

And then we said, we just simply -- just give them the data, they will improve. And one was the GCS. I'm impressed that even like -- one was the GCS, the other one was three vital signs in presence. And we're up to 93.5%, only 6.5% are incomplete. This is a huge --

DR. SAFFORD: And this is automatically sent back to all of the different regions.

MS. CRITTENDEN: So it is put in -- excerpts of it are put in the quarterly report that goes to the Advisory Board,

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which is posted to the web site. And then this gets put on the web site also. And then the regional councils, they have the reports.

They -- they all have access to the [inaudible] system, too. It's in there. They see it and then the agencies can run the same report, also.

DR. ABOUTANOS: Yeah. And it's by region. You can --

MS. CRITTENDEN: The vital signs -- the vital sign report. The analysis is done here, but the vital sign report [inaudible].

DR. ABOUTANOS: So if we look at this, we have 97% of systolic blood pressure recorded, 97% respire rate, and 96.7% GCS documented. This is huge improvement over the past three years from one -- from one part.

And then, the second thing that we also looked at with the quarterly report is if those met the step one

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criteria, how many end up going to Level I and Level II? How many go -- go to non-trauma center designation. And that's also listed here. I think it's on page -- what page it is.

Table four. And so -- those were the regular data that came out of the pre-committee from this committee. And that -- then I think the work of many, many years to get to this level.

That's what this report -- it's a product of this. And -- so I think it would helpful to eventually just go through this, find out what -- you know, what we're doing. One aspect that we have for this and -- is the fact that this is very pre-hospital based.

DR. SAFFORD: Right.

DR. ABOUTANOS: Right? So now with our trauma system plan, our next level is that can we also now have the hospital-based, especially now that the trauma sits at the EMS Advisory Board and that aspect.

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We're part of trauma system plan. So this is something to base on. And the second part is how do we now also look at, not just one database, but the -- the registry database as well. And that was the talk the last six months prior to this.

MS. CRITTENDEN: Right. Narad has been working on that, seeing what we can do about -- because we're right now focusing on this -- from here the patients that got -- didn't get taken to a trauma center. We've been digging in there, we can link the EMS --

DR. SAFFORD: What percent -- because I can't tell. Because that's not really out of this, is the percentage of patients not --

MS. CRITTENDEN: No, we didn't -- oh.

DR. SAFFORD: Percent not taken to the appropriate level.

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DR. ABOUTANOS: We have it. Yeah, it's right there.

COMMITTEE MEMBER: 26% or something of one. Still I and II were not taken.

DR. SAFFORD: I gotcha.

MS. CRITTENDEN: So we're taking that 26% that went to the non-trauma centers and -- and trying to -- linking the EMS run with the trauma registry data to see what that patient -- discharge from that ED, do they transfer to a trauma center or they die in that ED?

Did they get admitted to a bed or ICU? Just kind of digging in. So he's -- the first step is the one we're getting to, he's been working on it.

DR. ABOUTANOS: Yeah. But 26% is actually much better number than before. We were like at what? Close to 40-some percent, right? It was --

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MS. CRITTENDEN: Oh, yeah.

DR. ABOUTANOS: Yeah. I think nationally --

DR. SAFFORD: I think what would help, though, is actually having -- when you have your -- the trauma incidents that met Step One criteria.

And with -- you giving that by a percentage in that table would be helpful. Because that -- because really it's tough to -- so look --

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COMMITTEE MEMBER: The numbers?

DR. SAFFORD: Yeah. So looking at the med step one criteria -- so I'm assuming that's like a Level I criteria.

DR. ABOUTANOS: Yeah.

DR. SAFFORD: It would be helpful not to have raw numbers. It would be helpful to have percentages in -- in the

table --

DR. ABOUTANOS: The step one criteria, Shawn, is on here. It says your first step. So the way -- the way we have done it before, and I like that it's at the beginning.

This should be part of the agenda. As you ask him, he comes up, he gives us a report.

DR. SAFFORD: Right.

DR. ABOUTANOS: And we'll talk -- talk about it. That would only accomplish one part we worked on past few years.

DR. SAFFORD: Right.

DR. ABOUTANOS: Before we start moving into more additional things.

DR. SAFFORD: Yeah, except to me, it's kind of what we've done and then what we're going to do.

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DR. ABOUTANOS: But these -- not forget what we've done, because this was a lot, a lot of amazing work to actually have --

DR. SAFFORD: Oh, yeah.

DR. ABOUTANOS: -- the pre-hospital guys step up to that level. So, you know what would be really helpful? My -- my suggestion now that we're beginning new is, you know like I mentioned, where it was much better than before. Maybe look at --

DR. SAFFORD: Trends.

DR. ABOUTANOS: -- trends. Exactly. Where were we two years ago, 2016, '17, '18. The last one that we have, and then our ability to kind of get a little grasp of -- you know, that should not be -- because we have the report from -- from previous years, right? Yeah.

DR. SAFFORD: And -- and again, to

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that point, geographic trends is important, too, as where are the -- where are the -- you know, kind of areas that -- that seem to be issues with family -- with families.

