

Virginia Department of Health
Office of Emergency Medical Services



Quarterly Report to the
State EMS Advisory Board

Friday, August 7, 2015

Executive Management, Administration & Finance

**Office of Emergency Medical Services
Report to The
State EMS Advisory Board
August 7, 2015**

MISSION STATEMENT:

To reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide emergency medical services (EMS) system; and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need.

I. Executive Management, Administration & Finance

a) Action Items before the State EMS Advisory for August 7, 2015

Action items for the State EMS Advisory Board include the following:

- Review and vote on REPLICA - see item c) of this section and **Appendix A.**
- Review and vote on expanding the scope of practice formulary for Emergency Medical Responders to allow the administration of naloxone – see **Appendix D.**
- Review and vote on expanding the scope of practice formulary for ocular analgesics to the EMT level – see **Appendix E.**

b) Selected Staff Highlights

- Gary Brown, Office of EMS director and Warren Short, training manager, participated in the Virginia Association of Volunteer Rescue Squads' spring Board of Governors meeting that was held in Fredericksburg. Approximately 200 participants received updated information pertaining to the Trauma Registry and anticipated changes in EMS continuing education. They also covered the CE Scanner loaner program that the office participates in to assist with local "Super CE Weekends" that help to accurately and expeditiously record provider CE, the Intermediate 99 workgroup, which will investigate the continuance of Intermediate 99 certification upon the withdrawal of National Registry from that process, updates to the EMS portal that will make the system multi-browser compatible and a presentation regarding a new philosophy in EMS initial certification courses that will be offered starting July 1, 2015.

- The EMS for Children (EMSC) program within the Office of EMS recently purchased and distributed 160 pediatric immobilization devices with volunteer EMS agencies in Virginia. These devices will allow EMS providers to more quickly and appropriately immobilize children with traumatic injuries for transport to hospitals by ground ambulance. Funding for the purchase (more than \$47,000) was provided completely by federal EMS for Children funding through Human Resources and Services Administration (HRSA) and shows that Virginia is continuing to make progress toward achieving equipment and supply national EMSC performance measures.
- Michael Berg, regulation and compliance manager presented “Permissive Hypotension” at the UVA-Pegasus Critical Response Annual Continuing Education Program. He also attended an Education Forum in Gaithersburg, MD for the Data Bank (HRSA program).
- Dr. George Lindbeck, State EMS Medical Director along with Dr. Allen Yee, Chesterfield Fire and EMS Operational Medical Director conducted an EMS Physician training in Danville, Virginia. Six OMD’s attended the training to include two out-of-state Medevac agency OMDs who are co-licensed in Virginia. The course was sponsored in part by the Virginia College of Emergency Physicians (VACEP) and the Western Virginia EMS Council. Endorsed EMS Physicians in Virginia must attend two such session in their 5 year endorsement period. CE is also provided by VACEP to the attendees.
- The Office of EMS Division of Educational Development conducted its monthly EMSAT webcast, “Neonatal Resuscitation,” that aired to designated emergency medical satellite training (EMSAT) sites across Virginia. Ten percent of all neonates require some assistance around the time of their birth. This webcast featured Dr. Russell Moores and Dr. Alison Chapman of the Children’s Hospital of Richmond at VCU.
- Members of the Office of EMS Division of Educational Development, Greg Neiman, Adam Harrell, Debbie Akers, and Warren Short, conducted an EMS educator update in Staunton, Virginia at the Central Shenandoah EMS Council Training Center. There were 25 EMS educators in attendance. The program provided an update to relevant changes on delivery of EMS education, Ebola Virus Disease resources, accreditation and OEMS activities involving education and certification as well as an open forum to discuss their concerns and recommendations for the continuing improvement of the EMS system’s education, certification and recertification programs.
- The Division of Educational Development conducted an EMS Education Coordinator update at the new Alexandria Fire Training Center in the Northern Virginia EMS region. A total of 31 Education Coordinators/ALS Coordinators were in attendance. Debbie Akers, Greg Neiman and Adam Harrell provided information to the attendees on upcoming changes in EMS Education. Some of the items discussed included the new delivery options for EMS Educational programs; effective July 1, 2015, new continuing education requirements starting in April, 2016, and guidance on National Registry testing. At the conclusion of the update, optical scanner training was conducted for five

individuals and training on submitting online course enrollment information and student registration procedures was conducted for four individuals.

- Greg Neiman, Basic Life Support (BLS) training specialist, hosted an education coordinator candidate practical exam on Saturday, May 9 in the Richmond area. This exam was held for candidates who want to become an EMS education coordinator. The exam lasted approximately five hours.
- Adam Harrell, training and development coordinator, is updating the continuing education (CE) scanners with a new operating system. He has updated almost 300 CE scanners thus far, and he will continue this process through August 1. This program is being updated for any EMS entity that owns a CE scanner in Virginia.
- Gary Brown, director, Office of Office of EMS, was invited to participate in a National Security Staff Meeting hosted by the White House. Gary was invited to attend this roundtable initiative, “Bystanders: Our Nation’s Immediate Responders,” the goal of which was to build national resilience by providing information and tools the general public could use to save lives. The Roundtable gathered leaders from organizations representing emergency management, healthcare, public health, public safety; key federal personnel; and National Security Council staff. Gary attended this meeting on behalf of the National Association of State EMS Officials.
- Dr. Lindbeck, Office of EMS, State Operational Medical Director (OMD) and Michael Berg, manager, Regulation and Compliance conducted an OMD Current’s Session Thursday, May 14. Dr. Allen Yee, former interim State OMD also was part of the faculty.
- Michael Berg, manager, Regulation and Compliance participated as a featured speaker at the EMS Expo conducted by the Peninsulas EMS Council at the Glenn Campus of the Rappahannock Community College May 15-17. Presentations included a regulatory update as well as a clinical presentation on allergic reaction.
- Michael Berg, Office of EMS (OEMS) regulation and compliance manager, participated in a Fire/EMS study in Essex County. This is a multi-discipline team, at the request of local government, which conducts a cost-free in-depth review of the current Fire/EMS system and offers a report that includes best practices, identifies opportunities for efficiencies in operations, to include facilities, equipment, staffing and more. This also incorporates the local 911 dispatch system.
- Karen Owens, Office of EMS, emergency operations manager; Winnie Pennington, emergency operations planner and Marian Hunter, public relations coordinator attended the Public Health & Health Care Preparedness Academy, May 18-19. They participated in the Ebola Exercise Workshop as evaluators and facilitators, and also attended various seminars.
- Gary Brown, Office of EMS director; Scott Winston, assistant director; Tim Perkins, EMS systems planner and various OEMS staff attended the Thomas Jefferson and

Peninsulas Regional EMS Council Awards on May 13 and 23. Winners of the Regional EMS Awards will be eligible to receive the Governor's EMS Awards, which are announced at the Annual Virginia EMS Symposium in November.

- The Virginia Office of EMS celebrated EMS Week in Virginia, May 17-23, as proclaimed by Governor Terry McAuliffe. Marian Hunter, Office of EMS public relations coordinator and Tristen Graves, public relations assistant promoted this special event through the VDH website, social media sites, listserv and press release. We kept engagement high by promoting events and giveaways for providers on our social media pages. While EMS Week garnered nearly 20,000 in total reach* on the Office of EMS' Facebook page, one of our Facebook posts had an especially high post reach*. The Governor's proclamation for EMS Week had an estimated reach of 10,072 people and 406 likes, comments and shares!

**Total Reach - The number of people who were served any activity from your page, including posts, post to your page by other people, mentions, etc.*

** Post Reach – The number of people your post was served to.*

- During EMS Week (May 16-23), OEMS EMS Systems Planner Tim Perkins joined over 200 bike riders and ride support crew from all across the country in the 2015 National EMS Memorial Bike Ride, a cycling event from Boston, MA to Alexandria, VA. Over seven days, Tim and other riders pedaled over 500 miles to honor EMS providers who have died in the line of duty, and to bring attention to the health and safety of Emergency Medical Services providers. Tim has participated in the Ride since 2008, and currently serves on the organization's Board of Directors. Tim rode in honor of Beverly Luther, a provider from the Tuckahoe Rescue Squad in Richmond, who succumbed to injuries sustained in a motor vehicle accident in 2014. Information on the National EMS Memorial Bike Ride can be found at www.muddyangels.com.
- The Division of Educational Development has conducted seven webinars to date regarding the upcoming release of Non-Traditional Course delivery options. The webinars provide up-to-date information about the delivery options on July 1, 2015. The Non-Traditional Course delivery options will allow for Virginia Initial Certification program to deliver didactic course content in methods other than face-to-face. This will allow for new distance education options for initial certification education in Virginia. The webinars have been conducted with Education Coordinators (ECs) from all over Virginia to gain current information about the Non-Traditional Course Delivery options available to them, how this delivery method will affect their course conduction, and the specific requirements still involved in course delivery.
- The Office of EMS Director Gary Brown, Training Manager Warren Short, Trauma and Critical Care Manager Paul Sharpe and Regulation and Compliance Manager Michael Berg attended the Virginia Fire Chiefs Association Summit, Friday, May 29 to provide agency updates. Also in attendance were Deputy Secretary of Public Safety and

Homeland Security Adam Theil, Virginia Department of Fire Programs Director Melvin Carter and Dr. Jeffrey Stern with the Virginia Department of Emergency Management.

- On June 6, the annual Virginia Fallen Firefighters and Emergency Medical Services Memorial Service was held at the Richmond International Raceway. State Health Commissioner Marissa J. Levine, MD, FAAFP, spoke at the memorial service and the following Office of EMS staff were also in attendance: Director Gary Brown, Regulation and Compliance Manager Michael Berg, EMS Systems Planner Tim Perkins and State EMS Advisory Board Chair Gary Critzer.

This memorial service marked the beginning of Fire and EMS Memorial Week in Virginia, June 7 – 13, 2015, as proclaimed by Governor Terence R. McAuliffe. During this special week, Fire and EMS providers who die in the line of duty are honored along with those who risk their lives daily to serve and protect the citizens of the Commonwealth.

- Chief Deputy Commissioner for Public Health and Preparedness David H. Trump, MD, MPH, MPA and Michael Berg, regulation and compliance manager for the Office of EMS attended the Western Virginia EMS Council's Regional EMS Awards Ceremony on Thursday, June 11. Each Regional EMS Council holds a regional EMS awards program and seeks nominees from 10 categories and one scholarship. Winners from each region will then go on to contend for a chance to win the coveted Governor's EMS Awards, which are presented at the Annual Virginia EMS Symposium in November.
- Michael Berg, regulation and compliance manager participated with the Virginia Department of Fire Programs in a Fire and EMS Study in Powhatan, Va. This study is part of an ongoing partnership that the Office participates in. A locality can request a fire study as part of the Fire Services Board's responsibilities under the Code of Virginia. The Office has participated in more than 25 of these studies over the course of several years, and another is scheduled in July for Pittsylvania County. We make recommendations in certain areas to include best practices for the local government to consider. All of these recommendations are advisory in nature. This study involves a multi-disciplinary approach, which includes Fire Services Board members, Department of Fire Programs, Department of Forestry and EMS.
- Dr. Lindbeck, Office of EMS, state operational medical director (OMD) and Michael Berg, regulation and compliance manager conducted an OMD Current's Session, Friday, June 12 at Virginia Tech.
- Dr. George Lindbeck, state operational medical director and Michael Berg, regulation and compliance manager attended the Physician Ordered Life Sustaining Treatment (POST) Executive Committee at the Medical Society of Virginia to discuss ways to address concerns surrounding terminology in the *Code of Virginia, DDNR Regulations* in recognizing the POST document as a viable "other DDNR Form". Concerns by attorneys and risk management from certain facilities feel there is not the same liability protection afforded if the POST form is not specifically identified as an "other DDNR Form". The

Office of EMS will expand and update our training for field providers on the use of the POST form via the online PowerPoint presentation and with an updated EMSAT production tentatively scheduled for January 2016.

- The Division of Educational Development conducted the following trainings:
 - On Friday, June 12, an EMS Educator Update was conducted in Christiansburg. There were 37 participants in attendance and topics included updates for administrative issues pertaining to EMS education, EVD update, Continuing Education (CE) scanner upgrades (which can only be done by OEMS), Web enrollment program and general discussion to hear educators' concerns.
 - On Saturday, June 13, an EMS Educator Update was conducted at Virginia Tech in association with the Virginia Association of Volunteer Rescue Squads' Rescue College. There were eight attendees who participated. The same topics as seen above were covered.
 - On June 15 and 16, an EMS Educator Institute was hosted. This institute is held in order to train new EMS educators. There were seven people that were in attendance. CE scanner upgrades were also conducted.
- Michael Berg, regulation and compliance manager attended the quarterly Virginia Fire Chiefs Association meeting in Chesterfield County. The Virginia Department of Fire Programs was also in attendance at this meeting. Mr. Berg attended as a representative of the Office of EMS (OEMS) and was available to provide an OEMS update as well as to answer any questions.
- Michael Berg, regulation and compliance manager and S. Heather Phillips-Greene, OEMS program representative for the Central Shenandoah region met with the county and assistant county administrators along with the chief, deputy chief and the Operational Medical Director for Shenandoah County to address performance and reporting issues with a specific EMS agency within that county.
- Warren Short, training manager and Debbie Akers, ALS Training Specialist with the Division of Educational Development attended a meeting with the Tidewater Fire Chiefs and Tidewater Community College concerning the EMS curriculum. Discussion covered some of the issues faced by the EMS programs and some of the options to address said issues. Warren and Debbie attended as assistance staff from the Office of EMS should any questions arise that only the state could answer. Following the meeting, Warren and Debbie had a two hour discussion with Tidewater Community College's EMS dean and faculty about the new possibilities that existed with the July 1 initiation of non-traditional EMS education.
- Michael Berg, regulation and compliance manager participated in a four-day Fire/EMS study for Pittsylvania County in collaboration with the Virginia Fire Service Board, Virginia Department of Fire Programs and Forestry. An evaluation of current services

and needs took place and a report will be completed and presented in the late winter. Here is a link from the story, which was covered by the Register & Bee: http://www.godanriver.com/news/pittsylvania_county/pittsylvania-fire-ems-volunteers-vent-concerns/article_c9e359f2-250e-11e5-9285-bffee66228f1.html.

c) **Recognition of EMS Personnel Licensure Interstate Compact (REPLICA) Resolution**

During the 2015 session of the Virginia General Assembly several bills were introduced to adopt REPLICA in Virginia. Unfortunately, each bill (SB877 and HB1660) was ultimately left in subcommittee #3 of the House Health, Welfare and Institutions (HWI) committee. SB 877 was unanimously passed by the Senate before being assigned to subcommittee #3 of HWI where it was “laid on the table” without a vote. HB 1660 did not make it to the full HWI committee for a vote because it was left in subcommittee #3 and therefore was not eligible to pass over to the Senate where it would have been heard by the Senate Education and Health committee.

At the November 5, 2014 meeting of the state EMS Advisory Board, the Board unanimously approved a motion from the Legislation and Planning Committee to support adoption of the model language for REPLICA and the subsequent introduction of legislation during the 2015 session that if passed would allow the commonwealth to enter into the compact as a member state.

Although REPLICA was not adopted by the legislature and signed into law by the Governor, there continues to be widespread support from all key EMS stakeholder groups in VA for the provisions of REPLICA and a desire to have Virginia participate as a member state. At the request of the Chair of the EMS Advisory Board and the Executive Committee of the Board, a resolution (**Appendix A**) has been developed for use by EMS providers, agencies, organizations, associations, and localities in Virginia to express and encourage strong support by their legislators and constituents for the adoption of REPLICA in VA.

This draft resolution is presented to the Board for their review and vote of approval.

d) **E.V.E.N.T.**



E.V.E.N.T. is a program of the Center for Leadership, Innovation, and Research in EMS (CLIR) with sponsorship provided by the North Central EMS Institute (NCEMSI), the National EMS Management Association (NEMSMA), the Paramedic Chiefs of Canada (PCC), the National

Association of Emergency Medical Technicians (NAEMT) and the National Association of State EMS Officials (NASEMSO).

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected is used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool (Patient Safety Event, Near Miss Event, Violence Event, Line of Duty Death). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

Second quarter 2015 (April through June 2015) EMS Voluntary Event Notification Tool (E.V.E.N.T.) anonymously reported patient safety and provider violence summary reports have been posted on the website. To access them, go to www.emseventreport.com and then click on either Patient Safety or Provider Violence and use the links on the left side of those pages, or simply use these links below:

Appendix B contains an aggregate report of **patient safety events** reported to E.V.E.N.T. in the second quarter of 2015 (April through June 2015). [Second Quarter 2015 EVENT Patient Safety Summary Report](#)

Appendix C contains an aggregate report of the **provider violence events** reported to E.V.E.N.T. for the second quarter of 2015 (April through June 2015). [Second Quarter 2015 EVENT Provider Violence Summary Report](#)

There were not enough incidents to report any meaningful data on **Near Miss** for the second quarter of 2015.

Visit www.emseventreport.com for more information about E.V.E.N.T.

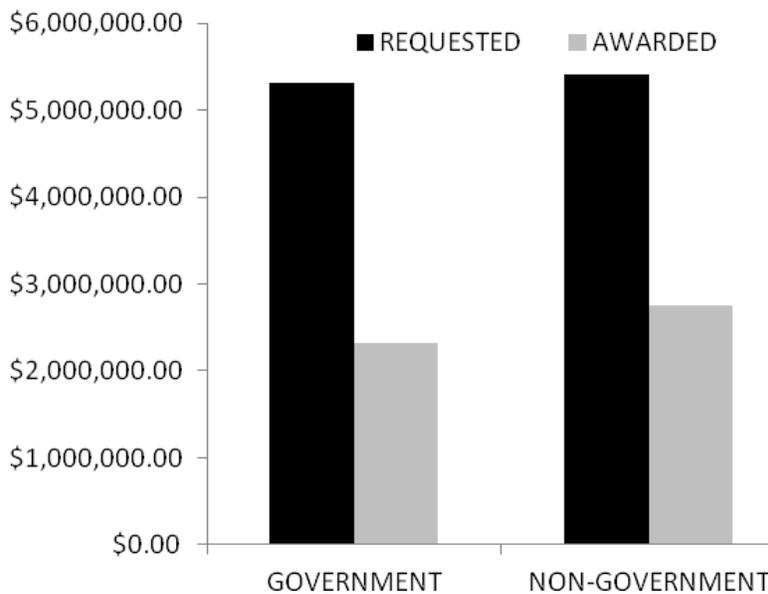
e) Financial Assistance for Emergency Medical Services (FAEMS) Grant Program, known as the Rescue Squad Assistance Fund (RSAF)

The RSAF grant deadline for the Spring 2015 grant cycle was March 15, 2015, OEMS received 152 grant applications requesting \$10,724,108.00 in funding. OEMS funded 115 agencies in the amount of \$5,068,323.88.

Funding was awarded in the following agency categories:

- 66 Non-Government Agencies awarded \$2,748,468.00
- 49 Government Agencies awarded \$2,319,856.00

Figure 1: Requested vs Amount Awarded by Agency Category

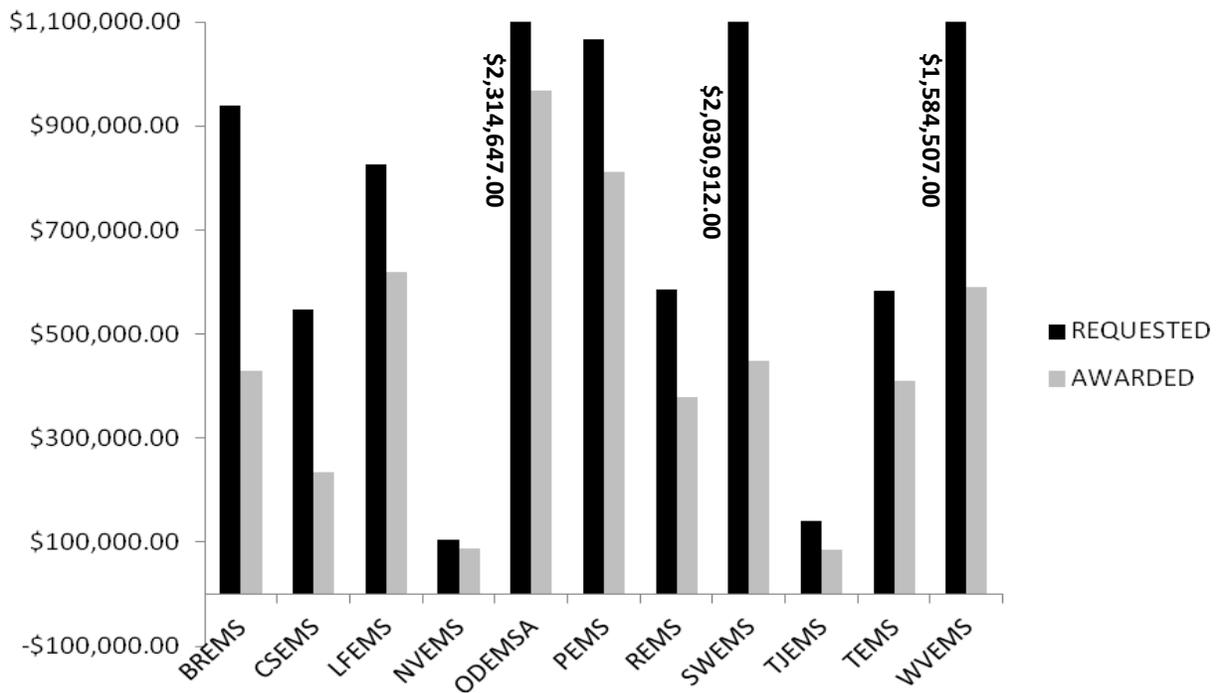


The following EMS regional areas were awarded funding in the following amounts:

- Blue Ridge EMS Council – 6 agencies awarded \$429,262.00
- Central Shenandoah EMS Council – 7 agencies awarded \$235,391.00
- Lord Fairfax EMS Council – 7 agencies awarded \$620,241.00
- Northern Virginia EMS Council - 5 agencies awarded \$88,626.00
- Old Dominion EMS Alliance – 21 agencies awarded \$966,903.00
- Peninsulas EMS Council – 17 agencies awarded \$812,048.00
- Rappahannock EMS Council – 11 agencies awarded \$379,343.00

- Southwestern Virginia EMS Council – 11 agencies awarded \$448,811.00
- Thomas Jefferson EMS Council – 5 agencies awarded \$86,546.00
- Tidewater EMS Council – 10 agencies awarded \$411,110.00
- Western Virginia EMS Council – 14 agencies awarded \$590,044.00

Figure 2: Requested vs Amount Awarded by EMS Regions



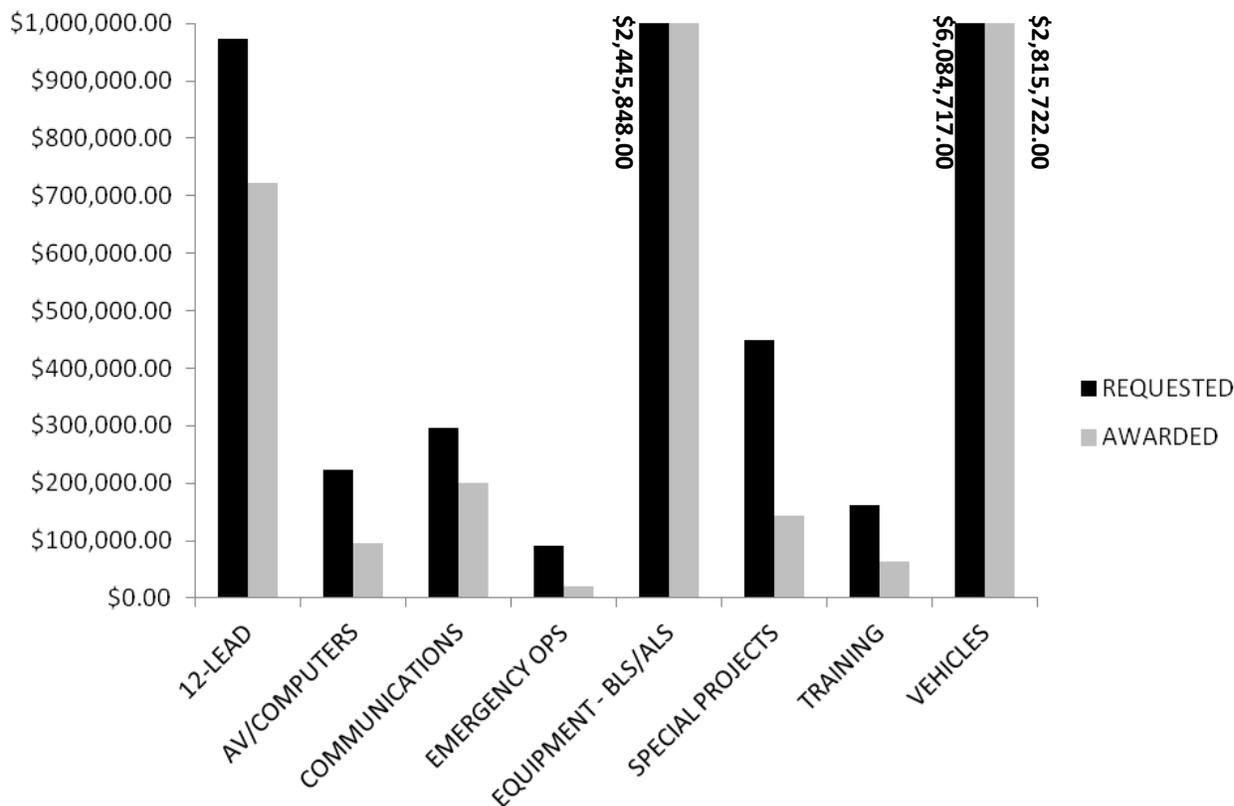
Note: Three of the Regional Councils had a higher requested amount than shown, the figure represents categories up to \$1,100,000.00 to give a clearer picture of the data.

