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VIRGINIA DEPARTMENT OF HEALTH ADVISORY BOARD
OFFICE OF EMERGENCY MEDICAL SERVICES

ACUTE CARE COMMITTEE

THURSDAY, MAY 05, 2022
3:00 P.M.

EMBASSY SUITES BY HILTON RICHMOND
2925 EMORYWOOD PARKWAY
RICHMOND, VIRGINIA 23294

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APPEARANCES

COMMITTEE MEMBERS IN APPEARANCE :

JEFFREY YOUNG, CHAIR

SHELDON BARR, TRAUMA CENTER ADMINISTRATOR

BETH BROERING, LEVEL I TRAUMA CENTER

KELLY BROWN, LEVEL II TRAUMA CENTER

DR. BRYAN COLLIER, LEVEL I TRAUMA CENTER

SONIA COOPER, BURN CENTER

PIER FERGUSON, NON-DESIGNATED HOSPITAL

DR. TERRAL GOODE, LEVEL II TRAUMA CENTER

TRACEY JEFFERS, LEVEL III TRAUMA CENTER

CATHY PETERSON, PEDIATRIC TRAUMA CENTER

DR. KEITH STEPHENSON, LEVEL III TRAUMA CENTER

RICHARD SZYMCZYK, PHC REP

OTHERS IN APPEARANCE

VALERIE QUICK

RON PASSMORE

GEORGE LINDBECK

MOHAMED ABBAMIN

WILLIAM WEBER

AMANDA TURNER

ROBERT TEWEY

AMANDA LORETI

LORI STURT

- 1 JOSH ORZEL
- 2 DALLAS TAYLOR
- 3 TIMOTHY KENNEDY
- 4 KATHY BUTLER
- 5 CHRIS MONTERA
- 6 WHITNEY PIERCE
- 7 JAMES GIEBFRIED
- 8 MINDY CARTER
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1 **VIRGINIA DEPARTMENT OF HEALTH ADVISORY BOARD**

2 **OFFICE OF EMERGENCY MEDICAL SERVICES**

3 **ACUTE CARE COMMITTEE**

4 **THURSDAY, MAY 05, 2022**

5 **3:00 P.M.**

6 **CHAIR YOUNG:** Everybody, we can get
7 started. It'll be a little casual. I can't even
8 remember when the last meeting was. Did we get
9 minutes of any kind?

10 **MS. CARTER:** I don't have, do you
11 have them in front of you because ...

12 **CHAIR YOUNG:** No.

13 **MS. CARTER:** I can't even pull them
14 up right now.

15 **CHAIR YOUNG:** Well, we can vote on
16 to approve them anyway. So basically, what we
17 have been working on, we've been working on these
18 2 same things for nigh on 2 and a half years at
19 this point, which was the trauma program managers
20 working on revising the Commonwealth Designation
21 Manual, part one. And that revision also entailed
22 looking at the College of Surgeons' optimal
23 resources document and looking at what kind of
24 crosstalk there was between those two. And that
25 is what percent done that first part?

1 **MS. BROERING:** I'll defer to Tracey
2 as the newly elected leader of the Trauma Program
3 Managers.

4 **CHAIR YOUNG:** So, Tracey.

5 **MS. JEFFERS:** The trauma
6 designation manual, the trauma program, managers
7 workgroup, we have actually, that one has come to
8 completion. We've gone through everything and
9 capability forms that we've also looked at as
10 part of the designation. And those are going to
11 be talked about today. We just received the burn.
12 We have received peds and adults from their
13 specialties also. I know that.

14 **CHAIR YOUNG:** Okay. So this still
15 has to go through the whole thing, right? Does
16 this whole committee have to approve everything?

17 **MS. JEFFERS:** This committee asked
18 for the trauma program management group to do
19 this task.

20 **CHAIR YOUNG:** Right.

21 **MS. JEFFERS:** Part of the task has
22 been completed which would be the designation
23 manual. So that would have to come back to this
24 committee. And this committee would have to
25 review and then it would go to the final of the

1 Office of EMS.

2 **CHAIR YOUNG:** So can that document
3 be sent out? Or does it have to be reviewed,
4 whatever their revised document can be sent to
5 the committee?

6 **MS. JEFFERS:** Yeah.

7 **CHAIR YOUNG:** Because otherwise,
8 it'd be impossible to look through the whole
9 thing here, obviously.

10 **MS. CARTER:** It could be sent to
11 the committee. There is no issue that.

12 **CHAIR YOUNG:** And, did you by any
13 chance highlight those areas that changed?

14 Is there at least a track change?
15 Copy?

16 **MS. JEFFERS:** We put one to a close
17 together, but it's significant to change.

18 **CHAIR YOUNG:** Well, I mean, let's
19 say we discuss it next time as we discuss it, if
20 you could then say, okay, go to this page, we
21 change this, that's probably all we need. But I
22 think people are going to have to look at it
23 somewhat beforehand.

24 **MS. JEFFERS:** Okay. We can send it
25 out to this group without a problem. For God's

1 sake, do not reply all if you have a question or
2 comment.

3 **CHAIR YOUNG:** So that is part one
4 of that task. Now, the new optimal resource
5 document has come out. After that is done, do you
6 want to then do a crosswalk with that before it
7 goes up? We can't send it up and then send it up
8 again later.

9 **MS. JEFFERS:** That would be to the
10 discretion of this committee. That's when it's
11 just come out ...

12 **CHAIR YOUNG:** I think what we could
13 do is look at what you have. And some of us are
14 getting to know the new document pretty well from
15 the college. And we can just kind of get a
16 spitball of what looks best. Is that okay, that
17 we just kind of, because I don't think there are
18 any monumental changes. I mean, a lot of them are
19 IR and some other stuff.

20 **MS. BROERING:** This is Beth
21 Broering from the Trauma Level 1 representative.
22 I think it behooves us to take the recommended
23 standard changes the trauma program managers went
24 through the recommendations, and then compare
25 this to what I'm gonna call a draft final

1 document. And then compare those two standards
2 that include process measures that are nuances of
3 the new ACS standards for all levels and say, "Do
4 we need to make modifications to what we
5 suggested?" Because if we don't, then we're going
6 to be years behind the national standard.

