Office of Emergency Medical Services
Report to The
State EMS Advisory Board
February 13, 2009

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. Administration and Finance

OEMS Budget Reductions

a) 2008-2010 Biennium Budget

The Governor presented his 2008-2010 Biennium Budget to the Joint meeting of the House Appropriations Committee, House Finance Committee, the Senate Finance Committee and members of the General Assembly and public on December 17, 2008. Below is a copy of items in the budget language that affects EMS.

Consolidate Poison Control Centers into one statewide center

Focuses the services provided by all three centers into one statewide center. There are three poison control programs serving Virginia located at the University of Virginia in Charlottesville, Virginia Commonwealth University in Richmond, and the National Capital Poison Center in Washington, D.C. Services will not be impacted by this savings strategy.

	FY 2009		FY 2010
General Fund Savings	$ 0		$ (1,049,691)

Redirect the new "4-for-Life" revenue to the Department of State Police

Transfers the revenue generated from motor vehicle registration fees to the State Police's medevac program. Revenue generated by the additional $0.25 of the fee, approved by the 2008 General Assembly, is deposited into the Rescue Squad Assistance Fund and used only to pay for the costs

associated with the certification and recertification training of emergency medical services personnel. The revenue, $1.6 million, will now be used to support med-flight missions. This a language-only amendment. The Department of State Police is supplanting general fund appropriation equal to the new "4-for-Life" revenue as part of the Governor's 2008-2010 Reduction Plan. The nongeneral fund appropriation increase is included in the Department of State Police's budget for FY 2010.

	FY 2009		FY 2010

Transfer excess nongeneral fund balances to the general fund

Provides a one-time cash transfer to the general fund.

	FY 2009		FY 2010
Revenue / Transfers	$ 3,500,000		$ 0

As reported in the November 12, 2008 Quarterly Report to the State EMS Advisory Board, the following Budget Reductions were previously implemented by Governor Kaine in October, 2008:

- OEMS has been directed to transfer $503,757 to the Treasury of Virginia from the Rescue Squad Assistance Fund Grant program[1].
- The following positions [2] were eliminated:
    - Consolidated Test Site Coordinator
    - Stroke Care Coordinator (although the 2008 Virginia General Assembly passed legislation and established this FTE for OEMS)
    - CISM Coordinator

1. As a footnote, it should also be mentioned that this fund is an interest bearing account. In FY 2007and until further notice, the Governor has retained interest earned on all interest bearing accounts and the funds will be transferred to the general fund. This has an approximate effect of reducing grant funds by $0.5M or more per year. Interest was previously rolled into available funding for EMS agencies.
2. Although the positions were eliminated, the programs were not eliminated which requires OEMS to develop strategies for continuation of these programs. Two of the positions were vacant; whereas, the CISM Coordinator position was filled. Under state layoff policies, the employee had the right to move into a similar role/position. OEMS was able to relocate this person and did not have to implement a layoff of this individual.

b) 2009 Legislation Affecting EMS

Each Friday or Saturday during the 2009 Virginia General Assembly session, OEMS will provide the State EMS Advisory Board members, Regional EMS Councils and other EMS stakeholders an OEMS Legislative Grid and Report on all legislation we are tracking.

If you would like to have a full copy of any bill, please contact OEMS or log onto: http://leg1.state.va.us/lis.htm and you can download any bill of interest.

OEMS has also added a link on its Web site under EMS News titled "2009 Legislative Bill Watch." You can also access all bills being tracked by OEMS at that Web site address: http://www.vdh.virginia.gov/OEMS/news_page/2009Legislative.htm.

Please let OEMS know if there are any bills you would like for us to add to our profile list. OEMS encourages you to forward this information to your constituents and group lists to keep them updated.

If you have any questions at any time, please do not hesitate to the Office. If you experience any problems in receiving or opening the attached files, please let the Office know immediately.

NOTE: OEMS will provide a report to the State EMS Advisory Board on February 13, 2009 regarding the status of legislative bills and Budget Amendments affecting EMS.

Other Projects

n) Audit of Financial Records and Programs:

The Office of Emergency Medical Services (OEMS) has entered into a contract with Clifton Gunderson to conduct audits of Rescue Squad Assistance Fund grants, local governments on their use of Return to Locality funds and, the Regional EMS Councils. OEMS provides more than $17.8 million annually to these organizations. Recommendations from Joint Legislative Audit and Review Committee and best business practice necessitates that OEMS ensure funds are being utilized for its intended purpose. OEMS does not have the professional staff necessary to conduct audits and a risk assessment/evaluation of internal controls. Therefore, this office sought Request for Proposals (RFP) from professional audit services and through competitive negotiations Clifton Gunderson was awarded a 3 year contract.

OEMS is currently undergoing an internal audit by the agency's Internal Audit Division. This audit is an extensive review that crosses all divisions and functions to include: Travel, Contracting, Purchasing, Small Purchase Charge Cards, HIPPA Compliance, Payroll, Invoice Payment Processing and Prompt Pay Act, Cash Receipts/Collections, Equipment Inventory Control and Reconciliation of Funds. It is anticipated that this audit will be a central focus of activity for this division.

Rescue Squad Assistance Fund (RSAF)

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

The RSAF grant award meetings for the December 2008 grant cycle took place on December 4-5, 2008. This cycle received requests from 117 agencies in the amount of $6,672,212.13, of those 98 grants were awarded for $3,364,850.79. This grant cycle was awarded on January 1, 2009 and will end December 31, 2009. The following agency categories were awarded during the December 2008 cycle:

- 66 Volunteer Agencies in the amount of $2,303,407.11
- 22 Government Agencies in the amount of $679,463.00
- 10 Non-Profit Agencies in the amount of $381,980.68

The following provides a breakdown of grants awarded by each Regional EMS Council area:

- Blue Ridge EMS Council – 11 agencies in the amount of $304,085.00
- Central Shenandoah EMS Council – 5 agencies in the amount of $200,439.69
- Lord Fairfax EMS Council – 6 agencies in the amount of $260,826.40
- Northern Virginia EMS Council – 1 agency in the amount of $64,195.00
- Old Dominion EMS Alliance – 12 agencies in the amount of $367,903.90
- Peninsulas EMS Council – 9 agencies in the amount of $203,235.62
- Rappahannock EMS Council – 6 agencies in the amount of $140,410.19
- Southwestern Virginia EMS Council – 17 agencies in the amount of $466,936.15
- Thomas Jefferson EMS Council – 6 agencies in the amount of $264,250.10
- Tidewater EMS Council – 8 agencies in the amount of $285,925.86
- Western Virginia EMS Council – 15 agencies in the amount of $756,642.88

Figure 1: Requested vs. Awarded by EMS Region:

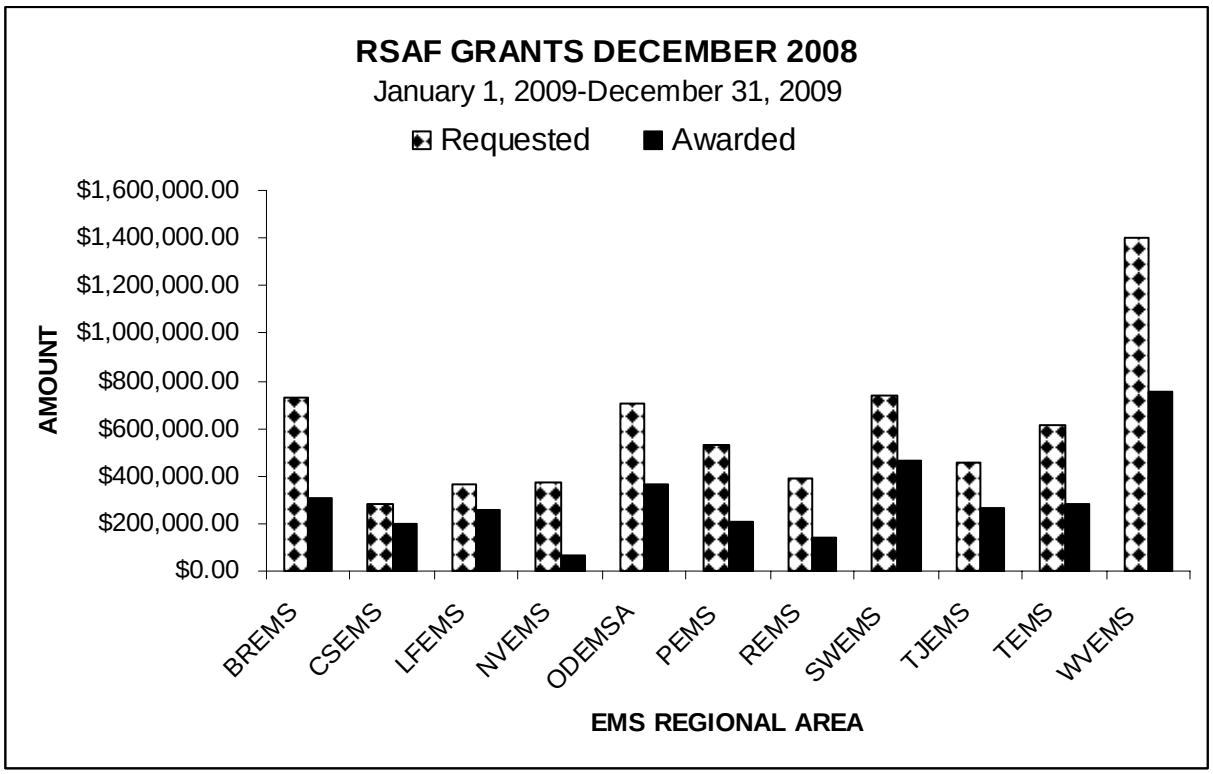
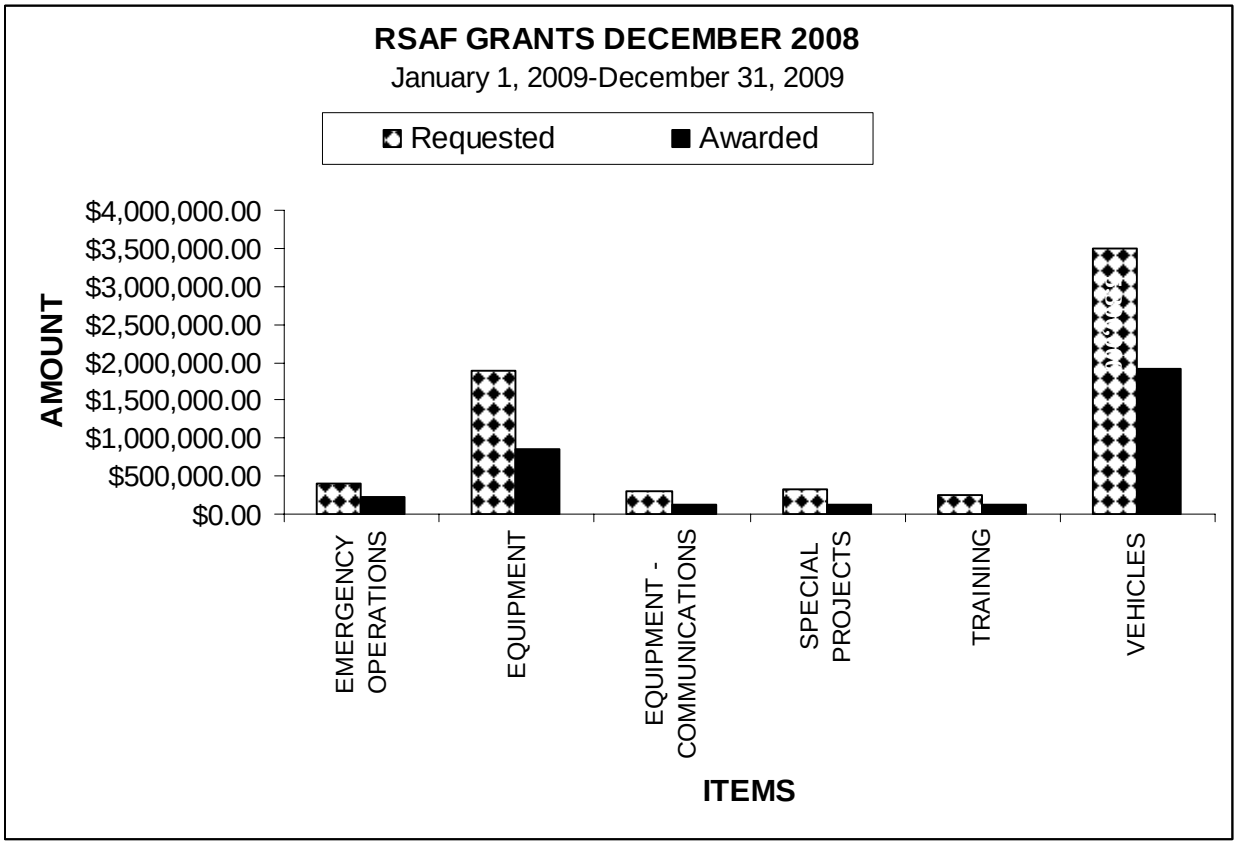


Figure 2: Requested vs. Awarded by Item Category:



- Emergency Operations
  - Includes items such as Mass Casualty Incident (MCI) trailers and equipment, Disaster Medical Assistance Team (DMAT) equipment, extrication equipment, and Health and Medical Emergency Response Team (HMERT) vehicles and equipment. 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)
  - Includes any medical care equipment for sustaining life, including defibrillation, airway management, and supplies.
- Equipment – Communications
  - Includes items for EMS dispatching, mobile/portable radios, pagers, and other communications system technology.
- Special Projects
  - This category includes computers, computer hardware, audio visual equipment, recruitment and retention projects, research, studies and any other project, program or equipment that is used for innovative EMS developments.
- Training
  - 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
  - Includes ambulances and quick response vehicles.

The next RSAF grant submission cycle will open February 2, 2009 and have a deadline of March 16, 2009. The grant cycle will run from July 1, 2009 through June 30, 2010.

n) Grant Web Based Program

OEMS is continuing development of the web based program for the Financial Assistance for Emergency Medical Services Grant Program, known as RSAF. The business analyst has completed the project charter and project proposal as required by the Virginia Information Technology Agency (VITA) and is awaiting review. This grant management system will consolidate all grant application information, grant review data and necessary reports into one database that can be accessed via the internet. The Business Analyst has met with the Virginia Department of Health (VDH) – Office of Information Management (OIM) to discuss utilizing an off-the-shelf software program vs. developing the system internally. The Business Analyst is planning on holding Joint Application Development (JAD) sessions in regional areas during the beginning of 2009 in order to gain user group input for the web development.

Federal Grants

n) Homeland Security for EMS

- The 2008 Department of Homeland Security Grant was awarded to the Office of Emergency Medical Services (OEMS) on September 2, 2008 in the amount of $1,391,000.00. The 2008 grant award is to expand upon the 2007 DHS award toward the development of the PPCR web-based system. The 2009 DHS grant process has begun and meetings have taken place to start to develop the investment justification (IJ) for OEMS. The following dates have been confirmed for the 2009 DHS process:

    - IJ (VDEM) – January 29th
    - IJ Mid-Term Review from FEMA – due by COB on February 4th
    - Final IJ Draft due to VDEM from Leads – February 11th
    - IJ Feedback from FEMA – February 20th
    - Final modifications (using FEMA comments) to IJ's – February 21 - 26
    - Executive Summary submitted – February 27th
    - Grant submission to FEMA – March 18th

n) Virginia Communications Index for Public Safety (VCIPS)

The Grants Manager is working with VITA – 911, OCP and VDEM in consolidating all public safety communications grants within state government throughout Virginia. This compendium will act as a resource for those looking for public safety grants concerning specific elements, items, programs or equipment. The EMS Advisory Board Communications Committee is assisting in this development and has begun to create a communications portion of the compendium providing resources for funding equipment.

Human Resources

The activity in Human Resources for OEMS was central to the budget cuts previously reported. Recruitment activity for the Accountant position vacated by Henry Bosman and the part-time wage position (Media Technician) vacated by Dave Hellman, has been completed.

n) OEMS Accountant

Brenda Carroll was hired as OEMS' Accountant and began employment with our office on Thursday, 12/4/08. Brenda came to us from VDOT where she served as their Business Operations Specialist. Brenda has significant experience with the state and her prior role was Senior Accountant with VDH, Office of Family Health Services. She has held various positions and advanced her career within the state from a fiscal technician, fiscal technician senior, grant administrator, accountant and, senior accountant. Brenda is well known and respected for her performance, attention to detail and hard work. We are confident that she will complement our Administration and Financial Division and will be a mentor for our team while serving as a resource for our program managers.

n) Media Technician

Edward (Ed) Damerel was recently hired as OEMS' wage (part-time) Media Technician and began employment on Tuesday, 12/23/2008. Ed recently retired from the Department of Education after 28 years of service. He served as their Chief Engineer in the area of Media Technology. Ed also has prior experience in broadcasting, video and film production. We welcome Ed to the Virginia Department of Health – Office of EMS and look forward to him using his expertise in assisting Terry Coy and the Division of Education and Training.

n) Technical Assistance Coordinator

Ms. Carol Morrow assumed the position of OEMS Technical Assistance Coordinator at the Office of EMS in November 2008. Carol has been with the Office for 19 years and previously served as the RSAF Grant Manager (1990-2006) and the CISM Program Manager (1997-2008).

Carol has been involved in EMS since 1978 and a paramedic for 26 years of that time. Her knowledge and EMS experience as a rescue squad president and captain will benefit Carol in her new duties and responsibilities as Technical Assistance Coordinator.

n) VDH APPOINTS NEW DEPUTY COMMISSIONER FOR EMERGENCY PREPAREDNESS AND RESPONSE

State Health Commissioner Karen Remley, M.D., MBA, has appointed Mark. J. Levine, M.D., MPH, as the Deputy Commissioner for Emergency Preparedness and Response Programs.

The Deputy Commissioner is responsible for public health planning and preparation for naturally occurring and man made disasters and threats and for the Virginia Department of Health's Office of Emergency Medical Services. This office plans and coordinates the statewide emergency medical services system, which includes 720 EMS agencies and 33,000 EMS providers covering every community in the state. The program licenses EMS community agencies, certifies service providers, designates trauma centers and inspects and issues permits for emergency medical service vehicles.

Dr. Levine is currently the Director for the Henrico Health District. His hands-on experience in EP&R and EMS program management includes having served as Health/Medical Incident Commander for the agency following Hurricane Katrina and co-chairing an agency panel that reviewed operations during Hurricane Isabel. He has worked closely with the local EMS community in his health district, which includes several rural municipalities.

“Dr. Levine has a demonstrated ability to bring together the medical and educational communities, local governmental and civic groups and volunteers to plan and prepare for public health emergencies. Utilizing these same skills, his health district has been in the forefront of our efforts to achieve national recognition under the auspices of Project Public Health Ready,” Commissioner Remley said.

Project Public Health Ready is a program of the National Association of County and City Officials that measures the effectiveness of a community’s plans and processes, workforce development and outreach in protecting public health in an emergency.

Dr. Levine joins an EP&R office that is the only such state program to achieve a perfect score two consecutive years in the report by the Trust for America’s Health and the Robert Wood Johnson Foundation, “Ready or Not? Protecting the Public’s Health from Diseases, Disasters and Bioterrorism.” The annual report evaluates every state’s ability to protect its residents from disease outbreaks, natural disasters and bioterrorism based upon 10 key indicators that assess health emergency preparedness capabilities.

“It is a privilege to be joining a world class team, one with top quality professionals, a highly concentrated focus on excellence and great leadership in building and benefiting from strong partnerships,” Dr. Levine said. “To paraphrase one of history’s leading disease-prevention pioneers, Dr. Louis Pasteur, ‘chance favors the prepared community.’ My goal is to use this continuous improvement approach to keep our residents as safe as possible from all future threats.”

Dr. Levine will assume his new duties on Feb. 10. He succeeds Dr. Lisa Kaplowitz, who was the agency’s first Deputy Commissioner for Emergency Preparedness and Response Programs. Dr. Kaplowitz, who is the Health Director in Alexandria, has also been serving as the interim EP&R deputy commissioner.

Dr. Levine joined the Virginia Department of Health as the Director of its Piedmont District in 2002. He became Henrico’s Health District Director in 2005. Under his leadership, the Henrico district developed one of the state’s most active Medical Reserve Corp programs, involving nearly 300 volunteers in emergency response activities. He holds clinical assistant professor appointments with the University of Virginia and with Virginia Commonwealth University.

Prior to his public health service, Dr. Levine was a practicing family physician; a Director of the Hamot Family Practice Residency at the Hamot Medical Center; and a clinical assistant professor with the Department of Family Practice at what is now Drexel University College of Medicine and with Penn State College of Medicine. He graduated from the University of Rochester and received his M.D. from the Albert Einstein College of Medicine of Yeshiva University. He did his residency in family practice at the University of Virginia and holds a Master of Public Health degree from the Johns Hopkins Bloomberg School of Public Health, where he was selected for the public health honor society, Delta Omega.

n) OEMS spreads VDH message on preventing infant mortality

Dr. Remley has praised OEMS Program Representative Supervisor Jimmy Burch in her recent Weekly Report distributed to all VDH employees. Dr. Remley stated the following: **"**OEMS Program Representative Supervisor **Jimmy Burch** in Chase City has taken up my challenge to spread the message of preventing infant deaths. He recently conducted a four-hour presentation in South Boston as part of the annual continuing education weekend held for local EMS providers. Inspired by my presentation at the OEMS symposium last fall, Jimmy requested information on infant mortality to include in his talk.. Of special interest to the more than 80 EMS providers was information on educating babysitters and other care providers on the need to put infants to bed on their backs, Jimmy said. Two other CE instructors have asked to borrow Jimmy's presentation so that they may include the information in future CE classes. My thanks to Jimmy for going the extra mile to ensure that all aspects of VDH address this important issue."

n) EMS Medical Director Training Courses

Information about the availability of EMS Medical Director Training course offerings for 2009 is now posted on the OEMS Web site. This information may be accessed from the Home Page of the OEMS Web site under "EMS News" or by using the following direct link http://www.vdh.virginia.gov/OEMS/news_page/MedicalDirectorTraining.htm.

There will be at least four (4) face to face EMS Medical Director training courses offered between now and August 31, 2009 (deadline for EMS Physician Endorsements). Two courses have been scheduled and work continues to confirm dates and locations for two other courses. Additional courses may be held based on local demand or special requests.

The tentative 2009 schedule for EMS Medical Director Courses is:

Monday, Feb. 9	The Homestead	Hot Springs, VA
Thursday, March 12	Southwest Virginia Higher Education Center	Abingdon, VA
Week of June 8 – 13	Danville Area (Western VA EMS Council area)	
Week of August 10 – 14	Warrenton/Culpeper Area (Rappahannock EMS Council area)	
Nov. 12	Norfolk Waterside Marriott	Norfolk, VA

OEMS is working with VACEP and the Critical Illness and Trauma Foundation (www.citmt.org) to finalize agreements and a contract to offer an on-line EMS Medical Director training program. It is anticipated this option will be available within the next thirty (30) days. We will keep you posted and advise you when this option is available.

OEMS respectfully asks that you please share this information with your local/regional EMS agencies, personnel and medical facilities.

If anyone has any questions, please do not hesitate to contact OEMS or Dr. George Lindbeck, State EMS Medical Director.

n) Joint Legislative Audit and Review Commission (JLARC) Study of autism services in the Commonwealth.

With the passage of HJR 105 in the 2008 session of the Virginia General Assembly, JLARC was directed to study autism services in the Commonwealth. Autism spectrum disorders (ASDs) are a group of developmental disabilities defined by significant impairments in social interaction and communication and the presence of unusual stereotypical or repetitive behaviors, interests, and activities that often appear before the age of three and affect all racial, ethnic and socioeconomic groups.

The rate of autism among the general population has grown by 173% over the past decade and in 2007, one in every 150 eight-year-old children had a diagnosed ASD. Between 1998 and 2006, the number of children aged three to 22 with an identified ASD enrolled in the Virginia Public School System increased by more than 400%.

JLARC must submit an executive summary of its findings and recommendations no later than the first day of the 2010 session of the General Assembly. In the resolution JLARC was instructed to identify current autism educational and training opportunities available to or provided to EMS personnel, among others. In general, law-enforcement officers, public safety personnel, first responders, judges, magistrates, attorneys for the Commonwealth, public defenders, and various personnel involved in the legal system are unaware of the impacts of ASDs or of the best ways to assist individuals with ASDs.

OEMS staff recently met with several legislative analysts from JLARC and advised them that autism training is not required in the initial or continuing education (CE) curriculum for EMS personnel. However, autism training could be approved for credit to meet mandatory CE requirements at the basic and advanced EMS certification levels. In addition, the analysts were advised that OEMS routinely includes classes at the annual EMS Symposium that address the EMS management of the autistic patient.

OEMS will monitor the progress of this study and advise the EMS community if there are any findings or recommendations related to the education and training of EMS personnel related to the care and management of patients with a diagnosed ASD.

II. Division of Educational Development

Committees

I. **Committees**

A. **The Professional Development Committee** (PDC): The committee met on January 7, 2009. Copies of past minutes are available from the Office of EMS web page at: http://www.vdh.virginia.gov/OEMS/Training/Committees.htm

1. Action Items:
    a. The BLS Accreditation document was approved. It is important to note that the accreditation at the BLS Level is only an option to traditional BLS Instruction. **Please see Appendix A.**
    b. The proposal to revamp the Instructor and ALS Coordinator certification process was approved. **Please see Appendix B.**
2. The next meeting of the PDC is scheduled for Wednesday, April 8, 2009

B. **The Medical Direction Committee (MDC)** met on January 8, 2009. Copies of past minutes are available from the Office of EMS web page at: http://www.vdh.virginia.gov/OEMS/Training/Committees.asp

1. The Medical Direction Committee (MDC) **finalized a review of the** Virginia Procedures and Formulary documents. **Please see Appendix C.**

Advanced Life Support Programs

C. **An ALS-Coordinator Seminar** was conducted on January 10, 2009 in Norfolk with 30 new ALS-Coordinators completing the administrative program.

Basic Life Support Program

D. **Instructor Institutes**

1. Twenty-five (25) Instructor candidates attended a Practical Exam on Saturday, December 6, 2008 in the Tidewater EMS Council Area. Twenty-four successfully passed the exam. The Office took this opportunity to pilot the New BLS Practical Exam processes, forms and stations. The pilot was a success and OEMS received positive comments from both the evaluators and candidates.
2. Twenty-three (23) Instructor Candidates attended the EMT-Instructor Institute in Norfolk, Virginia January 24-28, 2009.
3. One of the three EMT-Instructors who received conditional certification from the September 2008 Institute has completed his requirements and received full EMT-Instructor certification. The other two are actively teaching under a certified EMT Instructor and are expected to be finished soon.

4. The next Instructor Practical is scheduled for April, 2009. The Office will again pilot the new practical exam at this test site. The deadline to take the written instructor pre-test is February 11, 2009.

5. The next EMT-Instructor Institute is scheduled for June 13-17, 2009 and will be held in conjunction with the VAVRS Rescue College in Blacksburg, VA.

6. Important Instructor Institute dates/deadlines are posted on the web at: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

E. **EMS Instructor Updates:**

1. In response to the current budget deficit the Division of Educational Development is continuing to pursue other avenues to allow EMT-Instructors/ALS-Coordinators/Emergency Operations Instructors to complete their required Update.

2. Implementation of alternative methods to conduct administrative updates for instructors has been slow. Therefore, the Office is extending the Instructor certification dates of providers expiring between January and June until July 31, 2009 to allow more time to complete the implementation process. Important information is posted on the Web at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

F. **New BLS Practical Exam**

1. The Office piloted the new BLS Practical Exam processes, forms and stations at the EMT-Instructor Practical Exam held on Dec. 6, 2008. The Pilot was a success and we received positive comments from both the evaluators and candidates.

2. The test will be piloted again at the Instructor Practical Exam on April 11, 2009. A third pilot is planned with around 50 High School EMT Students in May, 2009.

3. In October 2008, the Virginia Tech Rescue Squad assisted in the video production of the new practical stations. The footage will be used to create a training video for EMT Instructors and Examiners, a second video to train Evaluators and also an EMSAT Broadcast.

4. An implementation timeline has been completed, which includes training all Certification Examiners and EMS Program Representatives by May 31, 2009 and all Evaluators by August 31, 2009. The new BLS Practical will go into effect on September 1, 2009. A plan is being developed to address any retests necessary under the old practical exam. Candidates who are required to take their primary retest will be allowed to retest under the old practical until November 29, 2009 (90 days after September 1, 2009). Any candidate required to retest their Secondary Eligibility after September 1, 2009 will be required to test under the new Practical.

5. The Practical Exam Users Guide has been distributed electronically to all EMT-Instructors for which we had valid e-mail addresses and will be posted on a special page on the OEMS Website along with the implementation timeline and a FAQ which will contain questions sent to the Office.

6. The Office is also conducting a survey of the Regional EMS Councils to determine what the equipment needs and budget impact will be to implement this new exam process.

EMS Training Funds

Beginning July 1, 2008, the Office of EMS launched the new Emergency Medical Services Training Fund (EMSTF) program. The Office of EMS (OEMS) developed this new funding program in response to recommendations made by a Joint Legislative Sub-committee formed in 2007 to Study Recruitment and Retention Incentives for Volunteer Fire and EMS Personnel (HJR-743). The new training funds program provides increased funding opportunities for both EMT-Instructors and ALS-Coordinators. Additionally, OEMS has created a new financial tracking system which enables the Office to show how additional revenue generated by HJR-743 (2007)—estimated at $1.6 million—would dedicate funds for recruitment, retention and training.

G. **This is the inaugural year of the EMS Training Fund Program**—a $3 million outcomes and performance based program for training of EMS providers across the Commonwealth. The EMS Training Funds (EMSTF) program is made possible by the dedicated members of the Joint Legislative sub-committee formed in 2007 to examine incentives for recruitment and retention of fire and EMS personnel (HJR-743).

To date, participation in the EMSTF program has far exceeded our expectations across the Commonwealth. As of December 16th, the Office reached a milestone having contracted for more than $2.5 million in training services through this program for FY09.

H. **The Future of the EMS Training Fund Program**

The Governor has released his revised budget for FY10. In this budget, the Governor has proposed appropriation of an additional $1.6 million to the Department of State Police for its aviation (Med-Flight) operations. According to budget language, this $1.6 million *"shall be derived from the additional $0.25 of the motor vehicle registration fee approved by the 2008 General Assembly and deposited to the Virginia Rescue Squad Assistance Fund for the certification and recertification training of emergency medical services personnel."*

If this budget amendment passes the General Assembly and is signed into law, the EMS Training Funds program will suffer a huge loss. Based upon the proposed budget, the EMSTF program will lose over half of its funding allocated for FY2009. The $1.6 million proposed removal will bring the available funding for training programs to a range of $1.2 to $1.4 million.

Over the next several months, the Office will be reviewing all EMSTF funding categories to determine what cuts will be necessary in order to continue the EMSTF program.

I. **The following chart shows disbursements from the new EMS Training Fund for Q1 and Q2 of FY09.**

Training Fund	$ Budgeted	$ Obligated	Remaining Funds
Grand Total	**$ 3,000,000.00**	**$ 2,708,744.00**	**$ 291,226.00**

EMSAT/Electronic CE

J. OEMS users make up the largest sub-group of the entire TRAINVirginia System in Virginia. The Office has seen a 259% growth rate in the number of users from 2007 through 2008 for TRAINVirginia .

TRAINVirginia*	2008	2007
Total System Users:	17891	12032
EMS Users:	5373	2071
VDH Users:	4097	3728
Total Volunteer Users:	2419	850
MRC Users:	588	-
Active Course Providers:	137	-

* These numbers may include some duplicate accounts.

Working with the Epilepsy Foundation of Virginia, OEMS recently produced an EMSAT on Seizures. OEMS is considering distributing this EMSAT program to all Virginia EMS agencies, along with ALS Coordinators, EMT Instructors and hospitals.

Mr. Ed Damerel has been hired to work with the OEMS DED TRAIN website and on TRAIN Virginia.

EMSAT programs for the next three months include:

1 February 18: Geriatric Trauma Care
2. March 18: Tazers, Pepper Spray and Other Unpleasant Events
3 April 15: Beyond the Burn: the Latest in Burn Management

Accreditation

The number of accredited EMT-Paramedic training institutions stands at 13. The total of both primary and alternate accredited EMT-Paramedic training sites now stands at 29 unique sites across Virginia.

The number of accredited EMT-Intermediate training institutions stands at 14. The total of both primary and alternate accredited EMT-Intermediate training sites now stands at 15 unique sites across Virginia.

Other Activities

K. OEMS has approved HealthStream, Inc. as the fourth on-line commercial vendor for online EMS continuing education.

L. EMS Practice Analysis - The Office continues to participate with the Atlantic EMS Council to develop and conduct an EMS practice analysis for the member states (PA, WV, MD, DE, VA, DC, NC, and SC). This included participation from randomly selected symposium participants at the 2008 symposium. A “beta” pilot will be

conducted in February, 2009. The office has asked the regional EMS Councils and multiple providers from across the state to participate in the "beta" survey. OEMS anticipates sending the practice analysis survey to about 750 randomly selected EMS providers in Virginia by late spring to early summer. This project will be completed late summer to early autumn.

M. The Office Training Manger continues to actively participate with the Training Coordinators group of the Atlantic EMS Council. The Council will be expanding and broadening its role in publishing multiple levels of EMS certification examinations for participating states.

N. OEMS is including various Virginia EMS Instructor groups to assist the Atlantic EMS Council develop an implementation program for the new National EMS Education Standards expected to be adopted by the National Highway Traffic Safety Administration, Department of Transportation later this spring or summer. It has been suggested that the Standards will be implemented in 2011.

O. Although Virginia has an established accreditation program, OEMS is working with CAAHEP (Commission on Accreditation of Allied Health Education Programs) and CoAEMSP (Committee on Accreditation of Educational Programs for the EMS Professions) to address issues surrounding the accreditation process for new EMS educational programs. Beginning in 2013, the National Registry of EMT's anticipates implementing a requirement that all candidates for NREMT certification must have attended a nationally accredited EMS education program.

III. Emergency Operations

Operations

a) 2009 Inauguration Participation

During this quarter, the Division of Emergency Operations actively participated in the planning, preparation, and response phases for the 2009 Presidential Inauguration. Prior to the event members of the Division of Emergency Operations staff actively participated in meetings and conference calls to finalize plans and logistical support for the event. Two HMERT EMS Task Forces (Crater 6 and Thomas Jefferson 2) were placed on alert and available to respond to any received requests during the event. Two members of the Coordination Team were also available. The Emergency Planner and Communications Coordinator staffed the ESF-8 desk onsite at the Virginia EOC for the period of the Inauguration and immediately following. The Emergency Operations Manager, Assistant Manager, HMERT Coordinator, and Office of EMS Director, staffed an Emergency Support Center at East Hanover Volunteer Rescue Squad in Mechanicsville Virginia to continually monitor the event and respond to any situation should the need arise. Thankfully there were no EMS requests made during the event and the Emergency Operations Division demobilized January 20, 2009 at 1530 hours.