RSAF Grants Awarded by item categories:

- 12 –Lead – \$723,416.00
 - Includes all 12-Lead Defibrillators.
- Audio Visual/Computer Hardware - \$2,445,848.00
 - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - \$ 199,792
 - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.
- Emergency Operations - \$21,292.00
 - Includes items such as Mass Casualty Incident (MCI), extrication equipment, rescue boat and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.
- Equipment - Basic and Advanced Life Support Equipment - \$1,005,047.00
 - Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.
- Special Projects - \$143,326.00
 - Includes projects such as Special Project material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects, Protocol Projects and other innovative programs.
- Training - \$64,827.00
 - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.
- Vehicles - \$2,815,722.00
 - This category includes all vehicles such as ambulances, re-chassis, re-mounts and quick response vehicles.

Figure 3: Requested vs Amount Awarded by Item



Note: The Vehicles category had a requested amount of \$6,084,717.00 with an award amount of \$2,815,722.00. The figure represents categories up to \$1,000,000.00 to give a clearer picture of the data.

The Fall 2015 grant cycle will begin on August 1, 2015 with a deadline of September 15, 2015; grants will be awarded January 1, 2016.

Cot Retention System Requirements

Change Notice 8 from the General Services Administration (GSA) became effective July 1, 2015 and requires the construction of a patient loading and transport system (cot retention system) within all new ambulances. Because of this directive, all RSAF grant applications that are requesting new ambulances must submit a quote from the vendor to include the construction of a cot retention system in all new ambulances. For more information check the GSA website at <https://apps.fas.gsa.gov/vehiclestandards/> or contact Amanda Davis, OEMS Grants Manager at amanda.davis@vdh.virginia.gov.

Rescue Squad Assistance Fund Emergency Grants

Lebanon Lifesaving Crew was awarded 1 new engine for their existing ambulance (2008 Ambulance) at a 100/0 (state/agency) funding level for \$19,650.70 on May 20, 2015. This agency was not in a financial position to purchase this engine and this vehicle being out of service was a detriment to patient care in Russell County.

EMS – Grant Information Funding Tool (E-GIFT)

The E-GIFT is close to being completed for all phases outlined in the initial project proposal. E-GIFT has provided a more efficient and effective process for implementing OEMS grants along with reducing redundancy in grant maintenance for applicants and OEMS grant staff. E-GIFT is required for all grant submissions and grant requirements, including any emergency grant applications, grant correspondence and invoice submissions.

EMS on the National Scene

II. EMS On the National Scene

a) New Study Reflects Incomplete Data on Naloxone Use by EMS

A recent issue of the American Journal of Public Health, a study (Faul et al in Disparity in Naloxone Administration by Emergency Medical Service Providers and the Burden of Drug Overdose in Rural Communities, Am J Public Health. 2015 Apr 23:e1-e7) funded by the Centers for Disease Control and Prevention (CDC) reports on the use of naloxone by EMS Provider level, asserting that “As of 2014, only 12 states allowed basic EMS staff to administer naloxone for a suspected opioid overdose; all 50 states allow advanced EMS staff to administer the overdose reversal treatment.”

However, a study conducted by the Network of Public Health Law more accurately reports, “...as of September, 2014, all states permit paramedics to administer naloxone and all but one (MS) permit AEMTs or the state’s equivalent intermediate-level EMS providers to do so. Twenty-four permit EMTs and 13 permit EMRs to administer the medication. The corresponding numbers for EMTs and EMRs as of November 2013 were 12 and 3 respectively, a testament to the rapid uptake of this scope of practice change.” Readers are strongly encouraged to refer to the most up-to-date data including citations to state laws reflected in “*Legal Interventions to Reduce Overdose Mortality: Emergency Medical Services Naloxone Access.*”

b) FAA Issues AC on Helicopter Air Ambulance Operations

The Federal Aviation Administration (FAA) has issued an advisory circular (AC) to provide information and guidelines to assist existing Helicopter Air Ambulance (HAA) operators, other Title 14 of the Code of Federal Regulations (14 CFR) part 135 operators considering becoming an HAA operator and those considering new-startup HAA operations. To address an increase in fatal HAA accidents, the FAA has implemented new operational procedures and additional equipment requirements for HAA operations. For more information go to: https://www.faa.gov/regulations_policies/advisory_circulars/index.cfm/go/document.information/documentID/1027108.

c) OIG Audit: Suboptimal Results by FAA to Enhance HEMS Safety

The Federal Aviation Administration (FAA) issued a final Helicopter EMS (HEMS rule) in February 2014 and subsequently Congress passed the FAA Modernization and Reform Act of 2012 (FMRA). In light of these efforts, the Ranking Member of the House Aviation Subcommittee requested that the Office of the Inspector General (OIG) review FAA’s progress in improving air ambulance safety. The results of this investigation, OIG Audit Report: Delays in Meeting Statutory Requirements and Oversight Challenges Reduce FAA’s Opportunities To Enhance HEMS Safety (AV-2015-039), is now available.

The audit concludes that ...”continued delays in finalizing the remaining mandates affect FAA’s ability to focus its accident reduction efforts and limit the effectiveness of safety initiatives. Additionally, until FAA updates key oversight policies and obtains meaningful safety data to analyze for trends, it will not be well positioned to effectively oversee a rapidly expanding HEMS industry.” For more information go to:

<https://www.oig.dot.gov/sites/default/files/FAA%20HEMS%20Progress%20and%20Oversight%20Final%20Report%5E4-8-15.pdf>.

d) NCSL 911 Legislation Database Now Available

State legislatures passed a variety of measures in 2014 to support and improve the operations of public emergency communication services for today's digital mobile society. Once again a number of states enacted legislation providing immunity for individuals who report drug and alcohol overdoses. Alaska, Colorado, Georgia, Indiana, Louisiana, Maryland, Oregon, Pennsylvania, Utah and Wisconsin are among the states that enacted legislation in this area. At least three states—California, Kansas and Tennessee—passed legislation related to next-generation 911, allowing users to send text, video and picture messages in addition to making phone calls to 911. California’s legislation requires the development of a plan and timeline for testing, implementing and operating NG911 throughout the state.

The National Conference of State Legislatures (NCSL) announces that all 2014 amendments to 911 laws nationwide are available to review. The legislation listed includes key 2014 enactments, excluding appropriations. See NCSL's 9-1-1 Legislation Database for a more complete list of 2014 introduced and enacted 9-1-1 legislation. For more information go to: <http://www.ncsl.org/research/telecommunications-and-information-technology/2014-key-enacted-9-1-1-related-legislation.aspx>.

e) EMSC Seeks to Improve Pediatric Care Nationwide

The National Pediatric Readiness Project (Peds Ready) is an ongoing quality improvement (QI) project designed to promote optimal care of children in all U.S. and territory emergency departments (ED). The primary purpose of Peds Ready is three-fold: (1) to establish a composite baseline of the nation’s capacity to provide care to children in the ED; (2) to create a foundation for EDs to engage in ongoing QI processes that includes implementing the “Guidelines for the Care of Children in the Emergency Department;” and (3) to establish a benchmark that measures an ED’s improvement over time. For more information go to: <http://www.pediatricreadiness.org/>.

f) DHS S&T Releases Safety Resources for Ambulances

The Department of Homeland Security (DHS) Science and Technology Directorate (S&T) has announced the release of two ambulance safety resources for emergency medical services (EMS) leaders, professionals and organizations nationwide. The documents aim to reduce the injury and fatality rate of EMS personnel. According to data from the National Highway Traffic Safety Administration (NHTSA), the fatality rate of EMS professionals is three times greater than the

average in any other occupation. The first of the two resources released, the *Ambulance Patient Compartment Human Factors Design Guidebook*, recommends improved physical design standards (go to:

<http://www.firstresponder.gov/TechnologyDocuments/Ambulance%20Patient%20Compartment%20Human%20Factors%20Design%20Guidebook.pdf>).

The second resource, the *Research Study of Ambulance Operations and Best Practice Considerations for Emergency Medical Services Personnel*, addresses operational procedures and practices while operating an ambulance. To develop design guidelines, S&T coordinated with the National Institute for Occupational Safety and Health (NIOSH) and the National Institute of Standards and Technology (NIST) to observe EMS professionals in the back of ambulances, specifically looking at the ergonomics of the patient compartment. They worked with EMS providers to determine the safest position for the caregiver and the patient. Additionally, the multi-agency team looked at the safety of the individual aspects of the vehicle in the event of a crash, and developed recommendations for EMS provider and patient restraints, cots and equipment mountings.

(go to:

<http://www.firstresponder.gov/TechnologyDocuments/Ambulance%20Driver%20%28Operator%29%20Best%20Practices%20Report.pdf>).

g) NREMT Introduces New Paramedic Psychomotor Competency Portfolio Exam

Following pilot projects in several states, the National Registry of Emergency Medical Technicians (NREMT) has revised the design for paramedic testing. The NREMT developed a portfolio of vital skills that each paramedic student must master in order to qualify for the National Registry Paramedic Certification examination. Each student's portfolio is tracked by the program throughout the formative and summative phases of education in the classroom, laboratory, clinical, and field internship settings. The completed portfolio becomes a part of the student's permanent educational file and is a prerequisite to seeking National Registry Paramedic Certification. The six (6) skills that will comprise the National Registry Paramedic Psychomotor examination effective August 1, 2016, are as follows:

1. Patient Assessment – Trauma
2. Oral Station – Case A
3. Oral Station – Case B
4. Dynamic Cardiology
5. Static Cardiology
6. Out-of-hospital Scenario

Please visit this link (<http://tinyurl.com/NREMT-PPCP>) for documents and essays used during the laboratory, clinical, and capstone phases of a student's education. Students and educational programs are welcome to use these documents for non-commercial purposes of educational or scientific advancement.

In related news, the NREMT announced its plan for its recertification model, the National Continued Competency Program (NCCP) in its [Spring newsletter](#). Constructed using

methodology similar to that of the American Board of Medical Specialty requirements, the new NCCP model streamlines the recertification process into three strategic categories of continuing education: National, Local, and Individual. Overall, the total number of CE hours has been reduced. The changes allow a platform for evidenced-based medicine to reach EMS professionals all over the country, give state and local agencies the freedom to dictate a portion of the recertification requirements and provide a foundation for the EMS professional to embrace life-long learning through self-assessment.

h) Simulation Use in Paramedic Education Research (SUPER): A Descriptive Study

A research study was conducted by a subcommittee of the National Association of EMS Educators' Research Committee, composed of members with expertise in EMS education and healthcare simulation. The group conducted a cross-sectional census survey of 638 Paramedic programs that were either accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or holding a Letter of Review by the CoAEMSP.

The purpose of this research was to characterize the use of simulation in initial Paramedic education programs in order to assist stakeholders' efforts to target educational initiatives and resources. This group sought to provide a snapshot of what simulation resources programs have or have access to and how they are used; faculty perceptions about simulation; whether program characteristics, resources, or faculty training influence simulation use; and if simulation resources are uniform for patients of all ages. Learn more about the findings of the descriptive study at: <http://files.ctctcdn.com/e56edc5d001/7caf2693-cfa1-432d-b144-b6a3eec3fe82.pdf>.

i) Rescue Workers Use Apps to Help Save Lives

When 911 dispatchers get a call that someone has collapsed and stopped breathing, they quickly notify first responders. In hundreds of communities across the U.S., they now also send out a smartphone app alert summoning citizens trained in CPR. If those Good Samaritans arrive at the scene first, they can start resuscitation efforts until the professionals get there. The mobile app is called [PulsePoint](#), and it was devised to aid victims who have suffered cardiac arrest. It's one of a number of apps that rescue workers, hospital staffers and patients themselves are using to try and improve responses to health emergencies and help save lives.

A software developer in Falls Church, Virginia, for example, created the free [911HelpSMS](#) app, which informs a user of where he is located before he calls 911 in a medical emergency. It also instantly texts multiple family members and gives them the person's GPS location. Another free app called [EMNet finderER](#) was developed Massachusetts General Hospital. It allows users, including sick people, EMTs, doctors and caregivers, to quickly locate the nearest hospital in an emergency, whether they're in a part of town they're not familiar with or they're on vacation. Unlike PulsePoint, most emergency health-related apps don't just target one type of medical crisis. The [ICEBlueButton](#) app, for example, lets users store information on their smartphone that can be used during any medical emergency. That can include their doctor's name, emergency contacts, allergies, medications and medical conditions. A barcode then is generated that can be accessed on the phone's lock screen and scanned and downloaded by emergency responders,

using a scanner app. Another app, [Twiage](#), allows first responders to instantly and securely send patient information from the ambulance to the hospital, including photos, videos and EKG results. The information appears on a computer screen at the emergency room, along with the GPS-tagged estimated time of arrival.

j) NASEMSO Congratulates NEMSAC Members on Reappointment

NASEMSO congratulates members Terry Mullins, Dr. Carol Cunningham, and Katrina Altenhofen for their recent reappointments to the National EMS Advisory Council. NEMSAC is authorized by Congress to provide expert advice and recommendations to the US Department of Transportation and the Federal Interagency Committee on EMS (FICEMS) on key issues such as data collection, performance measurement, and the EMS workforce and we are extremely proud of their accomplishments! For more information go to:

<http://www.nhtsa.gov/About+NHTSA/Press+Releases/2015/new-ems-advisory-council-members-named-2015>.

k) NASEMSO Rebrands Its Biannual Meetings; Preliminary Fall Schedule Announced

The NASEMSO Program Committee, chaired by Gary R. Brown (VA) has been exploring ways to better support its members and partners in attending its biannual meetings while avoiding conflicts with other groups and fiscal year calendars. Previously known as the “Mid Year” and “Annual” meetings, NASEMSO now refers to its meetings in regards to the season they are held in—Spring and Fall. Updated meeting information on the NASEMSO Fall 2015 Meeting and Tradeshow is now available including Exhibitor and sponsorship opportunities, preliminary program, travel support applications, hotel information, and the call for abstracts/posters on the [NASEMSO web site \(https://www.nasemso.org/Meetings/Annual/AnnualMeeting2015.asp\)](https://www.nasemso.org/Meetings/Annual/AnnualMeeting2015.asp). Hope to see you in Derby City (Louisville, Kentucky) October 12-16, 2015!!!

l) New DOT Guidelines Support State Authorities to Regulate Medical Functions of Air Ambulances

In response to [recommendations](#) (issued in 2009) by the National Transportation Safety Board (NTSB) intended to improve safety in the air medical transport industry, the Federal Aviation Administration (FAA) issued various resource documents regarding helicopter air ambulance safety and operations. (Quick links to these resources are available on the [NASEMSO web site](#).) NTSB safety recommendations A-09-102 and A-09-103 related to the air medical transport of patients with emergency medical conditions were addressed specifically to the Federal Interagency Committee on EMS (FICEMS). New guidelines recently published by the US Department of Transportation (USDOT) Office of General Counsel refer to medical standards of care that serve primarily a patient objective as “properly within a state’s regulatory authority.” The guidelines outline opportunities for state regulations that address outcomes related to:

- the quality of emergency medical care provided to patients
- requirements related to the qualifications and training of air ambulance medical personnel
- scope of practice and credentialing
- maintenance of medical records, data collection, and reporting

- medically related equipment standards
- patient care environments
- EMS radio communications
- medically related dispatch requirements
- medical transport plans including transport to appropriate facilities
- other medical licensing requirements

“*Guidelines for the Use and Availability of Helicopter Emergency Medical Transport (HEMS)*” describes the regulatory and oversight framework for helicopter air ambulance operations that state emergency medical services (EMS) system planners should consider in developing regulations to help ensure patients receive appropriate medical attention and care. FICEMS recently transmitted these guidelines to the NTSB as a component of its response to A-09-102. For more information go to:

[http://www.transportation.gov/sites/dot.gov/files/docs/Guidelines%20for%20the%20Use%20and%20Availability%20of%20Helicopter%20Emergency%20Medical%20Transport%20\(HEMS\)%20OCR.pdf](http://www.transportation.gov/sites/dot.gov/files/docs/Guidelines%20for%20the%20Use%20and%20Availability%20of%20Helicopter%20Emergency%20Medical%20Transport%20(HEMS)%20OCR.pdf).

m) House Bill Proposes to Restore Funding to SWICs

A House Homeland Security subcommittee has unanimously approved bi-partisan legislation aimed at improving interoperable communications for first responders. In recent years, states have been able to rely on the U.S. Department of Homeland Security’s Interoperable Emergency Communications Grant Program to support their communications governance structures and their Statewide Interoperability Coordinators (SWIC), who are charged with coordinating interoperability activities across all levels of government.

However, due to the elimination of the Interoperable Emergency Communications Grant Program and reduced funding for other state and local homeland security grant programs, some states are eliminating SWICs. As a result, activities critical to maintaining and advancing interoperable emergency communications policies are not being effectively coordinated. The *Statewide Interoperable Communications (SWIC) Enhancement Act of 2015* (H.R. 2206) ensures that states maintain the progress that has been made toward achieving interoperability by requiring states to have a SWIC or to delegate activities related to achieving interoperability to other individuals. For more information go to: <https://www.congress.gov/bill/114th-congress/house-bill/2206>.

n) ICMA InFocus Series Highlights EMS Value

Abstract: Despite a tremendous diversity in how emergency medical services (EMS) are provided in municipalities around the country, most U.S. EMS systems share one commonality: They remain primarily focused on responding quickly to serious accidents and critical emergencies even though patients increasingly call 911 for less severe or chronic health problems. Recent efforts in health care to improve quality and reduce costs pose significant challenges to the existing EMS response model.

Health care payers have become increasingly unwilling to reimburse for services that fail to prove their value. As a consequence, EMS agencies will soon be required to demonstrate their worth like never before. It's critical for city and county managers to know that despite these challenges, the changing health care landscape also presents opportunities for EMS systems to evolve from a reactive to a proactive model of health care delivery—one that better meets the needs of their communities by preventing unnecessary ambulance transports, reducing emergency department visits, and providing better care at a lower cost. This InFocus is intended as a guide to identify challenges and opportunities and help you measure your efforts and define success. Read *The New EMS Imperative: Demonstrating Value* (ICMA membership or purchase required).

In related news, *EMS in the Era of Health Care Reform* is a free article from Fitch and Associates that discusses opportunities for EMS systems to evolve from a reactive to a proactive model of health care delivery.

o) Congressman Introduces Legislation to Establish National EMS Memorial in Washington DC

Massachusetts Congressman Stephen F. Lynch recently introduced H.R. 2274, a *Bill to Establish a National EMS Memorial*. The legislation creates the National Emergency Medical Services Memorial Foundation, which will undertake the effort of designing, siting, and creating a memorial in Washington, D.C to honor the service and sacrifice of the nation's EMS members. H.R. 2274 is co-sponsored by Congressman Peter King (R-NY), Congresswoman Katherine Clark (D-MA), Congressman Bobby L. Rush (D-IL), Congressman James McGovern (D-MA), Congressman William Keating (D-MA), Congressman Daniel Lipinski (D-IL), Congressman Richard Neal (D-MA), and Congresswoman Diana DeGette (D-CO). For more information go to: <https://www.congress.gov/bill/114th-congress/house-bill/2274>.

p) EVENT Program Intended to Improve EMS Safety and Quality

EMS Voluntary Event Notification Tool (E.V.E.N.T.) is a program of the Center for Leadership, Innovation, and Research in EMS (CLIR) with sponsorship provided by the North Central EMS Institute (NCEMSI), the National EMS Management Association (NEMSMA), the Paramedic Chiefs of Canada (PCC), the National Association of Emergency Medical Technicians (NAEMT) and the National Association of State EMS Officials (NASEMSO). Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool. The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion. The first quarter 2015 (January – March) EMS Voluntary Event Notification Tool (E.V.E.N.T.) summary reports are available for download on the individual reporting web pages on www.emseventreport.com,

q) NAEMT Releases MIH-CP Survey Report

The National Association of EMTs (NAEMT) conducted a national survey to help EMS practitioners and legislative decision-makers understand the opportunities and challenges of Mobile Integrated Healthcare and Community Paramedicine (MIH-CP). More than 100 EMS agencies nationwide responded. They shared information about their programs, such as services offered, financial arrangements, the training and education of practitioners, challenges faced and lessons learned. This report enabled NAEMT to provide the first nationwide look at the growth of MIH-CP, and the strategies EMS is using to further the Triple Aim of improved patient experience, improved patient health, and reduced costs. The report was published as a supplement to the May issue of *EMS World Magazine*, and distributed to members of Congress and key federal agencies. [View/download the MIH-CP survey report at: http://www.naemt.org/docs/default-source/MIH-CP/naemt-mih-cp-report.pdf?status=Temp&sfvrsn=0.09835989241509824](http://www.naemt.org/docs/default-source/MIH-CP/naemt-mih-cp-report.pdf?status=Temp&sfvrsn=0.09835989241509824).