7 **CHAIR YOUNG:** Right. So we're not
8 going to send this past this committee until we
9 do that. Correct? We shouldn't. I mean,
10 otherwise. Yeah. Okay. So what we can say is next
11 time at the minutes, next time we have this
12 meeting, I would say that should be pretty much
13 the meeting. Then, we'll have this set out
14 beforehand. We'll discuss what it is such that at
15 the end, so you're not going to be, "Well, it's 3
16 months," right? Do you think you'd have some
17 opportunity to see the crosswalk with the new
18 optimal dock by 3 months from now? Or I could try
19 and do it too, between the 2 of us, hopefully, we
20 can.

21 **MS. BROERING:** It may actually be
22 helpful to have a fresh set of eyes.

23 **CHAIR YOUNG:** Okay, well, the,
24 that's pretty fresh to me at this point, but I'll
25 look at it. I'll try to figure it out. Okay. So

1 for the next meeting, pretty much the entire
2 agenda is going to be reviewing the changes in
3 the new designation manual and making
4 recommendations. If we have to make new edits,
5 we'll recommend those and if not, theoretically,
6 it could be approved. I think we should try to
7 get this comparison to the new optimal dock done
8 at the next meeting. Otherwise, it'll be 9
9 months, right? So there'll be another 3 months
10 before we can do that, and then another 3 months
11 before it could go up to the board, right? So
12 it'd be 9 months. So we should probably try our
13 best to take a shot at it next time.

14 **MS. CARTER:** So, before we go any
15 further, I just wanted to say that all these
16 little devices on the table are recording
17 devices. They are alive. Please announce your
18 name before you speak and do not turn them off.
19 The company will come in and turn those off at
20 the end of the meeting.

21 **CHAIR YOUNG:** All right.

22 **MS. JEFFERS:** I asked the program
23 managers. I did not want to speak for the
24 committee commitment. I'm sorry, this is Tracey
25 Jeffers, I currently am sitting at the level of 3

1 representatives of this committee. And I am no
2 longer with a level 3, I'm now at a level 2. And
3 that's there that I can keep that seat. So we
4 will need a new member to be brought forward for
5 my level 3 position.

6 **CHAIR YOUNG:** But you will still be
7 the TPM?

8 **MS. JEFFERS:** I will be the TPM.

9 **CHAIR YOUNG:** Okay. So, do we have
10 a quorum? So the recommendation and has already
11 been asked is that Mark Dave from Virginia Beach
12 fills that spot? If we have a quorum, are there
13 any other nominations to fill the spot? Looks
14 like there are 7.

15 **MS. CARTER:** One. Two. Three. Four.
16 Five. Six, and you're seven?

17 **CHAIR YOUNG:** Okay. Does anyone
18 else have any other nominations for that Level 3
19 TPM spot? Okay, closing nominations. All in favor
20 of Mark Day being appointed?

21 **COMMITTEE MEMBERS:** Aye.

22 **CHAIR YOUNG:** Any opposed?

23 **(WHEREUPON, no response.)**

24 **CHAIR YOUNG:** All right? Give him
25 the congratulatory text. Make sure he comes to

1 the meetings. Alright. So we decided that that
2 will be the cornerstone of the next meeting.
3 We'll have the recommended changes beforehand.
4 And we'll hash it out at the next meeting. The
5 next thing that, yes, I'm sorry.

6 **COMMITTEE MEMBER:** If you're going
7 to send this out, does that mean that we just
8 review it, and then don't do anything with it
9 until, but I could still talk with like, who's
10 gonna send it out? I guess? What person could I
11 talk to? The person who actually sends out the
12 actual document, correct?

13 **MS. CARTER:** Tracey has taken on
14 the task of sending that out to the committee.

15 **CHAIR YOUNG:** And that's a
16 subgroup.

17 **COMMITTEE MEMBER:** I'll be able to
18 correspond with you?

19 **MS. JEFFERS:** Yes.

20 **COMMITTEE MEMBER:** Okay.

21 **CHAIR YOUNG:** Just don't hit reply
22 all.

23 **MS. JEFFERS:** Yeah. No "reply all."

24 **CHAIR YOUNG:** The next thing I just
25 wanted to bring up was making an official Vice-

1 Chair of the committee. There is no official
2 Vice-Chair. Correct?

3 **MS. CARTER:** There was one recorded
4 but I don't think that he's ever been to a
5 meeting. So, yes, we can go on.

6 **CHAIR YOUNG:** Terral, are you
7 willing to?

8 **DR. GOODE:** Yes.

9 **CHAIR YOUNG:** Okay. Any other
10 nominations? All right. All in favor of Dr. Goode
11 being the Vice-Chair of this committee say aye.

12 **COMMITTEE MEMBERS:** Aye.

13 **CHAIR YOUNG:** Any opposed? Get
14 stuff done. All right.

15 **MS. CARTER:** That's what happens
16 when you have a quorum.

17 **CHAIR YOUNG:** So the next thing
18 that we have somewhat put on the backburner with
19 this designation manual dance has been the whole
20 question of the "dual verified centers" and what
21 we should do about that. So if people think we
22 can make some progress discussing that today, we
23 haven't discussed it in probably a year. Happy to
24 talk about it. Does anybody remember where we
25 were, we were really just spitballing at that

1 point? Correct? We're talking about whether it
2 could be a combined visit, we were talking about
3 whether it should be within a certain period and
4 several other TPM said having a state and an ACS
5 visit within a constrained amount of time could
6 be very, very difficult. It was very, very
7 difficult. And since you have a gestalt of what
8 the new designation manual is, will that make it
9 any easier? To have them close to get one? Okay.

10 So I'm not sure how much farther,
11 does anybody have proposals on how far we can go
12 with that? I know some of us in the ACS centers
13 would like to just have one visit, but that's
14 probably not going to happen. Does anyone have
15 any proposals on what to do? Terral?

16 **DR. GOODE:** For clarification.
17 When you say not close together, does that mean
18 that the state comes in very similar after ACS
19 comes? That's difficult for our combined visit in
20 general, doesn't seem feasible.

21 **MS. JEFFERS:** I think there were 2
22 questions on the table. One of those was can we
23 combine them? That was one question. And then the
24 other question is if you cannot do that, can we
25 make them close together?

1 **CHAIR YOUNG:** And I think people
2 said they'd rather combine.

