Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, February 5, 2016

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board

February 5, 2016

MISSION STATEMENT:

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

I. Executive Management, Administration & Finance

A) Action Items before the State EMS Advisory for February 5, 2016

At the time of finishing this report there were no action items reported from any Standing Committees or Work Groups of the Board.

B) Proposed Emergency Medical Services Budget for 2016 – 2018 Biennium

Item 289	First Year - FY2017	Second Year - FY2018
Emergency Medical Services (40200)	$42,969,058	$42,969,058
Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	$35,159,839	$35,159,839
State Office of Emergency Medical Services (40204)	$7,809,219	$7,809,219
Fund Sources:		
Special	$18,184,334	$18,184,334
Dedicated Special Revenue	$24,379,141	$24,379,141
Federal Trust	$405,583	$405,583

Authority: §§ 32.1-111.1 through 32.1-111.16, 32.1-116.1 through 32.1-116.3, and 46.2-694 A 13, Code of Virginia.

A. Out of this appropriation, $25,000 the first year and $25,000 the second year from special funds shall be provided to the Department of State Police for administration of criminal history record information for local volunteer fire and rescue squad personnel (pursuant to § 19.2-389 A 11, Code of Virginia).

B. Distributions made under § 46.2-694 A 13 b (iii), Code of Virginia, shall be made only to nonprofit emergency medical services organizations.

C. Out of this appropriation, $1,045,375 the first year and $1,045,375 the second year from the Virginia Rescue Squad Assistance Fund and $2,052,723 the first year and $2,052,723 the second year from the special emergency medical services fund shall be provided to the Department of State Police for aviation (med-flight) operations.

D. The State Health Commissioner shall review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state and local level that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens. As sources are identified, the commissioner shall work with any federal and state agencies and the Trauma System Oversight and Management Committee to assist in securing additional funding for the trauma system.

E. Notwithstanding any other provision of law or regulation, the Board of Health shall not modify the geographic or designated service areas of designated regional emergency medical services councils in effect on January 1, 2008, or make such modifications a criterion in approving or renewing applications for such designation or receiving and disbursing state funds.

F. Notwithstanding any other provision of law or regulation, funds from the $0.25 of the $4.25 for Life fee shall be provided for the payment of the initial basic level emergency medical services certification examination provided by the National Registry of Emergency Medical Technicians (NREMT). The Board of Health shall determine an allocation methodology upon recommendation by the State EMS Advisory Board to ensure that funds are available for the payment of initial NREMT testing and distributed to those individuals seeking certification as an Emergency Medical Services provider in the Commonwealth of Virginia.

G. Out of this appropriation, up to $400,000 the first year and up to $400,000 the second year from the Virginia Rescue Squad Assistance Fund shall be used for grants to

emergency medical services organizations to purchase 12-lead electrocardiograph monitors.

H. Out of this appropriation, $90,000 the first year and $90,000 the second year from the Virginia Rescue Squad Assistance Fund shall be provided for national background checks on persons applying to serve as a licensed provider in a licensed emergency medical services agency. The Office of Emergency Medical Services may transfer funding to the Office of State Police for national background checks as necessary.

C) § 3-1.01 INTERFUND TRANSFERS

S. The State Comptroller shall transfer quarterly, one-half of the revenue received pursuant to § 18.2-270.01, of the Code of Virginia, and consistent with the provisions of § 3-6.03 of this act, to the general fund in an amount not to exceed $6,055,000 the first year, and $6,055,000 the second year from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203).

X. On or before June 30 each year, the State Comptroller shall transfer $7,518,587 the first year and $7,518,587 the second year to the general fund from the $2.00 increase in the annual vehicle registration fee from the special emergency medical services fund contained in the Department of Health's Emergency Medical Services Program (40200).

D) § 3-6.00 Adjustments and Modifications to Fees

§3-6.02 ANNUAL VEHICLE REGISTRATION FEE ($4.25 FOR LIFE)

Notwithstanding §46.2-694 paragraph 13 of the Code of Virginia, the additional fee that shall be charged and collected at the time of registration of each pickup or panel truck and each motor vehicle shall be $6.25.

§ 3-6.03 DRIVERS LICENSE REINSTATEMENT FEE

Notwithstanding § 46.2-411 of the Code of Virginia, the drivers license reinstatement fee payable to the Trauma Center Fund shall be $100.

E) Rescue Squad Assistance Fund for Ambulance Stretcher Retention

Systems (language only)

Item 289 #1h

Office of Health and Human Resources

Department of Health

Language

Page 238, line 21, after "B." insert "1."

Page 238, after line 22, insert:

"2. Out of the distribution made from paragraph B.1. from the special emergency medical services fund for the Virginia Rescue Squad Assistance Fund, $840,000 the first year and $840,000 the second year shall be used for the purchase of new ambulance stretcher retention systems as required by the federal General Services Administration."

Explanation

(This amendment allocates $840,000 each year from the Virginia Rescue Squad Assistance Fund (RSAF) for the purchase of federally required ambulance stretcher retention systems. Language allows only non-profit Emergency Medical Services agencies to receive the funds. The costs to meet the new federal standards is $40,000 per unit.)

F) Legislation Introduced in the 2016 Virginia General Assembly Directly Impacting EMS or Bills of Interest to EMS.

Legislation tracked by the Office of EMS is included in a Grid in **Appendix A** of this report. The statuses of these bills are as of Friday, January 22, 2016. There are four (4) bills that the Office of EMS has been assigned as lead agency to track, testify and make recommendations to the Commissioner of Health. These six bills follow:

1. **HB222 - Recognition of EMS Personnel Licensure Interstate Compact.**

   Creates the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact to(i) protect the public through verification of competency and ensure accountability for patient-care-related activities of licensed emergency medical services (EMS) personnel, (ii) facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority, and (iii) authorize state EMS offices to afford immediate legal recognition to EMS personnel

licensed in a member state. The bill includes an enactment clause authorizing the State Emergency Medical Services Advisory Board to review decisions of the Interstate Commission for EMS Personnel Practice and, upon approval by the Interstate Commission of any action that will have the result of increasing the cost to the Commonwealth of membership in the compact, recommend to the General Assembly that the Commonwealth withdraw from the compact. The bill also provides that the compact shall expire on July 1, 2021, if it has not become effective as a result of enactment into law by at least 10 member states.

2. **HB1007 - Recognition of EMS Personnel Licensure Interstate Compact.**

   This bill is a duplicate of HB222 with the exception of the Enactment Clauses.

3. **SB233 - Recognition of EMS Personnel Licensure Interstate Compact.**

   This bill is a duplicate of HB222

4. **HB311 - Emergency medical services providers; interstate agreements.**

   Directs the Secretary of Health and Human Resources to undertake efforts to establish collaborative agreements with other states to allow emergency medical services providers to provide emergency medical services across state lines and to report back to the General Assembly regarding the status of such efforts no later than November 1, 2016. The bill contains an emergency clause.
   Delegate Orrock has indicated his support for the REPLICA legislation. He also has indicated that he has offered this legislation as an interim measure, since REPLICA does not become effective until 10 states have adopted REPLICA. Currently, four states have enacted REPLICA legislation.

G) EMS Voluntary Event Notification Tool (E.V.E.N.T.)

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

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

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate

E.V.E.N.T. Notification Tool (Patient Safety Event, Near Miss Event, Violence Event). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

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

Appendix B contains an aggregate report of **patient safety events** reported to E.V.E.N.T. in the third quarter of 2015 (July through September 2015). **Third Quarter 2015 EVENT Patient Safety Summary Report**

Appendix C contains an aggregate report of the **provider violence events** reported to E.V.E.N.T. for the third quarter of 2015 (July through September 2015). **Third Quarter 2015 EVENT Provider Violence Summary Report**

Appendix D contains an aggregate report on **Near Miss** for the second (April through June 2015) and third quarter of 2015 (July through September 2015). Second and Third Quarter 2015 EVENT Near Miss Summary Report

Support of this online reporting tool by EMS organizations across the nation is key to its successful use. The Virginia Office of EMS is a site partner and is recognized by our logo posted on the E.V.E.N.T. site. A link to the E.V.E.N.T. site is also posted on the OEMS Web site at http://www.vdh.virginia.gov/OEMS/EO/EVENT.htm . EMS agencies that already have internal reporting processes are asked to also submit their incidents into E.V.E.N.T.

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

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

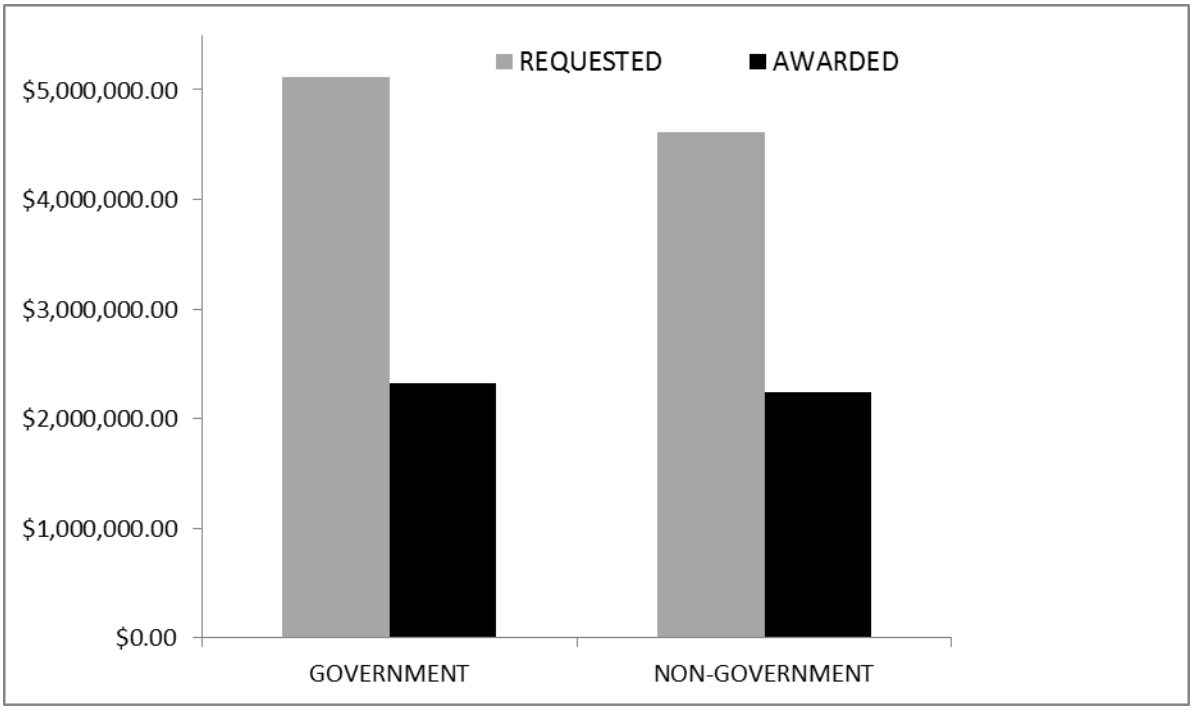
The RSAF grant deadline for the Fall 2015 grant cycle was September 15, 2015, OEMS received 116 grant applications requesting $9,723,262.00 in funding, $4,558,021.81 in funding was awarded to 86 agencies.

Funding was awarded in the following agency categories:

- 52 Non-Government Agencies awarded $2,239,809.00

- 34 Government Agencies awarded $2,318,213.00

Figure 1: Requested vs Amount Awarded by Agency Category

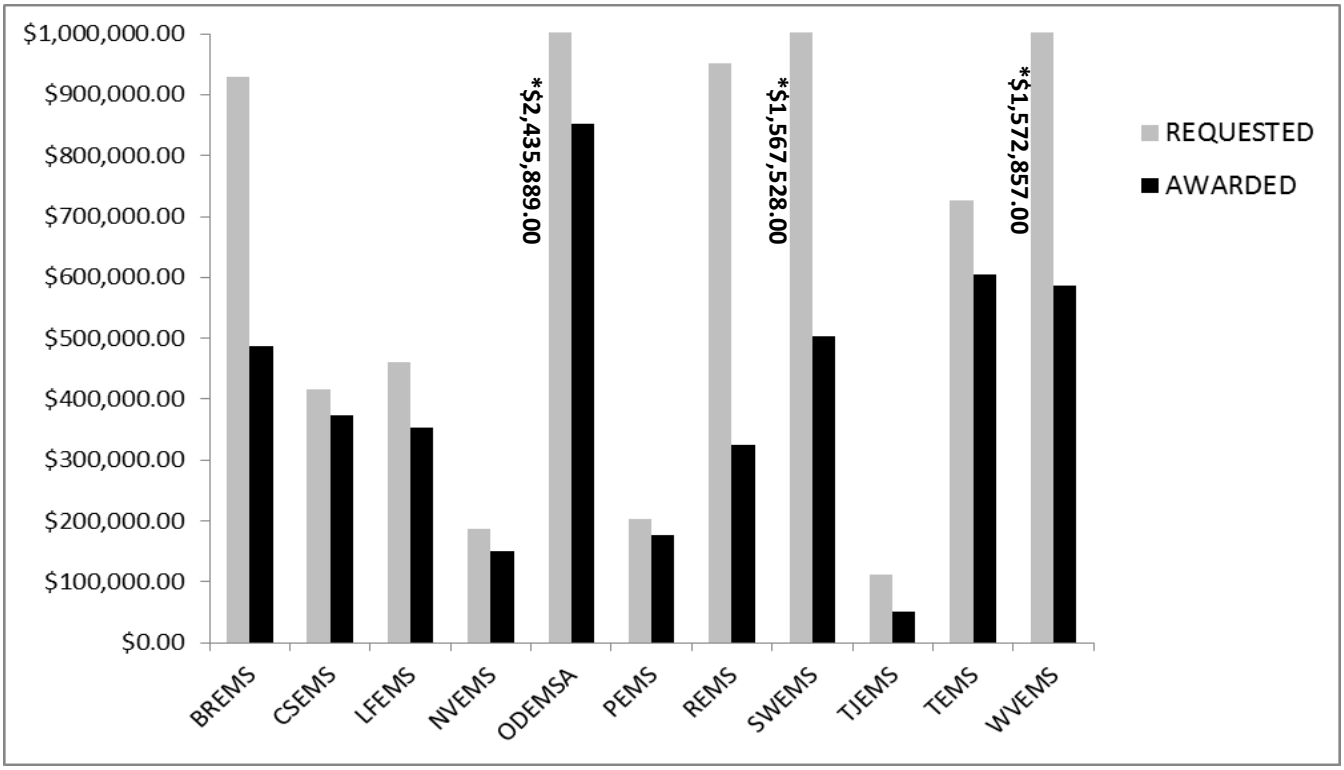


The following EMS regional areas were awarded funding in the following amounts:

- Blue Ridge EMS Council – 7 agencies awarded $486,182.00
- Central Shenandoah EMS Council – 8 agencies awarded $373,985.00
- Lord Fairfax EMS Council – 4 agencies awarded $353,854.00
- Northern Virginia EMS Council - 2 agencies awarded $150,912.00
- Old Dominion EMS Alliance – 16 agencies awarded $851,582.00
- Peninsulas EMS Council – 5 agencies awarded $177,763.00
- Rappahannock EMS Council – 10 agencies awarded $325,439.00
- Southwestern Virginia EMS Council – 9 agencies awarded $502,904.00
- Thomas Jefferson EMS Council – 2 agencies awarded $50,805.00
- Tidewater EMS Council – 9 agencies awarded $604,761.00
- Western Virginia EMS Council – 12 agencies awarded $587,059.00

Note: Two non-affiliated agencies were awarded funding in the amount of $92,775.00

Figure 2: Requested vs Amount Awarded by EMS Regions



*Note: Three of the Regional Councils had a higher requested amount than shown, the figure represents categories up to $1,000,000.00 to give a clearer picture of the data.

Note: There were two non-affiliated agencies that are not represented on the map that requested funding in the amount of $98,775.00, those two agencies were awarded funding in the amount of $92,775.00.

RSAF Grants Awarded by item categories:

- 12 –Lead – $798,178.00
  - Includes all 12-Lead Defibrillators.

  Audio Visual/Computer Hardware - $99,464.00
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - $231,823.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.

- Emergency Operations - $97,410.00
  - Includes items such as Mass Casualty Incident (MCI), extrication equipment, rescue boat and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.

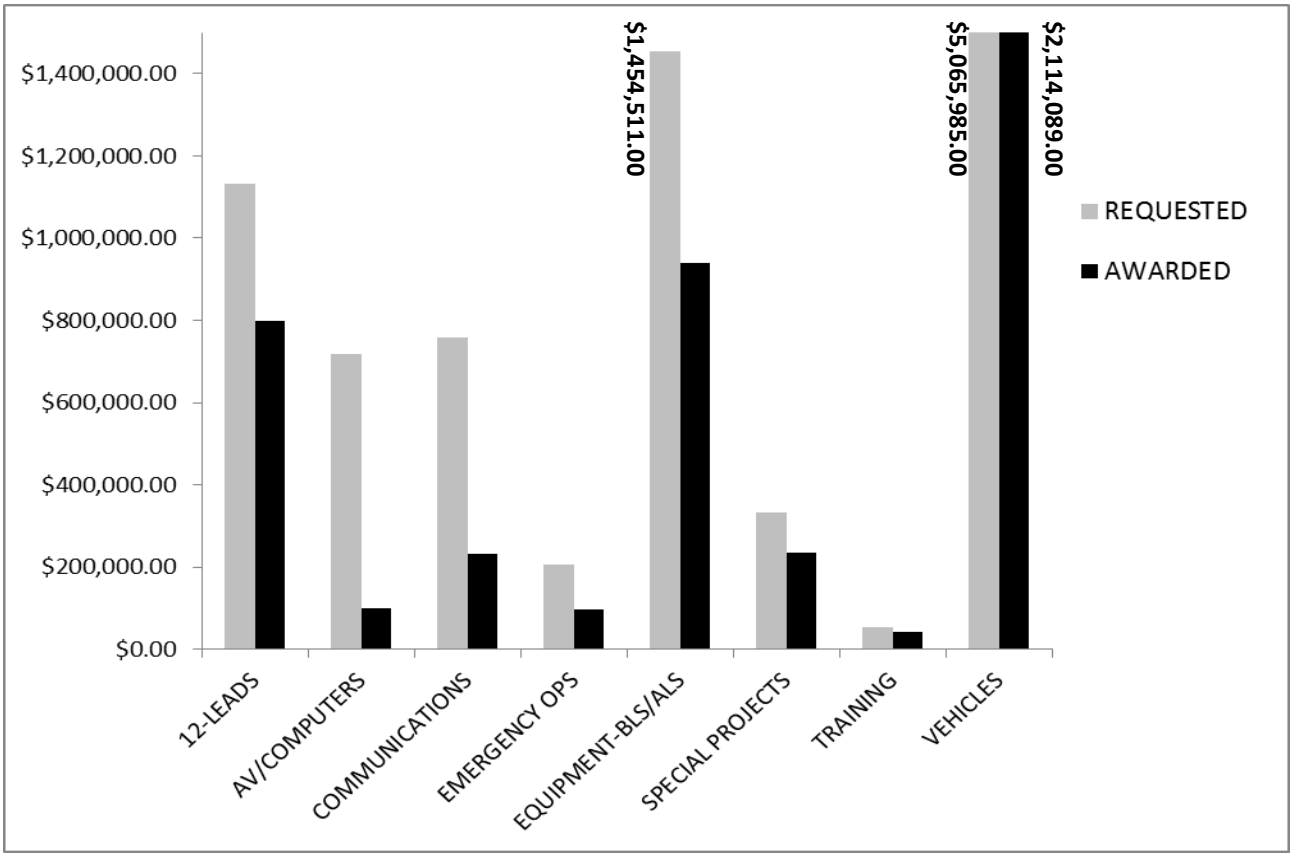
- Equipment - Basic and Advanced Life Support Equipment - $938,933.00
    - Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.

- Special Projects - $234,801.00
    - Includes projects such as Special Project material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects, Protocol Projects and other innovative programs.

- Training - $43,324.00
    - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.

- Vehicles - $2,114,089.00
    - This category includes all vehicles such as ambulances, re-chassis, re-mounts and quick response vehicles.

Figure 3: Requested vs Amount Awarded by Item



Note: The Vehicles category had a requested amount of $5,065,985.00 with an award amount of $2,114,089.00. The figure represents categories up to $1,400,000.00 to give a clearer picture of the data.

The Spring 2016 grant cycle will begin on February 1, 2016 with a deadline of March 15, 2016; grants will be awarded July 1, 2016.

Rescue Squad Assistance Fund Emergency Grants

Cana Volunteer Rescue Squad was awarded an emergency grant for 1 2016 Ford F-450 Ambulance in the amount of $207,345.00 at a 100/0 (state/agency) funding level. This grant was awarded due to a mass vehicle collision from an on-coming vehicle causing damage to the unit that was unable to be repaired. An ambulance, power-load system and power stretcher were awarded.

EMS on the National Scene

II. EMS On the National Scene

National Association of State EMS Officials (NASEMSO)

Note: The Virginia Office of EMS is an active participant in the NASEMSO and has leadership roles on the Board of Directors and in each NASEMSO Council. The National Association of State EMS Officials is the lead national organization for EMS, a respected voice for national EMS policy with comprehensive concern and commitment for the development of effective, integrated, community-based, universal and consistent EMS systems. Its members are the leaders of their state and territory EMS systems.

a) Public Comment Opportunity Available on EMS Fatigue Project

The National Association of State EMS Officials (NASEMSO) recently finalized a contract with the National Highway Traffic Safety Administration (NHTSA) Office of Behavioral Safety Research to help address the growing concern for the sleep health and fatigue of emergency medical services (EMS) clinicians and the impact of fatigued workers on crew and patient safety. Dr. Daniel Patterson, NRP of the Carolinas Health System will serve as the Principal Investigator. NHTSA will officially announce the initiative and accept comments from the public about the development of voluntary fatigue risk management guidelines and resources tailored to the EMS occupation at a national stakeholder meeting on February 2, 2016 in Washington, DC. Brief presentations will address the potential dangers of drowsy and fatigued driving and the work of EMS practitioners, including the risk of traffic crashes and providing patient care, a summary of the project goals and methods for coming to consensus on EBG fatigue risk management guidelines, the plan for dissemination of EBGs, and additional project related activities and information. A majority of the time in the meeting will be set aside to accept questions and comments from registered attendees. This is to ensure that the voluntary fatigue risk management guidelines will address the needs of the entire and diverse EMS community. Individuals and organizations can provide electronic comments via http://www.regulations.gov Docket No. NHTSA-2015-0121 or pursuant to the instructions included in the Federal Register Notice. To register for the meeting by including your name and organization and whether or not you wish to submit verbal or written comments please email: james.higgins@dot.gov

b) NASEMSO Facilitates Discussion on "New MS" Value Proposition

A steering committee of national EMS organizations has formed to provide guidance and resources and to provide consensus on issues of nomenclature in addressing the evolving world of community paramedicine (CP) and mobile integrated healthcare (MIH). A "first draft" document has been circulated for organizational input and endorsement that is now available on the NASEMSO web site at:
http://www.nasemso.org/Projects/MobileIntegratedHealth/documents/Defining-the-Role-of-EMS-in-our-Nations-Health-Care-Transformation.pdf

c) New NTAS Widget an Added Feature to NASEMSO Web Site

The Department of Homeland Security (DHS) recently added a feature to its National Terrorism Advisory System (NTAS) that has been incorporated into NASEMSO's web site under Domestic Preparedness. In 2011, the DHS replaced the color-coded alerts of the Homeland Security Advisory System (HSAS) with the NTAS, designed to more effectively communicate information about terrorist threats by providing timely, detailed information to the American public. NTAS will now consist of two types of advisories: Bulletins and Alerts. DHS has added Bulletins to the advisory system to be able to communicate current developments or general trends regarding threats of terrorism. NTAS Bulletins permit the Secretary to communicate critical terrorism information that, while not necessarily indicative of a specific threat against the United States, can reach homeland security partners or the public quickly, thereby allowing recipients to implement necessary protective measures. Because DHS may issue NTAS Bulletins in circumstances not warranting a more specific warning, NTAS Bulletins provide the Secretary with greater flexibility to provide timely information to stakeholders and members of the public. Alerts may take one of two forms: Elevated, if DHS has credible threat information, but only general information about timing and target such that it is reasonable to recommend implementation of protective measures to thwart or mitigate against an attack, or Imminent, if the Agency believes the threat is credible, specific, and impending in the very near term. Go to: https://www.nasemso.org/Projects/DomesticPreparedness/.

d) NASEMSO Adds Voice to Sponsor Letter on DEA Regulation of Field EMS

Considerable confusion exists around Drug Enforcement Agency (DEA) regulations and expectations regarding controlled substance medications in the field EMS environment as current regulations do not take into account the significant differences between field EMS practice and that of other healthcare entities covered by the same regulation. DEA anticipates releasing regulations with greater clarity but they have indicated that they will continue to prohibit "standing orders" in regard to dispensing controlled substances to field EMS patient. The National Association of State EMS Officials (NASEMSO) has endorsed a multiorganizational letter to support the efforts of Congressman Richard Hudson (NC) to introduce a Bill that would amend the Controlled Substances Act by adding a new section that would create an appropriate

DEA regulation for field EMS. Hudson's "Protecting Patient Access to Emergency Medications Act" provides the DEA a firm statutory foundation from which to oversee the use of controlled substances in field EMS and prevent drug diversion while ensuring essential medicines are provided to patients in need. A copy of the letter is available at: http://www.nasemso.org/Advocacy/Supported/index.asp.

e) NAEMSP Posts Toolkit for Supporters of H.R. 4365: Protecting Patient Access to Emergency Medications Act of 2016

The Protecting Patient Access to Emergency Medications Act of 2016 (H.R. 4365) was introduced Jan. 12, 2016, by Rep. Richard Hudson (R-NC). H.R. 4365 would codify the practice of allowing EMS providers to administer controlled substances per standing order by a physician medical director. In addition, it would allow the EMS agency to register for the DEA number, rather than rely on the physician medical director's DEA registration. Download the bill text at: https://www.congress.gov/bill/114th-congress/house-bill/4365/.