You've got the locations of the 30-minute drive to trauma centers. But if you could almost have a geographic understanding of that, it's kind of a next level evaluation.

Okay. So to review membership, we still -- let me see the -- where's the sign-in sheet again?

MR. ERSKINE: Valeria's hogging it again.

DR. SAFFORD: It looks like we are still missing a citizen rep, EPR rep --

MR. ERSKINE: Oh, emergency preparedness and response. However, they're meeting right now. This was a -- this was an organizational -- organizational screw-up on my part. So we have to work on re-arranging times -- beginning times.

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DR. SAFFORD: Okay.

DR. ABOUTANOS: So the committees don't meet at the same time is what you're saying.

MR. ERSKINE: Right. I mean, otherwise you can't cross pollinate.

DR. SAFFORD: Okay.

MR. ERSKINE: So they -- they're right next door.

DR. SAFFORD: We would almost have to always be independently --

MR. ERSKINE: Yes.

DR. SAFFORD: -- meeting for -- for the --

DR. ABOUTANOS: For this to work.

DR. SAFFORD: -- for this to work.

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Yeah.

DR. ABOUTANOS: Yeah.

DR. SAFFORD: Non-designated hospital.

MR. ERSKINE: Working on that.

DR. SAFFORD: And then -- we have a -- we've -- we've put up for recommendation Maureen McCusker. Can you just give a brief --

MS. MCCUSKER: Sure.

DR. SAFFORD: -- introduction yourself?

MS. MCCUSKER: Hi, I'm Maureen McCusker. I am currently a post-doc fellow at Army Research Institute at -- in Fort Belvoir. I earned my Ph D in [unintelligible] organizational psychology last year. My background is really in

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studying individual leadership and team insistent dynamics and -- and how we can improve then become more efficient. So...

DR. SAFFORD: So I -- I've recommended her -- her to be added to the committee, as I think it'd be adding an important other kind of thought process as we start thinking about kind of any more global systems improvement standpoint. So hopefully, it will be extremely helpful.

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MR. ERSKINE: Okay.

DR. SAFFORD: So then next, Tim had sent this to me. But Brian and I -- and actually, I'm on the NQF committee at the -- at the national level.

Tim had sent this to us, so I wanted to review -- I'm going to step to the side so I can look at it as we go through this. So at the NQF Metropolitan Forum in B, had discussed in 2018 looking at systems --

MR. ERSKINE: Did you want this or did you want the --

DR. SAFFORD: No, no. My -- my slides.

MR. ERSKINE: Okay.

DR. SAFFORD: At the NQF level, they had looked at identifying ways for systems to evaluate the quality of programs at a system-wide level.

They broke them into four different domains that access the trauma services. Trauma critical care, cost resource, use and prevention of trauma.

Those -- those have been broken down into their sub-domains, assistance capacity, availability, timeliness, resource matching.

The trauma clinical care, acute care, post-care, longitudinal. Cost and resource at the individual level. The trauma center system isn't at the societal level. And then finally, prevention with

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engineering, education, legislation and enforcement. I think it's really interesting that basically all of our committees -- it's amazing how well we matched and aligned to many of those sub-categories.

So we really have ways for, in my mind, the -- the protocol or -- or kind of way you can reach out to each of these sub-groups -- I just -- the committees to identify areas within that.

So that -- if you hit the next slide. The access to trauma services, those are broken down into that capacity services, availability of services, timeliness, resource matching.

Can you go to the next slide? Acute care, post care, next slide. I kind of went through the previous -- one more. And then one more.

If you look at these broken down, they actually tried to identify specific metrics that can then hit within each of those categories. Kind of low hanging fruit. And so if you look at these,

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you know, our -- what we just discussed this morning is a portion of the population field triage guidelines, but did not go to trauma center. Again, check.

We're kind of working on that. Because as you can see, these are very nicely aligned with, I think, what our missions are.

And the data we can provide to the State level that'll help us identify needs. Some of our issues are, I think, we all -- you know, those -- the lack of -- of data was our first problem.

That's the stuff that was addressed with, you know, with [unintelligible] in the past. But some of the problems, we don't know what the problems are until we started doing the analysis.

So I -- again, these -- these provide the frame work from which we can actually provide back to the different sub-committees recommendations that they choose. Let's choose one or two out of each of these categories. Hit the next one.

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Cost and resource, again, the sub-domains are broken down by these different identified low hanging fruit on methods of identifying.

Cost per -- cost per year, lives saved. I mean, those are things that I had -- at a State level would be, I think, impactful. Re-admission rates, identified stratified by type of trauma.

These are all things looking at the various levels of care as well. Next slide. Trauma clinical care. Again, identifying within this group and ideally, we're going to -- I'd like to present this back to the larger committee as the frame work.

And then have them see if they can identify back to us, as a group, a few of these that -- we're not choosing them, but rather they're being chosen by the different experts in the area as well.

And then finally, the last one is the prevention of trauma. And here again, these are very easily identifiable data from the trauma database that, if we

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can create these reports -- again, this is probably the -- in my mind, was the easiest one to kind of hit and to say it's far more easily identifiable.