As part of the Commonwealth's response to the Inauguration, Division of Emergency Operations personnel assisted the Statewide Mutual Aid Coordinator, Kenny Hayes, with securing resources for Statewide Mutual Aid requests received in support of the Inauguration. This included a request for an ALS Strike Team for Fairfax County.

b) Change in CISM Responsibilities

As a result of the budget crisis within the Commonwealth, the Office of EMS was informed that the position of Critical Incident Stress Management (CISM) Coordinator was eliminated, effective November 25, 2008. However, while the position has been eliminated, the CISM program will continue. The OEMS Emergency Operations Division will incorporate the functions of the CISM program into current division staff to ensure the continuation of service. All CISM inquiries are now handled by Karen Owens, Emergency Operations Assistant Manager.

c) HMERT Coordination

The HMERT Coordinator continued to work on the rewriting of the Guidance Documents to reflect the new Health and Medical Emergency Response Team (HMERT) structure. Additional work was done on the applications and processes for the new system.

d) Safety Vests

The HMERT Coordinator continued to work on the Safety Vest Program with ordering the product and receiving the first shipment. Distribution of the partial shipment was completed to all vehicles. A policy was drafted and approved by upper management and placed in effect.

e) Symposium

Division of Emergency Operations personnel participated in the 2008 EMS Symposium held in Norfolk Virginia November 12-16, 2008. The HMERT Coordinator served as the Logistics Section Chief and assisted in ensuring any logistical support necessary was provided. Emergency Operations staff served as instructors, room hosts, and position fill-ins throughout the weekend. They also attended classes to assist them in staying up-to-date in skills and information.

Planning

f) Continued Re-write of OEMS COOP/Business Recovery Plan

On January 27, 2009 members of the OEMS Administrative Division and Emergency Operations Division met to discuss continued plans for the development and finalization of the Office Business Recovery/Continuity of Operations Plan. All staff members, specifically Division Managers, were asked to review their specific parts of the plan to assist in the rewrite process.

g) Assist Commonwealth in developing Family Assistance Plan (FAC) for Virginia

The Emergency Planner reviewed a draft of the Family Assistance Plan and submitted final comments from OEMS to the Department of Social Services

h) ESF-8 Annex to Commonwealth of Virginia Emergency Operations Plan

The OEMS Emergency Planner assisted EP&R with technical rewriting of the Emergency Support Function-8 (ESF-8) Annex for publication in the revised Commonwealth of Virginia Emergency Operations Plan.

Committees/Meetings

i) 2009 Symposium Planning Committee

The Emergency Operations Assistant Manager attended multiple meetings of the EMS Symposium Planning Committee to begin the process for planning and scheduling the 2009 EMS Symposium.

j) Regional Resource Committee

Frank Cheatham, HMERT Coordinator, attended the regularly scheduled meeting of the Region 1 Resource group on January 13, 2009.

k) Hurricane Evacuation Committee

On December 11, 2008, the HMERT Coordinator attended the Hurricane Evacuation Committee on Lane Reversal.

l) Hospital Emergency Management Committee (HEMC)

The HEMC meetings are now being held on a quarterly schedule. The Emergency Operations Manager will continue to attend these.

m) Virginia Disaster Medical Assistance Team (VA-1 DMAT)

The Emergency Operations Manager continued to attend the monthly VA-1 DMAT leadership and membership meetings. The HMERT Coordinator also attended the membership meetings. The team had deployments to: Frederick, MD to assist with equipment logistics, Washington D.C. to assist with Incident Response Coordination Team (IRCT) and two doctors to serve as Chief Medical Officers with each supervising a Medical Division in the Mall area, Baltimore, MD to assist with establishing a Mobile Aero-medical Staging Facility (MASF), Martinsburg, WV to assist with establishing a Mobile Aero-medical Staging Facility (MASF), Maryland staged to establish a 250 bed Federal Medical Station (FMS), and two members deployed for pharmacy logistic support. A total of 45 VA-1 team members on deployments to assist with the 2009 inauguration.

n) NHTSA Conference Call on State Pandemic Influenza Plan

On November 20, 2008, Winnie Pennington, Emergency Planner, along with Jim Nogle and Karen Owens participated in a conference call with representatives from the National Highway Transportation Safety Administration (NHTSA) to discuss EMS portion of the State Pandemic Influenza Plan.

o) Office of Commonwealth Preparedness Strategic Planning Meeting

On December 9, 2008, the Emergency Planner represented the Office of EMS at a meeting to discuss objectives for 5-year plan including the state's role in mass casualty planning and support.

p) Pandemic Influenza Webinar (December 12, 2008)

On December 12, 2008, Winnie Pennington, Emergency Planner, participated in webinar from federal government to update planners on latest information and statistics on Pandemic Influenza worldwide.

q) EMS Communications Committee

The EMS Communications Committee held its quarterly meeting on November 13, 2008 in Norfolk at the Sheraton Waterside Hotel in conjunction with the Virginia EMS Symposium. Discussion included the Virginia Communications Index for Public Safety (VCIPS). This project is to provide a central location for agencies to locate and find information on grants available for public safety communications. OEMS Grants Coordinator Amanda Davis is working w/representatives from VITA 911 and Office of Commonwealth Preparedness Interoperability on this project. Other discussion included modifying the PSAP Accreditation program to include that dispatchers must receive certification from a recognized EMD training organization.

Training

r) HMERT Training

Frank Cheatham, HMERT Coordinator, conducted classes with EMS Task Force, Crater 6, to train new members and to present the new structure of the HMERT System. The HMERT Coordinator also held a class at Salem Rescue to present information on the HMERT System and to train new potential HMERT members.

s) Vehicle Rescue Program

The HMERT Coordinator and OEMS Vehicle Rescue Coordinator attended a pilot Vehicle Awareness and Operations Class hosted by the Department of Fire Programs in Hampton Virginia on January 10, 2009.

t) Training

The HMERT Coordinator and Emergency Planner attended a Technical Writing course at VCU on December 10, 2008.

Communications

u) Statewide Agencies Radio System/User Agency Review Committee (STARS/UARC)

STARS Representative Michael Deane contacted OEMS to attempt to schedule the final OEMS and VDH vehicle radio installs. OEMS Communications is working with Regulation and Compliance Manager Mike Berg and VDH Bill Webb to coordinate.

v) OEMS Public Safety Answering Point (PSAP) & 911 Center accreditation

Ken Crumpler presented the OEMS PSAP Accreditation to the Charlottesville/Albemarle/UVA 9-1-1 Center on November 18, 2008. A pending application from Botetourt Co. 9-1-1 will be presented to the EMS Advisory Board Communication Committee at the next meeting. Updating the parameters for accreditation to include "*Emergency Medical Dispatchers must be trained and certified by an OEMS recognized emergency dispatch training organization meeting or exceeding standards established by the National Highway Traffic Safety Administration (NHTSA) and accepted and recognized by the American Society for Testing Materials (ASTM). Examples of approved systems include, but are not limited to, programs offered by the Association of Public Safety Communications Officers, International (APCO), Powerphone®, Priority Dispatch® or National Emergency Communications Institute®."* This will also be presented for review to the EMS Advisory Board Communications Committee

w) Association of Public Safety Communications Officers (APCO)

The Office of EMS was represented by Ken Crumpler at the Virginia Chapter APCO/NENA Winter meeting at Henrico 9-1-1 training center on January 15, 2009. Mr. Crumpler relayed that it is the desire of OEMS to provide CISM training for 9-1-1 communications staff at the Fall APCO/NENA/Interoperability Conference in Roanoke and the Virginia EMS Symposium. Mr.

Crumpler has been requested to be an instructor at the Spring APCO/NENA Conference in Virginia Beach.

x) Virginia State Interoperability Executive Committee (SIEC)

Ken Crumpler, Communications Coordinator, represented the Office of EMS at the State Interoperability Executive Committee Meeting on January 14, 2009 in Richmond. Mr. Crumpler also attended the Regional Planning Action Committee Meeting in Chesterfield on December 15, 2008 in Chesterfield County.

IV. National EMS News

a) New Report from NASEMSO on Domestic Preparedness Funds

The National Association of State EMS Officials has recently completed another report on "State EMS Office Involvement in Domestic Preparedness Efforts, 2008."

This report is based upon a follow-up survey to the NASEMSO 2007 Domestic Preparedness Survey. The object of the 2007 survey was to ascertain the extent to which state EMS offices are involved and included in federally supported preparedness efforts occurring at the state level. The 2008 Addendum is a follow-up effort aimed at gathering additional information on the utility and allocation of those funds as well as structural information on various protocols for preparedness.

The report is posted at
http://www.nasemso.org/Projects/DomesticPreparedness/documents/08DPAddendumReport-2.pdf .

b) CDC Rollout of Trauma Field Triage Decision Scheme Announced

In an effort to encourage use of improved triage procedures, the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC) worked with experts and partner organizations to develop the 2006 Field Triage Decision Scheme which is discussed in the January 23, 2009 issue of Morbidity and Mortality Weekly Report (MMWR). In support of the 2006 Field Triage Decision Scheme, NCIPC also developed an educational initiative and multi-media toolkit to help emergency medical services (EMS) professionals (administrators, medical directors, trauma system leadership, and providers) learn about and implement the revised Field Triage Decision Scheme. The toolkit includes "A Guide to the Field Triage Decision Scheme: The National Trauma Triage Protocol", a poster, CD-ROM, and pocket card to help EMS providers, planners, and administrators effectively train others and use the Decision Scheme criteria within their own systems. The national release of the CDC's materials will follow the publication of the related MMWR.

c) NTSB Calls on States to Continue Adopting "Most Wanted" Highway Safety Items

The National Transportation Safety Board stated that although there were some modest gains in the past year on several of its Most Wanted safety improvements directed at State governments, much more needs to be accomplished before any of the items can be removed from the list. NTSB members reviewed the past year's progress in getting States to enact safety legislation and updated the public on the status of the State portion of the NTSB's Most Wanted List. The NTSB cites four States that have adopted more elements on the Most Wanted List than any others – New Jersey, Oregon, Tennessee and Washington. In contrast, five States – Arizona, Arkansas, Montana, North Dakota and South Dakota – have adopted the fewest number of Most Wanted items. Maps and tables providing State-by-State details for each of the recommendations can be found on the Board's website.

d) SAMHSA Releases New Data on Drug-related Hospital Emergency Department Visits

The latest Drug Abuse Warning Network (DAWN) report - drawn from a sample of hospital emergency departments across the Nation - indicates that more than 1.7 million visits for treatment were associated with some form of substance misuse or abuse. The 2006 DAWN report, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides the latest estimates on how substance use affects this critical part of the Nation's healthcare system. The

DAWN report provides a great deal of detailed information on how problems with a wide range of other substances contribute to hospital emergency department visits. The full DAWN report is available at http://dawninfo.samhsa.gov/pubs/edpubs/default.asp.

e) 2009 Emergency Medicine Report Card Now Available

The National Report Card on the State of Emergency Medicine assesses the support that each state and the District of Columbia provides for their emergency care systems. The results of the 2009 Report Card present a picture of an emergency care system fraught with significant challenges and under more stress than ever before. The overall grade for the nation across all five categories is a C-. This low grade is particularly reflective of the poor score in Access to Emergency Care (D-). Because of its direct impact on emergency services and capacity for patient care, this category of indicators accounts for 30 percent of the Report Card grade, so the poor score is especially relevant. For more information and to download state-by-state results, go to http://www.emreportcard.org/overview.aspx?id=388 .

f) NFPA Approves Technical Committee to Develop Ambulance Standards

During its October 2008 meeting, the National Fire Protection Association Standards Council approved a request from the Technical Committee on Fire Department Apparatus to form a new project to develop ambulance standards. Please visit their web site at: http://www.nfpa.org/codesTC .

g) NASEMSO Releases New Communications Monograph

NASEMSO recently conducted a nationwide survey of State EMS Directors to ascertain the status of EMS communications capabilities, oversight and development. Communication technologies are central to the efficient coordination and delivery of Emergency Medical Services in everyday operation and in mass casualty and domestic preparedness endeavors. The results of this survey are being reported in a new NASEMSO monograph, “The Status of State EMS Office Involvement in Emergency Medical Services Communications.” Each state EMS office and each associate, corporate and sponsoring member has received one hard copy in the mail. State EMS offices can request up to four additional copies at no charge, and all NASEMSO members can request additional copies at a 50% discount off the $60 price.

h) DHS Announces Revised National Incident Management System

The U.S. Department of Homeland Security’s (DHS) Federal Emergency Management Agency (FEMA) has released a revised National Incident Management System (NIMS)—the national standard for incident management. NIMS establishes standardized incident management processes, protocols, and procedures that all federal, state, tribal and local responders will use to coordinate and conduct response actions. NIMS expands on the original version released in March 2004 by clarifying existing NIMS concepts, better incorporating preparedness and planning and improving the overall readability of the document. The revised document also differentiates between the purposes of NIMS and the National Response Framework (NRF) by identifying how NIMS provides the action template for the management of incidents, while the NRF provides the policy structure and mechanisms for national-level policy for incident management. The basic tenets of NIMS remain the same. There have been several improvements to the revised NIMS document which will aid in readability and usefulness of preparing, preventing, and responding to incidents. To view and download the new NIMS and companion documents, visit the NIMS Resource Center at http://www.fema.gov/emergency/nims/#.

i) FEMA Releases Draft Credentialing Guideline

The Federal Emergency Management Agency (FEMA) has released draft guidance for credentialing first responders that doesn't mandate a federal technical standard for identification cards. Instead, the agency is asking state and local agencies to voluntarily follow the rules. In a 25-page draft of the National Incident Management System Guideline for the Credentialing of Personnel, FEMA encourages state and local governments to voluntarily adopt interoperable identification credentials. FEMA began working on the national guideline for first responder credentials more than a year ago. In the draft document, FEMA states that its guideline is voluntary but that adopting it will strengthen agencies' eligibility for federal emergency preparedness grants. The document offers advice on registration and enrollment, eligibility and risk assessments, issuance, verification and use, expiration and revocation, and redress and waiver. The Guideline provides guidance on how to best credential the personnel who respond to incidents, including large scale terrorist attacks and catastrophic natural disasters that require inter-State deployable mutual aid. To view, go to: http://www.regulations.gov/fdmspublic/component/main?main=DocketDetail&d=FEMA-2008-0015

In related news, FEMA has posted an illustration of its "Recommended NIMS Personnel Credentialing Process" at http://www.fema.gov/emergency/nims/Credentialing.htm.

j) FEMA Releases Draft NIMS I&I

The Federal Emergency Management Agency (FEMA) is accepting comments on the National Incident Management System (NIMS) Intelligence/Investigations Function Guidance Document (NIMS I&I). This document provides guidance on utilizing and integrating the Intelligence/Investigations Function while adhering to the concepts and principles of the NIMS. NIMS I&I presents information intended for the ICS practitioner that will assist in the decision-making process regarding the placement of the Function within the command structure, and provides tools that may be used while implementing the Function. The Function has aspects that cross disciplines, including traditional law enforcement, epidemiological investigations, regulatory investigations, and medical examiner/coroner investigations, as well as those conducted by the National Transportation Safety Board or other investigatory agencies. To view, go to: http://www.regulations.gov/fdmspublic/component/main?main=DocketDetail&d=FEMA-2008-0016

k) NEMSIS Procedure Code Update for Version 2.2.1

Developers have announced an update for the NEMSIS D04_04 Procedures data element code list for the NEMSIS Version 2.2.1 data dictionary and XSD. There have been several requests to add procedures to this list to accommodate new skills and also to allow documentation of Specialty Center Notification relative to Trauma, Stroke, and STEMI care. These changes will not impact the structure of the Version 2.2.1 XSD so there should not be an impact on any software which continues to use the 2.2.1 XSD. It will allow new procedures to be validated and transmitted through the existing NEMSIS 2.2.1 XML. Comments and suggestions for any procedures which are missing from the D04_04 data element are requested. Additions so far include Trauma Center Notification, STEMI Center Notification, Stroke Center Notification, Airway-King LT, Wound Care with Hemostatic Agent, Wound Care-Taser Removal, and Airway-Foreign Body Removal. This update was implemented in late January. Please forward any suggestions directly to Greg Mears at gdm@med.unc.edu.

l) State Budget Cuts Jeopardize America's Health

Shrinking state health department budgets, brought on by the current economic downturn, are forcing cuts in critical public health programs and reductions in workforce that will have wide ranging effects.

This is according to a recent survey of state and territorial health agencies, conducted by the Association of State and Territorial Health Officials (ASTHO). According to the ASTHO survey:

- Nearly 30% of states' FY08 health department budgets were cut below their FY07 level.
- Almost two-thirds of state health departments expect FY09 budgets to be cut below their FY08 level.
- All health departments that weathered cuts in FY08 expect further cuts in FY09.
- 22% of health departments expect at least a cut of at least 10% for FY09.
- Federal dollars make up about half of the average state's public health budget.

m) California Good Samaritan Can Be Sued for Non-Medical Care

According to the Los Angeles Times, the California Supreme Court has ruled that a young woman who pulled a co-worker from a crashed vehicle isn't immune from civil liability because the care she rendered wasn't medical. The divided high court appeared to signal that rescue efforts are the responsibility of trained professionals. It was also thought to be the first ruling by the court that someone who intervened in an accident in good faith could be sued.

n) FEMA Launches New Website for Disaster Assistance

FEMA introduces the launch of a new user-friendly website called Disasterassistance.gov on December 31, 2008. The website was created as part of the Disaster Assistance Improvement Plan (DAIP). After Hurricane Katrina, President Bush signed Executive Order 13411 on August 29, 2007 in an effort to improve delivery of federal disaster assistance. This website will centralize the application process for federal disaster assistance and offer a clearinghouse for information on programs administered at the federal, state and local levels. For more information, go to http://www.disasterassistance.gov/.

o) NCTC Releases 2009 Counterterrorism Calendar

The National Counterterrorism Center (NCTC) has announced the release of its 2009 counterterrorism calendar. The calendar, popular with a broad spectrum of federal, state, and local first responders; homeland security professionals; policy makers; and counterterrorism experts, is now available via NCTC's website as both a downloadable PDF and a multimedia website. NCTC has published a "daily planner" print version of its counterterrorism calendar since 2005. This year's print calendar contains 160 pages of information on known terrorist groups, individual terrorists, and technical information on topics such as biological and chemical threats and explosives. The 2009 edition contains more counterterrorism information than any previous edition, as well as the most comprehensive index to date, making it easier for law enforcement and first responders to find the information they need about everything from Anthrax to VBEIDs (Vehicle-Borne Improvised Explosive Devices). The online multimedia version includes a new interactive map feature. For more information, go to www.nctc.gov.

p) Study Finds Healthcare Employment Linked With Increased Bloodborne Pathogen Mortality

NIOSH researchers found an association, over a 20-year period, between employment in the healthcare industry and deaths from several bloodborne pathogens and their related conditions among males but only with hepatitis C virus among females. Results of the study were published in an article co-authored by Sara E. Luckhaupt and Geoffrey M. Calvert, titled "Deaths Due to Bloodborne Infections and Their Sequelae Among Health-Care Workers," in the November 2008 issue of the American Journal of Industrial Medicine (51:812–824).

q) New Computer Simulation Shows Movement of Population Using Navteq

Researchers from Virginia Tech are developing a computer simulation that matches the movements of all 300 million people in towns across the US. The team hopes that the model will help them understand the spread of contagious diseases, fads, and traffic flows. The software, called EpiSimdemics, can provide an accurate simulation of the demographic attributes of groups composed of 1500 people or more. Based on the data, the software generates individuals to populate real US cities, giving them real street addresses and real jobs or schools within a reasonable distance from their address. Individuals are also matched to local grocery stores and shopping centers, which are identified through a database from Navteq, a digital mapping company. One of the first applications for compiling all this data will be studying how contagious diseases, such as a flu epidemic, might spread through different regions. The software infects a few simulated individuals with the flu, and tracks them as they go about their daily lives. The model gives each person a different probability of responding to the virus, derived from the individual's data, such as age and general health.

r) USFA Releases Provisional 2008 Firefighter Fatality Statistics

The United States Fire Administration (USFA) announced today there were 114 on-duty firefighter fatalities in the United States as a result of incidents that occurred in 2008. During this period, there were firefighters lost from 34 states and one from the Virgin Islands. North Carolina experienced the highest number of fatalities (11), while Oregon (9), Pennsylvania (9), California (8), New York (7), Illinois (6), Missouri (6), and Ohio (6) each suffered more than 5 on-duty losses. As the USFA continues to collect and evaluate information regarding the 2008 on-duty firefighter deaths, here are some of the early known facts:

1. Preliminary estimates indicate that heart attacks and strokes were responsible for the deaths of 50 firefighters (43.8%) in 2008.
2. In 2008, 26 on-duty firefighters died in association with wildland fires.
3. For 2008, 64.9% of all firefighter fatalities occurred while performing emergency duties.
4. Twenty-nine firefighters died in 2008 as the result of vehicle crashes. Six firefighters were killed in crashes involving their personal vehicles and three died in water tender (tanker) crashes. These two vehicle types have historically been most often involved in crashes that take the lives of firefighters. Speed and a lack of seat belt use historically contribute to these incidents.

These fatality statistics for 2008 are provisional and subject to change as the USFA contacts State Fire Marshals to verify the names of firefighters reported to have died on-duty during 2008. The final number of firefighter fatalities will be reported in USFA's annual firefighter fatality report and is expected to be available by early July. For additional information on firefighter fatalities, including the annual fatality reports from 1986 through 2007 and the Firefighter Fatality Retrospective Study 1990–2000, please visit the USFA Web site.

s) OIG Issues Advisory Opinions on Tax Payments as Revenue to Fund EMS Transportation

The Office of the Inspector General has posted two advisory opinions (08-18 and 08-23) related to tax revenue being used as cost-sharing amounts for EMS transportation under the anti-kickback statute. The opinions are available at:http://www.oig.hhs.gov/fraud/advisoryopinions/opinions.asp. An OIG advisory opinion is a legal opinion issued by the Office of Inspector General ("OIG") to one or more requesting parties about the application of the OIG's fraud and abuse authorities to the party's existing

or proposed business arrangement. An OIG advisory opinion is legally binding on the Department of Health and Human Services (the "Department") and the requesting party or parties. It is not binding on any other governmental department or agency. Only the party that receives a favorable advisory opinion is protected from OIG administrative sanctions, so long as the arrangement at issue is conducted in accordance with the facts submitted to the OIG.

t) Fire Service Organizations Want FEMA to Stay at DHS

Three prominent fire and emergency service organizations are urging President Barack Obama to leave the Federal Emergency Management Administration (FEMA) in the Department of Homeland Security, DHS. To move FEMA out of DHS could endanger America's emergency response capabilities, said the leaders of the International Association of Fire Chiefs (IAFC), International Association of Fire Fighters (IAFF) and the Congressional Fire Service Institute (CFSI) in a letter December 22 to (then) President-Elect Obama. Over the past month, press reports have cited opinions from emergency management groups and others that FEMA should be removed from DHS, an idea that alarmed these fire service leaders. For a copy of the letter to President Obama, go to the www.iafc.org: Government Relations > Issues: Homeland Security.

u) NASEMSO Joins Organizations in Support for Trauma Systems Funding

NASEMSO has signed on to a letter of national organizations circulated by the Trauma Coalition addressed to Chairman Harkin of the Labor-HHS-Education Subcommittee to support funding for Title XII of the Public Health Service Act, trauma care system planning and development, at the authorized level of $10 million in the pending FY 2009 omnibus appropriations package. While a continuing resolution has stayed the federal budget for now, the House and Senate are preparing to reconcile the FY 2009 Labor-HHS-Education legislation in preparation of an omnibus appropriations bill. The final letter will be posted on the Association's web site www.nasemso.org when it becomes available.

v) New High Visibility Rule Now in Effect

Pursuant to Section 1402 of the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU), the Federal Highway Administration (FHWA) Final Rule which establishes a policy for the use of high-visibility safety apparel is now in effect. The FHWA establishes a new Part in Title 23, Code of Federal Regulations (CFR) that requires the use of high-visibility safety apparel and provides guidance on its application. This rulemaking applies only to workers who are working within the rights-of-way of Federal-aid highways and includes emergency responders such as EMS. The FHWA is taking this action to decrease the likelihood of fatalities or injuries to workers on foot who are exposed either to traffic (vehicles using the highway for purposes of travel) or to construction vehicles or equipment while working within the rights-of-way of Federal-aid highways. An Interim Final Rule posted within the Federal Register on November 21, 2008, amends the requirement for firefighters and other emergency responders engaged in emergency operations that expose them to flame, fire, heat, and/or hazardous materials.

w) NHTSA Project to Focus on Children in Emergency Vehicles

The National Highway Traffic Safety Administration (NHTSA) has announced the initiation of its "Solutions for Safely Transporting Children in Emergency Vehicles" project, a partnership between the NHTSA Occupant Protection Division and NHTSA's Office of Emergency Medical Services. The primary objective of this two-year project is to develop a set of recommendations for the emergency medical services (EMS) community to use to safely and appropriately transport children in a ground ambulance from the scene of a crash or other emergency incident. Components include a

comprehensive literature review, the development of draft recommendations, and the convening of a National Meeting to discuss and finalize the recommendations. Potential resources to be reviewed include peer-reviewed journal articles, Web-based publications, papers presented at national meetings and training curricula. For more information on NHTSA or the Office of EMS, access the Web sites at http://www.nhtsa.gov/ or www.ems.gov.

x) NFPA Releases New and Revised Standards Related to EMS

NEW:

- NFPA 1584: Standard on the Rehabilitation Process for Members During Emergency Operations and Training Exercises outlines the responsibilities for responders at fires (and other incidents) by specifying the standards for rehabilitation (also referred to as "rehab") to preserve continuity of operations. According to the NFPA, rehab should occur whenever on-scene activities pose the risk of emergency personnel exceeding a safe level of physical or mental endurance. The types of incidents will vary from structural and wildland fires, hazmat incidents, multiple casualty incidents, and any prolonged operation during bad weather. The standard specifies that fire and emergency medical services are expected to take the lead in sharing the rehab concept with law enforcement and other emergency departments and agencies that take part at the scene. The new standard defines eight key objectives for rehab. These include relief from environmental conditions, rest and recovery, and active or passive cooling or warming as needed. They also include rehydration, calorie and electrolyte replacement, medical monitoring, member accountability, and release for return to duty. Hot conditions will require shelter from the sun, sunscreen, hydration, and prevention of burns from contacting hot asphalt. Cold weather priorities may include shelter from wind and snow, frostbite prevention, increased caloric intake, and methods for thawing gear.

REVISED:

- NFPA 450: Guide for Emergency Medical Services and Systems, 2009 version is designed to assist individuals, agencies, organizations, or systems as well as those interested or involved in emergency medical services (EMS) system design.

- NFPA 473: Standard for Competencies for EMS Personnel Responding to Hazardous Materials/WMD Incidents, this standard identifies the levels of competence required of emergency medical services (EMS) personnel who respond to incidents involving hazardous materials or weapons of mass destruction (WMD). It specifically covers the requirements for basic life support and advanced life support personnel in the pre-hospital setting and is based on the premise that all EMS responders are trained to meet at least the core competencies of the operations level responders as defined in Chapter 5 of NFPA 472, Standard for Competence of Responders to Hazardous Materials/Weapons of Mass Destruction Incidents.

- NFPA 1026: Standard for Incident Management Personnel Professional Qualifications identifies the minimum job performance requirements for personnel performing roles within an all hazard incident management system.

NFPA Standards Related to EMS Currently Available for Comment

- NFPA 1071: Standard for Emergency Vehicle Technician Professional Qualifications is now available for public comment. This standard shall identify and define the minimum job performance requirements (JPRs) for a person to be considered qualified as an emergency

vehicle technician (EVT) and shall apply to personnel who are engaged in the inspection, diagnosis, maintenance, repair, and testing of emergency response vehicles. Comment Closing Date: 9/4/2009

- NFPA 1201: Standard for Providing Emergency Services to the Public contains requirements on the structure and operations of emergency service organizations (ESOs). Comment Closing Date: 3/6/2009
- NFPA 1250: Recommended Practice in Emergency Service Organization Risk Management establishes minimum criteria to develop, implement, or evaluate an emergency service organization risk management program for effective risk identification, control, and financing. Comment Closing Date: 3/6/2009

To download the required comment form, go to http://www.nfpa.org/assets/files/PDF/CodesStandards/NFPACommentForm.doc .

In related news, the comment period for the following standards has expired.

- NFPA 1710 Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments

- NFPA 1720 Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations and Special Operations to the Public by Volunteer Fire Departments

NFPA is expected to distribute the "Report on Comments" for these standards on 2/20/2009 and revised editions will be available in 2010.

V. Public Information and Education

Symposium

After reviewing the 2008 symposium evaluations, some of the members of the planning committee felt that OEMS should address some of the concerns that were mentioned in many of the evaluations. PI&E drafted an e-mail to all registrants that addressed these concerns. The response from the e-mail was very positive.

Planning for the 2009 Symposium is on track. This year marks the 30th anniversary for the symposium and PI&E is working on a media and marketing plan to promote this milestone. PI&E has been working with the Symposium Planning Committee and has started production of the pre-conference brochure. Recent restrictions on printing will affect some of the promotion of the symposium. The pre-conference brochure will not be printed, but will be distributed through the e-mail list serv, through e-mail to past symposium attendees and will be posted on the OEMS Web site.

It is very likely that the printing restrictions will also affect the printing of the symposium catalog. PI&E has been discussing a plan with the OEMS Web designer on a new design for the symposium section of the Web site to ensure ease of use and limit confusion for those who have never registered online before. The catalog will still be produced, and will be posted on the Web site as a printable PDF. Since most people register online now, it is unlikely that it will have a large affect.

Budget restrictions will affect the procurement of promotional items that are normally given away to symposium attendees. This year all promotional items can only be purchased with money that has been donated. PI&E is working closely with previous donors and is trying to cultivate new relationships with organizations that can provide sponsorship.

Governor's Awards

The 2009 recognition calendar were mailed to all EMS agencies and other key EMS stakeholder groups. The regional councils all each received a supply of the calendars to hand out, and requests from individuals for the calendar increased this year.

PI&E produced press releases for the winners of the Governor's EMS Awards. These press releases were regional and were sent to the council to submit to local papers. PI&E also submitted the releases to local papers.

The search for a key note speaker for the banquet continues. PI&E has contacted several people to inquire about availability and cost. Right now there are requests out to Michael Perry, who is a humorist and EMS novelist; Michelle Obama, First Lady and Patch Adams.

PI&E has produced a flier and poster for the Regional Councils to post in their regions to help promote their awards programs. Also, an ad for the symposium and the awards program was submitted to the Virginia Fire Chief's Association Conference publication. PI&E is collecting the deadlines and banquet dates for each council and will post these on the OEMS Web site and new media outlets.

An informational sheet was posted on the OEMS Web site about the awards process and has been sent to all councils to post on their Web sites. This will help take some of the mystery out of how the winners are selected.

One thing that is often mentioned in the symposium evaluations is how people get into the banquet. It is rather chaotic and can be frustrating for those who wait an hour outside the door to get in. PI&E is working with OEMS executive staff to establish a new procedure for admitting people into the banquet hall.

Conference & Event Participations

A schedule of conferences and events has been created by PI&E for 2009. PI&E is working with OEMS staff to ensure that someone will be attending these key conferences and that we will have an informational booth in the vendor areas.

PI&E registered OEMS for the Virginia Fire Chief's Conference. VFCA provided OEMS with the informational booth space for free and PI&E is working with OEMS staff to ensure that it will be staffed. PI&E helped to promote the VFCA conference through the OEMS list serv and through the OEMS new media outlets.

Marketing & Promotion

a. *OEMS Annual report* – The 2008 Annual Report is posted on the OEMS Web site and will be featured in the Winter Bulletin. Each GAB member will receive the report on disc.

b. OEMS New Media – The MySpace and Facebook pages continue to grow and are a popular resource for providers. We receive an average of 30 new friends a week and we receive messages and e-mails through the site requesting information on training, volunteer opportunities, OEMS news and more. PI&E is in the process of starting a Twitter site to help share even more information and reach more people.

c. EMS Bulletin – PI&E has established the editorial schedule for the quarterly EMS Bulletin and is working with program managers to ensure new and interesting articles are included in each edition. The winter bulletin will be posted by mid-February.

d. Rural EMS Summit – PI&E is working with the Technical Assistance Coordinator and staff from the VDH Office of Minority Health on the Rural EMS Summit that will take place in March in Abingdon. PI&E is contacting key groups like the Virginia Municipal League, VAVRS and others to help increase attendance to this important summit. PI&E is also working with the Office of Minority Health on their blog for the summit and promoting it to rural media outlets and the general public. The blog's goals are to get information from people on the positive and negative encounters with EMS in rural areas.

e. EMS Week – PI&E placed the order for the 2009 EMS Week planning kits. These kits are then mailed to all EMS agencies to help them plan their EMS week events and promotion. PI&E is working closely with the National EMS Memorial Bike Ride to help promote the bike ride to EMS providers and to help establish rest stops in Virginia. PI&E will also work to get media coverage of the ride and the Memorial Service.

f. RSAF Grants – Press releases have been drafted and sent to local media about grants that have been awarded to agencies in their media market area. PI&E worked with the Grants Manager and Executive Management to select certain grants to promote through the media releases.

Media Relations

The Office of EMS had answered media inquiries from the Associated Press on convicted criminals and sex offenders becoming EMS providers and what Virginia's Regulations have in place to protect the patient. This article ran and some of the local media in the Richmond area were interested in information for their area. The stories were then dropped and the media outlets only ran a re-cap of the AP article.

The Washington Post contacted the VDH Director of Communications on hospital diversions and tracking hospital closures. The reporter found information on an old system, but the PI&E Coordinator worked with the Northern Virginia Regional Council and the Trauma Coordinator to get the most recent information for the reporter.

The OEMS Communications Coordinator spoke with the Sarasota Herald (Florida) on the Virginia PSAP Accreditation program. The reporter was interested in the Virginia program because Sarasota is looking at modeling a program after ours.

VDH Communications

The PI&E Coordinator worked with local media on coordinating interviews and providing information about the VDH Flu Ex Exercise.

The new VDH Communications Director has requested the PI&E Coordinator to lead a project looking at the VDH Web site. This project will review who comes to the site, what they click on, ways to make it more user friendly and more. The PI&E Coordinator is also lead on the new employee recognition program. This will feature a VDH employee on the Web site each week and discuss how this employee's work is benefiting the community and the state.