On Jan. 20, the National Association of EMS Physicians posted a toolkit to encourage grassroots support of H.R. 4365, in order to gain co-sponsors and support for the bill. The toolkit, available at: http://www.naemsp.org/Pages/Advocates-for-EMS.aspx provdies a sample letter, talking points, a fact sheet, and contact information for the health care legislative aid for each office.

f) Congresswoman Sheila Jackson Lee Thanks NASEMSO for Supporting the FRIENDS Act

The First Responder Identification of Emergency Needs in Disaster Situations (FRIENDS Act) passed the House on Dec. 10, 2015, by a roll call vote of 396 to 12, with 25 not voting. The Congresswoman in her statement acknowledged and thanked NASEMSO for its assistance with the bill, saying the support of the National Association of State EMS Officials was invaluable to the passage of the FRIENDS Act. She is looking forward to continuing to work with NASEMSO on getting bill through the Senate and to the President's desk. Download her statement at: http://www.nasemso.org/Advocacy/Supported/documents/SJL-FloorStatement-HR2795-10Dec2015.pdf.

g) NASEMSO Sends Letter SSL/CSG on Suggested State Legislation Item 07-37A-07 on MIH Care

NASEMSO sent a recommendation to the Suggested State Legislation (SSL) Committee of the Council of State Governments (CSG) urging them to initiate its process for developing and inserting a note for community paramedicine-mobile integrated healthcare (CP-MIH) in the SSL publication being considered, rather than accepting item 07-37A-07 on Mobile Integrated Health Care, at its recent meeting in Nashville. The letter stated that developing a well-considered note concerning this state issue of national significance in place of accepting item 07-37A-07 is a prudent course of action. Download the letter here: http://www.nasemso.org/Advocacy/Supported/documents/NASEMSO-Letter-to-CSGSSL-03Dec2015.pdf.

h) NAEMSE and NREMT Partner to Offer Scenario Development Workshops

Beginning January 1, 2017, the NREMT will start testing Phase 1 of the new scenario psychomotor exam. In this phase, a total of six (6) skills will be tested, five (5) currently evaluated in the NRP psychomotor examination and one (1) out-of-hospital scenario. This out-of-hospital scenario will reflect either a pediatric, geriatric, or adult patient. Each candidate will be provided with a trained paramedic partner and evaluated on his/her ability to manage a call, lead the team, effectively communicate, and maintain professionalism throughout the simulated patient encounter. To assist Paramedic programs in preparing for these changes, the NREMT & NAEMSE will be conducting Regional Scenario Development Workshops in 2016. Workshops will be limited to 50 participants who will be guided through the scenario development process by NREMT staff. Topics that will be covered are scenario writing, calibration, and evaluation in the workshop. All of the scenarios created will then be available for use by participants in their training programs following the workshop.

For more information go to: http://naemse.org/?page=nremt.

i) New NAEMSE Vision Paper Supports SUPER Study

The National Association of EMS Educators (NAEMSE) is proud to announce the release of a new Vision Paper that coincides with the extensive simulation report entitled "Simulation Use in Paramedic Education Research (SUPER): A Descriptive Study," which was released earlier this year. It is the hope of NAEMSE that this new Vision Paper will help to build a more complete body of knowledge regarding use of simulation, uncover barriers to effective implementation, and outline recommendations for improvement. For more information go to: https://c.ymcdn.com/sites/naemse.site-ym.com/resource/resmgr/Docs/SimPressRelease15.pdf.

j) NFPA 1917 Standard Comment Period Now Open

The National Fire Protection Association (NFPA) 1917 Standard for Automotive Ambulances -- NFPA 1917, 2016 edition is now able to accept public inputs for the next edition. The link can be accessed at: www.nfpa.org/1917.

k) Petition Being Circulated to Support a National EMS Memorial in Washington DC

Congressman Stephen F. Lynch recently introduced H.R. 2274, a bill to establish a National EMS Memorial. The legislation creates the National Emergency Medical Services Memorial Foundation, which will undertake the effort of designing, siting, and creating a memorial in Washington, D.C., to honor the service and sacrifice of the nation's EMS members. Each year, 850,000 EMS providers answer more than 30 million calls to serve 22 million patients in need of care at a moment's notice and without reservation. To date, more than 600 men and women have died in the line of duty while caring for others. H.R. 2274 will ensure that a commemorative work is created in the nation's capital that will recognize the ultimate sacrifice of EMS providers and will honor the dedication of EMS members nationwide. See online petition at:

https://petitions.whitehouse.gov/petition/support-hr-2274-bill-establish-national-emergency-medical-services-memorial-washington-dc.

l) FAA Offers Technical Amendment for Pilot Qualifications Under Part 135 Operations

The Federal Aviation Administration (FAA) is correcting a final rule published on July 15, 2013. In that rule, the FAA amended its regulations to create new certification and qualification requirements for pilots in air carrier operations. The FAA unintentionally required without notice and comment that if a certificate holder conducting part 135 operations who has voluntarily chosen and been authorized to comply with the part 121 training and qualification requirements, a pilot serving as a second in command in part 135 for that certificate holder is required to have an airline transport pilot certificate and an aircraft type rating. This document corrects those errors and makes several additional miscellaneous corrections to part 61 and a cross-reference error in part 121.

m) House and Senate Bills Advocate for Higher Air Ambulance Reimbursement

As S.1149 and its companion Bill in the House (H.R.822) continue to wind through House and Senate Committees of the 114th Congress, the following summary is provided for informational purposes:

- This bill amends title XVIII (Medicare) of the Social Security Act to direct the Secretary of Health and Human Services, with respect to air ambulance services furnished during 2017 or any subsequent year, to reduce the mandatory percentage increase (inflation adjustment) for payments under the fee schedule by 2.0% for any supplier or provider that fails to submit to the Secretary specified data.
- The Secretary is required to select at least two quality measures with respect to which such providers and suppliers may voluntarily submit such data.

- The Government Accountability Office is required to report to Congress on all such data, together with a recommendation on the adequate amount of Medicare reimbursement to providers and suppliers that would reflect their operational costs and preserve access to critical air medical services.

- The Secretary is required, in the case of air ambulance services furnished during calendar 2017 through 2021 to make a percentage increase in the base rate of the fee schedule: (1) by 20% during 2017, and (2) by 5% during 2018-2020.

- The Secretary must also, for 2017 through 2020, adjust such percentages, by either increasing or reducing them (but in no case below zero) to ensure that the increased expenditures under this Act are equal to the reduced expenditures.

n) AHRQ Study: Ambulatory 'Revisits' Occur Frequently, Often Due to Complications

Ambulatory "revisits"—the outpatient equivalent of hospital readmissions—occur frequently and are often associated with complications, a new AHRQ-funded study found. The study, published as a research letter in JAMA, used AHRQ's Healthcare Cost and Utilization Project to analyze data from more than 480,000 low- to moderate-risk ambulatory operations. Researchers found a rate of 95 all-cause revisits per 1,000 operations; most revisits were to emergency departments (59 per 1,000 operations) followed by inpatient surgery settings (27 per 1,000 operations). Across all operations and settings, two-thirds of the revisits (65 per 1,000) were for complications related to the procedure, with the remaining being attributed to unrelated conditions. The authors concluded that more detailed study is needed to understand the nature of these revisits and determine which complications may be preventable. Read the research letter at: http://jama.jamanetwork.com/article.aspx?articleid=2449176.

o) DOT Invites Public Comment on State Submission of NEMSIS Data

NHTSA supports and funds NEMSIS to further its goal of reducing death and disability on the Nation's roadways. The NEMSIS Technical Assistance Center (TAC) assists State and local EMS agencies and software vendors in implementing NEMSIS Version 3.0 (and higher)-compliant EMS data systems and the corresponding XML standard to support data transmission and interoperability. NHTSA also maintains the National EMS Database and a national reporting system. NHTSA supported the initial development of the National EMS Information System, including the supporting Data Dictionary and technology infrastructure, at the request of the National Association of State EMS Officials. This effort developed the first-ever standardized EMS patient care reporting mechanism, which would provide essential information that could lead to improved patient care at local, State and national levels. In order for NHTSA to continue to collect NEMSIS data from states, federal regulations require NHTSA to obtain Office of Management and Budget (OMB) approval. Under procedures established by the Paperwork Reduction Act of 1995, before seeking OMB approval, Federal agencies must solicit public comment on proposed collections of information, including extensions and reinstatement of previously approved collections. Readers that understand the value of NEMSIS data and participation by the states are encouraged to submit comments in support of the program to Federal Docket No. NHTSA-2015-0051 "Agency Request for Approval of a New Information Collection: National Emergency Medical Services Information System- State Submission to National EMS Database" prior to the February 4, 2016 deadline. For more information go to: https://www.gpo.gov/fdsys/pkg/FR-2016-01-05/pdf/2015-33134.pdf.

p) NEMSIS Dataset Available for Research Purposes

The NEMSIS TAC released the 2014 NEMSIS Public-Release Research Dataset in August of 2015. The dataset contains 25,835,729 EMS activations submitted by 9,693 EMS agencies

serving 48 states and territories during the 2014 calendar year. This dataset is made available (free of charge) to persons interested in conducting EMS-related research at: http://www.nemsis.org/reportingTools/requestNEMSISData.html.

The data may also be accessed (online) using the NEMSIS Cube, which includes a three-year rolling dataset (over 60 million EMS activations). The NEMSIS Cube is available at: http://www.nemsis.org/reportingTools/reports/nationalReports/createAReport.html.

For additional information contact N. Clay Mann at: clay.mann@hsc.utah.edu.

q) FirstNet Board Approves Release of RFP

The First Responder Network Authority (FirstNet) Board recently approved the Request for Proposal (RFP) to deploy the nationwide public safety broadband network (NPSBN) and directed management to take all necessary actions to release the RFP in early January. The Board's approval advances FirstNet's Strategic Program Roadmap and moves FirstNet a step closer to establishing a public-private partnership to build, operate, and maintain the NPSBN. The FirstNet RFP is objectives based and incorporates public safety's needs for a nationwide broadband network. Central to this approach, FirstNet issued multiple Requests for Information, Public Notices, and Special Notices for public comment. FirstNet also collected vital stakeholder feedback on the RFP documents through consultation and outreach with public safety partners nationwide.

r) 2016 Health IT Interoperability Standards Now Available

The Office of the National Coordinator for Health Information Technology (ONC) has issued its 2016 catalog of standards for interoperable health IT, which incorporates two rounds of public comments and recommendations made in response to the inaugural 2015 document. The 2016 Interoperability Standards Advisory serves as the single resource of emerging and existing federally recognized health IT standards. In a recent post to the HealthITBuzz blog, two ONC officials called the 2016 Interoperability Standards Advisory a "critical element" of the vision for healthcare delivery reform because it enables health data to be unlocked, securely accessed and applied to healthcare decisions. Specifically, the 2016 Interoperability Standards Advisory includes significant structural changes. These changes expanded the Standards Advisory's depth and breadth. Most notably, the 2016 Advisory includes six informative characteristics for each standard and implementation specification referenced. For more information go to: https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf.

s) OIG Identifies Security Concerns with FEMA eGrants System

In a recent report by the Department of Homeland Security's (DHS) Office of Inspector General, recommendations to address weaknesses in FEMA's eGrant program are presented. The OIG

notes that since 2001, FEMA provided first responder organizations with more than $9 billion through the AFG and Staffing for Adequate Fire and Emergency Response (SAFER) programs. According to FEMA, it began using the eGrants system in 2003 to manage the funds awarded through these programs. However, the eGrants system does not comply with Department of Homeland Security (DHS) information system security requirements. Specifically, access to the eGrants system is not controlled or limited because FEMA instructs grantees to share usernames and passwords within the grantee's organization and with contractors who manage grants. As a result, someone other than the primary point of contact can take action or make changes in eGrants without the grantee's knowledge. Additionally, in June 2014, DHS's Office of Cyber Security advised FEMA it should not authorize eGrants to operate because it poses an unacceptable level of risk to the agency. FEMA's Chief Information Officer acknowledged the high level of risk posed by system deficiencies and vulnerabilities but according to program personnel, technical resources allocated to the program have not been adequate to do so, and no alternative system is currently available to manage AFG programs. According to FEMA, it began using eGrants in 2003 as a temporary grant management system, but it is still operating in 2015. For more information go to: https://www.oig.dhs.gov/assets/Mgmt/2016/OIG-16-11-Nov15.pdf.

t) NIH-Funded Study Compares CPR Methods by EMS Providers

In a study published in the New England Journal of Medicine, researchers found that cardiopulmonary resuscitation (CPR) administered by emergency medical services (EMS) providers following sudden cardiac arrest that combines chest compressions with interruptions for ventilation resulted in longer survival times and shorter hospital stays than CPR that uses continuous chest compressions. Although compressions with pauses for ventilation lead to more hospital-free days within 30 days of the cardiac arrest, both methods achieved similar overall survival to hospital discharge, the study noted. The compressions with interruptions consisted of 30 compressions then pauses for two ventilations. The continuous chest compressions consisted of 100 compressions per minute with simultaneous ventilations at 10 per minute. In both groups, emergency medical services (EMS) providers gave ventilations using a bag and mask. The study, funded in part by the National Heart, Lung, and Blood Institute (NHLBI), is the largest of its kind to date to evaluate CPR practices among firefighters and paramedics and suggests the importance of ventilation in CPR by EMS providers, the investigators say. The study was presented at the American Heart Association 2015 Scientific Sessions in Orlando. For more information go to: http://www.nih.gov/news-events/news-releases/large-study-reports-results-comparing-two-cpr-methods-used-ems-providers-following-sudden-cardiac-arrest.

u) USFA Partners with IAFF and Drexel University to Study First Responder Violence

The U.S. Fire Administration (USFA) is partnering on a project with the International Association of Fire Fighters (IAFF) and Drexel University in Philadelphia to research the occurrences and effects of violence against firefighters and EMS responders. The study will examine the circumstances surrounding these acts and determine ways to mitigate workplace/on-duty incidents of violence against responders. The study will also provide examples of current best practices where they exist. For more information go to: https://www.usfa.fema.gov/operations/ops_safety.html.

Readers interested in this topic can also access the Emergency Nurses Association (ENA) *50 State Survey Criminal Laws Protecting Health Professionals* at: *https://www.ena.org/government/State/Documents/StateLawsWorkplaceViolenceSheet.pdf*.

Several state laws protecting emergency department personnel include provisions for EMS. See also ENA's Workplace Violence Penalties and Terminology Database. Last Fall, ENA announced that Colorado joined thirty-one other states that have enacted laws making it a felony to assault or batter an emergency nurse and/or other emergency medical care provider. Now acknowledged by safety advocates as a "model", the Colorado law can be found at: http://www.leg.state.co.us/clics/clics2015a/csl.nsf/fsbillcont2/4B260F9643B580CA87257DA20061781B/$FILE/067_enr.pdf.

v) HRSA Releases EMSC Targeted Issue Funding Opportunity

The Health Resources and Services Administration (HRSA) recently released the guidance for the EMSC Targeted Issues (TI) program funding opportunity. TI grants support projects to improve the quality of pediatric care delivered in emergency care settings across the continuum of emergency care through the implementation of pediatric emergency care research and innovative cross-cutting projects. Two categories of grants will be funded. A single Category I award will support leadership for and implementation of a multi-site pediatric prehospital EMS Research Node Consortium. Four Category II awards will support investigator-initiated projects to improve the quality of pediatric emergency care in the prehospital and/or hospital emergency care settings through innovative approaches. Applications are due by February 29, 2016.

For more information go to: http://www.hrsa.gov/grants/index.html.

w) CAAS Achieves ANSI-Accredited Standards Developer Status

The Commission on Accreditation of Ambulance Services (CAAS) is pleased to announce that it has achieved accreditation from the American National Standards Institute (ANSI) for its standards development program. ANSI fosters the U.S. standardization system by accrediting the procedures of standard-setting organizations and subsequently approving individual documents as American National Standards (ANS). Over 230 ANSI-Accredited Standards Developers are now engaged in the creation and maintenance of voluntary consensus standards that are being used in virtually every industry sector. As an ANSI-Accredited Standards Developer, CAAS may

now submit its standards for approval as American National Standards (ANS). Such standards must demonstrate adherence to ANSI's Essential Requirements, which outline the Institute's requirements for openness, balance, lack of dominance, due process, and consensus in standards development.

For more information go to: http://www.caas.org/news/caas-news/the-commission-on-accreditation-of-ambulance-services-caas-becomes-an-ansi-accredited-standards-developer.

x) Nurses Retain Top Spot As Most Highly Rated Profession

Nurses have topped Gallup's Honesty and Ethics ranking every year but one since they were added to the list in 1999. The exception is 2001, when firefighters were included on the list on a one-time basis, shortly after the Sept. 11 terrorist attacks. (Firefighters earned a record-high 90% honesty and ethics rating in that survey.) With an 85% honesty and ethics rating -- tying their high point -- nurses have no serious competition atop the Gallup ranking this year. Pharmacists and medical doctors constitute the next tier, with about two-thirds of Americans viewing each highly, followed by high school teachers at 60% and police officers at 56%. There is little good news in the numbers for members of Congress, telemarketers and lobbyists. Solid majorities of Americans consider the honesty and ethics of these professions to be low or very low, while fewer than one in 10 believe they have high ethics. For more information go to: http://www.gallup.com/home.aspx.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The Training and Certification Committee met on Wednesday, January 6, 2016. There are no action items.

Copies of past minutes are available on the Office of EMS Web page at:

http://www.vdh.virginia.gov/OEMS/Training/Committees-PDC.htm

B. **The Medical Direction Committee (MDC)** The Medical Direction Committee met on Thursday, January 7, 2016. There are no action items for consideration.

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

Advanced Life Support (ALS) Program

A. Virginia I-99 students who still have their National Registry certification continue the transition process that allows them to gain certification at the Paramedic level after completion of a Virginia approved Intermediate-99 to Paramedic bridge program. This transition process will end in 2018/2019 when their last certification cycle with National Registry expires as referenced in B below.

B. All National Registry I-99 certified providers must complete the transition process to Paramedic level by 2018/2019 or their certification level with National Registry will become Advanced EMT (AEMT.) This will NOT affect their Virginia certification level which will remain Intermediate 99.

C. ALS Coordinator re-endorsement requires an update every two years and the submission of a re-endorsement application. The application must be signed by an EMS Physician. Additionally it must contain the signature of the regional EMS council director if courses are to be offered in their region.

D. The 2015 Paramedic Psychomotor Competency Portfolio (PPCP) has been mailed to all accredited Paramedic programs in Virginia from National Registry. All students enrolling in Paramedic programs that start after August 1, 2016 will be required to master the portfolio of vital skills to qualify for the National Registry Paramedic (NRP) Certification examination.

E. In April, 2016, all Virginia Enhanced providers will be transitioned to the Virginia Advanced EMT level. All current CE will be moved to the new certification level with recertification requirements remaining the same. A new certification card will be mailed to each of these providers and the certification expiration date will remain the same.

F. As approved at the last state EMS Advisory Board meeting, continuing education requirements will change in July, 2016. At that time the new recertification requirements will be implemented and existing CE will be updated and moved to the new categories in each provider's CE report. If a provider has gained recertification eligibility under the old CE process, they will maintain that eligibility until recertified at which time they will be required to meet the new continuing education requirements.

Basic Life Support Program

A. EMS Education Coordinator (EC) Institute

1. The first EC Institute of 2016 was held at Henrico Fire Training, January 30-February 3rd.
2. The deadline to pass the EC cognitive exam in order to be eligible for the June Institute held in conjunction with the VAVRS Rescue College in Blacksburg, VA is April 10, 2016. The next EC psychomotor exam is scheduled for May 7, 2016 in the Richmond Area.
3. EMS providers interested in becoming an Education Coordinator please contact Mr. Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
4. A schedule of the various deadlines and EC Institutes can be found on the OEMS website at: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Education Coordinator Updates:

1. For 2016, the Division of Educational Development will continue to provide in-person Educator Updates in the various regional EMS Council regions.
2. With the success of the Friday update held in the Western Virginia EMS Council region in June of 2015 and at the request of our Educators, the Office will offer two Friday updates in addition to the normal Saturday updates. The first was on Friday, January 29th at Henrico Fire in the ODEMSA region and the second will be on Friday, September 9th at the Fairfax County Fire Training Center. Both are scheduled from 1-5pm.

3. The schedule of future updates can be found on the OEMS web at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

EMS Training Funds

FY14

	Commit $	Payment $	Balance $
Emergency Ops Funding	$1,120.00	$360.00	$760.00
BLS Initial Course Funding	$785,196.00	$380,237.25	$404,958.75
BLS CE Course Funding	$94,010.00	$39,182.50	$54,827.50
ALS CE Course Funding	$224,950.00	$80,115.00	$144,835.00
BLS Auxiliary Program	$130,000.00	$61,300.00	$68,700.00
ALS Auxiliary Program	$304,000.00	$177,985.00	$126,015.00
ALS Initial Course Funding	$1,188,504.00	$615,334.15	$573,169.85
Totals	**$2,727,780.00**	**$1,354,513.90**	**$1,373,266.10**

FY15

	Commit $	Payment $	Balance $
Emergency Ops Funding	$2,480.00	$540.00	$1,940.00
BLS Initial Course Funding	$737,320.50	$354,375.75	$382,944.75
EMT Initial Course	$4,284.00	$0.00	$4,284.00
BLS CE Course Funding	$58,460.00	$32,663.80	$25,796.20
ALS CE Course Funding	$146,335.00	$66,263.75	$80,071.25
BLS Auxiliary Program	$88,705.00	$17,960.00	$70,745.00
ALS Auxiliary Program	$548,376.00	$141,720.00	$406,656.00
ALS Initial Course Funding	$1,009,204.00	$591,193.05	$418,010.95

Totals	**$2,595,164.50**	**$1,204,716.35**	**$1,390,448.15**

FY16

	Commit $	Payment $	Balance $
BLS Initial Course Funding	$0.00	$46,544.28	($46,544.28)
EMT Initial Course	$534,888.00	$132,599.47	$402,288.53
BLS CE Course Funding	$0.00	$5,320.00	($5,320.00)
Category 1 CE Course	$123,902.50	$16,563.75	$107,338.75
ALS CE Course Funding	$0.00	$8,251.25	($8,251.25)
Auxiliary Course	$365,440.00	$34,000.00	$331,440.00
BLS Auxiliary Program	$0.00	$4,280.00	($4,280.00)
ALS Auxiliary Program	$0.00	$39,360.00	($39,360.00)
ALS Initial Course	$979,200.00	$268,497.46	$710,702.54
ALS Initial Course Funding	$0.00	$92,486.90	($92,486.90)
BLS Initial Course Funding	$0.00	$46,544.28	($46,544.28)
Totals	**$2,003,430.50**	**$647,903.11**	**$1,355,527.39**

EMS Education Program Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
   a) No new accreditation packets have been received.

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

3. Intermediate – Reaccreditation
   a) Roanoke Valley Regional Fire/EMS Training Center has been granted a one year probationary status that will expire on July 31, 2016.

4. Intermediate – Initial
   a) Southwest Virginia EMS Council has been granted conditional accreditation with review. Their initial Intermediate course has ended and the Office of EMS will be visiting the program in the next month to review their progress.
   b) Paul D. Camp Community College has been granted a one year conditional accreditation. The Office of EMS will conduct a follow up visit after the completion of their first cohort class to assure that the requirements of accreditation are being met before full accreditation is issued.
   c) Henrico Fire & EMS had their site visit in August, 2015. They have been granted accreditation from the Office of EMS.

5. Paramedic – Initial
   a) Prince William County CoAEMSP site visit was conducted in November. Their site results will be reviewed by CoAEMSP and then forwarded to CAAHEP for consideration at their next meeting.
   b) Historic Triangle EMS Institute voluntarily retired their CoAEMSP accreditation in April, 2017. The students enrolled in their current program are not affected and will be allowed to test for their National Registry Paramedic certification.
   c) John Tyler Community College has been granted a Letter of Review (LoR) from CoAEMSP.
   d) ECPI has submitted their Letter of Review Self-Study Report (LSSR) to CoAEMSP as the first step to receiving a LoR.

6. Paramedic – Reaccreditation
   a) Piedmont Virginia Community College has gained full accreditation with CoAEMSP/CAAHEP.
   b) American National University in Salem, VA has placed their accreditation status on hold for a period of two years.

B. For more detailed information, please view the Accredited Site Directory found on the OEMS web site at:
   1. http://www.vdh.state.va.us/OEMS/Training/Accreditation.htm

C. All students must enroll in a nationally accredited paramedic program to qualify for National Registry certification. National accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).

National Registry

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

On Line EMS Continuing Education

Distributive Continuing Education

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

EMSAT

EMSAT programs for the next three months include:

Feb. 17, DNR – Post Palliative Care
Instructor: Matthew Kestenbaum, MD, Christopher Pile, MD
Cat. 1 ALS, Area 72, Cat. 1 BLS, Area 02

Mar. 16, New AHA Guidelines

Instructor: Joseph Ornato, MD
Cat. 1, ALS, Area 72, Cat. 1 BLS, Area 05

Apr. 20, Transport Ventilators
Instructor: Randy Geldreich, MD
Cat. 1 ALS, Area 71, Cat. 1 BLS, Area 03

The EMS Portal

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

CTS

A. 31 - CTS, 2- EMT accredited course and 6- ALS psychomotor test sites were conducted from October 19, 2015 through January 12, 2016.

B. Vacant OEMS Test Examiner positions in Northern Virginia have been advertised. Additional open positions in the Western/Southwestern and ODEMSA regions will be advertised after the Northern Virginia positions are filled. Hiring for these positions continues to be preempted for hiring vacant full time OEMS office positions.

C. The updated Psychomotor Examination Guide (PEG) is in review and is expected to be released soon.

D. Current Psychomotor Examination scenarios are being reviewed for revision.

E. Medical scenarios have been updated reflecting recent changes of standards of care for stroke and heart attack patients.

F. OEMS National Registry Examiners will be attending an update session in May.

Other Activities

- Debbie Akers continues to participate in the NASEMSO webinars Community Paramedicine Insights Forum.

- Debbie Akers is serving as the staff liaison to a Mobile Integrated Healthcare workgroup. The workgroup has representation from the following disciplines: Fire based EMS, EMS OMD, ED Physician, EMS Administrator, EMS Provider, Regional EMS Councils, Hospital Accountable Care Organizations, Pediatrics, Commercial EMS, VDH Licensure, Primary Care Physician, Virginia Hospital and Healthcare Association (VHHA), Department of Medical Assistance Services (DMAS), VA Association for Home Care and Hospice and the VA Association for Hospices and Palliative Care. The workgroup is being chaired by Dr. Allen Yee.

- Warren Short continues participating with the NASEMSO's Education and Professional Standards Committee's (EPSC) monthly conference calls.

- Greg Neiman continues to participate on the Autism Public Safety Workgroup working toward improving EMS and Fire interface when responding to a patient with autism.

Emergency Operations

IV. Emergency Operations

Operations

- **2015 EMS Symposium**

Connie Green, Emergency Operations Assistant Manager, Winnie Pennington, Emergency Operations Planner, Frank Cheatham, HMERT Coordinator, and Ken Crumpler, Emergency Communications Coordinator, all attended the 2015 Annual EMS Symposium.

Frank Cheatham, HMERT Coordinator, served as the Logistics Section Chief for the 2015 Annual EMS Symposium. This included not only on site activities but several meetings pre event as well as post event.

Ken Crumpler, Emergency Communications Coordinator, taught the "Role of PSAP in Medivac Operations" course. Ken Crumpler, Emergency Communications Coordinator, also oversaw the staff communications for the event. Equipment assistance was provided by the loaning of portable radios from Gately Communications (a public safety communications vendor) and the Virginia Communications Cache, Hampton. Personnel from Richmond Ambulance Authority, Norfolk 911, Chesterfield 911, Hanover 911, Fairfax 911, and Tazewell 911 assisted with staffing event communications as well.

Winnie Pennington, Emergency Operations Planner, taught the courses "What if we were dispatched and it's our own building: A Review of Continuity Planning Concepts for Fire/EMS Agencies" and "Patient Tracking, So What?" Winnie Pennington, Emergency Operations Planner, also assisted with staffing the registration desk and attended classes.

Connie Green, Emergency Operations Assistant Manager, taught the "Mass Casualty Incident Management (MCIM) I & II" and "MCIM Train-the-Trainer" courses. Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner, also served as room hosts for multiple classes.

- **Virginia-1 DMAT**

Frank Cheatham, HMERT Coordinator continues to attend Va-1 DMAT meetings as a representative of the Office of EMS. He coordinates facilities for meetings and training in the Richmond area.

- **HMERT Activities**

Over the past quarter, Frank Cheatham, HMERT Coordinator, has worked to continue recruitment efforts for the Task Force teams. There are several agencies that are working on becoming one of the types of Task Forces to become a part of the system. Frank Cheatham continues to keep up to date on storm activity and keep information flowing to the teams.

Committees/Meetings

- **EMS Communications Committee**

The EMS Communications Committee met on Thursday, November 12, 2015 in Norfolk Virginia in conjunction with the Virginia EMS Symposium. Committee Chair Gary Critzer reported that the committee will be tasked with reviewing the communications sections of the Code of Virginia EMS Regulations to recommend updates, edits, or changes.

Mike Keefe-Thomas (Virginia Dept. of Emergency Management VDEM) reported that VDEM will be the lead agency for future communications interoperability projects in Virginia. This includes the pending FirstNet wireless voice and data project.

The OEMS PSAP Accreditation application from King & Queen Co. 911 was reviewed and tabled until the next meeting. The committee determined the application was incomplete and if King & Queen Co. 911 provided an updated, complete application, it would be reviewed at the next communications committee meeting.

- **Provider Health and Safety Committee**

Connie Green, Emergency Operations Assistant Manager, met with the Provider Health & Safety Chairman, Dan Wildman, at the 2015 Symposium to discuss work plans and schedules for the committee for 2016. Connie Green, Emergency Operations Assistant Manager, also distributed and collected the 2015 EMS Provider Fatigue survey at the 2015 Symposium on the behalf of the Provider Health & Safety Committee. The monthly safety bulletins also continue to be distributed for the committee.

- **Emergency Management Committee**

Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner, attended the Emergency Management Committee meeting on November 11,

2015. The committee discussed the MCIM/MUCC training for EMS providers and its potential impact on the regions and jurisdictions.

- **Traffic Incident Management (TIM)**

Frank Cheatham, HMERT Coordinator, continues to work with the TIM program. He attended a meeting of the TIM Steering Committee on November 5, 2015 as well as the Statewide TIM Committee on November 10, 2015. He attended a Webinar on TIM Performance Measures November 19, 2015. He completed submitting the paperwork for a Train the Trainer held in October 2015 at the Office of EMS. He constantly monitors various websites for incidents to see if there are any lessons to be learned. When notified of classes, he submits those for inclusion on the OEMS website.

- **Lane Reversal Coordination**

Frank Cheatham, HMERT Coordinator, continues to attend meetings in regards to Lane Reversal. He has been appointed to two workgroups of that committee and they will be meeting on January 25 & 27, 2016.

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

Frank Cheatham, HMERT Coordinator, continues to attend NASEMSO HITS Committee conference calls and serves on a committee on various aspects of Vehicle Rescue focusing on electric and hybrid vehicles. The Committee has recently been updated on a new grant that NFPA received that will result in some training on Alternative Fuel Vehicles.

- **Strategic Highway Safety Plan**

Frank Cheatham serves on the SHSP Steering Committee and attended a day long workshop on December 10, 2015 designed to assist with the next update of Virginia's Strategic Highway Safety Plan.

- **VDH Worksite Wellness Committee**

Connie Green, Emergency Operations Assistant Manager, participated in a VDH Worksite Wellness Committee meeting on December 21, 2015. The committee is charged with efforts to reenergize and enhance worksite wellness within VDH, and to assist in the implementation of an employee wellness challenge starting in January 2016.

- **EVD Activities**

Winnie Pennington, Emergency Operations Planner, participated in a VDEM sponsored meeting on the development of an EVD "Exercise-in-a-Box", on December 9, 2015 and January 6, 2016.

- **Eastern States EMS Mutual Aid Group**

Karen Owens, Emergency Operations Manager, participated in the Eastern States EMS Mutual Aid Group call on November 20, 2015. The call serves as an opportunity for Eastern States to prepare for providing assistance in possible emergency events.

- **Medical Direction Committee**

Emergency Operations Manager, Karen Owens, presented information to the Medical Direction Committee regarding the potential switch from the START Triage to SALT Triage.

- **VDH VEST Operations Planning Meeting**

Winnie Pennington, Emergency Operations Planner, participated in meetings of VDH committee for development/update of VDH VEST Operations Plan November 6, 2015 and 23, 2015.

- **CISM Meet and Greet**

Connie Green, Emergency Operations Assistant Manager, participated in a gathering of regional CISM team representatives at the 2015 Symposium. Topics covered included regional and state CISM activity reviews, potential areas for collaboration, education and outreach efforts, and potentially developing a regular schedule of meetings for the group to provide input to the Provider Health & Safety Committee.

- **Vicarious Trauma Toolkit**

Karen Owens continues to represent the Virginia Office of EMS and the National Association of State EMS Officials (NASEMSO) on the Vicarious Trauma Toolkit workgroup. The workgroup held a conference call on November 20th to discuss the current status of grants and determine the next steps in development of the toolkit.

Training

- **2015 OEMS COOP Exercise**

Winnie Pennington, Emergency Operations Planner, continued with the second phase of the office wide COOP Exercise December 2-16, 2015. The Regulation and Compliance Division, the Administrative Division and the Emergency Operations Division all participated in a review of their division's exercise results with Q&A regarding exercise effectiveness and improvement plan ideas for the coming year.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 5 events, including education sessions, training classes, and debriefings (both group and one-on-one).

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

The Regional EMS Councils have submitted their FY16 Second Quarter (Q2) contract reports throughout the month of January, and their reports and deliverables are under review. OEMS has transitioned to a web based reporting application to replace Lotus Notes, for the Regional EMS Councils to submit quarterly deliverables.

Applications for Regional EMS Council re-designation from each of the existing regional EMS councils were submitted to OEMS on October 1, 2015, and are under review. Designation site visits and evaluations will be conducted in February and March of 2016. The next designation period begins on July 1, 2016.

The EMS Systems Planner attended meetings of the Northern Virginia, Peninsulas, and Tidewater EMS Council board of directors during the quarter.

Medevac Program

The Medevac Committee is scheduled to meet on February 4, 2016. The minutes of the November 11, 2015 meeting are available on the OEMS website at http://www.vdh.virginia.gov/OEMS/Files_Page/Medevac/Minutes/Medevac11-11-15.pdf

The Medevac Helicopter EMS application (formerly known as WeatherSafe) continues to grow in the amount of data submitted. In terms of weather turndowns, there were 681 entries into the Helicopter EMS system in the third quarter (Q3) of 2015. 56% of those entries (373 entries) were for interfacility transports, which is slightly lower than information from previous quarters. The total number of turndowns is an increase from 572 entries in the third quarter (Q3) of 2014. For the 2015 calendar year, there were 2,333 entries into the system, an increase from the 2,252 entries in 2014. 63% of those entries (1401 entries) were for interfacility transports. This data continues to show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

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

transported to/treated at a rural hospital first, then transported by air to a specialty facility for interventional treatment.

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

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

Data has been collected since April 1, but at this point, is too premature to make any proper evaluations or conclusions, but the workgroup aims to present a report to the state EMS Advisory Board at a future meeting.

The Committee is also evaluating the increased use of unmanned aircraft (drones), and the increased presence in the airspace of Virginia. A workgroup has been formed to raise awareness among landing zone (LZ) commanders and helipad security personnel. The workgroup has developed a safety flyer that will easily be able to be distributed and posted to the hospital and EMS communities.

The EMS Systems Planner also participates on the NASEMSO Air Medical Committee. The committee met several times throughout the end of 2015.

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

State EMS Plan

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

As has been done in the past, the committees of the state EMS Advisory Board, as well as OEMS staff, and regional EMS Council staff, will be tasked with evaluating the current Plan, and proposing additions and/or deletions, as well as a SWOT analysis, as it pertains to their particular subject area. Templates for these planning sessions are being distributed in February 2016. The goal is to solicit input from stakeholders throughout 2016, with an anticipated approval of an updated Plan by the state EMS Advisory Board in late 2016 and presentation to the Board of Health in early 2017.

The current version of the State EMS Plan is available for download via the OEMS website at http://www.vdh.virginia.gov/OEMS/EMSPlan/index.htm.

Public Information and Education

VI. Public Information and Education

Public Relations

Promotions

EMS Bulletin

PR coordinator completed the winter edition of the EMS Bulletin, December 18, 2015. It was posted online and shared through social media and listserv email. It was the top downloaded item in December with 54,736 downloads.

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

- **October -** Tactical Combat Casualty Care (TCCC) Combined Provider Course, 36th Annual Virginia EMS Symposium registration deadline, emergency flood relief efforts in South Carolina, VDH emergency closure info, state trauma system assessment exit interview video, holiday office closures, Provider Health and Safety Committee quick tips for cancer awareness and download instructions for the new mobile app for 2015 Virginia EMS Symposium.

- **November -** Virginia EMS Symposium class change, Flu Shot Clinic, box lunches, on-site events, vendor hall exhibit hours, Governor's EMS Awards ceremony, American College of Surgeons (ACS) Consultation Report, Winter Preparedness Week, food safety tips during the holidays and state office holiday closures.

- **December -** 2015 Governor's EMS Award winners press release, healthy eating and nutrition tips from the Provider Health and Safety Committee, 2016 EMS Symposium hotel reservations for the Norfolk Waterside Marriott and Sheraton, story about Gov. Award winner, Winter driving tips from the Provider Health and Safety Committee, 2016 Va. EMS Symposium Call for Presentation extension date and EMS Bulletin – winter edition, state office holiday closures.

Via GovDelivery E-mail Listserv (October - December)

- Oct. 9 – ACS Visit Exit Interview video
- Oct. 13 – Governor's EMS Awards invitation to nominees
- Oct. 29 – New Mobile App Announcement for the Virginia EMS Symposium
- Nov. 6 – Important Reminders for Virginia EMS Symposium attendees
- Nov. 23 – ACS Trauma System Consultation Report
- Dec. 4 – Hotel Lodging Reservations for 2016 Symposium
- Dec. 8 – Governor's EMS Award Winners Announced
- Dec. 21 – EMS Bulletin

Customer Service Feedback Form (Ongoing)

- PR assistant provides monthly reports to EMS management regarding OEMS Customer Service Feedback Form.

- PR assistant also provides bi-weekly attention notices (when necessary) to director and assistant director concerning responses that may require immediate attention.

Social Media and Website Statistics

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

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

***As of January 6, 2016, the OEMS Facebook page had 4,458 likes, which is an increase of 55 new likes since October 23, 2015. As of January 6, 2016, the OEMS Twitter page had 3,515 followers, which is an increase of 93 followers since October 23, 2015.**

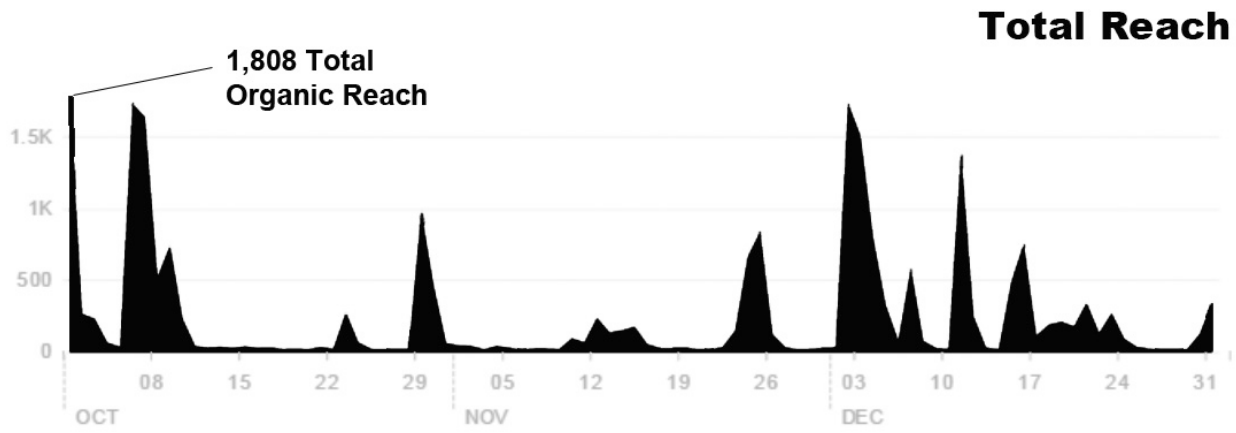


Figure 2: This table represents the top five downloaded items on the OEMS website from October – December.

October	1. 2010 EMS Symposium presentation LMGT-732 (22,776) 2. 2015 Symposium Catalog (20,241) 3. 2012 EMS Symposium presentation OPE-4006 (6,626) 4. 2013 EMS Symposium presentation PRE-025-CasualtySimulation (5,991) 5. 2009 EMS Symposium presentation SPE-1008 (5,471)
November	1. 2010 EMS Symposium presentation LMGT-732 (19,274) 2. 2015 Symposium Catalog (19,108) 3. 2014 EMS Symposium presentation PRE-020 (9,931) 4. EMS Bulletin – summer edition (7,264) 5. EMSAT CentreLearn instructions (6,056)
December	1. EMS Bulletin – winter edition (54,736) 2. 2010 EMS Symposium presentation LMGT-732 (30,707) 3. 2012 EMS Symposium presentations OPE-4006 (7,506) 4. EMSAT CentreLearn instructions (6,956) 5. 2012 EMS Symposium presentation OPE-4022 (6,050)

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

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
October	91,318	2,945	14:46
November	87,050	2,901	14:02
December	89,643	2,891	15:11

EMS Symposium

- PR assistant updated the classroom locations in the symposium database.
- PR assistant printed name badges for symposium attendees.
- PR assistant created bingo cards for participating sponsors and printed 1,800 copies for the symposium bags. Karen Owens, emergency operations manager, coordinated and obtained bingo and symposium event prizes from various symposium vendors and local retailers.
- PR coordinator finished the design of the On-Site Guide and sent it for print October 16, 2015.
- PR coordinator printed and collated all registration letters for symposium packets.
- PR coordinator continued to work with Web coordinator to update symposium sponsors on the OEMS website.
- PR coordinator finalized on-site event signage and submitted it for print.

- PR coordinator finalized event plans for Flu Shot Clinic with the Norfolk HD.
- Attended meetings with OIM to test the features of the new symposium mobile app, check its functionality and verify that the content mimicked the On-Site Guide.
- Coordinated all handouts (from sponsors and OEMS staff) to be included in the registration packets. The week of November 2-6, stuffed and packed 1,800 registration packets.
- Continued to field calls and emails from providers regarding registration, cancellations and vendors regarding sponsorship opportunities and the availability of vendor hall space.
- Attended the 36th Annual Virginia EMS Symposium, November 11-15, 2015. Assisted with registration and signage, coordination of the Governor's EMS Awards ceremony and reception, the flu shot clinic and other on-site events. Assisted with the vendor hall and updated social media sites with classroom/instructor updates and other event info.
- After the conclusion of the Symposium (in December), the PR assistant emailed Leadership and Management honorary certificates to eligible Symposium attendees who signed up and met the certificate requirements.

Governor's EMS Awards Program

- PR assistant sent an email invite to all Governor's EMS Award nominees to attend the 2015 Annual Governor's EMS Awards ceremony, and monitored nominee's RSVP to the award ceremony.
- PR assistant prepared the presentation book that contained the award winner's brief bios, which were read during the award ceremony.
- PR assistant designed the PowerPoint presentation that was shown at the beginning of the ceremony and displayed the award nominees' photo and agency affiliation.
- PR coordinator prepared the Governor's EMS Award winners bios and pictures and had it posted it on the OEMS website homepage.
- PR coordinator sent out a statewide press release announcing the Governor's EMS Award winners December 2, 2015.
- Promoted award winners through Facebook and Twitter social media sites.
- Fielded media calls regarding the press release and sent additional information and photos as requested.
- Sent email through the OEMS listserv recognizing the 2015 Governor's EMS Award winners.

Media Coverage

The PR coordinator was responsible for fielding the following OEMS media inquiries October – December, and submitting media alerts for the following requests:

- Dec. 4 – Reporter from WDBJ7 inquired about the Governor's EMS Award Winner in the Southwest region.
- Dec. 10 – Reporter from WTVR6 inquired about the Governor's EMS Award winner in the Rappahannock region.

OEMS Communications

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

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

VDH Communications

VDH Communications Tasks– The PR coordinator was responsible for covering the following VDH communications tasks from October – December:

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

Commissioner's Weekly Email – The PR coordinator submitted the following OEMS story to the commissioner's weekly email. Submissions that were recognized appear as follows:

- **Dec. 14 - OEMS Hosts 36th Annual Virginia EMS Symposium**

  The Virginia Office of Emergency Medical Services (OEMS) recently hosted the 36th Annual Virginia EMS Symposium. The largest EMS training event in the state, and one of the largest in the nation, welcomed 1,644 registered attendees. The symposium offered 15 course tracks and 245 courses covering everything from hands-on training in trauma, medical and cardiac care to education for pediatrics, operations, and health and safety. Approximately 23, 483 hours of continuing education credits were granted. New this year, the EMS Symposium app for Android was launched to assist participants with on-site event information.

  The symposium also included a two-day youth rescue camp for children ages 8 – 12 and the Governor's EMS Awards. Many thanks to the entire OEMS staff whose assistance and dedication make this annual event a continued success. Additional thanks go to staff responsible for preplanning, event coordination and on-site assistance: Gary Brown, director; Scott Winston, assistant director; Warren Short, EMS training manager; Dr. George Lindbeck, state operational medical director; Debbie Akers, ALS training specialist; Frank Cheatham, HMERT coordinator; Terry Coy, media specialist; Tristen Graves, public relations assistant; Irene Hamilton, executive secretary; Adam Harrell, training and development specialist; Norma Howard, continuing education coordinator; Marian Hunter, public relations coordinator; and Greg Neiman, BLS training specialist. Thanks also to the following for their support: Michael Berg, Wayne Berry, Peter Brown, James Burch, Pat Couser, Ken Crumpler, Kapil Daddikar, Sudheer Dadivela, Ed Damerel, Amanda Davis, David Edwards, Paul Fleenor, Constance Green, Dheeraj Katangur, Ron Kendrick, Doug Layton, Stephen McNeer, Manoj Madhavan, Kimberly Owens, Winnie Pennington, Tim Perkins, Heather Phillips-Greene, Wanda Street, Robert Swander and Scotty Williams.

- **Norfolk HD Participates in Flu Clinic at EMS Symposium**

  The Norfolk Health Department, in coordination with the OEMS, hosted a free Flu Shot Clinic for all symposium participants. Approximately 147 vaccinations were administered to attendees. Thanks to the following for making this event successful: Norfolk Medical Reserve Corps (MRC) Coordinator Linda Botts, Immunization Action Program Nurse Joyce Sample, Local Emergency Health Coordinator (LHEC) Eve Zentrich, Public Health Nurses Jessica Brooks and Jennifer Kenworthy, Outreach Worker Katie Wiggins, and nine MRC volunteers.