Educational Development

III. Educational Development

Committees

- A. **The Training and Certification Committee (TCC):** The Training and Certification Committee meeting was held on Wednesday, July 8, 2015. There are no action items.

Copies of past minutes are available on the Office of EMS Web page here:
<http://www.vdh.virginia.gov/OEMS/Training/Committees-PDC.htm>

- B. **The Medical Direction Committee (MDC)** The Medical Direction Committee meeting met on Thursday, July 9, 2015. There are two action items for consideration. See **Appendix D** and **Appendix E**.

Copies of past minutes are available from the Office of EMS web page at:
<http://www.vdh.virginia.gov/OEMS/Training/Committees.asp>

Advanced Life Support Program

- A. Virginia I-99 to Paramedic student's are continuing the transition process that allows them to gain certification at the Paramedic level after completion of a Virginia approved Intermediate-99 to Paramedic bridge program.
- B. All National Registry I-99 certified providers must complete the transition process to Paramedic level by 2018/2019 or their certification level with National Registry will be AEMT. This will NOT affect their Virginia certification level which will remain Intermediate 99.
- C. ALS Coordinator re-endorsement requires an update every two years and the submission of a re-endorsement application. The application must be signed by an EMS Physician. Additionally it must contain the signature of the regional EMS council director if courses are to be offered in their region.
- D. The 2015 Paramedic Psychomotor Competency Portfolio (PPCP) has been mailed to all accredited Paramedic programs in Virginia from National Registry. All students enrolling in Paramedic programs that start after August 1, 2016 will be required to master the portfolio of vital skills to qualify for the National Registry Paramedic (NRP) Certification examination.

Basic Life Support Program

A. Education Coordinator Institute

1. The Office held the second Education Coordinator Institute for 2015, June 13-17 in conjunction with the VAVRS Rescue College in Blacksburg. Eight (8) candidates attended and six (6) were certified, Due to the small number, the Adult Education was canceled and rescheduled for the next Institute, where the remaining two (2) candidates will complete the process..
2. The deadline to pass the EC Cognitive exam in order to be eligible for the next Institute was July 12, 2015. The next EC Psychomotor Exam is scheduled for August 1, 2015 in the Richmond Area.
3. The Next EC Institute is scheduled for September and will be held in the Winchester Area.
4. EMS Providers interested in becoming an Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
5. Schedule of the various deadlines and EC Institutes can be found on our website:
http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Educator Updates:

1. For 2015, the Division of Educational Development continued to provide in-person Educator Updates.
2. The Office conducted an in-person EMS Instructor Update on Friday, June 12 and Saturday June 13 in the WVEMS Council area.
3. The schedule of future updates can be found on the Web at:
http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

EMS Training Funds

FY13

	Commit \$	Payment \$	Balance \$
Emergency Ops Funding	\$1,460.00	\$675.00	\$785.00
BLS Initial Course Funding	\$729,348.00	\$369,101.72	\$360,246.28
BLS CE Course Funding	\$125,160.00	\$46,768.71	\$78,391.29
ALS CE Course Funding	\$297,360.00	\$77,402.50	\$219,957.50
BLS Auxiliary Program	\$80,000.00	\$16,200.00	\$63,800.00
ALS Auxiliary Program	\$350,000.00	\$170,620.00	\$179,380.00
ALS Initial Course Funding	\$1,102,668.00	\$624,125.61	\$478,542.39
Totals	\$2,685,996.00	\$1,304,893.54	\$1,381,102.46

FY14

	Commit \$	Payment \$	Balance \$
Emergency Ops Funding	\$1,120.00	\$360.00	\$760.00
BLS Initial Course Funding	\$780,912.00	\$380,237.25	\$400,674.75
BLS CE Course Funding	\$94,010.00	\$39,182.50	\$54,827.50
ALS CE Course Funding	\$224,950.00	\$80,115.00	\$144,835.00
BLS Auxiliary Program	\$130,000.00	\$61,300.00	\$68,700.00
ALS Auxiliary Program	\$304,000.00	\$177,985.00	\$126,015.00
ALS Initial Course Funding	\$1,188,504.00	\$615,334.15	\$573,169.85
Totals	\$2,723,496.00	\$1,354,513.90	\$1,368,982.10

FY15

	Commit \$**	Payment \$	Balance \$**
Emergency Ops Funding	\$-----	\$540.00	\$-----
BLS Initial Course Funding	\$-----	\$354,375.75	\$-----
BLS CE Course Funding	\$-----	\$32,663.80	\$-----
ALS CE Course Funding	\$-----	\$66,263.75	\$-----
BLS Auxiliary Program	\$-----	\$17,960.00	\$-----
ALS Auxiliary Program	\$-----	\$141,720.00	\$-----
ALS Initial Course Funding	\$-----	\$591,193.05	\$-----
Totals	\$-----	\$1,207,698.35	\$-----

** Due to current maintenance & upgrades to Lotus Notes, this information was not available at the time of report.

EMS Education Program Accreditation
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A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
 - a) Frederick County Fire and Rescue has been granted a one year conditional accreditation. The Office of EMS will conduct a follow up visit after the completion of their first cohort class to assure that the requirements of accreditation are being met before full accreditation is issued.
 - b) Chesterfield Fire/EMS has been granted a one year conditional accreditation. The Office of EMS will conduct a follow up visit after the completion of their first cohort class to assure that the requirements of accreditation are being met before full accreditation is issued.
 - c) Harrisonburg Rescue Squad's site visit was conducted and their final report is being completed.

2. Advanced Emergency Medical Technician (AEMT)

- a) Frederick County Fire and Rescue has been granted a one year conditional accreditation. The Office of EMS will conduct a follow up visit after the completion of their first cohort class to assure that the requirements of accreditation are being met before full accreditation is issued.

3. Intermediate – Reaccreditation

- a) Roanoke Valley Regional Fire/EMS Training Center reaccreditation site visit was conducted in June. Their final report is being completed.

4. Intermediate – Initial

- a) Southwest Virginia EMS Council has been granted conditional accreditation with review. Their initial Intermediate course is underway and the Office of EMS will be visiting the program in the coming months to review their progress.
- b) Paul D. Camp Community College has been granted a one year conditional accreditation. The Office of EMS will conduct a follow up visit after the completion of their first cohort class to assure that the requirements of accreditation are being met before full accreditation is issued.

5. Paramedic – Initial

- a) Germanna-Rappahannock EMS Council withdrew their self study with CoAEMSP due to changes required by SACS. They will be required to resubmit an application for evaluation when ready to move forward.
- b) Prince William County has completed their initial cohort class and their CoAEMSP self study visit has been scheduled.
- c) Historic Triangle EMS Institute voluntarily retired their CoAEMSP accreditation in April, 2017. The students enrolled in their current program are not affected and will be allowed to test for their National Registry Paramedic certification.

6. Paramedic – Reaccreditation

- a) Piedmont Virginia Community College has gained full accreditation with CoAEMSP/CAAHEP.

- b) American National University in Salem, VA has placed their accreditation status on hold for a period of two years.
- B. For more detailed information, please view the Accredited Site Directory found on the OEMS web site at:
 - 1. <http://www.vdh.state.va.us/OEMS/Training/Accreditation.htm>
- C. All students must enroll in a nationally accredited paramedic program to qualify for National Registry certification. National accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).

National Registry

The NREMT will be increasing the initial certification fees effective January 1, 2017. The NREMT Board of Directors approved the fee increase effective 2017 following a ten-year price freeze (2007 -2017). The 2017 fee increase reflects the renewed relationship between the NREMT and Pearson VUE.

On Line EMS Continuing Education

Distributive Continuing Education

EMSAT programs are available FREE on the internet. Certified Virginia EMS providers can receive free EMSAT continuing education courses on your home or station PCs. Fifty to sixty EMSAT programs are available on CentreLearn Solutions LLC, at no cost to Virginia EMS providers. For specifics, please view the instructions listed under Education & Certification, EMSAT Online Training. For more information on EMSAT, including schedule and designated receive sites, visit the OEMS Web page at:
<http://www.vdh.virginia.gov/OEMS/Training/WebBasedCE.htm>

EMSAT

EMSAT programs for the next three months include:

Aug.. 19 , You're Not Out of the Woods Yet!
Instructor: Max Frayser, Hanover Fire -EMS Cat. 1 ALS, Area 89 , Cat. 1 BLS, Area 05

Sept. 16 , Technical Emergency Casualty Care: High Threat Medical Principles
Geoff Shapiro, MD, Cat. 1, ALS, Area 78 , Cat. 1 BLS, Area 04

The EMS Portal

The Virginia EMS Portal now functions across multiple browsers. **If you are using Internet Explorer, be sure your compatibility mode is off.** Having compatibility mode on may reduce the functionality of the Portal. The Virginia EMS Portal supports Internet Explorer 8 or later versions, Google Chrome 4.0 or later versions, and Apple Safari 4.0 or later versions. We hope to add Mozilla Firefox later this summer. Future plans will include mobile compatibility.

CTS

- A. There have been 37 - CTS, 3- EMT accredited course and 16- ALS psychomotor test sites conducted from April 18, 2015 through July 14, 2015.
- B. Vacant OEMS Test Examiner positions in Northern Virginia were advertised on the COV Online Employment System July 10, 2015 - July 20, 2015. Additional open positions in the Western/Southwestern and ODEMSA regions will be advertised after the Northern Virginia positions are filled.
- C. The Psychomotor Examination Guide has been updated and is going through final review. It will be released soon.

Other Activities

- Debbie Akers continues to participate in the NASEMSO webinars Community Paramedicine Insights Forum.
- Debbie Akers is serving as the staff liaison to a Mobile Integrated Healthcare workgroup. The workgroup has representation from the following: Fire based EMS, EMS OMD, ED Physician, EMS Administrator, EMS Provider, Regional Councils, Hospital ACA, Pediatrics, Commercial EMS, VDH Licensure, Primary Care Physician, VHHA, DMAS, Va Association for Home Care and Hospice and the VA Association for Hospices and Palliative Care. The workgroup is being chaired by Dr. Allen Yee.
- Debbie Akers has been invited to participate in the National Registry Item Writing workshop in August, 2015 in Columbus, Ohio.
- Warren continues participating with the NASEMSO's Education and Professional Standards Committee's (EPSC) Monthly conference calls.

- Warren plans to participate in a meeting of the Atlantic EMS Councils EPSC committee August 24th through August 26th.
- The Office discovered mid-March the Motorola CE Scanners would require a security update to continue functioning. This security update has to be applied by the Office at no cost to the instructor. Adam Harrell has been facilitating these updates, and currently has successfully updated 231 devices. The update has to be applied no later than July 15, 2015 to maintain functionality. Adam has made eligibility for the office to visit areas having difficulty with scanners and through this process visited multiple facilities this summer.
- Greg Neiman continues to participate on the Autism Public Safety Workgroup working toward improving EMS and Fire interface when responding to a patient with autism. The June EMSAT program was on Autism and was coordinated through the Workgroup to satisfy the JLARC findings for training of EMS and Fire personnel.
- The office conducted a webinar for the new course delivery option on the following dates: May 26, May 27, May 29 and May 30, and two on June 4th.
- Debbie and Warren participated in a meeting with Tidewater Community College at a meeting of the regions Fire Chiefs on July 1.

Emergency Operations

IV. Emergency Operations

Operations

- **Ebola Preparedness and Planning**

The Division of Emergency Operations continues to be active in supporting VDH planning and preparedness efforts as it relates to Ebola. Activities include attending monthly meetings of the State Incident Management Team (IMT), the VDH IMT, and the EVD Exercise Planning Team. Additionally, Karen Owens, Emergency Operations Manager, Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner served as facilitators for the Ebola Locality Exercise on May 19, 2015. During the exercise discussion were held regarding the role of state and local assets to respond to potential EVD patients.

- **OEMS VERTEX**

Winnie Pennington, Emergency Operations Planner conducted the annual OEMS VERTEX exercise the week of June 8-12, 2015.

- **OEMS Fire Drill**

Winnie Pennington, Emergency Operations Planner, conducted the OEMS Office Fire Drill on June 17, 2015. All employees and guests present participated in the drill.

- **Virginia 1 DMAT**

Frank Cheatham, HMERT Coordinator continues to attend Va-1 DMAT meetings as a representative of the Office of EMS. He also assisted with a day that members were able to self evaluate themselves for upcoming physical requirements for membership on DMAT.

- **Medical Surge Webinar**

Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Emergency Planner participated in the National Emergency Medical Services and Medical Surge: Essential Legal Issues Webinar on May 20, 2015.

- **Preparedness Webinars**

Winnie Pennington, Emergency Operations Planner, attended National Planning Framework Webinar on May 27, 2015. Additionally the Emergency Operations Planner participated in a series of online Hurrevac Webinars sponsored by FEMA, NOAA and USACE from July 27 to 31, 2015.

- **World Police & Fire Games**

The Emergency Operations Division managed the on-call status for ESF-8 throughout the entire duration of the World Police & Fire Games in Fairfax, VA from June 26 through July 7, 2015.

- **STARS**

All OEMS STARS radios were upgraded with the most current programming on July 7, 2015. The upgrades were performed by VSP radio technicians, onsite at OEMS.

Committees/Meetings

- **Patient Evacuation Workshop**

On July 9, 2015 Karen Owens, Emergency Operations Manager, participated in an HHS/ASPR Patient Movement Workshop to discuss the role of state agencies in hurricane evacuation and patient movement. The meeting included representatives of HHS, FEMA, and various Virginia agencies.

- **MutualAid.Net**

On June 23, 2015 Karen Owens, Emergency Operations Manager, attended a meeting to begin implementation of a resource tracking program to assist in coordinating mutual aid assistance during emergency events throughout the state. The project involves the Department of Fire Programs, Department of Emergency Management, State Fire Chiefs Association, and the Office of Emergency Medical Services.

- **EMS Communications Committee**

The EMS Communications Committee met on Friday, May 8, 2015 in Glen Allen, VA.

A proposal to eliminate Section “C” of the OEMS PSAP Accreditation guideline: *“Minimum of one person on staff certified as an emergency medical dispatch instructor through an approved EMD program (as described in section A) OR a memorandum of understanding with adjacent jurisdiction(s) for cooperative training. This may include coordination of interagency training programs or cooperation on hosting EMD system provider trainers”* was approved by the committee via motion and vote. OEMS PSAP Accreditation applications were reviewed from Dickenson and Madison Co. 911 centers. It was brought to the attention of the committee that due to unclear wording in the accreditation standards, neither PSAP technically qualified for accreditation. Mr. Crumpler, Emergency Operations Communications Coordinator, will edit the dated wording in the standard for presentation to the committee at the next scheduled meeting. The two applications were also shelved until the next scheduled meeting. The next scheduled meeting is August 7, 2015 in Glen Allen, VA.

Additionally, Mr. Derrick Ruble of Tazewell Co. 911 was selected by the committee to fill the vacant seat reserved for a representative from southwestern Virginia.

Also, Mr. Jeff Korman of Fairfax Co. 911 was selected to be the Virginia APCO representative to the State EMS Advisory Board and will fill that vacancy on the committee.

The VDEM Representative, Mr. Vic Buisset, announced his retirement from VDEM and as he will no longer be a member of the committee, a letter was sent from OEMS Director Gary Brown to VDEM Director Jeffrey Stern requesting a replacement.

- **Provider Health and Safety Committee**

Connie Green, Emergency Operations Assistant Manager, attended the Provider Health & Safety Committee meeting on May 8, 2015. The committee discussed the monthly safety bulletins and assigned topics for the coming months; the patient abandonment project; EMS Safety Officers; ambulance safety resources; connected vehicle technology and the status of CISM in Virginia, including various training conferences.

- **Emergency Management Committee**

Karen Owens, Emergency Operations Manager, and Connie Green, Emergency Operations Assistant Manager, attended the Emergency Management Committee meeting on May 7, 2015. The committee discussed the rollout of Mutual AidNet across the Commonwealth, tactical medic training plans, and COOP training for agency heads.

- **OEMS COOP Committee**

Karen Owens, Emergency Operations Manager, Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington Emergency Operations Emergency Planner participated in the OEMS COOP Committee meeting on June 22, 2015. Activities discussed included objectives for the upcoming COOP Exercise and lessons learned from the previous exercise.

- **Traffic Incident Management (TIM)**

Frank Cheatham, HMERT Coordinator, continues to work with the TIM program. He held a meeting of the Best Practices workgroup to update them on the Job Aid and to also look at the next items that the group needed to consider. The group is working with the Office of the Chief Medical Examiner on several issues regarding incidents involving fatalities on the highways. He also attended the meeting of the Training Oversight Committee for the Statewide Committee. Frank also attended other meetings to further the deployment of TIM Training in the immediate Richmond area.

- **Lane Reversal Coordination**

Frank Cheatham, HMERT Coordinator, continues to attend meetings in regards to Lane Reversal. He continues to look at various means of supporting the mission should OEMS be called on.

- **Task Force Meetings**

Over the past quarter, Frank Cheatham, HMERT Coordinator, has worked to continue the recruitment efforts for the Task Force teams. There are several agencies that are working on becoming one of the types of Task Forces to become a part of the system. Additionally, a training class for new members for one of the Task Forces was held, which resulted in several new members for that group and several Task Forces were assisted by providing guidance and suggestions on viability and readiness. Frank Cheatham has also been updating asset lists in preparation for the upcoming storm season.

- **Task Force Deployment**

Task Force TJ-2 out of Charlottesville has assisted in the RAM Event held in Southwest Virginia from July 17-19, 2015. They assisted again this year providing support in various capacities throughout the event. A group of 10 people went with several ambulances and various other equipment traveled for the event.

- **NASEMSO Highway Incident Traffic Safety (HITS) Committee**

Frank Cheatham, HMERT Coordinator, continues to attend NASEMSO HITS Committee conference calls and serves on a committee on various aspects of Vehicle Rescue focusing on electric and hybrid vehicles.

- **VDH Patient Tracking Workgroup**

Winnie Pennington, Emergency Operations Planner continues to attend the VDH Patient Tracking Workgroup meetings and has been actively participating in the development of the Patient Tracking Video.

- **VDH Ebola TTX Workgroup**

Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner, participated in the VDH EVD TTX Planning Meeting for the first exercise on May 1 and May 12, 2015 at VDEM. Karen Owens, Emergency Operations Manager, Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner, participated in the VDH Ebola Locality Table Top Exercise on May 19, 2015.

- **UCI 2015 World Cycling Championships VDH Planning Meeting**

Karen Owens, Emergency Operations Manager, continues to participate in UCI 2015 World Cycling Championship planning meetings to prepare for the event in September.

Training

- **Traffic Incident Management Train-the-Trainer**

Frank Cheatham, HMERT Coordinator, and Connie Green, Emergency Operations Assistant Manager, met with First Sgt. Michelle Ticho and an RPD Sgt regarding coordination of the TIM Train-the-Trainer program on May 10, 2015.

- **Mass Casualty Training**

Frank Cheatham, HMERT Coordinator, traveled to Anniston Alabama to the CDP Training facility for a class on Healthcare Leadership for Mass Casualty Incidents from July 26 through August 1, 2015.

- **Hanover Tomato Festival**

Karen Owens, Emergency Operations Manager and Frank Cheatham, HMERT Coordinator, continued to attend meeting in support of the Hanover Tomato Festival. Frank Cheatham, HMERT Coordinator, attended the Hanover Tomato Festival on July 11, 2015 to support the event with Misters and tents as well as providing our Command Trailer.

- **Vicarious Trauma Toolkit**

Karen Owens, Emergency Operations Manager continues to represent the National Association of State EMS Officials (NASEMSO) on the national panel to develop a Vicarious Trauma Toolkit. She has participated in monthly conference calls and in this quarter travelled to Asheville, North Carolina to roll out the toolkit as a pilot. Additionally Karen traveled to Boston to participate in the 2015 Summit to work on implementing updates to the toolkit based on pilot site input.

- **Vehicle Rescue Training**

The Office of EMS sponsored a vehicle extrication class May 14-15 and May 22-23. Each class, attended by 20 students, prepares EMS provider to respond to vehicle accidents that require extrication of patients.

- **Tactical Medic Project**

Connie Green, Emergency Operations Assistant Manager, participated in the NREMT Tactical Combat Casualty Care medic class held at Richmond Ambulance on May 27 & 28, 2015. Information was collected regarding regional tactical medic policies and best practices.

Mrs. Green also participated in the Henrico Tactical Emergency Combat Care medic class held at Henrico Fire Training on June 23, 2015. This course covered casualty care from a civilian responder perspective, which will allow for a more thorough comparison of the available programs for this project. In addition to that class she also participated in the Henrico Tactical Casualty Combat Care medic class held at Henrico Fire Training on July 23 & 24, 2015 as part of the requirement to become an NREMT certified TCCC instructor.

Karen Owens, Emergency Operations Manager and Connie Green, Emergency Operations Assistant Manager, met with VSP Officers A. Galton and A. Brenner on June 16, 2015 to begin to develop the framework for collaborating on the Tactical Medic Project for the Emergency Management Committee. The objectives are to develop a website of useful data, policies and promising practices to be available for EMS and other partner agencies to review when considering developing a tactical medic program or team. Additionally, courses may be developed to offer in the coming years for interested departments and providers.

- **VDH E-Learning Design Course**

Connie Green, Emergency Operations Assistant Manager, participated in the VDH Fundamentals of Rapid E-Learning Design Training on June 17, 2015. Essential elements of E-Learning Design were covered and active learning exercises were used to provide real-world learning scenarios to bring back to course development activities at the office.

- **VDH STARS Training**

Karen Owens, Connie Green, Frank Cheatham, Ken Crumpler, and Winnie Pennington, Emergency Operations Planner, participated in the VDH STARS Training on June 25, 2015. The training covered protocols and usage of the new STARS radio systems that will be installed in the OEMS vehicles in the future.

- **CISM Training**

Connie Green, Emergency Operations Assistant Manager, participated in the CISM for Healthcare Professionals Training Conference from August 24 to September 1, 2015. The training, hosted by Old Dominion EMS Alliance provided training in various CISM programs.

- **Preparedness Training**

Winnie Pennington, Emergency Operations Planner, attended the VDH Preparedness Academy on May 18-19, 2015.

Communications

- **OEMS Public Safety Answering Point (PSAP) & 911 Center Accreditation**

PSAP Accreditation applications for Madison Co. 911 and Dickenson Co. 911 were shelved at the last Communications Committee meeting until the accreditation standard wording can be updated. Loudoun Co. 911 and King & Queen 911 have also submitted an application for accreditation. All applications will be reviewed and considered for approval at the next scheduled meeting.