The PI&E Coordinator also collects updates and information on OEMS projects and programs to include in the report to the Secretary and the weekly e-mail from the Commissioner.

VI. Regional Coordination and Planning

Regional EMS Councils

During the quarter, the OEMS EMS Systems Planner attended the Board of Directors meetings of the Lord Fairfax and Rappahannock EMS Councils. The Regional EMS Councils are currently submitting their second quarter FY09 deliverables for review and evaluation by OEMS staff. Development of the 2010 Fiscal Year contracts will commence in February.

FLEX Projects

OEMS has again partnered with the Office of Minority Health and Public Health Policy (OMHPHP) on projects to conduct evaluations of the EMS System capabilities in the areas surrounding three Critical Access Hospitals (CAH): Page Memorial Hospital in Luray, Shenandoah Memorial Hospital in Woodstock, and Dickenson Memorial Hospital in Clintwood. Site visits were conducted in both Page County and Shenandoah County this quarter, including visits to both CAH facilities in those counties. The Final Reports for Dickenson, Page, and Shenandoah should be complete by the end of February, with a formal presentation on all six system evaluations performed by OEMS to be made at the Rural EMS Summit in Abingdon on March 11.

Regional Coordination/Process Action Team

As was reported at previous EMS Advisory Board meetings, a Process Action Team (PAT) has been created to evaluate the existing designated regional service areas, and recommend the most effective and efficient arrangement of regional service areas, based on numerous national and state criteria, considerations and attributes.

This PAT is comprised of representatives of the entities that comprise the EMS system in the Commonwealth of Virginia. The charter of the PAT, as well as its membership can be found on the OEMS Web page under “Regional Coordination.”

During the quarter, a PAT meeting, including a facilitated two day retreat was held in Waynesboro on November 20 & 21. The report from the retreat, including the recommendations and action items are included as an attachment to this report. **Please see Appendix D.**

The PAT chair anticipates holding another meeting between the February and May EMS Advisory Board meetings. All PAT meeting minutes are available on the “Regional Coordination” page of the OEMS Website.

Regulations Governing Regional EMS Councils went into effect in January 2008. The regulations require entities seeking designation as a Regional EMS Council to file an application packet no later than October 1 to be considered for designation commencing July 1 of the following year (2009).

In March 2008, after receiving feedback following the first PAT committee meeting and in light of the strong interest expressed by the EMS community during the public hearing held on February 25, 2008,

Karen Remley, MD, MBA, FAAP, State Health Commissioner, decided to delay the process of designating regional EMS.

Dr. Remley issued a variance to the Regulations that has the effect of extending the application deadline from October 1, 2008 to March 1, 2009 as well as extending the current regulatory deadline for designation of Regional EMS Councils from July 1, 2009 to July 1, 2010.

At this time, neither Dr. Remley's variance language, nor the budget bill language have been changed.

Medevac Program

A Medevac system stakeholder Summit, was held in Charlottesville on October 3, 2008. This summit involved a facilitated discussion on the state of the Medevac system, and laid the groundwork for some strategic planning at a meeting that was held on January 9, in Richmond. The meeting identified 4 critical attention areas for the future of the Medevac System in Virginia: Communications, Regulation/Oversight, Safety, and Helicopter Utilization. Subgroups made up of Medevac stakeholders are working on these critical attention areas, and will be utilizing assistance from members of the state Medical Direction Committee as these critical areas are addressed.

OEMS staff continues to follow information and discussion at the Federal level, involving the FAA, NTSB, and NHTSA pertaining to Medevac Operations, Utilization, and Safety.

VII. Regulation and Compliance

Compliance

The EMS Program Representatives have completed several investigations on EMS agencies and individuals during the fourth quarter of 2008. These investigations relate to issues concerning failure to submit quarterly prehospital patient care data, violation of EMS vehicle equipment and supply requirements, failure to secure medications and medication kits, failure to staff the ambulance with minimum personnel and individuals with felony convictions. The following is a summary of the Division's activities:

Enforcement

Citations Issued: 6 Providers: 2 Agencies: 3 for a total of 4

Compliance Cases

New Cases: 12 Cases closed: 5

Suspensions: 7

Revocations: 1

EMS Agency Inspections

Licensed EMS agencies: 702 Permitted Vehicles: 3,940

Recertification: Agencies: 69 Vehicles: 361

New agencies: 5

Spot Inspections: 28

Hearings

Inforal Fact Finding Conference (IFFC): 2 scheduled, 1 cancelled

Variances

Approved: 28 Disapproved: 17 Note: Since 1993 –to-date: Approved: 2, 145
Denied: 628

Mileage

Total: 35,516 miles traveled Average per Program Representative: 4,432

Consolidated Test Sites

Scheduled: 49 Cancelled: 8

Operational Medical Director (OMD)/Physician Course Directors (PCD) Endorsements

Total: 336 Re-Endorsement: 102 (to-date) New: 3
NOTE: 234 OMD/PCD endorsements are scheduled to expire in 2009

EMS Regulations

OEMS staff has submitted the regulatory paperwork necessary for the upcoming Board of Health (BOH) meeting on February 13, 2009 to solicit their approval to move forward with the proposed draft regulations for both 12VAC5-31 and for the Durable Do Not Resuscitate regulations, 12VAC5-66.

Once the above proposed draft regulations are approved by the BOH, public hearings will be scheduled to solicit pubic input on both documents.

Noteworthy Matters

1. On January 9, 2009 EMS Program Representative Andrew Daniel met with Culpeper County Rescue Squad to review the second benchmark in their issued Correction Order. Staff is pleased to announce that there have been many steps to improve the agency's membership through recruitment and retention activities. The organization has exceeded the benchmark established for the second review period for EMS responses and will continue to improve in order to meet the next benchmark as scheduled.

2. OEMS Staff (Training and Compliance) along with Dr. Lindbeck, State EMS Medical Director, continue their work, along with the Virginia Chapter of the College of Emergency Physicians (VACEP) to schedule EMS Medical Director workshops for the remaining OMD/PCD necessary for initial and re-endorsement. To date a course is scheduled on February 9th at the Homestead in Hot Springs, VA in conjunction with the winter conference for VACEP, March 12th in Abingdon in conjunction with the Virginia Rural Health Summit, and additional locations are being scheduled prior to the August 31, 2009 deadline. In addition, the on-line program is in its final stages awaiting final contract review and approval prior to being available for OMD/PCD's use.

Division Work Activity

1. Staff has participated in several local meetings and /or conferences to discuss local issues or provide technical assistance. The Division continually offers to provide seminars and/or open discussion forums with agency or local level departments of councils with regards to the EMS Regulations or other matters related to the Regulation and Compliance Division. Staff joined

the many participants of the annual EMS Symposium not only as participants but also as presenters for several key topics.

2. State Ambulance Contract - OEMS Staff, in conjunction with Department of General Services, Division of Purchases and Supply met with the Transportation Committee to finalize their discussion regarding the state ambulance contract. As a result of this meeting, staff will be developing resources and materials for posting on the OEMS Web site regarding best practices related to ambulance design, safety and procurement. In addition, a list of existing ambulance cooperative contracts in Virginia and across the country as well as a list of vendors will be maintained to help EMS agencies that are will be purchasing a new ambulance. The state Office of EMS will no longer maintain an ambulance contract for use by EMS agencies in VA.

3. Staff (Training and Compliance) is finalizing the work process to provide updated information to the test site coordinators, certification examiners and regional EMS council staff regarding changes in practical testing for basic EMS providers. The target date for implementation is September, 2009.

4. Staff has initiated discussion with the IT staff to begin the development of a single database for all work within the division. Currently field staff utilizes a Lotus Notes database application while the remaining division's within OEMS utilize both Lotus Notes and Oracle databases. Migrating to a single database will greatly assist in information sharing and data management that is reliable and real-time.

VIII. Technical Assistance to Agencies and Localities

Rural EMS Summit

2009 Virginia Rural EMS and Health Summit, March 10 - 13, 2009
Southwest Virginia Higher Education Center
One Partnership Circle
Abingdon, VA 24210

The Virginia Office of EMS in conjunction with the Virginia Department of Health, Office of Minority Health and Public Health Policy (OMHPHP) and the Council for Rural Virginia will hold a Rural Health Summit in Abingdon, VA at the Southwest Virginia Center for Higher Education.

A component or track at this summit will focus on rural EMS issues. One day will be dedicated to offering a budget model workshop to assist EMS agency leaders from rural Virginia establish an annual budget and calculate the value of services they provide to their community (see below for a description of this program). Many volunteers who manage rural EMS agencies have limited experience in the financial and budgeting aspects of public, private or not-for-profit organizations. The Budget Model tool was developed to assist rural EMS agencies, both volunteer and paid, in establishing an annual budget. It also helps calculate the value of services donated to the EMS agency by other entities and the value of donated services provided by the EMS Agency to the community.

This is a unique opportunity for you to attend a rural health summit to learn about the issues facing rural EMS in Virginia as well as being part of the solution. There is no cost for these classes and lunch will be served. Assistance with the cost of lodging and travel is available. Please contact Ms. Carol Morrow, Technical Assistance Coordinator, Virginia Office of EMS at: 804-864-7646 or carol.morrow@vdh.virginia.gov for further information or if you have questions regarding this great opportunity.

EMS Pre-Summit Meeting
Budget Model Workshop
Tuesday, March 10 / 8:00 AM – 5:00 PM

This course will teach students how to develop an operational budget for their EMS agency. Participants will be required to come to the class with a laptop computer with a recent version of MS Excel ™ installed.
They will also be required to complete an informational worksheet for their service that contains information such as the year their vehicles were purchased, mileage on each vehicle, number of emergency and non-emergency transports and other demographic descriptors that they will "plug into" the budget worksheet during the training session. Once the budget it completed, it can be migrated into Intuit QuickBooks ™ to serve as an accounting and budget monitoring tool. There is **NO CHARGE** for this workshop.

IMPORTANT: Students must be familiar with MS Excel and bring a laptop with a recent version of MS Excel.

The Class is limited **24 students**

Register for Budget Model Workshop at **http://www.vaems.org/rhs**

EMS Pre-Summit Meeting
Budget Model Workshop Train the Trainer
Wednesday, March 11 / 8:00 AM – 12 Noon

There will be a Budget Model Workshop Train the Trainer workshop on the morning of March 11, 2009. This class builds on the Budget Model Workshop and includes up to 6 students that are pre-selected.

Pre-requisites: *Must* have attended the full day Budget Model Workshop on March 10 and have a full understanding of material taught; must have a **strong** working knowledge of MS Excel; must be recommended by regional EMS council director. Recommend – train the trainer candidates have a profession that requires budget development. The newly trained trainers will be expected to conduct their first budget model workshop together in peer mentored capacity within 120 days of completion of their training.

Staff from the Rural EMS and Trauma Technical Assistance Center (REMSTTAC), a program of the Critical Illness and Trauma Foundation, will conduct the budget model workshops and teach trainers how to work with local EMS agency officials to use a budget model available free of charge from REMSTTAC (www.remsttac.org). Focus will be on identifying tools and tips that will help trainers be successful with this program.

IMPORTANT: If interested in attending, please contact your local regional EMS council director for more information.
The class is limited to **6 students**.

EMS Pre-Summit Meeting
Rural EMS Roundtable Discussion
Wednesday, March 11 / 12:00 Noon – 5:30 PM

During the afternoon of the second day of the Virginia Rural Health Summit a rural EMS Roundtable discussion will take place to discuss unique issues and challenges faced by rural EMS agencies in Virginia. National studies have found that funding for EMS, access and availability of EMS education and training, medical direction; recruitment and retention of EMS personnel, and EMS management training are some common concerns in rural communities.

An interactive roundtable discussion of these and other items and issues will help identify strategies to develop solutions to address:

- What is the role of EMS?
- Legislative initiatives and policies related to rural EMS issues
- Who is responsible for EMS in rural communities?
- Development of a rural EMS white paper detailing the parameters of rural EMS.
- Recommendations to strengthen existing EMS structures in rural Virginia

Bring your ideas about addressing these issues and don't miss your chance to be heard. **Limited to 75.**

In addition, during this afternoon session information about the Critical Access Hospital (CAH) regional EMS assessments conducted by the Office of EMS around Page Memorial Hospital in Luray, Shenandoah Memorial Hospital in Woodstock, and Dickenson Memorial Hospital in Clintwood will be discussed.

Register for Rural EMS Roundtable Discussion at **http://www.vaems.org/rhs**

Keeping the Best! EMS Workforce Retention Workshops

The Keeping the Best! How to Use EMS Retention Principles workshop was held in early January in Prince William County. The workshop was attended by 15 EMS providers from Prince William, Fairfax and Loudoun counties. The workshop was held at Dale City Volunteer Fire Department.

OEMS is developing a new marketing approach for the Keeping the Best! workbooks and workshops which will consider:

- Lowering the number of hours for each workshop (currently 8 hours)
- Developing a course DVD
- Advertising to Virginia county and municipal EMS coordinators
- Advertising to EMS association officers
- Providing perks for attendance

EMS Workforce Development Committee

EMS Workforce Development Committee

The committee has not met in the last quarter. Mr. Kevin Dillard as requested to step down as Chairman for this committee. Following the appointment and swearing in of new members to the state EMS Advisory Board a new Chairman will be elected.

IX. Trauma and Critical Care

Emergency Medical Informatics

The OEMS Web page has been updated to better reflect the Informatics Program. PPCR, Trauma Registry, and the PPCR upgrade project can now be found at http://www.vdh.virginia.gov/OEMS/Trauma/Informatics.htm

EMS Registry (upgrading PPCR)

OEMS is continuing to make progress in the area of significantly upgrading its current Prehospital Patient Care Reporting (PPCR) program. With the exception of OEMS' focus on ensuring compliance with PPCR submission this upgrade will be the first major change in the PPCR program since it was launched in 2000. The upgrade will include technical and dataset changes that are likely to affect all EMS agencies to some degree. The purpose of the PPCR upgrade is to modernize OEMS PPCR database and to move the entire Commonwealth to the national standards for EMS data collection, frequently referred to as being "NEMSIS" compliant.

On December 19, 2008 a Request For Proposals **(Please see Appendix E)** for a new commercial off the shelf EMS data collection and reporting tool was posted publicly by VDH. Each National EMS Information System (NEMSIS) "Gold Certified" vendor was contacted by telephone, e-mail, and US Postal Service mail notifying them of the posting of the RFP. Additionally, the Request For Proposals (RFP) was posted on Electronic Virginia (eVA) the states procurement agency, the OEMS Web site, and the NEMSIS Web site. It was also sent out via the NEMSIS list serve.

On January 22, 2009 a mandatory pre-bid conference was held at VDH to review the RFP process, as well as the scope of work being requested via the RFP. Approximately 12 EMS software vendors attended the pre-bid conference and attendance was a mandatory requirement to submit a bid. The list of vendors who attended the meeting is not released until an award is made. The RFP will close on February 23, 2009 at 2:00 pm. To view the RFP, those interested can go to the eVA Web site at http://www.eva.virginia.gov/ click on the quick link titled "Solicitations and Awards (VBO)". The solicitation number is 601:217-09-102 and the project name is the "EMS Registry". State procurement policies can also be seen on the eVA Web site.

To begin informing EMS agencies of the upcoming changes OEMS has developed a new Web page dedicated to the EMS Registry project and to providing information as it becomes available (http://www.vdh.virginia.gov/OEMS/Trauma/EMSRegistry.htm). In addition each agency has been notified in writing of the upcoming change, how to prepare for the change, and how to monitor for information related to the transition. In addition, when each agency submits current PPCR data through the OEMS website they receive notification of the pending changes and where to monitor for information.

Each vendor is required to submit an implementation plan and a training plan as part of their proposal. Once an award is made these plans will be further negotiated with the vendor and submitted to Virginia Information Technology Agency (VITA) for approval. Once approved all EMS agencies will be notified of the timeline for implementation and how to receive training as needed.

Major Goals for upgrading the program include:

- Overall upgrade of the technology being used to collect EMS data
- To be the 13th NEMSIS state by
    - Updating our dataset to NHTSA's version 2 (aka NEMSIS compliant)
    - Changing the states technical format requirement to the NEMSIS format
- Provide each agency with the ability to access their own data in the state database
- Provide a means of Performance Improvement (PI) for agencies through the EMS Registry Program

The project planning for the upgrade of PPCR is the first project that the Office of EMS has had to develop under the oversight of the Virginia Information Technology Agency (VITA). As of July 2007 any major information technology (IT) project developed by a state agency is controlled by the VITA Project Management Division. There are multiple items associated with the development of an IT project under VITA which can be found at http://www.vita.virginia.gov/oversight/projects/ .

Virginia Statewide Trauma Registry (VSTR):

Trauma Registry Compliance:
Quarterly audits continue to show the majority of facilities are in compliance with their data submissions. Increased communication with field users, education and sending out reminder notices has resulted in success, but the primary reason for falling into non-compliance remains attributable to staff changes/staff turnover.

Mount Vernon Hospital, which previously had been the only facility not in compliance, has successful submitted data for the past two quarters.

Our pre-audit in January 2009 for the fourth quarter of 2008 disclosed the following facilities have either submitted no data or little data since our last audit:

* HCA Retreat Hospital
Shenandoah Memorial Hospital
Southern VA Regional Medical Center
Mary Immaculate Hospital
Maryview Medical Center
Danville Regional Medical Center
MSHA Smyth County Community
Rappahannock General Hospital
RJ Reynolds Patrick County Hospital
Southampton Memorial Hospital
Tazewell Community Hospital

Follow-up correspondence was sent to remind them to get their data in before our next scheduled official audit which will be conducted on February 15th. To date, only Southampton Memorial has responded back. However, since implementing the practice of a pre-audit with reminder emails, the overall compliance level has increased as many of those found in non-compliance, when notified, are able to get their data in to us before the official audit is conducted.

*HCA Retreat Hospital has been previously notified and will have their non-compliance elevated to the next level.

Pre-hospital Patient Care Reporting (PPCR)

Data Submission

Early in 2008, the Division of Trauma/Critical Care began working extensively with the Division of Regulation and Compliance to focus on increasing compliance with submission of PPCR data. Since those efforts began, data submission percentages continue to go up. Overall, approximately 88% of agencies throughout the Commonwealth are on time with submitting their pre-hospital data. The small percentages that are not up to date are grouped into three categories:

1. Agencies non-compliant between six months-one year
2. Agencies non-compliant between one-two years
3. Agencies non-compliant greater than two years

The chart below is a breakdown of non-compliance by time period. It is important to note that non-compliance is not limited to agencies that have not submitted data. Other common reasons for non-compliance are:

- Not meeting the technical specifications/data file format (usually occurs when a vendor failed to go through the OEMS vendor approval process)
- Gross errors and/or omissions in submitted data
- Abuse of "not applicable" or "unknown"
- Resubmission of duplicate files

Period of non-compliance	**Percentage of non-compliant agencies for 3rd Quarter 2008**	**Change in non-compliant totals from previous quarter**
Between 6 months and 1 year	5%	No Change
1-2 years	5%	1% Decrease
Greater than 2 years	2%	No Change

Below is a list of agencies that fall within the first category and have not submitted data for **two years or more:**

DAVENPORT LIFESAVING CREW INC*****	RADFORD UNIVERSITY EMS
HARDY LIFESAVING & RESCUE	STERLING VOL RS*****
KERR'S CREEK VFD	TOGA FD*****
LEXINGTON LIFE SAVING & 1st Aid	UVA HEALTH SYSTEMS*****
LOUDOUN-FAIRFAX AMBULANCE*****	WALKERS CREEK VFD*****
PURCELLVILLE VFD*****	

* Agency was listed in previously quarterly report as non-compliant

Informatics Projects

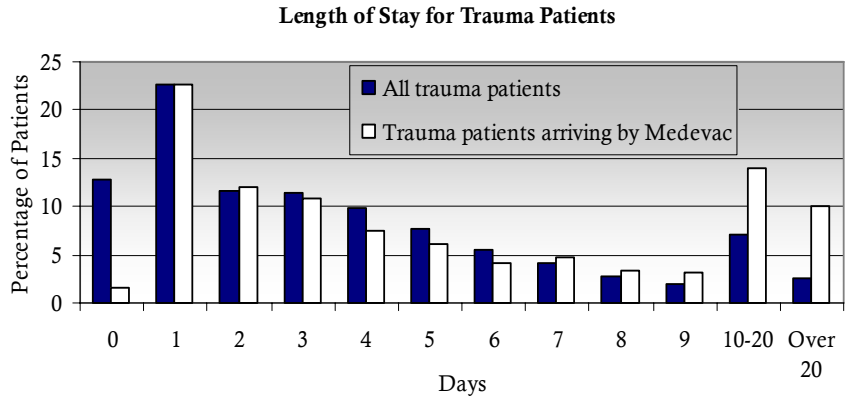
2007 Medevac Utilization

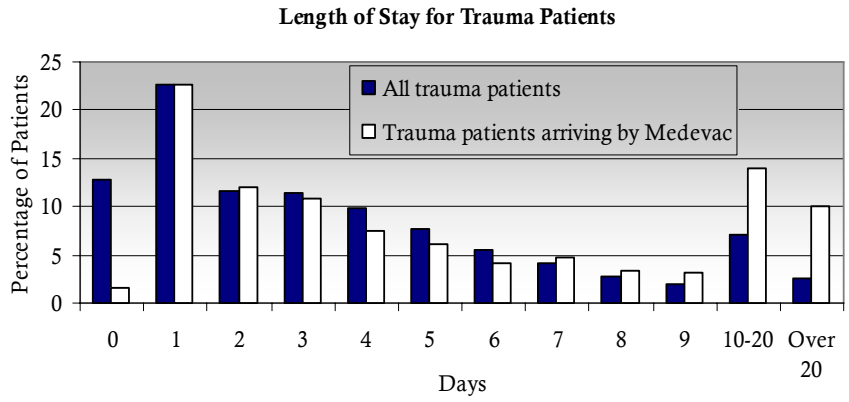
The graphs below include data from the Virginia Statewide Trauma Registry for 2007. . Trauma patients arriving by or transported by Medevac refer to those patients that had a "transport mode" of "helicopter". When referring to the "Level I" trauma centers, this includes data for: VCU, UVA, Inova Fairfax, Norfolk General, and Roanoke Memorial Hospitals.

Length of Stay (in days)				
	Total Frequency	Mean	Median	Mode
All traumas	34,273	4.51	3	1
All traumas "discharged home"	20,336	3.75	2	1
All traumas transported by Medevac	2,208	8.54	4	1
All trauma transported by Medevac and discharged home	1,613	6.17	3	1

Measures of Central Tendency

Mean: The sum of the values divided by the number of values. Also referred to as the "average"
Median: The value which divides the values into two equal halves, with half of the values being lower than the median and half being higher.





The length of stay of a trauma patient can range from 0 days to indefinite. For the purpose of submitting data to the VSTR, patients must have either been admitted to the hospital, transferred to another facility or have died in the ED. Those patients that were treated and released from the ED are not captured in the VSTR.

Trauma System

The last Trauma System Oversight and Management Committee meeting was held on December 4th. The Committee discussed several goals they would like to work on during 2009. The trauma nurse coordinators are planning a second annual retreat where trauma program coordinators and trauma registrars from the 14 centers can collaborate on programmatic issues. Three sub-committees were established to review the current trauma center criteria and add measurable language to criterion as needed, another will be reviewing trauma triage, and another establishing a process to monitor trauma triage on an ongoing basis as required by Code.

Trauma Triage

Trauma Triage was enacted into law in 1999 and at its tenth anniversary the Division of Trauma/Critical Care has reviewed the process and developed recommendations for the future of the program. This review will also influence how OEMS proceeds with our Stroke and STEMI triage programs. **This report is attached as Appendix F.**

Trauma Center Designation

Under the Code of Virginia the State Health Commissioner designate hospitals that choose to apply for designation as a trauma center. Hospitals that choose to be designated as a trauma center commit to continuously providing a higher level injury care than is required by routine hospital licensure. The cornerstones to trauma center designation are to have an organized approach to trauma care 24/7, provide rapid specialty care, have a trauma focused/specific performance improvement program, and trauma specific education. Virginia currently has 14 designated trauma centers that are one of three levels of designation; Level I (highest level), Level II, and Level III. Details on trauma center designation can be found on the OEMS Trauma Program Web page.

The list of hospitals below underwent a trauma center verification site review for the 2008 review cycle. This site review season marks the completion of all trauma centers being reviewed under the newest set of criteria. Also noteworthy, none of these facilities received critical deficiencies which require immediate remediation.

- 8/29 Centra Lynchburg General Hospital
- 10/28 CJW Chippenham Campus
- 11/3 University of Virginia Health Systems
- 11/17 Carilion Roanoke Memorial Hospital
- 11/19 Riverside Regional Medical Center
- 12/12 Sentara Virginia Beach General Hospital
- 1/12/09 Carilion New River Valley Medical Center

Trauma Center Fund

The Virginia Trauma Center Fund distributes funds to Virginia Designated Trauma Centers to offset the costs associated with being designated. The funds are collected from two sources including DMV license reinstatement fees and DUI fines. The Office of EMS is the designee that is charged with developing a distribution model for these funds and providing payment to Virginia designated trauma centers. 100% of the funds collected are passed on to the qualifying hospitals on a quarterly basis. The most recent distribution is shown below:

Trauma Center Level	Percent Distribution	Previous Quarterly Distribution	December 08 FY09	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	10.33%	$250,686.66	$222,285.01	$3,097,306.81
Inova Fairfax Hospital	22.29%	$540,879.65	$479,600.48	$6,655,219.44
Norfolk General Hospital	12.63%	$306,379.58	$271,668.19	$3,605,013.15
UVA Health System	15.20%	$368,794.04	$327,011.38	$3,552,516.30
VCU Health Systems	24.36%	$591,154.13	$524,179.10	$5,647,725.76
II				
Lynchburg General Hospital	3.97%	$96,228.02	$85,325.83	$534,732.88
Riverside Regional Medical Ctr.	3.03%	$73,525.62	$65,195.50	$573,817.02
Winchester Medical Ctr.	4.10%	$99,588.80	$88,305.85	$865,930.15
III				
New River Valley Medical Ctr.	0.31%	$7,544.60	$6,689.84	$67,746.06
CJW Medical Ctr.	0.48%	$11,659.84	$10,338.83	$321,867.91
Montgomery Regional Hospital	0.04%	$960.22	$851.43	$111,860.98
Southside Regional Medical Ctr.	0.47%	$11,545.08	$10,156.39	$147,481.50
Virginia Beach Gen'l Hospital	2.78%	$67,421.34	$59,782.82	$1,119,346.11
Total	99.99%		$2,151,390.65	$26,300,564.07
FY09 Funding Projection		$8,605,562.60		

More information on the Trauma Center Fund can be found on the OEMS Trauma System Web page at: http://www.vdh.virginia.gov/OEMS/Trauma/TraumaSystem.htm

Stroke System

In 2008 the Code of Virginia § 32.1-111.3 the Statewide Emergency Medical Care System was amended to add a statewide pre-hospital and inter-hospital stroke triage plan designed to promote rapid access for stroke patients to organized stroke care. The section of Code language that mandates the designation and use of trauma centers has always included "specialty centers", but until 2008 other specialty centers had not been identified. The designation of certain hospitals as either a trauma center or as a specialty center is to be based on applicable national systems.

When the stroke legislation was first signed into law it was decided that two different areas of the Virginia Department of Health would be involved in the stroke system. The Division of Chronic Disease Prevention and Control, Heart Disease and Stroke Prevention (HDSP) and OEMS are those two areas. HDSP has been assigned to staff and support the Virginia Stroke System Task Force (VSSTF) and OEMS to manage the EMS component. Information on the VSSTF will soon be available on their new Web site at www.virginiastrokesystem.org and a new Web page has been added to the OEMS Web page to pass EMS related information.

The EMS related goals for the VSSTF include dispatch guidelines, transport protocols (stroke triage), EMS assessment tool (i.e. Cincinnati Stroke Scale, 3 hr. window for acute stroke), and standard stroke treatment protocols. The task force has multiple other non-EMS related areas of focus including stroke prevention, early recognition, acute care/hospital clinical pathways, rehabilitation guidelines and more.

What can be expected within the EMS system: OEMS will develop a stroke triage plan and identify those hospitals in the Commonwealth that are designated as a Primary Stroke Center. Virginia stroke designation at this time will be based on certification by the Joint Commission on Accreditation of Hospitals Organization. Other stroke care resources will be identified for those jurisdictions that may not have a designated stroke center within their catchment area. Stroke triage will be focused on "acute strokes" or those with an onset of three hours or less and ensuring these patients reach definitive stroke care within the three hour window. Stroke specific information will be added to the State's PPCR form and collected to monitor the stroke triage process.

Establishing dispatch protocols that promote rapidly entering acute stroke patients into the stroke system is a goal of the VSSTF and the American Stroke Association (ASA). OEMS is beginning to explore how this can best be initiated in Virginia and will begin by communicating this need to the Communications Committee. It is also the goal of these organizations to also establish statewide treatment protocols for acute strokes. The Medical Direction Committee has begun early discussions on developing statewide treatment protocols and OEMS would like to present this goal to MDC for development as one of the initial statewide protocols. The VSSTF is prepared to assist or manage the development of these two goals as needed.

A new OEMS Stroke Systems Web page has been established to allow for posting information related to this program. The Webpage can be found at the following link
http://www.vdh.virginia.gov/OEMS/Trauma/Stroke.htm

STEMI Update

A new effort is underway to establish a STEMI system in Virginia. The American College of Cardiologists and the American Heart Association have spearheaded the formation of the Virginia Heart Attack Coalition (VHAC). Much like the new stroke system VHAC will be working to identify hospitals that provide definitive cardiac care and a system that ensures patients are rapidly entered into a system dedicated to restoring perfusion during a STEMI. VHAC's second meeting date was January 28, 2009 and an update will be included in the next quarterly report. The OEMS participates as a member of VHAC and its steering committee.

Emergency Medical Services for Children (EMSC)

Child Abuse Mandatory Reporting Begins in March

The legislation adding certified EMS personnel as mandatory reporters of suspected child abuse/neglect in Virginia goes into effect March 1, 2009. An EMSAT video on the subject previously aired last August is being provided to all EMS agencies and EMS instructors in the state, along with posters, wallet cards and other supporting information. Hospitals are also receiving posters suitable for display in Emergency Department areas where EMS crews complete their paperwork, and free on-line training for all mandatory reporters is available on the Department of Social Services Web site (http://www.dss.virginia.gov/family/cps/mandated_reporters.cgi). Reports to the Child Abuse Hotline (800-552-7096) made by EMS providers are now being tracked and statistics related to these will be available from DSS at some point in the future. The EMS for Children portion of the OEMS website has additional resources and links to assist instructors and providers in meeting this obligation.

EMSC Committee Facilitates Support of Pediatric Training

The EMSC Committee, in conjunction with OEMS' EMS for Children Program, continues to search for ways to facilitate increased pediatric emergency care training opportunities in the Commonwealth. Federal funding has been requested (through the EMSC Program) to assist in effort by purchasing additional pediatric training equipment, supporting Symposium pediatric education topics, and by sponsoring special courses where participants from all EMS regions will be invited. The EMSC Program will receive word this month as to the outcome of this request.

Hospital Pediatric Assessments Underway

Critical Access Hospitals (CAH) are being visited as part of an overall effort to assess and improve hospital pediatric emergency care capabilities in Virginia. The purpose of these efforts is to assure that proper sizes and types of pediatric emergency equipment are immediately available and to encourage key staff to maintain a reasonable level of specialized pediatric expertise. In addition, the visits are being used to assist in the creation/adoption of written pediatric transport guidelines and agreements that help EDs identify critical pediatric cases that need to be transported quickly to hospitals clinically able to handle those emergencies. These activities are closely aligned with mass casualty planning and hospital surge capacity planning required by various emergency preparedness initiatives, and are in part supported by funding from the Flex-Grant within the Virginia Department of Health.

National Hospital Pediatric Surveys Continue

Virginia, as well as many other states, is working to achieve an 80% compliance rate for hospital pediatric surveys during February. The previous survey attempt captured a 30% compliance rate; hospitals that did not participate during the first round of surveys are being targeted in an effort to reach the 80% rate required to achieve the national EMS for Children performance measure related to this assessment.

Regional Councils Receiving SCOPE Instructor Kits

SCOPE (Special Children's Outreach and Pre-hospital Education) toolkits prepared by Betsy Smith as part of an EMSC Committee initiative have been completed and are now being distributed to all EMS Regional Councils for use by qualified instructors teaching SCOPE. These kits include a variety of specialized teaching aids/resources, and additional resources will be available for download on the EMSC portion of the OEMS Web site.

HRSA Performance Review Final Session

The final meetings concluding the recent in-depth "performance review" process by officials of the Health Resource Services Administration were held January 28th. The EMS for Children (EMSC) program underwent the review to examine major challenges to achieving federal EMSC objectives (performance measures), and to provide constructive feedback and potential additional resources in developing effective strategies for achieving long-term goals. Multiple agencies within the Department of Health collaborated in these final sessions to review the findings and explore ways they could cooperate and assist each other where common missions had been identified for these federally funded projects.

NEDARC Workshop Upcoming

The EMS for Children Coordinator will be attending a special workshop in early May designed to assist state EMSC coordinators in finding effective ways to disseminate findings from the performance measure surveys being used nationwide as part of the Health Resource and Services Administration (HRSA) EMS for Children Program. The workshop is being provided by the National EMS for Children Data Analysis Resource Center.

Virginia Poison Control Network

The Office of EMS serves as the Virginia Poison Control Network (VPCN) contract administrator on behalf of the Virginia Department of Health. The Virginia Poison Control Network is comprised of the Blue Ridge Poison Center at the University of Virginia, the Virginia Poison Center at the Virginia Commonwealth University, and the National Capital Poison Center. Item 297.W of the proposed FY10 state budget proposes that the funded amount to the VPCN be decreased by 66% and that the number of poison centers is cut from three to one. Item W states: "*Out of this appropriation, $1,549,691 the first year and $500,000 the second year from the general fund shall be provided to fund the Poison Control Centers. The Department of Health shall consolidate the services of all three Poison Control Centers into one statewide center by June 30, 2010*".

Durable Do Not Resuscitate (DDNR)

The total number of forms mailed out during 2008 was **95,308,** 10,000 more than 2007.

Legislation has been proposed in the current General Assembly related to the Durable DNR program. Senate Bill 1085 as introduced, will amend § 54.1-2987.1 to state that only the person named on a Durable Do Not Resuscitate (DDNR) order may revoke the order or in the case of a minor the person authorized to consent on the minor's behalf. Additionally, this bill adds healthcare practitioners operating within any facility, program, or organization operated by the Department of Social Services (DSS) to the list of those allowed to follow a DDNR order. These changes will affect EMS providers as well.