3 **MS. JEFFERS:** With being combined,
4 I think that goes back to the office of BMS, and
5 their decision so that if you're not spinning
6 your wheels and wasting your time or not going,
7 sorry this is Tracey, maybe we go to Gary.

8 **CHAIRMAN YOUNG:** To what? Go to
9 what?

10 **MS. JEFFERS:** Go to Gary. And say
11 what are the probability possibility of this
12 occurring, so that this committee could then
13 embark on the task, other than that.

14 **CHAIR YOUNG:** So having done a lot
15 of state visits on a college visit, I think the
16 main difficulty is the chart poll, right? College
17 is not going to adopt the state's chart poll
18 requirements. But if the state could adopt the
19 method by which the college does it, I don't
20 think there's a whole lot, I just kind of been
21 visiting Colorado and visiting other states.
22 Basically, New York, New Jersey, Pennsylvania,
23 North Carolina, Colorado, and Florida, all have
24 an OEMS rep that is with the team. So the Office
25 of EMS is with the college team. They attend all

1 the meetings together. And often, they will have
2 their separate criteria on a separate sheet.

3 And they have the ACS Senior
4 Reviewer affirm that they've met all the state
5 criteria. So I'm just saying ways it's done in
6 other states. And that is the most common. Well,
7 the most common way is they just accept the ACSs.
8 But it is known in other places that you have
9 both teams there, you do your best to try to make
10 it so there's as much overlap as possible. And
11 then there's a discussion between the OEMs. And
12 it is possible in certain states that they would
13 not meet state criteria, or ACS or vice versa,
14 I've seen that happen. So I go with what you're
15 saying. Let's ask Gary what's possible.

16 **MS. JEFFERS:** Yeah.

17 **CHAIR YOUNG:** If it is possible to
18 somehow figure out a method to combine them, then
19 the committee can work on the process to combine
20 them.

21 **MS. BROERING:** I think the question
22 was what does good look like that is optimal for
23 the state to ensure that a hospital has met the
24 standard or the minimum standards that are in
25 place to provide optimal trauma care for their

1 population and that their data or their PI
2 process, etcetera. So what does that look like?
3 What does good look like for the state for a
4 hospital that also has gone through ACS
5 verification? And how do we meet that in the
6 middle to make it efficient and effective for the
7 hospital and hospital personnel to be able to
8 meet those needs?

9 **CHAIR YOUNG:** Yeah, I think the
10 biggest, well, the first thing is to ask Gary.
11 Second, the biggest obstacle is really seeing
12 what needs to be seen, what is really markedly
13 different between the two. And as far as my
14 memory, the chart poll is markedly different.
15 Because you only poll 25 charts for the college.

16 **MS. CARTER:** And the ACS is also
17 doing a virtual review versus us doing an in-
18 person review and I don't think that we really
19 have any, there's been no intentionality on the
20 part of the office to even consider virtual
21 reviews at this point.

22 **CHAIR YOUNG:** It was a smaller area
23 to cover. No, that's a good point. I'm not sure
24 that could be combined. If that's the case.

25 **MS. BROERING:** Well, I mean, the

1 review is a process, it's a process of validating
2 the Physical Review, whether it's virtual or in-
3 person, and only a process is being done to
4 validate the standards are being met. And care is
5 being provided in the best way. And that's the
6 methodology virtual versus in-person or whatever.
7 I guess the question is, are the standards being
8 met? And how can they be verified? And how can
9 that be verified in the best way that does not
10 put a huge burden on the trauma center?

11 **CHAIR YOUNG:** All right, so
12 let's...

13 **MS. BROERING:** Because right now,
14 for those Trauma Centers, who are both ACS and
15 state designated or verified, regardless of what
16 level, the burden is on the personnel of the
17 trauma center to do the work, right? I mean, it's
18 incredibly...

19 **CHAIR YOUNG:** So the first step
20 might be to make sure that we just don't have two
21 completely different manuals, which it sounds
22 like we probably do not, correct? So, there are
23 lots of ideas on how to do it. If we stick with
24 face-to-face in the state, the college doesn't
25 care. So the state visits usually only take 7, or

1 8 hours in general anyway if that. As long as the
2 chart poll was the same, and you kind of did your
3 best to not have to do all kinds of different
4 things with paperwork, the state could have a
5 face-to-face the day before the college. I would
6 be perfectly willing to have that as long as it
7 wasn't two completely separate amounts of work
8 that you had to put together, the state could
9 come in person the day before the college could
10 do it virtually. The day and a half after it
11 would still only be probably 48 hours. It's a
12 half-day on one, a full day, and then a half-day.
13 So that would address several other things. We
14 just don't want to do that if the state is going
15 to require a whole different amount of work.

16 **MS. BROERING:** Well, there is that
17 onus, I mean, again, somebody else speak up,
18 please.

19 **MS. CARTER:** This is Beth
20 speaking.

21 **MS. BROERING:** They are completely
22 separate applications and the amount of work and
23 the data poll for the ACS application and the
24 types of data that are submitted for an ACS
25 application. And then what is submitted for the

1 state is quite different as well. There are
2 aspects of the state application like the
3 question describing your trauma service structure
4 and describing your coverage of attending
5 surgeons and staff. You can copy and paste that
6 kind of question or answer some of those
7 questions or describe your injury prevention. But
8 there are very unique data aspects for college...

9 **CHAIR YOUNG:** Is the state
10 designation manual application codified in the,
11 is the application codified in the designation
12 manual?

13 **MS. BROERING:** No.

14 **CHAIR YOUNG:** So we could change
15 the application?

16 **MS. BROERING:** You can change the
17 application.

18 **CHAIR YOUNG:** So there are several
19 steps here. I guess step one, I would imagine
20 being what we're going to...

21 **MS. BROERING:** I mean, I'm
22 speaking, I'm probably speaking.

23 **CHAIR YOUNG:** Is it true?

24 **MS. CARTER:** I actually have plans
25 to revise part of that application. And that is

1 driven by being on this side of things now, in
2 terms of the amount of time that we have to
3 actually go do a review and the number of people
4 that we are able to take realistically to do it.
5 Right now I am very frequently going back to the
6 Trauma Program Managers and asking for additional
7 documents that are not currently included in that
8 listing of documents that we're supposed to
9 review. And to be blunt with you, as you
10 mentioned 6 or 7 hours, is almost an impossible
11 thing to do. There's an awful lot of work that
12 goes in on my part before we ever go to review to
13 make sure...