- **The Association of Public Safety Communications Officers (APCO) and National Emergency Number Association (NENA)**

Ken Crumpler represented OEMS at the Spring NENA/APCO conference at Virginia Beach April 22 through 24, 2015. Mr. Crumpler spoke to the general membership regarding the then vacant APCO seat on the State EMS Advisory Board and encouraged members interested in serving to submit curriculum vitae to the Virginia APCO Board for review and selection. The Virginia APCO Board selected three candidates they deemed most qualified to submit to the Office of the Governor.

- **OEMS Wireless Telecommunications Committee**

The OEMS Wireless Telecommunications Committee met on Friday, June 26, 2015 at OEMS to review the most recent Verizon Wireless bill and discuss any ongoing telecommunications issues. It was agreed the meetings will now be held quarterly, on the third Thursday of the month beginning in September.

- **Navigator Conference, International Academy of Emergency Dispatch**

Mr. Crumpler attended the annual Navigator conference, hosted by the International Academy of Emergency Dispatch from April 28 through May 2, 2015 in Las Vegas, NV. The focus of this conference was training and advancements in emergency medical dispatch and 911 as it relates to public safety response, especially EMS.

- **Emergency Medical Telecommunications Conference**

Mr. Crumpler attended the first Emergency Medical Telecommunications conference in Virginia Beach on Monday, July 13, 2015. The Virginia Department of Education led program is being designed to introduce 911 and emergency dispatcher training and education in Virginia high schools. The curriculum will be based on the International Academy of Emergency Dispatch “Emergency Telecommunicator” certification. This program will not provide a certification in any emergency medical dispatch protocol, but is considering a vocational education program to expose high school students to 911 as a profession.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 17 events, including education sessions, training classes, and debriefings (both group and one-on-one).

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

The Regional EMS Councils have submitted their FY15 Fourth Quarter contract reports throughout the month of July, and are under review.

Contract renewal agreements for the FY16 fiscal year have been signed by both VDH and the Regional EMS Councils, and are in effect.

The EMS Systems Planner attended the regional award programs and/or board meetings for the Blue Ridge, Central Shenandoah, Lord Fairfax, Northern Virginia, Rappahannock, Thomas Jefferson, and Tidewater EMS Councils during the quarter.

Medevac Program

The Medevac Committee is scheduled to meet on August 6, 2015. The minutes of the May 7, 2015 meeting are available on the OEMS website.

The Medevac Helicopter EMS application (formerly known as WeatherSafe) continues to grow in the amount of data submitted. In terms of weather turndowns, there were 559 entries into the Helicopter EMS system in the second quarter of 2015. 65% of those entries (364 entries) were for interfacility transports, which is close to the average from information from previous quarters. The total number of turndowns is an increase from 480 entries in the second quarter of 2014. This data continues to show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

The Virginia State Medevac Committee is performing an evaluation to determine whether or not there is an opportunity for the ST Segment Elevation Myocardial Infarction (STEMI) scene patient to have been transported by air to a specialty facility from the initial scene, versus being transported to/treated at a rural hospital first, then transported by air to a specialty facility for interventional treatment.

The aim of this retrospective chart review of ground and air transported STEMI patients between January 1, 2015 – December 31, 2015 is to:

- Determine if there is a greater opportunity to air transport the STEMI patient from the scene to a PCI center.
- Determine if air transport of the STEMI patient directly from the scene to a PCI center impacts the patient's length of stay.

Data has been collected since April 1, but at this point, is too premature to make any proper evaluations or conclusions.

Anita Perry and Tim Perkins made a presentation on the Medevac STEMI study at the annual meeting of the Virginia Heart Attack Coalition in Lynchburg in May, which was well received by attendees.

On February 21, 2014, The Federal Aviation Administration (FAA) released new rules and regulations governing Helicopter Air Ambulance Operations. These regulations were to be implemented on April 22, 2014. On April 21, 2014, the FAA released notification that the implementation date had been extended to April 22, 2015. This allows certificate holders sufficient time to implement the new requirements based on the regulations.

The EMS Systems Planner also participates on the NASEMSO Air Medical Committee. The committee met on July 9 and July 30, 2015.

OEMS and Medevac stakeholders continue to monitor developments regarding federal legislation and other documents related to Medevac safety and regulation.

State EMS Plan

The Virginia Office of EMS Strategic and Operational Plan is mandated through *The Code of Virginia* to be reviewed and revised on a triennial basis. The current version of the plan was approved by the State Board of Health on June 5, 2014.

The current version of the State EMS Plan is available for download via the OEMS website.

Public Information and Education

VI. Public Information and Education

Public Relations

Promotions

Via Social Media Outlets

We continue to keep OEMS' Twitter and Facebook pages active, educational and relevant by posting daily and/or weekly updates that provide important announcements and health-related topics to increase awareness and promote the mission of OEMS and VDH. Some of the subjects that were featured from January - March are as follows:

- **April** – National Public Health Week, 2016 Draft Federal Vehicle Standards and an update on Proposed Change Notice 8, National Public Safety Telecommunicators Week and proclamation, 2015 Trauma Trot and Kids Safety Expo registration and EMS Strong Day at Camden Yards.
- **May** - EMS Compass, National EMS Week, EMS Nights at the Diamond, EMS Week proclamation, EMS Strong essay contest, EMS Week press release, EMS for Children Day, EMS Week special events and promotions, holiday office closures and National Hurricane Preparedness week.
- **June** - Move Over Awareness Month, [Fairfax County Fire and Rescue Department Urban Search and Rescue Virginia Task Force 1](#) Nepal Earthquake response story, EMS Strong contest winners announced, Fire and EMS Memorial Week, 2015 Fallen Firefighters and EMS Memorial Service, updated policy regarding background checks for EMS agency affiliation, extreme heat and heat-related illness facts, extreme heat and heat related illness infographics, Ebola, MERS-CoV and travelers clinician letter, Va. Fallen Firefighter and EMS Memorial Service video tribute, National EMS Memorial Service, summer EMS Bulletin and fireworks safety tips.

Via GovDelivery E-mail Listserv (April -June)

We are currently in the process of changing our listserv provider, so there are limited emails being sent via the listserv.

- May 20 – National EMS Week
- June 9 – Fire and EMS Memorial Week

Customer Service Feedback Form (Ongoing)

- PR assistant provides monthly reports to EMS management regarding OEMS Customer Service Feedback Form.
- PR assistant also provides bi-weekly attention notices (when necessary) to director and assistant director concerning responses that may require immediate attention.

Social Media and Website Statistics

Figure 1: This graph shows the total organic reach of users who saw content from our Facebook page, April – June 2015. Each point represents the total reach of organic users in the 7-day period ending with that day.

Organic reach is the number of unique people who saw our post in the newsfeed or on our page, including people who saw it from a story shared by a friend when they liked it, commented on it, shared our post, answered a question or responded to an event. Also includes page mentions and check-ins. Viral reach is counted as part of organic reach.

***As of July 22, 2015, the OEMS Facebook page had 4,360 likes, which is an increase of 132 new likes since April 22, 2015. As of July 22, 2015, the OEMS Twitter page had 3,292 followers, which is an increase of 126 followers since April 22, 2015.**

Total Reach

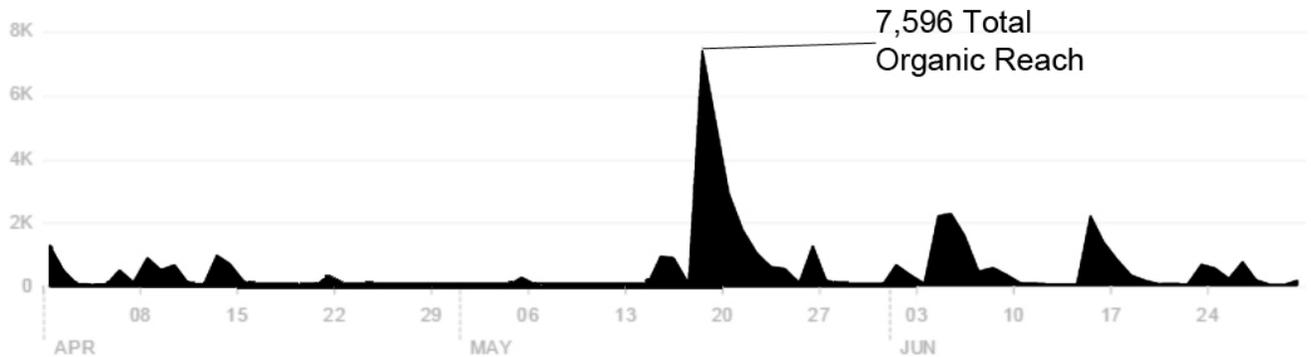


Figure 2: This table represents the top five downloaded items on the OEMS website from April – June.

April	<ol style="list-style-type: none"> 1. 2010 Symposium presentation - LMGT-732 (30,544) 2. 2014 Symposium presentation - PRE-004 (21,406) 3. EMSAT Centrelearn Instructions (15,923) 4. 2014 Symposium presentation - TRA-1701 (9,414) 5. 2009 Symposium presentation - SPE-1008 (6,934)
May	<ol style="list-style-type: none"> 1. 2014 Symposium presentation - PRE-004 (51,204) 2. 2010 Symposium presentation - LMGT-732 (25,676) 3. 2014 Symposium presentation - PRE-020 (15,837) 4. EMSAT Centrelearn Instructions (15,121) 5. 2014 Symposium presentation - TRA-1701 (6,896)
June	<ol style="list-style-type: none"> 1. 2014 Symposium presentations - PRE-020 (59,926) 2. 2010 Symposium presentations - LMGT-732 (23,736)

3. 2014 Symposium presentation - TRA-1702 (12,753)
4. EMSAT Centrelearn Instructions (11,952)
5. 2014 Symposium presentation - HEA-1008 (10,106)

Figure 3: This table identifies the number of unique visitors, the average hits per day and the average visit length by minutes to the OEMS website from April – June. *Visitors* are defined as the number of unduplicated (counted only once) visitors to your website over the course of a specified time period, whereas the *average hits per day* include both unique visitors and repeat visitors.

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
April	86,833	2,894	14:53
May	92,452	2,982	12:08
June	91,244	3,041	14:56

Events

EMS Week, May 17-23, 2015

- The Public Information and Education Unit developed two special promotions for EMS Week as a way to give back and recognize the EMS agencies and providers in Virginia. Each promotion seemed to be well received due to the excitement and engagement that it generated on the OEMS Facebook page.

EMS Week garnered nearly 20,000 in total reach* on the OEMS Facebook page. One of our Facebook posts had an especially high post reach*, the Governor’s proclamation for EMS Week had an estimated reach of 10,072 people and 406 likes, comments and shares!

**Total Reach - The number of people who were served any activity from your page, including posts, post to your page by other people, mentions, etc. Post Reach - The number of people your post was served to.*

- The EMS Week social media promotion included the following giveaways:
 - The “EMS Strong” essay contest asked Virginia EMS agencies to explain how their agency represented this year’s EMS Week theme, “EMS Strong”. OEMS awarded five EMS agencies with the top-rated submissions with 25 full size medical bags each. Due to the overwhelming response of remarkable submissions, an additional five agencies were selected as honorable mentions and sent 10 full-size medical bags each.
 - The challenge question giveaway involved questions about the Office of EMS, which were posted on the OEMS Facebook. Participants were required to search for the answer to the challenge question (all of which

could be found on the OEMS website) and then post the correct answer on the OEMS Facebook page. Winners with the correct answer were selected at random to win a full-size medical bag.

- PR assistant mailed out EMS Week planning guides to all affiliated EMS agencies in Virginia.
- PR assistant received proclamation from the Governor's Office recognizing EMS Week in Virginia.
- PR assistant sent EMS Week info via listserv email.
- PR coordinator prepared and distributed press release for EMS Week to all media.
- PR coordinator posted event information on the VDH and OEMS homepage, Facebook and Twitter pages. Information shared included the press release, Governor's proclamation, local promotions offered by area retailers and events occurring across the state in honor of EMS Week.
- Shared various promotions on Facebook and Twitter that were being offered for EMS Week by area retailers, in addition to events occurring across the state in honor of this special week.

Fire and EMS Memorial Week, June 7 – 13, 2015

- PR coordinator included Fire and EMS Memorial Week info (date and location of event) in the EMS Week press release.
- PR coordinator created a special page about Fire and EMS Memorial Week to be posted on the VDH and OEMS homepage.
- Shared VDFP social media posts on the OEMS Facebook page.
- Sent out an email through our listserv to promote Fire and EMS Memorial Week.

EMS Symposium

- PR coordinator continued drafting the Symposium Catalog, to be posted online in July when registration is set to open.
- On May 29, the PR coordinator submitted a Symposium ad to the July 2015 Commonwealth Chief magazine.

Training

- May 8-12 – Public Information and Education unit participated in a virtual OEMS VERT Exercise through the Web-EOC.
- June 12 - PR coordinator participated in the annual VDH Information Security Awareness training.

Governor's EMS Awards Program

- PR assistant drafted press releases covering the Blue Ridge, Central Shenandoah, Lord Fairfax, Northern Virginia, Peninsulas, Rappahannock, Tidewater, Thomas Jefferson and Western Virginia award ceremonies and regional EMS award recipients.
 - Press releases were posted to the VDH regional press release webpage and sent out to local media.
- PR assistant helped to coordinate EMS staff attendance at the Regional EMS Council Award ceremonies.

OEMS Communications

The PR assistant is responsible for the following internal and external communications at OEMS:

- On a daily basis, the PR assistant monitors and provides assistance to the emails received through the EMS Tech Assist account and forwards messages to the respective divisions.
- The PR assistant is the CommonHealth coordinator at OEMS, and as such sends out weekly CommonHealth Wellnotes to the OEMS staff.

VDH Communications

VDH Communications Tasks– The PR coordinator was responsible for covering the following

VDH communications tasks from April – June:

- **April -June** – Responsible for providing back up for the PR team, to include covering media alerts, VDH in the News, media assistance and other duties as needed.
- **VDH Communications Conference Calls (Ongoing)** - The PR coordinator participates in bi-weekly conference calls and polycoms for the VDH Communications team.

- **Virginia Public Health and Healthcare Preparedness Academy** – PR coordinator attended the Virginia Public Health and Healthcare Preparedness Academy, May 18 – 19. At this event, I assisted as an evaluator for the Ebola TTX training and submitted an evaluator report after the event.

Commissioner’s Weekly Email

The PR coordinator and the PR assistant submitted the following OEMS stories to the commissioner’s weekly email. Submissions that were recognized appear as follows:

- **April 20 - EMS Provides Pediatric Immobilization Devices to Volunteer Agencies**

David Edwards, Virginia Emergency Medical Services for Children (EMSC) coordinator, recently worked with the state’s volunteer EMS agencies to purchase and distribute 160 pediatric immobilization devices. These devices will allow EMS providers to more quickly and appropriately immobilize children with traumatic injuries for transport to hospitals by ground ambulance. Federal funding for the purchase of these devices totaled more than \$47,000 and demonstrates Virginia’s continued progress toward achieving equipment and supplies for the improvement of the national EMSC performance measures.

- **May 11 - OEMS Training Hosts Education Coordinator Update Session**

The Office of Emergency Medical Services (OEMS) Division of Educational Development recently hosted a gathering of 31 education coordinators and advanced life support (ALS) coordinators at the new Alexandria Fire Training Center. Thanks to OEMS’ ALS Training Specialist Debbie Akers, Basic Life Support Training Specialist Greg Neiman and Training and Development Specialist Adam Harrell, who discussed upcoming changes in EMS education, new delivery options for EMS educational programs for this year, new continuing education requirements for next year, and guidance on testing for the National Registry. Five coordinators also received optical scanner training and four others received training on online course enrollment and student registration procedures.

- **May 25 - EMS Director Attends White House Roundtable**

Office of Emergency Medical Services Director Gary Brown was invited recently to participate in a National Security staff meeting hosted by the White House. This roundtable initiative, “Bystanders: Our Nation’s Immediate Responders,” was designed to build national resilience and save lives by providing emergency response information and tools for the general public. Attendees included leaders from emergency management, health care, public health and public safety agencies, plus key federal personnel and National Security Council staff. Gary attended on behalf of the National Association of State EMS Officials.

- **June 8 - OEMS Employee Participates in National EMS Memorial Bike Ride**

During Emergency Management Services (EMS) Week, **Tim Perkins**, Office of EMS systems planner, and more than 200 bike riders and ride support crew from across the country participated in the 2015 National EMS Memorial Bike Ride. The northeastern leg of this event started in Boston and ended in Alexandria. Over the course of seven days, Tim and other riders pedaled more than 500 miles in honor of EMS providers who died in the line of duty. Tim has participated in the annual memorial ride since 2008, and currently serves on the organization's board of directors. Tim rode in honor of Beverly Luther, a provider from the Tuckahoe Rescue Squad in Richmond, who died in 2014. For more information on the National EMS Memorial Bike Ride, visit www.muddyangels.com.

Regulation and Compliance

VII. Regulation and Compliance

EMS Agency/Provider Compliance

The EMS Program Representatives continue to complete investigations pertaining to EMS agencies and providers. These investigations relate to issues concerning failure to submit prehospital patient care data and/or quality (VPHIB), violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to meet minimum staffing requirements for EMS vehicles and individuals with criminal convictions. The following is a summary of the Division's activities for the second quarter 2015:

Compliance

Enforcement	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD	CY2014
Citations	10	18			28	40
Agency	4	12			16	22
Provider	6	6			12	18
Verbal Warning	2	0			2	21
Agency	2	0			2	11
Provider	0	0			0	10
Correction Order	10	29			39	59
Agency	10	29			39	59
Provider	0	0			0	0
Temp. Suspension	5	9			14	20
Agency	0	0			0	0
Provider	5	9			14	12
Suspension	2	5			7	11
Agency	0	0			0	1
Provider	2	5			7	5
Revocation	1	4			5	7
Agency	0	0			0	0

Provider	1	4			5	4
Compliance Cases	49	63			112	202
Opened	38	40			78	140
Closed	11	23			34	62
Drug Diversions	3	3			6	21
Variances	6	2			8	29
Approved	2	1			3	16
Denied	4	1			5	13

Note: Not all enforcement actions require opening a compliance case. Because some actions are stand-alone, on the spot infractions, a full compliance case is not opened. Therefore, the number of enforcement actions will not equal the total number of compliance cases.

Hearings

April 30 – Stilwell
 May 13 – Thomas
 May 28 – Berry
 May 28 – Henke
 June 3 – Britt

Licensure

Licensure	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	2014
Agency	669	656			669
New	2	3			
Vehicles	4,140	4,142			4137
Inspection					
Agency	116	103			289
Vehicles	741	733			2,261
Spot	124	161			447

Background Unit

The Office of EMS has begun the process of conducting criminal history records utilizing the FBI fingerprinting process through the Virginia State Police effective July 1, 2014. A dedicated section of the OEMS website has updated and relevant information on this new process and can be found at the following URL:

<http://www.vdh.virginia.gov/OEMS/Agency/RegCompliance/CriminalHistoryRecord.htm>.

Background Checks	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD	2014
Processed	2,125	1,889			4,014	3,488
Eligible	1,380	1,676			3,059	2,683
Non-Eligible	18	12			30	19
Outstanding	726	201			927	546

Regulatory

Staff continues to work with the various stakeholder groups to review suggested revisions to sections of the current EMS Regulations. Once completed, they will be directed through the Rules and Regulations Committee to be submitted as a regulatory review packet.

- The Fast Track Regulatory Packet for changes to the Financial Assistance to EMS agencies (FARC) is within the regulatory process and currently is at the Secretary Of Health and Human Services for review and actions
(<http://townhall.virginia.gov/L/viewstage.cfm?stageid=6969>)
- A Fast Track regulatory package to include the terminology of “affiliation” in the language of 12VAC-5-31-910 is within the regulatory process and currently resides in the Governors’ Office for the analyst to review and approve,
(<http://townhall.virginia.gov/L/viewstage.cfm?stageid=7067>)
- Staff has developed the Final-Exempt Regulatory Packet to address changes in definitions from 2015 General Assembly actions, SB938 and its companion bill, HB1584 Technical clean-up bill and have submitted to VDH Executive management for review and approval to move forward.

EMS Physician Endorsement

Endorsed EMS Physicians: As of July 10, 2015: 218

OMD Workshops continue as scheduled for 2015: April 15 – Danville, May 14 – ODEMSA, June 12 – Blacksburg. Planning has already begun for the next edition of “Currents” sessions. Staff is also reviewing and updating the on-line OMD training program that is utilized as a pre-requisite for anyone interested in becoming an OMD in Virginia.

Additional Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on June 3-5 in Glen Allen, Virginia.

OEMS staff continues to offer technical assistance and educational presentations to EMS agencies, entities and local governments as requested:

- May 4 – Chesterfield Insurers
- May 15 – PEMS Mini-Conference
- May 20-21 – Essex County Fire/EMS Study
- June 7-9 – Powhatan Fire/EMS Study
- June 17 – POST Executive Committee
- June 23 – Virginia Fire Chief Association meeting
- June 24 – Shenandoah County Administration

Field staff continues to assist the OEMS Grants Manager and the RSAF program by performing reviews for submitted grant requests as well as ongoing verification of RSAF grants awarded each cycle.

Michael Berg attended a one day “workshop” in Gaithersburg, Maryland with other compliance and credentialing staff for an update and training with the National Practioner’s Databank (NPDB).

Staff continues its work at the national level in the development of ambulance standards:

CAAS GVS 2015:

Staff is scheduled to participate in a conference call regarding any submitted public comments on version 1 of the GVS v1 standards. An October 2015 release date is anticipated.

NFPA 1917

All comments have been reviewed and addressed. The second version of the NFPA 1917 document is expected to be released August of 2015 with an implementation date of January 2016.

KKK-1822-F (GSA)

Change Notice 8 was implemented on July 1, 2015;

<http://www.nasemso.org/Projects/AgencyAndVehicleLicensure/documents/KKK-A-1822F-change-notice8-01July2015-FINAL.pdf>

Staff is working with the Transportation Committee to review and submit recommendations as to what ambulance standard Virginia should adopt in regulations and to identify any “Virginia” specific requirements.

Staff also continues to work with Dr. Mark Kirk (UVA) and Virginia Paramedic Rita Krenz as prehospital provider/reviewers with the National Library of Medicine/National Institute of Health in the development of a first responder/first receiver product with smart phone application. This team has met via webinar and conference calls the following dates: April 3 and May 12,

Additional Personnel Matters

We are most pleased to announce the hiring of Ms. Cynthia Fein as our second wage staff person whose primary responsibility is working in the Backgrounds Unit along with Mrs. Garcia. Ms. Fein joined OEMS on May 18 and has been a much welcomed addition to the Division and the Background Unit.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee is scheduled to meet on August 6, 2015. The minutes of the May 7, 2015 meeting are available on the OEMS website. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

The EMS Officer Sub-committee has met several times since the last State EMS Advisory Board meeting. The sub-committee has been working on developing an EMS Officer I course based on the Fire Officer I course material in the Jones and Bartlett Fire Officer Principles and Practice (Third Edition) text book.