Additionally, OEMS is involved in revising the regulations related to the Durable Do Not Resuscitate (DDNR) program. The draft revisions will be presented at the February 13th State Board of Health Meeting and then will enter the second phase of the Notice of Intended Regulatory Action (NOIRA) process. The Virginia Town Hall can be found on-line at http://townhall.virginia.gov/index.cfm this is the official Web site that Virginia Governmental Agencies are required to post proposed regulations, minutes to public meetings, and announce public meetings.

Respectfully Submitted
OEMS Staff

Appendix A

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

VIRGINIA COMPETENCY-BASED EMT ACCREDITATION APPROVAL POLICIES AND PROCEDURES

TABLE OF CONTENTS

Office of Emergency Medical Services
Virginia Department of Health
James Madison Building Suite UB-55
109 Governor Street
Richmond, VA 23219

Telephone number: 804-864-7600
Fax number: 804-864-7580

I. INTRODUCTION

In compliance with 12 VAC 5-31, the Virginia Office of Emergency Medical Services (OEMS) has been delegated the authority by the State Board of Health to develop, implement and administer BLS programs in the Commonwealth.

The Educational Approval and Policies and Procedures set forth in this manual have been developed as an ***alternative*** to current Basic Life Support training polices and procedures. This approval process is ***voluntary*** for all Basic Life Support (BLS) education programs who wish to participate and conduct a competency-based BLS training program for personnel gaining certification as a BLS provider in the Commonwealth of Virginia. The purpose of this alternative approval program for BLS education programs is to ensure quality and consistent minimum standards in the delivery of these education programs on a statewide basis.

In an effort to achieve this, the primary goal established is to ensure that all Virginia BLS education programs meet the standards of quality outlined by the Office in this manual. A secondary goal established is to assist all existing and future BLS education programs conducted in Virginia in meeting the standards detailed in the regulations.

In an effort to best achieve the second goal, this manual has been developed to outline the procedures required to achieve State education program approval. It will assist education program administrators/coordinators in the preparation of information necessary to justify approval.

It is also important for BLS education programs to receive the recognition of their efforts in providing quality education and training for BLS providers in the Commonwealth. Being awarded approval signifies that the education program meets the high standards set forth by peers and EMS professionals across the State.

BLS Programs working under ALS accredited sites should still be able to be accredited for recognition and quality assurance.

Programs that attain BLS Accreditation only and then choose to revert back to the traditional BLS Program format are prohibited from seeking re-accreditation for five (5) years. ALS Accredited programs that add BLS Accreditation may not revert back to the traditional BLS Program.

Failure to maintain or loss of accreditation will require that all programs being conducted under that accreditation be suspended immediately.

Accredited programs must not announce a course that ends after the expiration date of their Accreditation.

II. APPLICATION PROCESS

1. An Application Form shall be provided by OEMS (Attachment A). The Application for BLS Competency-based Education Program Approval shall be completed in its entirety and submitted to the Office of Emergency Medical Services Division of Educational Development by one of the two designated deadlines.
    1. Application Deadlines - Application for BLS Competency-based Education Program Approval shall be received at least six (6) months before the first competency-based course begins.

    2. Programs seeking Accreditation shall not announce, advertise, recruit or promote a competency-based EMT course until a grant of Accreditation has been received from the Office of Emergency Medical Services .

2. The completed Application for BLS Competency-based Education Program Approval with attachments must be submitted to:

    Office of Emergency Medical Services
    Virginia Department of Health
    James Madison Building Suite UB-55
    109 Governor Street
    Richmond, VA 23219

    Attn: Chad Blosser

3. BLS education programs accredited by the Commission on Approval of Allied Health Education Programs (CAAHEP) applying for Virginia approval shall submit the following documents:

    a. A copy of the Site Visit Report submitted to the CoAEMSP by CAAHEAP.

    b. A copy of the letter awarding accreditation from the CoAEMSP must be attached.

    c. Any portion of the Virginia BLS Competency-based Education Program Approval application that is not duplicated in the CAAHEP accreditation process.

4. The completed Application Form for BLS Competency-based Education Program Approval must be accompanied by two (2) attachments.

    A. A cover letter, written on the agency/institution letterhead responsible for conducting/supporting the educational program, must be attached, requesting program approval. The letter must confirm continued support for the BLS Competency-based education program during the five-(5) year approval period.

B. Three (3) copies of the Self Assessment Document shall be attached to the Application for BLS Competency-based Education Program Approval.

5. A letter from OEMS acknowledging receipt of the Application for BLS Competency-based Education Program Approval shall be sent to the requesting agency/institution.

6. Timeline – The process for BLS Accreditation will follow the timeline as listed in the Training Program Administration Manual (TPAM).

7. Existing ALS Accredited Programs – Accredited ALS Programs may apply to the Office of Emergency Medical Services to add BLS Accreditation by completing an application and demonstrate they have the facilities and equipment necessary to conduct successful programs.

III. SELF ASSESSMENT STUDY DOCUMENT

1. The Self Assessment Study Document provides each BLS education program with an opportunity to assess their objectives and degree of compliance with BLS education approval program standards set forth in the Training Programs Administration Manual and 12 VAC 5-31. This evaluation should be comprehensive and clearly identify the program's strengths and limitations.

2. Each BLS education program is expected to complete the Self Assessment Study document accurately and thoroughly.

3. Completion of the Self Assessment Study Document should involve the entire BLS program staff. This is to include but not limited to the program medical director, administrator/coordinator, BLS administrative staff, BLS faculty, EMT students, and others in the health care delivery system involved in the BLS educational program.

4. The Self Assessment Study document and attachments will be reviewed by OEMS and if the program appears to be in compliance with standards, a site visit will be scheduled.

5. The format for the Self Assessment Study is depicted in Attachment B.

    A. Content of Self Assessment Study Document

        1. Begin with an overview of BLS education program to include a brief statement regarding the development of program, target students, and communities of interest served by the BLS providers. Also addressed should be any special considerations impacting program delivery such as financial constraints, availability of clinical facilities, etc. This portion should not exceed two (2) pages in length.

        2. Identify agencies/institutions responsible for the oversight of the BLS education program.

        3. Each BLS education program shall have a written statement of the program's goals, consistent with the sponsoring agency/institution's mission statement and the needs of the community. They shall serve as a guide for developing, implementing, and evaluating the educational program. A copy of the program's goals should be included in the self-assessment study document.

        4. The BLS education program shall have defined the educational goals and competencies for each program delivered [FR or EMT-B]. The goals shall be clearly stated, measurable, and attainable. They shall serve as the foundation for developing, implementing, and evaluating the educational program and shall identify the expected competencies of students completing the program.

        5. BLS education programs are delivered utilizing a variety of schedules to

meet the needs of the student population served and the agency/institution. A copy of the course syllabus for each different program/class i.e. FR and EMT-B shall be attached to the self-assessment study document.

6. Resource availability is a crucial part of any BLS education program. These resources include administrative personnel, financial support, faculty/staff, teaching facilities, and available clinical and field experiences. Medical guidance of the program is an essential component. The Self Assessment Study Document should contain the following information/attachments for the programs resources.

B. Organization of Personnel

1. Attach a copy of the organizational chart that shows the relationship among students, faculty, medical director, program coordinator and other personnel for each course (which shall demonstrate the relationship of the program and it's staff to the sponsoring agency/organization.) The lines of authority, responsibility and communications shall be clearly indicated.

2. Program job titles, all full-time, part-time and volunteer positions, shall be included with a position description of each. The names of individuals holding these job titles shall also be listed.

C. Medical Director

Each program shall have a Medical Director who shall oversee the educational content and field internship experiences of the program. He/She shall ensure the content and the quality meet required standards.

1. Attach the medical director's job description, duties, and responsibilities in his/her role in the BLS education program.

2. Include a copy of the medical director's curriculum vitae

D. Program Director

Each BLS education program shall have a program director to manage the overall aspects of the BLS education program.

1. The program director ensures the success of the educational program. He/She is responsible for the organization, administration, evaluation, continued development and effectiveness of the educational program. He/She is the only person who can announce courses to the Office of EMS for the program.

2. Attach a copy of the program director's curriculum vitae which

substantiates that the individual is certified as an EMT Instructor or ALS Coordinator or EMS Education Coordinator with experience instructing and evaluating EMS students, and experience with administration of educational programs. The director shall demonstrate knowledge of 12 VAC5-31, the Training Program Administration Manual and of the issues currently impacting the prehospital care provider.

E. Instructors

The FR or EMT course shall be taught by an EMS provider who is certified at the EMT level or higher or by a person who is knowledgeable in the subject matter being instructed. The Instructor shall work with the program director in preparation and delivery of the course content.

F. Clinical/Field Coordinator

The Clinical/Field Coordinator may be designated by the program. They are responsible for oversight and coordination of the Clinical/Field Components of the FR and/or EMT course. In smaller programs this function may be met by the program director.

G. Preceptors

Preceptors for clinical and/or field rotations will be designated by the program and approved by the program Medical Director. The preceptor must be certified at or above the level of the certification being sought by the student.

H. Financial Support Sources for Program

Financial support for many of the BLS education programs comes from a variety of sources. These may include but not be limited to the local jurisdiction, volunteer organization, EMS Training Funds (EMSTF) or a combination of the above. Within the application, the BLS education program shall present a budget disclosing expected expenses and the sources of revenue that will support the program.

I. Instructional Facilities

Each program shall maintain facilities adequate for presentation of didactic, skill instruction and practice sessions. Medical sharps and drugs shall be stored in a secured area. A secure record storage area must be used for student and program files. The application shall:

1. Indicate the maximum number of students that can be accepted into the program. If there is a minimum number of students required to conduct the program, that number shall also be included in this section.

2. Describe the classrooms to include location, student capacity, labs, instructional materials, and BLS education equipment utilized in the program. Describe how the skills laboratory is utilized in the curriculum.

J. Students

Students' success in the BLS education programs is dependent upon many factors some of which are not under the students' control. Each

student deserves a fair opportunity to succeed.

1. Describe criteria for student selection.

2. Attach a copy of any information packet provided to students accepted into the BLS education program.

3. Describe any resources available to assist students with problems encountered during the BLS education program. These problems may be related to educational difficulties, skill performance problems, or behavioral problems. If resources are unavailable, explain how these problems are managed.

4. Describe all measures used to promote student progress and success such as tutoring capabilities, remedial training, and self study computer programs, as examples.

5. Describe how the program measures student progress in the course. Include which evaluation tools are used and how they are weighted.

6. Indicate the manner and frequency in which student performance feedback is provided. Include the forms used for student action plans and student counseling.

7. Describe or attach policies and procedures, which define conditions and the process used for dismissal of students from the program;

8. Describe the appeal process students may use to request a review of evaluations or disciplinary actions;

9. Describe how the student records are maintained which ensures their confidentiality.

10. Describe how students are identified in the field internship areas.

11. Describe Americans with Disabilities Act (ADA) policies as they relate to the program.

K. Program evaluation

Each program, in an effort to continuously improve the quality of the BLS education delivered, shall have a written policy and procedure for evaluation of the BLS education program. Evaluation shall be done annually and provide written objective evidence that the program is meeting its objectives and the changing needs of EMS care. Input should be gathered from students as well as faculty members.

1. Attach copies of program evaluation tools used by both student and faculty members to provide feedback about the program.

2. Include a report analyzing the evaluation results data on the effectiveness of:
    a. Program
    b. Resources
    c. Responsiveness to recommendations to change
    d. Faculty
    e. Students ability to function as entry-level providers upon successful completion of the BLS course

3. Describe methods developed to improve weak areas identified and indicate if changes initiated.

L. Satellite BLS education programs provisions

There may be instances where BLS education programs are conducted by approved programs but at a different location and/or for another agency/institution.

1. Parent BLS education program must have received full accreditation.

2. The satellite BLS education program must operate under the parent program's approval.

3. The BLS education program shall be conducted in the same fashion as the parent program.

4. Faculty of the satellite BLS education program must have their credentials on file with the parent BLS education program. Faculty members must meet the same education, experience and preparation requirements.

5. Classroom and lab facilities utilized for didactic and clinical instruction at the satellite program shall meet the same requirements as listed in Section I.

IV. Site Visit

A visit to the BLS education program site shall be conducted, at a mutually convenient time, to observe the BLS education conducted by the program.

A. The time frame for site visit shall be planned for a one (1) day visit. During the site visit, the didactic and field BLS educational sites may be visited and evaluated. The didactic and field preceptors and students may be interviewed.

1. Schedule of site visit- A suggested schedule for activities during the site visit has been developed. If there are valid reasons why the schedule should be changed at the request of the BLS education program or the site visit team, this must be arranged prior to the arrival of the site visit team. This is a very ambitious schedule and the cooperation of the BLS education program and its personnel is essential if the activities are to be completed within the one (1) day time frame. The schedule for the site visit may be determined by the Self Assessment Document.

Suggested schedule may include:

8:00 am

Meet with Program Director and Administrative Staff

- The site visit team members will briefly review the approval process, implication of status assigned, and function of site visit.
- It may be necessary to get additional information on educational philosophies, operational procedures, curriculum content and sequence delivery of the BLS education program

9:00 am

Meet with Medical Director

- The site visit team may need to clarify or assess the level of medical involvement and accountability in all phases of BLS education program.

10:00 am

Meet with Instructors responsible for Didactic Instruction

- The site visit team may need to obtain additional or clarify information on course content, teaching strategies utilized, and testing mechanisms. At this time an exchange of ideas between site visit team and faculty may occur to introduce new ideas/techniques for possible use in improving the program delivery

11:00 am

Meet with Students currently in BLS Education Program

- The site visit team will meet with a representative group of students to assess student reactions to BLS education program, the student's perception of their responsibilities and how their role changes once they complete the certification process.

12:00 - 1:30 pm

Working Lunch

- The site visit team shall review the BLS education program records, student files/records, course records, and testing records. They shall also review the written and practical evaluation tools used to determine students' success or failure in the program.
- A review of how the program maintains all academic records will also be done.

1:30 - 3:30 pm

Visit to Clinical/Field Internship Sites, Interview Clinical/Field Training Preceptors

- Members of the site visit team will want to assess the general quality of the clinical teaching environment, and general resources available in the field internship sites. They will also want to interview some of the faculty providing the supervised practice of students.

4:00 - 4:30 pm

Final Meeting with Program Director

- The members of the site visit team will again meet with the program director to answer any final questions the site visit team may have regarding the program or administration.
- Collect Site Visit Evaluation Form from program representative

4:30 - 5:30 pm

Site Visit Team Meeting

- The members of the site visit team will meet to complete their site visit reports and come to a consensus on the recommendation regarding the accreditation status to be recommended to OEMS. The BLS education program is requested to provide a secure meeting place for the team to meet.

V. Composition of Site Visit Team

The Site Visit Team shall be composed of persons with demonstrated expertise in the areas of BLS education, program administration, and Medical Direction. After a careful review of the Self Assessment Documentation and other information submitted by the program, they shall visit the program to clarify any questions and see the resources utilized by the program.

A. The Site Visit Team shall consist of an OEMS Representative and two (2) additional members represented by any of the following:
    1. A system medical director or a BLS education program medical director;
    2. BLS faculty or program director of an Accredited Program
    3. Others as necessary, designated by the Office of EMS

B. Criteria for site team

Site visit team members must have a working knowledge of BLS education.

1. The Medical Director may be an Operational or a Program Medical Director. The Medical Director for the BLS Educational Program may not serve as a member of the site visit team for a program under his/her supervision. (The Medical Director must have at least 3 years experience as a Medical Director)

2. The BLS program director or faculty member must have a minimum of 2 years experience or equivalent education.

3. The OEMS designated representative must have a minimum of 2 years experience in EMS education/program administration or the equivalent educational preparation.

4. The OEMS representative will be responsible for arranging the site visit.

C. Selection Process for Site Visit Team Members

Site Visit Team members shall be selected from a qualified group of BLS Program Directors or faculty members and Medical Directors. Individuals meeting the minimum requirements interested in serving on the site visit team shall notify OEMS in writing of their interest.

1. Site Visit Team members will be selected by OEMS and subject to their availability from their primary program commitments. Team members shall indicate any potential conflicts with serving on the site visit team to OEMS representative when initially requested to serve.

2. If an applicant can demonstrate in writing a reasonable basis for

concern, OEMS shall consider allegations that conflicts of interest exist between a site reviewer and an applicant.

D. Length of visit at BLS education program

The site visit team plan to spend one (1) day evaluating the program but this may be extended, if necessary, in order to adequately evaluate program resources. This would occur only in unusual circumstances and upon mutual agreement between the host program coordinator and team leader.

E. Personnel interviews to be conducted during site visit

Program Director/Course Coordinators shall arrange for interviews with the following program personnel during the site team visit:

1. Program Director
2. Medical Director/Physician Course Director
3. Current students (suggested minimum of 3)
4. Clinical Coordinator
5. Instructors
6. Others as requested by the review team

F. Review of BLS Education Program Files

Program Directors shall arrange for site visit team to review the following program files:
(An example is available on the OEMS website http://www.vdh.state.va.us/OEMS/Training/ResourceCD/studentfiles.htm)

1. Instructor files
2. Student files
3. Counseling procedures and records
4. Testing procedures utilized
5. Methods of test development
6. Validation procedures used for tests/questions
7. All written and practical exams
8. Test security procedures
9. Attendance records and requirements
10. Clinical Experience Agreements/Contracts

G. BLS Education Program Facilities

Site visit team shall be permitted to see and examine the following program facilities:

1. Classrooms used for presentation of didactic material
2. Sufficient dedicated Program equipment for use only in BLS skills education and practice

3. If dedicated didactic classrooms, all laboratory space for skills instruction and practice
4. Clinical Facilities and/or Field Locations

H. Confidentiality of information gathered during site visit and included in report.

All information collected by persons involved in the approval process shall be maintained with highest confidentiality. All printed materials such as the application, self-assessment document and site visit report will be read only by the site visit team, Program Approval processing staff, Governor's EMS Advisory Board members if necessary, and other authorized persons.

I. Site visit report

During the site visit each team member shall complete a report of his or her findings. These reports shall be completed at the end of the site visit and submitted to the OEMS representative. A consensus Site Review Team Report will be developed with a recommendation in regard to Approval status and submitted to OEMS. A copy of the Site Visit Report Form is attached. (See Attachment: D)

The program director/course coordinator of program being evaluated shall complete an Evaluation of the Site Visit. This shall be submitted to the Site Visit Team leader at the completion of the visit. A copy of the Evaluation Form is attached. (See Attachment: E)

1. Completion Time Frame

2. The final written report of the site team visit will be completed within 30 days of the site visit and submitted to OEMS for approval.

3. Report to BLS Education Program On Approval Status

4. The BLS education program will be officially notified in writing of the OEMS decision regarding Approval Status assignment within two (2) weeks of the decision

VI. Categories of Approval

A. A BLS education program shall be assigned one (1) of the three (3) categories of approval status by OEMS following the application review, site team visit and review of site team visit report.

1. Provisional Accreditation (1-year period). This status is assigned to successful initial applicants and/or when the Application Form for BLS Competency-based Education Program Approval and the site visit report substantiate limitations in meeting criteria which can be resolved within the definite time frame of one (1) year.
    a. The applicant is required to submit a written progress report addressing these limitations to the BLS Education Approval Program Office at the OEMS semiannually.
    b. A second site visit may be required to verify that all limitations are resolved. If a second site visit is required, a revised Self Assessment Study report addressing all criteria including changes made since initial site visit shall be required prior to conducting the visit.
    c. At the end of the one (1) year provisional accreditation period the OEMS may:
        i. Confer Full Accreditation for the remainder of the five (5) year period, if the applicant has satisfied all requirements, or
        ii. A second 1 year Provisional Accreditation or
        iii. deny accreditation or
        iv. revoke accreditation

2. Full Accreditation (5-year period). This status is assigned when the Application Form for BLS Competency-based Education Program Approval has been submitted and site visit report substantiates that the program meets criteria. An annual written report of BLS educational activities and progress shall be submitted to the Office of Emergency Medical Services Division of Educational Development. CAAHEP accredited programs shall also submit an annual report and updated CAAHEP status (if applicable).Denial or Revocation of Accreditation

3. Denial or Revocation of Accreditation. This status is assigned when the Application Form for BLS Competency-based Education Program Approval and the site visit report substantiates that the program/organization is not in compliance with the criteria set forth in 12 VAC 5-31 and the Training Programs Administration Manual. The program shall be notified by mail of the EMS Board's decision.

B. The Office of Emergency Medical Services reserves the right to visit Accredited programs at any time to ensure compliance with the standards for approval.

VII. Appeal Policies and Procedures

A. Appeal Procedure

An applicant program may contest an adverse decision by the OEMS with regard to the approval status assigned.

1. A written notice of appeal must be directed to the Office of Emergency Medical Services Division of Educational Development and submitted within fifteen (15) days after receipt of written notification of the OEMS decision. The request must include reasons and documentation why the original decision should be revisited.
2. The appeal will follow the Virginia's Administrative Process Act.
3. If the written appeal request is not submitted within the specified time frame of fifteen (15) days, the Office of EMS's decision stands as final.

VIII. Annual report

A. Each accredited BLS education program must submit to the Division of Educational Development at the OEMS a report of BLS educational activities conducted during the past year. The report shall be submitted by July 30th of each academic year. It should be submitted in a manner as prescribed by the Office of EMS.

IX. Requirements for Maintaining Approval

All agencies/institutions conducting BLS education programs in Virginia are required to comply with the Office of Emergency Medical Services Regulations and TPAM in order to maintain approval status including the:

A. Adherence to all BLS Program Standards as approved by the Office of Emergency Medical Services.

B. Advising OEMS within fifteen (15) days, of any changes in personnel directly responsible for the administration/coordination of the program such as the Medical Director or Program Coordinator.

C. Advising OEMS within fifteen (15) days, of any organizational or programmatic changes which adversely affect the approved programs ability to meet the established criteria.

D. Maintenance of an ongoing quality improvement process.

E. Conducting a minimum of one (1) BLS competency-based education program every two (2) years.

F. Maintenance of the integrity of the curricula, resources, facilities, finances, equipment and evaluation requirements.

G. Submission of required annual reports about the BLS Competency-based Education Approved Program to the OEMS by the program director on forms provided by the OEMS. Attachment F.

Appendix B

Draft Recommendations of the Virginia Department of Health, Office of EMS, Professional Development Committee, EMS Instructor Credentialing Ad-hoc Sub-Committee.

The EMS Instructor Credentialing Ad-hoc Sub-Committee proposes the following:

1. The current EMT-Instructor and Endorsed ALS Coordinator certification levels be replaced with one, all inclusive certification.
    a. Title: EMS Education Coordinator
    b. Term: 3 years
    c. Effective date: with new regulations
    d. The Office will establish a transition process to move all current EMT Instructors and ALS Coordinators to the new Education Coordinator Certification.
    e. The EMS Education Coordinator certification does not authorize the holder to practice as a Certified EMS provider. Certified EMS Education Coordinators shall maintain current EMS provider certification.

2. Prerequisites for the EMS Education Coordinator shall be:
    a. General
        i. 21 years of age
        ii. High school diploma or equivalent
        iii. 3 years Medical Experience with a minimum of 2 years verified field experience as an EMS provider at the appropriate level, or two years of experience as a RN, PA, MD, or DO and current Virginia Licensure/Certification.
        iv. Have not received enforcement action by the Office of EMS within the previous 5 years.
    b. Pre-testing
        i. Applicants for the EMS Education Coordinator shall successfully complete the pretesting requirements established by the Virginia Office of EMS, Department of Education Development.
            1. Written testing
            2. Practical testing

3. Educational Requirements
    a. All new EMS Education Coordinator candidates must attend and successfully complete the VOEMS approved Instructional Excellence Institute.
    b. Hold and maintain current Certification at or above the Certification level of the course being coordinated.

4. Instructional Excellence Institute
    a. The Virginia EMS Education Coordinator Instructional Excellence Institute shall contain the instructional modules identified by the Office of EMS and meet the current US D.O.T.'s national EMS Educator guidelines.

5. Recertification
    a. The EMS Education Coordinator must complete the following requirements to maintain certification:
        i. Teach 50 hours per certification period in approved courses.
        ii. Maintain current Certification as a provider at or above the Certification level of the courses being coordinated.
        iii. Attend one (1) OEMS Instructor Update every certification period.

Appendix C

Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

CATEGORY		FR	EMT	AEMT	I	P
Analgesics						
	Acetaminophen		X	X	X	X
	Nonsteroidal anti-inflammatory		X	X	X	X
	Opiates and related narcotics			X	X	X
Anesthetics						
	Otic			X	X	X
	General - initiate					X
	General - maintenance				X	X
	Ocular			X	X	X
	Inhaled-self administered		X	X	X	X
	Local			X	X	X
Anticonvulsants				X	X	X
Glucose Altering Agents						
	Glucose Elevating Agents					
	po/pr		X	X	X	X
	inh		X	X	X	X
	iv			X	X	X
	Glucose Lowering Agents				X	X
Antidotes						
	Anticholinergic Antagonists				X	X
	Anticholenesterase Antagonists	X	X	X	X	X
	Benzodiazepine Antagonists					
	Narcotic Antagonists		X	X	X	X
	Nondepolarizing Muscle Relaxant Antagonist					
	Beta/Calcium Channel Blocker Antidote				X	X
	Tricyclic Antidepressant Overdose				X	X
	Cyanide Antidote				X	X
	Cholensterase Reactivator	X	X	X	X	X
Antihistamines & Combinations				X	X	X
Biologicals						
	Immune Serums				X	X
	Vaccines		X	X	X	X
	Antibiotics		X	X	X	X

Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

CATEGORY		FR	EMT	AEMT	I	P
Blood/Blood products						
	Initiate					X
	Maintain				X	X
Blood Modifiers						
	Anticoagulants				X	X
	Antiplatelet Agents		X	X	X	X
	Hemostatic Agents		X	X	X	X
	Thrombolytics					X
Cardiovascular Agents						
	Alpha Adrenergic Blockers				X	X
	Adrenergic Stimulants				X	X
	Antiarrhythmics				X	X
	Beta Adrenergic Blockers				X	X
	Calcium Channel Blockers				X	X
	Diuretics				X	X
	Inotropic Agents				X	X
	Vasodilatory Agents		X	X	X	X
	Vasopressors				X	X
Central Nervous System	Antipsychotic				X	X
Dietary Supplements/Electrolyte	Vitamins					
	Minerals - start at a heath care facility	See section: Intravenous Fluids				
	Salts - start at a heath care facility					
	Electrolytes Solutions - start at a heath care facility					
	Hypertonic Saline				X	X
Gas						
	Oxygen	X	X	X	X	X
	Heliox					X
Gastrointestinal						
	Antacids					
	OTC			X	X	X
	Antidiarrheals		X	X	X	X

Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

CATEGORY		FR	EMT	AEMT	I	P
	Antiemetics		X	X	X	X
	H2 Blockers		X	X	X	X
Hormones	Steroids			X	X	X
Intravenous Fluids	isotonic			X	X	X
	hypotonic			X	X	X
	hypertonic				X	X
	M = Maintenance I = Initiate					
	Normal Saline Solutions (NSS - 0.9%)		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	Lactated Ringers		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	D5 1/2 NSS (0.45%)		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	D5 1/4 NSS (0.25%)		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	D5 1/3 NSS (0.33%)		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	1/2 NSS		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	1/3 NSS		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	1/4 NSS		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
	D5LR		M	I/M	I/M	I/M
	with Multi=vitamins		M	M	M	M
	with Thiamine		M	M	M	M
Neuromuscular Blockers						X
Respiratory	Anticholinergics		X	X	X	X
	Sympathomimetics		X	X	X	X
M = Maintenance						
I = Iniatiate						

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

PROCEDURE	SKILL	EMR	EMT	AEMT	I	P
AIRWAY TECHNIQUES						
Airway Adjuncts						
	Oropharyngeal Airway	X	X	X	X	X
	Nasopharyngeal Airway	✓	X	X	X	X
Airway Maneuvers						
	Head tilt jaw thrust	X	X	X	X	X
	Jaw thrust	X	X	X	X	X
	Chin lift	X	X	X	X	X
	Cricoid Pressure	X	X	X	X	X
	Management of existing Tracheostomy		✓	✓	✓	✓
Alternate Airway Devices						
	Non Visualized Airway Devices		✓	X	X	X
Cricothyrotomy						
	Needle					X
	Surgical					✓
Obstructed Airway Clearance						
	Manual	X	X	X	X	X
	Visualize Upper-airway			X	X	X
	Lower Airway Mechanical					
Intubation						
	Nasotracheal					i
	Orotracheal ? As to age groups				✓	X
	Pharmacological facilitation with paralytic					✓
	Pharmacological facilitation without paralytic					✓
	Confirmation procedures		✓	✓	✓	✓
	Pediatric neonate (up to12 but not yet 12 but size appropriate)					
	Pediatric Orotracheal					✓
	Pediatric paralytics					✓
	Pediatric sedation					✓
** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic						
Oxygen Delivery Systems						
	Nasal Cannula	X	X	X	X	X
	Venturi Mask		X	X	X	X
	Simple Face Mask	X	X	X	X	X
	Partial Rebreather Face Mask		X	X	X	X
	Non-rebreather Face Mask	X	X	X	X	X
	Face Tent		X	X	X	X
	Tracheal Cuff		X	X	X	X
	Oxygen Hood				X	X
	O2 Powered Flow restricted device		X	X	X	X
	Humidification		X	X	X	X

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

PROCEDURE	SKILL	EMR	EMT	AEMT	I	P
Suction						
	Manually Operated	X	X	X	X	X
	Mechanically Operated	X	X	X	X	X
	Pharyngeal	X	X	X	X	X
	Bronchial-Tracheal		✓	X	X	X
	Oral Suctioning	X	X	X	X	X
	Naso-pharyngeal Suctioning		X	X	X	X
	Endotracheal Suctioning		✓	X	X	X
	Meconium Aspiration Neonate with ET					X
Ventilation – assisted / mechanical						
	Mouth to Mask	X	X	X	X	X
	Mouth to Mask with O2	X	X	X	X	X
	Bag-Valve-Mask Adult	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 Adult	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 and reservoir Adult	X	X	X	X	X
	Bag-Valve-Mask Pediatric	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 Pediatric	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 and reservoir Pediatric	X	X	X	X	X
	Bag-Valve-Mask neonate/infant	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 Neonate/Infant	X	X	X	X	X
	Bag-Valve-Mask with supplemental O2 and reservoir Neonate/Infant	X	X	X	X	X
	Noninvasive positive Pressure Vent.		X	X	X	X
	Jet insufflation					✓
	Mechanical Ventilator (Manual/Automated Transport Ventilator)			x	X	X
Anesthesia (Local)					✓	✓
Pain Control & Sedation						
	Self Administered inhaled analgesics		✓	X	X	X
	Pharmacological (non-inhaled)			✓	X	X
Blood and Component Therapy Administration					✓	✓
Diagnostic Procedures						
	Blood chemistry analysis		✓	X	X	X
	Capnography		✓	✓	X	X
	Pulmonary function measurement			✓	✓	✓
	Pulse Oximetry		X	X	X	X
	Ultrasonography					✓
Genital/Urinary						
	Bladder catheterization					
	Foley catheter					✓

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

PROCEDURE	SKILL	EMR	EMT	AEMT	I	P
Head and Neck						
	ICP Monitor					✓
	Control of epistaxis	X	X	X	X	X
	Tooth replacement	✓	✓	✓	✓	✓
Hemodynamic Techniques						
	Arterial catheter maintenance					✓
	Central venous maintenance			✓	✓	X
	Access indwelling port				✓	X
	Intraosseous access & infusion			X	X	X
	Peripheral venous access and maintenance			X	X	X
	Umbilical Catheter Insertion/Management					✓
	Cutdown					✓
	Monitoring Existing IVs		✓	X	X	X
	Mechanical IV Pumps			✓	X	X
Hemodynamic Monitoring						
	ECG acquiring	✓	✓	✓	X	X
	interpretation				✓	X
	Invasive Hemodynamic Monitoring					✓
Obstetrics						
	Delivery of newborn	X	X	X	X	X
Other Techniques						
	Vital Signs	X	X	X	X	X
	Bleeding control					
	Foreign body removal					✓
	Incision/Drainage					✓
	Intravenous therapy			X	X	X
	Medication administration		X	X	X	X
	Orogastric tube		✓	✓	✓	X
	Pericardiocentesis					✓
	Pleural decompression (? Chest tube)				✓	X
	Patient restraint physical		X	X	X	X
	Patient restraint chemical				✓	✓
	Sexual assault victim management		✓	✓	✓	✓
	Trephination of nails					✓
	Wound closure techniques				✓	✓
	Wound management	X	X	X	X	X
	Pressure Bag for High altitude					✓
	Treat and Release (?)		✓	✓	✓	✓
Resuscitation						
	Cardiopulmonary resuscitation (CPR) (all ages	X	X	X	X	X
	Cardiac pacing				X	X
	Defibrillation/Cardioversion	X	X	X	X	X
	Post resuscitative care		✓	✓	✓	✓

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

These are ***educational minimums*** and ***practice maximums***.

PROCEDURE	SKILL	EMR	EMT	AEMT	I	P
Skeletal Procedures						
	Care of the amputated part	?	✓	✓	✓	✓
	Fracture/Dislocation immobilization techniques	X	X	X	X	X
	Fracture/Dislocation reduction techniques					X
	Spine immobilization techniques	X	X	X	X	X
Thoracic						
	Thoracostomy (see above)					✓
Body Substance Isolation / PPE		X	X	X	X	X
Lifting and moving techniques		X	X	X	X	X
Gastro-Intestinal Techniques						
	Management of non-displaced gastrostomy tube					✓
Ophthalmological						
	Morgan Lenses		✓	✓	✓	X
	Corneal Exam with fluorescein				✓	✓
	Ocular irrigation	X	X	X	X	X
X = Part of the NSOP and Education Standards						
✓ = Virginia SOP						

Appendix D

REGIONAL EMS COUNCIL
PROCESS ACTION TEAM
Planning Session

November 20-21, 2008
Best Western Hotel – Waynesboro, VA

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REGIONAL EMS COUNCIL PROCESS ACTION TEAM PLANNING SESSION
November 20-21, 2008
Best Western Hotel – Waynesboro, VA

SESSION GOALS

1. Reaffirm the outcome that the Process Action Team (PAT) is to achieve
2. Agree on behavioral norms for a successful process
3. Develop a summary vision for Virginia's EMS system (most significant future attributes/outcomes)
4. Review elements of the process and identify what participants have learned
5. Resolve fundamental decision points
6. Identify opportunities for improvement
7. Develop specific recommendations and strategies for improvement
8. Identify next steps

BEHAVIORAL NORMS FOR A SUCCESSFUL PROCESS

- Work together for a common solution (not individually)
- Seek stakeholder input
- Have an open mind; be willing to consider all solutions
- Participate
- Work for what is good for the Commonwealth, not individual constituencies
- Recognize that not everyone can be made 100% happy; compromise
- Be nice

Where are We?