14 **CHAIR YOUNG:** No, but the actual
15 in-person review, you start in the morning and
16 you go home by 3:30.

17 **MS. CARTER:** Yeah, but what I'm
18 seeing is the application itself, I do have plans
19 to modify that to some degree to make sure that
20 we can fit that, that we get more documentation
21 on the front end in some respects.

22 **CHAIR YOUNG:** Yes.

23 **COMMITTEE MEMBER:** So, to your
24 knowledge, other states who have decided that
25 they want to align with ACS, have there been

1 other states who have had a representative from
2 ACS to help to guide this unification process?
3 'Cause, there's somebody on that side who has
4 seen this happen.

5 **CHAIR YOUNG:** The only state that
6 is completely outside ACS now is Pennsylvania.
7 Ohio does both. But I've visited 25 states. So
8 most states do not have better or anyone, is
9 anyone else aware of this completely parallel
10 process? I'm not aware of it anywhere else.

11 **MS. BROERING:** There may be others
12 and it may be different today. But if I recall
13 correctly, in some of the original conversations,
14 4 or 5 years ago, even. At the time of the Trauma
15 System Assessment, when the college was here for
16 the Trauma Systems Assessment, there was a
17 discussion about North Carolina being an example
18 that we could benchmark against where there are
19 big state and ACS level centers that have
20 somewhat of a combined visit.

21 **CHAIR YOUNG:** Yeah, so the way
22 North Carolina works is the EMS Medical Director
23 for the state, the Trauma Medical Director, who
24 has always been Mike Thomas, and the nurse
25 administrator, for them come to the visit with

1 the college team. They sit in a separate room,
2 and they review those documents that are specific
3 to Carolina. And I believe they just provide kind
4 of a checklist, but the college report is the
5 report that goes in. But that's exactly what we
6 were saying. That whole team goes, they do their
7 own examination. We just would have to do our
8 best to make sure those two examinations are not
9 wildly different, because there's really no
10 reason for them to be wildly different. I mean,
11 there are 400 trauma centers verified by the ACS.

12 I know people feel strongly that
13 we have certain things that we want to preserve
14 in the Virginia system, the college system is
15 pretty well put together. And the way that they
16 do the manuals, we've had this conversation
17 before. So, we're not going to get rid of the
18 Commonwealth system. I would think figuring out a
19 way that we can decrease the amount of work for
20 the centers would be best. I mean, the other is
21 just to make sure that they're off cycle. But
22 that's even worse because then you're preparing
23 for a visit every 18 months. Well, let other
24 people talk.

25 It just seems to me that bending

1 over backward to try to preserve two completely
2 independent systems is not consistent with what
3 the rest of the country is doing. If we want to
4 live free and die and just say that's what we're
5 going to do here, that's fine, but it's not
6 consistent with what the rest of the country is
7 doing. And I think we would have to show that
8 there's value for us being one of the few states
9 in the country that doesn't do it that way.

10 **COMMITTEE MEMBER:** Yeah, I think a
11 lot of it makes a lot of sense. There's a lot of
12 aspiration for centers who want to do with that
13 to give both verifications. No, as you say, do it
14 in an off-cycle way, that's terrible.

15 **CHAIR YOUNG:** That's worse.

16 **COMMITTEE MEMBER:** I can't, I want
17 to throw myself on the track or something. I
18 would need to have it so that it is, very much
19 like you said, it's either a day, three-day
20 combined day visit. And if there's a path
21 forward, it's already been forged. If it's
22 somebody who already blazed this trail, I think
23 maybe our time is better served to not the kind
24 of reinvent the wheel again and see how is this
25 successfully implemented. Yes. Your point is that

1 maybe not a lot we're doing quite this way. If
2 that's the case, are we trying to blaze this
3 trail? And really, there's an easier way to do
4 it.

5 **CHAIR YOUNG:** Yeah, I mean, the one
6 thing that we've said from the beginning is we
7 would not require, there are states, Illinois, a
8 bunch of states require you to be visited by the
9 ACS. I don't think we would ever do that. I don't
10 think that's what the Commonwealth would want.
11 And if the center doesn't want the ACS coming,
12 they should be perfect. So we still have to
13 preserve some sort of state site visiting
14 process, because not everybody's going to do the
15 ACS, right? So that's number one. I don't know.
16 Correct me if I'm wrong, but I think it's
17 unlikely Virginia would just put into their code
18 like the other states have that the ACS has their
19 verification system. So bearing that in mind, we
20 would have to have a separate parallel ability to
21 do site visits independent of the ACS, right? But
22 as we've seen over the past 10 years, that number
23 of places has dropped smaller and smaller, as
24 most places have gotten all the level ones or ACS
25 now. And I don't know how many of the level twos.

1 **MS. CARTER:** Not all.

2 **COMMITTEE MEMBER:** No, not all of
3 them.

4 **CHAIR YOUNG:** They're getting
5 visited this, which one?

6 **COMMITTEE MEMBER:** Norfolk General.

7 **CHAIR YOUNG:** I thought they just
8 got visited.

9 **MS. CARTER:** No. They, no.

10 **CHAIR YOUNG:** Okay, we won't talk
11 about it. Anyway, so I think, number one, we
12 still have to preserve some part of the
13 Commonwealth site visit system, because number
14 one, not everybody's gonna want to have the ACS
15 come in. Number 2 is simple, I think. We should
16 look at what really brings value that needs to be
17 continued to be preserved in the Commonwealth
18 system that is not just bringing extra work
19 without bringing value.

20 **COMMITTEE MEMBER:** That was my next
21 question you brought up that was very interesting
22 is that there are certain aspects of the current
23 Commonwealth system that people really care a lot
24 about. I don't know that that's something that's
25 really well-publicized. Is that something that

1 only people in the know, know? Or what? It would
2 be nice to have that somehow so that, if it is
3 something that can be preserved that doesn't
4 negatively impact the ACS sytem, then it can
5 remain in that and it wouldn't be an issue versus
6 something that is contradictory to what ACS is
7 doing. And so how do we have to align those
8 particular line items to fit the ACS model.
9 You're right, I think to do that, you're gonna be
10 well-positioned to move forward much more
11 successfully.

12 **CHAIR YOUNG:** Yeah, and we want to
13 appreciate the work of TPM because this has been
14 a completely moving target as to what we're going
15 to do here. Made worse by the fact that we have
16 met twice in 3 years. But what I remember from
17 the conversations around this room was nursing
18 education was a big difference. And that's easy
19 to preserve. I think if they see a senator is
20 like if you said okay, we'll make you do that.
21 That sounds great. I mean Nursing Education was
22 the thing that was, CME was a big difference and
23 we changed that. I don't want to put anyone on
24 the spot, that's the one thing that struck me
25 that was people consistently brought up that the

1 requirements for nursing education were higher in
2 the commonwealth, right? And wanted to preserve
3 that. All right, so the people, this is a
4 conversation we've had before. Do people have
5 suggestions of what we should do? Yes.

6 **MR. TAYLOR:** This is Dallas Taylor.
7 I would probably just make sure that the state
8 has no issue with the virtual piece that Beth
9 alludes to. There are some big differences in
10 how we refer to ACS versus the state. That
11 virtual view, the tour and all that, and how good
12 the charts. Make sure that's what we meet, and
13 how they want to do the charts.

14 **CHAIR YOUNG:** Yeah, I think they
15 were saying they would never want a virtual.

16 **MR. TAYLOR:** But about the chart
17 review, so like are we saying that when the HCS
18 reviewers review the charts and whatever feedback
19 they had, they would go along with that or...

20 **CHAIR YOUNG:** I think that one has
21 to be figured out.

22 **MR. TAYLOR:** Yeah.

23 **MS. BROERING:** I think the
24 challenge, and, I'm sorry, I interrupted you
25 Kathy, so go ahead. I think the challenge, at

1 least I can speak for myself, but others can
2 speak up. It is incredibly difficult on a day-to-
3 day basis for program managers to say, to group
4 some individuals, whether it's nurses or
5 physicians, or hospital administration. "Well, we
6 have to do this, but then we have to do this."
7 Well, who do you have to do what for? And then
8 so, CME was one of them, especially if you are in
9 an opposite cycle. Like, I have been, until I'm
10 more closely aligned now. But it's like, we have
11 to meet for this, we have to do this for this.
12 And then, you're constantly bantering people for
13 additional documents. You're asking for a
14 neurosurgeon, you're asking for this, you're
15 asking for a different report.

16 So, in being a good steward to our
17 Trauma Center and then the people that we work
18 with on a day-to-day basis and that
19 organizational leaders and administrators across
20 the visions of departments and services, you want
21 to be able to have clear communication, you want
22 to have accurate communication and you want to
23 make it so that it's easy for your teams to be
24 able to meet those standards as well. Because
25 they're the ones that are meeting the standards,

1 not you, not me. I'm just the messenger a lot of
2 times, and then, the messenger of, saying can you
3 provide me this, whether it's staffing ratios, or
4 CME, or reports to IR, whatever that is, you're
5 the messenger and you're helping them, helping
6 the center.

7 And so, the more those messages
8 can be timely consistent and then, because
9 there's reporting for lots of other things, like
10 scrubs and other things, so we want to be good
11 stewards of that for our hospitals. And that's
12 what I think a lot, that's to me what I'm asking
13 for is let's make it work so that we're not
14 individually working very hard twice...

15 **CHAIR YOUNG:** And that would be
16 okay if there's a lot of value in it. But we have
17 determined there's a lot of value in it.

18 **MS. BROERING:** Right.

19 **COMMITTEE MEMBER:** And also, as you
20 said about the inconsistency, it does, it eludes
21 credibility quite often if you say we need to do
22 this, and then I come back 3 or 4 months later,
23 I'm like, "I thought I need to do this but..."

24 **CHAIR YOUNG:** That works very very
25 poorly to do that.

1 **MS. BROERING:** Yeah.

2 **CHAIR YOUNG:** Let's see, what would
3 be the possibility that we could present the
4 advisory board with a total package? Like a total
5 package of not only a revised designation manual
6 but an administrative document and site visits to
7 get voted on all at once

8 **MS. CARTER:** It's a lot of
9 information and does consider that ultimately,
10 even if it goes to the GAB, the final decisions
11 are with the Office of EMS, which is an advisory
12 committee as they are.

13 **CHAIR YOUNG:** So that's why we'd
14 have to talk to Gary.

15 **MS. CARTER:** Yes.

16 **CHAIR YOUNG:** So circling back, I
17 think at our next meeting, I think we have to
18 have a truly no BS assessment of what is the
19 critical differences between what is expected to
20 be the revised, Commonwealth document and the
21 current optimal resource documents. I think we
22 might be surprised that there aren't that many
23 differences. And then a lot of it is
24 administrative. A lot of it is the way the
25 application is set up. And a lot of it is the way

1 the documents are put together and the way the
2 charts are put together. And if that is the only
3 difference, that does not seem to me to be a
4 sufficient reason to not try to create some
5 synergy between the 2 processes. So can we try to
6 do that? If you send me the document, I'm happy
7 to go through the chapters and look at what the
8 differences are.

9 **MR. TAYLOR:** This is Dallas. I'll
10 tell you, there are some service line differences
11 that the ACS requires you to have versus what ...

12 **CHAIR YOUNG:** Like which?

13 **MR. TAYLOR:** Like your level twos,
14 for example, State Bar and ACS, for example, and
15 there's a lot of stuff on that.

16 **CHAIR YOUNG:** Yeah, I think stuff
17 like that's easy.

18 **MR. TAYLOR:** But then there's a
19 quality matrix that ACS looks at, the states make
20 you look at ACS. That's the main thing. There is
21 some quality stuff that's stated in front.

22 **CHAIR YOUNG:** Oh, you mean time
23 antibiotic administration time to femur fracture
24 excision? Yeah. So if that's all the differences
25 there are, I would think that's surmountable,

1 that we just wouldn't have that in the state
2 part, that would just be an extra thing.

3 If you didn't want to be ACS
4 verified, you could just do what the state
5 requires. Most of us are both. I mean, you're
6 never gonna have the state circumvent the ACS. So
7 if there's some of that quality data poll, now
8 you do know also the ACS, none of those are
9 criteria. There are no criteria for 80% femur
10 fracture within 24 hours. There are no criteria
11 for antibiotics within an hour. You can't fail
12 that. So it's just information. Which is just
13 another way we could say it. Cathy, do you have
14 anything?

15 **MS. PETERSON:** In addition, a
16 process that if you were ACS center, that even
17 went through the head and abbreviated on-site
18 state, nailed the areas. And so if you're not
19 ACS, you don't think that because we have another
20 area that's very different, just the PI area,
21 because we, from a state, wanted to utilize their
22 state data to drive PI needs within our state,
23 but we've really honestly never really gotten
24 there yet.

25 **CHAIR YOUNG:** And T quips a million

1 times more advanced.

2 **MS. PETERSON:** And so I think
3 personally, I think the area that's the most
4 robust with the state stamina, or the nursing
5 education piece, other than that, I don't think
6 there's a huge difference.

7 **CHAIR YOUNG:** I mean, what you just
8 said is how I imagined it would look that we
9 would for those places that want to do the state
10 would have the state for those places want to do
11 both, they would go through their ACs process,
12 and there would be an additional process in
13 person or whatever, to go over those things and
14 that we're different. And make sure that those
15 are verified.

16 **COMMITTEE MEMBER:** I mean, I think,
17 from a workflow standpoint would be advantageous.
18 I mean, I know that COVID's kind of thrown a
19 monkey wrench backlog, and create opportunities
20 to come to do full state visit to each one of
21 these centers. It's already a huge mountain to
22 climb as it is, now being able to decrease some
23 of that would be raised.

24 **CHAIR YOUNG:** I don't know who
25 either knows the ACS process very well. But I

1 think the PRQ application process is much easier
2 and much more straightforward. And so I think
3 we'd have to be open to looking at the
4 application process for the state and preserving
5 what needs to be preserved, but not stubbornly
6 keeping stuff in there, just because it's been in
7 there for 10 years.

8 **MS. BROERING:** Yeah, I think I
9 mean, I think the one thing that Mindy alluded to
10 is we the capabilities, the standards are one
11 thing, do you meet the standards, and then the
12 interpretive guidance of how do you look at a
13 center to meet that standard? And maybe some
14 additional tweaking to that. I mean, I think the
15 trauma program managers with the work teams or
16 groups did a great job with that. I think my
17 suggestion would be the capabilities document and
18 the actual application for the state is sort of
19 the combination of what ACS PRQ is. So, somebody
20 else please chime in, besides me.

21 **CHAIR YOUNG:** No, I think it is
22 ...

23 **MS. BROERING:** So I think, again,
24 one more step is to work closely to align that
25 information so that the burden is removed from

1 the trauma program managers and those individuals
2 that are having to write the applications and get
3 the information or write a report. So the more we
4 can align, the easier it becomes for the center
5 to do the work to meet those, to meet and be
6 successful, and help the reviewers be really
7 successful and happy with what is provided to
8 them. I'm comfortable with that.

9 **CHAIR YOUNG:** I don't know how many
10 people who are uncomfortable with the college
11 process actually know the college process, have
12 actually gone through a PRQ or seen what the
13 output of a PRQ looks like. So, I'm happy to
14 provide that. I'm happy to provide our PRQ. And
15 people can look at it and like, "Oh, wow, there's
16 really nothing more that we need in this. There
17 may be more in it than we need regarding the
18 metrics, but those metrics aren't horrible to
19 know how many femur fractures you're fixing in 24
20 hours, et cetera. All right, so first of all, am
21 I allowed to talk to Gary outside of this
22 meeting?

23 **MS. CARTER:** You can talk to
24 anybody you like outside this meeting.

25 **CHAIR YOUNG:** I still don't

1 understand all these rules.

2 **MS. CARTER:** I'm not the thought
3 police.

4 **CHAIR YOUNG:** So why don't you send
5 out what you have, like your final draft of what
6 the revisions are. And I will take it from there,
7 or if anybody wants to help me, I have the
8 Gradebook at home. And I'll try to go through it
9 section by section and see what the differences
10 are. And then we'd have to deal with the
11 application. I'm sorry, Tracey.

12 **COMMITTEE MEMBER:** Oh, I was gonna
13 ask if you were going to ask for some others to
14 help with, like, how would you, and we can talk
15 about it offline if you want, but how would you
16 divide up that work?

17 **MS. JEFFERS:** So that's...

18 **CHAIR YOUNG:** I would just divide
19 the book in half.

20 **MS. JEFFERS:** This is Tracey
21 Jeffers, by the way. The trauma program managers
22 will meet at 4:30. We are the group that has
23 painstakingly gone through this manual, and
24 meetings and I looked at both. When we first
25 started, we compared ACS to the current manual

1 that we had. And we decided we needed to change
2 our manuals that we did that work, then we looked
3 at all the paperwork and went with [in
4 capabilities. And so all of those things have
5 been talked about, looked at, changed over. But I
6 don't think we've looked at it as a whole. And to
7 have just gotten the gray book to live our lives
8 by, so I think we need some time with that. And
9 to kind of absorb that. So I think handing over a
10 document that we think might be a good thing, I
11 don't think that that's going to move in one in
12 this group, or it's gonna get anything done any
13 faster.

14 **CHAIR YOUNG:** So that's another 3
15 months?

16 **MS. JEFFERS:** The trauma program
17 managers have worked on this. I would like to
18 defer to that meeting. So that we can hash these
19 things out on how we should present this, we
20 would love to have you as of 4:30 here, if you
21 can attend with us. And we can work as a
22 workgroup and separate into some workgroups so
23 that we're not attacking each other with our
24 people. So I would defer that. And also, before
25 we do all of this work once again, we have

1 earnest and honest conversations with the Office
2 of EMS, so that we understand why-

3 **CHAIR YOUNG:** Well, I will talk to
4 them about what is possible. But the concept of
5 sunk costs, if things that we worked on 3 years
6 ago simply are not optimal and not relevant now,
7 they should be discarded. Even if they took a
8 whole lot of work, and we really appreciate that
9 work. But that's the way it works.

10 **MS. JEFFERS:** Well, I think the
11 designation manual along with all the company
12 documents definitely needs to be looked at and
13 worked over. And we have definitely given its due
14 diligence. So I think that's something that...

15 **CHAIR YOUNG:** So you all may decide
16 that we can see a draft and you may all decide we
17 can't see a draft.

18 **MS. JEFFERS:** You can see the
19 draft. I'm plugging the information ...

20 **MS. CARTER:** That's the definition
21 of a draft.

22 **MS. JEFFERS:** ... right now.

23 **CHAIR YOUNG:** Whatever most recent
24 document is on their computer.

25 **MS. BROERING:** I agree with what

1 Tracey says and I said it before. The trauma
2 program managers worked incredibly hard over the
3 last year to kind of go standard by standard to
4 say, does this make sense? Should it be updated?
5 How should it be changed? And I think we were
6 thoughtful and methodical. We have not said okay,
7 what we said should be there compared to what the
8 grade book says. And we all said from the very
9 beginning because we talked about it several
10 times, on multiple occasions during the meetings,
11 we're going to have to see what the gray book
12 says. It could be subject to change once the gray
13 book comes out, you know, this standard may have
14 to change or be augmented. So I do think that we
15 are, we should do that. But the standards and the
16 process are two different things, two completely
17 separate things, they are very interconnected.
18 But meeting the standards is one thing, and the
19 process of verifying that we meet standards is
20 another and that's where I have to make sure that
21 we're sort of separating that to a certain extent
22 that how do we do a process in the state, and
23 then these are the standards. So I don't think
24 that we should mix them up until...

25 **CHAIR YOUNG:** This is Jeff.

1 Unfortunately, it's somewhat algorithmic, because
2 if the two sets of standards are going to be
3 wildly different, there's probably not any reason
4 to go any farther with doing anything about the
5 process. So I think the first thing is to see,
6 are they reasonably similar, and I'll ask Gary
7 what is within his comfort zone of what we could
8 do? Oh, look, who's here. I may talk to you in 10
9 minutes if I can. And so like, if they're
10 reasonably similar, but we've preserved what we
11 want from the Commonwealth if that's the case,
12 and I think we can pursue the process, right? Do
13 you do we all think that we'd have to have the
14 entire designation manual up through all of the
15 levels before we even talked about the process?

16 **MS. JEFFERS:** For that task to work
17 for the trauma program manager workgroup. So at
18 any point, you wanted to see where we were, or
19 are we staying with the documents we've been
20 working on? They're yours to look at? That's not
21 a problem at all. So I mean, I will send you what
22 we have so that you have an idea of what's been
23 said and done, I don't think that we have any
24 problem with that as a group. Because this
25 committee asked for it.

1 **CHAIR YOUNG:** I guess. So. I'm just
2 getting a little confused. So then what was the
3 concern that you brought up? That just we don't
4 interpret it as being in its final form?

5 **MS. JEFFERS:** The concern is it's
6 not ready to hand over the state, because the
7 gray book came out ...

8 **CHAIR YOUNG:** Okay. No, I don't
9 think anybody thought that was the case.

10 **MS. JEFFERS:** Now. As I said, you
11 tasked us with that anytime this committee,
12 anyone else really wanted to see those documents
13 that were available, or that weren't conveyed?

14 **CHAIR YOUNG:** Well, we don't really
15 have a Dropbox site.

16 **MS. JEFFERS:** You can E-mail
17 directly.

18 **CHAIR YOUNG:** But there was some
19 time in the past three years that we did do it,
20 we put it on the screen. And we went through a
21 variety of things. And that's where I got the
22 nursing education bug in my head and that's when
23 we determined CME.

24 **COMMITTEE MEMBER:** For the
25 Gradebook. I guess I'm not expecting it to be

1 changed in bold in the book, but there's an
2 update that explains the differenc is between the
3 old and new.

4 **CHAIR YOUNG:** No, I got it. I can
5 give it to you. It's an education session that
6 the VRC puts out.

7 **COMMITTEE MEMBER:** That way you
8 don't need to comb the whole book.

9 **CHAIR YOUNG:** Right. But that's the
10 difference between the old optimal resources and
11 the new optimal resources, not the difference
12 between theirs and the optimal resource?

13 **MS. PETERSON:** We're most
14 concerned about our conflicting areas on the same
15 topic.

16 **CHAIR YOUNG:** Right. That should
17 only be preserved if there's a really good
18 reason.

19 **MS. PETERSON:** ... we in essence
20 have done that because we've done that, we just
21 didn't have the grade book. What's the next plan?
22 Yeah, the grade book came out.

23 **CHAIR YOUNG:** So you guys just want
24 to do that. I mean, I'm happy to just say I'm
25 happy to help. Terrell is happy to help. But do

1 you want that just to be the next step of what
2 you do now that you can get the Gradebook off the
3 web whenever you want? Okay.

4 **(WHEREUPON, simultaneous talking.)**

5 **CHAIR YOUNG:** So if that somehow
6 gets done between now and the next meeting, and
7 you feel comfortable sending it to the committee
8 after you've done that part, then you can send
9 it. If not, we can just discuss it in the next
10 meeting.

11 **MS. JEFFERS:** I feel very confident
12 about what we have done.

13 **CHAIR YOUNG:** Okay.

14 **MS. JEFFERS:** We meet monthly and
15 sometimes every two weeks to get this done.

16 **CHAIR YOUNG:** Okay. I think we've
17 beaten that enough. So then, really, the only
18 other thing on the agenda was the combining of
19 the visits for dually verified centers, and I
20 have to talk to Gary Brown about what's possible.
21 But from the committee if I'm not misinterpreting
22 them, one thing we don't want is a site visit by
23 someone every 18 months, right? That would be
24 sub-optimal. And we would want as best we can
25 that the preparation for both visits there could

1 certainly be different, but they should try to be
2 as synergistic as possible. And that we have to
3 preserve a genuine designation system because
4 everybody will want to be in the ACS. So all of
5 that infrastructure still needs to be in place. I
6 just want to say about the application. I did a
7 site visit in Florida. They have a 1500-page
8 Trauma Center document that they put together. It
9 has pictures of every room in it. And it was the
10 dumbest thing I've ever seen.

11 So we just don't need to go down
12 that rabbit hole. I mean, I think we could take a
13 real honest look at what the documents are
14 required in the grade book, like what documents
15 are not required in the grade book that the state
16 would require, and just not perpetuate something
17 that may be incredibly difficult for you to deal
18 with. And asking for more papers and asking more
19 stuff. The other thing that several of us would
20 gladly be able to share privately is the way the
21 administrative documents are set up for the
22 college because they are very prescriptive about
23 what needs to be in each folder. And that may
24 address many of your concerns.

25 So I think there's still a little

1 bit of a knowledge gap between what's in the two
2 ACS process and what's now in the upcoming
3 Virginia process. So I think we just need to
4 close that gap. And then we can move on. Anything
5 else on that? 15 minutes. Anybody? All right. New
6 business. Please don't bring anything up. No, I'm
7 just kidding. Any new business? Did we vote on
8 everybody. So Mark Day, we voted on Vice-Chair.
9 All right. Was there anything else? One other
10 thing?

11 **MS. CARTER:** Well, there are still
12 a couple of gaps there. So we're gonna have to
13 identify just some replacements.

14 **CHAIR YOUNG:** Was that the other
15 one that we had to? The pediatrics? Or did we
16 settle it?

17 **MS. CARTER:** We haven't settled
18 pediatrics. And that's okay. We can wait till
19 next time to do that.

20 **CHAIR YOUNG:** No. Well, I mean,
21 we'd haven't asked anybody if they want to do it
22 yet. Right?

23 **MS. CARTER:** I think there's also
24 the other thing that we need to talk about is,
25 that it doesn't have to be the day but at some

1 point, there are some folks who do have seats on
2 the current committee that has actually never
3 been to a meeting or have very sporadically even
4 before.

5 **CHAIR YOUNG:** Do we have any regs
6 about that at all? If you don't attend three
7 meetings in a row or something.

8 **MS. CARTER:** I don't think that's
9 in the bylaws, Gary, but I think we certainly
10 have the ability going forward to make those
11 changes.

12 **CHAIR YOUNG:** Okay. The other
13 spitball something, if you don't come to a
14 meeting for an entire year, you can be removed
15 from the committee. That's four meetings, right.

16 **MR. BROWN:** The Advisory Board
17 members, if you've missed two unexcused meetings
18 in a row, we would contact the organization that
19 you wish to represent on the board and notify
20 them of your absenteeism. And maybe it is up to
21 that organization what action they will take.

22 **CHAIR YOUNG:** Okay, what do people
23 think. I don't want to throw something out there.
24 What do people think is reasonable? Three
25 meetings in a row. We can't do 12 months, because

1 COVID may come back again. So we'd have to say
2 four meetings or three meetings.

3 **COMMITTEE MEMBER:** I think three
4 meetings are reasonable.

5 **CHAIR YOUNG:** In a row or not? I
6 mean, after three in a row or three out of five
7 or something.

8 **MS. CARTER:** I think that's
9 something we can consider next time. After three
10 meetings, you've conducted three months' worth of
11 business and they haven't been there. And if
12 you're trying to preserve a quorum, I think that
13 we need to maybe think a little less than three.

14 **CHAIR YOUNG:** Okay. Go ahead Val.
15 Val Quick University of Virginia.

16 **MS. QUICK:** One of the things that
17 we've been tasked to do with the government
18 advisory board is we have a Bylaws Committee or
19 bylaws workgroup. And we have a compensation
20 workgroup. And one of the things that we actually
21 are looking at specifically are committee
22 members, but have they been there, what the
23 relevancy of each one of the committees are? Is
24 there any overlap? And how do we make it more
25 efficient? And I think that what we probably need

1 to do is it needs to be across the board.

2 **CHAIR YOUNG:** Right. I thought the
3 ACC can make their own rules for the kickoff of
4 the committee.

5 **MS. CARTER:** I think that's
6 appropriate.

7 **CHAIR YOUNG:** Paul was probably
8 gonna lead that.

9 **MS. QUICK:** So I think if we could,
10 there certainly needs to be expectations and
11 accountability. And I think that is definitely
12 something that we looked at and that is going to
13 be something that we're going to ask each of the
14 individual committees to report back to us, and
15 understanding that COVID has been here having
16 messed up that the attendance apart from this
17 part for really from 2021 forward, going back and
18 looking to make sure that we are consistent.

19 **CHAIR YOUNG:** So can you tell me
20 functionally how that would work like would Paul
21 say it and then has to be voted on by the tag or
22 like how would that even work?

23 **COMMITTEE MEMBER:** Well, right now
24 they will continue to get the products or
25 suggestions from the [inaudible] to workgroups.

1 Okay, that will come back to the executive
2 committee. Upon review, the executive committee
3 may take it back to the workgroups.

4 **CHAIR YOUNG:** Yeah, I mean, so it's
5 a little different on the board, because there's
6 no level three Trauma Center Group, kind of, we
7 can kick it back to. So it would probably have to
8 be your warned after X. And then if you miss the
9 next one.

10 **MR. BROWN:** As Valerie says, We
11 want to keep it consistent with the Fore Board
12 and the standard including something that came up
13 today and executive committees as well as
14 tomorrow for what is an electronic participation
15 policy. So in other words, allowing you to
16 participate electronically; however, the board
17 has to accept a policy first, so the department
18 of the state, and then each committee would have
19 to come up with their policy approved by the
20 board within the guidelines that are provided.
21 And there would be parameters. In other words,
22 let's say you have four meetings a year. It's not
23 to be that you can participate electronically
24 four times, and you can only do it two times. It
25 will be like, "Okay, in four meetings, you may

1 deal with over the participating group," one of
2 those four electronically per year, which
3 means...

4 **CHAIR YOUNG:** Well, it sounds like
5 you guys need to get that settled first.

6 **MR. BROWN:** Yeah. Yes, there's a
7 lot to be done. But we want to be very
8 comprehensive in what we're doing.

9 **CHAIR YOUNG:** So yeah, no, I agree.
10 I thought it would have been a bridge too far for
11 us to actually make that rule. But good. What
12 else did you have? Alright, anything else? All
13 right. Thank you all.

14 **(WHEREUPON, the Meeting ended at 3:55 p.m.)**

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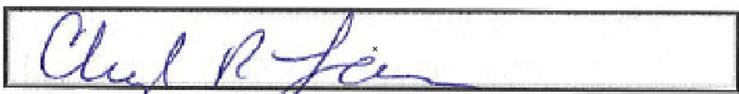
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05 4:4	4	absorb 37:9	8:21 11:11
1	4 21:14	ACC 48:3	19:24 20:3
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