The committee continues to make edits to the draft content of all the modules of EMS Officer I. There is no updated completion date, or a date of the launch of the pilot courses.

Standards of Excellence (SoE) Sub-Committee

The SoE Assessment program is a voluntary self-evaluation process for EMS agencies in Virginia based on eight Areas of Excellence – or areas of critical importance to succeed and remain viable as an EMS agency.

Each Area of the Excellence is reviewed using an assessment document that details optimal tasks, procedures, guidelines and best practices necessary to maintain the business of operating an EMS agency.

All documents related to the SoE program can be found on the OEMS website. The sub-committee has identified EMS agencies in different parts of the Commonwealth who are willing to participate in the pilot phase of SoE.

The self-survey has been completed by two agencies, and efforts are underway to schedule site visits for those agencies. The pilot phase is scheduled to be completed by October 2015 – at which time changes may be made to the process based on the outcome of the pilots.

The Virginia Recruitment and Retention Network

The Virginia Recruitment and Retention Network was scheduled to meet on Saturday, May 16, 2015. But the meeting was postponed.

The next meeting is scheduled for July 31, 2015, in conjunction with the VFSA Conference at the Hampton Convention Center.

Several changes have been made to the Recruitment and Retention page on the OEMS website to give it a more streamlined appearance. Links to pertinent reference documents are expected to be added to the page in the coming months.

The mission of the Virginia Recruitment and Retention Network is “to foster an open and unselfish exchange of information and ideas aimed at improving staffing” for volunteer and career fire and EMS agencies and organizations.

Trauma and Critical Care

IX. Trauma and Critical Care

Division of Trauma/Critical Care Staffing

OEMS continues to work to replace position EM007 which is the statistical analyst with the Division of Trauma/Critical Care (Div. TCC.) The Div. of TCC has also submitted a request to add an additional FTE to the division dedicated to data output from the Virginia Statewide Trauma Registry (VSTR) and the Virginia Pre Hospital Information Bridge (VPHIB.)

With a second FTE dedicated to data output it is our intention to have one position focus on minor to moderate level reports and our traditional position to continue to focus on the higher level reports. With this approach it is hoped that we will significantly increase the volume of data output and move our reporting tools to being more performance improvement based.

National Participation by Div. of TCC Trauma System

National Participation

Members of the Div. of TCC routinely participate on the national level in a variety of roles. David Edwards is the Immediate Past Chair for the National Association of State EMS Officials' ([NASEMSO](#)) Pediatric Emergency Care Council ([PECC](#)), Robin Pearce represents Virginia on NASEMSO's State Trauma Managers Council, and Paul Sharpe is the current Chair of NASEMSO's State Data Managers Council ([DMC](#)). As the Chair of the DMC he serves as the states representative on the National EMS Information System' (NEMSIS) [Steering Committee](#)

Each of these national bodies continue to meet on a monthly basis on projects that will affect EMS systems on a national level.

During this quarter, staff attended 10 webinar sessions hosted by the [EMS Compass](#) project. The EMS Compass project is being funded by the federal government and its goals are to create EMS performance measures and move EMS reimbursement to more of a quality of care model and away from a fee for service model. Each of the ten webinars were focused on the "domains" that the EMS performance measures will be developed under; and include:

- Patient and Family Engagement
- Patient Safety
- Clinical Process/Effectiveness
- EMS Workforce
- EMS Fleet
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- EMS Data
- EMS Finance

Trauma System

American College of Surgeon's (ACS) State Trauma System Consultative Visit

Work continues in preparation of the ACS State Consultative Visit, September 1-4, 2015. The Pre-review Questionnaire (PRQ) was delivered to the ACS on July the 6th. The timely completion of this document would not have been possible without the generous assistance of many individuals. Thank you for your time and efforts on behalf of the trauma system if you or your agency was one of the many that helped to track down documents, examples, and editorial support. Your help is greatly appreciated.

Gaps that have been identified during the writing of the PRQ include; lack of a statistician in the VDH/OEMS office, coordinated injury prevention efforts, and rehabilitation integration into the trauma system.

Invitations have gone out to selected stakeholders with the goal of having a firm guest list by July 24, 2015. We are waiting to hear from the ACS on who will serve on the ACS site review team and final detailed agenda.

VDH/OEMS has contracted with the ACS to provide us with a more in depth focus on our pediatric patients. Our focus questions for our pediatric patient population include:

1. Advice on the wisdom and feasibility of statewide pediatric trauma & EMS protocols with built in performance measures like those in use in North Carolina and Pennsylvania.
2. How best to improve the patient quality/patient safety in the EMS environment for pediatrics i.e. weight based treatment, underutilization of pain medications for pain control, vital sign documentation and the value of a through patient assessment.
3. Would the Virginia (VA) trauma and EMS system benefit from categorization of all hospitals' capabilities to care for children? What would be the key elements for this categorization (i.e. equipment, training, PI, transfer protocols, and agreements)?
4. How could VA improve the minimum level of pediatric readiness in all EDs?
5. How could the patient quality/patient safety in the ED be monitored and improved across all facilities and not just trauma centers?

It is our hope that the closing presentation from the ACS will be videotaped and placed on the VDH/OEMS website for review by all interested stakeholders.

Trauma System Oversight and Management Committee (TSO&MC)

The TSO&MC last met on June 4th, 2015. The draft minutes to the meeting can be found on-line on the [Virginia Regulatory Town Hall](#).

The Trauma Performance Improvement Committee (TPIC) did not meet on June 4 2015. Dr. Forrest Calland shared that several of the EMS regions had strong concerns over the content of the report released in January. When the VDH/OEMS staffing includes a statistician, the work of the committee will resume. Dr. Calland also shared that with the changes in the numbers and levels of trauma centers the membership of the committee will need to be adjusted.

Nancy Malhotra presented the work of Phase I and II of the Geriatric trauma taskforce. This included their recommendations for changes to the state prehospital field and inter-hospital triage criteria, and hospital capabilities. Phase III, which will be led by Beth Broering, will focus on rehabilitation.

LeAnna Harris and Mark Day from Sentara Virginia Beach General Hospital presented their facilities implementation of a geriatric trauma alert, which they have named a delta alert. Their experience and positive patient outcomes generated a great deal of discussion, and the committee looks forward to seeing a comparison of data from April/May 2014 to April/May 2015.

At the request of the ACS, the TSO&MC and its stakeholders completed a modified Benchmarks, Indicators, and Scoring of the trauma system (BIS) tool in the spring and reviewed the results with the group. The opportunity for those who did not complete the survey was provided and that information was added to the data already collected for the ACS. The survey will be repeated in one year to review the impact the ACS site visit has on the trauma system.

Dr. Keith Stephenson is the new Level III representative for the TSO&MC replacing Dr. Ray Makhoul. Dr. Stephenson is affiliated with Carilion New River Valley hospital in Christiansburg, Virginia. The committee thanked Dr. Makhoul for his work on the TPIC and TSO&MC committees. The search continues for a survivor/citizen representative.

The newly formed Injury & Violence prevention sub-committee solicited for members. They have met twice since June 4th and are completing a gap analysis and developing a plan for a statewide project.

Trauma Center Designation

Johnston Willis Hospital had their one-year verification visit in June and had a successful review. Please join us in congratulating their staff on their Level III designation. The staffs of the VDH/OEMS and former site review team members are actively developing educational materials for orienting new and existing reviewers based on the [Virginia Trauma Center Designation Manual](#) 2015 version. All reviewers will need to complete the education prior to performing a site visit.

Trauma Triage

The trauma triage task force continues to meet monthly to work on their recommendations to the state trauma triage and inter-facility transfer guidelines. The group has incorporated the information sent forward by the geriatric trauma task force into the field trauma triage decision scheme and transfer guidelines. After their most recent meeting the group has reached out to members of the Helicopter EMS community for input on the trauma patient transport considerations and the inter-hospital transports by helicopter sections. Review of pediatric considerations will be addressed in future meetings with the help of members of the EMSC committee.

Trauma Center Fund

Trauma center funds were disbursed in May. These funds are seen in Figure 1. Since 2006 when the trauma fund was instituted, OEMS has distributed over \$85 million to the designated trauma centers. Each year, on or about July 1st the distribution percentages are recalculated. These new amounts are seen in Figure 2.

Figure 1 Recent Trauma Center Fund Disbursements

Trauma Center Level	Percent Distribution FY15	Previous Quarterly Distribution	May 2015	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	12.88%	\$286,621.15	\$515,222.80	\$10,916,544.67
Inova Fairfax Hospital	15.58%	\$341,729.64	\$614,284.41	\$16,258,420.20
Norfolk General Hospital	12.77%	\$284,375.99	\$511,186.95	\$10,561,240.78
UVA Health System	12.61%	\$281,110.30	\$505,316.63	\$11,616,229.08
VCU Health Systems	25.97%	\$553,795.31	\$995,488.19	\$20,567,898.70
II				
Lynchburg General Hospital	2.52%	\$75,167.80	\$135,119.70	\$2,291,476.84
Mary Washington	4.62%	\$118,029.97	\$212,167.63	\$2,254,206.59
Riverside Regional Medical Ctr.	3.01%	\$85,168.97	\$153,097.55	\$2,681,997.77
Winchester Medical Ctr.	4.00%	\$105,375.42	\$189,420.15	\$3,402,171.03
III				
New River Valley Medical Ctr.	0.32%	\$30,264.58	\$54,402.83	\$451,770.06
CJW Medical Ctr.	1.14%	\$47,001.24	\$84,488.21	\$1,079,514.20
Montgomery Regional Hospital	0.24%	\$28,631.74	\$51,467.67	\$440,202.20
Southside Regional Medical Ctr.	3.73%	\$99,864.57	\$179,513.98	\$914,506.14
Virginia Beach Gen'l Hospital	0.61%	\$36,183.64	\$65,042.78	\$2,536,059.33
Total	100.00%	\$1,550,025.00	\$4,266,219.48	\$85,972,237.59

Figure 2 2016 Disbursement Percentages

Trauma Center & Level	Percent Distribution FY15	# Qualified Admission Days CY 14	Percent Distribution FY16	Difference FY15 & FY16
I				
Inova Fairfax Hospital	15.58%	4,891	16.1718%	0.59%
Norfolk General Hospital	12.77%	3,517	11.6288%	-1.14%
Roanoke Memorial Hospital	12.88%	4,020	13.2919%	0.41%
UVA Health System	12.61%	3,394	11.2221%	-1.39%
VCU Health Systems	25.97%	8,342	27.5823%	1.61%
II				
Chippenham Hospital.	1.14%	480	1.5871%	0.45%
Lynchburg General Hospital	2.52%	602	1.9905%	-0.53%
Mary Washington Hospital	4.62%	1,146	3.7892%	-0.83%
Riverside Regional Medical Ctr.	3.01%	1,671	5.5251%	2.52%
Winchester Medical Ctr.	4.00%	761	2.5162%	-1.49%
III				
Johnston Willis Hospital	0%	30	0.0992%	0.10%
Montgomery Regional Hospital	0.24%	50	0.1653%	-0.08%
New River Valley Medical Ctr.	0.32%	51	0.1686%	-0.15%
Southside Regional Medical Ctr.	0.61%	108	0.3571%	-0.25%
Virginia Beach Gen'l Hospital	3.73%	1181	3.9049%	0.16%
Total		30,244	100.00%	

Patient Care Information System – VPHIB & VSTR

Migration to Virginia’s Version 3 EMS dataset (VAv3)

“Don’t Say You Didn’t Know”

Most of the version 3 information below is the same as our last quarter report, but the information will remain relevant through the summer of 2016 so it is our intention to leave the implementation resource information in the report.

With VAv3 implementation deadlines rapidly approaching, the VPHIB program continues to offer what we feel are a simple guide and tools for VPHIB administrators to plan the transition from VPHIB version 2 to VPHIB VAv3. Even those with third party vendors may find these to be very help aids in your migration to VAv3. There is a transition checklist, a project timeline were you can plug in your go-live date and it will provide you with milestones for accomplishing migration tasks, and videos on a variety of setup issues.

Below is a screenshot (don’t click on the links in the figure while in public, it is a picture) and can be found on-line at <http://www.vdh.virginia.gov/OEMS/Trauma/VPHIBv3Migration.htm>. The video files are too large to post on the VPHIB Support Suite site so these have been added to the OEMS website. Anyone having internet challenges downloading them can contact VPHIB support and we will make you a CD.

Figure 3 EMS Agency Implementation Packet

- [Transition Checklist](#) - Provides a comprehensive list of items to be done during and after your agency's transition.
- [Transition Spreadsheet](#) - Provides a recommended timeline to be used as a guide by agencies to accomplish the checklist items.
- Overview videos to be used to help agency personnel get up to speed on the use of the new program. These videos are formatted as WMV files and should be viewable in any windows environment.
 1. [VAv3 Setup and Transition](#) - Designed to show existing VPHIB administrators how to do the basic setups to ensure that computers are ready to go
 2. [VAv3 Administrator Overview](#) - Designed to give the existing VPHIB administrator an overview of all current functionality
 3. [VAv3 EMS Agency Staff Overview](#) - Designed to explain to staff members how to navigate through the system and give an overview of the current access
 4. [VAv3 Medical Director Overview](#) - Designed to explain to medical directors how to navigate through the system and give an overview of the current access
 5. [VAv3 Field Setup](#) - Designed to show any individual that currently uses FieldBridge how to do the initial setup prior to beginning a medical record
 6. [VAv3 EMR Online access](#) - Designed to show those few agencies that currently enter in medical records directly into VPHIB how to access a new medical record form in VAv3
 7. [VAv3 EMR Overview](#) - Designed to show all users how to navigate the new medical record form and how the features contained within the form work.

To find out deadline for any single agency you can go to our support suite at <http://oemssupport.kayako.com/Knowledgebase/List/Index/47/timelinesdeadlines>.

Figure 4 Vav2 to VAv3 Migration Deadlines

Virginia Timeline for Migration from Vav2 to VAv3

Roll-out Groups	2015												2016						
	May_2015	Jun_2015	Jul_2015	Aug_2015	Sep_2015	Oct_2015	Nov_2015	Dec_2015	Jan_2016	Feb_2016	Mar_2016	Apr_2016	May_2016	Jun_2016	Jul_2016				
Group 1 - State Field Bridge Users Non-billing	Green	Green	Yellow	Yellow	Red														
Group 2 - State Field Bridge Users That Bill	Green	Green	Green	Green	Yellow	Yellow	Red												
Group 3 - EMS Agencies w/3rd Party Software (includes Service Bridges)	Green	Green	Green	Green	Green	Green	Yellow	Yellow	Red										
Group 4 - Fire Based EMS Agencies (includes EMS agencies that submit via a fire service)	Green	Yellow	Yellow	Red															

<http://oemssupport.kayako.com/Knowledgebase/List/Index/47/timelinesdeadlines>

Key:

- May be on v2: 
- Need to move to v3 during the time period: 
- V2 data no longer accepted v2 accounts killed: 

Resources Available to Agencies and Vendors for VAv3 (Updated)

A variety of time saving resources have been created either, nationally, by OEMS, or our vendor. These resources should make setting up your system easier and eliminate many of the issues that cause poor data quality, import errors, and other technical problems.

- 1) Schematron File – this is a file your vendor is required by NEMSIS certification to be able to import into their systems that contain most of the State’s validation rules. Out of over 500 rules less than 20 are not in our Schematron file. VPHIB staff continue to have serious concerns that this functionality may never actually come to fruition. However, we continue to strive to be a strong partner in the efforts to mature our national EMS data standards.

VPHIB staff submitted a state Schematron file to the NEMSIS Technical Assistance Center (TAC) and the file passed the NEMSIS process. However, when Zoll attempted to utilize our Schematron file it was not operational. A new Schematron file has been submitted to NEMSIS, but at this time we have not received feedback on the file.

There are no requirements that states or vendors create/provide a means to create a state Schematron file and VPHIB staffs have consistently provided the message that we only are creating and providing a state Schematron file as a courtesy. Schematron cannot provide the functionality needed by the state to assess, monitor, and provide feedback related to data quality.

- 2) State File (StateDataSet) – Again, this is a NEMSIS product where state data managers are able to enter the various lists that are specific to our state programs. Like the state Schematron file above, this file is not mandatory, is not part of NEMSIS certification, and vendors and states are free to use or not use this process.

Again, trying to be a partner in the NEMSIS program VPHIB staffs took the time to manually enter all of the values for the various v3 lists below into NEMSIS' on-line tool. It was our hope this process would allow third party vendors to simply upload VPHIB data element values so each agency wouldn't have to set them up manually.

Unfortunately, the tool created by NEMSIS was far from creating useful file and we had requested it be pulled from the NEMSIS website. It is our understanding that NEMSIS staffs have been tasked with manually creating these files for states. We will not be asking them to create a file for Virginia as manual development by an outside party is prone to errors. The NEMSIS state file attempted to place the below lists into a single consumable file. To obtain these list Virginia agencies and their vendors should utilize the documents at <http://OEMSSupport.Kayako.com>:

- a. Any custom elements;
 - b. All of our state required data elements;
 - c. The certification levels accepted by VPHIB;
 - d. The procedures that VPHIB will accept;
 - e. The medications that VPHIB will accept;
 - f. The protocols that VPHIB will accept;
 - g. The list of all EMS agencies in VPHIB; and
 - h. The facilities VPHIB will accept (this will be our hospitals).
 - i.
- 3) EMS Electronic Medical Record (EMR) a.k.a. our run form/ePCR. Staff has placed a copy of our EMR within the ImageTrend library. Any EMS agencies that wish to download the Virginia EMR to use or use as a starting point to create their own can download it into their own ImageTrend product.

Several states have also asked to use the Virginia EMR as a base to setup their state's EMR.

- 4) Version 3 products should allow agencies to upload most agency and provider demographic information. It will not upload VPHIB user accounts. If user accounts are applicable to your agency they will need to be recreated.
- 5) VAv3 Data Dictionary – detailed information about the collection of VAv3 data. Maintained by VPHIB staffs and an official regulatory document.

- 6) VPHIB VAv3 Validation Rules – Similar to our EMR being uploaded the ImageTrend Library soon our validation rules will also be uploaded to the library for use by Virginia EMS agencies, other states, and ImageTrend customers throughout the country.

Unfortunately, when VPHIB staffs attempted to upload our validation rules the ImageTrend Library would not load them. ImageTrend is actively working to perform fixes that will allow Virginia’s rules to be included in their Library.

- 7) Suggested lists – These are based of the national suggested list which were developed by the data managers for each state and contain the below lists and the values accepted by VPHIB. Additions can be made upon request:
 - a. Procedures
 - b. Medications
 - c. Cause of Injury
 - d. Incident Location
 - e. Protocols
 - f. Impressions (primary & secondary)
 - g. Symptoms (primary & associated)
 - h. Hospitals

Other VPHIB Activities:

- Provided support to the Project Manager in planning, organizing, implementing and controlling the version 3 migration
- Updated the Pending Issues spreadsheet as issues were identified.
- Assisted new users via tickets and telephone inquiries
- Reviewed and provided editorial assistance on the VAv3 videos
- Drafted a procedure for the above reports
- Assisted agencies with Field Bridge downloads
- Assisted users in the process of correcting validation rule errors resulting in improved scores
- Aided agencies in developing reports in Report Writer
- Created new user accounts and associated existing ones
- Worked with third party vendors to correct errors and other pertinent issues
- Answered questions and researched issues billing companies were experiencing with VPHIB

Virginia Statewide Trauma Registry (VSTR)

It has now been one year since all hospitals in Virginia have move to our new VSTR product. During this quarter, staffs performed a deep dive into issues and concerns received by some hospitals. After reviewing these items all some adjustments to validation rules were made and

the data dictionary and some other resource information was updated to clarify what information was being requested.

The validations of concern were turned off and all submissions revalidated so hospitals can start with a clean slate as the VSTR begins reporting submission and quality compliance reporting. As submission and quality monitoring was new for EMS data submission five years; this is a change for hospitals. One area that is of particular importance is the timely receipt and fully documented EMS response information.

Other VSTR Activities:

- Worked extensively with DARS on registering and training users and explaining the content and quality of their reports
- Worked with third party vendors to correct errors that occurred with import files
- Wrote an Ad Hoc monthly report for HCA as requested by them in their training
- Provided telephone training to non-compliant facilities including multi hospital organizations Bon Secours, Sentara and Inova
- Created new user accounts
- Assisted users with validity issues, explaining and interpreting the Data Dictionary
- Supported users with ICD-9, ICD-10 and AIS coding issues
- Assisted users in interpreting Trauma Case Finding flow chart

EMS agency licensure and inspections databases

The OEMS has decided to move towards replacing its existing EMS agency licensure and regulatory databases that have become antiquated. The decision has been made to secure the ImageTrend modules that support collecting, managing, and reporting on what has traditionally been Division of Regulation and Compliance data.

In an effort to consolidate various data siloes within the OEMS, VPHIB, VSTR, and licensure systems will all be interconnected and housed within the same server environment. Licensure data will move to using the NEMESIS version 3 standard where available, the National EMS Workforce Data Definitions where possible, and then Virginia specific elements where not covered by national datasets.

Div. of TCC staffs are going to lead in the development of the new licensure database while working with regulation and compliance staffs to learn what tools they need and orient them to the ImageTrend products.

What does this mean to EMS agencies? On the high level agencies will not need to maintain agency demographic information with both the Div. of Regulation and Compliance and VPHIB separately. Changes to an agency's demographic information will be done through licensure and transferred into VPHIB and the VSTR. Standardizing licensure data will help the OEMS to be able to cut down on relying on surveys and other efforts to develop EMS system statistics.

We will be able to report more on this as the project gets underway.

Emergency Medical Services for Children (EMSC)

Heat Stroke Awareness and Prevention

The Virginia EMS for Children (EMSC) program is working closely with the Division of Injury and Health Promotion in VDH to raise awareness regarding summer weather and the associated risks of inadvertently leaving children in automobiles. We are also partnering with the national and Virginia chapters of SAFE KIDS and KidsandCars.org in this same effort.

The EMSC program will be sending out (through OEMS public information personnel) facebook and twitter messages related to preventing child vehicular heat stroke. The EMSC Program will have about 700 window clings to distribute. In addition, 350 Virginia libraries will affix them to their doors, many clings will be circulated through Child Passenger Safety Seat Check Stations, 250 at Low Income Safety Seat Distribution and Education Program operational sites, and all health districts and local health departments will receive the clings as well.

A joint letter from the Virginia EMSC program and from injury prevention program supervisor (Lisa Wooten) at VDH is being sent to childcare providers, librarians, safety professionals, and community stakeholders. In the letter, we suggest primary prevention strategies for reducing hospitalizations and deaths relating to child vehicular heat stroke, and we encourage folks to visit the website <http://www.vdh.virginia.gov/ofhs/prevention/cps/> to find more strategies related to preventing these tragedies (of which there were 37 last year).