Reflecting on all the information that has been presented and discussed, what is the most significant conclusion that you have come to (individually) about what we need to do to achieve the Summary Vision for Virginia's Regional EMS Council system?

Tina: Over the past many months this has been a healthy assessment and we should do that on a fairly regular basis (take a look at our system.) There are areas where each of us can improve and areas where we can share best practices. There also needs to be a move toward more accountability. As a PAT Member looking at the maps, I see that there are more opportunities for collaboration. I'd like to create a system that works more collaboratively to achieve our vision. A lot of us talk about it, but we need to do it.

Donna: We all share the same vision and want the same good care for our patients. Geographic boundaries don't really affect the vision, so making different boundaries shouldn't be part of the vision. There is a perception that there that OEMS is on one side and the regional councils are on the other. It's okay to disagree, but things have gone beyond that. We should be more friendly to each other, be honest, and not do things that others don't know about that are destructive.

Dreama: We have a lot of vision [themes] in which everyone is interested, including patient care, standardization, and others. As a result of this process, were people forced to say that collaboration is needed and will they slide back when the process stops? We need input from localities about what will work best for them. There are a lot of things locally that have to be specialized so we need input on that. I'm leaning toward the council offices becoming state offices because they already have things in place to create a smoother transition toward the things that we want.

Randy: I agree that good things have come out of the process and that we need to do self-evaluations. But the process has gotten kind of broken as we have reduced it from an issue perspective to a personality perspective. The trust factor is hampering this process and may do so in the future. I think that the public/ private partnership has suffered a death knell. When people question your intent behind your back, the system suffers. I would like to think that the system is not failing because we have a lot of good people in it. But we need to be able to do our work objectively and fairly and get to the outcome. I suggested to the PAT Chair that we set up an ethics board so that we can deal with folks who don't stay within the process. The State has a lot to offer, but we get caught up in the minutiae and are not able to do the professional work we need to do.

Rob: In our fact-finding stage, we learned that we have some opportunities for improvement and that consolidation just for consolidation's sake is not what we wanted. The proposed realignment did cause us to come to this process. We learned that it was very difficult to overcome the issue of self-preservation. We now know that we must seize every opportunity that we have to work together, engender trust, and do all this to achieve the vision that we created this morning.

Gary B: We need to put our personal agendas and turf issues aside, focus on the bigger picture, and come to consensus. Everyone will need to give a little bit and not everyone will be 100% happy.

Scott W: Align our shared goals and objectives and make a decision about where we are going. It's hard to have dispassionate discourse around issues that are highly emotional. We need to be mindful in here of every party's perspective without dismissing it because of its emotional content but move forward in consideration of it.

Scott H: We were a system in need of an overhaul. This process has allowed me to shift my mindset and I appreciate the opportunity. We need to talk to each other and not at each other. We need to share information about successful solutions and not worry about the competitive component. We need to put personal feelings aside and make recommendations that will serve our citizens. We need to return to a "boots on the ground" (grass roots) approach and compromise within our regional areas to reach solutions. Personally, I think that merging councils just to reach a number is not a solution. If it works to merge, let's facilitate that process. For councils that are working well, let them continue to do the job that they are doing.

Chris: Our "historian" told us how councils were created and it served the Commonwealth well for a long time, but we now have the opportunity not to live in the past, but to live in the future. We have to focus on the future and be open to potential change that affects our statewide EMS system as long as it enhances the services that we are providing to our citizens. I don't want to see change just for the sake of change. I, too, share concerns that things will slip back to where they were if we don't have some mechanisms in place to keep us going. The change needs to have some deliberate focus so that we don't slip back.

Theresa: I've learned an incredible amount and there are many things that the system does well. We have to work together for the good of the system as a whole. We need to work on the underlying trust issue in order to move forward. This rebuilding of trust needs to be done so that we can all move on – we need to make it a priority.

Jason: I have come to the conclusion that the regional councils are the most influential part of VA's EMS system. They are the gatekeepers and they set the tone. There are some opportunities for consolidation and there are opportunities for collaboration. There also need to be some improvements in fiscal accountability to insure that the councils are delivering the contracted services.

Bruce: We need to create and maintain consistent ongoing collaborative efforts among and between regional councils. Some of the concerns have been expressed are in this trust issue. We have more collaboration since this committee brought the need for it to light and there is fear that it will go away when the process is over. The distrust between government and regional councils may be helped by having a regional representative at the local level to strengthen collaboration and trust. We are in this situation because that's the way we designed the system to enable each council to design its own delivery system. But to achieve statewide standardization, there will have to be a change in how that works. Collaboration will only work so far; after that, we will have to be willing to make changes in this particular structure. Can we streamline things by having a service area served by two regional councils – would that push them toward more collaboration?

Gary C: During the last 9 months, I believe that we have identified lots of good things that are going on across the state, but we have also identified a lot of weaknesses. There are some equity issues and some service issues. There are problems with the contracts. If the deliverables are not being delivered, are we holding people accountable? Are we sharing best practices? There are opportunities for communication, collaboration, and sharing best practices. We need to look at the contract to evaluate it to make sure that what is in it is what we need to get to our summary vision. Whatever is in the vision, that accountability factor needs to be in there. Our grass roots participation is one of the strengths in VA's EMS system in that the providers have had a voice. The OEMS has always tried to include them, but we need to make sure that the grass roots involvement is maintained.

THEMES/CONCLUSIONS REGARDING WHAT WE HAVE LEARNED

1. STRUCTURE - We should not redraw boundaries just to make fewer numbers

2. TRUST - There are significant trust issues that need to be addressed. Need to find a way to tackle it head on so that we can spend our time productively and not waste time that keeps us from focusing on our mission; find a way to rebuild relationships to overcome the trust issue

3. COLLABORATION - Collaboration is the key to the effort. Any model that we find will find upsides and downsides but it is collaboration that enables you to make it work.

4. ACCOUNTABILITY - We have to insure that there is accountability in the system and that it is sustained beyond this process. We are speaking of both programmatic and fiscal accountability.

FUNDAMENTAL DECISIONS

1. Should we go to State regional offices? (Table)

2. Should we redraw the service areas as proposed in Map C? No

3. Based on our collaborations in the proposed regions, are there any "friendly mergers" or changes in regional composition that may be advantageous? (see below)

4. If we are not going to consolidate, what opportunities for improvement need to be pursued in the system to achieve the vision for the Commonwealth's EMS system?

<u>What are we trying to achieve in realigning the service areas</u>?

- As a system, be able to go to Board of Health with a solid proposal that we can all stand behind
- Rise above the issues that have been surfaced in the last year
- Come to a consensus that could move us forward a couple of notches

<u>Why are service areas established</u>?

- The Code requires service areas; they identify entities that are attached to an area that are responsible for the provision of services to the jurisdictions, licensed agencies, constituents
- Service areas should facilitate the achievement of the EMS Summary Vision
- If we designate a broader service area, the providers would feel ownership for both areas and be encouraged to have more commonality in service delivery
- Broader service area would stimulate more opportunities for collaboration
- Enable us to make improvements in the system without losing our identities

<u>Go to Board of Health and ask them to make changes in the service areas as follows:</u>

1. SWVAEMS
2. NVEMS
3. PEMS
4. TEMS
5. ODEMSA
6. BREMS AND WVEMS
7. FEDERATION

Factors that may help us with our recommendations:

- Recognize that service areas may have multiple regional council contracts within them
- Moving from 8 services areas to 6 or 7 would show due diligence
- Representation on the Governor's Advisory Board would not change
- Include language in the Designation Manual that requires collaboration and accountability for it
- OEMS can temporarily waive the sections of the Designation Manual to facilitate this structure
- In addition, show Board of Health what we are going to do to improve the system in addition to changes in the service areas
- Make sure that we have the flexibility to incorporate neighboring localities where these discussions have taken place and where the councils wish to do so
- The service contracts need to be fixed – hold feet to fire regarding accomplishment of deliverables

REGIONAL EMS COUNCIL WORKING SUMMARY VISION FOR 2020

Note: This document, which is taken from the tag card grouping done by the PAT on 11-20-08, should be considered a draft document only. Should the PAT decide to use it in the future, further discussion and clear consensus on the Summary Vision is recommended.

We provide the highest level of quality in patient care to every citizen in the Commonwealth of Virginia as based on the best available evidence that is periodically reviewed and updated with continuous assessment and evaluation of outcomes and impact.

We do this as a system by our commitment to the achievement of the following outcomes:

1. TRUST: We have a regional system based on trust in which there is frank, honest and earnest discussion that is inclusive, representative of the system, and focused on our common goals for the Commonwealth.

2. SHARED VISION AND VALUES: We operate as a system of professionals with shared vision and values and philosophies. We are highly focused on the provision of effective, efficient, collaborative, and well-organized services at the regional and state level.

3. DATA DRIVEN PERFORMANCE IMPROVEMENT: We use research, science, and accurate data to constantly improve our performance and to assess patient outcome.

4. STANDARDIZATION OF CARE: We have a unified system of statewide protocols and are committed to doing things the same way to the degree that is appropriate so that patients receive a high quality standard of care. Our focus on high quality EMS education and training produces superbly trained EMS personnel.

5. SOUND BUSINESS MODEL: Our regional councils use a common, sustainable, and effective business model while routinely seeking efficiencies and applying current business practices.

6. EFFICIENT RESOURCE MANAGEMENT: The statewide EMS system has adequate well-trained personnel resources to deliver appropriate pre-hospital care based on measured standards and supported by sufficient equipment and supplies.

SMALL GROUP BRAINSTORM ON CHANGES TO ACHIEVE SUMMARY VISION

What are the specific changes that we need to make in the EMS system to achieve our Summary Vision?

TRUST

- Improve communications, relationships, involvement, disclosure, respect
- Expectations of system and its components clearly articulated
- Accountability and measurable outcomes
- Requisite support and resources to deliver those expectations
- Mechanism or forum for empowerment of system to contribute and shape expectations
- Trust is built by being tested (individual accountability)
- Vertical/horizontal open information exchange
- EMS community regain control of/establish balance with hospitals and other stakeholders
- Make sure shared information is accurate and well founded when presented/discussed outside of the EMS community
- Philosophy of "our system"
- Seek input/buy in from local government bodies (city councils, BOS, town councils); legislation to strengthen, then seek to ensure continuous delivery of EMS

PHILOSOPHY AND VALUES

- Develop a system of voluntary standards
- People have the ability to shape the objectives/the work being done (leave the "how to do it" to the people)
- All need to agree on shared objectives/vision
- Buy in; commitment to support collective decisions
- Commitment to openness
- Contract language – clear, accurate, measurable
- More assertiveness from OEMS – enforcement
- Science based decisions

SHARED VISION AND VALUES

- Promote buy in
- Need to hear voices of those who aren't in agreement
- Build consent; need to have good process
- Need more involvement (OMOS, providers, localities, other health care partners)
- Reaffirm a single voice (AD Board)
- Closer AB/BBOH relationship
- Engage all OMDs with vision (move toward statewide protocols, drug boxes, etc.)
- Engage AB with vision; engage regional council boards
- Use state EMS plan to implement elements of shared vision

CONSCIOUS AND DELIBERATE PRACTICE

- Develop and maintain plans that are used and studies
- True education and buy in on plans and practices
- Promote more awareness
- Make it easier for system to understand plans and practices
- Consumer/patient feedback and input

STANDARDIZATION OF CARE

- Protocols (drug box, stemi, uniform supply (hospital) exchange program
- Practice privilege
- Enforcement of regulations
- Base contracts with councils with meaningful relevant deliverables
- Regional RSAF grant review process (all levels)
- Develop a mechanism to review and score available evidence and accommodate emerging and evolving data
- Establish a process to create guidelines, voluntary standards and formulary
- Provide incentives and rewards for meeting voluntary standards and following guidelines and formulary
- Provide a mechanism for integrating innovation and evolution of clinical standards
- Review regional plans/contracts (crafted to shared vision)
- Work with Commissioner to establish direct lines between OEMS and public safety departments
- Continue aggressive pursuit of statewide, web-based PPCR collection and analysis system (linked to hospital data to determine outcome)

SOUND BUSINESS MODEL

- Electronic data system implementation
- Leadership qualification to include business knowledge, skills, and abilities
- Coordinated employee benefits
- Training of Council staff and leadership in fiscal management, HR management, topic areas best practice sharing/education, and mentoring
- Exploration of how to formulate consistent local government support (funding) process
- Greater consistency in stakeholder representation and local boards
- Develop a mechanism to evaluate current practices and to identify opportunities to improve efficiency and effectiveness
- Promote multilateral communication and contribution regarding the evaluation of current practices and efforts to improve efficiency and effectiveness
- Develop measurable and demonstrable outcome measures to validate any changes made in above and re-evaluate, refine, and redirect periodically

RESOURCE MANAGEMENT

- Overall RSAF process
- Workforce retention – demonstrated evidence of success
- Improve recruitment and retention of career and volunteer providers
- Review state guidelines of resources (equipment) needed to deliver effective and efficient care – make sure quantities of equipment support needs
- Develop method to identify and define strategies to resolve barriers or impediments to effective resourcing of all levels/parties
- Develop method to prioritize resource needs and communicate that method and process; communicate priorities and anticipated time frames

PROVIDERS

- Feedback
- Facilitate buy in from providers
- Education
- Retention

- Safety

ACTION PLANS

Small groups developed preliminary plans to address the outcomes in the EMS Summary Vision to include the following steps:

1. *Refine outcome statement*
2. *Develop objectives (major components of addressing the outcome; each would require an action plan)*
3. *Develop a list of possible key tasks and activities (not too detailed, no target dates)*
4. *Focus on an actionable plan that uses your best strategic thinking*

The plans will need more discussion and input from stakeholders in the system. The preliminary plans also have a direct relationship to the EMS Plan and could be aligned with these plans to enhance success.

TRUST

Outcome: We have a regional system based on trust in which there is a frank, honest, and earnest discussion that is inclusive, representative, and focused on our common goals for the Commonwealth

1. Improve Communication: Provide a platform for clear, accurate, and concise information sharing and improved communications

    - Conduct 7 Town Forums in each of the service areas annually
    - Continue to utilize information technology to improve timely communication with the system through the regional councils and OEMS
    - Develop agency e-mail list serve for every licensed agency
    - Develop a rumor control mechanism at the regional level for providers, agencies, and others
    - Develop a more formal mechanism to exchange information (OMES, Fire Programs, VDEM, regional councils)
    - Encourage information to be taken to the lowest level of agencies, organizations

2. Effective Relationships: Develop and maintain effective relationships among all EMS stakeholder groups
    - Regional Councils evaluate board make-up to ensure inclusiveness from within each system
    - Develop a mechanism or forum for the empowerment of the system so that it can contribute and shape expectations to achieve buy in
    - Establish clear expectations
    - No surprises

SHARED VISION AND VALUES

Outcome: We operate as a system of professionals with shared vision and values and philosophies. We are highly focused on the provision of effective, efficient, collaborative, and well-organized servies at the regional and state level.

1. Reaffirm the Governor's EMS Advisory Board as the unified voice to articulate shared vision and values of the system
    - Ensure the EMS Advisory Board is representative of all stakeholders
    - Engage all OMDs in process to develop to develop shared vision
    - Utilize the EMS plan to implement the elements of the shared vision
    - Support the legislative efforts in securing a dedicated EMS seat on the Board of Health

STANDARDIZATION OF CARE

Outcome: We have a unified system of statewide protocols and are committed to doing things the same way to the degree that is appropriate so that patients receive a high quality standard of care. Our focus on high quality EMS education and training produces superbly trained EMS personnel.

1. Implement statewide protocols
    - Review literature
    - Define standards
    - Authoring education leading to implementation
    - Assess impact (S/P/O)
    - Periodic programmed review and revision
    - Establish a functional means to accommodate innovation

2. Implement standardization of practice privileges
    - Evidence-based scope of practice
    - Where evidence is sparse, generate study to define

3. Standardize contracts
    - Define the desired standard to ensure measurable, defined deliverables tied to discrete outcomes
    - Pursue performance-based funding ("at risk funding")

DATA DRIVEN PERFORMANCE IMPROVEMENT

Outcome: We use research, science, and accurate data to constantly improve our performance and to assess patient outcome.

1. Develop data driven performance improvement approach
    - Reliable and sound data collection
        - Collected, collated, transparent, and accessible so as to allow independent analysis
        - Analyzed and reported
        - Accountability for submission requirement
    - Linked to hospital data (and other sources)
    - Adjusting strategies based on performance data
    - Evaluate performance based on data

SOUND BUSINESS MODEL

Outcome: Our regional councils use common, sustainable, and effective business model while routinely seeking efficiencies and applying current business practices.

1. Secure adequate funding for all regional councils
    - Identify revenue sources (state, local, federal, private, etc.)
    - Prepare and prioritize program budget
    - Periodically review expenditures to ensure budget compliance
    - Re-evaluate results and adjust

2. Establish, maintain, and refine compliant fiscal management policies
    - Offer annual audit compliance updates
    - Conduct annual review of regional contracts for compliance

- Maintain competent business support staff

EFFICIENT RESOURCE MANAGEMENT

Outcome: The statewide EMS system has adequate well-trained personnel resources to deliver appropriate pre-hospital care based on measured standards and supported by sufficient equipment and supplies.

1. Recruit and retain an adequate number of trained personnel
    - Develop, implement, and maintain
        - Training programs
        - Recruitment strategies
        - Retention strategies
        - Marketing strategies
        - Mentoring strategies

2. Acquire and maintain sufficient equipment and supplies
    - Identify and obtain equipment
    - Educate providers and agencies on the effective use of RSAF to purchase equpment
    - Foster more effective use of equipment

OBSERVATIONS ABOUT OUR ROLE AND NEXT STEPS

- We need to work on this more to develop a high quality approach
- We have the issue of buy in to address
- We have an obligation to bring people on board because of our leadership role
- The work we have done is closely related to the State EMS Plan and needs to be aligned. The State Advisory Board should use an integrated plan to make decisions. The Plan has been removed from the Code to make it more adaptive.

Next Steps	Who/When
1. Clarify/interpret the language in the Designation Manual to insure that more than one council can serve a service area (insure that that language does not exist in more than one area of the manual)	Tim, Dave C, Tina, and PAT Chair by 12/31/08
2. Develop a FACT sheet on the PAT's work and recommendations to include roster that summarizes the process, proposal, and the agreement. Clarify that PAT members fully participated and a public comment period allowed for others to provide additional information. Send to the PAT Members for review and comment before distribution.	PAT Chair, PAT Vice Chair, Tim, Dave C.
3. Each PAT member will make a report to the group that they represent using the FACT sheet. The group commits to utilizing the final approved FACT sheet as the primary method of communication to avoid confusion and misinformation.	
4. A small group will meet with Delegate Abbott to tell him that there has been agreement to the 7 service areas and ask him to remove the budget bill language.	Donna, PAT Chair, Jason
5. The 7 service areas that we have agreed upon will be presented to the EMS Advisory Board for adoption so that the proposal can go forward to the Commissioner.	2/13/09
6. Commissioner Remley and the Chair of the EMS Advisory Board will present the results of the PAT process to the Board of Health.	
7. OEMS will implement the designation process and send out the package, including the clarification regarding the ability of more than one council to serve within one service area. The Regional Councils will apply for designation.	
8. If councils submit their packages by March 1, 2009, regional contracts will be awarded by a date to be identified by OEMS (after conferring with legal counsel). The group would prefer July 2010 to enable improvements in the contract.	
9. The Chair will work with OEMS and other stakeholders to define an ongoing structure for implementation of the Summary Vision and other PAT/EMS issues.	
10. The PAT process will continue to develop the EMS Summary Vision and its strategies, including the use of teams (new or existing) to bring in more stakeholder input and potentially including the use of technology.	Quarterly?

Appendix E

REQUEST FOR PROPOSALS (RFP)

Issue Date: December 18, 2008 **RFP #**: 601:517-09-102

Title: Emergency Medical Services Registry

Commodity Code: 92000

Issuing Agency: Virginia Department of Health
Office of Emergency Medical Services
109 Governor Street, Room UB-55
Richmond, VA 23219

Period Of Contract: From Upon award of the contract through 3 years (negotiable). (Renewable)

Sealed Proposals, for furnishing the services specified herein, must be received by the Virginia Department of Health, Office of Purchasing and General Services (OPGS) located at Room 1214, 12th Floor, 109 Governor St., Richmond, VA 23219 not later than **2:00** p.m., on **February 23, 2009**. To be considered, all proposals must be received at this address on or before the date and hour stipulated. Offerors should pay particular attention to ensure that their proposals are properly addressed. The state is not responsible for proposals that do not reach the specific destination by the appointed time. Proposals received after the date and hour designated are automatically disqualified and will not be considered. The official time used in the receipt of responses is that time on the automatic time stamp machine in the Office of Purchasing and General Services.

The response may be sent via U.S. mail to the post office box address listed above provided that it is submitted in adequate time to allow for delivery to the specific office location, Suite 1214, Attention: Connie Hall, James Madison Building, 109 Governor Street, Richmond, Virginia 23219. Offerors are responsible for assuring timely receipt of the proposal at the specific office location and should make allowance for the possibility of an untoward event.

The safest way to insure that the proposal is delivered on time, especially if it is submitted within the last seven (7) days prior to the due date, is to deliver it in person. The alternative is to use a commercial delivery service such as FedEx or UPS, or the U.S. Post Office Express Mail Service. If any of these services are used, send the proposal to the following address:

VIRGINIA DEPARTMENT OF HEALTH
JAMES MADISON BUILDING, SUITE 1214
ATTENTION: CONNIE HALL
109 GOVERNOR STREET
RICHMOND, VA 23219

Note: This Public Body does not discriminate against faith-based organizations in accordance with the Code of Virginia, Section 2.2-4310A or against a bidder or offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

All inquiries for program specific information should be submitted in writing to: Paul Sharpe, Office of Emergency Medical Services, email – Paul.Sharpe@vdh.virginia.gov. Questions are due by **5:00 p.m. (EST)** on **January 9, 2009**. Questions received after that date may not be answered. Answer will be given via an addendum posted at the same location as the original RFP. All other inquiries should be directed to, Connie L. Hall, Office of Purchasing and General Services, who may be reached at (804) 864-7539.

In order for proposals to be considered, this cover page and pricing must be submitted to the Agency.
In Compliance With This Request For Proposals And To All The Conditions Imposed Herein And Hereby Incorporated By Reference, The Undersigned Offers And Agrees to Furnish The Goods/Services in accordance with the attached signed proposal or as mutually agreed upon by subsequent negotiations.

A mandatory pre-proposal conference will be held at **10:00 a.m. (EST)** on **January 22, 2008**. NO ONE WILL BE ADMITTED AFTER 10:00 a.m. Interested parties are requested to notify Ms. Wanda Street by Noon the day before, of their intention to participate at (804) 864-7643, email- wanda.street@vdh.virginia.gov.

Name And Address Of Firm:

_____ Date: _____

_____ By: _____
(Signature in Ink)

_____ Name: _____

Telephone Number: _____ Title: _____

Fed ID Number_____ e-mail Address: _____

TABLE OF CONTENTS FOR RFP# 601:517-08-106

I. PURPOSE:

The purpose of this Request for Proposal (RFP) is to solicit sealed proposals to establish a contract through competitive negotiation for the purchase of an Emergency Medical Services Registry by the Virginia Department of Health, Office of Emergency Medical Services (OEMS), an agency of the Commonwealth of Virginia.

This solution shall be based upon open internet standards, and will be used throughout the Commonwealth of Virginia for collection of pre-hospital data via a secure web-based portal.

This solution should be for use by the Virginia Department of Health (VDH), Office of Emergency Medical Services (OEMS) (as defined by § 2.2-4301 and referenced by § 2.2-4304 of the Code of Virginia). All potential suppliers should be aware that the VDH may need to conduct a security background check on any or all personnel involved in the implementation of this project.

As part of the VDH's on-going commitment to evaluate and improve processes and service delivery methods, the Agency is looking to the supplier community for quality and best-of-practice solutions. The goal of this initiative is to obtain current and relevant EMS data to assist the VDH in achieving its long-term planning goals.

Once the proposal data have been received and evaluated by the OEMS evaluation team, the team will be in the position to determine the best course of action. Although it is the intent of the VDH to accomplish substantial service improvements and cost efficiencies as the result of this project, the VDH may determine that no change is warranted at this time. While it is the objective of this project to select one prime solution provider, at the VDH's sole discretion, the Agency may decide to make one award, multiple awards, or none at all.

The scope included in the Office of Emergency Medical Services - EMSR is listed below:

EMSR Activity:

Application Software	Reporting capabilities
Application Implementation	Implementation and training

It is not necessary for a single supplier to be able to provide all requested services. Alliances between suppliers are acceptable. However, the VDH is interested in simplifying the process and having a single point of interface where possible.

Section III, sets forth the actual service/solution requirements in detail. Should the VDH decide to request proposals for additional areas of service, a separate RFP will be issued at a later date.

This RFP represents the best effort of the VDH to document the requirements for the OEMS-EMSR. The VDH reserves the right to adjust the specifications or scope of effort stated in this RFP. In the event that any modifications become necessary, writing by means of an amendment to this RFP will be posted on eVA.

II. BACKGROUND:

A. Overview

The VDH is dedicated to protecting and promoting the health of Virginians. The VDH is made up of a statewide central office located in the City of Richmond and 35 local health districts throughout the Commonwealth. These entities work together to promote healthy lifestyle choices that can combat chronic disease, to educate the public about emergency preparedness and threats to their health, and to track disease outbreaks in Virginia.

The OEMS is one of four offices under the Department Emergency Preparedness and Response (EP&R) within the VDH. The mission of the OEMS is 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.

The OEMS, as the designee of the VDH, is responsible under §32.1-116.1 of the *Code of Virginia* (*COV*) to establish and maintain an emergency medical services patient care information system. Under this section of the *COV* all Virginia Licensed EMS agencies are required to submit a minimum dataset. The *COV* mandates the data set include, but not be limited to, the nature of EMS call, response time, clinical assessment and treatment provided by the EMS response team. There are approximately one million submissions per year in the Commonwealth of Virginia.

In the interest of improving the quality of patient care and system development, the OEMS has signed a Memorandum of Agreement (MOA) with the National Emergency Medical Services Information System (NEMSIS) project. The NEMSIS project is an effort to establish a National EMS database that will contain data from local and State agencies from across the nation. The national database is being established as a means to improve patient care and EMS curriculum while defining metrics to measure the success of care provided. To ensure the success of the NEMSIS project, NEMSIS is funded by Federal Agencies such as the National Highway Traffic Safety Administration (NHTSA), the Health Resources Services Administration (HRSA), and the CDC (Centers for Disease Control and Prevention). In addition, many other federal agencies have given their support to the NEMSIS project.

B. Background

The Virginia EMS system is a very large and complex system of independent organizations, that includes a wide variety of EMS agencies and personnel, including volunteer and career providers functioning in volunteer rescue squads, municipal fire departments, commercial ambulance services, hospitals, and a number of other settings to enable the EMS community to provide the highest quality emergency medical care possible to those in need.

The OEMS states its mission as follows: 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 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.

In fulfilling that mission, the VDH, OEMS is responsible for collecting pre-hospital patient care data on EMS incidents within the Commonwealth of Virginia. The pre-hospital patient care data is essential for statewide planning and coordination to assure the availability of quality emergency medical care across the Commonwealth and to provide a more coordinated response in large scale or mass casualty events requiring resources from a large number of EMS agencies and personnel. The OEMS uses the pre-hospital patient care data to evaluate current processes and techniques to ensure a high level of care for the Commonwealth.

Pre-hospital patient care data is currently collected in the Commonwealth of Virginia using the Pre-hospital Patient Care Reporting System (PPCR). In its eight years the PPCR system has evolved into a database with disparate tables of information that are not amenable to cross-system querying. As a result, the PPCR program has become insufficient in meeting the long-term goals of the OEMS.

The PPCR system has been identified not only internally as not meeting the long-term vision of the VDH, but also by two separate Joint Legislative Audit and Review Commissions (JLARC) reports. In addition, the current system does not account for most of the data requirements as set forth in the NHTSA data standard.

In achieving the long-term vision and goals of the VDH, the OEMS has identified a need for a more robust and Web based application that will provide all Virginia certified EMS personnel, agencies, and hospitals with the systems functionality listed in this RFP document.

C. Present Situation

The VDH has been granted approval from the Virginia Information Technology Agency (VITA) to begin project development for the procurement of a statewide, web-based data collection tool that will modernize the technology used to collect EMS data and encourage the use of electronic medical record technology (electronic patient care reporting or ePCR) and decrease the dependency on the current paper based system.

A goal of the proposed EMS Registry by moving to a web based data collection tool is to enable submissions to be entered directly into the database decreasing the time that data is available for analysis. Decreasing the period that data is available will allow for active surveillance and improved evidence based decision making. The EMS Registry will have an open scalable architecture and support standards, which are key to streamlined processing and data exchange. The EMS Registry will further provide a secure method of collecting pre-hospital data, extracting existing data, and exporting or sharing data for strategic planning and process improvement initiatives. By upgrading the technology used by utilizing a web based program will provide higher quality data collection. While upgrading the technology used with this database, the OEMS will upgrade the dataset to the most recent NHTSA EMS dataset and create a more patient care focused dataset compared to the past response oriented dataset.

III. STATEMENT OF NEEDS:

A. Overview

In this RFP, the OEMS has identified requirements for a commercial off-the-shelf pre-hospital patient care data system.

The contractor shall provide all software, labor, supervision, tools, materials, training, and incidentals necessary to implement all mandatory items required in this RFP. The system shall be hosted on hardware managed by the Virginia Information Technology Agency (VITA) and it is mandatory to meet VITA's requirements.

Offerors must identify how they will meet each of the following requirements. Proposals should use the columns beside the requirement to respond to each item. Should a requirement consist of several sections (for example, 27(a), (b), (c), etc.), the response should address each of the sections in the requirement. As such, the boxes may be expanded as necessary. If an item is covered elsewhere, an appropriate cross-reference should be included. It is intended that full responses be included in the box beside the requirement, but if this is not possible, and an attachment is necessary, the text box must reference the attachment.

The acceptable codes for Column A are as follows:

Y - "Yes" - You can fully meet the requirement as documented with your current application or proposed solution. Include documentation showing how you will fulfill the requirement, including any alliances with other suppliers. Indicate in Column B a cross-reference to the appropriate section or attachment of your proposal.

F - "Yes, Future" - You will be able to fully meet this requirement in the near (not longer than twelve months) future. Provide a proposed start date, completion date, and any additional costs associated with the development of the requirement. Cross-reference any attached documentation in Column B.

N - "No" - You cannot meet the requirement and you have no firm plans within twelve months to be in the position to meet this need.

Note: A blank or NA in any box in column A will be interpreted by the VDH as an "N" response.

In a few instances, we have posed some open-ended questions in situations where the answer will not be a yes or no. Please provide a cross reference in Column B to allow the VDH to properly evaluate your proposal. The VDH requests that all cross referenced attachments to the proposal follow the order of requirements.

Any requirement marked with an **M** is a mandatory item **– the lack or omission of any of the Mandatory requirements will cause the proposal to be regarded as non-responsive.** For any requirement marked with an (M), for must have, the only acceptable response in column A is "Y". Responses of "N" or "F" will result in your proposal being excluded from consideration.

A. Mandatory Requirements

The Mandatory requirements / evaluation criteria are essential to have in order to be eligible to bid on this RFP. All responses of **YES** will require verification during the evaluation process.

The Statement of Needs section outlines the actual solution requirements of the different modules the OEMS is considering. Response in this section should reflect the contractor's ability to provide a basic set of criteria to establish a functional statewide pre-hospital patient care data reporting system. The data system must have the ability to collect and use the data for the purpose of evaluating and improving Virginia's EMS System.

Understanding the rapidly growing technology involved in the delivery of EMS, the system shall have certain "modules" available to discourage the need for disparate systems and allow for further growth of the EMS data collection system and for use by EMS agencies that have technology needs above, the basic State provided system used for data collection. Additional modules shall be made available at each agency's request and expense as it suits the needs of their organization. The contractor will have modules on the resultant State contract as requested by OEMS to allow agencies to receive the other products at pre negotiated rates. A state contract will be posted on the Electronic Virginia (eVA) Procurement Website. The contractor must be a registered vendor with eVA at the time of contract award (refer to section III, V).

Also, understanding the vast amount of technology used in the delivery of EMS, the contractor shall demonstrate and make the program capable of accommodating other (commercial or homegrown) systems already invested in by EMS agencies in Virginia. The contractor will provide an interface to be used for the collection of flat files from other programs. There should be no additional cost for receiving data from other software programs provided they meet the current NHTSA XML and XSD requirements. Mapping information should be available at no cost for use by other programs to create their own export tool to submit to the Virginia EMS database. Offeror costs should include for the contractor to provide an export tool for other programs wishing to submit to the Virginia EMS database.

This section is to establish what is minimally expected by the contractor as to functional features that are desired by the OEMS. These requirements are provided to give the contractor a sense of what the OEMS requirements are. It is by no means to be construed as a complete requirements statement, nor does it relieve the contractor from conducting an open and comprehensive requirements analysis.

Mandatory Evaluation Criteria		**Column A**	**Column B**
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
A	The solution offered must have achieved and maintain a status of NEMSIS Gold Compliance. **(M)**		
B	The solution offered will be capable of being provided as: a fully hosted solution, using dedicated lines, dedicated hardware, a fully in-house (Commonwealth internal network) solution or any combination of these solutions. Describe how your solution meets this requirement.		
C	The system must be an off-the-shelf product that uniquely integrates all of the underlying functionality to minimize developments and customization considerations. **(M)**		
	The solution offered must be a web based data collection, analysis, and reporting tool accessible by multiple levels of users based on assigned role codes. **(M)**		

D	The solution must have the ability for its owners to access data by ODBC, canned reports, and ad-hoc reports. The canned reports feature should be able to be updated, at a minimum, by the OEMS. **(M)**		
E	Users (EMS agencies) will have independent access to their own data.		
F	The offeror will have as a component an electronic patient care reporting (ePCR) program that OEMS can freely distribute to Virginia licensed EMS agencies as they choose move to ePCR.		
G	The offeror must provide technical support for its data collection, analysis and reporting tool Monday – Friday 8:00 a.m.. – 5:00 p.m. EST, excluding federal/state holidays. **(M)** 24/7 support for ePCR users is preferred.		
H	An implementation plan must be provided for installation, testing and implementation. **(M)**		
I	A training plan must be provided describing in detail how users will be trained on any application provided by the Offeror on a statewide basis **(M)**		
J	To ensure cost efficiency of ownership and connectivity throughout the State of Virginia, and to minimize the risk of potential failure due to the network's configuration, the system will not be based on proprietary technology. Does your solution meet this requirement?		
K	Supplier accepts the statutorily mandated provisions at the following URL, including the contractual claims provision number 5 Payment (§2.2-4363 of the Code of Virginia): http://www.vita.virginia.gov/uploadedFiles/SCM/StatutorilyMandatedTsandCs.pdf **(M)**		
L	The awarded vendor's system and its network requirements must be able to conform to the following Commonwealth of Virginia Security Policies, Standards, and Procedures, and Federal HHS HIPAA Security Requirements: **(M)**		
	i. Commonwealth of Virginia - Information Technology Security Standard (COV ITRM Standard SEC2001-01.1) VDH SEC IT Security Policy VDH SEC Firewall and VPN Policy VDH SEC Security and Architectural Review Policy 45 CFR Department of Health and Human Services **(M)**		
	ii. Commonwealth of Virginia policies may be found on the VITA web site, http://www.vita.virginia.gov **(M)**		

B. Business Requirements

The Business Requirements include meeting the Commonwealth of Virginia's Information Technology and Standards and the overall vision of the OEMS. Included in the business requirements is the conversion of legacy data. The OEMS estimates that there are approximately 4 million records that need to be mapped and converted to the most current NHTSA approved dataset. Currently, the OEMS is collecting pre-hospital patient care data using version 1 of the NHTSA dataset.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Business Requirements			
1	Supplier accepts the statutorily mandated provisions at the following URL, including the contractual claims provision number 5 Payment (§2.2-4363 of the Code of Virginia): http://www.vita.virginia.gov/uploadedFiles/SCM/StatutorilyMandatedTsandCs.pdf **(M)**		
2	The system must be an off-the-shelf product that uniquely integrates all of the underlying functionality to minimize development and customization considerations. **(M)**		
3	The awarded contractor must provide a list, to include point of contact information of experiences deploying an application to a similar size and type of system. **(M)** Experience deploying an application for a governmental entity is preferred.		
4	To ensure cost efficiency of ownership and connectivity throughout the State of Virginia, and to minimize the risk of potential failure due to the network's configuration, the system must not be based on proprietary technology. **(M)**		
5	The contractor will implement, and turn over to the OEMS, a fully functional Pre-hospital collection and reporting system in accordance with the provisions and requirements set forth in this and subsequent documents. The contractor will ensure that by the turnover phase of the contract, the Pre-hospital data collection and reporting system will meet all functional and performance standards established by the OEMS.		
6	The applications (State reporting application and ePCR application) must be easily and inexpensively deployable to all Virginia Licensed EMS agencies through a bulk licensing agreement.		
7	The contractor must provide a minimum of one (1) year warranty after acceptance of final software application, and be willing to correct problems in a timely manner that is acceptable to OEMS, with unmodified code/components at no cost to the OEMS. **(M)**		
8	Authorized Users must be able to perform self maintenance to keep their profile up to date. **(M)**		
9	Maintenance support should include new versions, upgrades, security updates, and patches that are issued during the term of the contract. **(M)**		

10	Define present and future training costs associated with maintenance of the internet-based application.		
11	Provide examples of the User Manuals for administrators and end users. **(M)**		
12	Provide examples of the documentation for technical systems		
13	Provide examples of on screen help. **(M)**		
14	Training materials should include both general overview on concepts, and detailed hands on exercises.		
15	Vendor is responsible for the legacy data conversion of the existing Virginia EMS database, which is "based" on the National Highway Traffic Safety Administration (NHTSA) version 1 to the most current version of the NHTSA / NEMSIS dataset (Approx 4 million records).		

C. Change Management Requirements

Implementation Plan - the OEMS is looking to the Offeror to provide a Virginia EMS system specific detailed implementation plan for their solution as part of the response to this RFP. The plan needs to provide a timeline and implementation method that is both achievable and realistic in implementing the solution within the Virginia EMS system. The plan must include all aspects of implementing a statewide EMS data collection tool to a "go live" status to include, but not be limited to infrastructure requirements (e.g., hardware, applications, operating software, network), database establishment, distribution of software/access, roll out, communication of change management, etc. The plan must identify what resources are to be provided by the supplier and what resources will be required by the OEMS (work breakdown structure). Supplier costs for implementation should be included in the financial information included in this RFP.

Training Plan - although one of the primary requirements of this application is that it must be user friendly and easily navigated by non-technical users, there may still be some training requirements for both the end-user community and the OEMS staff. It will be the responsibility of the contractor to develop a **comprehensive training program** that will be presented and turned over to the OEMS staff. At a minimum, the training program shall have a visual presentation and written component free to be duplicated and distributed by the OEMS for those who will then train the statewide EMS community. As stated earlier in this document easy-to-use help tools are expected to be part of the design and development of the application. The plan must identify what resources are to be provided by the supplier and what resources will be required by the OEMS. Supplier costs for implementation should be included in the financial information included in this RFP.

Project Documentation – the Offeror will provide complete project documentation (flow diagrams, charts, word documents etc.) for the project life cycle in current UML standards.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Change Management Requirements			
16	The offeror must provide an implementation plan that includes how the application will be installed, testing and implementation on both the database level and by end users statewide. The implementation plan will detail what the scope of work for implementation for the offeror and the OEMS. **(M)**		
17	The implementation plan must include a work breakdown structure (WBS) for installation, testing, and implementation. **(M)**		
18	The offeror must provide a training plan detailing how education will be provided to the statewide users. The training plan will detail what the WBS will be for the offeror and the OEMS to train all levels of users. **(M)**		
19	The portion of the training program proposed that becomes the Offerors responsibility must consider the ongoing training needs of the system to include new users, training for upgrades, users that are assigned new roles, etc. **(M)**		

D. System Requirements

The following system requirements are recommended / mandatory for the optimal use and performance of the system.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
System Requirements			
20	The application must be a data collection tool capable of collecting and analyzing an EMS dataset. The application at minimum must allow for users to enter data via a Web based desktop system, and/or utilize electronic patient care reporting technology. **(M)**		
21	The solution offered must have achieved and maintain throughout the life of the contract, unless otherwise agreed upon in writing, NEMSIS Gold Compliance status. NEMSIS Gold Compliance is defined as providing the most current NHTSA EMS dataset, XML schema and XSDs. **(M)**		
22	The application must use the most current		

	Version of the NHTSA Dataset and its specific definitions/variables. **(M)**		
23	The application must use the most current Version of the NHTSA XSD standard to send and receive data. **(M)**		
24	The application must include the entire NEMSIS NHTSA data set. **(M)**		
25	The application must be able to utilize the entire NHTSA / NEMSIS XML structure. **(M)**		
26	The contractor will provide a fully functional administration tool for the application that allows the OEMS to manage/maintain the application for the statewide EMS community. **(M)**		
27	The administration tool must include the capability to activate/inactivate each of the fields that will be used in the application. **(M)**		
28	The administration tool must include the capability to modify the dataset above/beyond the NEMSIS dataset without compromising NEMSIS compliance. **(M)**		
29	The application must support additional user definable data elements as seen necessary by the OEMS or EMS agencies (user ID, password, CardCode, etc.). **(M)**		
30	Has an integrated method to ensure data submitted by an EMS agency is valid (i.e. is tested against the NHTSA/NEMSIS standard at the user interface level).		
31	The application will utilize probabilistic back-end data linkages to prevent the duplication of pre-hospital EMS data by multiple agencies (NOTE: A patient ID is not a suitable key for this application).		
32	The application will provide multiple logic checks and edits on data fields to ensure data integrity.		
33	Can be accessed by any authorized user via the Internet. Should be able to be accessed by average EMS users. **(M)**		
34	Operates efficiently with all levels and types of Internet connections from dial up to broadband. **(M)**		
35	The application must be compatible with MS Windows 2000 and later / XP / Vista server/operating systems. **(M)**		
36	The application should be scalable and have a standard that can be expanded to		

	encompass future data systems.		
37	The contractor will provide a web-based user interface/application, it must meet the following requirements: **(M including subsections)**		
	I. It must be compatible with multiple web browsers, including but not limited to, MS Internet Explorer, Netscape Navigator, AOL, Opera, yahoo, Mozilla, Firefox, among other mainstream browsers. **(M)**		
	II. It must be capable of providing128-bit SSL encryption, **(M)**		
	III. it must be built on current J2EE standards, **(M)**		
	IV. 90% of the back-end processes and validations must be handled by the server, **(M)**		
	V. GUI pages will contain minimal JavaScript. **(M)**		
38	The application must be able to handle multiple users at one time with no record locking. Offerors should document their ability to manage Virginia's volume across various internet access speeds as they would want to be noted in the final contract. The offeror should also state what hardware requirements it has to achieve this and other objectives. **(M)**		
39	It is the intention of the OEMS to serve this application on a SQL server(s).		
40	The application must provide multiple levels of user access based on login. **(M)**		
41	The application must have the ability to import and export data from other data collection systems if those applications utilize the most recent NHTSA EMS XML and XSD's. **(M including sub-sections)**		
	I. The offeror must provide at no additional cost the ability to receive and load data into the database with the same level of quality checks from other data collection applications as this application offers. (invalid or incomplete data should be prevented from entering the state database), **(M)**		
	II. The offeror is only required to receive data that also meets the technical format prescribed by the current NHTSA EMS database XML and XSD's, **(M)**		
	III. The offeror must make available the technical information needed for other programs to be able to "map" their data		

	to the state database (i.e. CSV to XML etc.), **(M)**		
	IV. The offeror must make available the service and cost of performing mapping for other programs. **(M)**		
42	The program must be optimized to allow for fast screen re-draws. Offerors will document their ability to manage Virginia's volume across various internet access speeds as they would want to be noted in the final contract. **(M)**		
43	The application must have the ability to quickly, easily, and securely send data to a central EMS database for collection and reporting in a real time capacity. **(M)**		
44	The application will provide a user friendly and easily navigated Graphical User Interface.		
45	Maintenance, new versions, upgrades, security updates, and patches must be easily deployable and preferably via an internet interface. **(M)**		

E. Security Requirements

The awarded system and its network requirements must be able to conform to the Commonwealth of Virginia Security Policies, Standards, and Procedures, as well as, Federal HHS HIPAA Security Requirements.

VITA Security Requirements

The supplier agrees to comply with all provisions of the then-current Commonwealth of Virginia security procedures, published by the Virginia Information Technologies Agency (VITA) and which may be found at (http://www.vita.virginia.gov/library/default.aspx?id=537#securityPSGs) or a successor URL(s), as are pertinent to the supplier's operation. The supplier further agrees to comply with all provisions of the relevant Authorized User's then-current security procedures as are pertinent to the supplier's operation and which have been supplied to the supplier by such Authorized User. The supplier shall also comply with all applicable federal, state and local laws and regulations. For any individual Authorized User location, security procedures may include but not be limited to: background checks, records verification, photographing, and fingerprinting of the supplier's employees or agents. The supplier may, at any time, be required to execute and complete, for each individual the supplier employee or agent, additional forms which may include non-disclosure agreements to be signed by the supplier's employees or agents acknowledging that all Authorized User information with which such employees and agents come into contact while at the Authorized User site is confidential and proprietary. *Any unauthorized release of proprietary information by the supplier or an employee or agent of the supplier shall constitute a breach of this Contract.*

Federal Health and Human Services / HIPAA Security Requirements

Suppliers also agree to comply with all provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services

("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

Further detail on the HIPAA security requirements and for other additional helpful information about how it applies, can be found at http://www.hhs.gov/ocr/hipaa.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Security Requirements			
46	Commonwealth of Virginia - Information Technology Security Standard (COV ITRM Standard SEC2001-01.1) VDH SEC IT Security Policy VDH SEC Firewall and VPN Policy VDH SEC Security and Architectural Review Policy 45 CFR Department of Health and Human Services. **(M)**		
47	Does the solution offered provide for multiple security levels, which can be allocated to users to allow or deny access to different portions of the system capabilities (i.e. recipient only, able to send alerts, able to manage other users, system administration, etc.)? **(M)**		
48	Does the solution also affect how a recipient's substitute gains access (or not) to data?		
49	The application must provide complete audit trail information. **(M)**		
50	The awarded system and its network requirements must be able to conform to the following Commonwealth of Virginia Security Policies, Standards, and Procedures, and Federal HHS HIPAA Security Requirements. **(M)**		
51	Meets or exceeds all applicable standards for privacy and security including, but not limited to HIPAA. System must be HIPAA compliant in both privacy rules and accepted data formats. Must also include procedures for safeguarding the system from unauthorized modification to the application programs and the data contained in the		

	application. **(M)**		

F. Support Requirements

In addition, the offeror needs to outline their support and maintenance plan identifying the resources provided by the offeror and the resources to be provided by VDH/OEMS, in addition to meeting the below requirements.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Support Requirements			
52	An on-line help "user's guide" should be implemented with the system(s).		
53	The offeror must provide technical support for its data collection, analysis and reporting tool Monday – Friday 8:00 a.m. – 5:00 p.m. EST, excluding federal/state holidays. **(M)** 24/7 support for ePCR users is preferred		
54	Support for non-ePCR users should be available at minimum during regular business hours (Virginia time zone). **(M)**		
55	Support should be offered via multi forms of communication to include:		
	I. Toll free telephone line,		
	II. E-mail,		
	III. Live on-line support,		
	IV. On-line knowledge base support.		
56	The application must provide easy to use help tools/dictionary with a key word search capability (wild card searches are not considered user friendly).		

G. Reporting and Operational Features:

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Reporting and Operational Requirements			
57	Contains an integrated method of communication between system administrators and end users within Virginia. **(M)**		
58	Does the system log a non-received message in the real time records management system as unable to pass the message data to the substitute? **(M)**		
59	Does the solution provide for references or a "knowledge base"?		
60	The application must be able to quickly, easily, and securely access and appropriately display previously stored data from the central EMS database in a real-time capacity. **(M)**		
61	The Web-based application will provide a relational database connectivity that will allow for robust analysis of data including predetermined reports, but also allow for detailed statistical analysis and querying of data for future or novel areas of interest which would support EMS in improving the delivery of pre-hospital care, improved funding, or resources allocation:		
	I. Basic data transactions and queries that can be handled by most relational database management systems (RDBMS),		
	II. Multidimensional queries for data analysis and complex reporting over multiyear periods.		
62	Allows for dynamic and customized analysis without additional programming (flexibility in analysis).		
63	The application contains a data mining tool for the administrative level users.		
64	Allow approved users to generate statistical information from the aggregate EMS data, through an Internet-based query tool. The OEMS shall be able to determine user levels for this query tool without the need for additional programming.		

65	Does the solution provide for both canned reports as well as ad hoc reporting?		
66	The application must have a performance improvement (PI) component capable of being used at the individual agency level and must include the ability to: **(M)**		
	I. Customize QA/PI projects,		
	II. Review patient documentation,		
	III. Perform call reviews,		
	IV. Multi-level user levels specific to PI (i.e. peer review, agency leadership, and medical director),		
	V. Have the ability to document and report PI within the component.		
67	Does the system allow real time, on screen monitoring of all details of an ongoing call out?		
68	The system should provide a selection of multiple standard reports during a call out or at the end of a call out that is automatically faxed, emailed or printed at regular intervals such as, but not limited to:		
	I. Overview of current call out by groups and individuals,		
	II. Details of current call out by groups and individual,		
	III. Summary of individuals who have not responded.		
69	Does the system allow for data to be exported to an outside analysis tool (.i.e. SPSS, SAS, Access, Excel) via an ODBC or similar connection? If so, what tools? **(M)**		
70	Does the system allow for both canned and ad hoc reports at both the agency level and a statewide level based on log-in access?		
71	Does the system allow for the development of new canned reports in-house without having to contact the vendor?		
72	Does the system have the ability to create and alter tables and views in the reporting database?		
73	Does the proposed system have the ability to operate on both production servers and querying servers in order to minimize server slow down during peak usage times?		
74	The system should allow for multiple methods of incident reporting within the same incident. Such as point and click, pull down menus and narratives.		

75	ePCR package must be able to be hosted on multiple mobile devices including but not limited to laptops and notebooks. **(M)**		
76	Does your ePCR package provide anatomical diagrams for incident tracking and reporting?		
77	ePCR/ability to have a paperless patient care reporting program:		
	I. An ePCR module should have the ability to submit data to the state database directly,		
	II. Contains an integrated method of communication between system administrators and end users within Virginia,		
	III. The application will be easily navigated, such that a certified paramedic can complete a Patient Care Report, including Advanced Life Support documentation, within a twenty (20) - minute time limit.		
78	ePCR package will include touch screen technology, handwriting recognition, and signature feature.		
79	ePCR package will have a GUI that individual agencies at a minimum can customize/modify/configure to allow the program to follow the natural progression of EMS incidents or business logic for their agency.		
80	The offeror must have a solution that provides patient care documentation to be provided to the receiving hospital at the time of transfer of care. Details of how this will be accomplished with the application being offered and any requirements that the state will be required to put into place to achieve this objective. **(M)**		
81	Agencies that choose to use the ePCR component should have the ability to reproduce single reports as they would with stored paper PCR's. **(M)**		
82	ePCR component must include an interface for electronic medical equipment such as cardiac monitors, automated external defibrillators etc. **(M)**		

H. Modules / Components available for purchase by EMS Agencies

The contractor's demonstrated ability to understand the rapidly growing evolution in the delivery of EMS is very important in the procurement process. The contractor's solution shall have certain "modules" available to allow for further growth of the EMS data collection system. These modules will be available for use by EMS agencies that have needs greater than the base State system that makes up the statewide data collection system. These additional modules shall be made available at the request and expense of the EMS agencies based on their organization's needs.

The OEMS intends to expand its data collection system to assist in other options such as patient tracking, knowledge base, hospital interface, census tracking, certification tracking, geo mapping and the ability to communicate with remote users.

Evaluation Criteria		Column A	Column B
No.	**Must Have (M) Criteria**	**Can you provide: Yes, No , Future**	**Comments or Reference**
Modules Available for Purchase by EMS Agencies			
83	Emergency Management component that includes: **(M)**		
	I. Patient tracking on-scene, during transportation and at facility.		
	II. Include the ability to customize facilities to allow for tracking outside hospitals,		
	III. Document care rendered including customizable treatments that may be added to respond to the event i.e. inoculations,		
	IV. MCI management,		
	V. Deployed wirelessly.		
84	Certification tracking. **(M)**		
85	Independent hospital status package that includes the ability to monitor multi level diversion status (full, cardiac, OB, etc.) **(M)**		
86	Component capable of meeting the needs of EMS agencies that charge a fee for service (billing) in-house or using a third party vendor. **(M)**		
87	There should be a component available to agencies that utilize ePCR to have the ability to accept data from CAD system into a run report.		
88	A component for agencies that choose to utilize GPS and/or GIS technology with ePCR. **(M)**		
89	Module capable of monitoring inventory based on data input into state database or e-PCR module.		
90	Module capable of managing vehicle maintenance.		

IV. PROPOSAL PREPARATION AND SUBMISSION INSTRUCTIONS:

A. GENERAL INSTRUCTIONS: This section is used to inform the potential Offerors of how many copies of the proposal must be submitted, how the proposal is to be prepared, the possibility of oral presentations by the Offerors, etc. To reduce administrative burden and costs, request enough copies so that each evaluator is provided a copy.

1. RFP Response: In order to be considered for selection, Offerors must submit a complete response to this RFP. One (1) original hard copy with signatures and ten (10) copies of each proposal must be submitted to the issuing agency. No other distribution of the proposal shall be made by the offeror.

2. Proposal Preparation:

a. Proposals shall be signed by an authorized representative of the offeror. All information requested should be submitted. Failure to submit all information requested may result in the purchasing agency requiring prompt submission of missing information and/or giving a lowered evaluation of the proposal. Proposals which are substantially incomplete or lack key information may be rejected by the purchasing agency. Mandatory requirements are those required by law or regulation or are such that they cannot be waived and are not subject to negotiation.

b. Proposals should be prepared simply and economically, providing a straightforward, concise description of capabilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

c. Proposals should be organized in the order in which the requirements are presented in the RFP. All pages of the proposal should be numbered. Each paragraph in the proposal should reference the paragraph number of the corresponding section of the RFP. It is also helpful to cite the paragraph number, sub-letter, and repeat the text of the requirement as it appears in the RFP. If a response covers more than one page, the paragraph number and sub-letter should be repeated at the top of the next page. The proposal should contain a table of contents which cross-references the RFP requirements. Information which the offeror desires to present that does not fall within any of the requirements of the RFP should be inserted at an appropriate place or be attached at the end of the proposal and designated as additional material. Proposals that are not organized in this manner risk elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed.

d. As used in this RFP, the terms "must", "shall", "should" and “may” identify the criticality of requirements. "Must" and "shall" identify requirements whose absence will have a major negative impact on the suitability of the proposed solution. Items labeled as "should" or “may” are highly desirable, although their absence will not have a large impact and would be useful, but are not necessary. Depending on the overall response to the RFP, some individual "must" and "shall" items may not be fully satisfied, but it is the intent to satisfy most, if not all, "must" and "shall" requirements. The inability of an Offeror to satisfy a "must" or "shall" requirement does not automatically remove that Offeror from consideration; however, it may seriously affect the overall rating of the Offerors’ proposal.

e. Each copy of the proposal should be bound or contained in a single volume where practical. All documentation submitted with the proposal should be contained in that single volume.

f. Ownership of all data, materials, and documentation originated and prepared for the State pursuant to the RFP shall belong exclusively to the State and be subject to public inspection in accordance with the *Virginia Freedom of Information Act*. Trade secrets or proprietary information submitted by an offeror shall not be subject to public disclosure under the *Virginia Freedom of Information Act*; however, the offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other

material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable and will result in rejection of the proposal.

3. Oral Presentation: Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the agency. This provides an opportunity for the offeror to clarify or elaborate on the proposal. This is a fact finding and explanation session only and does not include negotiation. The issuing agency will schedule the time and location of these presentations. Oral presentations are an option of the purchasing agency and may or may not be conducted.

B. **SPECIFIC PROPOSAL INSTRUCTIONS**: "Proposals should be as thorough and detailed as possible so that the Virginia Department of Health, Office of Emergency Medical Services may properly evaluate your capabilities to provide the required goods/services. Offerors are required to submit the following items as a complete proposal:

1. Return the RFP cover sheet and all addenda acknowledgments, if any, signed and filled out as required.

2. Offeror Data Sheet, included as Attachment A to the RFP, and other specific items or data requested in the RFP.

3. A written narrative statement to include:
   a. Experience in providing the goods/services described herein.
   b. Names, qualifications and experience of personnel to be assigned to the project.
   c. Resumes of staff to be assigned to the project.

4. Specific plans for providing the proposed goods/services including:
   a. List of proposed equipment/goods/etc. including operating parameters, illustrations, etc.
   b. What, when and how the service will be performed.
   c. Time frame for completion (if not otherwise specified by the agency in the statement of needs).

5. Proposed Price. Indicate in the pricing schedule, Section VII of the RFP, if provided.

6. Small Business Subcontracting Plan, Attachment B – Summarize the planned utilization of DMBE-certified small businesses which include businesses owned by women and minorities, when they have received DMBE small business certification, under the contract to be awarded as a result of this solicitation. This is a requirement for all prime contracts in excess of $100,000 unless the solicitation has been set-aside for small businesses or no subcontracting opportunities exist.
7. To ensure timely and adequate consideration of your proposal, **offers are to limit all contact**, whether verbal or written, pertaining to this RFP, to Mr. Paul Sharpe for the duration of this proposal process. Failure to do so will compound the complexity of this project and may jeopardize further consideration of supplier's proposal.

V. EVALUATION AND AWARD CRITERIA:

A. EVALUATION CRITERIA: "Proposals shall be evaluated by the Virginia Department of Health, Office of Emergency Medical Services, using the following criteria:"

OEMS will utilize a phased review process for the EMS Registry RFP process. The three phases of evaluation will be:

Phase 1: each proposal will be evaluated to determine whether is meets the proposal preparation and submission instructions in section IV of the RFP. This phase will be pass or fail and any proposal failing to meet the requirements stated in section IV will be subject to immediate disqualification without further review. All proposals meeting the proposal preparation and submission instructions will be given to the evaluation team.

Phase 2: the evaluation team will perform a review of the technical portion(s) of the RFP. The technical review will include that all mandatory requirements are present and if they are not then the proposal may be disqualified. The technical review will also include scoring the technical aspects of the proposals to contribute to the overall percentage assigned for the technical ability score.

Phase 3: proposals that are deemed eligible in phases one and two will be reviewed by the evaluation team to score the business, training and implementation plans, qualifications and experience, and cost proposal portions of the RFP. The business review will also include scoring the business aspects of the proposals to contribute to the overall percentage assigned for the business requirements score.

Each area reviewed will contribute to the overall RFP score as noted in the table below:

Description	Points
Quality of equipment and suitability for the intended purpose	25
Experience and qualifications of personnel in providing goods	20
Price	20
Small Business Subcontracting Plan	20
Maintenance Support	10
Scope and suitability of training offered to State personnel	05
TOTAL	100

B. AWARD OF CONTRACT: Selection shall be made of two or more Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each offeror so selected, the agency shall select the offeror which, in its opinion, has made the best proposal, and shall award the contract to that offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia*, § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one offeror is fully qualified, or that one offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated.

VI. REPORTING AND DELIVERY INSTRUCTIONS:

A. "The contractor shall provide the following documentation to Paul Sharpe, Contract Administrator, for approval by the agency" within the first fourteen (14) days after the award of the contract. The

documents will be provided in the Virginia Information Technology Agency (VITA) format or at the very least provide the same information.

1. Finalized Implementation Plan

2. Finalized Training Plan

B. "The contractor shall provide a Weekly progress report to Paul Sharpe, Contract Administrator outlining the following:"

1. The specific accomplishments achieved during the reporting period.

2. The specific tasks completed pursuant to the provisions of the contract and the completion dates of such tasks.

3. The projected completion dates for the remaining specific tasks required by the contract.

C. "The contractor shall provide within fourteen (14) days of request' the following documents in the VITA format or at the very least provide the same information."

1. Work Breakdown Structure

2. Activity Definition and Sequencing report

3. Resource Plan

4. Project Schedule

5. Risk Management Plan

6. Communications Plan

7. Testing Plan

8. Change and Configuration Management Plan

D. "Within thirty (30) calendar days after the award date of the contract, the contractor shall furnish a preliminary outline of the organizational structure of the final closeout report to Paul Sharpe, Contract Administrator."

1. The preliminary outline shall delineate the main topics and subtopics that will later be described in detail in the final report.

2. Beneath each topic and subtopic, the contractor shall furnish a brief narrative description of the subject matter encompassed by the topic or subtopic.

3. The agency shall have the right to edit, modify and/or rearrange the organizational structure, topics, and subtopics as it deems necessary to insure the inclusion of all work required by the contract.

E. "At least two (2) weeks prior to the submission of the final report, the contractor shall present a preliminary draft of the final report to Paul Sharpe, Contract Administrator. The agency shall have the right to modify and/or to require additional elaboration as it deems necessary to insure a comprehensive and thorough written study of all work required by the contract."

F. "On or before the date specified in the contract, a final report shall be delivered to Paul Sharpe, Contract Administrator, for its approval. The contractor shall furnish a final report in electronic format in word document format

G. "The contractor shall make at least one (1) oral presentation of the final report to persons or organizations as deemed necessary by the agency."

H. See 3.10 h. outlining requirements for a Small Business Subcontracting Plan in solicitations where the prime contract is in excess of $100,000. Prime contractors are required to complete Annex 7-G which should be attached to the RFP solicitation. For competitive negotiation, the Small Business Subcontracting Plan shall be used as one of the evaluation criteria. A DMBE-certified small business who serves as prime contractor will receive full credit for subcontracting for work performed by such prime. See Appendix B, Section II, 36 for the special term and condition that may be included in RFPs requiring the contractor to provide evidence of compliance with this requirement. Receipt of a small business subcontracting plan may be a condition of the award and if so, a requirement for a report from the prime contractor must be stated in the solicitation indicating the frequency of the report required in the contract.

VII. PREPROPOSAL CONFERENCE: A mandatory preproposal conference will be at **10:00 a.m. Thursday, January 22, 2009** at the Virginia Department of Health, 109 Governor St. Richmond, VA 23219, in the Office of Emergency Medical Services conference room, suite UB-55. The purpose of this conference is to allow potential offerors an opportunity to present questions and obtain clarification relative to any facet of this solicitation.

Due to the importance of all offerors having a clear understanding of the specifications/scope of work and requirements of this solicitation, attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those offerors who are represented at this pre-proposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be admitted after 10:00 a. m.

Bring a copy of the solicitation with you. Any changes resulting from this conference will be issued in a written addendum to the solicitation.

Questions should be submitted in writing (via e-mail, fax, or mail) to Mr. Paul Sharpe by January 9, 2009 to be covered during the Pre-Proposal conference. Interested parties are requested to notify Wanda Street (wanda.street@vdh.virginia.gov) by Noon the day before, of their intention to participate. Any changes or substantive clarifications to the RFP would be issued in the form of an Addendum, and be posted on the web and sent to all conference attendees and inquirers. Interested parties not attending the optional pre-proposal conference may request to be placed on a mailing list for any announcements and addenda.

VIII. GENERAL TERMS AND CONDITIONS:

A. VENDORS MANUAL: This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.state.va.us/dps under "Manuals."

B. APPLICABLE LAWS AND COURTS: This solicitation and any resulting contract shall be governed in all
respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, § 2.2-4366). ADR procedures

are described in Chapter 9 of the *Vendors Manual.* The contractor shall comply with all applicable federal, state and local laws, rules and regulations.

C. ANTI-DISCRIMINATION: By submitting their proposals, offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the *Virginia Public Procurement Act (VPPA).* If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1E).

In every contract over $10,000 the provisions in 1. and 2. below apply:

1. During the performance of this contract, the contractor agrees as follows:

a. The contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the contractor. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b. The contractor, in all solicitations or advertisements for employees placed by or on behalf of the contractor, will state that such contractor is an equal opportunity employer.

c. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

2. The contractor will include the provisions of 1. above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

D. ETHICS IN PUBLIC CONTRACTING: By submitting their proposals, offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

E. IMMIGRATION REFORM AND CONTROL ACT OF 1986: By entering into a written contract with the Commonwealth of Virginia, the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986..

F. DEBARMENT STATUS: By submitting their proposals, offerors certify that they are not currently debarred by the Commonwealth of Virginia from submitting bids or proposals on contracts for the type of goods and/or services covered by this solicitation, nor are they an agent of any person or entity that is currently so debarred.

G. ANTITRUST: By entering into a contract, the contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

H. MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS FOR RFPs: Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

I. CLARIFICATION OF TERMS: If any prospective offeror has questions about the specifications or other solicitation documents, the prospective offeror should contact the buyer whose name appears on the face of the solicitation no later than five working days before the due date. Any revisions to the solicitation will be made only by addendum issued by the buyer.

J. PAYMENT:

1. To Prime Contractor:

a. Invoices for items ordered, delivered and accepted shall be submitted by the contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).

b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.

c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the contractor at the contract price, regardless of which public agency is being billed.

d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.

e. **Unreasonable Charges**. Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges which are not in dispute (*Code of Virginia*, § 2.2-4363).

2. To Subcontractors:

a. A contractor awarded a contract under this solicitation is hereby obligated:

(1) To pay the subcontractor(s) within seven (7) days of the contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

(2) To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold payment and the reason.

b. The contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the contractor that remain unpaid seven (7) days following receipt of payment from the

Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier contractor performing under the primary contract. A contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime contractor who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

4. The Commonwealth of Virginia encourages contractors and subcontractors to accept electronic and credit card payments.

K. PRECEDENCE OF TERMS: Paragraphs A-J of these General Terms and Conditions shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

L. QUALIFICATIONS OF OFFERORS: The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the offeror to perform the services/furnish the goods and the offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect offeror's physical facilities prior to award to satisfy questions regarding the offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such offeror fails to satisfy the Commonwealth that such offeror is properly qualified to carry out the obligations of the contract and to provide the services and/or furnish the goods contemplated therein.

M. TESTING AND INSPECTION: The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

N. ASSIGNMENT OF CONTRACT: A contract shall not be assignable by the contractor in whole or in part without the written consent of the Commonwealth.

O. CHANGES TO THE CONTRACT: Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.

2. The Purchasing Agency may order changes within the general scope of the contract at any time by written notice to the contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The contractor shall comply with the notice upon receipt. The contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:

   a. By mutual agreement between the parties in writing; or
   b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the contractor accounts for the number of units of work performed, subject to the Purchasing Agency's right to audit the contractor's records and/or to determine the correct number of units independently; or
   c. By ordering the contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the

contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The contractor shall present the Purchasing Agency with all vouchers and records of expenses incurred and savings realized. The Purchasing Agency shall have the right to audit the records of the contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Purchasing Agency within thirty (30) days from the date of receipt of the written order from the Purchasing Agency. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the contractor from promptly complying with the changes ordered by the Purchasing Agency or with the performance of the contract generally.

P. **DEFAULT:** In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which the Commonwealth may have.

Q. **TAXES:** Sales to the Commonwealth of Virginia are normally exempt from State sales tax. State sales and use tax certificates of exemption, Form ST-12, will be issued upon request. Deliveries against this contract shall usually be free of Federal excise and transportation taxes. The Commonwealth's excise tax exemption registration number is 54-73-0076K

R. **INSURANCE:** By signing and submitting a bid or proposal under this solicitation, the bidder or offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The bidder or offeror further certifies that the contractor and any subcontractors will maintain these insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

INSURANCE COVERAGES AND LIMITS REQUIRED:

1. Workers' Compensation - Statutory requirements and benefits. Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.

2. Employer's Liability - $100,000.

3. Commercial General Liability - $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.

4. Automobile Liability - $1,000,000 per occurrence.

S. **ANNOUNCEMENT OF AWARD:** Upon the award or the announcement of the decision to award a contract over $30,000, as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA web site (www.eva.state.va.us) for a minimum of 10 days.

T. **DRUG-FREE WORKPLACE:** During the performance of this contract, the contractor agrees to (i) provide a drug-free workplace for the contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the contractor's workplace and specifying the actions that will be taken against

employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the contractor that the contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "*drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

U. **NONDISCRIMINATION OF CONTRACTORS**: A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

V. **eVA Business-To-Government Vendor Registration:** The eVA Internet electronic procurement solution, website portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

1. eVA Basic Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.
2. eVA Premium Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.
3. For orders prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.
4. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
   a. DMBE-certified Small Businesses: 1%, capped at $500 per order.
   b. Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.