Regulation and Compliance

VII. Regulation and Compliance

EMS Agency/Provider Compliance

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

Compliance

Enforcement	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	CY2015	CY2014
Citations	**10**	**18**	**15**	**12**	**55**	**40**
Agency	4	12	4	3	23	22
Provider	6	6	11	9	32	18
Verbal Warning	**2**	**0**	**1**	**3**	**6**	**21**
Agency	2	0	1	2	5	11
Provider	0	0	0	1	1	10
Correction Order	**10**	**29**	**10**	**15**	**64**	**59**
Agency	10	29	10	15	64	59
Provider	0	0	0	0	0	0

Temp. Suspension	**5**	**9**	**5**	**7**	**26**	**20**
Agency	0	0	0	0	0	0
Provider	5	9	5	7	26	12
Suspension	**2**	**5**	**6**	**2**	**15**	**11**
Agency	0	0	0	0	0	1
Provider	2	5	6	2	15	5
Revocation	**1**	**4**	**2**	**1**	**8**	**7**
Agency	0	0	0	0	0	0
Provider	1	4	2	1	8	4
Compliance Cases	**49**	**63**	**30**	**24**	**166**	**202**
Opened	38	40	14	20	112	140
Closed	11	23	16	4	54	62
Drug Diversions	**3**	**3**	**1**	**8**	**15**	**21**
Variances	**6**	**2**	**1**	**14**	**23**	**29**
Approved	2	1	1	10	14	16
Denied	4	1	0	4	9	13

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

x – Indicates data not available

Hearings

Oct 27 – Seekford	Nov 20 – White
Oct 27 – Moore	Nov 20 – Kellogg
Oct 27 – Lester	Nov 20 - Rollason

Licensure

Licensure	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**CY2015**	**CY2014**
Agency	669	656	645	646	646	669
New	2	3	x	X		
Vehicles	4,140	4,142	4,524	4,568	4,568	4,137
Inspection						
Agency	116	103	57	43	319	289
Vehicles	741	733	91	399	1,964	2,261
Spot	124	161	186	100	571	447

Background Unit

The Office of EMS began the process of conducting criminal history records utilizing the FBI fingerprinting process through the Virginia State Police on July 1, 2014. A dedicated section of the OEMS website has updated and relevant information on this new process and can be found at the following URL:
http://www.vdh.virginia.gov/OEMS/Agency/RegCompliance/CriminalHistoryRecord.htm.

Background Checks	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	CY2015	CY2014
Processed	2,125	1,889	1,006	1753	6,773	3,488
Eligible	1,380	1,676	858	1,501	5,415	2,683
Non-Eligible	18	12	11	9	50	19
Outstanding	726	201	112	52	1091	546
Jurisdiction Ordinance	x	x	25	164	189	

Regulatory

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

- A Fast Track regulatory package to include the terminology of "affiliation" in the language of 12VAC-5-31-910 is in the regulatory review process and currently resides in the Governors' Office for the analyst to review and approve, (http://townhall.virginia.gov/L/viewstage.cfm?stageid=7067)
  The Office has received communications that the Governor's Office does not support this regulatory packet as presented. OEMS staff will work to develop further clarifying language with input from the EMS Advisory Board and resubmit for review.

- The Periodic Review has concluded for the Durable Do Not Resuscitate (DDNR) regulations 12VAC5-66. Staff has developed a Fast Track regulatory packet to include the definition of "POST" in the definitions. This is currently under review by the Office of the Attorney General before moving forward in the regulatory process.

EMS Physician Endorsement

Endorsed EMS Physicians: As of December 2015: 217

The OMD workshops for 2016 have been finalized. The first "Currents" session was held at the Virginia EMS Symposium on November 12, 2015. An updated listing of workshops may be found at: http://www.vdh.virginia.gov/OEMS/MedicalDirectors/CEWorkshops.htm.

Staff is also reviewing and updating the on-line OMD training program that is utilized as a pre-requisite for anyone interested in becoming an endorsed EMS Physician in Virginia.

Additional Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on December 2-4, 2015 in Glen Allen, Virginia.

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

October 3-5 – Rockingham County Fire/EMS Study

October 8 – Supervisor training – Charlottesville

October 11-16 – NASEMSO Fall Meeting (presenter and committee chair)

October 29 – VFCA – Williamsburg

November 10-15 – Annual EMS Symposium – Norfolk

November 20 – BoP Conference Call

December 7 – Atlantic EMS Council – Washington, D.C.

December 10 – OMD Workshop – TEMS

December 12-14 – NASEMSO Executive Committee - Alexandria

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

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

Commission on the Accreditation of Ambulance Services (CAAS) Ground Veh. Standards v1:

CAAS announced it has achieved ANSI accreditation (January 11, 2016 press release). Once a consensus group (part of the ANSI accreditation process) has approved the document, it will be published. A draft document will be posted by GVS (http://www.groundvehiclestandard.org/). It is anticipated the document to be effective July 1, 2016.

National Fire Protection Association (NFPA) 1917

NFPA 1917 has begun soliciting public comment for Version 3 of this document. Directions can be found at the following link, http://www.nfpa.org/1917.

KKK-1822-F General Services Administration (GSA)

Change Notice 8 was implemented on July 1, 2015;
http://www.nasemso.org/Projects/AgencyAndVehicleLicensure/documents/KKK-A-1822F-change-notice8-01July2015-FINAL.pdf

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

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee met on February 4th. The minutes of the November 12, 2015 meeting are available on the OEMS website at http://www.vdh.virginia.gov/OEMS/Files_Page/Minutes/WDC11-12-15.pdf. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

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

The committee continues to make edits to the draft content of all the modules of EMS Officer I. There is no updated completion date, or a date of the launch of the pilot courses, but the goal is for the program to be launched in 2016. In addition, the committee is evaluating national efforts to produce similar training programs.

Standards of Excellence (SoE) Sub-Committee

The SoE Assessment program is a voluntary self-evaluation process for EMS agencies in Virginia based on eight (8) Areas of Excellence – or areas of critical importance to successful EMS agency management.

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

All documents related to the SoE program can be found on the OEMS website at http://www.vdh.virginia.gov/OEMS/Agency/SoE.htm .

The sub-committee has identified EMS agencies in different parts of the Commonwealth who are willing to participate in the pilot phase of SoE. Six EMS agencies were recognized as an Agency of Excellence at the 2015 Virginia EMS Symposium awards program.

The Virginia Recruitment and Retention Network

The Virginia Recruitment and Retention Network met on November 12, 2015, in conjunction with the Virginia EMS Symposium. A presentation was given by representatives of LifeCare on their CE program. The network is scheduled to meet on February 25, 2016, in conjunction with the Virginia Fire Chief's Association conference in Virginia Beach.

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

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

Trauma and Critical Care

IX. Trauma and Critical Care

It is with great sadness that the Trauma and Critical Care division reports the resignation of Paul Sharpe. He was a driving force for the many positive changes in the care of the acutely injured patient in Virginia and we wish him great success in his new endeavors.

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

The ACS State Consultative Visit was held September 1-4, 2015, with over a hundred of Virginia's stakeholders in attendance. These individuals graciously shared their knowledge, expertise and opinions to help the members of the review team develop a clear picture of the trauma system in Virginia. The VDH/OEMS staff would like to thank these individuals for their time and input into the review process. The completed report can be found on the OEMS website http://www.vdh.state.va.us/OEMS/Trauma/LinksDocuments.htm

b) Trauma System Oversight and Management Committee (TSO&MC)

The TSO&MC met in December and began review of the ACS document and recommendations. At this time the committee is working with the EMS Advisory Board Executive Committee to develop a framework for a response to the report.

The TPIC committee has begun work on the yearly report on trauma triage. Future projects of the TPIC committee will include reviewing disposition and outcomes of patients that meet two of the Step One trauma triage criteria.

The Injury & Violence prevention sub-committee has not met for the last two months. Leadership and staffing are in place to resume meeting in February. The committee is in the planning phase of a retreat to share ideas and resources which they hope to hold in March.

c) Trauma Center Designation

The fall was an active time for trauma designations in Virginia. The first provisional designation of a pediatric and burn trauma center was granted to Virginia Commonwealth University Health System in Richmond after their successful site visit in September. They were also verified as a Level I trauma center at that time. Carilion Roanoke Memorial Hospital and Sentra Norfolk General Hospital were both verified as Level I trauma centers in November. Winchester Medical Center was verified as a Level II trauma center in November as well. Chippenham Medical Center had their follow up review of their provisional Level II designation in December and they are now a verified Level II trauma center. The level of commitment to high quality patient care at all of these programs is to be commended.

d) Trauma Center Fund

Trauma center funds were disbursed in November. These funds are seen in Figure 1. Since 2006 when the trauma fund was instituted, OEMS has distributed over $ 89 million to the designated trauma centers.

Figure 1 Recent Trauma Center Fund Disbursements

Trauma Center Level	Percent Distribution FY16	Previous Quarterly Distribution	November 2015	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	13.29%	$166,585.46	$304,161.45	$11,387,291.58
Inova Fairfax Hospital	16.17%	$199,743.96	$364,704.18	$16,822,868.34
Norfolk General Hospital	11.63%	$147,436.91	$269,198.92	$10,977,876.61
UVA Health System	11.22%	$142,754.26	$260,649.06	$12,019,632.40
VCU Health Systems	27.58%	$331,121.81	$604,581.52	$21,503,602.03
II				
Chippenham Medical Center	1.59%	$31,819.11	$58,097.19	$89,916.30
Lynchburg General Hospital	1.99%	$36,463.76	$66,577.67	$2,394,518.27
Mary Washington	3.79%	$57,173.58	$104,390.86	$2,415,771.03
Riverside Regional Medical Ctr.	5.53%	$77,160.33	$140,883.83	$2,900,041.93
Winchester Medical Ctr.	2.52%	$42,516.55	$77,629.20	$3,533,316.78
III				
Johnston Willis Hospital	0.10%	$14,687.77	$26,817.80	$41,505.57
New River Valley Medical Ctr.	0.17%	$15,486.83	$28,207.38	$525,798.23
Montgomery Regional Hospital	0.17%	$15,448.84	$28,207.38	$483,858.42
Southside Regional Medical Ctr.	0.36%	$17,657.18	$32,239.50	$964,402.82
Virginia Beach Gen'l Hospital	3.90%	$58,505.72	$106,823.16	$2,701,388.21
Total	100.00%	$1,354,562.07	$2,473,238.48	$89,830,302.72

e) Trauma Triage

The trauma triage task force is in the process of finalizing their recommendations to the state trauma triage and inter-facility transfer guidelines. Next steps for these recommendations will be the TSO&MC.

Emergency Medical Services for Children (EMSC)

PedsReady Portal Open to Re-take Assessments

Hospitals that wish to re-take their Pediatric Readiness Assessment (previously done about 2 years ago) may do so now—and receive a new "readiness score" and a new "gap analysis". EMS for Children Committee members are asked to spread the word to hospitals in their area. Only one person from each hospital may fill out the assessment online, and access is gained by navigating to **www.pedsready.org**. The portal will be open until September 2016, and the process is once again intended as a performance improvement tool for hospitals to assess and improve their pediatric readiness.

Report From the ACS Site Visit

The results of the American College of Surgeons state trauma assessment of Virginia (November 2015), which included a pediatric component, were disseminated to EMS for Children Committee members electronically by Chair Sam Bartle prior to the January 7th meeting. State Trauma Coordinator Robin Pearce lead a focused discussion on the pediatric ACS recommendations during the EMS for Children Committee meeting.

EMSC State Partnership Grant Notes:

- The EMSC Program has a number of Broselow® Pediatric Emergency Tapes to distribute to agencies/ambulances that still need them. Once this distribution is completed, this will be a milestone in filling equipment/supply gaps related to pediatric patients.

- Paul Sharpe, current Principal Investigator for the EMS for Children State Partnership Grant and Program Manager of the Division of Trauma/Critical Care, is leaving the Office of Emergency Medical Services and the Virginia Department of Health. This will create some temporary difficulties with timelines related to data-related projects, and perhaps some other unforeseen challenges. We will miss having Paul's steadfast advocacy for children so close by and readily available.

- We are awaiting formal approval to begin our 4th and final budget year (set to start on March 1) on this EMSC cycle. Next year at this time we will presumably be awaiting results of our competing application for the newest cycle of EMSC State Partnership Grant funding.

- The federal government released a draft version in mid-December of proposed new national EMS for Children performance measures which, if adopted, will likely take effect in 2017. A brief opportunity for comments was provided (until 1/5/16) and essentially 4 performance measures are being retired, 3 new performance measures are being proposed and 7 are being retained—all with updated target dates, metrics and scoring details. The Virginia EMSC Coordinator submitted written comments to HRSA concerning 4 of the 10 performance measures, and these comments are available upon request.

The newly proposed/revised performance measures (stated simply) are:

- EMSC 01: The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office for submission to NEMSIS Technical Assistance Center TAC.
- EMSC 02: The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
- EMSC 03: The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

- The unchanged performance measures with updated targets will be:

  - EMSC 04 (previously PM 74): Hospital recognition system for pediatric medical emergencies.
  - EMSC 05 (previously PM 75): Hospital recognition system for pediatric trauma emergencies.
  - EMSC 06 (previously PM 76): Written inter-facility transfer guidelines.
  - EMSC 07 (previously PM 77): Written inter-facility transfer agreements.
  - EMSC 08 (previously PM 79): Established permanence of EMSC.
  - EMSC 09 (previously PM 80): Established permanence of EMSC by integrating EMSC priorities into statutes/regulations

Pediatric Medication Errors

As part of the action steps going forward in addressing concerns regarding potential pediatric medication errors, the EMSC program (after discussion and consensus with the EMSC Committee) plans the following action steps:

- Letter to Medical Direction Committee raising the issue Provide MI-MEDIC product to Medical Directors Committee for their comments (and potential adoption and conversion into a Virginia format)
- Letters to regional performance improvement entities (care of the regional councils)
- Statement of concern to EMS providers via state listserv (plea to document age, estimated weight in kg, etc.)
- Article in Spring EMS Bulletin (and submitted to next VAVRS newsletter)
- Single page descriptive/educational sheet for 2016 Symposium registration packet
- Proposing “pediatric medication errors” as an EMSAT subject
- Letters to all state-approved EMS education programs, EMS instructors and EMS Medical Directors emphasizing concern regarding pediatric medication errors
- Following internal OEMS progress of NEMSIS version 3.x to ensure implementation includes prompting for pediatric weight in kg

PedsReady Project

The Virginia EMS for Children program plans to focus its PedsReady efforts for 2016 on convincing every hospital emergency department to:

- Identify a physician and a nurse ED Pediatric Coordinator (advocate/champion).
- Measure and record the weight of pediatric patients in kilograms.
- Establish/review specific pediatric policies and safety procedures
- Establish written emergency pediatric transfer guidelines and agreements.

In addition, these EMSC webinars are archived on the EMSC National Resource Center website to help hospital ED's as part of the PedsReady Project:

- Is Your ED Ready for Children? Pediatric Emergency Care Coordinators Lead the Way to Readiness
- National Pediatric Readiness Project: Preparing the Emergency Department to Provide Psychosocial Support to Children and Families in a Disaster.

Every EMS agency in Virginia will be encouraged to appoint a pediatric advocate (work in progress).

Pediatric Disaster Preparedness

EMS for Children representation has been added to:

- Medically Vulnerable Populations Workgroup (now focusing on Pediatric Preparedness). This group is facilitated by Virginia Hospital & Healthcare Association (VHHA) and funded by the Assistant Secretary for Preparedness and Response (ASPR).
- Planning Committee for 2016 Public Health & Healthcare Preparedness Academy
- Planning Committee for 2016 CBERS (Community Based Emergency Response Seminars).

EMSC is also working with school nurses organizations and school nurses in the Virginia Department of Education to promote the role of school nurses in disaster planning and the response to disasters. Use of the NASEMSO tool (Checklist Tool for Pediatric Disaster Preparedness) has been a resource here, and introducing nurses to tools created by Illinois EMSC and others is expected to stimulate additional interest in the coming year.

On-Site Pediatric Training

The Virginia EMSC program will continue to facilitate access to pediatric education and training as requested and as funds allow, particularly in areas with historically difficult access to pediatric

training. EMS agencies interested in on-site pediatric training should contact David Edwards at 804-888-9144 (david.edwards@vdh.virginia.gov).

Requests for On-Site ED Pediatric Assessments

Any hospital emergency department (especially small and rural) that would like to have the EMS for Children program assist in an on-site collaborative assessment of pediatric needs and capabilities of their ED should contact David Edwards at the Office of EMS (david.edwards@vdh.virginia.gov) to obtain information and schedule a time and date.

Resource-based EMS for Children Website under Construction

Planned resource sections to aid in achieving national EMSC Performance Measures will be 1) Hospitals, 2) EMS agencies, 3) Injury Prevention, 4) Data, and 5) Pediatric Disaster Preparedness.

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

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

Respectfully Submitted

OEMS Staff

Appendix

A

2016 Office of EMS Legislative Grid
January 21, 2016

Bills	Committee	Last action	Date
HB 40 - Kory - Public safety answering points; deployment of text-to-9-1-1.	(H) Committee on Commerce and Labor	(H) Assigned to sub: Subcommittee #2	01/19/16
HB 199 - Boysko - Fire or rescue volunteers; mental health treatment; funding by locality.	(H) Committee on Counties, Cities and Towns	(H) Assigned to sub: Subcommittee #1	01/18/16
HB 222 - Stolle - Recognition of EMS Personnel Licensure Interstate Compact; created.	(H) Committee on Health, Welfare and Institutions	(H) Read second time and engrossed	01/21/16
HB 233 - Minchew - Fire or rescue volunteers; mental health treatment; funding by locality.	(H) Committee on Counties, Cities and Towns	(H) Assigned to sub: Subcommittee #1	01/18/16
HB 257 - LaRock - Fire or rescue volunteers; mental health treatment; funding by locality.	(H) Committee on Counties, Cities and Towns	(H) Assigned to sub: Subcommittee #1	01/18/16
HB 311 - Orrock - Emergency medical services providers; interstate agreements.	(H) Committee on Health, Welfare and Institutions	(H) Reported from Health, Welfare and Institutions (22-Y 0-N)	01/21/16
HB 312 - Orrock - VDH; increase sharing of electronic health records, report.	(H) Committee on Health, Welfare and Institutions	(H) Reported from Health, Welfare and Institutions with substitute (22-Y 0-N)	01/21/16
HB 331 - Pogge - Line of Duty Act; training and beneficiary identification.	(H) Committee on Appropriations	(H) Assigned to sub: Subcommittee Compensation and Retirement	01/14/16
HB 374 - Yancey - Registration of vehicles owned or used by emergency medical services agencies.	(H) Committee on Transportation	(H) Assigned to sub: Subcommittee Subcommittee #2	01/15/16
HB 756 - Lingamfelter - E-911 Services Board;	(H) Committee on Commerce and	(H) Assigned to sub: Subcommittee #2	01/21/16

designating as 9-1-1 Services Board.	Labor		
HB 825 - Stolle - Military medical personnel; pilot program for personnel to practice medicine.	(H) Committee on Health, Welfare and Institutions	(H) Referred to Committee on Health, Welfare and Institutions	01/12/16
HB 854 - Hugo - Firefighter or emergency medical services; personnel interrogation, observer.	(H) Committee for Courts of Justice	(H) Assigned to sub: Civil Law	01/19/16
HB 1007 - Levine - Recognition of EMS Personnel Licensure Interstate Compact; created.	(H) Committee on Health, Welfare and Institutions	(H) Stricken from docket by Health, Welfare and Institutions	01/21/16
HB 1021 - Sickles - Medicaid nonemergency transportation providers; criminal history background checks.	(H) Committee on Health, Welfare and Institutions	(H) Referred to Committee on Health, Welfare and Institutions	01/13/16
HB 1104 - Murphy - Firefighters employed by localities; entitlement to continued compensation.	(H) Committee on Counties, Cities and Towns	(H) Referred to Committee on Counties, Cities and Towns	01/13/16
HB 1239 - Wright - Fire Programs Fund; increases rate of assessment for Fund.	(H) Committee on Commerce and Labor	(H) Referred to Committee on Commerce and Labor	01/19/16
HJ 170 - Ware - Celebrating the life of James E. Hargrave.		(H) Agreed to by House	01/21/16
SB 19 - Stanley - Telemedicine; pilot program.	(S) Committee on Finance	(S) Rereferred to Finance	01/21/16
SB 35 - Carrico - Vehicle registration fees; funds allocated to Department of State Police.	(S) Committee on Finance	(S) Rereferred to Finance	01/20/16
SB 79 - Wexton - Fire or rescue volunteers; mental health treatment, funding by locality.	(S) Committee on Local Government	(S) Constitutional reading dispensed (39-Y 0-N)	01/21/16
SB 91 - Marsden - Emergency medical services agencies; registration of	(S) Committee on Transportation	(S) Reported from Transportation with amendments (10-Y 0-N	01/20/16

vehicles owned or used by agencies.		2-A)	
SB 134 - Favola - Fire or rescue volunteers; mental health treatment; funding by locality.	(S) Committee on Local Government	(S) Incorporated by Local Government (SB79-Wexton) (13-Y 0-N)	01/19/16
SB 149 - Reeves - Health insurance plan, local option; participation of regional emergency medical services councils.	(S) Committee on Finance	(S) Referred to Committee on Finance	12/29/15
SB 233 - Reeves - Recognition of EMS Personnel Licensure Interstate Compact.	(S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/06/16
SB 265 - Dance - Nurse Licensure Compact; current compact replaced with a revised version.	(S) Committee on Education and Health	(S) Referred to Committee on Education and Health	01/06/16
SB 523 - McPike - Line of Duty Act; includes firefighters and emergency medical services trainees in Act.	(S) Committee on Finance	(S) Referred to Committee on Finance	01/13/16
SJ 31 - Reeves - Celebrating the life of Kelly G. Southard.		(H) Laid on Speaker's table	01/15/16
SJ 66 - Hanger - Commending Joseph J. Fray.		(H) Laid on Speaker's table	01/15/16
SJ 67 - Hanger - Commending John T. Fray.		(H) Laid on Speaker's table	01/15/16
SJ 91 - Vogel - Confirming Governor's appointments of certain persons.	(S) Committee on Privileges and Elections	(S) Referred to Committee on Privileges and Elections	01/13/16

Appendix

B

SECOND & THIRD QUARTER 2015

E.V.E.N.T.
Near Miss Report

Welcome!

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

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

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

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

"…While rendering aid in back of ambulance our vehicle was struck from behind by a driver attempting to maneuver into alleyway blocked by ambulance……." ***– 3Q2015 EVENT Near Miss Report #1***

This is the aggregate Near Miss E.V.E.N.T. summary report for second & third quarter 2015.