Notes on Future Pediatric Facility Recognition Program

The EMSC program is reviewing another model program for a volunteer pediatric hospital facility recognition program; this one is from Montana and is a two-tiered system classifying hospital EDs as either:

- Pediatric Prepared Facility – Pediatric-Prepared Emergency Care, a voluntary program recognizing hospitals that have demonstrated their ability to provide advanced pediatric care for the majority of pediatric medical emergencies including illness and injury. Pediatric-Prepared Emergency Care is a partnership between hospitals, physicians, nurses, emergency personnel and the EMSC program at the Montana Department of Health and Human Services EMS & Trauma Systems and Child Ready MT.
- Pediatric Capable Facility - Pediatric-Capable Emergency Care, a voluntary program recognizing hospitals that have the ability to provide limited pediatric care and have a system in place to transfer to a pediatric prepared facility.

The makeup of Virginia's EDAP (Emergency Department Approved for Pediatrics) work group is being determined now, with several folks volunteering to be on the workgroup and the EMSC Committee will be a valued advisor in this effort. One suggested goal related to this project is to

facilitate at least minimum standards of care for pediatrics to help ensure *the right care, in the right place, at the right time with the right resources* no matter where the child lives.

ENA/EMSC Pilot Project—PedsReady State Champion Teams

Related to the EDAP topic above, a recent PedsReady Stakeholder meeting in Washington, DC was attended by all PedsReady partner organizations (ENA, AAP and ACEP) as well as numerous other key stakeholder organizations and federal programs involved in the PedsReady Project. At that meeting each of the three partners proposed a project that their organization will undertake in order to improve PedsReady nationally based on gaps identified by the national data collected from emergency departments in 2013. A selected group of State EMSC Partnership Managers will attend a 1-day meeting on August 13th in Des Plaines, Illinois (Chicago area) to begin working on these initiatives.

As we look ahead to PedsReady 2, and next steps in helping emergency departments become more ready to care for pediatric patients, the evolution of state PedsReady “Champion Teams” is a concept that PedsReady partner ENA is leading the development of in each state. State PedsReady Champion teams will consist of one member each from state chapters of ACEP, ENA and the AAP. They will work in partnership with others in the state, including the EMSC State Partnership Manager and Advisory Committees, to strategize on how best to assist emergency departments in their state to improve their current readiness to care for children on a daily basis.

The concept of partnering with national organizations at the state level has been proven to be successful in the past. Working in partnership with the EMSC Program, ENA will be piloting a yearlong effort in five states to establish the first state PedsReady Champion Teams. The states chosen for the pilot were Pennsylvania, Louisiana, Illinois, Colorado, and Indiana. As the pilot progresses some information will be shared with all other states as appropriate to help highlight best practices.

ACS Site Visit September 1-4, 2015

American College of Surgeons (ACS) is sending a site evaluation team to Virginia to provide a state trauma systems assessment, and we have asked them to include a pediatric component as part of this process. Some of the questions posed to the ACS team in advance of their arrival are below:

- Advice on the wisdom and feasibility of statewide pediatric trauma & EMS protocols with built in performance measures like NC and Penn. I attached a sample of a PA EMS patient care protocol that has the performance measure right in with the protocol. If you scroll to the end of the protocol you will see the performance measure at the end. I don't think any of our regionally funded protocols include this.
- How best to improve the patient quality/patient safety in the EMS environment for pediatrics i.e. weight based treatment, under utilization of pain medications for pain control, vital sign documentation and the value of a through patient assessment.

- Would the Virginia trauma and EMS system benefit from categorization of all hospitals capabilities to care for children? What would be the key elements for this categorization (i.e. equipment, training, PI, transfer protocols and agreements)
- How could VA improve the minimum level of pediatric readiness in all EDs?
- How could the patient quality/patient safety in the ED be monitored and improved across all facilities not just trauma centers?

Pediatric Medication Errors

In relation to the EMSC Committee’s continuing concern about pediatric medication errors and how to prevent them, the EMSC program shared the MI-MEDIC program from Michigan, where laminated cards (also available electronically) reference the proper dosages of pediatric medication based upon weight in kilos and coordinates with the Broselow® system of colors. There is a new version of this now available that corrected some minor errors in the original release, and there are discussions underway that may result in other states being able to adopt the same system and customize it to their own state. An instructional package (CE capable) is included as part of the implementation package.

Also, *The RightDose Pediatric (and adult) Drug Dosing Guide* used feedback from Virginia to add section tabs to their product, which has been examined by the EMSC Committee and can be obtained from Bob Steele at bob.steele@rightdose.net. *The RightDose Group* is hoping that states will adopt their product as an adjunct and customize to their own state.

We are still trying to mine Virginia EMS data to provide some context for the Committee’s efforts to evaluate the extent of pediatric medication errors in Virginia going forward.

Five Sections Planned for New EMSC website

The EMS for Children website (within the Office of EMS website) is under construction/revision. There will be five specific sections established:

- Hospitals
- EMS agencies
- Injury & Illness Prevention
- Data
- Pediatric Disaster Preparedness

The site will be unveiled and toured during a future EMSC Committee meeting.

On-Site Pediatric Training

The Virginia EMSC Program continues to facilitate access to pediatric education and training, especially in the form of EPC (*Emergency Pediatric Care*), *Emergency Nursing Pediatric Course* (ENPC), PALS (*Pediatric Advanced Life Support*), and PEPP (*Pediatric Education for*

Prehospital Professionals) courses around the Commonwealth, particularly in areas with historically difficult access to pediatric training.

The latest regional course we are supporting is at the end of July at Gloucester Volunteer Fire & Rescue, and we are providing PEPP, PALS and Pediatric ITLS textbooks. EMS agencies interested in on-site pediatric training should contact David Edwards at 804-888-9144 or by email (david.edwards@vdh.virginia.gov).

EMSC State Partnership Grant Notes

- The Virginia EMSC program is in its third year of an approved four-year grant cycle. At the end of the cycle there will be a “competing continuation process” in order to continue to receive federal grant support from the EMSC State Partnership Grant program.
- Petra Connell (FAN rep) and David Edwards (EMSC Coordinator) will be attending the *required* EMSC Mid Atlantic/New England Regional Symposium August 11-13, 2015 in Philadelphia. Every other year going forward, there will be alternating national and regional EMSC Grantee meetings.
- The first manuscript generated directly from the Pediatric Readiness Assessment of hospitals was published by JAMA, and you are encouraged to read this. We will be sending EMSC Committee members the article electronically. Use this link to connect to this article: [paper](#), or contact David Edwards at EMSC.
- The EMSC Program has now distributed pediatric “immobilizers” to quite a few volunteer EMS agencies, and may soon turn its attention to providing pediatric “restraint” systems as resources will allow. As you may remember, immobilization and restraint are two different concepts and require different methods and/or equipment.
- EMSC finally received shipment of the iSimulate ALSi system for training, which will enhance our ability to host technical stations at pediatric courses simultaneously (8 at once if necessary) more safely and cost effectively. Custody of this resource has been transferred to the OEMS Division of Educational Development.
- The EMSC program has obtained additional updated Broselow® tapes (Version 2011 Edition A) to distribute to ANY agencies/ambulances that still need them. Please contact David Edwards if you need an updated pediatric emergency tape(s). Once this process is completed, this will be a milestone in filling equipment/supply gaps related to pediatric patients in the national EMSC Performance Measures.

Note: These purchases/projects were supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H33MC07871 (EMSC State Partnership Grant). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

National Pediatric Disaster Coalition Conference

The Virginia EMSC Manager, as primary author of the NASEMSOs “*Checklist Tool for Pediatric Disaster Preparedness; A Tool for State EMS Offices*,” has been invited to attend this conference November 2-4 in Arizona. The purpose of the National Pediatric Disaster Coalition (NPDC) is to provide medical practitioners; clinical staff; hospital emergency management; other hospital representatives; local, state, and federal government; prehospital providers; community leaders; education, child care, and blood bank liaisons; school nurses and other school representatives; behavioral health providers; and faith-based organization representatives with tools, training, resources, and information to facilitate continuous improvement in pediatric disaster preparedness.

Speakers will examine a broad spectrum of pediatric disaster response, resilience, extended care, recovery, and coalition topics as gleaned from surviving Hurricane Sandy, the Boston Marathon bombing, the Joplin tornado, the Sandy Hook shooting, the Asiana plane crash, and more. Virginia’s EMSC Manager will also participate in a panel discussion at the conference.

Revision of School Nurse’s First-Aid Flipchart

The EMSC Manager is serving as an expert reviewer for the 2015 edition of the “*VDH First Aid Guide for School Emergencies*” First-Aid Flip Chart. First comments and suggestions related to the current draft were provided on July 8.

Suggestions/Questions

Suggestions or questions regarding the Virginia EMS for Children Program in the Virginia Department of Health should be submitted to David Edwards via email at david.edwards@vdh.virginia.gov, or by calling 804-888-9144 (direct line).



The EMS for Children Program is hosted by the Office of EMS, and is a function of the Division of Trauma/Critical Care.

Durable Do Not Resuscitate (DDNR)

We continue to support the DDNR program. There are no significant events to report this quarter.

Respectfully

Submitted

OEMS Staff

Appendix

A

**RESOLUTION IN SUPPORT OF
THE RECOGNITION OF EMS PERSONNEL LICENSURE INTERSTATE COMPACT
(REPLICA)**

WHEREAS, states have had the authority to license emergency medical service (EMS) personnel since the 1970s; and

WHEREAS, it is the states duty to protect the public through verification of competency and ensure accountability for patient care and related activities by the licensing of EMS personnel; and

WHEREAS, based on this authority, states have traditionally issued licenses according to their own individual regulations and assessments of an individual's fitness to practice; and

WHEREAS, these requirements vary considerably from state to state and no formal long-term inter-jurisdictional EMS licensing regime currently exists; and

WHEREAS, it is becoming increasingly common for EMS personnel to cross state borders to deliver emergency and life-saving services on a day-to-day basis; and

WHEREAS, this increased interstate movement places a new emphasis on how EMS personnel are licensed to ensure they are not practicing in a state in which they are not licensed to practice; and

WHEREAS, volunteer and career EMS personnel that cross state borders in their day to day operations are required to hold multiple state EMS licenses that require great time, inconvenience and expense to maintain; and

WHEREAS, EMS officials wish to eliminate state regulatory borders with a proposed law allowing them to honor other EMS licenses authorizing the privilege to practice; and

WHEREAS, the use of the interstate compact mechanism to address interstate emergencies and declared disasters is well established with interstate agreements such as the 50-state Emergency Management Assistance Compact (EMAC) and the regional Forest Fire Protection Compacts; and

WHEREAS, interstate compacts are governed by the tenets of contract law and provide states an enforceable, sustainable and durable tool capable of ensuring permanent change without federal intervention; and

WHEREAS, Virginia is a member to over 40 interstate compacts, the most of any state in the country; including drivers license, educational opportunities for military children, physical therapist, and nursing compacts; and

WHEREAS, The Council of State Governments (CSG), through its National Center for Interstate Compacts, and in partnership with the National Association of State EMS Officials (NASEMSO), with the support of the U.S. Department of Homeland Security has facilitated the development of the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA) as a 50-state solution to this challenging policy issue; and

WHEREAS, Virginia is home to twenty-seven (27) military bases, including the largest naval base in the world, and the personnel to operate these bases; REPLICA will expedite the processing of applications from veterans, service members separating from active duty and their spouses by recognizing their training as satisfying the minimum training and examination requirements for EMT certification; and

WHEREAS, rules for issuance of licenses to EMS personnel would be the same in all states that participate in REPLICA allowing appropriately credentialed EMS providers to use their skills in other member states by recognizing a credential on a short term, time limited basis that is portable; and

WHEREAS, REPLICA provides EMS personnel an immediate privilege to practice, and allows the exchange of information and data between states about EMS personnel that has never existed before as though they are all one state operating together; and

WHEREAS, with the enactment of REPLICA in Virginia, it will clarify that EMS personnel privileges exist within member states thereby resolving confusion concerning ability to practice, use of medical treatment protocols, medical direction, requirements to hold multiple EMS licenses, etc. leading to greater accountability for patient-care-related activities of licensed EMS personnel;

NOW, THEREFORE BE IT RESOLVED, that the state EMS Advisory Board supports the establishment of the Recognition of EMS Personnel Licensure Interstate Compact (REPLICA) and encourages all EMS personnel, agencies, associations, organizations and localities within Virginia to support the introduction and passage of legislation in Virginia to enact REPLICA.

Adopted this 7th Day of August, 2015 at the state EMS Advisory Board meeting in Glen Allen, VA.

Appendix

B

E.V.E.N.T. Provider Violence Report



Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the provider violence events reported to E.V.E.N.T. for the second quarter of 2015. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of Emergency Medical Services (EMS). It collects data submitted anonymously by EMS practitioners. The data collected will be used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool (Patient Safety Event, Near Miss Event, Violence Event). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

".....while beginning to initiate routine ALS on scene, the patient suddenly became aggressive, attempting to release safety belts and strike at EMS. EMT and Paramedic had to physically restrain patient who was covered in vomit...." – 2Q2015 EVENT Provider Violence Report #4

This is the aggregate Provider Violence E.V.E.N.T. summary report for Second Quarter 2015.

PROVIDED BY:

CLIR

*The Center for
Leadership, Innovation,
and Research in EMS
(CLIR)*

IN PARTNERSHIP WITH:



Table 1: Violence Events Quarterly

	2012	2013	2014	2015
Jan - Mar	1	3	10	9
Apr - Jun		5	5	5
Jul - Sep	9	18	5	
Oct - Dec	11	10	5	
Total	21	36	25	14

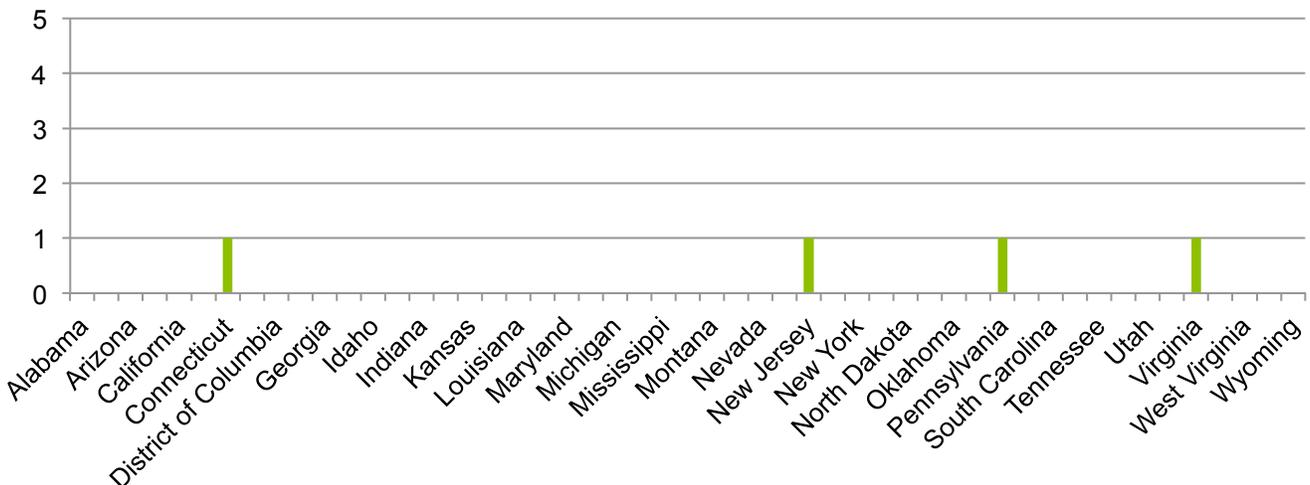


As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

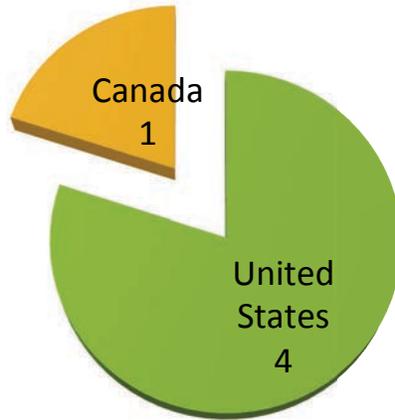


When an anonymous EVENT report is submitted, our team is notified by email. In the United States, the anonymous event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

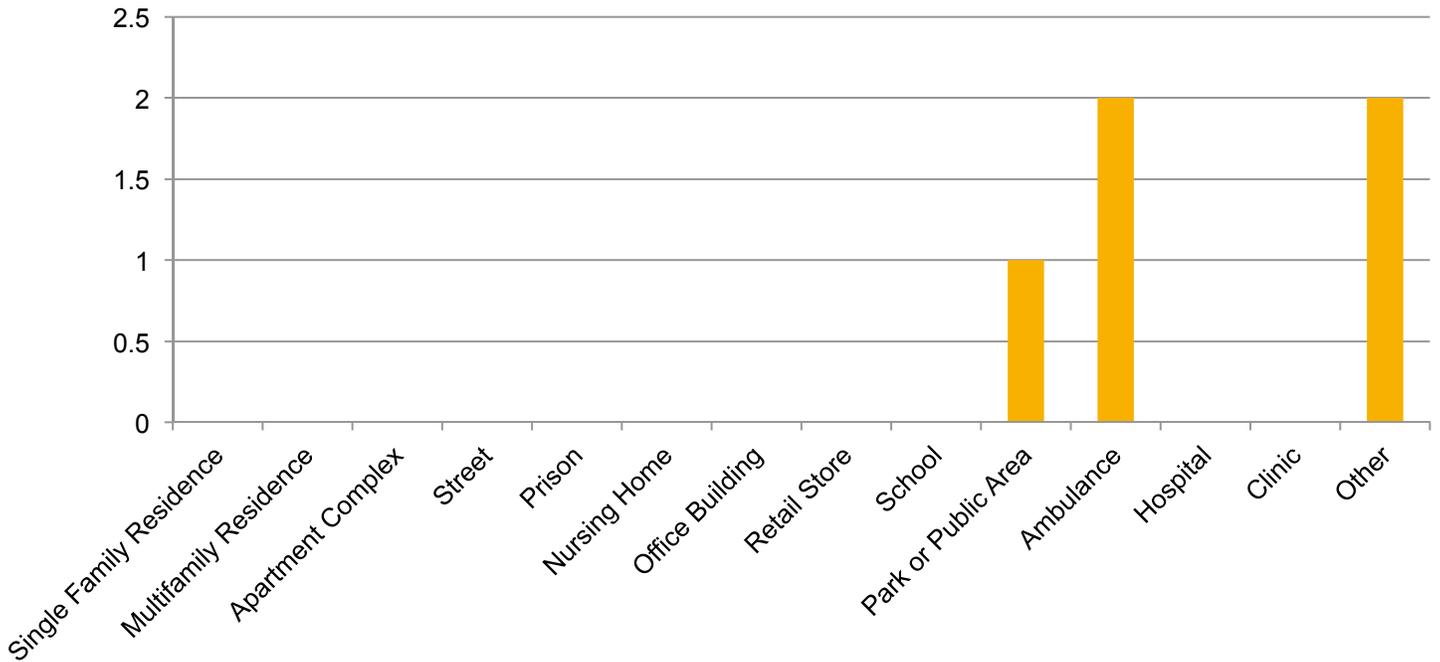
Violence Events by State



Quarterly Violence Events by Country



Place Violence Occurred

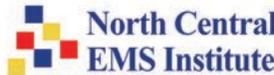




Supporting Those Who Serve



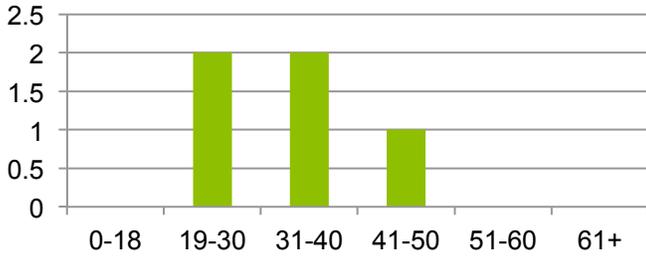
MEL AND ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health



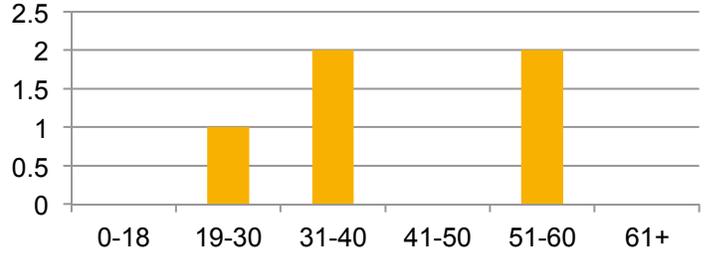
Paramedic Chiefs of Canada
Chefs Paramédics du Canada