W. **AVAILABILITY OF FUNDS:** It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

X. **INDEPENDENT CONTRACTOR:** When providing the services specified under this contract the Contractor shall not be deemed an "employee" or "agent" of the Virginia Department of Health. The Contractor shall act as an independent contractor and is responsible for obtaining and maintaining appropriate liability insurance, payment of all FICA, State and Federal taxes, and complying with other similar requirements which are customary in the industry. In addition, the Contractor certifies that they are not an employee, nor do they currently employ employees of the Virginia Department of Health.

Y. **CONFIDENTIALITY:**

1. CONFIDENTIALITY (Commonwealth): The Commonwealth agrees that neither it nor its employees, representatives, or agents shall knowingly divulge any proprietary information with

respect to the operation of the software, the technology embodied therein, or any other trade secret or proprietary information related thereto, except as specifically authorized by the contractor in writing or as required by the Freedom of Information Act or similar law. It shall be the contractor's responsibility to fully comply with § 2.2-4342F of the Code of Virginia. All trade secrets or proprietary information must be identified in writing or other tangible form and conspicuously labeled as "proprietary" either prior to or at the time of submission to the Commonwealth.

2. CONFIDENTIALITY (Contractor): The contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients will be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent. Any information to be disclosed, except to the agency, must be in summary, statistical, or other form which does not identify particular individuals. Contractors and their employees working on this project will be required to sign the Confidentiality statement in this solicitation.

IX. SPECIAL TERMS AND CONDITIONS:

A. ADVERTISING In the event a contract is awarded for supplies, equipment, or services resulting from this bid/proposal, no indication of such sales or services to the Commonwealth of Virginia or any agency or institution of the Commonwealth will be used in product literature or advertising. The contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services, and the contractor shall not include Commonwealth of Virginia or any agency or institution of the Commonwealth in any client list in advertising and promotional materials.

B. AUDIT: The contractor shall retain all books, records, and other documents relative to this contract for five (5) years after final payment, or until audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

C. AWARD: Selection shall be made of two or more offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each offeror so selected, the agency shall select the offeror which, in its opinion, has made the best proposal, and shall award the contract to that offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (Code of Virginia, § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one offeror is fully qualified, or that one offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated.

D. BEST AND FINAL OFFER (BAFO): At the conclusion of negotiations, the offeror(s) may be asked to submit in writing, a Best and Final Offer (BAFO).After the BAFO is submitted, no further negotiations shall be conducted with the offeror(s). The offeror's proposal will be rescored to combine and include the information contained in the BAFO. The decision to award will be based on the final evaluation including the BAFO.

E. PROPOSAL ACCEPTANCE PERIOD: Any proposal in response to this solicitation shall be valid for ninety (90) days. At the end of the 90 days the proposal may be withdrawn at the written request of the offeror. If the bid is not withdrawn at that time it remains in effect until an award is made or the solicitation is canceled.

F. CANCELLATION OF CONTRACT: The purchasing agency reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 60 days written notice to the contractor. In the event the initial contract period is for more than 12 months, the resulting contract may be terminated by either party, without penalty, after the initial 12 months of the contract period upon 60 days written notice to the other party. Any contract cancellation notice shall not relieve the

contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

G. INDEMNIFICATION: Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the contractor/any services of any kind or nature furnished by the contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the contractor on the materials, goods or equipment delivered.

H. IDENTIFICATION OF PROPOSAL ENVELOPE: If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From:_____ _____ _____
Name of Bidder/Offeror Due Date Time

_____ 601:517-09-102
Street or Box Number IFB No./RFP No.

_____ Emergency Medical Services Registry
City, State, Zip Code IFB/RFP Title

Name of Contract/Purchase Officer or Buyer Connie L. Hall

The envelope should be addressed as directed on Page 1 of the solicitation.

If a bid/proposal not contained in the special envelope is mailed, the bidder or offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the bid or proposal to be disqualified. Bids/proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other bids/proposals should be placed in the envelope.

I. SMALL BUSINESS SUBCONTRACTING AND EVIDENCE OF COMPLIANCE:

1. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential bidders/offerors are required to submit a Small Business Subcontracting Plan. Unless the bidder/offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No bidder/offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of bids or proposals. If small business subcontractors are used, the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.
2. Each prime contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a monthly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is

received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.

3. Each prime contractor who wins an award valued over $200,000 shall deliver to the contracting agency or institution on a monthly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information:
    a. Name of firm,
    b. Phone number,
    c. Total dollar amount subcontracted, and
    d. Type of product or service provided.

J. MANDATORY PREPROPOSAL CONFERENCE: A mandatory pre-proposal conference will be at **10:00 a.m. Thursday, January 22, 2009** at the Virginia Department of Health, 109 Governor St. Richmond, VA 23219. This mandatory conference will be held in the Office of Emergency Medical Services conference room, Suite UB-55. The purpose of this conference is to allow potential offerors an opportunity to present questions and obtain clarification relative to any facet of this solicitation.

Due to the importance of all offerors having a clear understanding of the specifications/scope of work and requirements of this solicitation, attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be admitted after 10:00 a. m

Bring a copy of the solicitation with you. Any changes resulting from this conference will be issued in a written addendum to the solicitation.

K. PRIME CONTRACTOR RESPONSIBILITIES: The contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that he may utilize, using his best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime contractor. The contractor agrees that he is as fully responsible for the acts and omissions of his subcontractors and of persons employed by them as he is for the acts and omissions of his own employees.

L. REFERENCES: Bidders shall provide a list of at least 3 references where similar goods and/or services have been provided. Each reference shall include the name of the organization, the complete mailing address, the name of the contact person and telephone number.

	ORGANIZATION	ADDRESS	CONTACT PERSON	TELEPHONE
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

M. RENEWAL OF CONTRACT: This contract may be renewed by the Commonwealth for three (3) successive one year periods under the terms and conditions of the original contract except as stated in 1. below. Price increases may be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew shall be given approximately 90 days prior to the expiration date of each contract period.

1. If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not exceed the contract price(s) of the previous renewal period increased/decreased by more than the percentage increase/decrease of the Other Good and Services category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

N. SUBCONTRACTS: No portion of the work shall be subcontracted without prior written consent of the purchasing agency. In the event that the contractor desires to subcontract some part of the work specified herein, the contractor shall furnish the purchasing agency the names, qualifications and experience of their proposed subcontractors. The contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

O. WARRANTY (COMMERCIAL): The contractor agrees that the goods or services furnished under any award resulting from this solicitation shall be covered by the most favorable commercial warranties the contractor gives any customer for such goods or services and that the rights and remedies provided therein are in addition to and do not limit hose available to the Commonwealth by any other clause of this solicitation. A copy of this warranty should be furnished with the bid/proposal.

P. eVA BUSINESS-TO-GOVERNMENT CONTRACTS: The contract will result in multiple purchase order(s) with the eVA transaction fee specified below assessed for each order.

1. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.
2. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
   a. DMBE-certified Small Businesses: 1%, Capped at $500 per order.
   b. Businesses that are not DMBE-certified Small Businesses: 1%, Capped at $1,500 per order.

The eVA transaction fee will be assessed approximately 30 days after each purchase order is issued. Any adjustments (increases/decreases) will be handled through eVA change orders.

Internet electronic procurement solution, website portal www.eva.state.va.us , streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following:

If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

Q. CONFIDENTIALITY OF PERSONALLY IDENTIFIABLE INFORMATION: The contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients will be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent and only in accordance with federal law or the Code of Virginia. Contractors who utilize, access, or store personally identifiable information as part of the performance of a contract are required to safeguard this information and immediately notify the agency of any breach or suspected breach in the security of such information. Contractors shall allow the agency to both participate in the investigation of incidents and exercise control over decisions regarding external reporting. Contractors and their employees working on this project may be required to sign a confidentiality statement.

R. DEFINITION - SOFTWARE: As used herein, the terms software, product, or software products shall include all related materials and documentation whether in machine readable or printed form.

S. DEMONSTRATIONS: By submitting a proposal, the offeror certifies that the specified equipment is in productive use and capable of demonstration in the proposed configuration. The Commonwealth reserves the right to require offerors to demonstrate the functionality of proposed equipment to its satisfaction prior to making an award decision. Such demonstration is intended to show that a vendor's products will perform in a completely satisfactory manner and that they will meet or exceed

the performance specifications contained in the solicitation. Failure by a vendor to promptly comply with a request for demonstration could result in their bid being rejected. Failure to reject shall not relieve the vendor of its obligation to fully comply with all requirements of the contract.

T. EXCESSIVE DOWNTIME: Equipment or software furnished under the contract shall be capable of continuous operation. Should the equipment or software become inoperable for a period of more than 24 hours, the contractor agrees to pro-rate maintenance charges to account for each full day of inoperability. The period of in operability shall commence upon initial notification. In the event the equipment or software remains inoperable for more than _3_ consecutive calendar days, the contractor shall promptly replace the equipment or software at no charge upon request of the procuring agency. Such replacement shall be with new, unused product(s) of comparable quality, and must be installed and operational within _3_ days following the request for replacement.

U. LIMITATION OF USE: The Commonwealth's right to use computer software developed entirely at private expense may be limited by the contractor as stipulated in this contract. Notwithstanding any provision to the contrary however, the Commonwealth shall have at a minimum: unlimited use of the software on the equipment for which it is purchased; use of the software on a secondary system for backup purposes should the primary system become unavailable, malfunction, or is otherwise rendered inoperable; use of the software at another Commonwealth site should the system be entirely transferred to that location; the right to make a backup copy for safekeeping; the right to modify or combine the software with other programs or materials at the Commonwealth's risk; and the right to reproduce any and all documentation provided such reproduction is for the sole use of the Commonwealth. These rights are perpetual and irrevocable; in the event of any actual or alleged breach by the Commonwealth, the contractor's sole remedy shall be to pursue a monetary claim in accordance with § 2.2-4363 of the *Code of Virginia*.

V. MAINTENANCE: Upon expiration of the specified warranty period and at the Commonwealth's option, the contractor shall provide up to three (3) additional one-year periods of on-site maintenance (including labor, parts, and travel) at the prices set forth in the pricing schedule. Maintenance shall not include external electrical work, providing supplies, and adding or removing accessories not provided for in the contract. Maintenance shall also not include repairs of damage resulting from: acts of God, transportation between state locations, negligence by state personnel, or other causes not related to ordinary use in the production environment in which installed. Each successive year of maintenance may be ordered by the Commonwealth in writing at least 90 days prior to expiration of the existing maintenance period.

W. QUALIFIED REPAIR PERSONNEL: All warranty or maintenance services to be performed on the items specified in this solicitation as well as any associated hardware or software shall be performed by qualified technicians properly authorized by the manufacturer to perform such services. The Commonwealth reserves the right to require proof of certification prior to award and at any time during the term of the contract.

X. RENEWAL OF MAINTENANCE: Maintenance of the hardware or software specified in the resultant contract may be renewed by the mutual written agreement of both parties for an additional one-year period(s), under the terms and conditions of the original contract except as noted herein. Price changes may be negotiated at time of renewal; however, in no case shall the maintenance costs for a succeeding one-year period exceed the prior year's contract price(s), increased or decreased by more than the percentage increase or decrease in the Other Goods and Services category of the CPI-W section of the US Bureau of Labor Statistics Consumer Price Index, for the latest twelve months for which statistics are available.

Y. TERM OF SOFTWARE LICENSE: Unless otherwise stated in the solicitation, the software license(s) identified in the pricing schedule shall be purchased on a perpetual basis and shall continue in perpetuity. However the Commonwealth reserves the right to terminate the license at any time, although the mere expiration or termination of this contract shall not be construed as an intent to terminate the license. All acquired license(s) shall be for use at any computing facilities, on any equipment, by any number of users, and for any purposes for which it is procured. The Commonwealth further reserves the right to transfer all rights under the license to another state agency to which some or all of its functions are transferred.

Z. THIRD PARTY ACQUISITION OF SOFTWARE: The contractor shall notify the procuring agency in writing should the intellectual property, associated business, or all of its assets be acquired by a third party. The contractor further agrees that the contract's terms and conditions, including any and all license rights and related services, shall not be affected by the acquisition. Prior to completion of the acquisition, the contractor shall obtain, for the Commonwealth's benefit and deliver thereto, the assignee's agreement to fully honor the terms of the contract.

AA. TITLE TO SOFTWARE: By submitting a bid or proposal, the bidder or offeror represents and warrants that it is the sole owner of the software or, if not the owner, that it has received all legally required authorizations from the owner to license the software, has the full power to grant the rights required by this solicitation, and that neither the software nor its use in accordance with the contract will violate or infringe upon any patent, copyright, trade secret, or any other property rights of another person or organization.

BB. WARRANTY AGAINST SHUTDOWN DEVICES: The contractor warrants that the equipment and software provided under the contract shall not contain any lock, counter, CPU reference, virus, worm, or other device capable of halting operations or erasing or altering data or programs. Contractor further warrants that neither it, nor its agents, employees, or subcontractors shall insert any shutdown device following delivery of the equipment and software.

CC. WARRANTY OF SOFTWARE: The contractor warrants the operation of all software products for a period of 12months from the date of acceptance. During the warranty period, the contractor shall provide ___ hour toll free phone support and all patches, fixes, revisions, updates, upgrades, and minor releases to both the software and its supporting documentation. In addition, the contractor shall provide a two hour return call response time and complete all necessary patches/fixes within hours of initial notification.

X. METHOD OF PAYMENT:

The Contractor shall be paid on the basis of invoices submitted. Invoices should be submitted not later than the 10th of the month following the month services were rendered, identify task per the pricing schedule, cite the contract number assigned to the contract, and be submitted to the following address:

Virginia Department of Health
Office of Emergency Medical Services
ATTN: Fiscal Section
P.O. Box 2448
Richmond, VA 23218-2448

XI. PRICING SCHEDULE:

The Offeror shall propose a pricing schedule using the below format which is not all inclusive. Items/products can be added to this list. The pricing schedule should relate to the products, major deliverables and/or milestones.

The Offeror shall place the proposed Pricing Schedule in the RFP Response Package.

Description	Unit Price	Unit of Issue	Extended Price
Software & Licenses:			
Application Modules (optional modules) [1] :			
ePCR module			
Billing module			
Emergency Management module			
Patient Tracking module			
Certification Tracking module			
Hospital Status module			
GPS/GIS module			
Inventory module			
Vehicle maintenance module			
Data Mining Tools:			
Mapping Tools:			
Implementation & Training Costs:			
Technical Support			
Monday – Friday			
ePCR 24/7			
Maintenance & Upgrades:			

Note: Optional Modules[1] may be purchased by the individual EMS agency

XII. ATTACHMENTS:

A. Offeror Data Sheet
B. SWAM Utilization Plan

ATTACHMENT A

OFFEROR DATA SHEET

1. QUALIFICATIONS OF OFFEROR: The Offeror must be currently licensed to provide the described services within the Commonwealth of Virginia, if required, and have the capability and capacity in all respects to fully satisfy the contractual requirements.

2. YEARS IN BUSINESS: Indicate the length of time the firm as been in business providing this type of service:

   Years___Months___.

3. REFERENCES: Identify at least four recent references for whom the firm has provided this type of service. Include the name of the client; client's location; dates of service; and the name and telephone number of the individual knowledgeable of this service the Department of Health has your permission to contact.

CLIENT & ADDRESS	DATES OF SERVICE	PERSON TO CONTACT & PHONE #

4. For statistical reporting purposes is the firm considered to be:

   a. Minority owned business? Yes _ No

   b. Women owned business? Yes _ No

   c, Small Business Yes No

Attachment B:
SWAM (Small, Women and Minority-owned Businesses) Utilization Plan

Offeror Name: _____ **Preparer Name:** _____
Date: _____

Is your firm a **Small Business Enterprise** certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a **Woman-owned Business Enterprise** certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a **Minority-Owned Business Enterprise** certified by the Department of Minority Business Enterprise? Yes____ No_____
If yes, certification number: _____ Certification date:_____

Instructions: *Populate the table below to show your firm's plans for utilization of small, women-owned and minority-owned business enterprises in the performance of the Collection Services contract. Describe plans to utilize SWAMs businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.*

Small Business Enterprise: "Small business enterprise" shall mean an independently owned and operated business which, together with affiliates, has 250 or fewer employees or average annual gross receipts of $10 million or less averaged over the previous three years. Nothing in this provision prevents a program, agency, institution or subdivision from complying with the qualification criteria of a specific state program or a federal guideline to be in compliance with a federal grant or program. **For purposes of the SWAM Program, the definition of small business enterprise shall be interpreted to include all certified women-owned and minority-owned businesses.**

Woman-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more women who are U.S. citizens or legal resident aliens, or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more women, and whose management and daily business operations are controlled by one or more of such individuals. **For purposes of the SWAM**

Program, all certified women-owned businesses are also a small business enterprise.
Minority-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more minorities or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more minorities and whose management and daily business operations are controlled by one or more of such individuals. **For purposes of the SWAM Program, all certified minority-owned businesses are also a small business enterprise.**

All small, women, and minority owned businesses must be certified by the Commonwealth of Virginia Department of Minority Business Enterprise (DMBE) to be counted in the SWAM program. Certification applications are available through DMBE at 800-223-0671 in Virginia, 804-786-6585 outside Virginia, or online at www.dmbe.virginia.gov (Customer Service).

1. Plans for utilization of SWAM Businesses					
SWAM Business Name & Address	**SWAM Status: Small (S), Women (W), Minority (M) & DMBE Certif. # & Date**	**Contact Person, Tele. & Email**	**Type of Goods and/or Services**	**Planned Contract Involvement**	**Planned Annual Contract Dollar Expenditure Amount**
Totals $					

Appendix F

The Current Regionalized Pre-hospital and Inter-hospital Trauma Triage Program Reviewed

An assessment of trauma triage, to benefit the trauma, stroke, and STEMI programs in Virginia.

Virginia Department of Heath
Office of Emergency Medical Services
Division of Trauma/Critical Care

January 25, 2009

Table of Contents

Executive Summary

The Commonwealth of Virginia's Trauma System compared to other statewide trauma programs is considered a "mature system". A trauma system includes all components of trauma care including, injury prevention, access to specialty trauma care, acute hospital care, rehabilitation, and research. The State Board of Health (BOH) is the State agency that ultimately oversees the Virginia Trauma System through the Virginia Department of Health (VDH). The VDH has several Divisions dedicated to injury prevention and acute care hospital licensure. Access to trauma care and trauma system development is managed through VDH's Office of Emergency Medical Services (OEMS). OEMS performs these functions in consultation with a state level trauma committee, the Trauma System Oversight and Management Committee, which is comprised of related organizations.

OEMS oversees the development and maintenance of Virginia's trauma center designation criteria and assures compliance by the designated trauma centers with those criteria. The Virginia Trauma System includes five Level I trauma centers, the highest level, four Level II centers, and five Level III centers. Level I and II centers by definition provide definitive trauma care, with the most complex patients typically requiring to be managed in Level I centers. Level III centers were traditionally considered to be most valuable at stabilize trauma patients in areas were the development of a Level I or II center is not feasible. Level III centers can also benefit the system by having a more involved role with managing specific types of trauma patients and helping to decompress the patient volume at higher level centers.

The Virginia Trauma System is in place to care for the over 7.7 million citizens of the Commonwealth and its visitors. One in every 350 person in Virginia will be affected by trauma each year. In Virginia currently the bulk of these patients are being treated in designated trauma centers. As little as ten years ago it could not always be stated that the most seriously injured patients, or *trauma patients* as they are commonly referred to as, were being treated in trauma centers. Because trauma centers have been proven to greatly benefit trauma patients, a system that addresses *access* was put into place to assure these patients are rapidly moved to a trauma center. The process used in Virginia is called pre-hospital and inter-hospital trauma triage (trauma triage).

OEMS is also responsible for assuring that emergency medical services (EMS) providers (EMTs and paramedics) and healthcare providers at non-trauma designated hospitals, referred throughout this document as community hospitals, treat and transfer trauma patients to designated trauma centers in a timely fashion. The focus of this document is on the *access* portion of the trauma system.

This document will address the question of whether regionalized trauma triage is effective in Virginia. Current triage plans are developed by the regional EMS councils as part of their annual performance based contracts. The ultimate goal is to have patients move through the EMS system and community hospitals so they may reach specialty care centers in an optimal fashion through improved patient outcomes. To fully appreciate the

analysis that follows some background information on Virginia's trauma triage system is offered in the next section.

Background

Trauma triage is simply the process used by EMS providers and hospitals to assure that seriously injured patients reach designated trauma centers in a timely fashion. Multiple studies over the past 20 or more years have shown that treating trauma patients in designated trauma centers can reduce mortality by 20% – 30% depending on the year and location of the study. This document only measures "triage" or the movement of patients and whether the current regionalized triage process continue to serve its intended purpose. This document is NOT intended to measure the quality of care being provided by EMS or hospitals; there are an adequate number of studies that demonstrate outcome data on trauma patients.

In Virginia, trauma triage exists both in law and regulation. The COV § 32.1-111.3 the *Statewide Emergency Medical Care System*[1] was amended to add establishing and maintaining a process of designating hospitals as trauma centers based on nationally accepted standards. In 1997, Senate Bill (SB) 1034[2] again amended § 32.1-111.3 and added the requirement that the Board of Health (BOH) promulgate regulations which …ensure that trauma patients receive rapid access to organized trauma care…

The 1997 amendment to § 32.1-111.3 came after two years of interest in the topic by the legislature. Initially in 1995 Senate Joint Resolution 353[3] resolved to have the Joint Commission on Health Care (JCHC) study the need for establishing a pre-hospital and inter-hospital trauma triage plan. The JCHC report or Senate Document 23 was titled the *Study of the Need For and Efficacy of a Statewide Trauma Triage Plan…*[4] This report did summarize that up to 32% of seriously injured were being admitted to non-trauma designated hospital depending on the region of the State that the injury occurred. The report also concluded that "statewide triage protocols" would provide for a more efficient use of our designated trauma centers and that with the vast amount of data available on the benefits of trauma patients being treated in trauma centers that many injured person would benefit from these protocols.

SB 551[5] of the 1998 General Assembly (GA) again amended § 32.1-111.3 and changed the trauma triage language from the requirement that the BOH promulgate regulations for trauma triage to include the development of formal regional trauma triage plans developed by the seven Regional EMS Councils (now 11 councils). House Bill (HB) 2161[6]of the 2007 GA amended trauma triage language and removed the requirement that trauma triage plans be developed by regional councils. The trail of trauma triage Code language ends here. It is important to know that § 32.1-116.1[7] also mandates the reporting of EMS and hospital data to support the trauma triage process and 12VAC5-31-390[8] requires that EMS agencies follow trauma triage plans established in § 32.1-111.3.

To date, there has not been another review of this program performed since the 1995 JCHC study or since regional councils began establishing trauma triage plans in 1999. During 2005 it was noted by OEMS that the trauma triage plans being financially

supported by the State were at best, being minimally performed and therefore considerable effort was made to resurrect the regionalized trauma triage program "as is" without much focus on whether the program was actually of benefit.

Nationally, Emergency Medical Services (EMS) in general does not have a strong history of utilizing evidenced based practice as other medical and non-medical disciplines do. The OEMS has committed to following the recommendation made in the June 2006 Institute of Medicine (IOM) report *Emergency Medical Services at the Crossroads*[9]. The IOM makes several recommendations for lead agencies to begin utilizing evidence based practice to establish emergency and trauma patient care [protocols] for treatment, triage, and transport of patients.

Reviewing trauma triage became especially important at this time because of new legislation that was passed during the 2008 GA that began requiring the establishment of a Stroke Triage process (HB479[10] and SB344[11]) and though not required by law [yet], a new Virginia Heart Attack Coalition has been formed to begin establishing a STEMI Triage process. STEMI is the common term used in health care for a patient whose ST segment on their electrocardiogram is elevated, which is the indication of a myocardial infarction or heart attack.

Regional EMS Councils are non-profit, 501(c)3 entities that function under a performance based contract with the OEMS. The regional councils hold no authority to enforce regulations or laws and function only under the assumption that agencies will desire to participate in their programs. There is often confusion within the State EMS system as to what the roles of the regional councils are and an assumption that they are an EMS authority.

In order to fully understand this issue it is also important to understand the history of how the trauma and EMS systems began to evolve in the late 1970's and early 1980's. The American College of Surgeons (ACS), Committee on Trauma (COT) has been the nationally accepted body that provides guidance to all phases of modern trauma systems and this began with their first publication entitled the *Optimal Hospital Resources for Care of the Injured Patient* in 1976. This document has continued to evolve to its most recent publication; *Resources for the Optimal Care of the Injured Patient 2006*[12]. The ACS/COT establishes standards for the designation of hospitals as trauma centers, guidelines for the flow of patients between community hospitals and trauma centers, direction for emergency medical services (EMS) providers to enter patients into the trauma system, performance improvement programs, research and other contributions to "trauma systems".

Regional councils which came to exist in EMS systems nationally when in approximately 1966 the National Highway and traffic safety Administration (NHTSA) published a white paper called the *Accidental Death and Disability: The Neglected Disease of Modern Society*[13] which identified that the lack of what is now referred to as an EMS system did not exist at that time. The NHTSA white paper is widely accepted as the birth of EMS systems and eventually as a result the 1973 Federal *EMS System Act* was passed. The

EMS System Act provided significant funding for the development of EMS systems, but only through block grants to non-profit regional councils. As a result Virginia's EMS system depended on the regional council structure to receive much need EMS funding. In the early 1970's many states did not have a state agency dedicated to EMS and with federal dollars being sent to non-profit agencies states were slow to develop state offices. In 1981, when the block grants were discontinued, States began to assume responsibility for maintaining an EMS system.

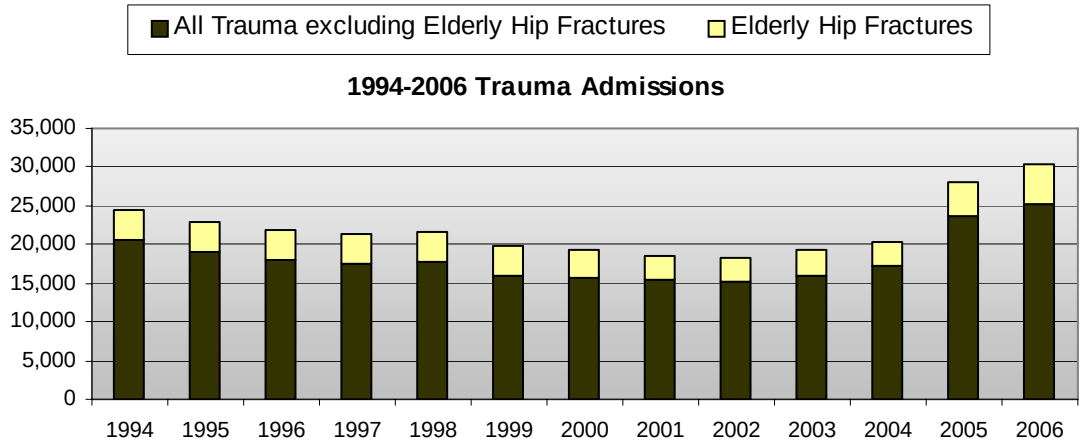
Another important item to note is that during this evolution the face of the EMS provider has changed from a majority volunteer system to a majority career system. There may currently be more licensed EMS agencies that would classify themselves as volunteer, but the volume of EMS responses is being managed by career agencies. A review of the top five EMS agencies in each EMS region by volume shows that 89% of calls (n=509,290) were managed by career/paid EMS agencies and 11% (n=60,936) by volunteer agencies[14]. During the last 25 years EMS has become a sophisticated medical discipline and emergency response system that requires oversight of standards of training, the delivery of health care, funding, and planning. Oversight of jurisdictions cannot be provided by a non-profit agency with no vested authority.

Current Process Reviewed

To measure the effectiveness of the trauma triage process that is currently being supported by VDH/OEMS several sources of information were used. Data from the Virginia Statewide Trauma Registry (VSTR) for the time period of 1994 through 2006 was reviewed, a survey using random sampling of EMS providers was performed, the regional trauma committee minutes, attendance, regional trauma triage plans and regional trauma performance improvement plans from the 11 regional councils was reviewed, the National Association of EMS Officials list serve was utilized to gather information, as was other state level programs from states that collaborate as the Atlantic EMS Council.

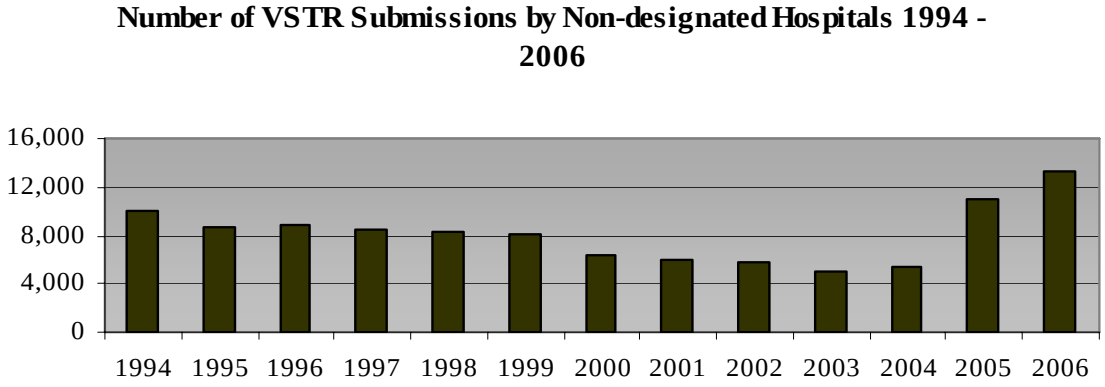
As a starting point for analyzing whether the current use of regional trauma triage plans is effective in assuring that *trauma patients*, as defined in the Virginia Statewide Trauma Triage Plan[15], reach definitive trauma care at a designated trauma center it was important to look at which hospitals were providing trauma care prior to the 1999 institution of trauma triage plans and then look at the same data after 1999. At first glance of VSTR data[16] (Figure 1) of the volume of trauma patients that were being admitted to community hospitals it appeared that there was a significant downward trend of admissions to community hospital after 1999. However, upon further evaluation, compliance with data submission by these hospitals suffered an almost identical downward trend until 2004 (Figure 2) when new attention to the program and the implementation of a Web-based VSTR were put into place.

Figure 1



(Source: Virginia Statewide Trauma Registry)

Figure 2



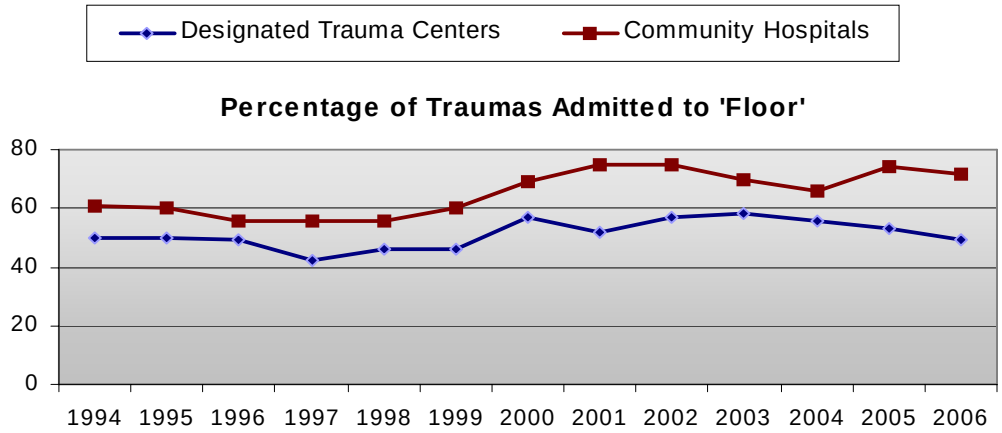
(Source: Virginia Statewide Trauma Registry)

Admission data compared to *submission data* seemed to show no significant change in trauma patients reaching trauma centers, but this analysis cannot be accepted as a validated comparison. To further look into any positive effect caused by the1999 trauma triage plans data comparing the acuity of injured patients being seen in community hospitals was performed. A general assumption can be made that a patient being admitted to a medical/surgical floor (floor) where there is no advanced monitoring and a higher patient to nurse ratio would be a *low acuity* patient. Additionally, patients admitted to an intensive care unit (ICU) may be considered of *moderate acuity*, while patients admitted directly to an operating room (OR) would be of the *highest acuity*.

Figure 3 demonstrates that patients being admitted to the floor of community hospitals slowly increased after 1999 with the exception of when lower data submission was occurring. This trend demonstrates an appropriate use of community hospitals as these facilities are quite capable of managing the isolated orthopaedic injury such as an arm or leg fracture, or admitting a patient for a short period of observation after an incident with

a significant mechanism were no serious physiological symptoms exist. The slight rise may be attributable to a natural increase in patient census based on increasing population, age, or perhaps hospitals in general gaining a better understanding of what types of injured patients can safely be managed within the community hospital environment.

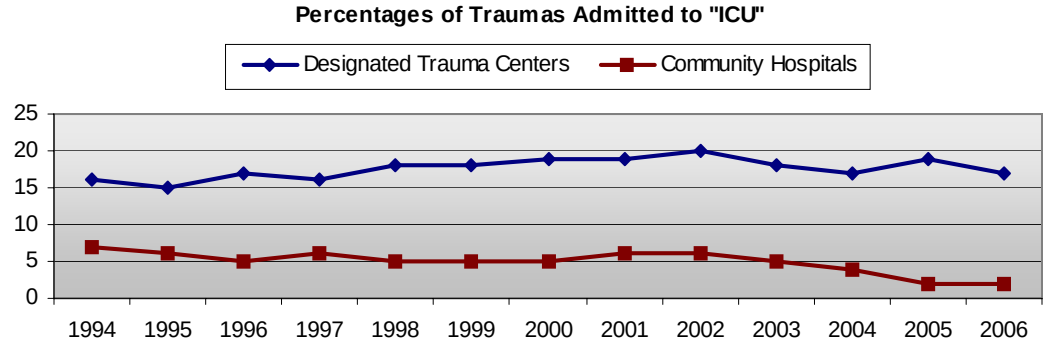
Figure 3



(Source: Virginia Statewide Trauma Registry)

When reviewing the data on moderately injured patients, or those injured patients requiring admission to an ICU instead of to a floor. A small increase, +/- 2% could be seen from 2000 through 2004. After 2004, a trend toward decreasing ICU admissions can be seen in community hospitals, but only at a rate of +/- 3%. The variations in this data could possibly be attributed to the fluctuation in compliance with data submission. This variable is suggestive of a slight improvement in moderately injured patients not being treated in community hospital ICU's. It is also suggestive, but not conclusive that in general, the treatment of moderately injured patients outside of trauma centers was not a significant issue pre or post trauma triage laws being instituted.

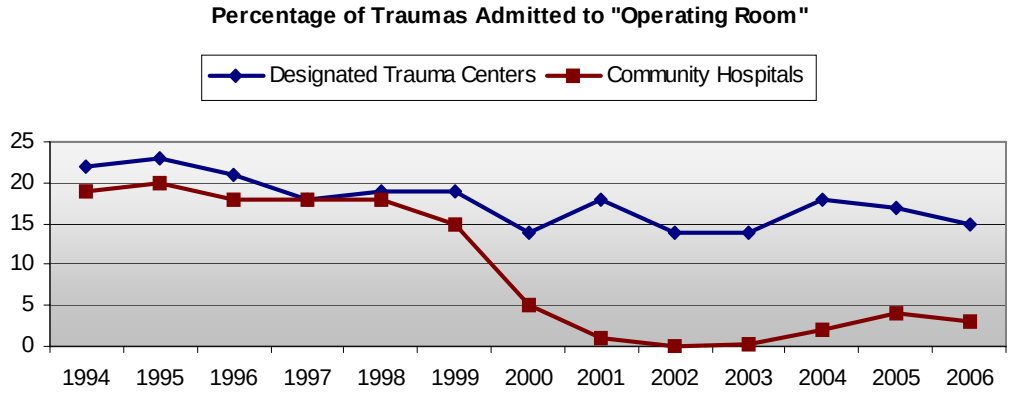
Figure 4



(Source: Virginia Statewide Trauma Registry)

Finally, in reviewing the most seriously injured patients, those requiring admission directly to an OR, up until 1998 the rate of patients treated in the OR of community hospitals versus those being treated in designated trauma centers was almost equivalent. Figure 5 demonstrates a sharp and statistically significant decrease in OR admissions to community hospitals after 1999.

Figure 5



(Source: Virginia Statewide Trauma Registry)

This high volume of acutely injured patients not being treated in specialty resource centers (trauma centers) was a significant issue and worthy of the legislation that was put into place to prevent it. Why is it important? Studies such as the one in the June 2006 issue of the New England Journal of Medicine have shown that patient mortality in the severely injured patient can be decreased by as much as 25 % when treated in a designated trauma center[17].

To further evaluate the effectiveness of Virginia's regional trauma triage plans and what they have contributed to patients being transported to trauma centers either directly by EMS or by community hospitals rapidly transferring trauma patients to trauma centers EMS providers were surveyed[18]. A random sampling survey of the EMS provider community was conducted to elicit from the "front line" provider what their comfort level with indentifying a trauma patient is and where they received an understanding of the decision process they use for "triaging" the patient, to receive appropriate trauma care in a timely fashion.

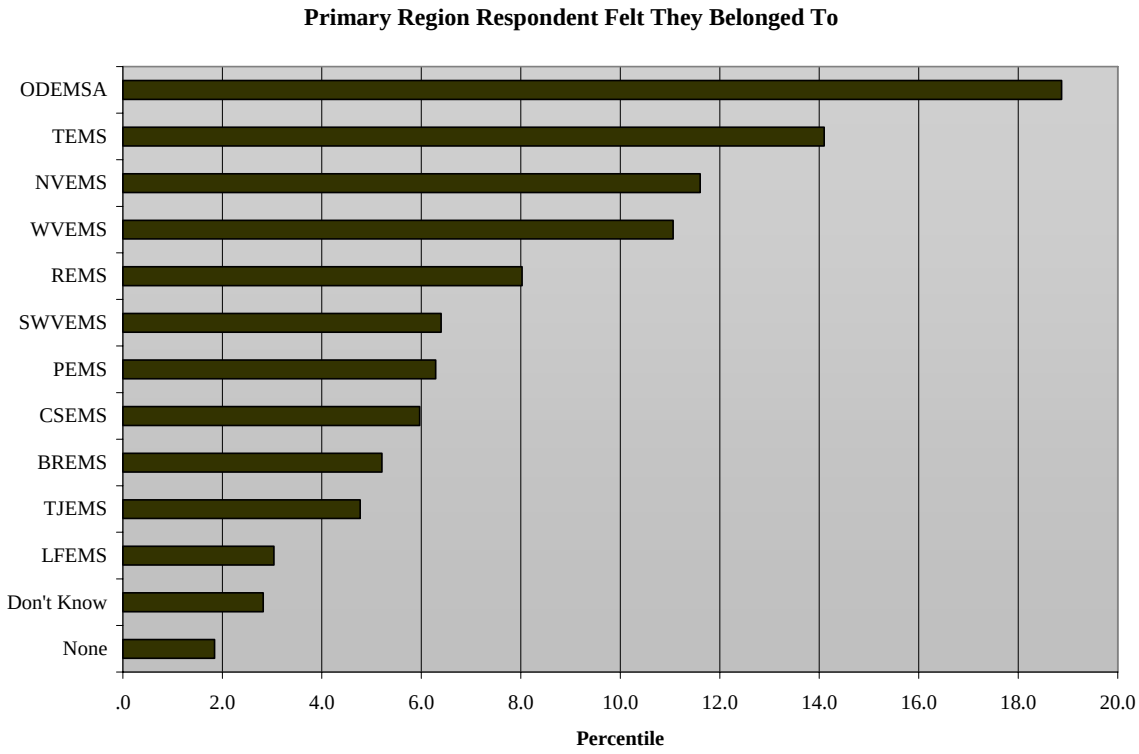
Virginia has approximately 33,000 certified EMS providers at various levels of basic and advanced life support levels. The survey also allowed the respondent to choose "Registered Nurse" (RN) as their highest level of certification. Any respondent that chose RN would also hold some type of EMS credential.

The OEMS certification database was randomly queried for a representative sample of the EMS community. 2,500 providers were invited to participate in the survey through a direct mailing. Each potential respondent was given a unique identifier which limited their response to only one entry and allowed for a follow up invitation for those who did not initially respond. This unique identifier also allowed for the assurance of a

representative sample from each EMS region and for each level of EMS certification. Respondents were asked to go to a survey Website (Survey Monkey) or respond by using an enclosed hard copy survey and return it in a supplied postage paid envelope.

The level of response to the survey allows the claim that the survey was statistically significant based on the distribution of respondents, primary regional affiliation, and the volume of responses. A +/- 3 sampling error could be assigned, which is a significant accomplishment.

Figure 6



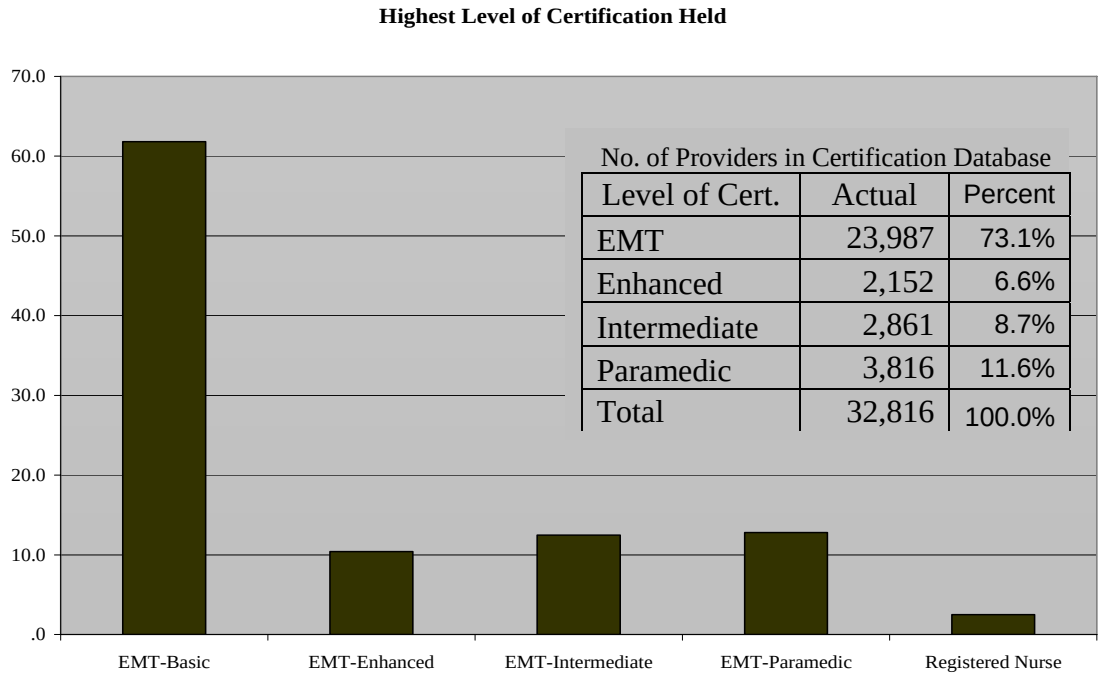
The respondents closely mirror the relative size of EMS regions within Virginia. Variations to the number of EMS agencies and localities in each region can be explained by the relative size of the region based on population. Table 1 contains the number of licensed EMS agencies, localities and the population that make up each regional council area

Table 1

Council	Agencies	Localities	Population
ODEMSA	106	27	1,207,127
WVEMS	103	18	672,029
SWEMS	91	17	400,848
REMS	73	10	380,027
CSEMS	64	10	258,789
TEMS	63	10	1,172,508
PEMS	56	16	588,737
NVEMS	55	8	2,200,000
BREMS	43	6	227,986
LFEMS	43	6	186,816
TJEMS	42	7	212,168

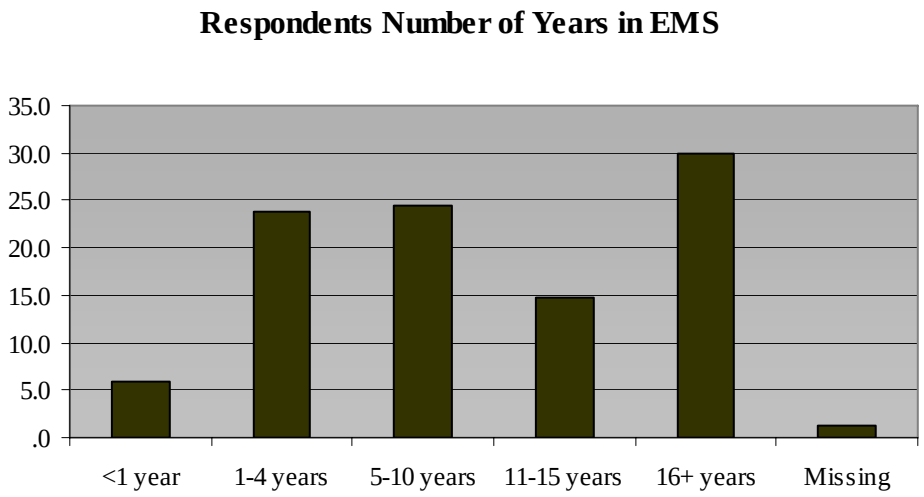
(Source: OEMS licensure database[19] and U.S Census Bureau[20])

Figure 7



Note: at the time of developing the sampling frame there were 1,332 certified first responders. The first responder level was eliminated from the survey as they are not likely to be in the position of making transport decisions autonomously. Additionally two certification levels were omitted from the survey because they have essentially been phased out with the exception of a small number of providers that do not expire until January 2009. Those two levels are the EMT-Shock Trauma (27) and EMT-Cardiac Tech (87).

Figure 8



Respondents were asked to rate how comfortable they felt in determining which patients are "trauma patients" and where these patients should be transported to. Table 2 and Table 3 provide their responses.

Table 2

How comfortable do you feel in determining whether patient has trauma?	
	Percent
Very Comfortable	67.6
Somewhat Comfortable	28.9
Somewhat Uncomfortable	2.1
Very Uncomfortable	1.5
Total	100

Table 3

How comfortable do you feel in determining where to take trauma patient?	
	Percent
Very Comfortable	71.6
Somewhat Comfortable	23.3
Somewhat Uncomfortable	3.3
Very Uncomfortable	1.7
Total	99.9
Missing	0.1
Total	100

Note: 96.5% of providers are comfortable, on some level, with identifying injured patients as "trauma patients" and 94.9% are comfortable, on some level, with determining the appropriate hospital to transport to. Previous trauma registry data demonstrated that patients are being currently transported to the appropriate hospital type. The survey also demonstrated that 84% of providers state that they are comfortable bypassing a community hospital and transporting directly to a trauma center.

Figure 9

Where Respondents Feel They Have Learned to Identify Trauma Patients

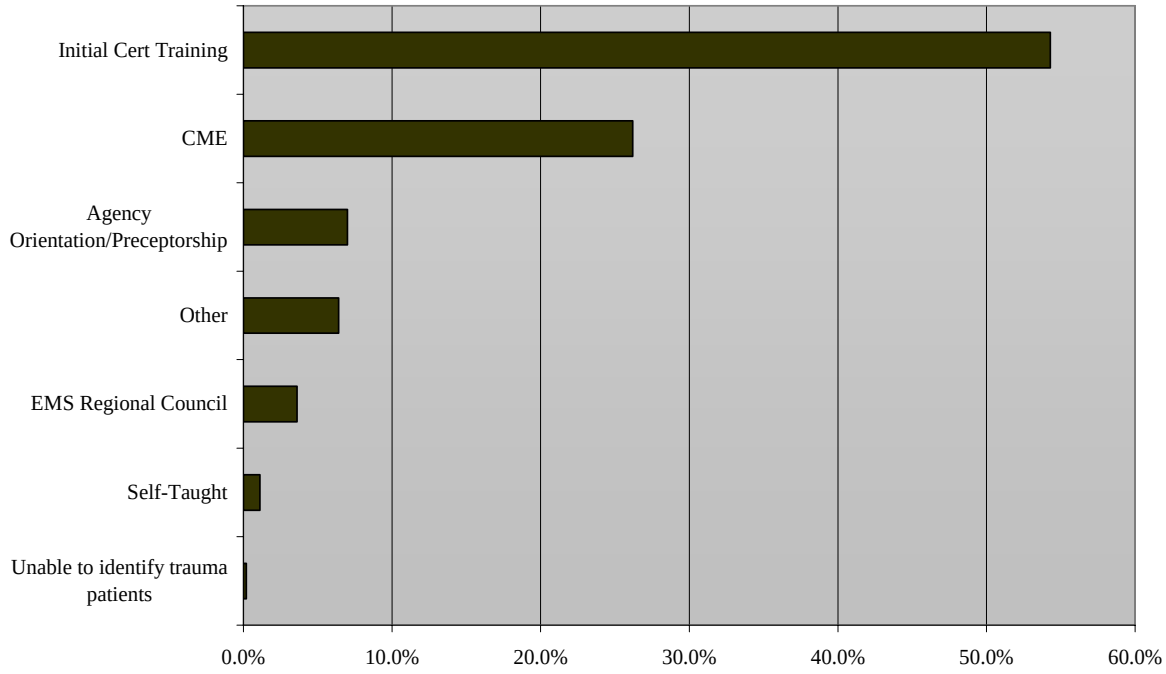


Figure 9 above shows how EMS providers state they learned to recognize the clinical conditions that identify patients as trauma patients. Overwhelmingly, respondents state they gain this understanding through initial training, ongoing continuing medical education (CME), and through agency specific orientation.

When measuring a mandatory statewide program typically a rate of 95% compliance or participation with the program would be considered excellent, 90% being satisfactory and down to 80% may be expectable. Programs with success rates of 80% - 90% should most likely be further developed so that the level of participation can be increased to 90% or better. Table 4 and Table 5 below are based on survey respondents' answers to whether they were familiar with regional trauma triage plans and which trauma triage plan their primary EMS agency utilizes.

Table 4

Number of Respondents Familiar With Their Regional Trauma Plan

	NVEMS	LFEMS	REMS	PEMS	CSEMS	TJEMS	ODEMSA	TEMS	BREMS	WVEMS	SWVEMS
Yes	58.3%	62.5%	57.1%	58.8%	37.5%	33.3%	47.6%	60.0%	75.0%	67.5%	55.6%
No	41.7%	37.5%	42.9%	41.2%	62.5%	66.7%	52.4%	40.0%	25.0%	32.5%	44.4%

Table 5

Respondents Were Asked What Triage Plan They Follow

	NVEMS	LFEMS	REMS	PEMS	CSEMS	TJEMS	ODEMSA	TEMS	BREMS	WVEMS	SWVEMS	Statewide
Agency	69.2%	28.6%	28.4%	17.2%	18.2%	25.0%	43.1%	32.3%	18.8%	26.7%	40.7%	31.6%
Region	20.6%	42.9%	59.5%	70.7%	65.5%	70.5%	39.1%	57.7%	66.7%	61.4%	39.0%	53.9%
State	7.5%	17.9%	6.8%	6.9%	10.9%	2.3%	9.8%	6.2%	12.5%	8.9%	18.6%	9.8%
None	0.9%	3.6%	2.7%	0.0%	0.0%	0.0%	5.2%	3.1%	0.0%	2.0%	1.7%	1.7%
Other	0.9%	0.0%	2.7%	0.0%	3.6%	2.3%	2.3%	0.0%	0.0%	0.0%	0.0%	1.1%
Don't Know	0.9%	7.1%	0.0%	5.2%	1.8%	0.0%	0.6%	0.8%	2.1%	1.0%	0.0%	1.8%
Total												100%

The intent of having regionalized trauma triage plans is to assure that all EMS agencies in any particular region have a sense of a point of entry plan to manage the appropriate disposition of the trauma patient. Point of entry plans should guide the attendant in charge (primary EMS caregiver) with making the correct decision about where to transport the patient. Point of entry should predetermine when to transport to the closest community hospital and when it is more beneficial to travel extra time and distance to a trauma center. Point of entry should also identify when it is appropriate to utilize an air medical resource based on time to definitive trauma care. The point of entry plan is [the] most important function of the regional trauma plan and it is vital that EMS providers and community hospitals understand its rational.

Typically point of entry plans are developed in a basic decision tree model such as the "Field Triage Decision Scheme" from the Centers for Disease Control and Prevention, which has also been adopted by the ACS/COT and the National Highway Traffic Safety Administration where the Federal Office of Emergency Medical Services resides. When reviewing the 11 Regional Trauma Triage Plans the only required section that directs EMS providers where they should transport trauma patients to is the "point of entry" section. Of the 11 regional plans four (36.6%) make some mention of point of entry and one of those essentially directs the EMS provider to contact a medical control physician for instructions. None have adopted a nationally recognized point of entry decision scheme.

To further evaluate the level of participation that exists through the regionalized trauma process by EMS agencies, community hospitals, and designated trauma centers involvement in regional trauma committees (trauma performance improvement and/or trauma triage committees) was reviewed. The level of participation of each of these groups was evaluated by reviewing all regional trauma committee meeting minutes for

FY08 using VDH/OEMS deliverables data and regional council websites as a secondary source.

What was found; 34.9 % of Virginia localities had some type of EMS agency representative at regional trauma committees. Additionally, EMS agency attendance at regional trauma meetings averaged only 6.9 % of licensed EMS agencies in Virginia. To assist in developing, monitoring, and improving trauma care in Virginia the trauma triage plans are required to involve "inter-hospital" trauma triage or the flow of trauma patients from community hospitals to designated trauma centers. The same review of quarterly trauma meetings in FY08 demonstrated that 11.3 % of community hospitals participated in this process and 55.2 % of designated trauma center participation was noted. Each designated trauma center is required to perform outreach to EMS agencies in its catchment area. EMS outreach should include EMS education, performance improvement, and provide a method of feedback on trauma patients they received by EMS agencies as outlined in section VII.D of the *Virginia Trauma Center Designation Manual*[21]. Trauma Centers are not required to do this through the regional councils.

Each regional council by contract is required to maintain a trauma performance improvement committee that meets quarterly. Of the 11 regions, seven have identified through their minutes and agendas an independent trauma PI committee and of those seven, four run their trauma performance improvement committee consecutively with their general EMS PI committee and in most cases have identical attendees on both sets of meeting minutes. A review of how much time each region dedicated to regional trauma meetings was attempted, but not enough data existed in the committee minutes. Of those with a call to order and adjourn time, the length of quarterly meetings varied from 30 minutes to 140 minutes.

Contracts between the State and the 11 regional councils no longer contain line item costs. The last year that line item costs were noted in the State contracts was in FY05 and the total cost annually for developing and maintaining Trauma Triage Plans was $66,000 and the cost associated with having a distinct regional trauma PI committee was $91,000 for a total of $157,000 per year. In FY05 most regions were not conducting these meetings and the performance noted supra for FY08 came after significant contention between the State and regions to provide the services being funded.

In an effort to have the original 1999 vision of the regional trauma triage plans and the regional trauma performance improvement committees receive all possibility of succeeding, increasing contract language has been steadily added to the State's Regional Council Contracts since 2004. Ultimately this resulted in language that defined what "regional representation" shall be. Table 6 shows the rate of compliance with quarterly trauma performance improvement committee meetings.

Table 6

Percentage of Required Attendance of Regional Performance Improvement (non-trauma)

Fiscal Year 2008	NVEMS	LFEMS	REMS	PEMS	CSEMS	TJEMS	ODEMSA	TEMS	BREMS	WVEMS	SWVEMS	Average Statewide Percentile Compliant
1st Qtr	86%	X	58%	67%	X	75%	45%	50%	53%	26%	22%	43.8%
2nd Qtr.	93%	56%	33%	33%	63%	58%	X	43%	100%	26%	28%	48.6%
3rd Qtr.	64%	67%	33%	56%	50%	50%	30%	36%	73%	35%	17%	46.6%
4th Qtr.	71%	44%	42%	28%	50%	50%	65%	36%	60%	X	11%	41.5%

(X=no meeting held)

Conclusion

The OEMS, as an agent of the State Board of Health (BOH) is required by § 32.1-111.3 to have programs in place that assist in reducing the time period between the recognition of an acutely ill or injured patient and these patients receiving definitive care. This responsibility includes designating specialty care centers such as trauma centers, now also stroke centers and it is likely that soon STEMI centers will be added and that these programs are developed based on "applicable national evaluation systems". The COV also states that OEMS shall promote and ensure a process of performance improvement for emergency care provided on scene, in transit, and within emergency departments and in-patient hospital environments.

The data in this report demonstrates that the intent of regionalized trauma triage plans is to ensure that trauma patients receive definitive trauma care within designated trauma centers, which is essential, is occurring as evidenced by the rapid drop in trauma patients receiving surgery in community hospitals which has been proven to have a higher mortality rate. The analysis supra demonstrates this rapid downward trend is more likely to have occurred as a result of the laws that were changed and the willingness of hospitals to "do the right thing" combined with complying with the new State laws. This position is taken as a result of the high volume of hospitals involved in the development of the State level trauma triage plan, therefore having a known awareness of the new laws, and that the downward trend seen in figure 5 began to occur prior to the regional plans being finalized and then being poorly distributed, especially to hospitals.

The data from the VSTR also demonstrates that trauma care is currently being provided in appropriate hospitals and a closer look at the slight increase in the trend of patients being admitted to the OR in community hospitals in figure 5 can be deemed appropriate with the exception of a total of 10 patients (three in WVEMS, three in ODEMSA, two in SWEMS, and two in PEMS regions). With little interaction occurring with community hospitals the assumption can be made that the referring of trauma patients to trauma centers by community hospitals is now a normal standard of care within the medical

community and with State level monitoring any hospital which becomes an outlier can be managed on an as needed basis.

Hospitals adopting the rapid stabilization and transfer of trauma patients as a standard of care is not likely a result of regional trauma plans as evidenced by the minimal level of community hospital involvement in the regionalized process. Regional interaction related to the movement of patients is likely only needed on the hospital level and not the EMS system level. Since the regional trauma triage plans have offered little support to inter-hospital transfer in the past, it is not likely that continued State funded support is needed to assure that these transfers occur. Current medical practice is already centered on patient transfer patterns from smaller hospitals to "referral centers" that are typically capable of providing a broader range of patient care.

EMS level regional trauma triage plans are noticeably not how EMT's and paramedics have gained their knowledge and understanding of where and when to transport patients to trauma centers. Clearly EMS providers receive this understanding through initial training and ongoing continuing medical education. As the data shows, use of regional trauma plans varies greatly from 20.6% to 70.7%. Clearly these percentage rates are not indicative of a successful statewide program, and ample efforts and opportunities have already been provided for the improvement of the current regional EMS council trauma triage program.

Furthermore, regionalized trauma triage plans are not likely to benefit EMS units as they typically deal with one patient at a time, perhaps up to four or five at incidents such as motor vehicle crash scenes. With this volume of patients, adequate resources (one ambulance for each one or two patients) are likely to be available and can function within their normal operating procedures which are guided by standard operating procedures or standing medical orders. Every EMS provider within the State operates under standing medical orders. If an incident requires regional level coordination there are adequate mass casualty, surge, and disaster plans in existence, especially post 9/11, that would manage the regional coordination originally envisioned in the pre-9/11 established trauma triage plans.

An example of how regional coordination of a mass casualty incident (MCI) would currently be managed is that there are five "regional coordination centers (RCC)," coincidentally the RCCs are our five Level I designated trauma centers, which have been identified to serve as "medical command" during an MCI. The RCC for the particular region that the incident was occurring in would connect all EMS units with all other hospitals via a dedicated radio frequency. The RCC would communicate to the EMS units at the scene of the incident where its patients will be transported to. By directing EMS units on scene, distribution of a high number of patients is evenly dispersed to all hospitals in the region and the most acutely injured transported to the designated trauma center. Consequently, regionalized trauma triage is actually being managed via a completely different process that has a proven history of success.

The existence of the current trauma triage process distracts from the development of, or support to, more efficient methods of assuring that the standards of trauma care are being followed by hospitals and EMS agencies. This assurance can only be managed by an agency that has the proper authority to intervene when needed, which is not frequently needed at this point. The current process also misuses State resources by providing over $157,000[22] in funding to a system that no data supports. In addition the manpower and resources being utilized to negotiate and manage the current process most likely exceeds the manpower that could be used to manage the isolated incidents that occur either in hospitals or with EMS providers in the field.

Two major events that drew the attention of the entire nation and were centered on traumatic incidents that should have been examples of regional trauma triage plans in action included the flying of a commercial jet airliner into the Pentagon on September 11, 2001 and the Virginia Tech shootings on April 16, 2007. Evidence of regional trauma triage plans being legitimate functional documents may include post incident reviews occurring after these two incidents. A request by OEMS for any post incident review of trauma triage after the Pentagon incident was answered by being told that Arlington Fire Department, who handled the incident, most likely reviewed the incident. Also, the regional council reported that no patients were taken to the local Level I trauma center and that all patients were transported to a nearby community hospital (personal communication 11/05/08)

With the Virginia Tech shootings the local regional council was asked by the OEMS for any post incident review of the regional trauma triage plan performed by the regional EMS council. The council referred only to a State level review which was performed under the direction of the State (personal communication 11/05/08). A review of this regional EMS council's trauma committee meeting minutes reveals that the Virginia Tech shooting incident was not discussed during the regional trauma meetings after the incident. To be precise this incident was reviewed, but not by the program being evaluated through this document.

Recommendations

Recommendation (1) – COV § 32.1-11.3 should be amended to remove the requirement of formalized regional trauma triage plans and instead require each EMS agency as part of its patient care standing medical orders to include the statewide decision scheme that identifies where patients should be transported to. The statewide protocol should give consideration to areas that do not have immediate access to trauma centers and the use of air medical resources (Medevac).

Amending the COV language related to trauma triage and specialty care hospitals to include statewide protocols on point of entry was the original recommendation of the 1995 JCHC study on trauma triage. Additionally, the original triage language placed in COV § 32.1-111.3 in the 1997 GA Session required the BOH to promulgate regulations requiring standards and criteria for the rapid access of trauma care to injured patients.

In 1998 the COV was amended to include "formalized regional trauma triage plans developed by the Regional EMS Councils". Ultimately, in the 2007 GA session the requirement that these plans be developed by the regional councils was removed. Essentially by the COV the State is required to develop regionalized trauma plans which have been demonstrated to have a low value and near 100% success could be achieved by adding the most valuable information in these plans to existing patient care protocols. This would decrease administrative processes for both the agencies and the State and provide ongoing reinforcement to health care providers of the need to transport specialty patients to specialty centers within state approved parameters.

By only requiring the point of entry decision scheme portion of the patient care protocols it allows individual agencies and their operational medical directors with the autonomy to continue developing the treatment portion of these protocols and therefore maintaining their autonomy. The science and data are conclusive on the subject of rapidly transporting/transferring trauma patients directly to trauma centers. Should an incident with a bad outcome occur it would be judged against these standards.

Recommendation (2) - OEMS should include as part of the proposed revised EMS Regulations revised language to 12VAC5-31-390 that requires EMS agencies to follow regional trauma triage plans. 12VAC5-31-390 should instead direct EMS agencies to include the triage of acutely ill or injured patients to the appropriate specialty care hospital i.e. trauma patient to trauma centers, stroke patients to stroke centers.

12VAC5-31-390. ~~Destination/trauma triage~~ Destination to specialty care hospitals.

~~An EMS agency shall participate in the regional Trauma Triage Plan established in accordance with § 32.1-111.3 of the Code of Virginia.~~

An EMS agency shall follow Specialty Care Hospital Triage Plans (Trauma, Stroke, and others as recognized by OEMS) established in accordance with § 32.1-111.3 of the Code of Virginia. EMS agencies shall have a component of their OMD approved patient care protocols; a triage component consistent with Code of Virginia mandated state specialty care hospital triage plans.

(Source: excerpted from the draft EMS Regulations currently being introduced into the Notice of Intended Regulatory Action process[23]).

It was clearly intended through the 1997 GA that the State should assure compliance with trauma triage (and now stroke triage since the 2008 GA) both in the pre-hospital and inter-hospital environment. Attempts were made to regionalize this process from its inception and then significant energy was again expelled in 2005 to encourage meeting the expectations of regional programs with little documented proof of its success.

Trauma Center Designation criteria in Virginia are developed based on accepted national standards such as the guidelines distributed by ACS/COT in their *Resources for the Optimal Care of the Injured Patient 2006*. Within this document is a triage scheme that has also been adopted by the CDC and NHTSA. OEMS should utilize this document as it has the rest of the ACS/COT book and develop a statewide trauma triage scheme that

will be incorporated into all EMS agencies patient care protocols in the applicable sections. This should in fact already be occurring.

Neighboring states such as Pennsylvania[24], Maryland[25], and North Carolina have adopted statewide triage protocols that mirror the ACS/COT triage scheme and provide clear guidelines of when bypassing community hospitals or use of air medical resources is appropriate. By placing such items in statewide protocols the wide gap in treatment protocols can become consistent, which will benefit patients by using science that has been proven to decrease morbidity and mortality. Many EMS providers also practice at more than one EMS agency and may have a variety of protocols to follow, furthering the gap.

Since the survey noted supra clearly demonstrates that education is the primary source of providers' knowledge and comfort with triage, adding the decision scheme to patient care protocols will ensure reinforcement during the EMS provider's orientation to their agency and while learning their scope of practice within that agency. Also, adding triage decision schemes to patient care protocols is likely to increase EMS provider exposure to triage closer to 100% rather than the varied 20% - 70% seen in the data analysis for this document.

Adequate resources exist on the State level to work with the trauma advisory committee to develop State level resource materials to assist EMS agencies and/or community hospitals with the information needed to develop patient care protocols (EMS) or transfer guidelines (hospitals). OEMS should request the Trauma System Oversight and Management Committee establish a trauma performance improvement committee to assist in blinded reviews of miss-triaged incidents. Responsibility for communicating cases deemed inappropriate should be between the State and the agency or hospital involved as needed. This should be a performance improvement based program to the extent possible.

Recommendation (3) – The OEMS should institute measures to monitor and ensure that trauma and other forms of time sensitive illnesses or injuries that are covered by the Code of Virginia and/or EMS Regulations are being transported to specialty resource centers as originally envisioned in § 32.1-111.3 and 12VAC5-31-390. § 32.116.1 allows the collection of data from hospitals and EMS agencies for this purpose. Deviations from the State standard of triage should be managed directly between the State and the specific hospital or EMS agency.

With the current system of non-profit entities being contracted with to provide assurance of proper triage there can be no guarantee of intervention for an incidence of improper triage by a hospital or EMS agency. This responsibility should be provided by the OEMS who has authority to act upon such events. Matters that can be better managed on a local level through established agency performance improvement programs, agency leadership, or operational medical directors should be handled within those processes. Incidents that rise above the level of being handle as a quality issue must be managed in accordance with the Administrative Process Act of Virginia § 2.2-4000[26].

Recommendation (4) - OEMS should continue to ensure that triage of patients to appropriate specialty resource centers remains part of EMS provider initial and ongoing education.

The statistically significant random survey of EMS providers understanding of trauma triage strongly identifies EMS education as a primary source of understanding the rational of triage

Recommendation (5) – OEMS should assure that the emerging Stroke Triage program and the potentially developing STEMI Triage program are developed in a similar fashion to Trauma Triage.

This "all hazards" approach to time sensitive illnesses and injury will result in a higher level of success for each program as educational opportunities will help to reinforce one another. Also, utilizing a similar basic scheme of identifying specialty patients and utilizing similar criteria of getting them to the appropriate specialty center will decrease the burden of implementing several different triage programs.

Developing multiple plans can lead to confusion for the frontline providers and burdens the leadership that has to develop the processes. By adopting more of an all hazards approach, Stroke Triage and likely soon to follow is STEMI Triage should be easily transitioned into the system with little use of limited resources. Similar methods can also be used to monitor areas that need improvement with any time sensitive illnesses or injuries.

Recommendation (6) – The FY10 Regional EMS Council Contracts should not include trauma triage or trauma specific performance improvement requirements. The section dedicated to the development of patient care protocols should be enhanced to include nationally accepted trauma and stroke decision schemes to assist the approximately 50% of EMS agencies that utilize regionally developed patient care protocols.

Clearly the data shows that that the success of regional trauma triage process and regional trauma performance improvement has an overall level of minimal success. As with other common EMS response types trauma care has an established standard of care that no longer requires regional monitoring above other medical conditions, it is clearly understood by EMS providers that severely injured persons are "trauma patients" and they need to be entered into the "trauma system", which includes community hospitals, bypassing community hospitals for trauma centers, use of air medical resources, or direct transfer to a trauma center.

With the recommended removal of these programs designated trauma centers will still be required to perform outreach, including performance improvement and education, to EMS agencies. This requirement is closely monitored through the Trauma Center Designation process. For EMS agencies they are required by 12VAC5-31-570 to have a

quality monitoring program in place. OEMS should place an emphasis on assuring that each agency has this quality monitoring in place and functioning and if a process of accrediting EMS agencies comes to fruition this should be a major focus of those efforts.

Additionally the draft EMS Regulations currently in the NOIRA process include expanding 12VAC5-31-570 to include that each EMS agency maintain a Quality/Data Officer to ensure that Code mandated and regulatory required quality and data submission programs are occurring within their agency. This will also allow the State to have a direct contact to pass on information related to items that need to be communicated to enhance quality.

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