PROVIDED BY:

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

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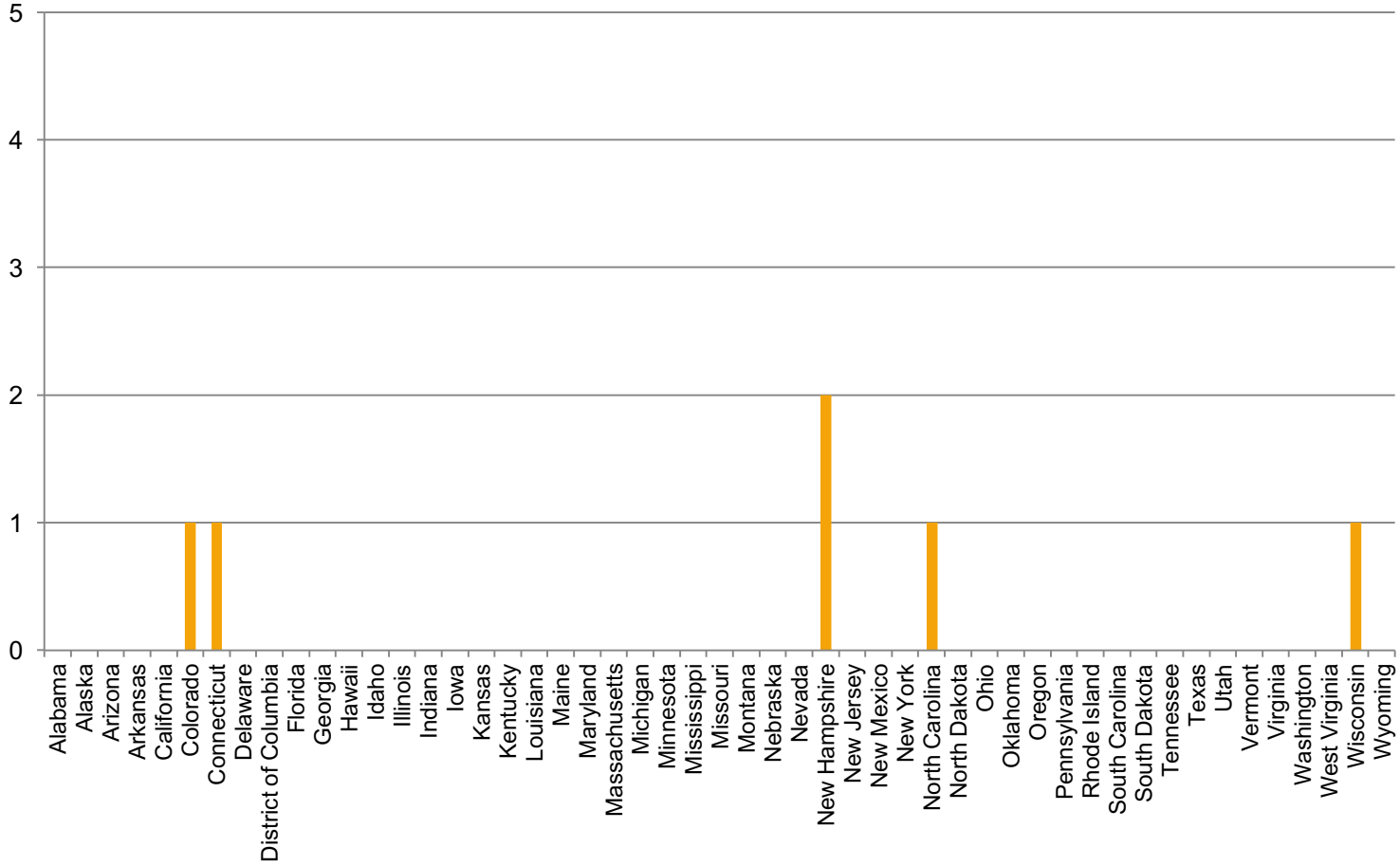
Near Miss Events Quarterly

	2012	2013	2014	2015
Jan - Mar	1	4	0	4
Apr - Jun	0	3	1	1
Jul - Sep	8	5	5	5
Oct - Dec	10	7	6	
Total	19	19	12	9

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

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

Near Miss Events by State (United States of America)




Alabama Emergency Medical Technicians Association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National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


Pennsylvania Emergency
Health Services Council
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION

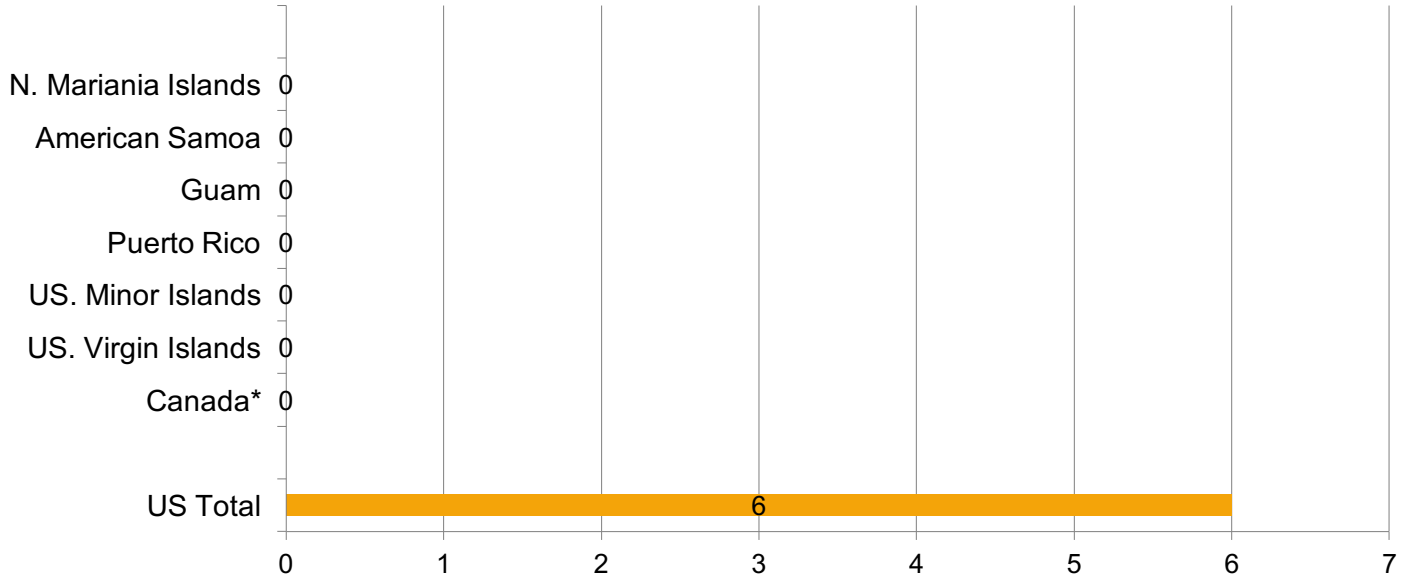

VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

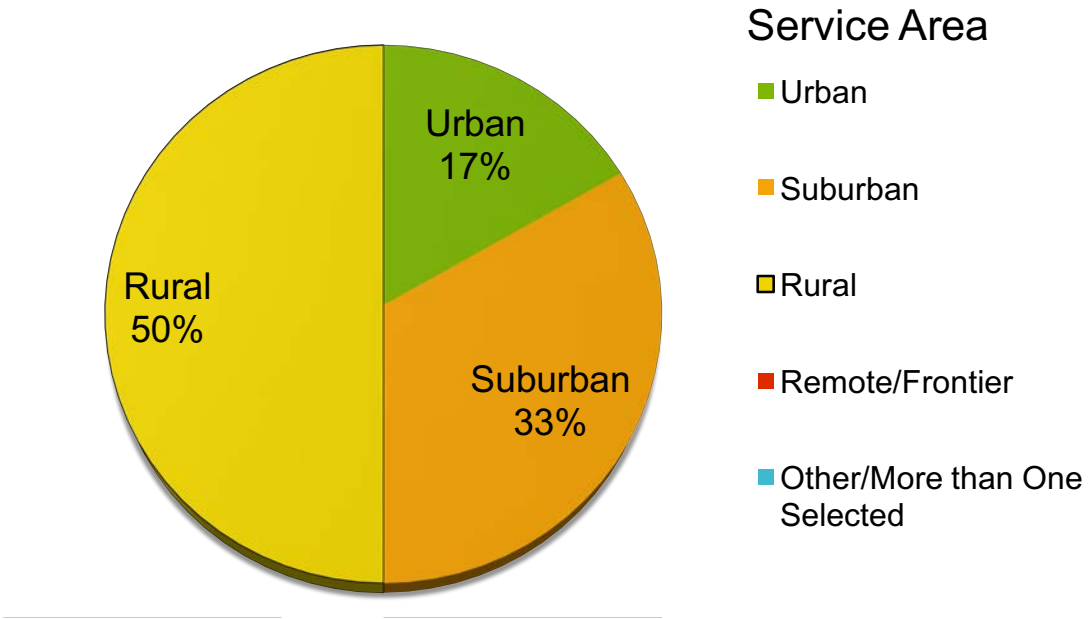

AAMS


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

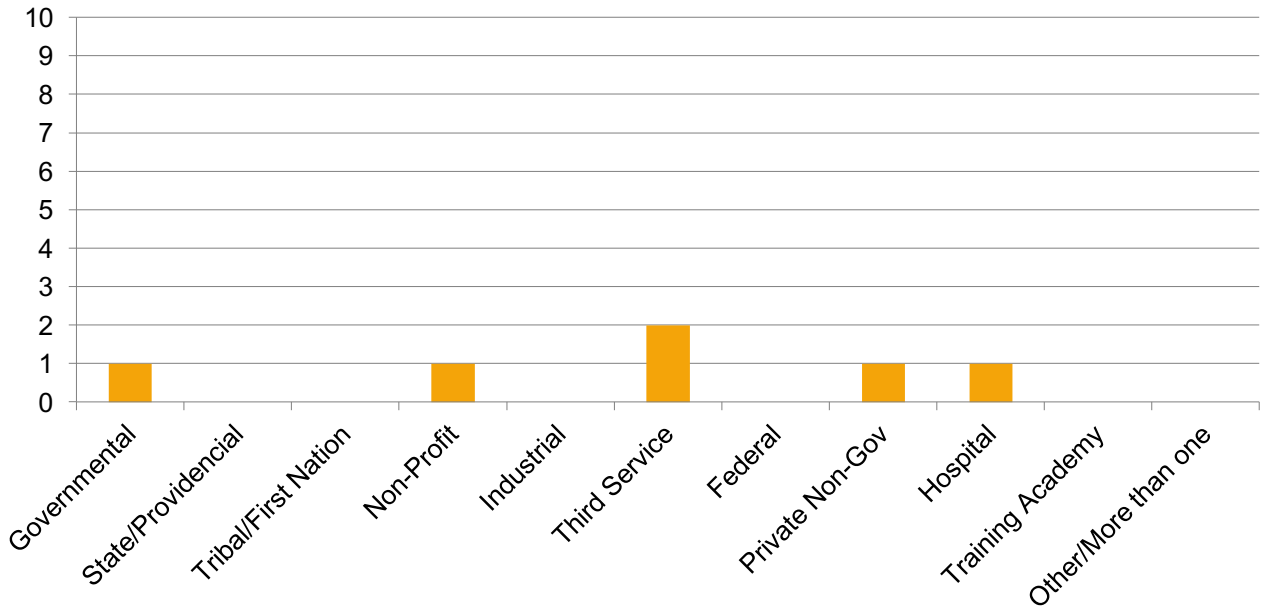
Near Misses in Canada and U.S. Territories



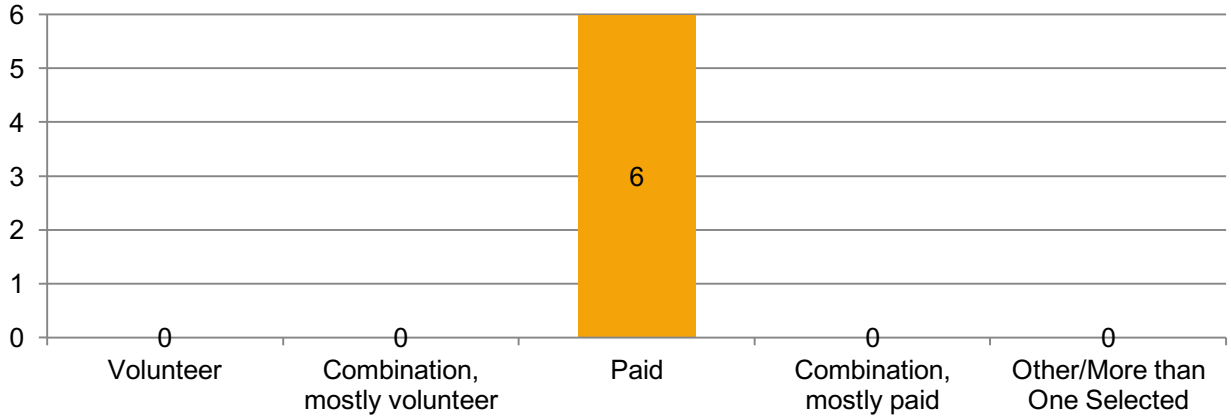
Near Miss Events Across Agency Characteristics



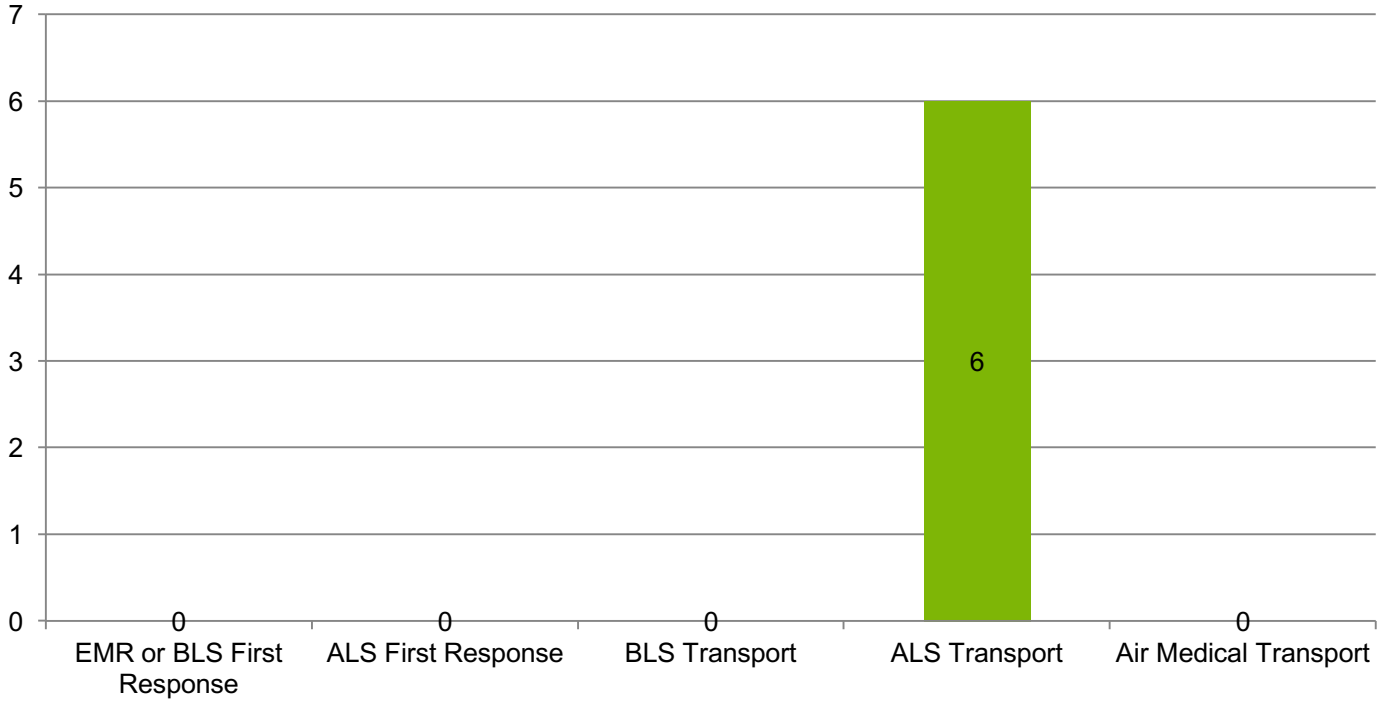
Frequency of NME by Agency Ownership



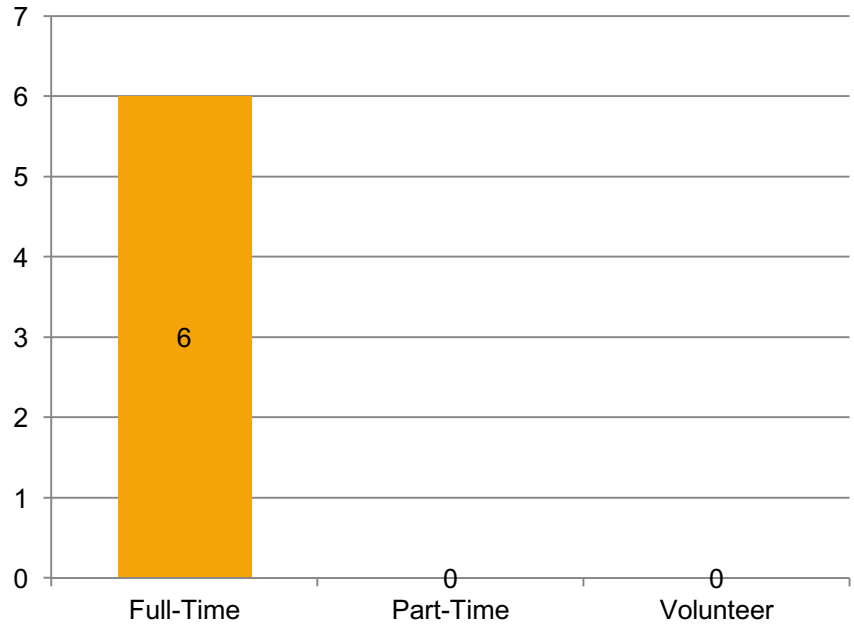
Department Type



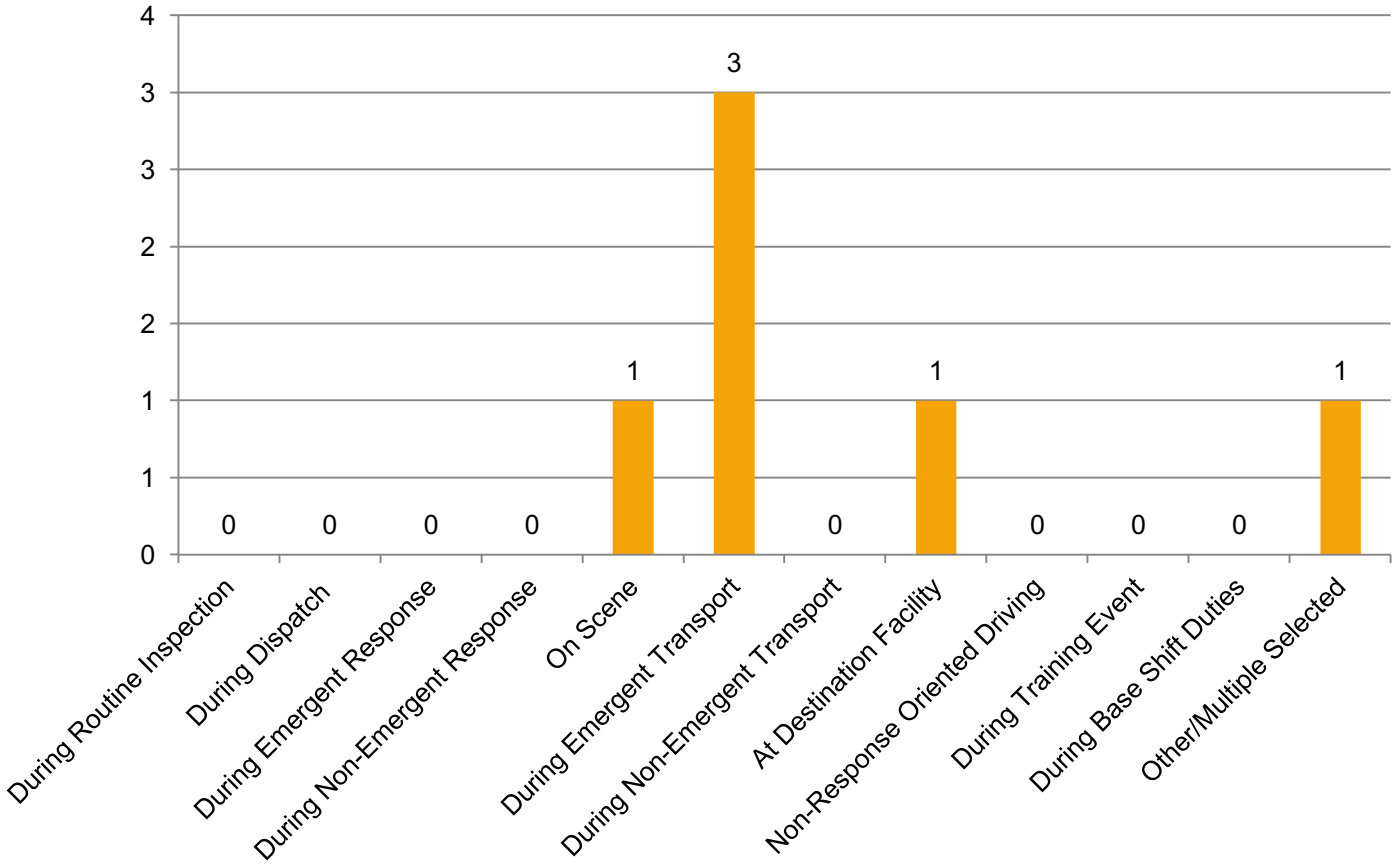
Level of Organization



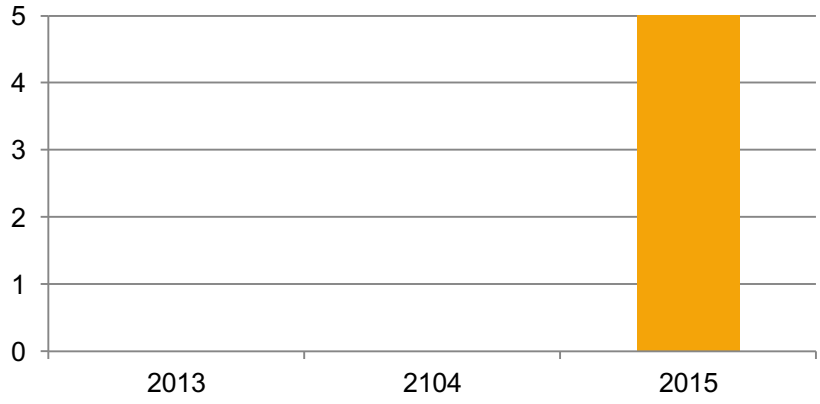
Employment



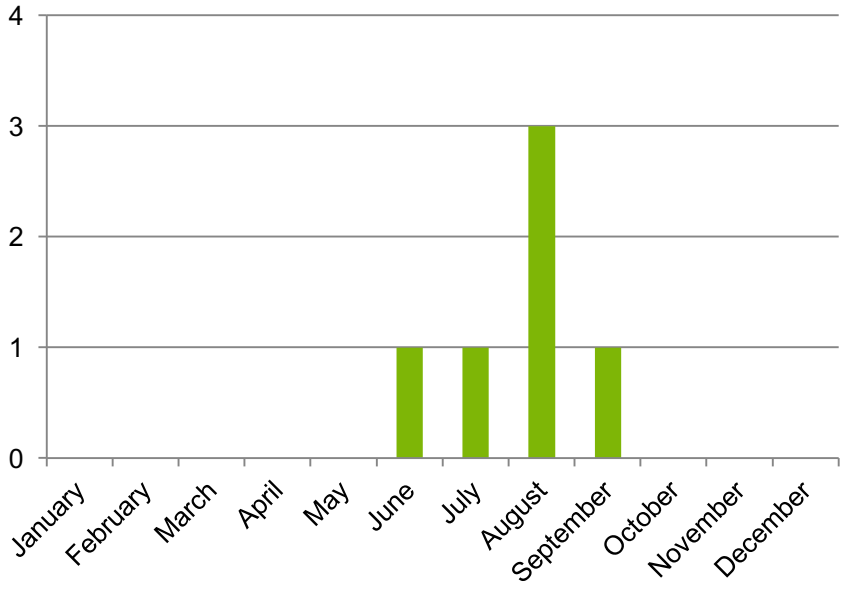
NME Occurrence During EMS Response Timeline



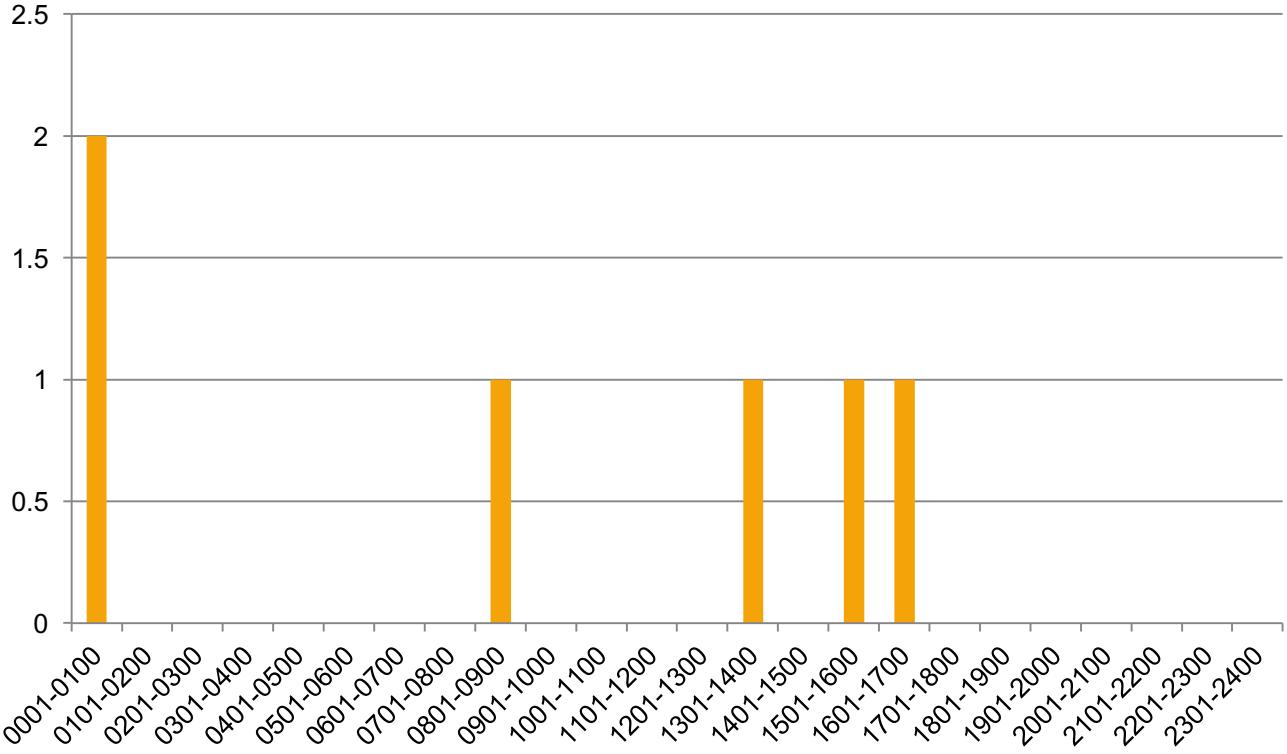
Year Reported Near Miss Event Occurred

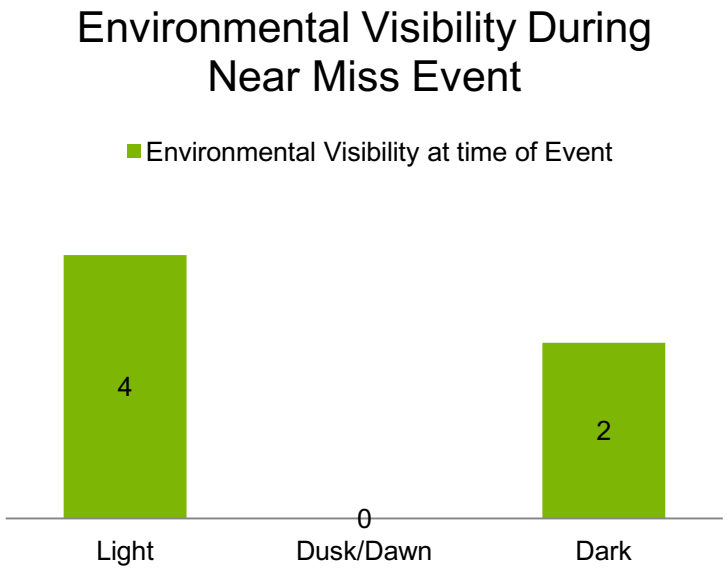


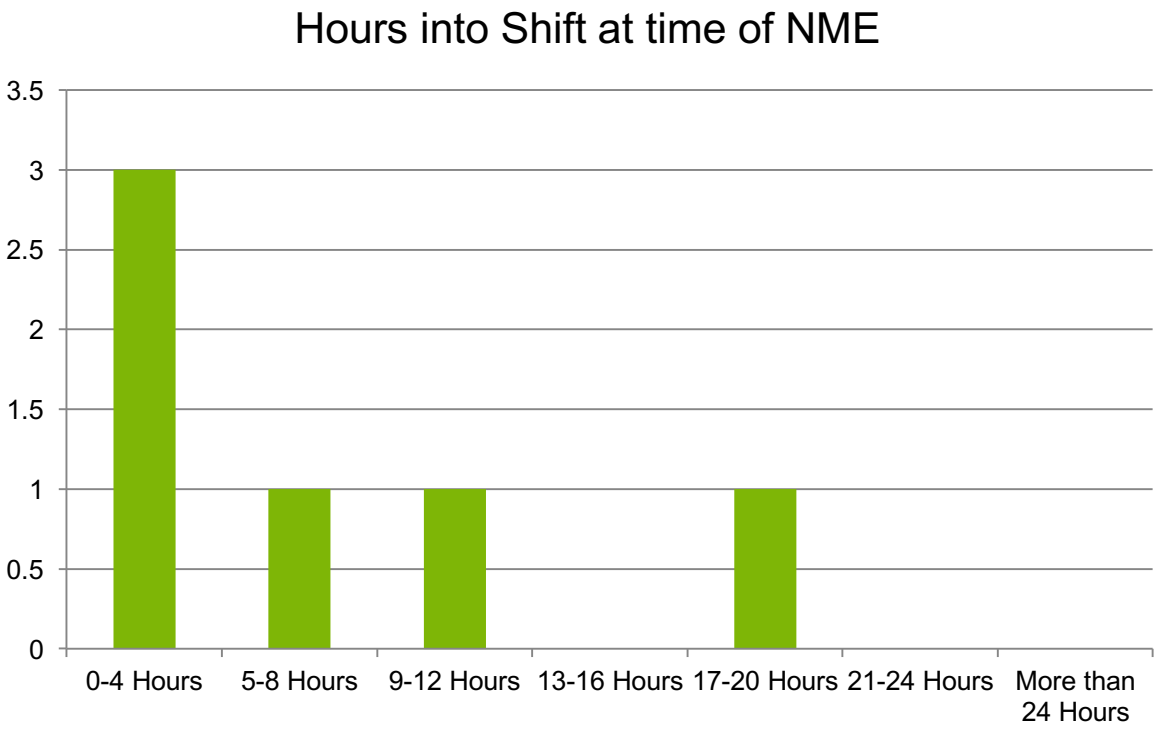
Month of Reported Near Miss Event



Time of Reported NME



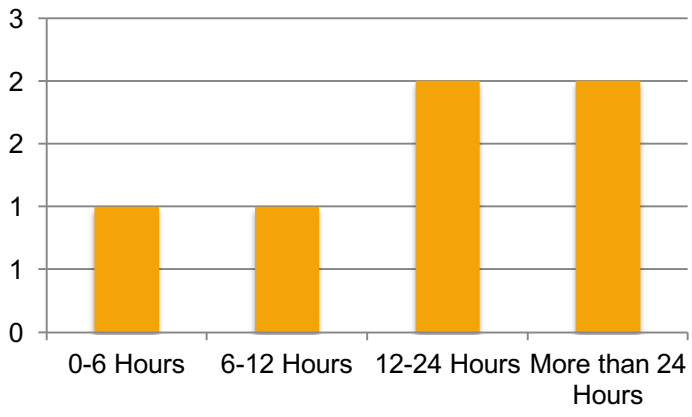

Environmental Visibility During Near Miss Event
Environmental Visibility at time of Event
4
0
2
Light
Dusk/Dawn
Dark


Hours into Shift at time of NME
3.5
3
2.5
2
1.5
1
0.5
0
0-4 Hours
5-8 Hours
9-12 Hours
13-16 Hours
17-20 Hours
21-24 Hours
More than 24 Hours

Contributing Factors to Near Miss Events: As Reported by Providers

	Frequency		Frequency
Accountability	0	Situational Awareness	3
Command	0	SOP/SOG	0
Communication	0	Staffing	0
Decision Making	1	Task Allocation	0
Equipment	1	Teamwork	0
Fatigue	1	Training Issue	0
Distracted Driver/Pilot	0	Unknown	0
Horseplay	0	Weather	0
Human Error	1	Violent Patient	0
Individual Action	1	Violent Non-Patient	0
Procedure	0	Inadequate Lighting	0
Protocol	0	Other	0

Time off before beginning of shift with NME



#	Description	Lessons Learned/System Change
1	While rendering aid in back of ambulance our vehicle was struck from behind by a driver attempting to maneuver into alleyway blocked by ambulance.	
2	We were dispatched for a female patient with seizures. Upon arrival and patient care we prepared stable patient for transport to our local hospital. En route to the hospital patient became nauseous. Per our protocol I was going to administer 4 mg Zofran slow IVP. I obtained the Zofran from our medication box and noticed the prefilled Zofran tubex was not Zofran. The packaging was the same as it is a distinct purple package with yellow. The medication was actually Toradol. The Toradol was not administered and I did give the patient the proper medication (Zofran).	Verification of right medication, right dose, right route, etc. The wrong medication was located in the spot for the proper med and as I verified the medication I discovered this. Different packaging for the medication #2, as they both look exactly alike.
3	After arrival at ED, pt's Rx bottles were being recorded in ePCR. EMS found a small caliber gun in the medication bag. PD off duty officer [redacted] was notified and took custody of the gun. Off duty officer [redacted] called for another officer to take the gun and keep possession of it since he was off duty.	Be aware of personal items brought from a patient's residence. Secure items appropriately (Rx to nurse, firearm to law enforcement).
4	Driver states he fell asleep while driving attendant and patient during late night interfacility transport.	Need to find way to monitor crew fatigue. Having a culture where a provider can "tap-out".
5	While making a right hand turn, a bicycle attempted to cross the intersection in front of the ambulance. The biker had a do not walk sign flashing. A collision was avoided by the driver of the ambulance braking.	Driver of the ambulance saw the biker and was able to avoid collision Be aware of pedestrians on sidewalks.
6	[This entry has been shortened to fit the space available.] The patient was in acute congestive heart failure. In the truck the I was preparing to put the patient on CPAP but discovered the main O2 tank was essentially empty. Having only portable tanks, I had to delay application of CPAP until closer to the hospital. Because of the situation the patient experienced a significant delay in obtaining the appropriate clinical treatment. Fortunately he was not harmed by this in my judgment, but this absolutely should not have happened. The primary ambulance had received their call Thursday morning at 07:19, 19 minutes after shift change. As I suspect the main O2 tank was low at shift change, this should have been enough time to become aware of it, but we are complacent with how quickly we check the trucks in the morning. This was exacerbated by the fact that the crew treated their patient with high flow O2 during most of the transport. The fact that the onboard O2 tank was empty should have been noticed by the crew at the completion of the run and we should not have transported in an ambulance depleted of oxygen.	The lessons to be learned are: #1. Particularly after the use of CPAP the crew needs to assess the main O2 status and not wait for the next crew to check the oxygen in the morning. #2. Checking the onboard oxygen tank is the first thing crews should do when doing truck checks in the morning. Notification of near miss incident to all staff.

Appendix

C

THIRD QUARTER 2015

EMS Patient Safety Event Report

E.V.E.N.T.
EMS Voluntary Event Notification Tool
An EMS Culture of Safety Initiative

Welcome!

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

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

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"…While rendering aid in back of ambulance our vehicle was struck from behind by a driver attempting to maneuver into alleyway blocked by ambulance……." ***– 3Q2015 EVENT Near Miss Report #1***

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

PROVIDED BY:

CLIR

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

NASEMSO

Patient Safety Event Reports Sorted Quarterly

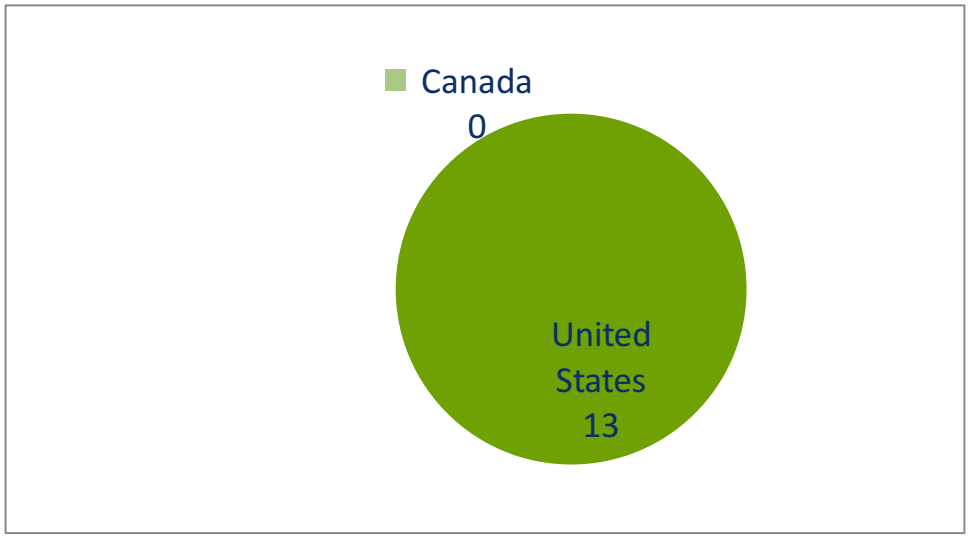
	2012	2013	2014	2015
Jan - Mar	6	31	30	19
Apr - Jun	9	39	29	18
Jul - Sep	13	35	24	12
Oct - Dec	6	32	30	
Total	34	136	117	49

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

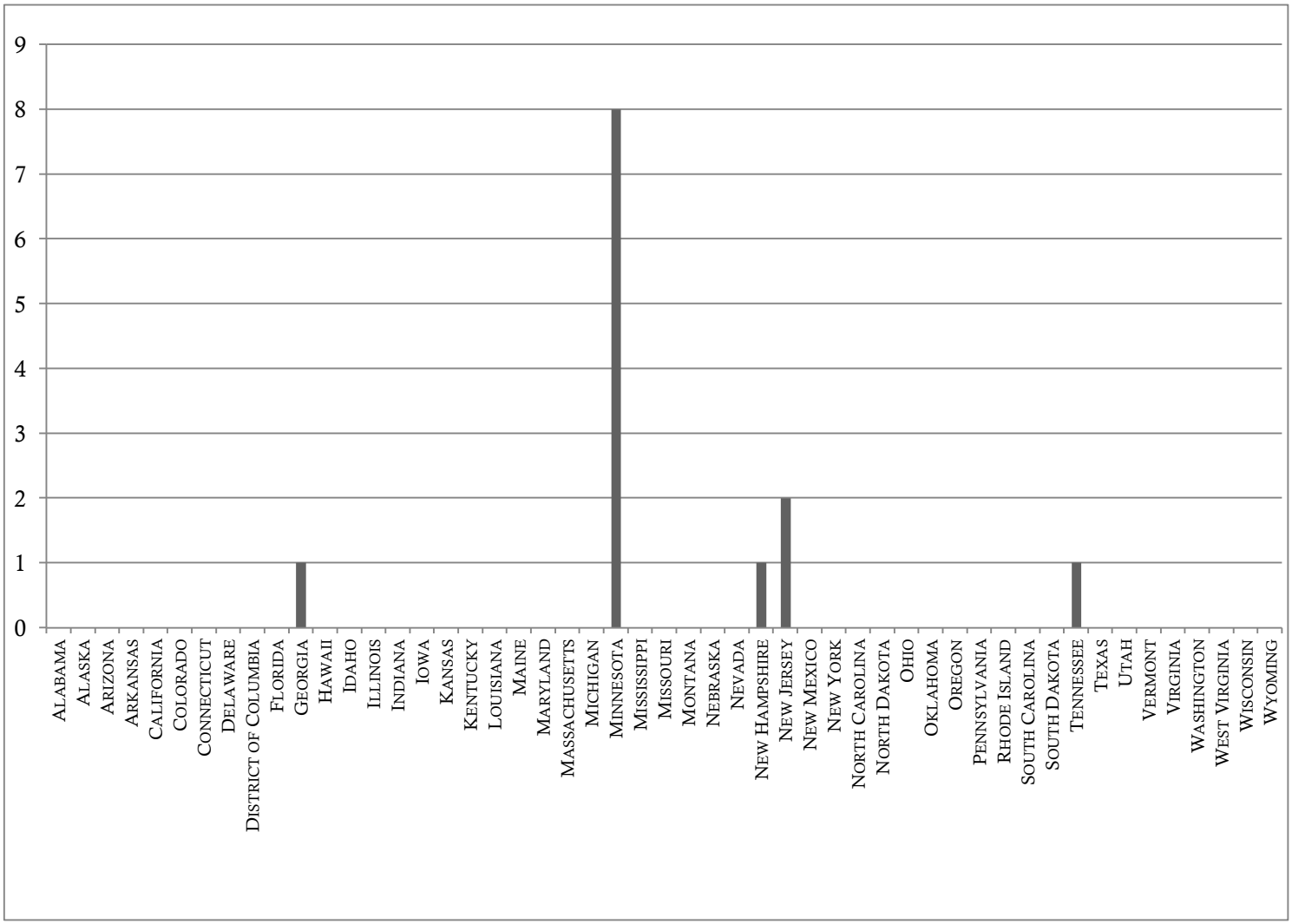
EMS Patient Safety Event → E.V.E.N.T. Report Completed Online → CLIR Notified of EMS Error → Quarterly/Annual Reports Generated

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

Quarterly Patient Safety Events by Country



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



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


Alabama Emergency Medical Technicians Association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HGH EMS
RESCUE


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AAMS


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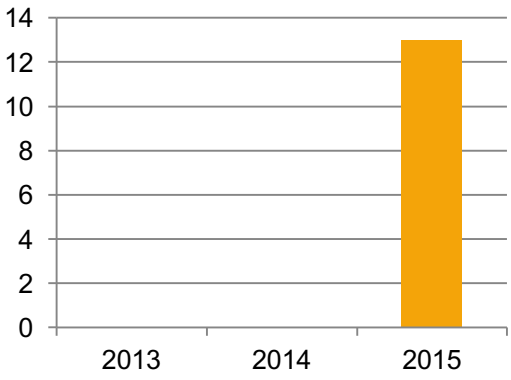
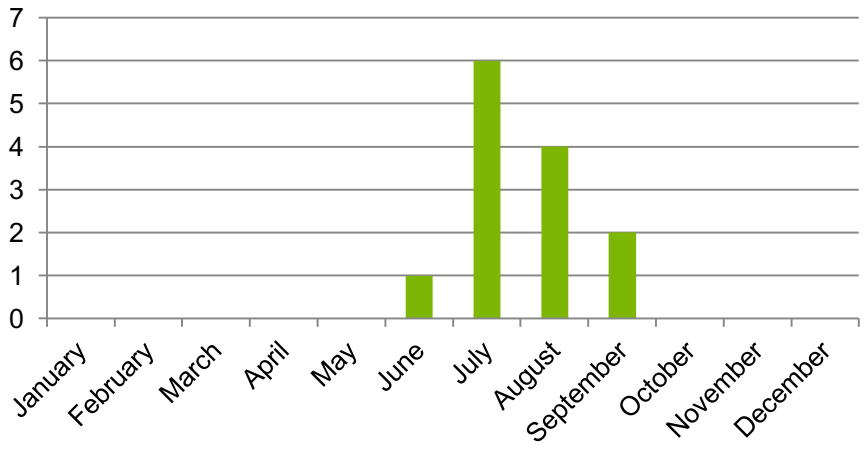
Center for Rural Health


CLIR
NATIONAL EMS MANAGEMENT ASSOCIATION
North Central EMS Institute
Paramedic Chiefs of Canada
Chefs Paramédics du Canada
The Center for Leadership, Innovation and Research in Emergency Medical Services

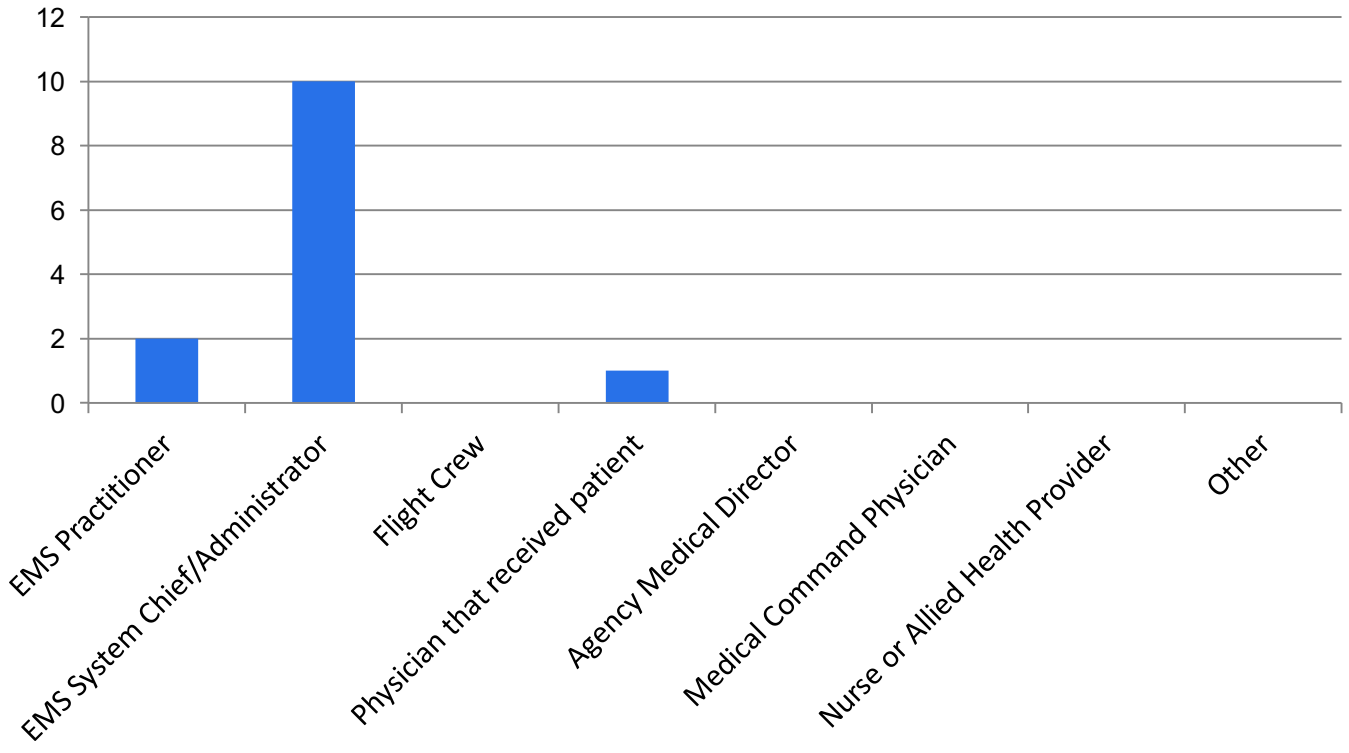
Year Reported Patient Safety Event Occurred



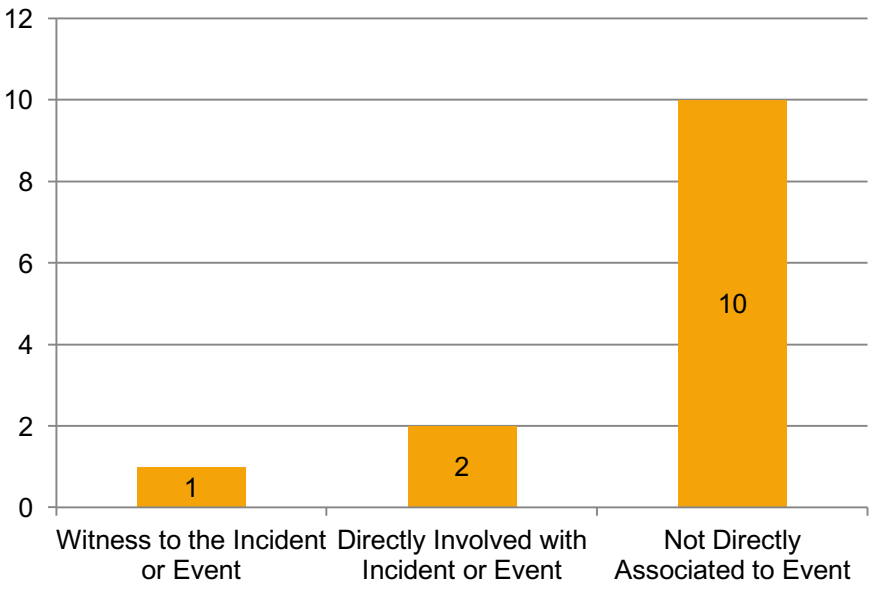
Month of Reported Patient Safety Event



Role of Person Reporting Incident

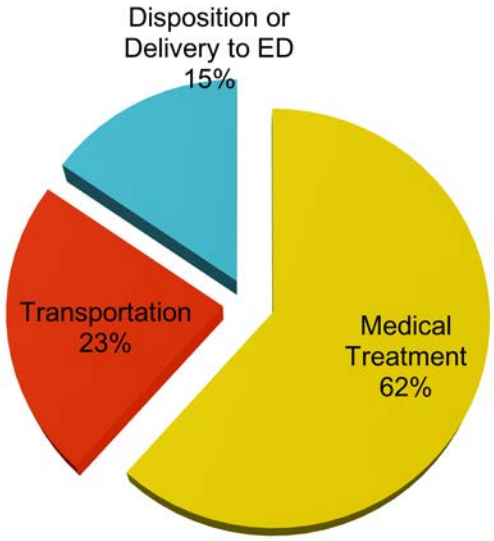


Involvement in Safety Event



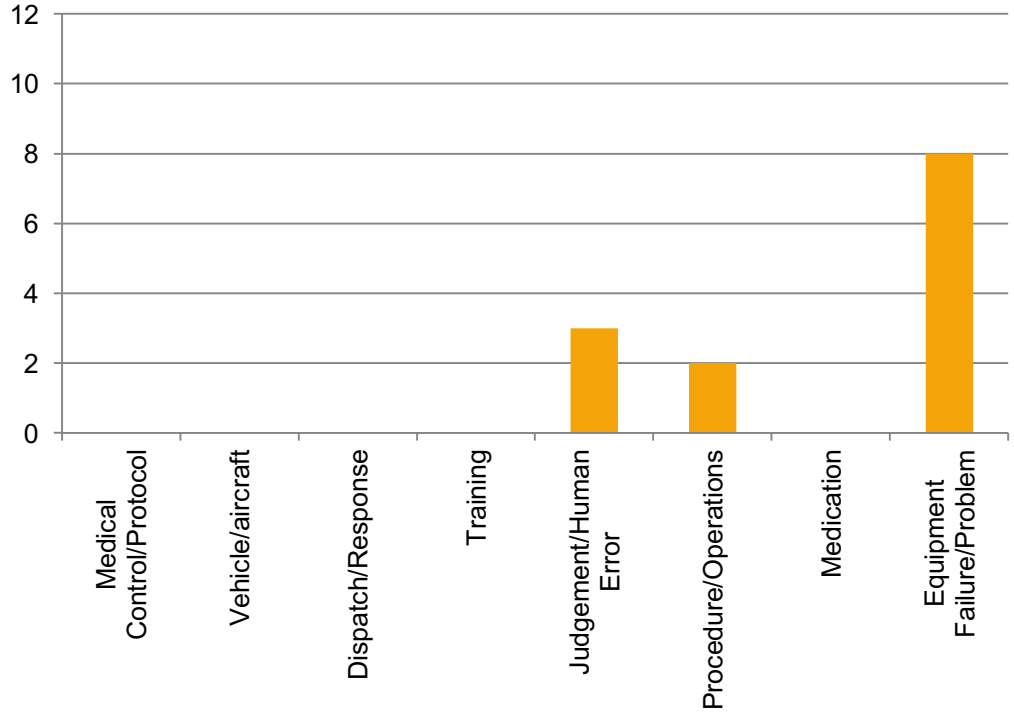
The reporters from this period are generally “not directly associated to the event”. The EMS system administrator dominates the “not directly associated” group.

Category of Event



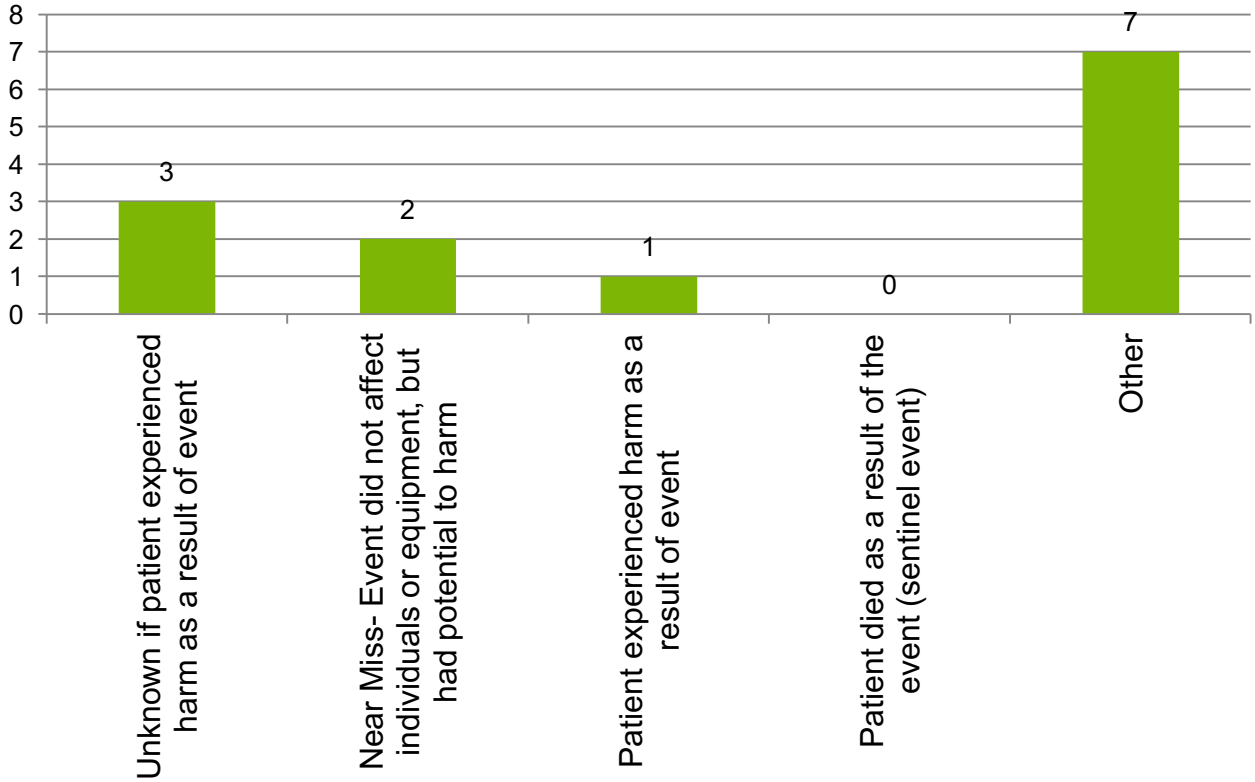
The vast majority of the events reported this period occurred in the medical treatment phase. Transportation is the second most reported.

Type of Patient Safety Event



Equipment failures dominated the type of event, followed by clinical judgment or human error and operations.

Patient Result of Patient Safety Event



#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
1	Patient was found near a hospital severely intoxicated. It appeared from the scene patient was riding a bicycle while intoxicated and finally fell off the bike onto the grass after he passed out. Crew Chief ordered that he be placed onto stretcher without spinal immobilization or performing any assessment other than baseline vitals (no rapid scan, etc.). Patient was then taken to the nearest hospital which was not our county designated alcohol/drug ER. While any hospital can accept an alcohol patient, while it is unlikely the patient was able to go more than 5MPH on the bicycle when he fell, onto grass, thus making it unlikely he suffered any major injuries, patient safety was compromised b/c without a full assessment and spinal immobilization prior to the determination that there were no spinal injuries, it could not have been known for sure that the patient did not actually hurt himself and thus, leaves the possibility that our "treatment" of this patient did/failed to prevent more harm to this patient.	Complacency and tiredness. The call was our 3rd in a row, in the middle of the night, and we were dispatched at approx. 0230. Additionally, our Crew Chief is an experienced crew chief who has seen numerous intoxication calls, and on top of that, the odds that someone would actually hurt themselves falling off a bicycle going at 5MPH onto soft ground is minimal. Strict protocols and enforcement that dictate that any trauma requires certain specific protocols regardless of circumstances and the same to dictate proper treatment/transport of an intoxicated person.
2	During a resuscitation attempt for a 23 y/o male with an unwitnessed arrest, the crew obtained a direct Medical Control order to discontinue at the scene based on over 33 minutes of no pulses, no response to 5 doses of epinephrine, and reporting by the crew paramedic that the ECG was asystole. 7-10 minutes after stopping CPR and providing death notification to the mother at the scene, ROSC was discovered with an SVT rhythm on the still attached ECG monitor. Care was resumed and during transport to the hospital the patient regained spontaneous breathing attempts and continued to have a pulse. The patient was admitted to the hospital with life support discontinued within a few days due to neurological damage. Preliminary information as to the cause of arrest and death was related to a history of drug abuse. Laboratory analysis found evidence for at least three controlled substance and street drugs.	There were two primary errors made by the attending paramedic which were the ultimate cause of the event: 1. Misinterpretation of the ECG as asystole and not recognizing the presence of a SVT rhythm. 2. Failure to reassess for pulses during the last few minutes of care and again after the orders were obtained from a direct medical control physician to discontinue. Use of the monitor chart recorder to print ECG sections is underutilized, especially during cardiac arrests, as in this event, and when administering anti-arrhythmic medications. It is difficult to always make an accurate ECG rhythm interpretation by only viewing the moving 4 second section on the screen which is also very busy and distracting with other displayed parameters and various colors. Not related to this event, the most frequent cause of other medication or electrical therapy errors is a misinterpretation of the ECG. I suggest adding to EMS patient care guidelines a requirement that the providers print and review at least a 20 second ECG segment before any of the following: 1. Discontinuing resuscitation for a patient where any procedures have been initiated, including CPR and AEDs. 2. Before administering any anti-arrhythmic medication. Include viewing this ECG segment as part of the medication safety check procedure when checking for contraindication.
3	The ambulance crew forgot their ECG patient cables at the hospital after dropping off a patient. The next response was a chest pain call and discovered missing cables when attempting to view ECG and acquire 12-lead. They later discovered that spare cables were in the vehicle cabinet resulting in a 5 min. delay to acquire the 12-lead. Hospital diagnosis was ETOH related pain and not a cardiac etiology. No patient harm.	The crew admits this is a human error type event by forgetting cables at the hospital and later forgetting they had a spare set which was a very recent addition to vehicle's cabinet inventory. Not an equipment failure event type. A more diligent checking of equipment readiness for the next call may have discovered the missing cables.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
4	While delivering a patient to the ED the automatic doors suddenly swung shut while the crew was passing through striking both of the patients elbows. The doors were pried open again and the patient brought into the ED. Patient sustained abrasions and contusions to both elbows. Receiving RN and Charge RN notified of the incident and injury.	Malfunction of automatic doors. Unknown, I am not aware of the cause of the malfunction.
5	While on a call for a patient in severe respiratory distress provider did not know how to properly utilize CPAP mask straps. Other provider had to instruct the provider to hold the CPAP mask over the patient's face to continue to create a seal, while other provider had to place straps to secure mask. After mask was secured provider attempted to make base hospital contact to secure orders to treat patient, but was unable to properly describe patient condition and necessary treatment requested.	Provider didn't take the time to ensure he knew how to utilize all the equipment that was provided to him on the ambulance, or where it was located. Provider failed to inform his supervisor that he didn't know how to get orders to give treatments requiring them. Ensure that all providers can demonstrate how to use each piece of equipment and know how to give a proper radio report to base hospital to receive orders to treat the patient.
6	While transporting to the ER with a patient in cardiac arrest the [manufacturer, model] monitor screen went blank and would not come back on. Lost all tracings of EKG, Sp02, and ETC02. At one point it randomly charged and had to be manually discharged.	Poor design of the monitor, there should be some way to know when the internal battery is weak and can cause potential harmful events. A way to test the internal battery. This unit had just received regular 6 month quality check and passed.
7	The cardiac monitor failed to acquire a 12-lead ECG for a chest pain patient indicating several V-leads were not connected. The limb lead signal was all intermittent and unreliable. The cause was later determined to be faulty main patient ECG cable, likely wire breaks. No apparent harm to the patient who was transported routinely to the hospital and was not having an AMI.	Faulty ECG cable. This 4 year old cable saw low frequency of use. ECG cables supplied by the manufacturers are not durable enough to stand-up to the rougher use seen in the EMS environment. This is a failure we encounter frequently.
8	When unloading a 205 lb. patient on a stretcher at the hospital garage, the height locking mechanism appeared to malfunction and the stretcher dropped from the highest unload position to position 2 or 3 lower height as it was being pulled back on the 4 main wheels. The drop ended with the loading wheels resting up against the step bumper. The assistant operator was still on the side of the stretcher and no one other than the foot-end operator was touching the [stretcher]. No patient harm & no crew injury. The stretcher was removed from service for inspection & repairs as needed. Initial indications are this may be a "false locking" event type. Inspection & testing revealed no damage or maintenance required & the device functioning normally. The stretcher was returned to service.	Unable to determine the cause or any contributors. The manufacturer labels this type of occurrence as a "false locking event." Regular stretcher inspections can sometimes identify maintenance needs related to the handle release mechanism or the two bars which contain the locking position notches.

#	Summary of Safety Event Reported	Summary of EMS Provider Opinions on the Cause of the Safety Event and their suggestions for mitigation
9	Patient arrived via medic and EMS to ER when squad was made aware by med com that facility had been on special studies divert as CT scan was unavailable. Patient had experienced syncope, striking a telephone pole head on with airbag deployment, and suffered facial contusions with periorbital swelling, chest wall contusion and dyspnea on presentation...obvious need for trauma CT scan. Squad stated patient receives [healthcare] in facility and he requested site. Patient states he requested different hospital but squad said it was too far. Transferred to trauma immediately.	Inappropriate disposition to a facility that did not have the capacity at that time to accommodate patient's immediate needs. Concern for delay in care due poor judgment of EMS crew. Upon informing squad and patient at bedside, EMT yelled at staff and myself, that she didn't like when I talk in front of the patient when an incident occurs. I told her a patient has the right to know that his care/prognosis may have been delayed and worsened due to their actions. Unprofessional behavior exhibited overall. Educate EMS to improve clinical judgment. Recognize that pt preference reason is not valid when a facility cannot accommodate immediate need for best pt care at that time. Exercise respect, courtesy, and maturity when interacting with ER staff and peers to provide comfortable and calm working environment.
10	Immediately after moving a patient on to the ambulance stretcher at a nursing home, the stretcher height position dropped about 6 inches & then again locked into position. No harm to the patient. The crew removed the stretcher for inspection & repairs if needed.	Inspection of the stretcher revealed no damage or maintenance required. The event was categorized into what the manufacturer describes as a "false locking" event related to the stretcher height mechanism. The manufacturer recommends that operators lift the stretcher slightly off the ground each time the height position is changed to assure the position is locked in.
11	During care of a 27 y/o chest pain patient, the cardiac monitor failed when attempting to ECG monitor & to obtain a 12-lead. Crew was later able to obtain limb-lead ECG only after manipulating patient ECG cable. ECG signal failure continued to be intermittent en route to hospital. No patient harm as pain suspected to be related to ETOH consumption & not cardiac causes and not an AMI or STEMI.	The main patient ECG cable tested faulty on simulator, likely breaks in several wires within the cable sheath. After the cable was replaced, the monitor tested OK & was returned to service. Many similar events where the main ECG cable fails. Cable supplied by manufacturer is not durable enough for frequent pre-hospital environment use and is easily damaged.
12	An IV pump alarmed with error code #322 during a hospital transfer with heparin drip running for a stable MI patient. The crew was able to turn-off and reset pump each time it failed with no harm to the patient. Most of the medication as was delivered as ordered by sending MD.	Error code 322 for this pump is a known door sensor fault (link switch error). The software is unable to sense the position of the door. The [manufacturer/model] pump was removed from service and sent for repairs following [manufacturer] product alert from Feb. 2014. Periodic preventative maintenance checking for this pump model sometimes discovers this type of failure (error code 322) before it reaches a patient use.
13	When attempting to acquire a 12-lead on a clinic response, the ECG monitor displayed a V-5 lead off error message & would not acquire. The failure was later determined to be a faulty ECG cable. The limb leads functioned normally and the ECG interpretation was clearly a 2nd degree HB. No harm to the patient who was asymptomatic & already a known pacer implant candidate.	The faulty ECG cables were replaced and the monitor returned to service after testing normally with the new cables. Faulty cable to be sent for testing & replacement. The main patient ECG cable supplied by the manufacturer is not rugged enough for the pre-hospital EMS environment.

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

Appendix

D

THIRD QUARTER 2015

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

Welcome!

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

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

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

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

*"…While rendering aid in back of ambulance our vehicle was struck from behind by a driver attempting to maneuver into alleyway blocked by ambulance……" – **3Q2015 EVENT Near Miss Report #1***

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

PROVIDED BY:

CLIR

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada / Chefs Paramédics du Canada

National EMS Management Association

NAEMT

NASEMSO

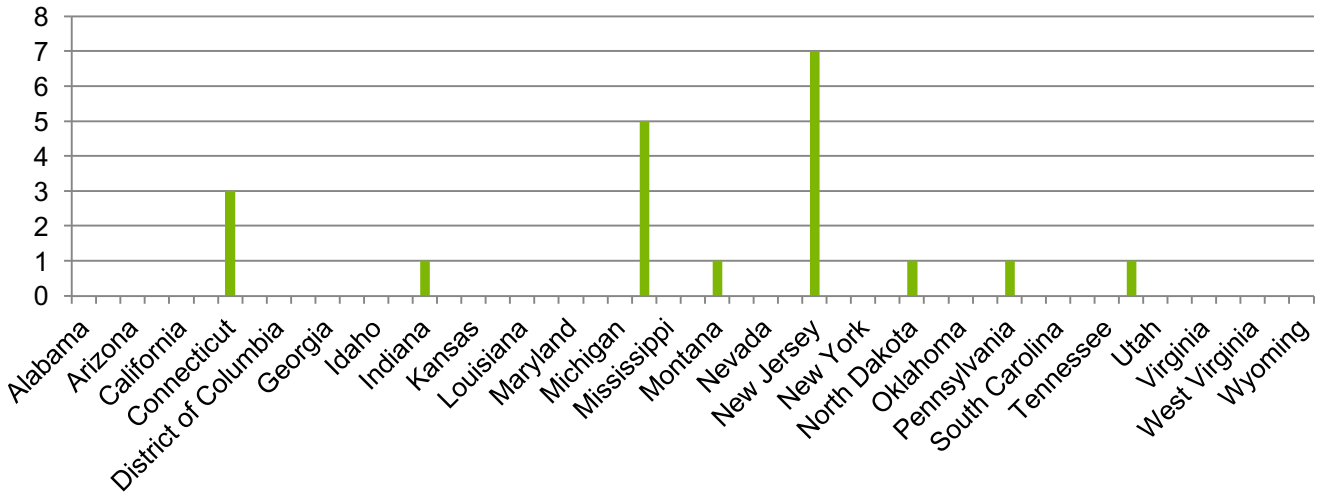
Table 1: Violence Events Quarterly

	2012	2013	2014	2015
Jan - Mar	1	3	10	9
Apr - Jun		5	5	6
Jul - Sep	9	18	5	19
Oct - Dec	11	10	5	
Total	21	36	25	34

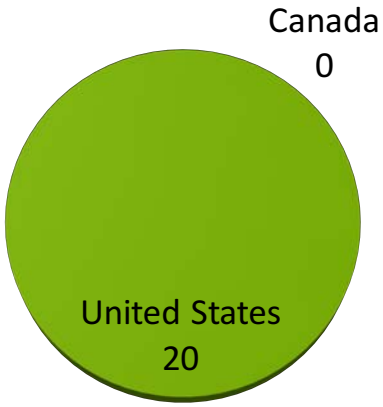
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

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

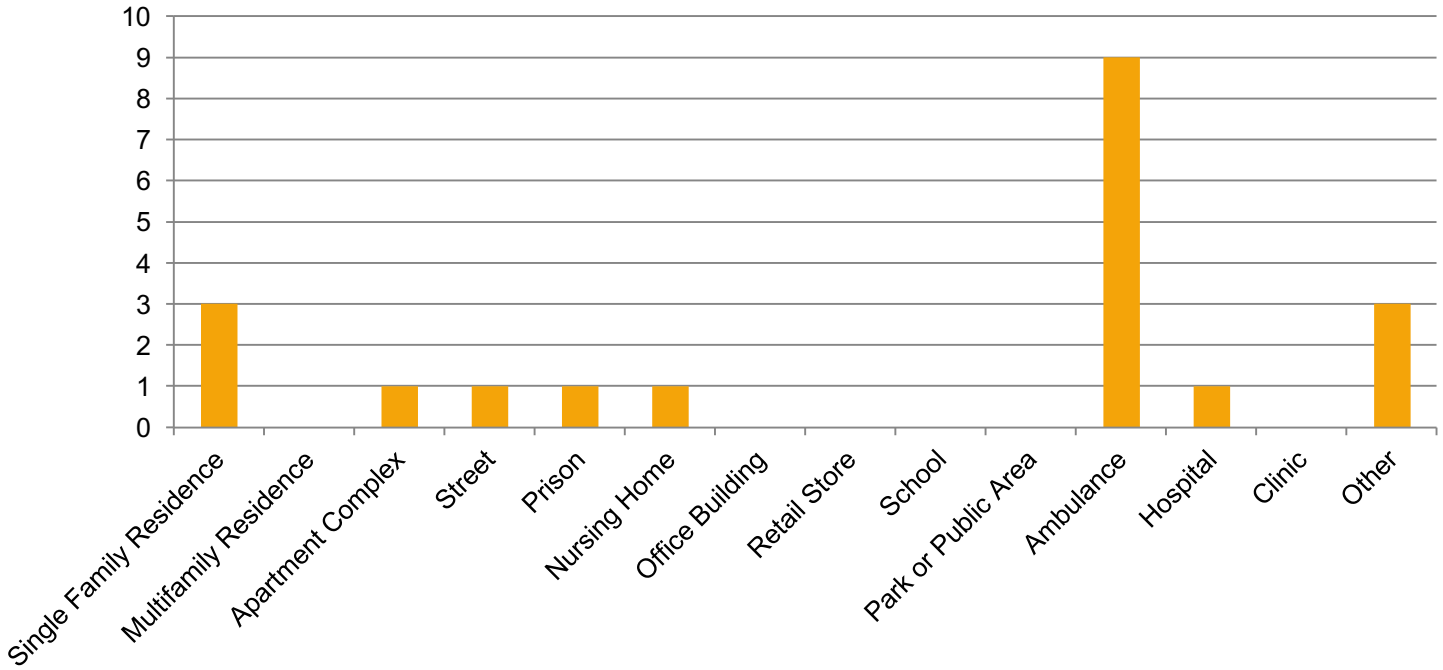
Violence Events by State



Quarterly Violence Events by Country



Place Violence Occurred




Alabama Emergency Medical Technicians Association


NAEMSP


CAA
HEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


National Registry of Emergency Medical Technicians
THE NATION'S EMS CERTIFICATION


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE
NEW YORK STATE
ASSOCIATION INC.


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION


VFIS
A Division of Glatfelter Insurance Group

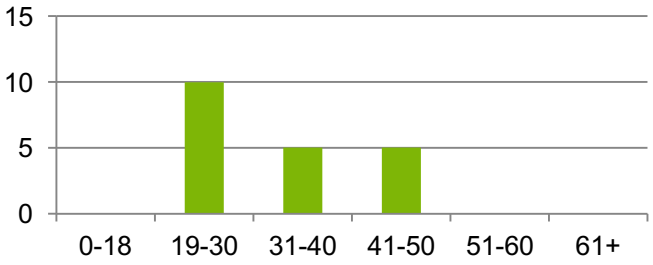

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health


AAMS

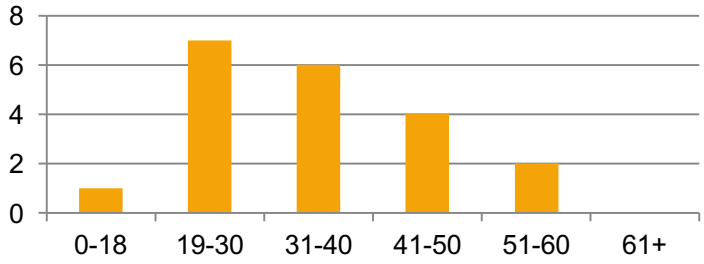

THE UNIVERSITY OF ARIZONA
MEL AND ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health


CLIR
NATIONAL EMS MANAGEMENT ASSOCIATION
North Central EMS Institute
Paramedic Chiefs of Canada
Chefs Paramédics du Canada
The Center for Leadership, Innovation and Research in Emergency Medical Services

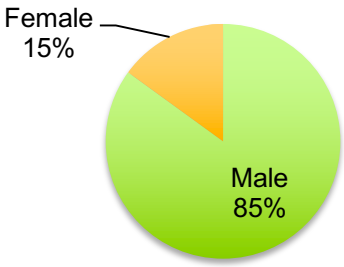
Victim Age



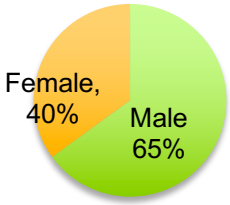
Assailant Age



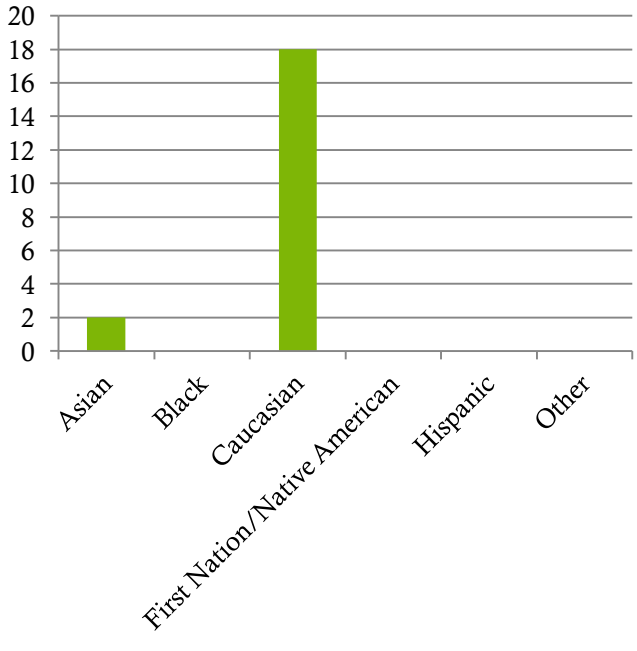
Victim Gender



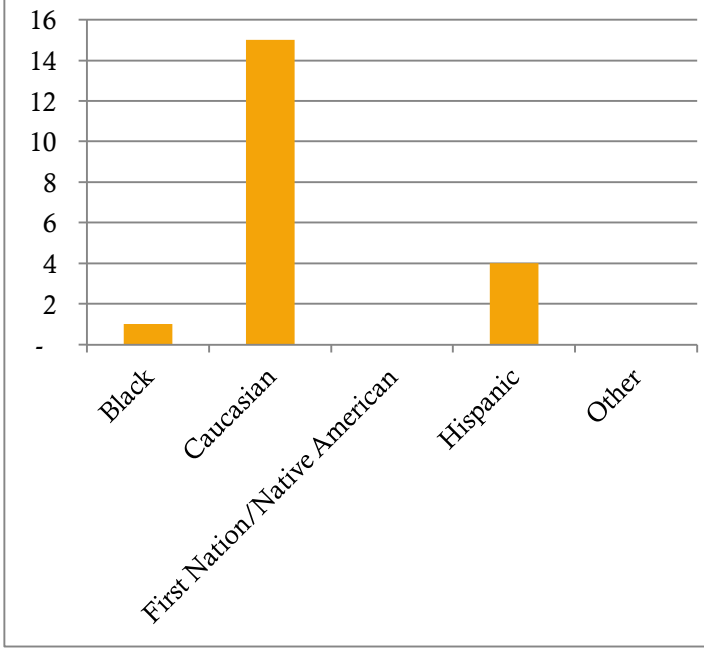
Assailant Gender



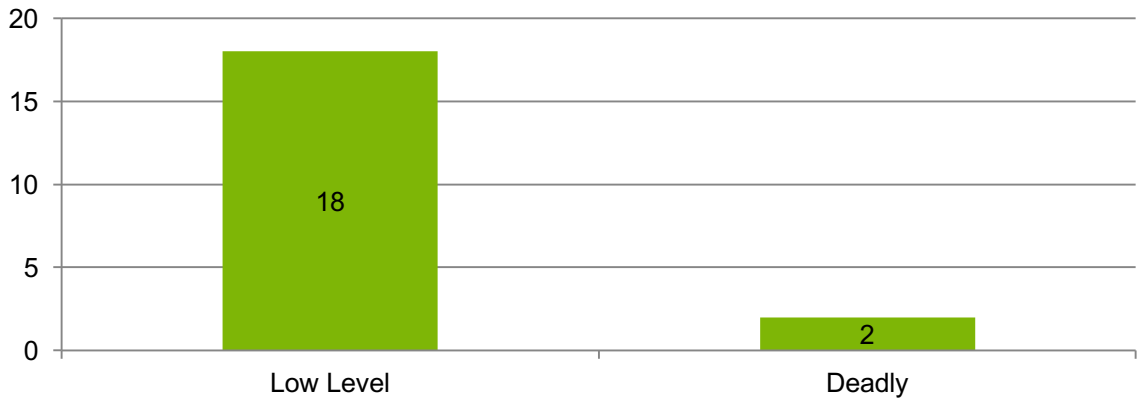
Victim Race



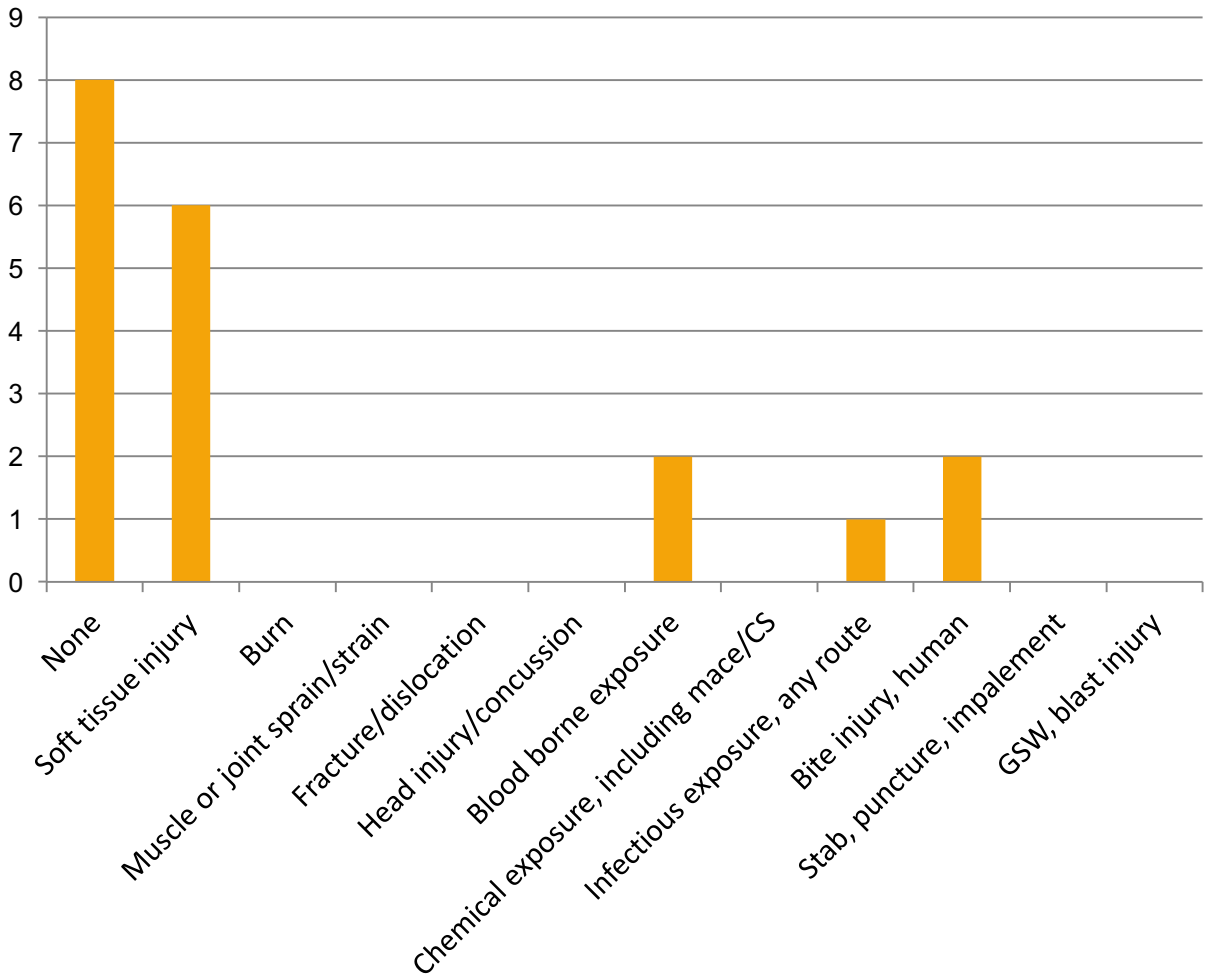
Asssailant Race



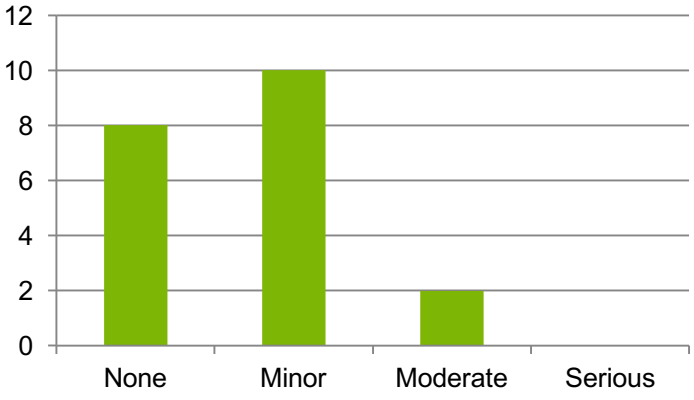
Paramedic's Perception of Harm



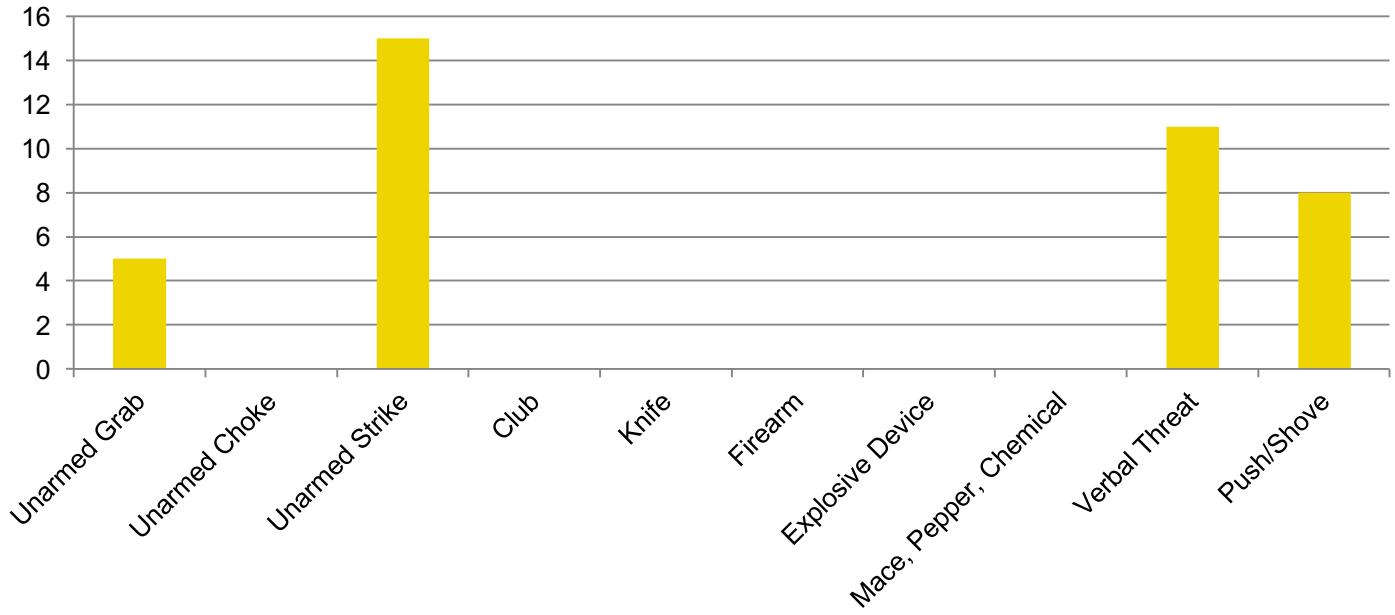
Type of Victim Injury



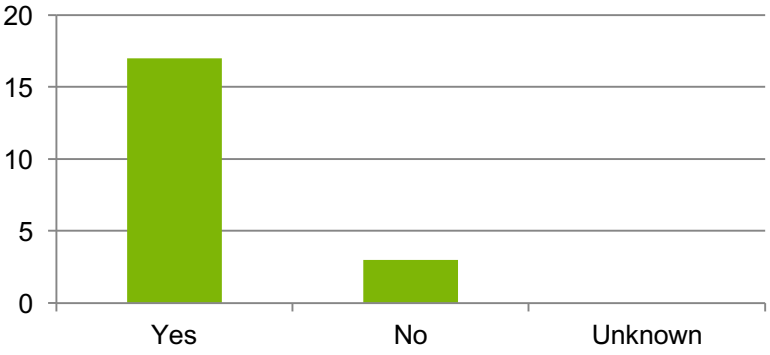
Type of Victim Treatment



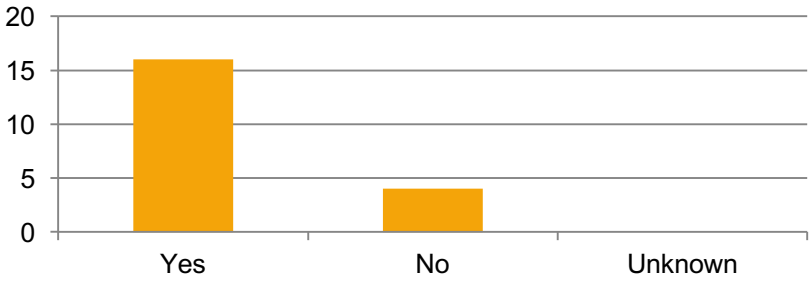
Method of Assault
Note: Multiple Options Reported



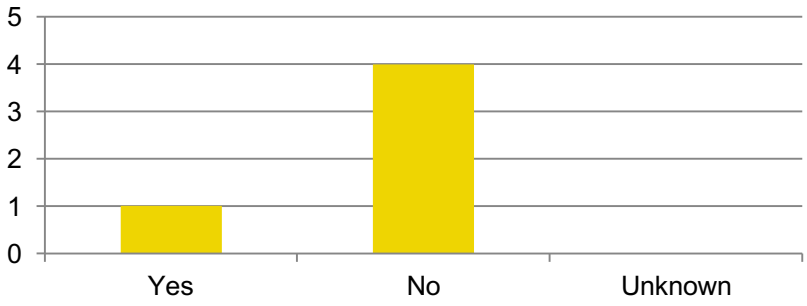
Internal Agency Report Filed



Law Enforcement Present or Notified



Assailant Arrest



#1	EMS were requested to the scene for trouble breathing. The patient is a resident at a group home with explosive disorder. The patient is non verbal and very agitated. Police are requested to the scene to assist EMS with transferring patient onto the stretcher. EMS planned to use soft restraints to restrain patient. Patient was agitated, throwing things around the residence, and swinging at EMS. Patient calmed down and was transported. Patient began to get agitated just prior to arrival at the hospital and swung his fist out, striking me in the abdomen. Patient's arm was restrained onto his side by me and ALS. Patient is unloaded from the ambulance and as I was grabbing the legs to release them on the stretcher the patient swung again striking me in the side of the head and ear. Patient is taken into the hospital where he is calm upon transfer of care.
#2	While working at a heavy metal concert, I was summoned by security guards for a presumably intoxicated female slumped in her seat, unresponsive. When I arrived an unknown male companion was attempting to move the unresponsive female by dragging her from where she was seated. She was unable to hold herself up so I immediately intervened. She was standing unsteadily but managing to stay upright at this point so I held her under her arm to keep her from falling, at which point, the male told me to let go of her. I told him that I needed to hold her up to keep her from falling but he attempted to physically keep me from holding her by pushing me and "swatting." I attempted to maintain control of the original patient to keep her from falling and also keep the male from assaulting me. While this was occurring, another male, later found to be the original patient's father, grabbed me from behind in a bear hug. At this point, I struggled with both until security intervened and forcibly removed both parties. The police were requested and both parties were taken into custody. I learned that they were charged with "disorderly" and not assault.
#3	Patient repeatedly kicked at the face of Provider while being loaded into the ambulance. Patient charged with aggravated assault, in violation of [state law].
#4	On the above night, victim was serving as a paramedic at a concert venue and encountered the assailant, who was grossly intoxicated; under the influence of alcohol and possibly CDS. After being handcuffed by the police and falling on his face due to his intoxication, EMS was summoned. Patient was cleaned and once police were told that they would need to accompany EMS to the hospital due to the handcuffs, patient was no longer under arrest and was secured to the ambulance stretcher and restrained with cravats on his wrists and ankles before being moved to the ambulance. Once in the ambulance, victim was attempting to start an IV while patient was attempting to get loose. Somehow, during the struggle, the victim was stuck with the dirty [IV needle] and when attempting to retreat, the assailant managed to get a leg loose from his restraints and kicked the victim multiple times in the head, arm and back. Police were summoned and assisted in restraining the patient again for transport to the hospital. Victim needed to have blood drawn and needed to be treated for his injuries. Upon researching, it turned out that the police agency involved did not charge the assailant with assault, but with disorderly conduct. This EMS agency is actively pursuing charges against the assailant.
#5	An ETOH intoxicated and uncooperative 46 y/o M patient known to be hepatitis C positive and

	possibly MRSA infected assaulted responders and spit on the paramedic attendant. The patient had a facial injury with blood in the nose area. The patient was aiming to spit on the law enforcement officer and struck the paramedic instead who was trying to secure the stretcher restraint belts. Law enforcement handcuffs, EMS spit-hood and posey type restraints to the stretcher were then applied before transport. No patient harm. An employee incident/injury report was filed and the crew member hit by spit was seen in ED for exposure protocol.
#6	While moving an unconscious patient he awoke and became argumentative before becoming physically violent requiring 3 providers to physically restrain him and chemically sedate him. During transport he slipped out of one arm restraint and attempted to remove other restraints and resumed combative behavior with EMS for remainder of transport. Patient threatened to gather his family and harm EMS as well as sue EMS.
#7	While moving an unconscious patient from prisoner processing area floor he regained consciousness and punched paramedic in genitals and spat in his face claiming he had AIDS and was Hepatitis C positive. During restraint process patient made attempts to bite and kick EMS and LEO staff. While moving patient on stretcher he kicked EMT personnel. During transport and despite multiple doses of chemical restraint the patient remained combative made numerous threats to kill providers and their families and continued to grab and kick at providers.
#8	While caring for suspected overdose patient who had witnessed seizure he became physically violent in ambulance after administration of narcan and Ativan. Patient removed large bore IV and covered back of ambulance and paramedic with blood during struggle with provider. Patient made attempts to kick and punch provider during transport and required physical restraint for remainder of transport.
#9	EMS was dispatched to local bar for intoxicated person. Upon arrival, crewmember was kicked in the rear end by patient. Patient was arrested. Crewmember was not injured.
#10	EMS was dispatched to local Police Department for intoxicated/emotionally disturbed person. Patient was uncooperative at scene. Once inside ambulance, patient spit at and scratched crewmember. Patient was arrested. Crewmember suffered minor injuries.
#11	A paramedic was bitten on the arm by a 14 year old female patient while attempting to restrain this combative patient's arms when she postured as if to punch his crew-mate while attempting IV access. The skin was not broken under the clothes & this was not a significant exposure. This patient was a suspected ETOH & other street drug OD response who suddenly became uncooperative. The bite did not leave any marks yet did cause pain. It took place in the patient compartment just before starting transport. This 14 year old was approximately 150 lb. and 5’-2’’ tall. She was responsive only to pain earlier when she presented in her residence lying on the floor. The parents were fairly certain she had

	ingested a combination of ETOH, cough syrup, and perhaps K2 street drugs. She had been carried on the soft stretcher out of the house and was now in the back of the ambulance when she woke and became uncooperative. The patient was already secured to the stretcher with the cot straps when the aggression started during the 2nd IV access attempt. The medic bitten had grabbed the patient's arms to protect the other medic in the process of connecting the IV tubing. After IV access was obtained with this 2nd attempt, she became quiet again. There were periods later during transport when the attendant had to again physically hold down the patient's arms.
#12	Original dispatch for complaint of a seizure. Arrived to find male kicking objects in residence and assaulting an animal and bystander on scene. I approached male initially to inquire as to what was happening when male began to verbally threaten me. Physical harm was imminent based physical gestures. EMS providers exited the residence and summoned law enforcement. Law enforcement arrived and physically detained the male subject. Subject was restrained to ambulance cot. Officer rode with EMS crew to hospital. Male attempted to spit on EMS providers. Spitting contained. Male eventually calmed down and transport remained without incident.
#13	EMS was dispatched to public street for intoxicated person. Upon arrival, patient was highly agitated. Patient spit at and kicked at crewmember. Patient also threatened to kill crewmember. Patient was arrested. Crewmember was not injured.
#14	EMS was dispatched for emotionally disturbed person. Patient was being escorted out of police department by law, patient became combative and was assisted onto stretcher. Patient was already handcuffed by law enforcement when placed on stretcher. Patient was restrained by crew and law enforcement officers when he became more aggressive/combative. Patient turned his head to the right and bit crew member on his left hand (knuckle area) when securing patient to stretcher via seat belts. Pt did not break crew member's skin. Patient transported to hospital w/o further incident. Unknown if patient was charged with any crime.
#15	A 21 y/o male patient punched one crew member in the face after transfer and arrival at the hospital bed & then attempted to escape from the ED. The patient was tackled and held by the other crew member as he tried to exit the ED exam room until security and law enforcement arrived. No apparent harm to the patient. This patient was originally found in an alley by law enforcement with ETOH intoxication and were called by law enforcement to evaluate. The patient was rolling around on the ground and eating dirt. The ETOH breathalyzer read at 0.23%. The patient was able to answer simple questions, appeared cooperative, and admitted to consuming other unspecified drugs and walked to the

	stretcher. Although his behavior & mentation was bizarre at the scene, he did not require restraints prior to transport. The patients vital signs were in a normal range with a GCS score of 14 and SpO2 at 97% on room air. His pupils were widely dilated. The crew initiated IV access and their BGL check was 111. The transport was uneventful and the patient remained alert and cooperative. After transferring to the hospital bed, the attending medic was simply adjusting the pillow for comfort when the patient punched him in the nose with a closed fist. The medic retreated and within about a minute, the patient climbed off the hospital bed and tried to exit the exam room when he became tangled in the curtain at the doorway. At this point, the 2nd crew member grabbed the patient and took him to the ground and physically detained the patient until law enforcement and security arrived to take custody.
#16	Verbally abusive patient. Under the influence of alcohol. Physically abusive to self and EMS crew. Patient hitting and spitting on EMS crew. EMS crews had exposure blood work drawn as well as source patient.
#17	During a response to a behavioral group home, the resident/patient twice punched the ambulance medic in the chin area. The crew was preparing to leave the scene with no transport indicated for this patient who had ingested Listerine and Medical Control advised that transport was not required. As the crew was preparing to leave & calmly reassuring the patient they did not require their care, the punching occurred. The assault was sudden, unprovoked & unexpected. Patient was then subdued by other crew member & EMRs before law enforcement arrived. The patient was now placed in restraints & spit-hood before transported to hospital. No harm to patient.
#18	During the of transport of an ETOH & other drug intoxicated 31 y/o male patient, the attending medic was spit in the face. Initially cooperative, the patient had become verbally assaultive, uncooperative & combative including trying to get off the stretcher within seconds after transport started. The vehicle was stopped and the same LE officers at the scene responded to the ambulance location, entered the patient compartment & assisted with applying four-point Posey restraints. Transport again resumed. The patient now began spitting and yelling curse words, all directed at the attendant. The vehicle was then stopped a 2nd time and the same police entered and assisted with applying a spit-hood. Chemical sedation was administered at this time as 1 mg of Versed IM route. Transport resumed for the 3rd time. Now the patient was able to slide his left hand restraint down on the stretcher attachment far enough to get his hand on the spit-hood and lift it above his mouth. When the attendant moved closer to intervene, the patient spit in his face, twice. No harm to the patient.
#19	Dispatched for Assist Law on a physical disturbance, no further details. Upon staging, EMS cleared to scene and entered residence. Arrived on scene to find a young female, approx. 120 lbs, patient found lying contorted on the floor, in obvious distress. Patients father reports that the patients psych

	medications were recently changed and that this happens every time her medications are changed. Patients father contacted 911 due to thinking that she was going to attack him. Upon Law Enforcement arrival patient was screaming and not making sense and was beating her head on the floor. Patient well known to law enforcement and EMS for mental health responses. Patient has extensive psychiatric history. Upon EMS arrival patient was lying contorted on the floor but was relatively calm. Patient initially appeared that she was going to cooperate with EMS saying she knew us then suddenly started grabbing at EMS staff stating that she was going to inflict pain on them. She became combative kicking one of the EMS staff in the head, screaming and kicking stating that we were all psychotic and that we were all crazy. Patient continued to talking not making any sense. After kicking EMS personnel patient was physically restrained by LE and EMS personnel and IM Versed was administered. No change noted with administration of IM versed. EMS Director notified and requested to respond. While patient was being physically restrained patient bit her own Left arm leaving significant bite marks and skin that was broken from the patient biting herself. EMS Director arrived on scene and assisted with patient care so primary paramedic could take a break due to injury. Patient administered IM Zyprexa and became slightly more compliant with the adminstration of IM Zyprexa however she continues to be combative and attempt to injure EMS and Law Enforcement personnel. Patient moved to stretcher and restrained with soft restraints to help prevent patient from continuing to harm herself or others. IV started once moved to the ambulance. Patient continues to make psychotic statements enroute and continues to attempt to grab and injure EMS. Patient calms down some with second dose of IV Versed. Upon arrival at the ER the patient becomes agitated again grabbing at EMS and hospital personnel. Administered a third dose of Versed to facilitate moving the patient from the EMS stretcher to the hospital bed and reduce the chance of the patient injuring herself or medical/law enforcement staff.
#20	Dispatched for an officer bit by a suspect. Upon arrival EMS directed to a 23yo male who was in custody of law enforcement. Patient was standing being held against a patrol car by 3 officers. Patient was screaming and combative, however answered EMS questions. Hx Patient was out at his bachelor party at the bar/grill. Patient had been consuming hard liquor and started a physical altercation. PD arrived on scene and tackled him to the ground. In the process of hand cuffing him, he bit an officer. The patient was then tased and handcuffed. Patient denies any drug use, just heavy ETOH, states he has no medical conditions, NKDA, and takes no medications. Assessment/Transport Patient was moved to the cot and strapped with all 3 cot straps. Patient was loaded into ambulance. While stepping into the ambulance from the rear bumper, the patient kicked [EMT]. [Paramedic], who was at the head of the cot, used a pressure point as a defensive measure as the patient tried to continue to kick [EMT]. Law enforcement entered the ambulance and subdued the patient. [Paramedic] began transportation to [hospital] ED. While transporting, the patient began spitting at officers and [EMT]. Law enforcement subdued the patient and a NRB was placed on him. Very little assessment was completed as patient was combative. Patient was incontinent and physically

	restrained. Patient had continuous medical observation. Upon arrival at [hospital] ED patient was moved to room 2 by cot and moved to ER bed. Verbal report was given to ED staff. Patient was unable to sign ABN and EMT/RN signed. [Paramedic unit] returned back to service.