The Center for Leadership, Innovation and Research in Emergency Medical Services

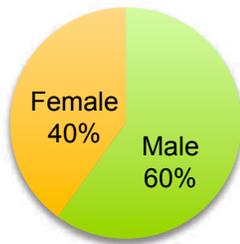
Victim Age



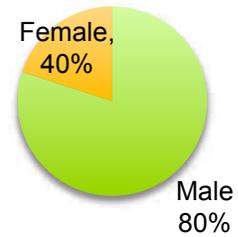
Assailant Age



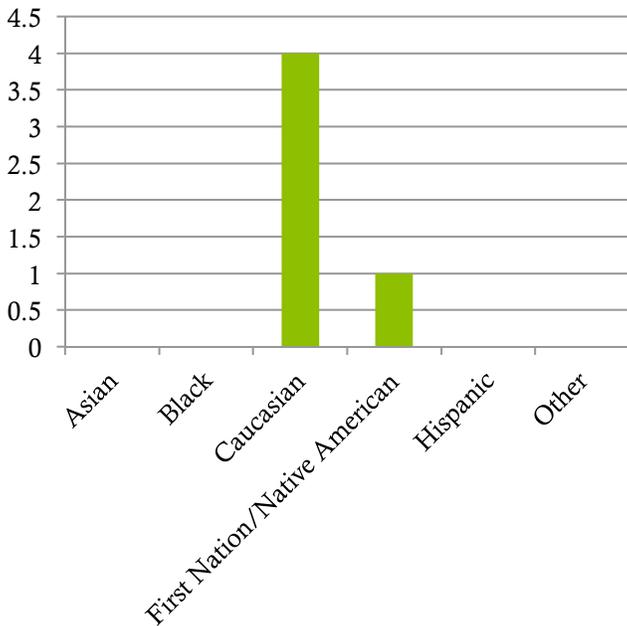
Victim Gender



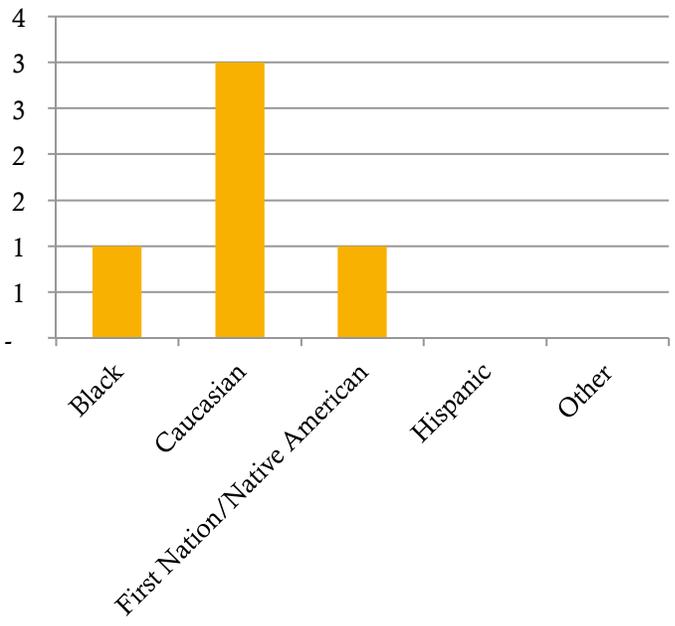
Assailant Gender



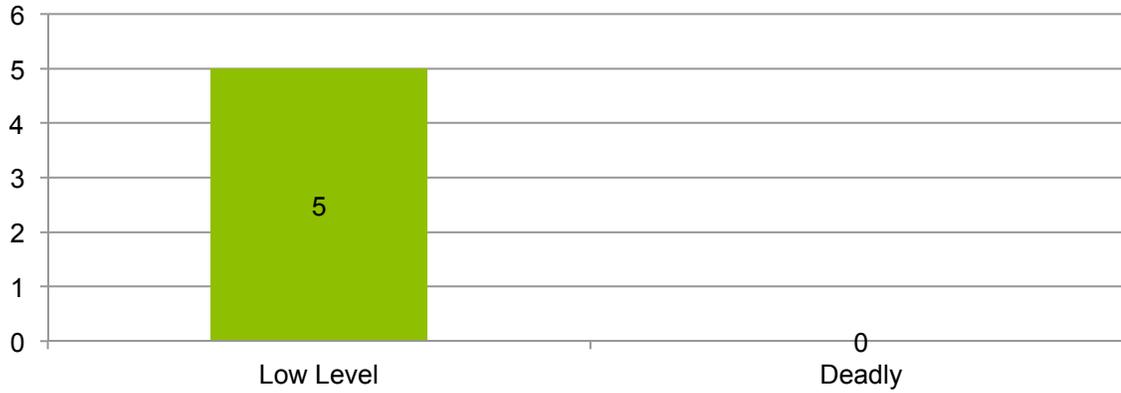
Victim Race



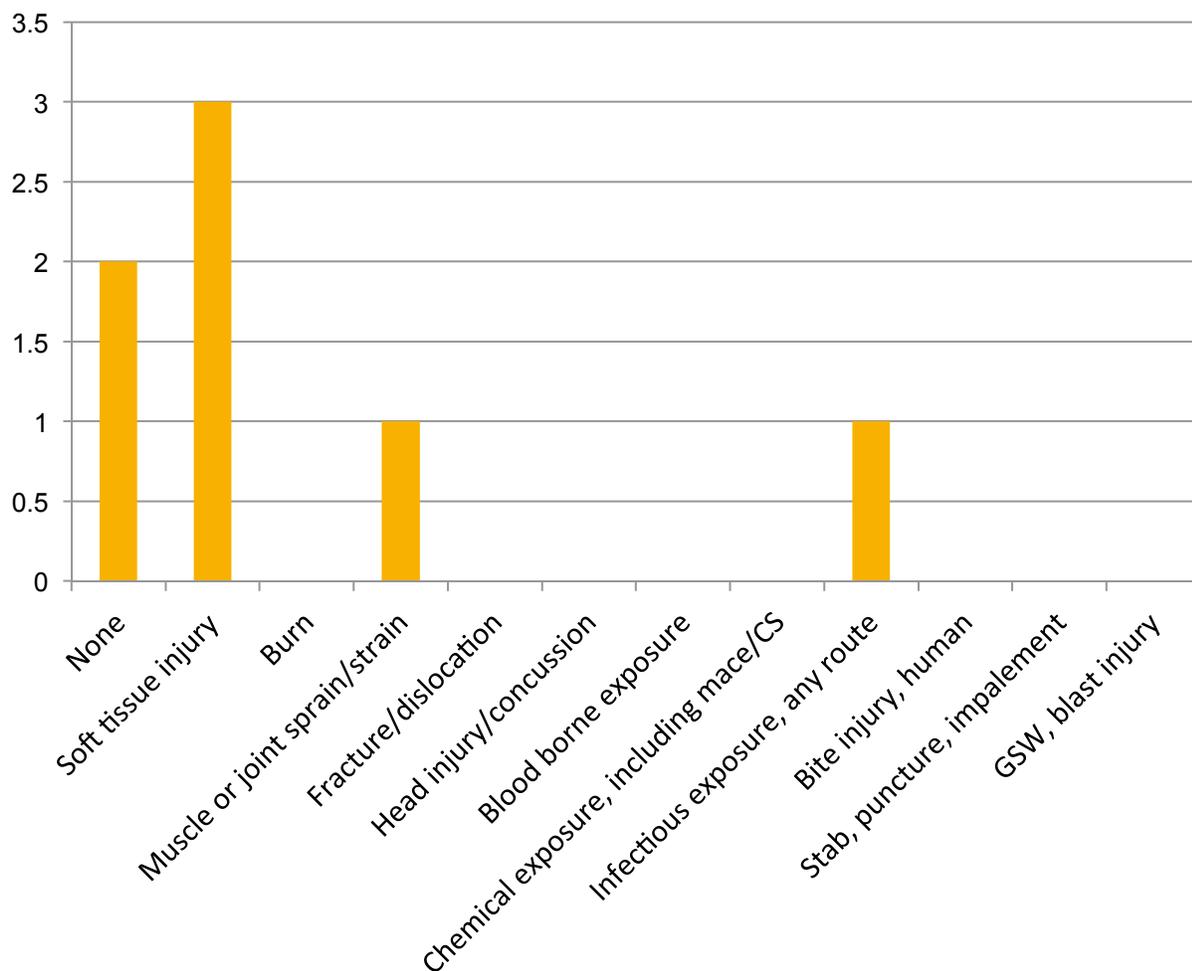
Assailant Race



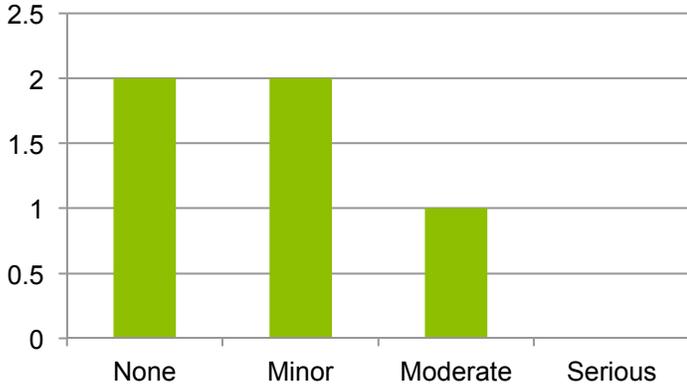
Paramedic's Perception of Harm



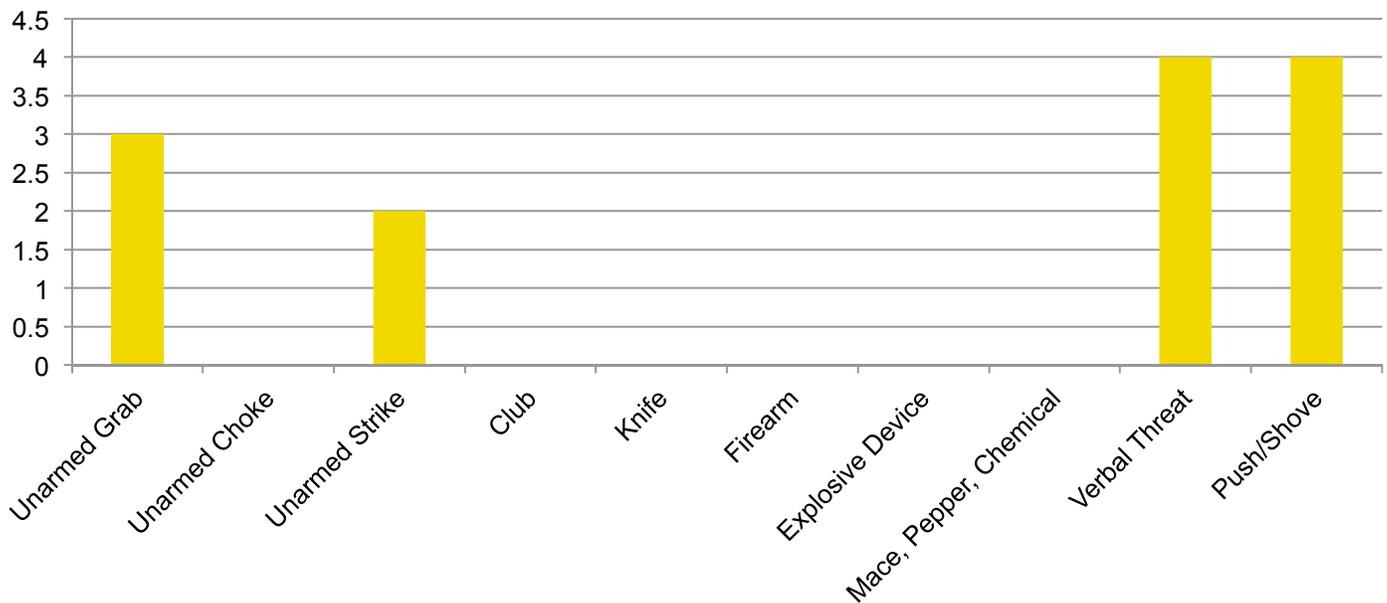
Type of Victim Injury



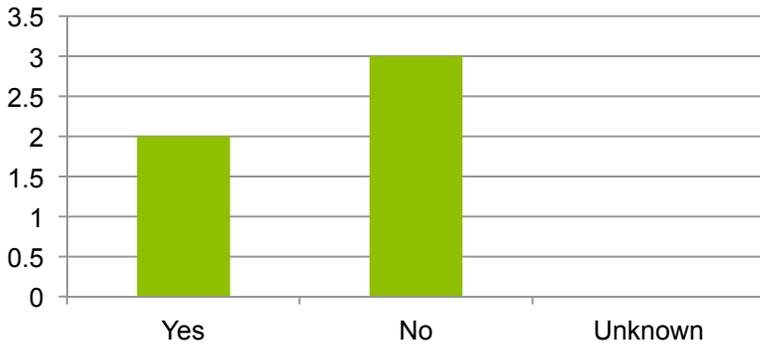
Type of Victim Treatment



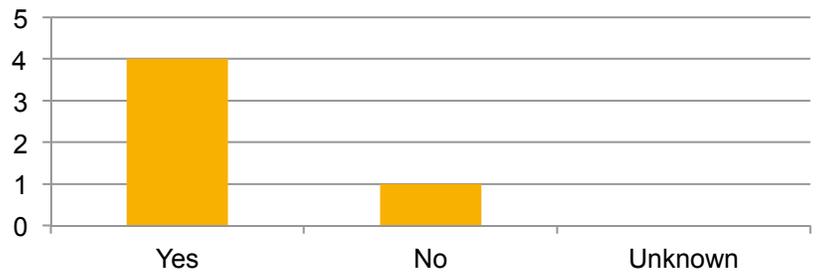
Method of Assault Note: Multiple Options Reported



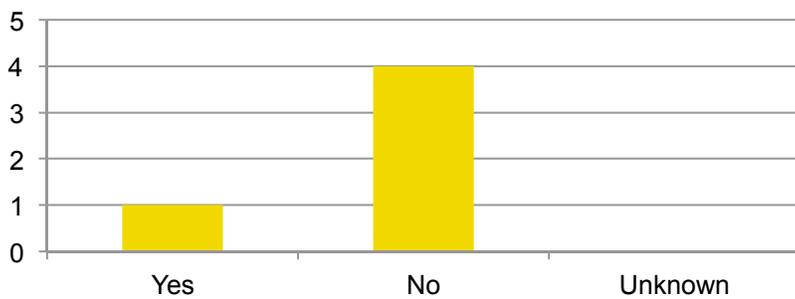
Internal Agency Report Filed



Law Enforcement Present or Notified



Assailant Arrest



#1	Hypoglycemic patient with altered LOC was very combative while being treated. Multiple IV attempts were made and IM Glucagon administered. The patient violently thrashed and kicked Medic while trying to treat the patient. After the patient BGL was normalized the patient declined additional treatment and transport; however, the Medic was taken to the hospital for evaluation of lower back pain.
#2	Patient presented w/AMS, potentially due to intoxication. The previously calm patient, while en route to the ED, removed the belts securing him to the stretcher and became verbally abusive and threatening toward the EMT. The partner had stopped the ambulance and requested LE assistance. While recurring the patient to the stretcher, the patient struck the EMTs w/ feet and hands. Additionally he spit into the face of the EMTs. After being re-secured (LE did not arrive) patient transport was re-initiated to the ED. Upon arrival at the ED, despite a prior request for security to meet the crew at the ambulance entrance, no security was present. Patient again became combative w/ EMS crew.
#3	Assailant's son was drowning victim, assailant demanded to be in the back of the ambulance with the patient. Many medics and EMTs were attending to the patient and the assailant was explained that they needed to work. The assailant threatened to run over an ambulance if it did not move prior to leaving the initial scene to respond to the landing zone. Assailant was calmed down; police left the landing zone scene. Police returned after being requested to expedite. Assailant attacked multiple EMTs and fire fighters on scene; they were there to assist with the son's care. Assailant eventually calmed down and was driven to the hospital by a neighbor.
#4	Patient was altered mental status due to illegal drug abuse, found lying prone on the sidewalk. Patient was calm and non-combative while assessing and moving to ambulance. While beginning to initiate routine ALS on scene, the patient suddenly became aggressive, attempting to release safety belts and strike at EMS. EMT and Paramedic had to physically restrain patient who was covered in vomit. Law enforcement officers were outside the ambulance but did not immediately recognize there was a struggle in the ambulance. Patient was eventually controlled and restrained with law enforcement assistance.
#5	Intoxicated patient threatened to stab paramedic if they performed any interventions.

Appendix

C

EMS Patient Safety Event Report



Welcome!

Welcome to the EMS Voluntary Event Notification Tool (E.V.E.N.T.)!

This is an aggregate report of the patient safety events reported to E.V.E.N.T. in the second quarter of 2015. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

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".....while beginning to initiate routine ALS on scene, the patient suddenly became aggressive, attempting to release safety belts and strike at EMS. EMT and Paramedic had to physically restrain patient who was covered in vomit...." – 2Q2015 EVENT Provider Violence Report #4

This is the aggregate Patient Safety E.V.E.N.T. summary report for second quarter 2015.

PROVIDED BY:



*The Center for
Leadership, Innovation,
and Research in EMS
(CLIR)*

IN PARTNERSHIP WITH:



Patient Safety Event Reports Sorted Quarterly

	2012	2013	2014	2015
Jan - Mar	6	31	30	19
Apr - Jun	9	39	29	17
Jul - Sep	13	35	24	
Oct - Dec	6	32	30	
Total	34	136	117	36

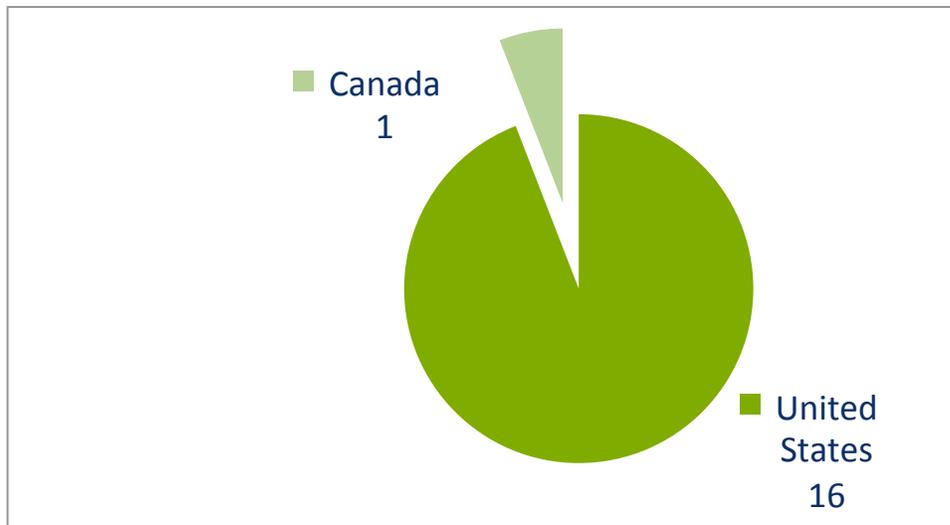


As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com

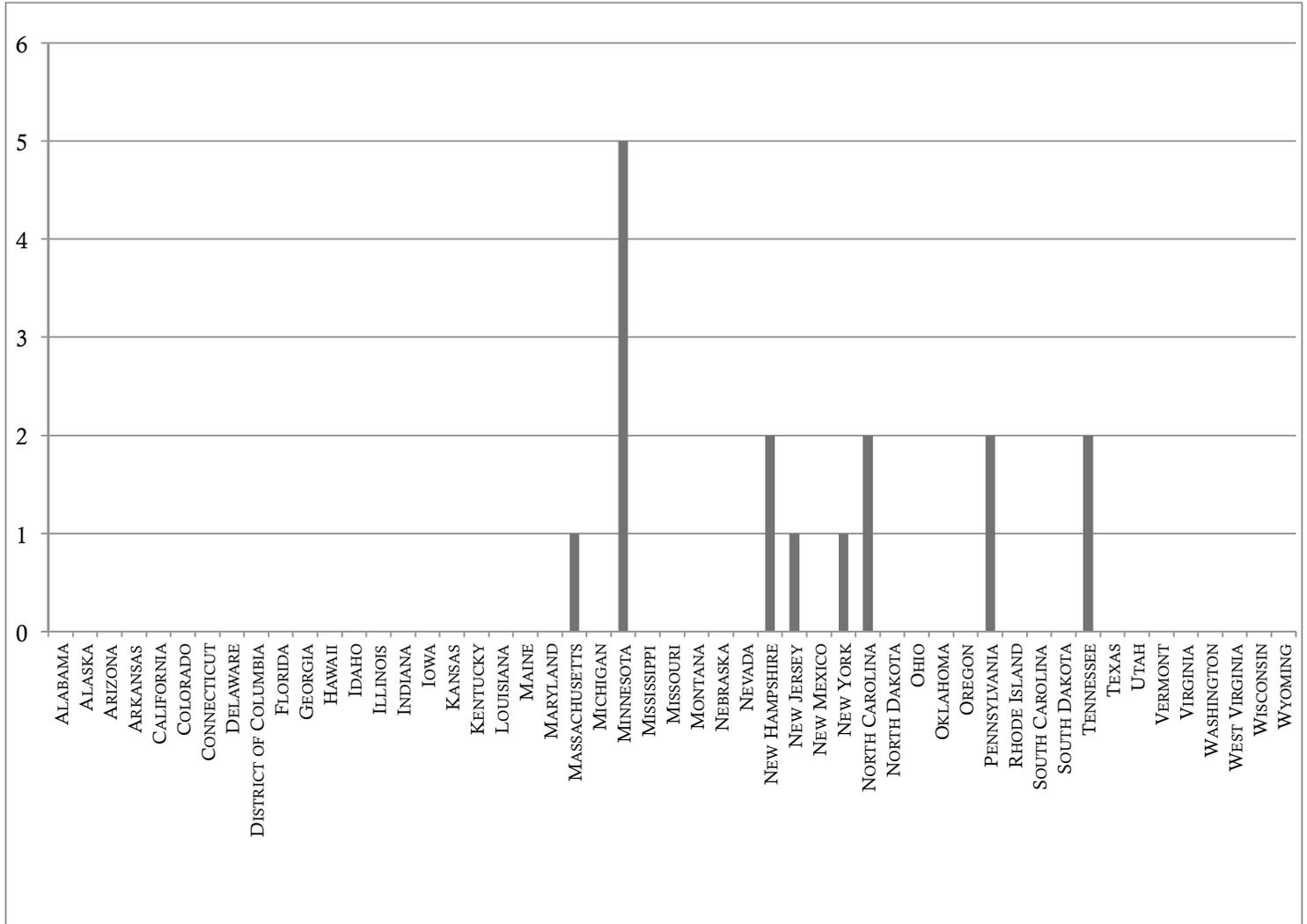


When an anonymous EVENT report is submitted, our team is notified by email. In the United States, the anonymous patient safety event report is shared with the state EMS office of the state in which the event was reported to have occurred. The state name in the report is then removed and the record is shared through our Google Group and kept for this summary report. Canadian records have the Province name removed, and then the reports are shared through the Paramedic Chiefs of Canada, and kept for inclusion in aggregate reports.

Quarterly Patient Safety Events by Country



Patient Safety Events Reported by State (United States of America)



Many of our reports this quarter have been generated from Minnesota. Thanks to the Minnesota agencies and practitioners for supporting this body of knowledge! Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania and Tennessee were also great contributors this quarter. If your EMS agency has an internal reporting system for patient safety events, we encourage you to have your staff member that receives those reports to also enter them into our anonymous system.