But again, would be important for the State overall. So this is the -- the frame work of that, I think we can use for this committee, marrying up with NQI. I get my -- my goal is for us to present this at the NQF level eventually.

Because no one else is doing this and using this -- this system yet. And so we can be the test for them to identify -- to -- to improve those outcomes, improve trauma care in general.

MR. ERSKINE: Okay. Comments.

DR. SAFFORD: Comments.

DR. ABOUTANOS: I'll give you my comment.

DR. SAFFORD: Yes, please.

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DR. ABOUTANOS: Number one, I love it. This -- this is exactly what I was hoping with this committee would go towards may -- if that's what's needed.

The -- I definitely think you should present it to the TAG just the same way. This is kind of a frame work. There is, obviously, the -- the -- the original frame of trade in the trauma system plan.

But this is -- matches -- makes it a little more manageable. What we have -- the phase would end right now as every committee is just trying to kind of figure out its members, trying to figure out, you know, who we are and what are we.

That has the risk of kind of being siloed or some committees are more advanced than others already. They jumping into the trees before you can see in the forest.

And so -- and so yesterday, I mentioned that to a few of the committees that I went to. And I was going to mention again today at the TAG is, we're going to plan a -- a meeting probably, I'd say June

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or July. Right, Cam? Something like that, with regard to the -- either the TAG or the chairs to get together and then outline this -- where we going to go.

And then every committee basically will follow this -- one -- one of the objective of the TAG says alignment of the various committees. All of them are dependent on what this committee does.

That's the importance of this committee. Everybody is, what is the data? Is this data aligned to the fact that we're all going toward the same goal. This is an excellent frame work that puts all this into context.

I would like to see what everybody else think, but I think this -- this would work very well on something for -- okay, every committee will -- will take part of this, you know.

And initially when I looked at the board, I thought you actually put in our committees in there. And then --

MR. ERSKINE: Yeah, right.

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DR. ABOUTANOS: -- that was already there. So that's -- it just shows that we're all on the same -- and so, this is excellent.

I mean, that kind of aspect because it show -- I give you an example. At the pre-hospital guys yesterday, they were talking about a lot of various small thing.

And when I asked, hey, let's go back and talk about what is your objective. Where are we going to go. They said, okay, well, what kind of data we need -- we need to get, you know.

That was the -- the last five minute, we're trying to talk about data. And this has solved a few things already here. What other specific things we going to do in order for us to be aligned?

So if this is already frame work and it hasn't been used, was it -- at the NQF, did they talk about specific for trauma, was it?

DR. SAFFORD: This -- no. This is

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just at a global NQF meeting.

DR. ABOUTANOS: Yeah.

DR. SAFFORD: And then this was the one that they -- this was trauma-specific NQF sub-group.

DR. ABOUTANOS: Yeah, oh.

MR. ERSKINE: That's being finalized right now.

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DR. SAFFORD: It's that -- this is hot off the presses. I mean --

MR. ERSKINE: Yeah.

DR. SAFFORD: -- this is not really even at the national level yet. So again, we have an opportunity, again, just thinking from an academic standpoint and a kind of representation of Virginia in the -- in the -- in the country --

DR. ABOUTANOS: Yeah.

DR. SAFFORD: -- we have an opportunity to really kind of say, we've taken this, married it and -- and run with it.

DR. ABOUTANOS: I think we have to present at the -- at the TAG and see what everybody else think about that.

DR. SAFFORD: I'll see them later today. I'll 'cc' it also.

MR. ERSKINE: Any other comments?

MS. MCDONNELL: I'm Anne. I'm from the Post-Acute Committee. And we began identifying some of the data points we wanted to look at. And they were on this list.

DR. ABOUTANOS: Oh, perfect.

MS. MCDONNELL: So you know --

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DR. SAFFORD: Awesome. That's awesome.

MS. MCDONNELL: -- we came up with a few more. But you know, then we started to realize we had to eat that -- eat the elephant a bite at a time.

DR. SAFFORD: Well, and they --

MS. MCDONNELL: And several of them were on there.

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DR. SAFFORD: I think that's a very important point, which is we need to -- you know, ideally -- you know, Cam and I were talking about this yesterday. We need make sure that we don't want to say, we want every point on this list tomorrow.

DR. ABOUTANOS: Yeah.

DR. SAFFORD: We need to figure out what is low hanging, what's effective and what's going to make an impact. I mean,

this -- this -- this is a perfect example of the -- of these criteria. We just need to have the GCS to understand what's going on.

We need vital signs to understand what's going on. And if you said this -- it doesn't sound fancy and sexy as far as we now just got vital signs. But that's critical.

So while I want to know that the -- the nuance, I think we just need -- as we approach forward, we need to be thoughtful of one or two out of each of these categories that -- let's have a goal of identifying and seeing what impact is over a year or two.

MR. ERSKINE: I'll send the NQF document to the chairs.

DR. ABOUTANOS: Yes.

MR. ERSKINE: The TSC chairs so that they've got that ahead of time.

DR. SAFFORD: Perfect. Any other

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comments?

DR. ABOUTANOS: I think maybe it would be important to also mention really what is NQF, you know. It's kind of a -- it's a vague --

DR. SAFFORD: Sure.

DR. ABOUTANOS: It's a vague thing. We're -- mostly all of us are in trauma. If we don't -- you know, trauma is not a[n] organization or a database or group or -- we don't look at it --

DR. SAFFORD: Yeah, yeah. I'll give this little slide and I'll -- I'll insert a slide on that.

DR. ABOUTANOS: Yeah, and then --

DR. SAFFORD: Uh-huh.

DR. ABOUTANOS: So maybe -- it would be good if you could present -- you

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have time, I mean, between now and the TAG?

DR. SAFFORD: Yeah.

DR. ABOUTANOS: Okay.

MR. ERSKINE: Yeah, and some -- something to include in that for the Pre-Hospital folks is the EMS Compass Project was based on the NQF process.

DR. ABOUTANOS: I have -- in the -- in the TAG agenda, there is a part after every system after every committee present, I have a part about where are we going to go? How are we going to put it? You might speak during that part, specifically on this --

DR. SAFFORD: Sure.

DR. ABOUTANOS: -- on this presentation.

DR. SAFFORD: You just tell me when

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to go --

DR. ABOUTANOS: Yeah.

DR. SAFFORD: -- and I'll go.

DR. ABOUTANOS: Perfect. Excellent. Okay, we'll have -- we'll have the slide set up like this.

DR. SAFFORD: Yep. Yeah, and I'll -- I'll send -- after this meeting, I may go -- Cam and I do a little bit extra in NQF. So is there public comment period? Any -- yes, please.

MS. CRITTENDEN: I have a comment. I would like to introduce Jessica Rosner. She's a new member of our team in the Office of EMS. She is an epidemiologist. So now we have two.

MR. ERSKINE: Yay.

MS. CRITTENDEN: Yes. We're fully

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-- yeah, we're very excited. She has an impressive background. Has worked in epidemiology at VDH for many years, has worked in private industry as an epidemiologist.

We're happy to have her, lucky to have her. She's familiar with, obviously, the other databases that are available.

She just said something to me about -- asking some questions about -- if I knew about patient outcomes that she had been reading since she saw Narad doing that. So I mean, I think we're really -- yeah.

So with the two of them together, I think that we're going to be able to do some fantastic things that can really make this get off the ground. So -- Cam's happy. Tim's happy.

DR. SAFFORD: That's awesome.

MS. CRITTENDEN: These are a great group of people and you'll get to meet everybody. But yeah, you're going to be

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very popular, the two of you are. So, thank y'all.

MS. MITCHELL: This is Valeria. And did say her last name was?

MS. ROSNER: Rosner, R-O-S-N-E-R.

MS. MITCHELL: Okay.

MS. ROSNER: N as in Nancy.

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MS. MITCHELL: Okay, thank you.

DR. SAFFORD: Any other comments? Unfinished business.

MR. ERSKINE: I don't think there was any from the last time.

DR. SAFFORD: Yeah. New business. I think at the next -- I think the next steps are we going to -- we will be presenting this to the, as we said, the TAG group today. I think once we get the

response back from that, I think there's a little bit of -- I just -- I -- I would love to not wait three -- I guess the question I have at the -- at the State level is, if they -- can we send this back to those committees and have them identify one or two of those low hanging fruit that they feel would be helpful?

That we then bring back to this committee at the next -- can there -- can there be something given back to us between the next -- this and the next meeting?

MS. CRITTENDEN: Sure.

DR. ABOUTANOS: I -- I do think, though, we -- so what we don't -- I think we should have our meeting with the chairs and --

DR. SAFFORD: Yeah.

DR. ABOUTANOS: -- present it then.

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DR. SAFFORD: Okay.

DR. ABOUTANOS: Because this -- there's a -- a strategy in it. So --

DR. SAFFORD: Sure.

DR. ABOUTANOS: -- we put it on and just say, hey just -- just do this. And somebody says, wait a second. For the past three years, we've put in all -- these are to stand, doing all this stuff.

You've asked us to be objective and now we're saying, hey, just focus on this.

DR. SAFFORD: Right.

DR. ABOUTANOS: So that's going to -- we will hear back about it. What -- what -- what are we doing here? Just because NQF put out --

DR. SAFFORD: Right.

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DR. ABOUTANOS: -- their ideas, it's actually the same thing.

DR. SAFFORD: Right.

DR. ABOUTANOS: It really is. And so -- because at a glance, when I looked at it just at a glance, I'm like yeah, this is -- it's actually aligned and -- and the entire report that we have.

So I think if we use this as a frame for the -- the meeting of all the -- the TAG in front of the chairs --

DR. SAFFORD: So you want to wait on this until we get to the chairs, to be presented to the chairs or --

DR. ABOUTANOS: No, no. We can present today to the -- to the TAG.

DR. SAFFORD: Okay.

DR. ABOUTANOS: And say, guys, this will be one frame work we're going to look

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at.

DR. SAFFORD: Okay. Perfect.

DR. ABOUTANOS: It -- it's a --

DR. SAFFORD: Yeah.

DR. ABOUTANOS: Instead of saying this is the frame work --

DR. SAFFORD: Yes.

DR. ABOUTANOS: This is one frame work we're going to look at. I think it's -- and I think it aligns with a lot of what we have. And gives us a structure to go with. But we want to give people time to digest it.

DR. SAFFORD: Sure.

DR. ABOUTANOS: You know, like we'll send it to the chairs, have them come back at the -- at the meeting we're going to

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have in July.

DR. SAFFORD: Okay.

DR. ABOUTANOS: And then, everybody can have time to look at it. And then it will -- every committee chair will -- will know it. Will give this more time during our -- it's kind of like a retreat for --

DR. SAFFORD: Sure.

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DR. ABOUTANOS: Anybody's welcome to come to that because it will be an open meeting. But it's mainly basically will be -- so this -- yeah. That --

DR. SAFFORD: Okay.

DR. ABOUTANOS: -- was the main aspect, you know, with regard to this.

DR. SAFFORD: All right.

DR. ABOUTANOS: It's the process of

getting all -- everybody there.

DR. SAFFORD: Any other new business?

DR. ABOUTANOS: The only thing I have is -- reiterating again what is -- you know, what's the function of this committee, going to the goals and all this stuff.

So as we -- one aspect I -- I encourage is that every committee chair and every committee is looking for kind of the data to -- to go with.

And looking for this committee to kind of help guide one part. And so that relationship needs to exist at each committee level.

So the way we have it -- we have it set up is that we changed this from being simply a committee that came -- that come up with what are the data quality toward having education being major part of this committee. It's a different frame work. And so maybe go back to our goals and finding out what's the goals of this

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committee. And then linking the -- saying okay, if we -- because -- so that our -- we look at this -- the new steps, the new plan. There are two core committees.

And then there are, what, five operational committees. This is one of the core infrastructure kind of committee, this and the TAG.

So one thing I will -- I will encourage us in this committee is to take a look at every committee that's operational and just say, how are we going to work with this committee?

What is -- what is it that that committee needs? And this is why you have every representative here, you know, to say -- okay, what do you need from -- so what are the data -- what are the overall database.

This frame work will eventually put it in a nice -- in a nice way. But it is like -- like we said in the Disaster Planning. It's not the -- the plan, it's the planning. And so the same thing here. So it's not only the frame

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work. It's the relationship that we develop with each committee. We risk -- the way we develop our plan, we risk of having a siloed group.

This committee's going to -- one of its objectives is to -- to prevent that silo from happening, you know. So in the one sense, we'll be after -- after every committee meeting is what do you guys need?

What are you after -- you are representatives here to the various aspect. So what we have done in the TAG -- and it's just one suggestion for you to consider everybody else.

After we're done, a report from every committee, okay? You may want to have here a report from every committee representative to say, this what we're struggling with.

Your objectives, is this based on data? Because the last thing we want is to have kind of emotions or aspects. So just --

DR. SAFFORD: And do we have a

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representative from each committee on this --

DR. ABOUTANOS: Let's -- let's find out. Do we have -- I think we have --

DR. SAFFORD: Yes. First, so we have five additional --

MR. ERSKINE: Yeah. They're -- they're not here, but we've got --

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COMMITTEE MEMBER: So the other two --

DR. SAFFORD: I guess -- I guess my other question is, and again, I've made a commitment personally. And I think that most of the people I've seen are committed to this committee, trying to get each one of us to at least public -- sit publicly on the other committees, too. Because I think that may help.

DR. ABOUTANOS: That's the

crossover.

DR. SAFFORD: Yeah. That we can be present as well as if they can't be present. I mean, that might be able to --

DR. ABOUTANOS: Yeah.

DR. SAFFORD: -- and we might be able to delve out amongst our committee. Hey, I can see -- and make sure we have a representative. And yes, we can't -- we can't dictate it. But if we could actually --

DR. ABOUTANOS: But -- but once you have the agendas, Shawn -- I think if you have the agenda and then somebody says, this is my report. And I'm the one that's going to give that report.

So from that committee, if -- if I'm the chair, let's just say, of the Post-Acute, right? And -- and I just say, okay. Hey, look, make sure when you represent, you're going to talk about this,

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this, this. Because this is what we need. Some of them, I think, the Post-Acute did that. I think Margaret did that, that she asked you to -- did she ask a couple of things that she wanted?

MS. MCDONNELL: She asked for a report on what we had discussed this last meeting. And we talked briefly about it. I didn't have the agenda, so I wasn't sure.

But that's why I was able to add that, you know, we came up with this data list yesterday --

DR. ABOUTANOS: Yeah.

MS. MCDONNELL: -- that pretty well mimicked what -- what was happening.

DR. ABOUTANOS: Yeah, so they -- I was impressed. I walked in, so -- and Margaret was -- oh, I'm sorry -- Maggie was basically had every -- what are all the databases, you know, for the Post-Acute. Where do they exist? Which one is valid?

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That was your comment, it's just a web site that doesn't give any data. Which one is truly -- so was really working hard on their part to identify.

And then they -- which element we need, you know. So it's really great, but it needs to link back to what the System Improvement is doing.

DR. SAFFORD: Mm-hmm.

DR. ABOUTANOS: And so -- the same thing with the -- with the Pre-Hospital. That came around also as far as -- so I asked them, you know, in Pre-Hospital.

They were working very hard, but it was all into kind of -- what was it -- just some basic things. Because I've been doing this for 30 years of Pre-Hospital.

Then I just said, hey, what's the Pre-Hospital mortality for trauma in the state? Silence. Silence. Just one simple question that we should be aware of. You know, people who are injured, how many die

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before they get to our hospital? How this -- you know, just identify the problem with this public health model, instead of going down and -- and you can see there's a shift.

And maybe just -- okay, where do we get this -- this data from? And so, I think this frame work would definitely help because that's where we're at. And -- because the relationship is important --

DR. SAFFORD: So to that point, then, I think we need to make part of our agenda reports from the committees.

DR. ABOUTANOS: Yeah.

DR. SAFFORD: I mean, I think that's a great -- I love that idea. I love that idea.

MS. NEWCOMB: Hi. Anna from Research Inova. I guess what would be helpful to me, because I haven't been involved in this for 30 years. I'm trying to -- I've been involved in it for an hour.

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It would possibly be helpful for me -- I know you sent it out or something like it, an organizational chart of all the folks who are here in these -- in these committees and how they relate to each other. So I'm hearing that there are a couple systems and there are a couple --

DR. ABOUTANOS: You didn't go through the orientation meeting?

MS. NEWCOMB: Yeah.

DR. ABOUTANOS: He set up an orientation for all the new members, right, pertaining to what you're supposed to know.

MR. ERSKINE: Yeah. And then the network went down and I lost it. No.

DR. SAFFORD: Were you blaming everything on the network --

MS. NEWCOMB: Yeah, that's what --

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MR. ERSKINE: It's a convenient excuse, yes.

MS. NEWCOMB: I'll be using that one, too. So if there's like a schematic that we could just post that we'll just have it. I mean, we don't have to go over it.

But as you speak of these things, it might be handy to know who's here and then what are their specific goals. So how I fit in our how they fit in --

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DR. SAFFORD: Yeah, we can get that for anyone --

DR. ABOUTANOS: We have that.

MS. NEWCOMB: -- who's interested.

DR. ABOUTANOS: We have that.

MS. NEWCOMB: Just to post it up there, yeah.

DR. ABOUTANOS: So this -- so what

you comment on is what we dealt with forever with the trauma system oversight -- we didn't know where we fit in. We had no idea who we were, what's our structure. And so -- and then so we created a chart.

MS. NEWCOMB: Now you know.

DR. ABOUTANOS: Yeah. But new -- every new member should know.

MS. NEWCOMB: Yeah.

DR. ABOUTANOS: You know, there's a chart. And I definitely encourage --

MR. ERSKINE: I'll just send it to everybody just to make sure --

DR. ABOUTANOS: And if you need the trauma system plan that we developed --

MS. NEWCOMB: Yeah, it's back here somewhere. But --

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DR. ABOUTANOS: But that also has -- that also has the new structure.

MS. NEWCOMB: Mm-hmm.

DR. ABOUTANOS: But --

MS. NEWCOMB: Okay, thank you.

DR. ABOUTANOS: But I think that's something Tim came up with. Every new member should go through this is who you are, this is where you sit. This is how the organization is. Because it does get confusing.

MS. NEWCOMB: Mm-hmm, thank you.

MR. ERSKINE: I'm not sure that schematic is -- actually clarifies it. But I'll send it to you anyway.

DR. ABOUTANOS: If it doesn't we have to make it clear. Because we have it -- we have it in PowerPoint. Because we --

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for a while, where do we sit? What's it -- and there's been some new changes that we -- so currently, for example, so right now we're a committee.

But we're not -- we don't have specific voting members on the EMS Advisory Board. That's something that's in the plan that we've asked for.

And eventually, when our plan -- an epidemiologist will sit on that -- you know, the way that where we've asked for one of them is from -- from that part and research aspect and -- and all this.

But yeah, I think if we could do that because you're not the only one that's a new member. There's a lot of new members.

DR. SAFFORD: Yeah. There at the end is the names of the representatives from the different -- the -- the --

MR. ERSKINE: Yes. Now, that one I can blame on the network, too.

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DR. SAFFORD: Okay. Yeah. Okay. Any other business?

DR. ABOUTANOS: Something else I was going to ask.

DR. SAFFORD: Yeah, please.

DR. ABOUTANOS: The -- so this -- so this was great, and I think even the report here would be very helpful. Like actually for us to see it.

Because if they ask us about it, also -- and EMS, for us to be able to speak to it. So when you come to -- to present today and say here is a report. You know, and --

DR. SAFFORD: I would love to actually present it. I mean, it would -- we probably should present it to the bigger groups.

DR. ABOUTANOS: Yeah.

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DR. SAFFORD: I mean --

DR. ABOUTANOS: That's -- that's your part.

DR. SAFFORD: Yeah.

DR. ABOUTANOS: So you could do that. So maybe you get together afterward and then you say --

DR. SAFFORD: Yeah.

DR. ABOUTANOS: -- guys, this is where we're at. The other -- the other part is, when -- I guess eventually to come up with, what is -- what -- may be based on the frame work you have, what's the -- what's the data we're going to get from the actual registry. We do not -- have not gone into that. Like that would be the next --

DR. SAFFORD: Right. Based on what -- what criteria we're looking at.

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DR. ABOUTANOS: What we're going to go with. I like the idea of what you said of low hanging fruit. Because it's -- if you start big, it's -- it's -- if we could -- if we can -- everyone has said for this year, these are the three deliverables that we must have.

And you could link those to other ones. You know, you just say this is -- this is our highest mortality and this is what's coming. That's right, okay. What's the Injury Prevention group doing about it?

Okay, what's that data about? So what's addressing that one point. Then we go to the next level. What's the Pre-Hospital group -- what is -- what does that involve?

Then the Hospital, then the Post-Acute part. Like linking the -- you know, this is eventually where -- we never thought of ourselves in a system plan.

It was always kind of based on what does a hospital do. And -- so this committee is vital for everything that we're doing. And some day, we're going to have

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all the PhD-er's you know, one, two and three. It's going to be a powerhouse.

MS. ARNOLD: Shelly Arnold representing the Acute Care Committee. Can we get these reports before the meetings so we can actually read them and review them and -- and be more prepared when we see them? I mean, is that possible for these to be sent out --

MS. CRITTENDEN: It's just the process has always just been that we presented them at the meetings so you all could review them then. Because TPIC always met before all the advisory --

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: So we can just switch it that way.

MS. ARNOLD: Sure.

DR. ABOUTANOS: So the way it

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worked before, I guess, so is that exactly what Cam said. So this gets presented because there's a lot of questions about it. And this committee says, can you present in a different way. I'm not sure about this data.

So this committee kind of really beats -- they beat down this report. And then they say, okay, then comes in the -- kind of the report that we want to send to everybody. It just -- there's been a change, that's all.

MS. ARNOLD: So wasn't the TPIC sort of more -- we began working on strategic plan and it kind of changed a little bit. We just kept it up --

DR. ABOUTANOS: Yeah.

DR. SAFFORD: But yeah. I think what she's saying is --

MS. ARNOLD: But with that --

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DR. SAFFORD: -- can the members of this committee --

MS. ARNOLD: This -- this body can -- can --

DR. SAFFORD: -- see it before this meeting.

MS. ARNOLD: -- see it before the Board meeting. So that we could've asked questions. And just like you said, the percentage showing on there is -- is vital.

You know, just asking the questions and getting a percentage differently before it's ready for distribution.

DR. ABOUTANOS: And we've done that before. It's exactly how we used to it.

MS. ARNOLD: Okay.

DR. ABOUTANOS: It goes out to the members of this committee.

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MS. ARNOLD: Okay.

DR. ABOUTANOS: It comes here, then everybody hash it out -- have the questions ready. And we have our epidemiologist present this.

And then we talk about what additional information -- I just -- all I'm asking is -- and I think, Shawn, you're asking the same thing -- is that we move beyond the Pre-Hospital. You know, like we even have to for every level.

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MR. ERSKINE: And again, I think identifying low hanging fruit at each of these phases and each of these committees really will help us not focus too much just on one.

DR. ABOUTANOS: Yeah.

MR. ERSKINE: And each committee should come up with a low hanging fruit that we can go after.

DR. ABOUTANOS: Because also --

MS. ARNOLD: And I know the Acute Care Committee talked just really, really briefly yesterday. But if we could get onto the trauma registry, the probability of survivals of trauma patients and then negative outcomes so -- to kind of look at that. I mean, that's just one of the pieces --

DR. ABOUTANOS: Yeah.

MS. ARNOLD: -- that we can look at to see how things are - are working within our system.

DR. ABOUTANOS: And this report, it also like -- so right now that we're changing -- so this all Pre-Hospital. The Pre-Hospital Committee should have this report. Because this is really about their part. And so -- and if they know that this is a report that's been hashed at the System Committee. Hey guys, we looked at it,

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etcetera, here's what we add. Now we're sending it to you for your comments back and forth. Then it'll be -- this report then eventually will come out of both committees.

And so you're seeking a -- the way -- I think -- show me every data report that comes out. It's hashed by here but it's all locate-able. Like in the prevention committee will be the same thing.

They will have their database, but -- so if we achieve that level, I think it would be an amazing, talk about network of -- of understanding what the problem is and having multiple committees working on this.

DR. SAFFORD: The field trauma triage --

DR. ABOUTANOS: Yeah.

DR. SAFFORD: Where is that coming from?

MR. ERSKINE: That's ours. That is

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Virginia approved field triage. It is -- it's based on the CDC.

DR. SAFFORD: Because it really -- again, just a -- I'm going to get a little bit in the weeds. But for children, now that we have peds trauma centers, I don't know if it really fully addresses that. This -- this is something --

MS. CRITTENDEN: It's a field triage scheme -- I don't know about that word -- hasn't been updated -- I think it was 2011. And that code, I've double checked -- double checked the language -- believe that the --

DR. ABOUTANOS: This?

MS. CRITTENDEN: Yeah. The -- the -- that gets redone by the trauma system committee, too. So we have -- I only double checked the code language --

DR. ABOUTANOS: Yeah. So this --

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this goes back -- we'll go back to the Pre-Hospital and to the TAG. But we looked at this because there was an update on this. We --

MS. CRITTENDEN: Yeah, but it -- it seems -- it can be updated again. Like he said --

DR. ABOUTANOS: Yeah.

MS. CRITTENDEN: -- we didn't have all of it.

MR. ERSKINE: We didn't have peds trauma centers or burn -- you know, I think there's trauma and peds -- burn and peds now making impact on -- on these.

DR. ABOUTANOS: Yeah. I mean, this was a big -- this is not exactly CDC. This deviated from the CDC when we met here. And so there was a big issue like in step one. CDC says go the highest level of care. Here we said Level I or Level II. And so there

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was some local issues with regard to a lot of this. So -- but this, we looked -- Valeria, you can talk about this. We talked -- we did this for a while, right?

MS. MITCHELL: Yeah.

DR. ABOUTANOS: As far as the triage and some -- so it was about three -- right before two thousand --

MS. CRITTENDEN: Yeah. I can't remember exactly when.

DR. SAFFORD: I guess time passed faster than you think.

MS. CRITTENDEN: Yeah. I think it was 2011 or '12. If you look at the date on the trauma triage plan on their web site, it's been a while. I remember it.

DR. SAFFORD: Sorry.

MS. CRITTENDEN: I don't know.

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Part of it. At 31 level, it was not trying.

MS. MITCHELL: But yeah. It was based on the CDC. And the CDC updated theirs, but then took it away. And it's still the 2011 criteria now still.

But I think the reason why we didn't address peds or burn is because the CDC didn't address that on their criteria.

DR. SAFFORD: But that was prior -- it was also prior to having -- us having burn and peds centers.

COMMITTEE MEMBER: Well, that's correct, but --

DR. SAFFORD: You couldn't have -- even if they didn't, wouldn't have been able to address it.

COMMITTEE MEMBER: Right, yeah.

DR. SAFFORD: Because we didn't have that.

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COMMITTEE MEMBER: We didn't have that.

DR. ABOUTANOS: So -- so this is interesting point. Okay, so we're saying why are we discussing it. Because if we're saying we're basing our quality on whether we're meeting these criteria.

Are these criteria the right criteria to me? So that's why you're asking that question. So we'll bring this back to the TAG and when -- when we assign a talk, there is -- the work group, the triage work group. Right? Are we looking at this again Monday or do you all know?

MR. ERSKINE: No. No, that -- that got passed the -- in what the review of the trauma triage -- it happened since I've been here.

DR. ABOUTANOS: Oh, yeah.

MR. ERSKINE: I wasn't -- I wasn't involved in it, but --

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MS. CRITTENDEN: Yeah, we did stroke triage. Yeah, we haven't done trauma triage.

MR. ERSKINE: Oh, that's right.

MS. CRITTENDEN: No, it was stroke triage plan that we did that has -- yeah. But we haven't done --

MR. ERSKINE: Stroke trauma is different.

MS. CRITTENDEN: Other -- it was before you were here.

MR. ERSKINE: I'll follow them down.

MS. MITCHELL: Which one did that come out of, Pre-Hospital or --

MS. CRITTENDEN: Virginia deaths, Virginia Stroke System Task Force.

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MS. MITCHELL: No, I meant the trauma triage.

MS. CRITTENDEN: No. It actually comes at TSO. It came from TSO and they pulled a group together. I wasn't part of that.

DR. ABOUTANOS: Yeah, we didn't -- that was -- that was TSO.

MS. MITCHELL: Well, I -- I know that. But --

DR. ABOUTANOS: But you mean now.

MS. MITCHELL: -- where are we coming from now? Which group would it come from now?

DR. ABOUTANOS: Now it would go -- I think it will start at the Pre-Hospital and -- and -- probably be the Pre-Hospital and the Acute both. And this will -- this will have to happen. Certain committee will

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work and -- and like a work group to simply look at this.

DR. SAFFORD: Mm-hmm.

DR. ABOUTANOS: I'm sure the Medical Decision Committee also --

MS. CRITTENDEN: I think MDC, EMS, trauma system.

DR. ABOUTANOS: But initially it should -- so I'll -- we'll bring this up at the TAG that this -- in order for to solve the criteria, this is good report based on this and know there's a lot more involved now with peds and burn that we saw.

DR. SAFFORD: Okay, we'll bring it up. All right. So any other new business or discussions? All right. If that's the case, then I call the conclusion. All in favor, aye.

COMMITTEE MEMBERS: Aye.

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DR. SAFFORD: All opposed? All right. End of the meeting. Thank you.

(The System Improvement Committee meeting concluded.)

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CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing SYSTEM IMPROVEMENT COMMITTEE heard on May 3rd, 2019, from digital media, and that the foregoing is a full and complete transcript of the said committee meeting to the best of my ability.

Given under my hand this 24th day of June, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.

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