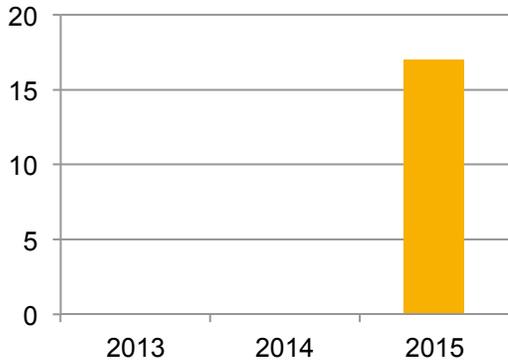
Supporting Those Who Serve



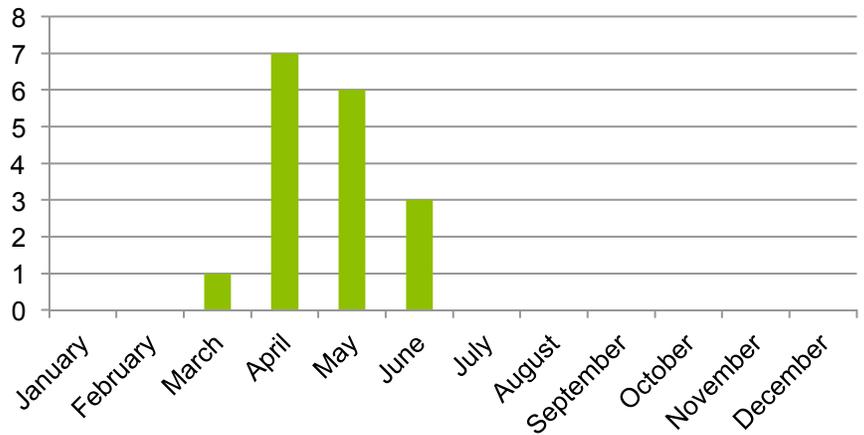
Paramedic Chiefs of Canada
Chefs Paramédics du Canada

The Center for Leadership, Innovation and Research in Emergency Medical Services

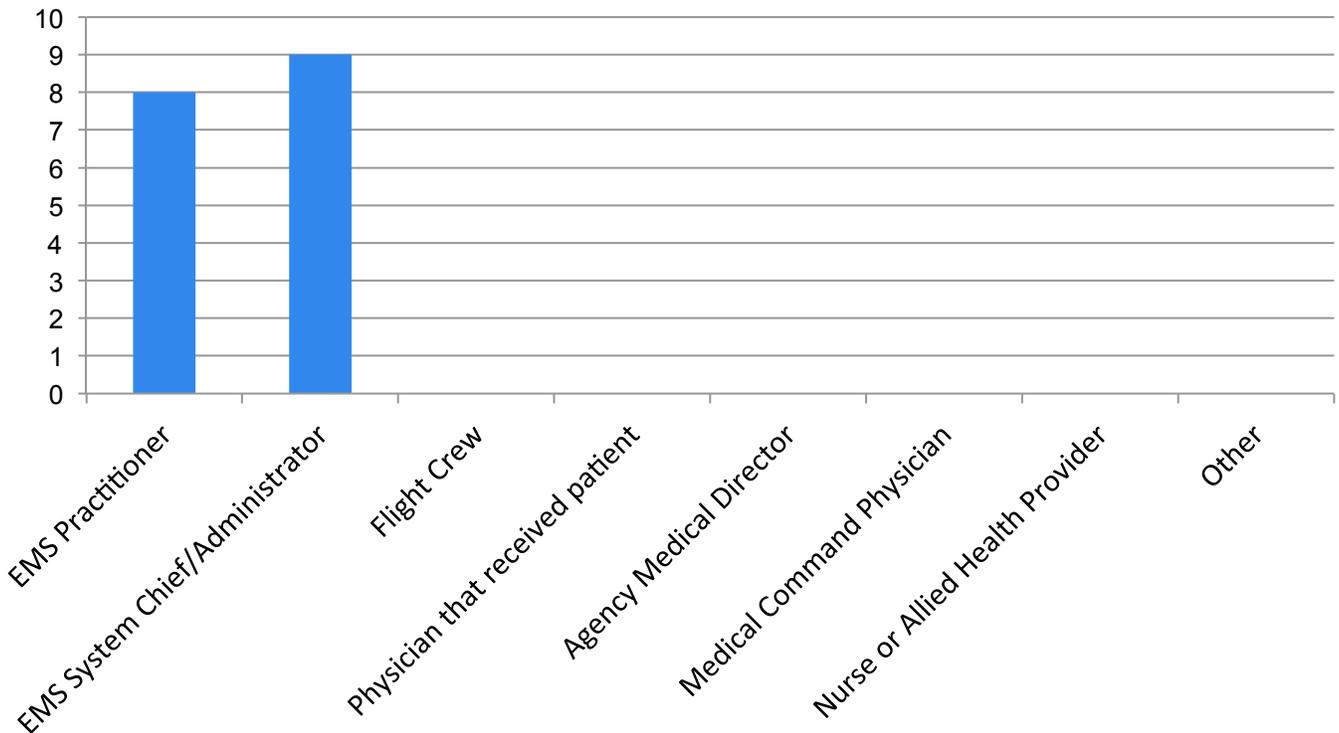
Year Reported Patient Safety Event Occurred



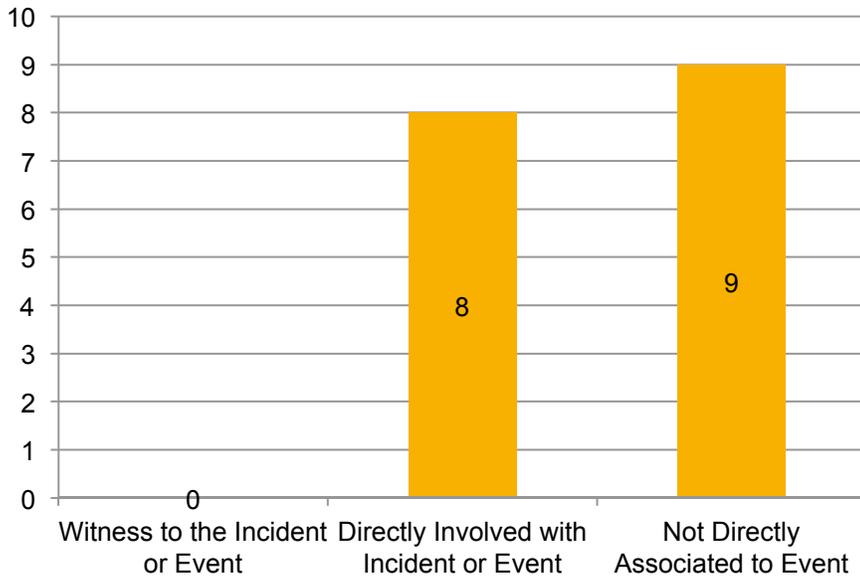
Month of Reported Patient Safety Event



Role of Person Reporting Incident

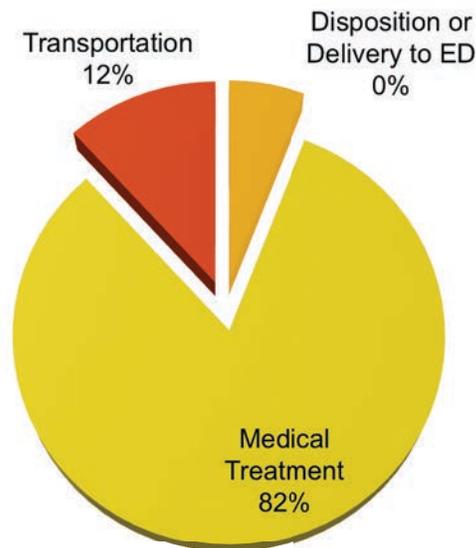


Involvement in Safety Event



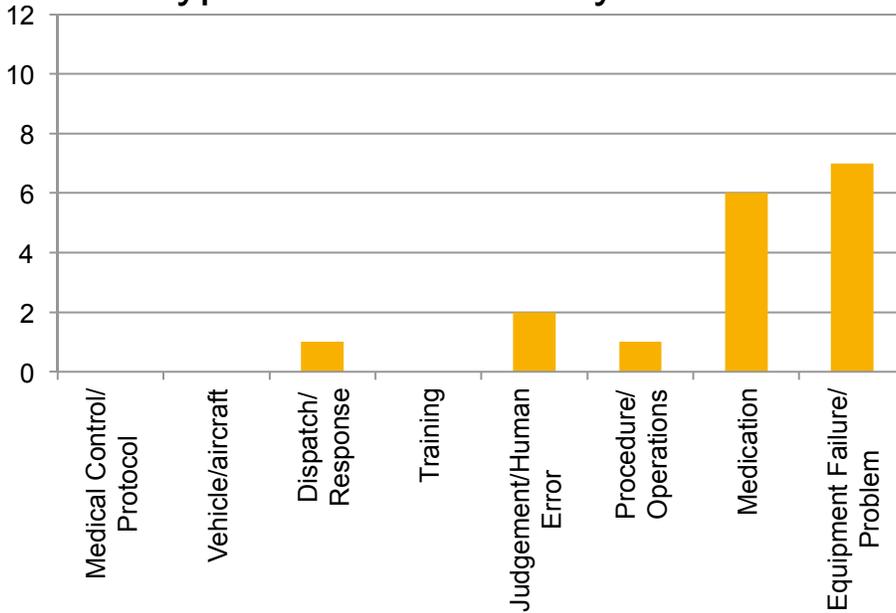
The reporters from this period are generally “not directly associated to the event”. The EMS system administrator dominates the “not directly associated” group.

Category of Event



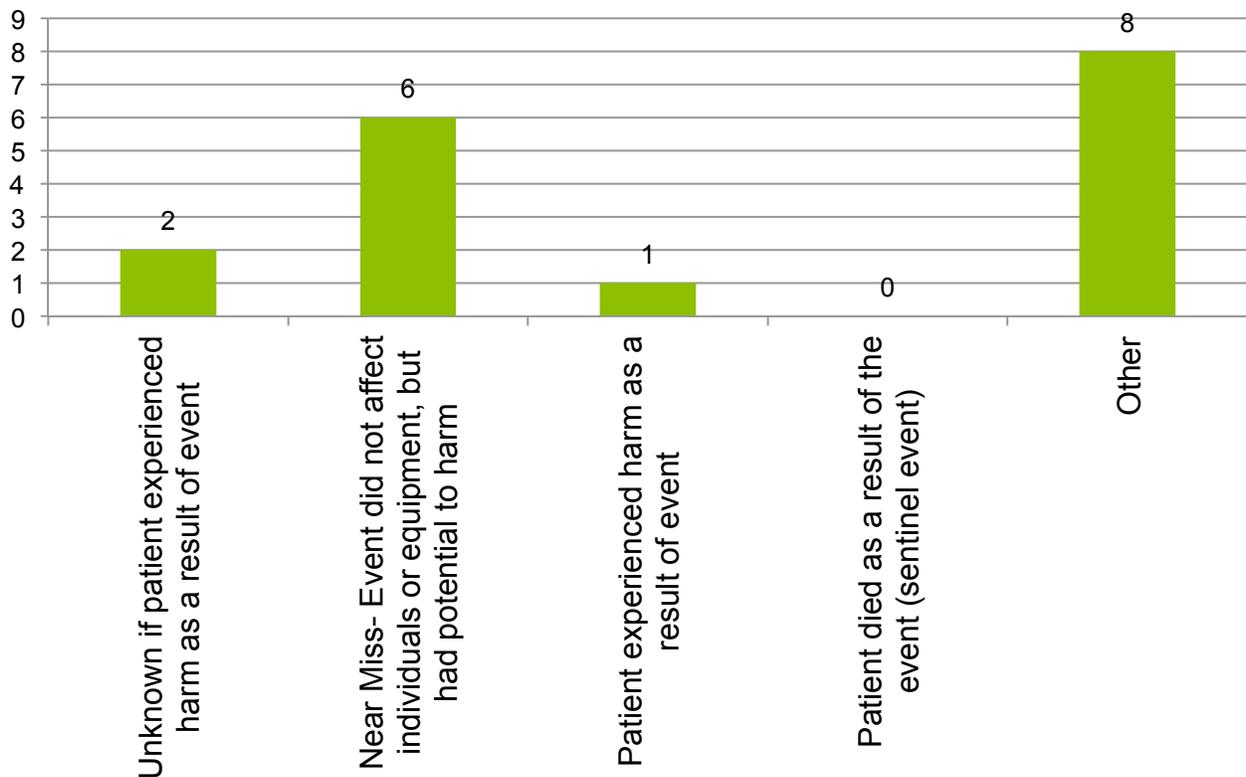
The vast majority of the events reported this period occurred in the medical treatment phase. Transportation is the second most reported.

Type of Patient Safety Event



Equipment failures dominated the type of event, followed closely by medication event. Clinical judgment or human error and dispatch/response events were also reported.

Patient Result of Patient Safety Event



#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
1	Address for the call was selected in dispatching app on the on-board tablet. 10 minutes into response it was noted that wrong address had been selected. A squad vehicle proceeded to address to lower response time. Stable patient was transported without incident.	Both crew members unfamiliar with the area and not ensuring the correct address was selected for the GPS. More situational awareness when navigating to an unfamiliar location. More time during training spent on area familiarization.
2	Patient in respiratory distress placed on [manufacturer] CPAP. CPAP device did sound as if it was functioning properly, however airflow could be felt through the mask. Patient reported no relief and did not improve. Quickly the decision was made to transfer the patient to the [different manufacturer] CPAP. Patient improved and reported relief.	Equipment malfunction with [original manufacturer] CPAP. On further inspection after the call it was still uncertain of the reason for failure.
3	We took a call for a man down, once we arrived we found a man sitting on a small workbench outside of his home with neighbors by his side. The only true medical history that we were given was that the patient was a diabetic. An IV was attempted twice by my partner and was not successful, so we could not give the patient D50 at the time the patient sugar was 23 by finger stick. After talking it over my partner asked me to get the glucagon ready so I did only because I have done it 100s of times at another Agency. I mixed the glucagon and pulled the mixture out of the vile and my partner and me spoke about the drug on what route the medication had to be given which in this case it was an IM injection. I gave him the injection and our patient started to slowly respond to the medication by opening his eyes and is able to hold a conversation patient knows where he lives what day it is. After returning from the call me and my partner spoke with the Lt. about the call, and who had to write up the call we soon found out I could not give that medication due to it being out of my scope of practice. I am only an EMT.	Not understanding that the medication is out of my scope of practice as well as my partner not knowing as well. CE on medication errors and how to correct them.
4	During training with cardiac monitor, [manufacturer, model] screen went blank (black) following defibrillation/energy delivery.	Unknown cause, batteries fully charged.
5	While attempting to get a 12 lead the monitor kept saying v6 lead off. It will not run a 12 lead without any errors.	Poor quality cables and ability for the monitor to self test any connectivity issues. Higher quality cables for the EMS environment. Ability for the monitor to self-test the cables.
6	While lifting a patient in cardiac arrest on a LSB the hand hold at the head of the patient broke.	Possible due to the age and use of the board over years. Daily inspections for any defects.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
7	<p>EMS practitioner on an inter-facility transfer accidentally overdosed a patient with insulin. Due to the extended distance of the transfer the sending facility RN provided EMS with insulin and syringe as the patient would need to have an injection to control her blood sugar during the trip. At the correct time the Paramedic obtained a BGL and assessed the result on a sliding scale and was to give 8 units. Because of unfamiliarity of the difference between insulin syringes and regular 1cc tuberculin syringe, he inadvertently administered 80 units of insulin. When the patient became symptomatic for hypoglycemia the practitioner reviewed the drug administration and recognized the error. He then took all the right corrective measures, which included on-line medical consultation with a physician, glucose administration and infusion as well as transparently reporting the incident.</p>	<p>Unfamiliarity of the difference between insulin syringes and regular 1cc tuberculin syringe Educate practitioners on the differences between insulin syringes and 1cc tuberculin syringes.</p> <p>Highlight the importance of extra vigilance when dealing with medications and equipment for which the practitioner may lack familiarity.</p> <p>Applaud the professionalism of the practitioner for transparent reporting in order to raise awareness and encourage others to report adverse events.</p>
8	<p>Twice in the past month, when we had secured a patient to our stair chair and were getting ready to carry the patient down a flight/flights of stairs, the stair chair would buckle in on itself. The stair chair would fold up into the position when you are putting it back when finished with it.</p>	<p>In both cases, the stair chair was the older style with the long metal latch that you press down to lock and unlock the device. The chair was checked both times before placing the patient onto the device to make sure it was locked into place and both times it was.</p> <p>These styles of stair chairs are old and out dated. There have always been issues with the locking mechanisms due to normal wear and tear, as well as just being an old outdated design. I've seen this happen and heard of this happening to other crews countless times over the years and I think the only to truly solve this issue is to completely discontinue the use of these devices.</p>
9	<p>When giving Fentanyl for pain control I administered 50 mcg thinking it was 25 mcg. A second dose was administered, which in my head equaled 50 mcg but was actually 100 mcg. The dose I gave was within the protocol, as was the dose I thought I gave.</p>	<p>My partner was helping to draw up the med, and when we verbalized the dose and the amount, it made sense. I didn't look at the bottle or read the concentration, which might have given me a clue as to the actual amount I was administering.</p> <p>If I had it to do over, I would ask to look at the med vial when I was handed the syringe of medication.</p>
10	<p>Upon injecting air in to vial, the plastic top popped off the vial.</p>	<p>Faulty manufacturing.</p>
11	<p>When giving patient 50 mcg of Fentanyl while ambulance was enroute to hospital, the ambulance braked hard and due to being jolted hard to the side, the patient was given 100mcg of Fentanyl not 50 as intended. This did not adversely affect the patient in any way, but it did result in the medication being given much quicker and in the obvious larger dose and if it was a different medication their could have been a different outcome.</p>	<p>Normal body reaction given the event during the active administration of medications.</p> <p>Either place the medication in NS first then administer or have some type of a failsafe device on the syringe that would prevent the plunger from being depressed any further than the intended amount, i.e. 0.5 ml or 1.0 ml etc. In the future, especially with certain patients who may be more sensitive to larger doses, i.e. peds, elderly etc., I will be placing the med in 9 ml NS before administration as long as their are no fluid restrictions.</p>

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
12	Patient fall due to stretcher tipped over.	Not using correct height of stretcher on uneven terrain. Only using stretcher at loading height when loading.
13	During a resuscitation attempt for a cardiac arrest in a bank office, the 2nd pre-filled vial of 1:10,000 epinephrine had the glass vial separate from the plug which attaches to the administration syringe device & spilled the contents. Another syringe was available & used to complete the drug administration. No harm to the patient & only a few seconds delay of the administration.	<p>The crew suspects that a contributor may be that the syringe involved was designed for use with a different brand of epinephrine vial.</p> <p>When pre-filled vials & syringes are removed from their boxes to save storage space, assure that the products match and are not mixed with similar products from different manufacturers.</p>
14	When attempting to administer CPAP to an 84 y/o with 10/10 respiratory distress, the CPAP equipment did not seem to function normally and did not sound like it was providing normal airway pressure gas flow. Both portable and main vehicle O2 tanks & regulators were tried with same poor results. The patient's condition did slightly improve and resulted in no harm. After arrival at the hospital, the switch to the hospital's CPAP device provided marked improvement in the patient's SpO2 and ease of breathing.	<p>Limited testing by the crew afterwards revealed this CPAP generator unit was providing limited and less than normal pressures. CPAP generator was removed from service for testing & repairs as needed. QA tested device and inspection found lower airflow as reported & needle valve visually appears narrower or blocked.</p> <p>Devices should receive periodic preventative maintenance to include measuring the gas flow. This equipment for testing is not typically available to the providers.</p>
15	During a hospital transfer with a severe back pain patient, the stopper on a vial of fentanyl was pushed into the 2 mL vial attempting to load a syringe, contaminating and spilling the contents. Dilaudid given PTOA at the hospital and two additional 100 mcg vials of fentanyl were not able to manage the patient's 10/10 pain. The crew decided to divert transport back to another hospital in the same city to help manage the pain as well as developing anxiety and hypertension. No harm to the patient related to the 100-mcg dose that was not available to be administered because of the spill.	<p>This vial stopper failure has occurred at our multiple sites and with other providers in the past with this same size & brand of fentanyl vial. The device used to access the vial was exactly what the manufacturer recommends.</p> <p>The medic drawing from the vial needs to be careful to puncture the stopper in the center and with just enough force. The product we are currently using will soon not be available for purchase. We are searching for a new design of vial access cannula that will work with the stopper for all brands of vials.</p>
16	The mother of a 5 y/o patient was injured exiting the ambulance. On arrival at the destination hospital, the mother, who was also riding in the patient compartment, attempted to exit on her own before the crew could assist her out the back doors. She landed hard negotiating the 18 inch step height and fell to the garage floor. She sustained an ankle injury later determined to be a sprain. The crew assisted the mother into a wheelchair and she was also seen as a patient in the ED.	<p>The rear doors of the ambulance are a known safety risk when used as a means of egress for ambulatory passengers or patients due to obstructions and the step height. Our policy instructs crews to use the side door, which is a lower step height and has assist rails. In this event, soiled linen and a lift device not yet removed from a previous run blocked the side door. Also, the passenger did not wait for instructions or assistance from the crew and attempted to exit under her own volition. This type of event is exactly why our policy instructs to use the side patient compartment door. For any passenger with impaired mobility, additional assistance with a step stool is also considered a safer option.</p> <p>Continue to reinforce existing policy for side door use with ambulatory passengers.</p>

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
17	<p>A cardiac monitor failed to acquire a 12-lead ECG for a 52 y/o male pt. with 10/10 chest pain & who had an AMI 1 month ago. The crew made 2 attempts, both times resulting in leads-off error messages. VS and limb-lead ECG were acceptable and pt. was transported to the ED and later transferred to the cath. lab. Crew did not delay transport and no patient harm resulted. The patient cable had a wire break near the distal block where the limb-leads exit. The plug-in cable extension at the back of box was also loose and faulty. The main ECG cable and the pig-tail extension were replaced and tested before returning monitor to service.</p>	<p>Cardiac monitoring cables supplied by the manufacturer are not rugged enough to survive the rigors of the pre-hospital environment.</p> <p>The [manufacturer, model] had a faulty cable near the distal block where the limb-leads exit. The plug-in cable extension at the back of box was also loose and causing loss of signal. The main ECG cable and the pig-tail extension were replaced and tested before returning monitor to service.</p>

Notice/disclaimer: all manufacturer and model names are removed from this document because EVENT is an anonymous system. The anonymity of EVENT reports is protected and the reporter cannot be verified as a neutral party trained to provide a fair and unbiased assessment of the events or product usage. For this reason we redact all names, including the manufacturer and model. We operate another reporting system, the Emergency Medical Error Reduction Group (EMERG), which can provide states or individual EMS agencies a non-anonymous error reporting system. As a designated Patient Safety Organization (PSO), EMERG has federal discovery protection for all information entered and analysis completed. EMERG can help identify actual manufacturing issues and partner with industry to correct issues and thereby improve the culture of safety in EMS. For more information please about EMERG, contact Matt Womble, MHA, Paramedic, Director of EMERG (matt.womble@emerg.org). (EMERG is federally designated as PSO # P0133 by the U.S. Department of Health and Human Services, Agency for Healthcare Research & Quality.)

Appendix

D

Committee Motion: Name: Medical Direction

Individual Motion: Name: _____

Motion:
Moves that the scope of practice formulary be expanded for Emergency Medical Responders/First Responders to allow the administration of naloxone.

EMS Plan Reference (include section number):

3.1.8 Through a consensus process, develop a recommendation for evidence-based patient care guidelines and formulary.
4.2.2 Assure adequate and appropriate education of EMS students.

Committee Minority Opinion (as needed):

For Board's secretary use only:
Motion Seconded
By: _____
Vote: By Acclamation: Approved Not Approved
By Count: Yea: _____ Nay: _____ Abstain: _____

Board Minority Opinion:

Meeting Date:

Appendix

E

Committee Motion: Name: Medical Direction

Individual Motion: Name: _____

Motion:
Moves that the scope of practice formulary be expanded for ocular analgesics to the EMT level,

EMS Plan Reference (include section number):

3.1.8 Through a consensus process, develop a recommendation for evidence-based patient care guidelines and formulary.

4.2.2 Assure adequate and appropriate education of EMS students.

Committee Minority Opinion (as needed):

For Board's secretary use only:

Motion Seconded

By: _____

Vote: By Acclamation: Approved Not Approved

By Count: Yea: _____ Nay: _____ Abstain: _____

Board Minority Opinion:

Meeting

Date: