Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, May 13, 2011

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
May 13, 2011

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) EMS Funding for FY2012

The Speaker of the House and the President of the Senate signed the reenrolled Budget Bill approved by the Virginia General Assembly on April 6, 2011. The final budget for emergency medical services follows:

Department of Health (601)

		FY2011	FY2012
281.	Emergency Medical Services (40200)	38,952,511	38,952,511
	Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	32,560,051	32,560,051
	State Office of Emergency Medical Services (40204)	6,392,460	6,392,460
Fund Sources:	Special	20,548,274	20,548,274
	Dedicated Special Revenue	17,998,654	17,998,654
	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 Commissioner of Health 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.

§3-1.01 INTERFUND TRANSFERS

A.1. In order to reimburse the general fund of the state treasury for expenses herein authorized to be paid therefrom on account of the activities listed below, the State Comptroller shall transfer the sums stated below to the general fund from the nongeneral funds specified, except as noted, on January 1 of each year of the current biennium.

Y. On or before June 30, 2011, the State Comptroller shall transfer $9,055,000 to the general fund from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203). Beginning July 1, 2011, 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 $9,055,000 from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203).

KK. On or before June 30 each year, the State Comptroller shall transfer $10,518,587 the first year and $10,518,587 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).

b) 2011 EMS Legislation Passed by the Virginia General Assembly

HB1675, introduced by Delegate Pogge amends § 32.1-111.9, *Code of Virginia* regarding applications for variances or exemptions. Variance and exemption applications from an agency or governmental entity would still require local governing body recommendation to be submitted to the Commissioner or Board of Health, however, variance and exemption applications from an individual would no longer require local governing body approval, but approval by the agency OMD and the agency head. The bill further clarifies the process for non-affiliated providers

HB2279, introduced by Delegate Keam amends § 32.1-111.5, *Code of Virginia* regarding certification and recertification of emergency medical services personnel. This bill requires the Board of Health to prescribe by regulation the qualifications required for certification of emergency medical care attendants. It adds that "*Such regulations shall include criteria for determining whether an applicant's relevant practical experience and didactic and clinical components of education and training completed during his service as a member of any branch of the armed forces of the United States may be accepted by the Commissioner as evidence of satisfaction of the requirements for certification."*

c) Line of Duty Act Fund

The 2010 Appropriations Act established a new Line of Duty Act (LODA) Fund with the Virginia Retirement System (VRS) as the investment manager. The LODA Fund provides a funding source for payment of Line of Duty Act benefits.

VRS recently started sending out packets to EMS agencies to gather specific information to help with managing this fund. At this time packets have been mailed to all city and county managers in the Commonwealth. The packets were mailed in three waves between March 30 and April 20 with a request that their edited and verified LODA Roster be returned by a specific deadline, with the last wave's deadline of May 6, 2011. The packet includes detailed instructions, County/City Code verification, LODA roster and additional information to establish rosters of hazardous duty professionals and more.

Verification of the information that is provided to VRS is not an election to participate in the LODA Fund. The purpose of gathering this information is to ensure the covered population is captured. OEMS urges accurate completion of this information and return to VRS by the deadline provided. This is an important program for EMS providers and public safety personnel. For more information on the LODA please visit http://valoda.org/.

d) Recognition of Dr. Gaylord Ray

On April 20, 2011 the Executive Committee of the State EMS Advisory Board approved a resolution recognizing the lifetime achievements of Dr. Gaylord Ray regarding his impact and influence on advancing the EMS system in the Commonwealth. The Executive Committee is asking for Board approval of the resolution at the May 13, 2011 meeting. See **APPENDIX A.**

e) Rider Alert Card

Richmond Ambulance Authority and Bon Secours Virginia Health System, in partnership with Motorcycle Virginia, Inc., are offering a program in Virginia called Rider Alert cards. The program provides free identification data cards that will help first responders provide rapid and accurate medical assistance to motorcyclists involved in serious accidents.
If you want your EMS Agency to become a Rider Alert Card distribution location or to learn more about the program visit: http://www.rideralert.org/. Please see **APPENDIX B.**

f) Office of EMS Announces New Governor's EMS Award Category Focused on Health and Safety

Did you know that the number of EMS providers injured or killed in the line of duty is on the rise? EMS providers that are killed in crashes are double that of fire and police. Additionally, heart attacks are one of the top reasons that EMS providers die on scene. This growing trend across the U.S. and the Commonwealth has spurred OEMS and the Governor's EMS Awards Committee to create a new award category focused on the health and safety of EMS providers.

This new award category entitled, "Outstanding Contribution to EMS Health and Safety" will recognize any individual, program, business or licensed EMS Agency within the Commonwealth of Virginia that has demonstrated comprehensive and/or significant accomplishments or programs that make a significant contribution to or provide for the health, safety and welfare of EMS providers. Some examples of programs meeting eligibility for this award would include EMS provider health and wellness programs (fitness and wellness, cardiovascular health), scene safety programs (aeromedical operations, emergency vehicle operations), and provider injury prevention programs designed to prevent line of duty death and injury. Also eligible would be persons or entities developing or managing such programs.

Whether it's your own personal well-being or the health and safety of your EMS agency that needs to improve, it's important to develop a plan for change today so you don't become a statistic tomorrow. Get your team involved by creating a health and safety program that everyone can follow. And remember, be the provider – not the patient!

g) EMS Week is May 15 – 21, 2011

This year, EMS Week will recognize everyday heroes - all of you who put on the uniform and respond to emergencies and serve your community.

The Office of EMS would like to thank each and every one of you for your hard work and dedication to EMS and your community. It is during this week that EMS agencies can become even more visible and reach out to their communities to provide public education and resources to help with things like injury prevention, emergency preparedness and much more.

OEMS is sending all EMS agencies the 2011 EMS Week Planning Guide from the American College of Emergency Physicians. This guide offers ideas and information on public education programs, working with the media and how EMS Week can help forge partnerships with the community and build a better relationship with your fellow agency members.

OEMS hopes that you take the time to read through this guide and think of some activities or programs that you can implement for EMS Week. Open houses are always a popular event, and can be a fun learning experience for children. It can help them learn about what happens when an ambulance comes, the importance of knowing how to dial 911, and things that they can do to prevent injuries. For more information on injury prevention visit www.vahealth.org/Injury/VIPP/.

During EMS Week, Wednesday, May 18th is Child Safety and Injury Prevention Day. This day provides an opportunity to focus on children through education and awareness. It may be a good day to arrange to take the ambulance to a local school or day care center and let the children explore the ambulance and talk about 911 for children and other important topics.

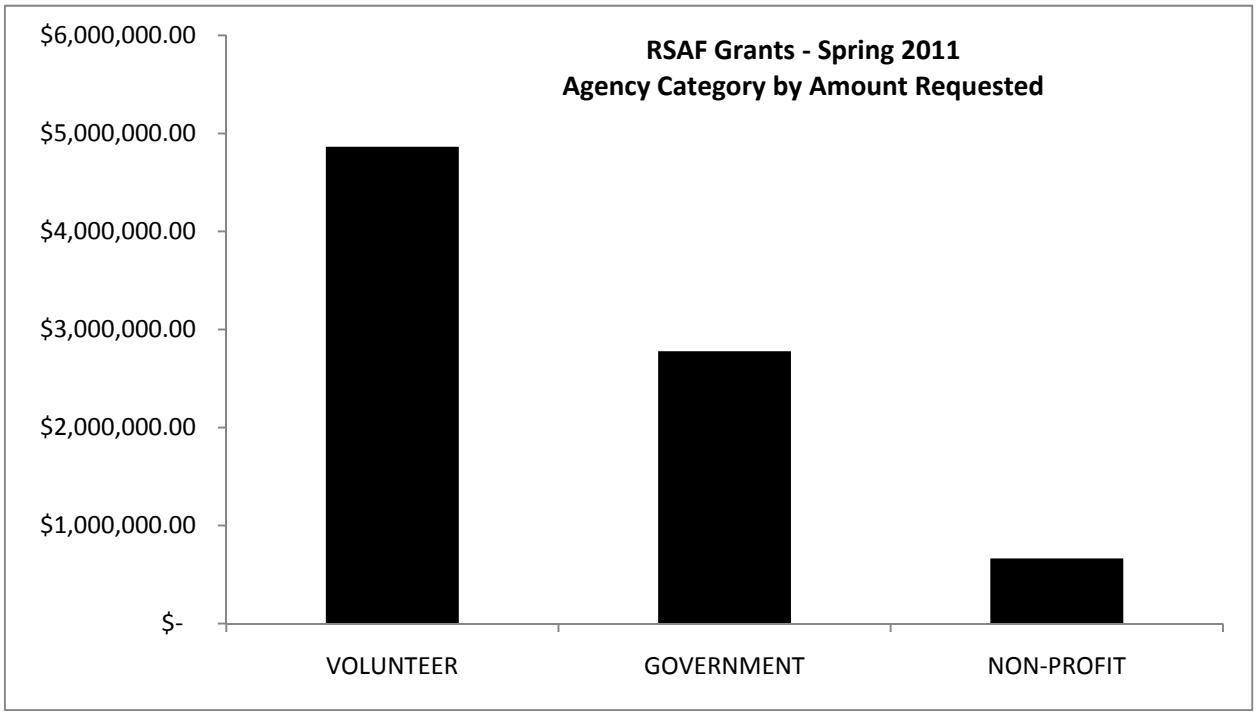
As you plan your events for EMS Week, also be sure to think about how these events may also become a recruitment opportunity. Be sure to have information on hand about applying for a job or volunteering with your agency. Remember, not all volunteers need to be on the ambulance, some may be able to provide resources like business management, equipment maintenance and building and grounds up-keep. For more information on EMS Week visit www.emsweek.org. Or for other resources or questions to help you plan your event you can e-mail emstechasst@vdh.virginia.gov.

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

The RSAF grant deadline for the Spring 2011 cycle was March 15, 2011, OEMS received 130 grant applications requesting $8,308,374.00 in funding. The following agency categories are requesting funding for the Spring 2011 grant cycle:

- 78 Volunteer Agencies requesting $4,864,734.00
- 40 Government Agencies requesting $2,778,685.00
- 12 Non-Profit Agencies requesting $664,955.00

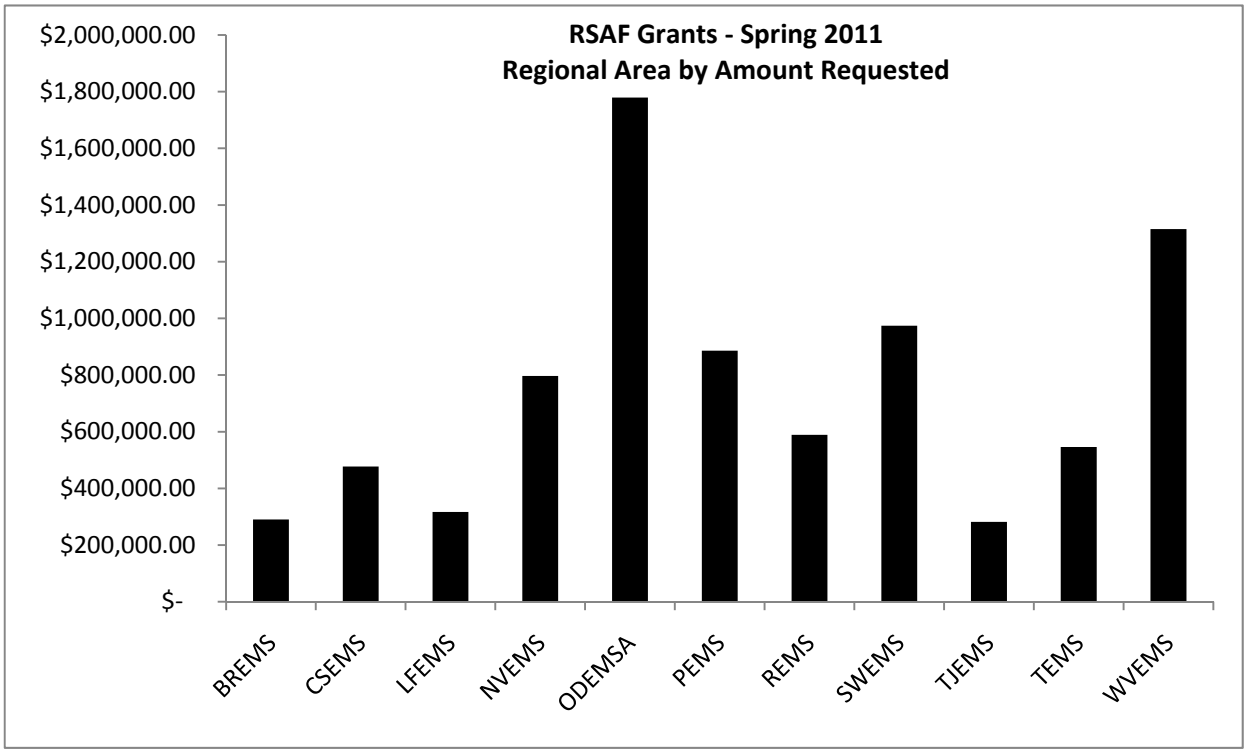
Figure 1: Agency Category by Amount Requested



The following regional areas are requesting funding in the following amounts:

- Blue Ridge EMS Council – 7 agencies requesting funding of $290,087.00
- Central Shenandoah EMS Council – 15 agencies requesting funding of $477,147.00
- Lord Fairfax EMS Council – 7 agencies requesting funding of $317,135.00
- Northern Virginia EMS Council – 7 agencies requesting funding of $796,961.00
- Old Dominion EMS Alliance – 19 agencies requesting funding of $1,779,271.00
- Peninsulas EMS Council – 9 agencies requesting funding of $885,842.00
- Rappahannock EMS Council – 12 agencies requesting funding of $589,258.00
- Southwestern Virginia EMS Council – 18 agencies requesting funding of $974,023.00
- Thomas Jefferson EMS Council – 4 agencies requesting funding of $282,024.00
- Tidewater EMS Council – 11 agencies requesting funding of $546,269.00
- Western Virginia EMS Council – 20 agencies requesting funding of $1,315,258.00
- Non-Affiliated Agencies – 1 agency requesting funding of $55,099.00

Figure 2: Regional Area by Amount Requested

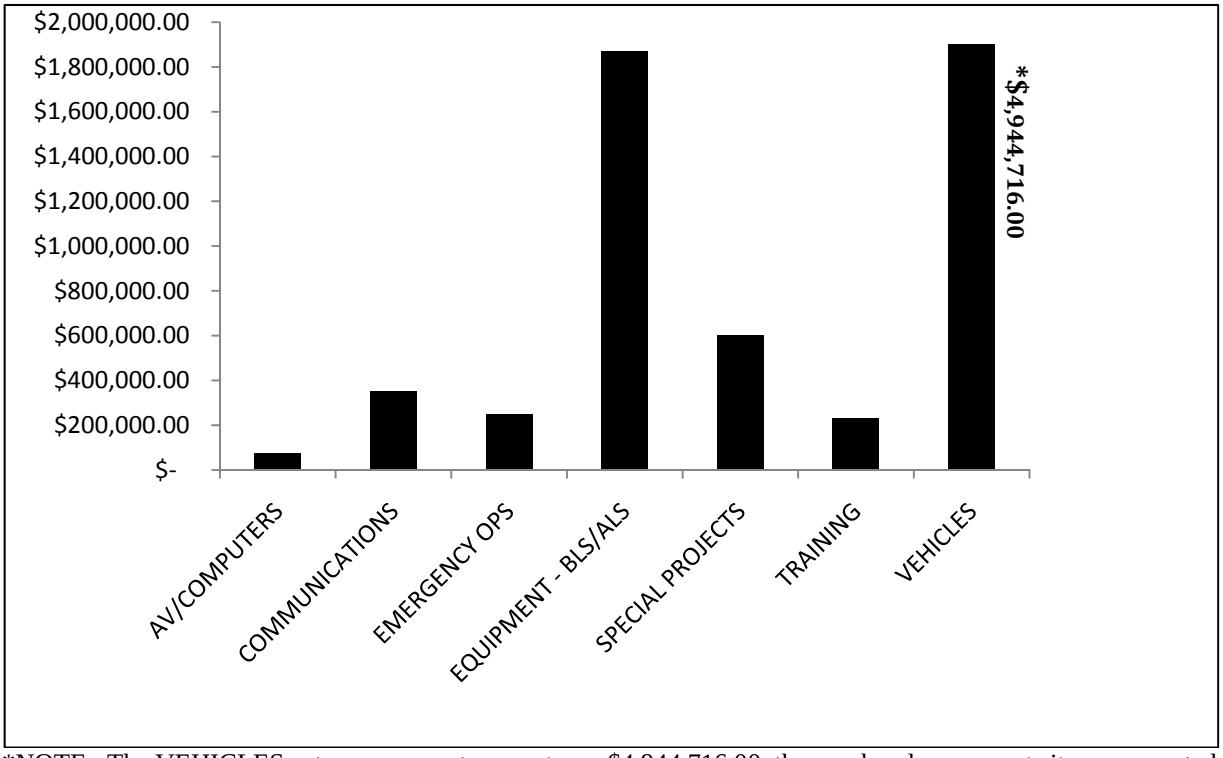


RSAF Grants by item categories:

- Audio Visual and Computers - $ 74,344.00
    - Includes projectors, computers, toughbooks, and other audio visual equipment.
- Communications - $ 348,837.00
    - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.
- Emergency Operations - $ 246,783.00
    - Includes items such as Mass Casualty Incident (MCI) trailers and equipment, extrication equipment, personal protection equipment (PPE) and Health and Medical Emergency Response Team (HMERT) equipment. The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.
- Equipment - Basic and Advanced Life Support Equipment - $ 1,868,137.00
    - Includes any medical care equipment for sustaining life, including defibrillation, airway management, and supplies.

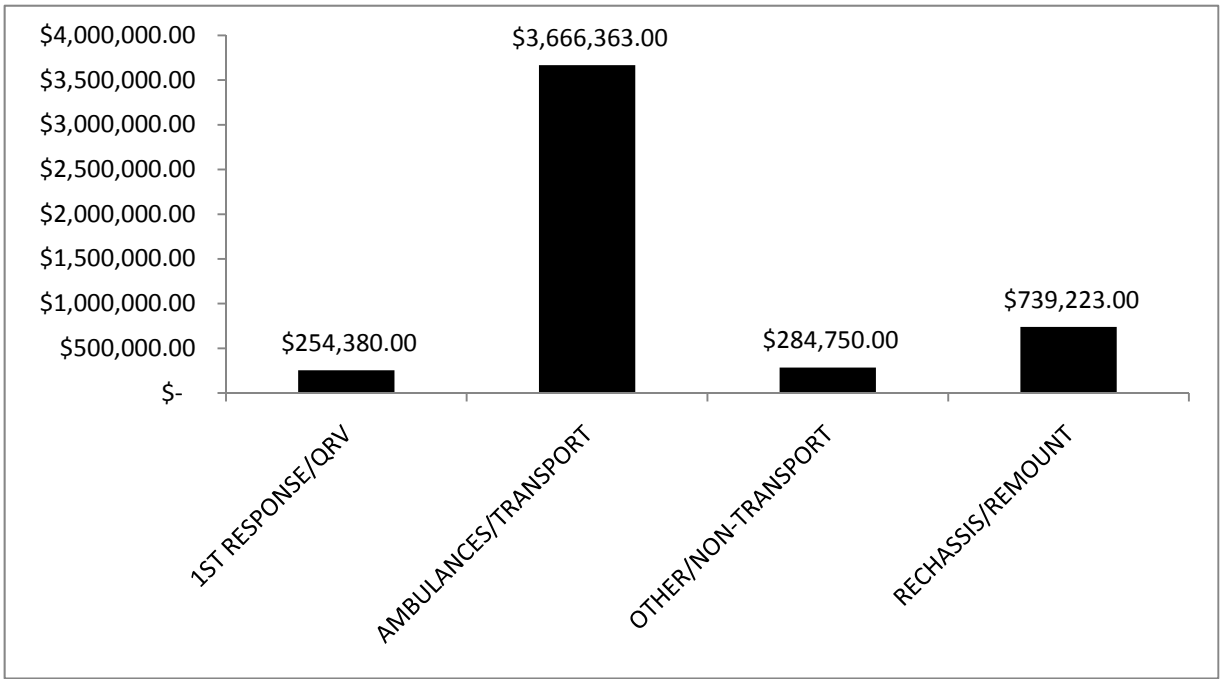
- Special Projects - $ 600,067.00
    - Includes projects such as Recruitment and Retention, Management and Leadership, Special Events Material, regional projects and Emergency Medical Dispatch (EMD) and other innovative programs.
- Training - $ 229,120.00
    - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.
- Vehicles - $ 4,944,716.00
    - Includes ambulances, 1st Response/Quick Response Vehicles (QRV), rechassis/remount of ambulances and all-terrain vehicles.

Figure 3: Item Requested by Amount Requested



*NOTE: The VEHICLES category request amount was $4,944,716.00, the graph only represents items requested up to $2,000,000.00 to visually display other items requested. A specific category list of vehicles is documented in Figure 4.

Figure 4: Vehicle Category by Amount Requested



The Spring 2011 grant cycle will be awarded on July 1, 2011. The next RSAF Grant cycle will open August 1, 2011 and close September 15, 2011.

i) 2011 Department of Homeland Security (DHS) Grant Application

OEMS Grants Manager met with the Virginia Department of Emergency Management (VDEM) grants staff on March 29, 2011. VDEM requested all state agencies submitting DHS grants to use the 2010 DHS grant guidance due to the fact that DHS has not released the 2011 grant guidance. Once the 2011 guidance has been released, VDEM will request a 2 week time limit for Investment Justifications (IJ) to be submitted. OEMS will request funding in the amount of $1,865,650.00 for the Virginia Emergency Medical Services Interoperable Communications (VEMSIC) Project. This project would provide radios, vehicle chargers, mounting kits for vehicular installation and speaker microphones for each licensed patient-transport vehicle for EMS agencies recognized by OEMS as a designated emergency response agency (DERA) as defined by the Virginia Administrative Code 12 VAC 5-31-370.
safety, and recommended steps that individuals and communities can take. Depending on the nature of the threat, the alert may be sent to a limited, particular audience like law enforcement, or a segment of the private sector, like shopping malls or hotels. The alert may also be issued more broadly to the American people distributed—through a statement from DHS—to the news media as well as via the DHS website (http://www.dhs.gov/index.shtm) and social media channels such as Facebook, Twitter and the DHS blog. The alerts will have a specified end date, which will be extended only if additional information becomes available or if the threat evolves.

EMS on the National Scene

II. EMS On the National Scene

a) Finally: A Federal EMS Office?

In what is rumored to be a heavy push from the Obama administration, it seems that a Federal Office of EMS is about to be created in short order. Two meetings have been held to solicit input on just where and how an EMS office should be established. Notice published in the March 18, 2011 Federal Register announced a Teleconference meeting of the Federal Interagency Committee on Emergency Medical Services (FICEMS) to receive input from stakeholders regarding the EMS role of the Federal government and options for establishing or designating a Federal lead office for EMS. Additionally, the National EMS Advisory Council (NEMSAC) scheduled a meeting to hear public comments. While a specific agenda has not been set, it is likely the FICEMS discussion will occupy a major part of the meeting. You can learn more about NEMSAC and FICEMS at www.ems.gov, the current Federal Government portal for EMS.

b) NCSL Posts Traffic Safety State Legislative Action

The National Conference of State Legislatures has published a report summarizing bills regarding traffic safety issues that were considered by state legislatures during the 2010 legislative sessions. Topics include the following:

Occupant Protection. At least 26 states considered bills to strengthen seat belt laws in 2010. These proposals included efforts to enact primary enforcement of existing seat belt laws and changing requirements for child restraint use.
Impaired Driving Issues. In 2010, lawmakers in 46 states introduced more than 300 bills related to impaired driving. They considered legislation related to stricter penalties for high blood alcohol concentration (BAC), ignition interlocks, breath tests and treatment.
Distracted Driving. Since 2000, legislatures in every state, the District of Columbia and Puerto Rico have considered legislation related to distracted driving and driver cell phone use. In 2010, legislators in 40 states considered 181 driver distraction bills.
Driver's Licensing. Each year, state legislatures debate hundreds of bills relating to various aspects of driver licensing, including REAL ID, unlicensed driving, older drivers and teen drivers. In 2010, 40 states debated more than 200 bills relating to drivers licensing.
Aggressive Driving. Laws in 10 states penalize aggressive drivers. Hand gestures, shouting, speeding, tailgating, driving on the shoulder, weaving in and out of traffic, or any combination of these activities may fall within the definition of aggressive driving.
Speed Limits. In 2010, 21 states considered bills regarding speed, including increased fines for speeding, setting speed limits, and punishing serious speeding offenders.
Automated Enforcement. Because law enforcement agencies struggle with limited resources, many municipal governments have turned to automated enforcement to control speed and reduce red light violations without diverting law enforcement resources from other areas. During 2010, legislators in 28 states debated nearly 100 bills regarding automated enforcement.

Motorcycle Safety. During the 2010 legislative session, 38 states considered more than 100 bills related to motorcycle helmets or driver training.
School Bus Safety. In 2010, nearly 60 bills regarding school bus safety were considered in state legislatures across the country. Many dealt with requiring children to wear seat belts on school buses and licensing procedures for school bus drivers.
Pedestrian and Bicycle Safety. For many pedestrians and bicyclists, safety is a major concern. In 2010, 34 states considered more than 100 bills regarding pedestrian and bicycle safety. Many addressed educating motorists about responsibilities at crosswalks and on roadways. Other proposals considered ways to increase safety near schools.

c) Rockefeller Broadband Bill Gains Support of Every Major National Public Safety Organization

Senator Jay Rockefeller IV, Chairman of the Senate Commerce, Science, and Transportation Committee, reintroduced ***The Public Safety Spectrum and Wireless Innovation Act of 2011 (S. 28)*** to build an effective, nationwide, interoperable broadband communications system for public safety. The Chairman's proposal to allocate 10 megahertz of the 700 MHz spectrum known as the "D-block" to public safety officials for a nationwide, interoperable, wireless broadband network has been embraced by national and local public safety organizations. This network will allow public safety officials to remotely access criminal databases, distribute surveillance video feeds to on-scene personnel, and receive high speed file downloads, such as floor plans for burning buildings, wirelessly. President Obama announced that he supports Chairman Rockefeller's approach. Building the network will not add to the deficit. In fact, the Wireless Association (CTIA) and the Consumer Electronics Association (CEA) announced this week that the incentive auctions will bring in more than $33 billion. Support for Chairman Rockefeller's Public Safety Spectrum and Wireless Innovation Act (S. 28) continues to grow. The National Association of State EMS Officials (NASEMSO) supports the Public Safety Alliance in urging all Members of the United States Congress to support public safety and the public's safety by co-sponsoring this legislation and a companion bill expected to be reintroduced in the House by Representative Peter King.

d) FCC Moves Ahead on Nationwide Broadband System for First Responders

The Federal Communications Commission has unanimously approved an order that would establish interoperability standards for a nationwide public safety communications network. The order, which the commission will publish in the *Federal Register* as a proposed rule, requires all public safety mobile broadband networks to use a common air interface, specifically Long-Term Evolution (LTE), to support roaming and interoperable communications. LTE is compatible with older and new devices, making network interconnection and interoperability more likely as technology continues to evolve, according to an FCC fact sheet.

In related news, the Federal Communications Commission has released a video that provides an overview on the Commission's Third Report and Order (Order) and Further Notice of Proposed Rulemaking (FNRPM) that were recently adopted. When implemented, the new and proposed rules will help advance interoperable broadband communications for America's first responders. Once built, the network will enable public safety broadband users to share information, videos,

photos and emails over robust, dedicated and secure mobile broadband networks across departments and jurisdictions nationwide for day-to-day operations and during large-scale emergencies. Members of the FCC's Emergency Response Interoperability Center (ERIC) which is part of the Public Safety and Homeland Security Bureau developed the video to provide the public with a broad overview of the Order and FNPRM. The short video focuses on the adoption of rules to require LTE as the common technology platform for all public safety broadband networks. The video also provides brief descriptions of proposed interoperability rules encompassing architectural vision of the network, open standards, system identifiers of network, roaming, applications, security, interconnectivity of networks, testing, coverage, performance, interference, out-of-band emission, and devices to mention a few. You can find this video on the FCC's YouTube page at: http://www.youtube.com/watch?v=h50Njf_Ga_A

e) NIFOG Now Available from DHS Office of Emergency Communications

The Office of Emergency Communications (OEC) publishes the National Interoperability Field Operations Guide (NIFOG) as a reference guide for public safety radio technicians and communications planners. The waterproof, pocket-sized guide (also available in PDF format) contains radio regulations, tables of radio channels, and technical reference information. If you are establishing or repairing emergency communications in a disaster area, this is a tool you should have. NIFOG is a technical reference for emergency communications planning and for radio technicians responsible for radios that will be used in disaster response. The NIFOG includes rules and regulations for use of nationwide and other interoperability channels, tables of frequencies and standard channel names, and other reference material, formatted as a pocket-sized guide for radio technicians to carry with them. To download or request copies of the NIFOG, please visit http://www.safecomprogram.gov/SAFECOM/nifog

f) Edgerton Named Branch Chief for EMSC and Injury Prevention

The Health Resources and Services Administration (HRSA) has announced that Elizabeth Edgerton, MD, MPH is the new Branch Chief for EMSC and Injury Prevention within the Division of Child, Adolescent and Family Health, the Maternal and Child Health Bureau (MCHB). As an accomplished academician and program administrator, Dr. Edgerton has worked in the fields of EMSC and injury prevention throughout her career. NASEMSO congratulates Dr. Edgerton on her new appointment!

g) National Fire Academy Completes New Emergency Medical Services Courses

The U.S. Fire Administration's (USFA) National Fire Academy (NFA) has completed development of the first two new Emergency Medical Services (EMS) courses in response to the U.S. Fire Administration Reauthorization Act of 2008. An additional six courses are in the process of development or revision. The Reauthorization Act included direction for the National Fire Academy to provide advanced EMS training. "In recognition of the value that fire-service based EMS provides American communities, the USFA's NFA is revising and improving the EMS program to meet the needs of EMS agencies," said NFA Superintendent Dr. Denis Onieal. "The EMS curriculum now offers courses specifically identified as gaps in EMS education that prepare today's EMS leaders to better manage their system's response abilities and organizational

quality control." The two new EMS courses are Emergency Medical Services Quality Management (EMS QM) and Emergency Medical Services Functions in the Incident Command System (EMS FICS). EMS QM is a six-day course offering to be conducted on the NETC campus, while EMS FICS is a two-day course offering to be conducted either on the NETC campus or locally through partnerships with State and metropolitan fire service training organizations. For more information about the new EMS curriculum or other USFA programs and offerings, visit www.usfa.dhs.gov.

h) National EMS Memorial Service Releases Names of 2011 Honorees

The National EMS Memorial Service has released the names of the 43 individuals from 18 states to be honored at the 2011 National EMS Memorial Service. Since 1992, the National EMS Memorial Service has been honoring America's EMS providers who have given their lives in the line of duty. The 43 individuals being honored this year join 538 others previously honored by the National EMS Memorial Service. Each year at the NEMSMS, members of the honoree's families are presented with a medallion, symbolizing eternal memory; a U.S. Flag which has flown over the Nation's Capital, symbolizing service to the country; and a white rose, symbolizing their undying love. The 2011 National EMS Memorial Service will be conducted at the First Presbyterian Church of Colorado Springs on June 25, 2011. Additional information on the National EMS Memorial Service is available from its web site at http://nemsms.org

i) New NAEMT EMS Safety Course

EMS Safety – Taking Safety to the Streets is designed to help reduce the number and intensity of injuries incurred by EMS practitioners in carrying out their work. The course increases students' awareness and understanding of EMS safety standards and practices and develops their ability to effectively implement these practices when on duty. This course is designed for all EMS practitioners, other medical professionals providing prehospital patient care, EMS supervisors and administrators. The curriculum covers safety in emergency vehicles, at the operational scene and while handling patients, as well as patient, practitioner and bystander safety and personal health. The course includes a student manual. This course was offered for the first time on March 1 in Baltimore, Maryland in conjunction with EMS Today. All NAEMT continuing education courses are CECBEMS accredited and meet NREMT recertification requirements. For more information go to: http://www.naemt.org/education/EMSSafety/EMSSafety.aspx

j) AEDs Appear To Give Accurate Readings in Moving Helicopters

Reuters (1/26, Norton) reports that automated external defibrillators appear to work in moving medevac helicopters, according to a study published online Jan. 18 in the journal Resuscitation. The study found that AEDs have consistently correct simulated heart-rhythm disturbance readings while the helicopters were flying. In fact, the AEDs in moving helicopters showed more accurate results than those in moving ambulances. The researchers attributed the better performance to the fact that the helicopters do not hit road bumps while traveling.

k) JNEMSLC Submits Comments to FCC on Framework for NG 9-1-1 Deployment

The Joint National EMS Leadership Conference, a coalition of national EMS organizations of which NASEMSO is a member, has filed its first ever filing done jointly by the JNEMSLC. The paper was submitted to the Federal Communications Commission (FCC) PS Docket No. 10-255 to reflect EMS concerns on the Notice of Inquiry for a Framework for Next Generation 9-1-1 Deployment. The document is posted on the NASEMSO web site at: http://www.nasemso.org/. Members with questions should contact NASEMSO Program Advisor Kevin McGinnis at: mcginnis@nasemso.org

l) FAA Reauthorization Act Passes Senate

The Senate recently passed the FAA Air Transportation Modernization and Safety Improvement Act which contains language that potentially impacts the air medical industry. Section 507 will effectively implement several of the recommendations that were identified following National Transportation Safety Board (NTSB) hearings on air medical safety in 2009. If the Bill becomes law, helicopter and fixed wing operators will be required to comply with part 135 of title 14, Code of Federal Regulations, if there is a medical crew on board, without regard to whether there are patients on board; install terrain awareness and warning systems; use a risk evaluation checklist to determine whether a mission should be accepted; implement performance based flight dispatch and flight-following procedures; participate in data collection activities related to the various demographics and the nature and conditions of flights by the service, and; anticipate federal regulations on recording voice communications and flight data information on board aircraft. Section 717 of the Act compels the Comptroller General to conduct a study of the helicopter and fixed-wing air ambulance industry to include information, analysis, and recommendations pertinent to ensuring a safe air ambulance industry, more specifically “the relationship between State regulation and Federal preemption of rates, routes, and services of air ambulances; (2) the extent to which Federal law may impact existing State regulation of air ambulances and the potential effect of greater State regulation; and (3) whether systemic or other problems exist on a statewide, regional, or national basis with the current system governing air ambulances.” It is noted that this data has previously been reported by the Government Accounting Office (GAO) in GAO-10-907 September 30, 2010. The $34.6 billion bill reauthorizes the Federal Aviation Administration for two years and sets aviation policies. The House is working on its own version of the bill that would cover four years. The text of the Senate Bill (S. 223) can be found at: www.thomas.gov.

National Association of State EMS Officials (NASEMSO)

Note: The Virginia Office of EMS is an active participant in the NASEMSO and has leadership roles 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.

m) NASEMSO Leadership Announcements

The National Association of State EMS Officials (NASEMSO) announces that Dia Gainor will join its staff on May 2, 2011, as the executive director and can be reached at dia@nasemso.org. In this new position, Gainor will be responsible for providing strategic leadership to promote and expand NASEMSO's presence and capacity as a national leader in emergency medical services.

As executive director, Gainor will act as a spokesperson for NASEMSO, positioning the association to pursue its vision with federal partners and other organizations. Her major duties and responsibilities will include outreach, representation and business development, along with staffing NASEMSO's EMS Data Council and the Pediatric Emergency Care Council. Elizabeth Armstrong, CAE, NASEMSO's executive director since 1996, will become NASEMSO's executive vice president. She will oversee NASEMSO's scope of operations and staff team delivery of services, programs and information beneficial to the members. She will continue to be responsible for the association's legal and corporate functions, financial management and leadership/governance support. "The addition of a new member on the NASEMSO staff team will give us the ability to contribute to the nation's EMS system on a whole new level," explains Armstrong.

"NASEMSO is an established source of leadership in emergency and trauma care systems. I am looking forward to contributing to its progress through building enhanced partnerships with other associations and federal agencies, and supporting projects of national significance," stated Gainor.

"We are extremely pleased to add Dia's talents and skills to the outstanding group of professional staff who support the National Association of State EMS Officials," said Randy Kuykendall, NASEMSO president and chief, Emergency Medical and Trauma Services Section, State of Colorado. "She brings a wealth of experience, insight and leadership to our organization, and we look forward to accomplishing many great things on behalf of the nation's EMS community."

Prior to coming to NASEMSO, Gainor was Idaho's State EMS Director for 19 years. She is a past president and treasurer of NASEMSO, and currently chairs its Highway Incident & Transportation Systems Committee. She is an "EMS 10 Innovator" and the 2010 recipient of the James O. Page/JEMS Award. Gainor's expertise is grounded in a Bachelor of Science in Emergency Health Services Administration, a Master's Degree in Public Administration, and 12 years of field experience as a paramedic and firefighter. In 2008, Gainor was appointed by

Secretary Peters to serve on the National EMS Advisory Council to the U.S. Department of Transportation (U.S. DOT) and was selected by the National Highway Traffic Safety Administration to serve as the Council's first chair. She also chairs the Intelligent Transportation Systems Transportation Safety Advancement Group (TSAG) for the U.S. DOT Research and Innovative Technology Administration, which focuses on interdisciplinary opportunities to promote technology solutions to protect public safety responders and travelers.

n) NASEMSO Highlights State EMS Office Involvement in Domestic Preparedness Efforts

"State EMS Office Involvement in Domestic Preparedness Efforts" is a report based upon a survey of the 56 state and territorial EMS agencies, and is intended to ascertain the extent to which state and territorial EMS offices are represented and supported in ongoing multi-agency coordination for readiness and planning. The report includes sections on: (A) the integration of preparedness and response activities, and (B) funding, including the degree of engagement of state and territorial EMS offices with federal grant resources for preparedness and response activities. Funding enables public health departments to have the capacity and capability needed for effective response to the public health consequences of terrorist incidents, infectious disease outbreaks, natural disasters and biological, chemical, nuclear and radiological emergencies. The full report can be found at:
http://www.nasemso.org/Projects/DomesticPreparedness/documents/2010_DP_Report_FINAL_Version.pdf

o) NASEMSO Implementation Team Proposes Instructor Qualifications

NASEMSO's Education Agenda Implementation Team has posted a matrix for states to consider when developing instructor qualifications. This document, *EMS Instructor Qualifications*, represents the latest in a series of planning templates for inclusion in NASEMSO's Implementation "Toolkit." The suggested criteria can be used as guidance to help states ensure that EMS educators are ready to meet the needs of students taught using the *Education Standards*. For more information go to:
http://www.nasemso.org/EMSEducationImplementationPlanning/index.asp

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The committee met on April 6, 2011.

1. No action items were forwarded from the committee.
2. Copies of past minutes are available on the Office of EMS Web page here: http://www.vdh.virginia.gov/OEMS/Training/Committees.htm
3. See **APPENDIX C** introducing the latest proposal being considered for the future of certification testing.

B. **The Medical Direction Committee (MDC)** met on April 7, 2011.

1. The Medical Direction Committee is working on producing 'white papers" to offer guidance on several topics to EMS agencies:

   a) Termination of resuscitation

   b) Refusals

   c) Cervical spine clearance

   d) Emergency Medical Dispatch

2. The Medical Direction Committee voted to retire the document "Statewide Weapons of Mass Destruction Treatment Guidelines" which was authored in March 2006. It was determined that much of the material was no longer pertinent to today's treatment modalities and it would be best to retire the document then to attempt to update it.

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

Advanced Life Support Program

The NREMTs will begin testing the 2010 AHA Guidelines for paramedics in November 2011 and all other certification levels beginning January 1, 2012. In addition, the NREMT will begin testing for the Advanced EMT (AEMT) beginning July 1, 2011. Virginia Enhanced providers who wish to test at the NREMT AEMT certification level may do so by completing the State Authorization for National Registry Advanced (AEMT) Test Eligibility form and following the instructions on the form. AEMT candidates will be required to complete the NREMT AEMT written exam at a Pearson-VUE Testing Center and the NREMT AEMT practical examination which includes seven practical stations:

1. Patient Assessment-Trauma
2. Patient Assessment-Medical
3. Airway Management –Bag Valve Mask (Adult)
4. Cardiac Arrest/AED Management
5. Intravenous Therapy/Bolus Administration
6. Pediatric Intraosseous
7. Random Skill

Basic Life Support Program

A. Instructor Institutes

1. The Office held an EMT Instructor Institute February 19-23, 2011 here in Richmond. 12 Candidates became EMT-Instructors.
2. The next EMT Instructor Practical is scheduled for Saturday, May 14, 2011. 29 candidates were invited.
3. The next Instructor Institute will be held in Blacksburg, VA on the campus of Virginia Tech, June 11-15, 2011
4. EMS Providers interested in becoming an Instructor or the process towards becoming an Education Coordinator in the future please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov

B. EMS Instructor Updates:

1. The Division of Educational Development continues to hold both online and in-person Instructor Updates.
2. Online Updates were held on the first Thursday evening in January, March and May. The last in-person update was held in conjunction with the Instructor Institute on Saturday February 19, 2011. Fifty-five Instructors/ALS Coordinators attended. The next in-person update is scheduled on Saturday, June 11, 2011 in conjunction with the VAVRS

Rescue College in Blacksburg, VA. Pre-registration is not required to attend.

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

EMS Training Funds

The Office is in the process of developing and obtaining the necessary approvals for the new EMSTF contracts for FY12. The Office is planning to launch the FY12 EMSTF program—funding for courses announced on or after July 1, 2011—at the beginning of June.

Financial Update on FY09, FY10 and FY11

FY09 as of October 21, 2010

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$814,237.00	$554,290.52	$259,946.48
BLS CE Course Funding	$113,400.00	$61,976.27	$51,423.73
ALS CE Course Funding	$304,920.00	$102,606.50	$202,313.50
BLS Auxiliary Program	$76,000.00	$19,520.00	$56,480.00
ALS Auxiliary Program	$840,000.00	$184,222.25	$655,777.75
ALS Initial Course Funding	$1,028,861.50	$689,357.59	$339,503.91
Totals	**$3,177,418.50**	**$1,611,973.13**	**$1,565,445.37**

FY10 as of October 21, 2010

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$442,119.00	$276,695.16	$165,423.84
BLS CE Course Funding	$66,360.00	$37,108.00	$29,252.00
ALS CE Course Funding	$194,880.00	$83,437.50	$111,442.50
BLS Auxiliary Program	$128,000.00	$13,280.00	$114,720.00
ALS Auxiliary Program	$476,000.00	$97,480.00	$378,520.00
ALS Initial Course Funding	$844,815.00	$392,342.16	$452,472.84
Totals	**$2,152,174.00**	**$900,342.82**	**$1,251,831.18**

FY11 as of October 21, 2010

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$767,676.00	$326,631.18	$441,044.82
BLS CE Course Funding	$83,160.00	$20,282.50	$62,877.50
ALS CE Course Funding	$231,840.00	$66,185.00	$165,655.00
BLS Auxiliary Program	$96,000.00	$3,480.00	$92,520.00
ALS Auxiliary Program	$389,680.00	$81,940.00	$307,740.00
ALS Initial Course Funding	$1,002,456.00	$348,786.93	$653,669.07
Totals	**$2,570,812.00**	**$847,375.61**	**$1,723,436.39**

EMS Education Program Accreditation

A. The Office is gearing up to implement the new optional EMT accreditation and the required Advanced EMT accreditation program.
    1. Emergency Medical Technician (EMT)
        a) No applications on file.
    2. Advanced Emergency Medical Technician (AEMT)
        a) No applications on file.
    3. Intermediate – Reaccreditation
        a) No applications on file.
    4. Intermediate – Initial
        a) Dabney S. Lancaster Community College in Clifton Forge.
            (1) A site visit for DSLCC was conducted on March 30 and April 1, 2011. The Office is waiting on the Final Report to be submitted by the Site Visit Team.
    5. Paramedic – Initial
        a) No applications on file.

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. Beginning January 1, 2013, paramedic students who are candidates for certification testing through the National Registry of EMT's (NREMT – www.nremt.org) are required to have graduated from a nationally accredited paramedic program—national accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).
    1. Virginia is well positioned to ensure that students completing paramedic training programs in the Commonwealth will be eligible to test NREMT beginning January 1, 2013.
    2. Of 16 accredited paramedic training programs, there are only a handful of programs which still need to obtain national accreditation through CoAEMSP/CAAHEP.
        a) Lord Fairfax Community College
        b) Patrick Henry Community College
        c) Rappahannock EMS Council Paramedic Program
        d) Southside Community College
        e) Prince William County Paramedic Program

D. For programs and entities NOT currently accredited at the paramedic level, accomplishing accreditation at this level will require the following steps:
    1. Currently accredited Virginia Intermediate programs wanting to conduct paramedic education will be required to first seek Virginia paramedic accreditation through the Office of EMS.
        a) If the site successfully completes the state paramedic accreditation process, they will be issued a grant of accreditation which will allow them to complete one (1) initial basic program (a cohort). CoAEMSP requires that each program seeking national

accreditation have successfully completed an initial paramedic cohort.

b) During training of this initial cohort, the program will be required to complete the CoAEMSP self study.

c) At the completion of the first cohort, the program will need to submit their self study to CoAEMSP.
   (1) When submitting the CoAEMSP self study, the program will have to request a *Letter of Review* from CoAEMSP. If the self study is complete and meets CoAEMSP requirements, the CoAEMSP staff will issue a *Letter of Review* attesting to the fact that the program has applied for national accreditation.

d) The program will be required to submit the *Letter of Review* to NREMT and request that their initial cohort be allowed to apply for and complete NREMT certification testing.
   (1) The ability for programs to announce and conduct additional initial paramedic training programs in Virginia will require that the program have successfully completed and been granted national accreditation through CoAEMSP/CAAHEP

On Line EMS Continuing Education

OEMS continues to work with third party continuing education vendors seeking to offer web-based continuing education in Virginia. To date, the Office has approved (five) 5 third party vendors: 24-7 EMS, CentreLearn, HealthStreams, Medic-CE and TargetSafety.

There are more than 475 OEMS approved online CE courses currently offered through these vendors. A vigorous screening process assures the programs are of quality and allows for the electronic submission of continuing education to the OEMS technician database.

For more information, visit the OEMS Web page at:
http://www.vdh.virginia.gov/OEMS/Training/WebBasedCE.htm

EMSAT

A. There are currently 57 Designated EMSAT Webcast Sites in Virginia. Most are located in rural areas and continue to offer free monthly CE training across the Commonwealth, mostly Category 1 ALS and Category 1 BLS classes. The Summer-Fall 2011 EMSAT Schedule will be posted on the OEMS Website in May.

B. EMSAT programs for the next three months include:
   1. May 18, Responding to Pill Parties
   2. June 15, When Normal Isn't: OB Patient Complications
   3. July 20, Infection Control Update 2011

The EMS Provider Portal

The Office extends an appreciation to the EMS constituents who are assisting in promoting the EMS Provider Portal. As of April 18, 2011, provider compliance is at 55%. The Office is hoping for full compliance before the end of the year.

The EMS Provider Portal is an all encompassing electronic dossier which provides unrivaled, 24/7/365 access to Virginia EMS personnel. Some of the features of the EMS Provider Portal include access to:

- EMS Agency affiliation data
- Continuing Education (CE) reports
- Enrolled course data
- Certification Test Eligibility letters
- Certification Test Results
- E-mail notifications of certification expiration
- Access to update/change address, phone number and e-mail address
- E-mail opt-in/opt-out functionality allowing for updates from various Divisions within the Office of EMS.

In addition, the approximately 600 EMS educators have the following additional access:

- Online course management tools
- Course Approval documents and notifications
- EMS Training Funds Contracts
- Various instructor reports
- Course statistics

The Office continues to see growth in the submission of CE from those using handheld scanners. The scanners also drastically reduce the number of errors in continuing education submissions, radically improving the efficiency in reporting. This innovative application of technology also reduces the time it takes to record continuing education from three to seven days to less than 24 hours. The long term payoff in scanner use is realized by:

- Reducing the need to hand deliver (drive) continuing education to the Office of EMS.
- Reducing the number of errors which result in additional mailings and staff time.
- Reducing the number of errors resulting in less recertification issues.
- Reducing the cost of printing and mailing by the office of continuing education cards (approximately savings of $4000 a year)
- An improved customer service environment.

If you would like information about the scanners, contact Chad Blosser at chad.blosser@vdh.virginia.gov.

Along with the introduction of electronic CE submission, EMS Instructors now have the ability to correct continuing education errors for providers attending their programs. This ability to correct continuing education errors includes continuing education submitted either electronically by scanners or by the traditional bubble card. This has significantly reduced the number of continuing education errors. However, there is still room for improvement as there remain just over 2,600 continuing education errors. The Office continues encouraging instructors to review their portals and address any errors they may have.

Other Activities

A. The Patient Care Guidelines Workgroup met on April 19th to conduct further work on the patient care guidelines.
B. Attended the Tidewater Community College Paramedic Program Re-Accreditation visit.
C. Conducted an initial Intermediate Accreditation visit for Dabney S. Lancaster Community College.

Emergency Operations

IV. Emergency Operations

Operations

- **Virginia 1 DMAT**

Frank Cheatham, HMERT Coordinator, attended the Anniversary meeting for Va 1 DMAT held in Williamsburg and also attended Leadership and Team meetings for VA 1 DMAT.

- **HMERT Operations**

The HMERT Coordinator, Frank Cheatham, attended a meeting of the NOVA 8 Task Force. During this meeting Frank discussed changes to the HEMRT structure and also provided training in various emergency management topics. He also met with the Task Force Commanders of TJ-2 Task Force and discussed the restructure process. METRO 11 also held a meeting to provide members with information about restructuring and training.

- **Bull Run Anniversary Celebration**

The Emergency Operations Assistant Manager and the HMERT Coordinator continue to assist in VDH planning for the 150th Anniversary of the First Battle of Bull Run. This event is scheduled to take place in late July 2011.

As part of the planning, Karen Owens attended a meeting at the Prince William Health Department Offices, with Michael Berg, Regulation and Compliance Manager. The meeting , attended by members of the Health Department, as well as representatives of Prince William County and City of Manassas Fire Department, allowed OEMS representatives to present information on regulation issues regarding the use of volunteer staff, as well as the resources OEMS can offer to assist.

- **VDH Statewide Exercise**

Karen Owens, Emergency Operations Acting Manager, attended a planning meeting for the Annual VDH Statewide Exercise. Along with members of the Office of Radiological preparedness, Office of the Chief Medical Examiner, Office of Emergency Preparedness, and other members of the Department of Health, Mrs. Owens has assist dint eh development of exercise injects and expectations to assist in meeting the set objectives.

- **Fire Department Instructors Conference (FDIC)**

Karen Owens, Emergency Operations Acting Manager and Frank Cheatham, HMERT Coordinator, attended the annual Fire Department Instructors Conference in Indianapolis, Indiana from March 20-26, 2011. Mrs. Owens presented two courses, one on ICS for EMS providers and the second on Rehab Operations for EMS providers. Mr. Cheatham presented a course on EMS planning for Special Events. The OEMS representatives also took the opportunity to attend classes in various aspects of EMS management and EMS Incident Operations.

Planning and Preparedness

- **Family Assistance Center (FAC) Planning**

The Emergency Planner continues to participate with the Department of Social Services (DSS), Department of Emergency Management (VDEM), Office of the Chief Medical Examiner (OCME), the Office of Emergency Preparedness (OEP), and other state agencies in updating the state FAC plan to reflect additional roles for VDH and others to make the plan more scalable, mobile, pro-active, and multi-functional. Meetings during this quarter were held February 1 and 15, March 1 and 15, and April 12 and 26.

- **Review of VDH COOP**

Winnie Pennington, Emergency Planner, reviewed the VDH COOP and sent recommendations to Gary Brown for changes based on OEMS mission and needs. Planner prepared a presentation for monthly Manager's meeting on March 1, 2011 to go over changes and responsibilities of the managers. Be the end of the calendar year, the Emergency Planner will develop an "all hands" staff meeting to inform staff of changes.

- **OEMS Tornado Drill**

In conjunction with the Business Manager, the Emergency Planner, developed and conducted an office wide tornado drill on March 15, 2010 (Tornado Preparedness day). Surveys were sent to employees for feedback and an After Action Report was developed.

- **Regional Council MCI and COOP Review**

At the request of the EMS Planner, the Emergency Planner is reviewing plans submitted under Council contracts and making comment and suggested improvements to these plans for the Regional Councils.

Committees/Meetings

- **EMS Emergency Management Meeting**

The EMS Emergency Management Committee met on March 17, 2011 and April 28, 2011. The committee continued work on finalization of the 2011 update of Mass Casualty Incident Management Module I and II.

- **Hurricane Evacuation Committee**

Frank Cheatham, HMERT Coordinator, continues to participate in the Hampton Roads Hurricane Evacuation Committee meetings.

- **EP&R Team Meetings**

The Emergency Planner continues to participate in the monthly EP&R meetings.

- **EMS Communications Committee**

The OEMS Communications Committee met on February 11, 2011. A presentation was conducted by Jeff Flournoy on a program being sponsored in the Eastern Shore area to educate the children in the community on proper use of 9-1-1.

- **COOP Committee**

Winnie Pennington provided updates for the OEMS COOP to committee members via e-mail. Once approved, updates were then provided to office staff accordingly.

- **Critical Incident Stress Management (CISM) Committee**

The Critical Incident Stress Management Committee continued to meet during the quarter. Focus of the meetings have been finalization of the Team Accreditation procedures and application process.

- **Regional Resource Meetings**

Frank Cheatham, HMERT Coordinator attended the Region 1 Resource meeting at the EOC and heard a presentation by the National Guard about the resources available from them.

- **Traffic Incident Management**

Frank Cheatham, HMERT Coordinator continues to work on a Traffic Incident Management Program with VDOT and other agencies.

Training

- **Vehicle Rescue Training Course**

The Division of Emergency Operations hosted a Vehicle Rescue Training Course in Clarksville, Virginia on April 2-3, 2011. The course, attended by 20 students, provides training in extricating patients from vehicles after a motor vehicle crash.

- **COOP Exercise 2011**

The Emergency Planner has coordinated the 2011 Office COOP Exercise. Designed to exercise the specifics of each division, the Division of Educational Development was held April 21, 2011. Exercises for all other divisions will be held in the next quarter.

- **AirCare5 Live Education Day**

On April 16, 2011, the OEMS Communications Coordinator presented "MCI and 9-1-1" at the AirCare5 Live Education day. The course is designed to provide a better understanding to dispatchers about their role in a mass casualty incident.

Communications

- **National Public-Safety Telecommunications Week**

Ken Crumpler, OEMS Communications Coordinator, attended observances of the national Public Safety Telecommunications Week at Hanover County 9-1-1 on April 12, 2011 and in the Eastern Shore 9-1-1 center on April 13, 2011. While visiting the Eastern Shore 9-1-1 center Mr. Crumpler presented "Are you Just a Dispatcher?"

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

PSAP Reaccreditation visits were conducted at Bedford and Campbell County 9-1-1 on

- **Virginia State Interoperability Executive Committee (SIEC)**

Office of EMS staff attended the State Interoperability planning workshops on March 11 and March 22. Ken Crumpler, Communications Coordinator.

Planning and Regional Coordination

VI. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

The Regional EMS Councils are in the process of submitting Third Quarter contract reports throughout the month of May. Submitted deliverable items are under review by OEMS.

OEMS Staff is also looking at the current contracts and budgets with the Regional EMS Councils, to determine if any modifications need to be made for FY12.

The EMS Systems Planner attended the board of director meeting of the Peninsulas EMS Council in March, and served on the interview committee for the vacant Executive Director position at the Rappahannock EMS Council.

Medevac Program

The Medevac Committee met on May 12, 2011. The minutes were not available at the time of the submission of the state EMS Advisory Board quarterly report. At a prior meeting, Dr. Remley tasked the State Medevac committee to examine the future status of air medical medicine in Virginia. Dr. Remley's directive also tasks the committee to partner with other stakeholders to propose a comprehensive voluntary statewide network committed to safety, access and quality. A draft was presented to VDH administration in March, and feedback has been received, leading to revisions.

OEMS and Medevac stakeholders continue to monitor developments regarding federal legislation and other documents related to Medevac safety and regulation. These documents can be found on the Medevac page of the OEMS web site at http://www.vdh.virginia.gov/OEMS/Medevac/Index.htm

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 in October of 2007.

Based on this timeline, OEMS, in coordination with the Executive Committee of the Advisory Board, the Finance, Legislation and Planning (FLAP) Committee, and the chairs of all the standing committees of the Advisory Board submitted planning templates created by OEMS; pertaining to each aspect of the EMS system that committee is tasked with.

A draft of the State EMS Plan was presented at the February 2010 meeting of the FL&P committee, and to the state EMS Advisory Board in May 2010. Following that meeting, the draft plan was

posted to the OEMS web page for public comment. The public comment period ended on July 16, 2010, with 47 comments submitted, which prompted a minor change to the plan, to include language related to the creation and maintenance of a ST Elevation Myocardial Infarction (STEMI) Triage Protocol. This addition is Key Strategic Initiative 4.1.4 of the plan.

The final draft of the plan was approved by the state EMS Advisory Board at their meeting in August 2010. OEMS presented the final approved Plan to the Board of Health at their meeting on October 15. Questions raised by Board members have made additional changes to the Plan necessary.

Recommended changes were made by OEMS staff, and presented to the Commissioner in December 2010. The Commissioner, on behalf of the Board of Health, approved the revised plan, prior to the next meeting of the Board, which was held in March 2011.

The State EMS plan has been posted to the OEMS webpage, and is attached as **APPENDIX D**.

Public Information & Education

V. Public Information and Education

Symposium

The pre-conference promotional guide will be released soon. We are working with the program committee to finalize details with instructors and information to include in the pre-conference guide and in the catalog.

We are also working on redesigning the on-site guide for easier use and readability. We reviewed all of the evaluations from the participants and are working on addressing some of the items that are most commonly discussed like providing healthier food options for the snacks. However, we would need to secure sponsorships to help with items like this.

We provided a sponsorship letter and form to Jennie Collins, who is working with AEMER to help secure sponsorships for the symposium. We are providing any support and contacts that Jennie may need to help with her sponsor requests.

Governors Awards

PI&E has been sending out monthly e-mails to the list serv featuring the winners from the 2010 awards. We have also been working to help promote the regional awards through our website, newsletter and social media.

We have been working to promote the new award category for Outstanding Contribution to EMS Health and Safety through the same promotional avenues and through advertising with trade publications.

The PI&E staff will be meeting with the regional directors to discuss this program, and look at new ways to promote the program, boost participation and maybe make some recommendations for changes to the program if necessary.

We are working with OEMS staff to ensure that we have OEMS staff at all of the regional award banquets.

Marketing & Promotion

American Heart Awareness Month

As part of the 2011 communications plan, American Heart Awareness Month was the feature for February. PI&E provided information to providers through our website and social media resources about being heart healthy and taking a proactive role in their own heart health. We also

provided messages about heart health for the VDH website and communications. An article in the spring newsletter focused on small things that providers can do to increase their physical activity.

National Poison Prevention Week

PI&E arranged to have Rutherford Rose, from the Virginia Poison Control Network appear on the Richmond CBS news to discuss poison prevention messages and tips and the role of the poison control network. PI&E also provided poison prevention messages for VDH social media and discussed the role of the poison control network on our social media sites, we posted presentations and information about the poison centers to the OEMS website and included prevention messages for providers.

National Public Safety Telecommunications Week

Several of the accredited PSAPs offered to open their doors to the media during this week. We contacted media outlets throughout the state to pitch the story idea and offer interviews and camera time in the PSAPs. Several outlets said they were interested and would cover stories for the week. Others that responded said that they already covered the story or would be interested at another time due to a high volume of other stories on their schedule. We will reach out to those outlets during National EMS Week and discuss the story idea of the proper use of 911. We posted information about this event on our website and in the newsletter.

2011 Spring EMS Bulletin

The Spring EMS Bulletin has been posted and sent to the EMS e-mail list serv. The bulletin featured articles on the new Trauma Triage Plan, agencies and providers preparing for emergencies, new officer and agency standards of excellence programs and much more.

Distracted Driving & Rider Safety

In conjunction with the VDH Office of Injury Prevention, we have helped promote their campaign on distracted driving and provided information and resources to providers through our social media, website and newsletter. We created a contract that providers can sign as a measure of good faith to stop participating in activities that keep their attention off the road while driving in the spring newsletter.

PI&E has also worked with Richmond Ambulance Authority to help promote the new program for motorcycle rider and safety cards. We are looking to get a supply of the cards to help distribute to EMS agencies with more information and we have posted information on our website.

National EMS Week

PI&E has distributed National EMS Week planning Guides to all EMS agencies. We will be working with Virginia media to promote EMS week and the National EMS Memorial Bike Ride. As stated earlier we will also pitch story ideas on using 911 properly.

Provider Health &Safety

The PI&E Coordinator met with the GAB chair and the chair for the Health & Safety committee to discuss the health and safety campaign and next steps for the creation of the committee. The PI&E Coordinator is developing a web resource with information and tools for provider health and safety.

We also completed a comprehensive grant application for the Healthy People 2020 initiative. This may have been able to provide funding for the campaign, specifically, the Health and Safety Advocate training program, however, another VDH office submitted an application as well, and we had to withdraw our application. We are currently looking for additional funding sources to help with this campaign.

OEMS Media

The PI&E Coordinator worked with Division of Regulations and Compliance on media requests about the Christiansburg Volunteer Rescue Squad for the Roanoke Times and the Bedford Life Saving Crew for WSLS in Roanoke.

We also worked with Division of Educational Development on an Associated Press request for information on EMT certifications for people in the military. We provided story ideas to the Danville Register Bee for EMS Week and injury prevention.

We created press releases to promote five of the grants that were awarded through the RSAF. These releases are currently on hold, until we get further direction from VDH leadership.

VDH Communications

Office of Licensure and Certification –The OEMS PI&E Coordinator provides media coverage and guidance for the Office of Licensure and Certification and continues to manage media inquiries for the office on a variety of topics like COPN, medical facility complaints and more.

Abortion Clinic Regulations – The PI&E Coordinator has been working with VDH leadership to manage the media inquiries about the new legislation that has required abortion clinics to become licensed facilities. The PI&E Coordinator managed media at the Board of Health Meeting, has been writing talking points and answer media inquiries and providing abortion and licensure data to the media and other organizations that request it.

VDH Media Coverage – The OEMS PI&E Coordinator provided support for the press conference with the Governor and First Lady on heart health awareness. Media coverage was provided to respond to a variety of requests like fluoride in water changes, flu information and more.

VDH Web Site Policy, Procedures and Design Committee – The PI&E Coordinator is managing the process to redesign the VDH website with the website committee. Contractors were hired to help with the design and content and are working with the various offices and health districts to manage the rollout of the new site. She is also managing the redesign of the OEMS section of the site and will be working with OEMS program managers to manage content.

VDH Branding – The PI&E Coordinator is on the ORCE Strategic Planning Committee assigned to the task for VDH Branding. This includes logo use policies, creating an agency style guide and templates for documents and more. The PI&E Coordinator is creating VDH PowerPoint templates that will be used by all offices and districts and working on an agency style guide.

Carbon Monoxide Prevention – The Office of Injury Prevention, OEMS and the Department of Fire Programs are going to send out a joint press release on carbon monoxide prevention and provide prevention messages on the VDH social media outlets. This release has been rescheduled to be sent to the media in conjunction with a better media topic like hurricane preparedness.

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

Regulation & Compliance

VII. Regulation and Compliance

Compliance

The EMS Program Representatives have completed several investigations on EMS agencies and individuals during the first quarter of 2011. These investigations relate to issues concerning failure to submit quarterly prehospital patient care data, violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to staff the ambulance with minimum personnel and individuals with felony convictions. The following is a summary of the Division's activities:

Enforcement

Citations Issued: 8 total
Providers: 4
EMS Agencies: 4

Compliance Cases

New Cases: 25

Cases closed: 3

Suspensions: 0

Temporary Suspensions: 3

Revocations: 0

Reinstatements: 0

EMS Agency Inspections

Licensed EMS agencies: 676 Active

Permitted EMS Vehicles: 4,240 (Active, Reserve, Temporary)

Recertification: Agencies: 119 Vehicles: 643

New EMS agencies: 4

Spot Inspections: 32

Hearings (Formal, IFFC)

January 12, 2011 – Henkle; Zawislak
Variances

Approved: 6 Disapproved: 4

Consolidated Test Sites

Scheduled: 58 Cancelled: 6

OMD/PCD Endorsements

As of April 25, 2011: 198 Endorsed

EMS Regulations

1. The Durable Do Not Resuscitate (DDNR) Regulations 12VAC5-66 is awaiting review and approval by the Governor's Office (4/25/2011).

2. The final draft of the Virginia Emergency Medical Services Regulations 12VAC5-31 resides with the Secretary of Health and Human Services awaiting hi review and approval (4/25/2011).

Noteworthy Matters

The Office has advertised for and interviewed several candidates for the vacant Northern Virginia Program Representative position. A candidate has been identified and an offer has been extended and accepted. The new employee is scheduled to start May 25, 2011.

Division Work Activity

1. The Division of Educational Development and the Regulation and Compliance staff along with the Executive Management of the Office are finalizing the Employee Work Profiles for the Consolidated Testing Supervisor as well as Consolidated Test Site Examiners. This will encompass both BLS and ALS testing. This activity was initiated to comply with the Internal Revenue Service's definition of an employee

versus a contractor. Testing will become the responsibility of the Division of Educational Development. Although a timeline for implementation has not been established – staff is working diligently to create the EWP's for review and classification by VDH, Office of Human Resources (OHR). Once this is complete, applications will be accepted for the wage positions, interviews conducted and qualified personnel hired.

2. Regulation and Compliance staff represented the Office of EMS in Fire/EMS studies conducted by the Virginia Fire Service Board for the following jurisdiction: Augusta County. In addition, staff will be part of a study team for Northampton County, Washington County and King George County.

3. Staff continues to offer technical assistance to EMS agencies, entities and local governments as requested. Most recently, staff offered technical assistance to Washington County in determining the need for a Fire/EMS study.

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

5. Staff is finalizing a proposal for review and approval by executive management to begin the replacement for the OEMS Program representative's vehicle over the course of the next several budget cycles. Emphasis will be placed on fuel economy as well as program support and needs.

6. Staff has also participated and /or supported the following events during the First quarter of 2011:

    a. Attended SWVA EMS Council Open House
    b. Attended Western-Albemarle Annual Banquet
    c. Faculty – EMS Expo, Henrico Fire
    d. Staff, OMD Training Program, Homestead
    e. Participated as faculty and support for Annual Fire Chief's Conference , Virginia Beach
    f. Attended Board of Health meeting
    g. Faculty, Annual ABC Weekend, Lynchburg
    h. Faculty, March Medical Madness, Fluvanna

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee met on April 20, 2011. The committee discussed the funding of Recruitment and Retention projects with RSAF grant funds. The committee also discussed the placement of specific conditions on grant awards to obtain statistical data on the effectiveness of EMS recruitment and retention projects funded by the RSAF.
The next meeting will be on July 20, 2011.

Work Groups

a) Virginia EMS Officer Standards

The EMS Officer Standards Committee has been meeting monthly – with the last meeting being on April 6, 2011. The current course of action is to review all similar programs (National EMS Curriculum and EMS Management and Leadership Development in America; An Agenda for the Future) and determine if the Virginia EMS Officer Standards – February 2010 edition should:

- Accept the committee drafted program as complete and continue the training curriculum design process
- Adopt a portion of an existing program to supplement the committee drafted program
- Replace totally, the committee drafted program with another existing EMS Officer program
- Start over

The sub-committee determined that the committee drafted document (February 2010 edition) was good – as far as the work went. In fact the competency areas addressed within the proposed Officer levels (I, II, III, IV) are very similar to other programs reviewed:

- Human Resource Management
- Community and Government Relations
- Administration
- Emergency Service Delivery
- Health and Safety

However, additional work is needed to add the competencies for each officer level. To begin this process, a comparison of competencies (from existing EMS officer programs), is being done and will be discussed at the next meeting.

The next meeting is scheduled for May 11, 2011.

b) Standards of Excellence

The workgroup is currently reviewing and re-writing all of the Performance Measures for the self-assessment survey.

c) Keeping the Best! EMS Workforce Retention Program

A Keeping the Best! EMS Workforce Retention Workshop was held at the Eastern Shore Fire Training Center in Melfa, Virginia on March 12. The class was taught by Dave Tesh and Jo Richmond and was well attended and well received.

2011 EMS Career Fair

The Second Annual EMS Career Fair will be held on November 10, 2011 in conjunction with the annual EMS Symposium at the Norfolk Marriott Waterside. The event will be held from 5:00 PM (right after classes end) until 7:00 PM. The evaluations from the 2010 Career Fair indicated that an earlier start time would be better – so that symposium participants could attend the event immediately after classes ended.

Recruitment and Retention Network

The Recruitment and Retention Network met on April 15, 2011 at the Fredericksburg Rescue Squad. Dave Tesh gave a presentation on "Making the Marriage Work". He discussed strategies and ideas on making the combination EMS (volunteer and career) system work most efficiently. The next meeting will be on June 10, 2011 in Augusta County.

Community Health Ambassador Program (CHAPS)

The Community Health Ambassador Program is a ten week series of lay health classes that include basic classes in health, hypertension, Type 2 Diabetes, home safety, nutrition, etc. Classes will be tailored to community-specific health outcome data. Ambassadors will receive information they can share with their friends and family members and throughout the community. They will be empowered by knowing the signs and symptoms of illness and will be able to encourage early medical intervention.

The Office of EMS will be assisting the Office of Minority Health and Health Equity, Virginia Department of Health with the CHAPS program. The first CHAPS lay health classes are scheduled to start in June 2011 in Essex County.

Additional CHAPS programs are planned for Rockbridge, Highland, Bath, Augusta and Alleghany counties later this year.

CLAS Act Initiative – Culturally & Linguistically Appropriate Health Care Services

OEMS staff recently met with Valerie McAllister and Karen Reed, Director, Division of Multicultural Health and Community Engagement, VDH, Office of Minority Health and Health Equity (OMHHE). The meeting was held at the request of OMHHE to discuss the possibility of collaboration on a project funded by Federal FLEX grant funds to assess, survey and determine the needs and feasibility of planning and conducting cultural competence training for EMS providers.

If funding is made available for this project, a survey will be conducted of EMS providers to determine the need for cultural and linguistic competence training.

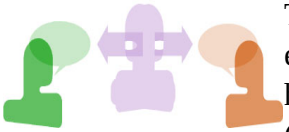
The CLAS Act Initiative strives to advance health equity for Virginia's increasingly diverse population by providing and developing resources related to culturally and linguistically appropriate health care services (CLAS). Projects within the initiative include:

The ClasActVirginia.org tool is a web-based resource guide designed to help health care providers meet the needs of Virginia's changing demographics.

VDH, Division of Multicultural Services and Community Engagement has designed a poster that informs patients in 32 languages of their rights to a trained interpreter at no cost copies of this poster should be displayed at all offices of the health district and, as appropriate, in multiple locations within offices. Click here to download this poster.

The assessments use Census 2000, Virginia Department of Health data to commonly-spoken language Virginia. Learn more click here.

Virginia Department of Education, and give a comprehensive snapshot of the most encountered in every health district in



The **Virginia Medical Interpreter Training Grants Program** was established to build capacity statewide to deliver linguistically appropriate healthcare services and communicate with limited English proficient (LEP) individuals in the event of a public health emergency. Funds are being made available to pay for the cost of tuition to a limited number of bilingual individuals each year who wish to be trained as medical interpreters through an authorized Virginia course provider.

For more information click here.

Read more archived news stories featuring the CLAS Act initiative.

For more information about culturally and linguistically appropriate health services, contact Valerie McAllister .

Trauma and Critical Care

IX. Trauma and Critical Care

Emergency Medical Informatics

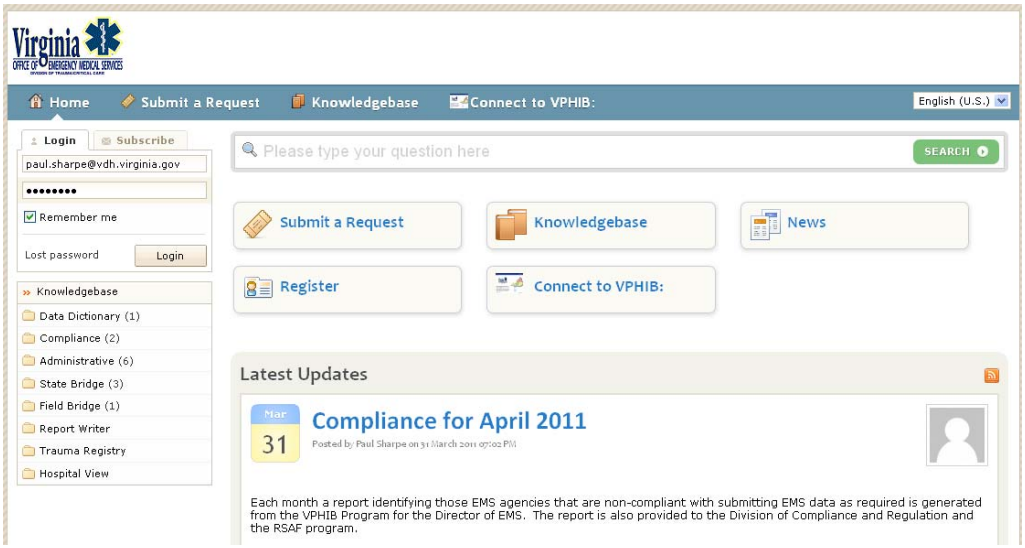
The Division of Trauma/Critical Care (TCC) is actively recruiting to fill the informatics Coordinator/Statistician position.

Virginia Pre-Hospital Information Bridge (VPHIB)

Support to Users: OEMS has stood up a new VPHIB Support Suite (Figure 1). This product allows a centralized program to collect, track, and respond to requests from VPHIB users. A unique telephone number was also created which can be answered at several workstations if needed. Both of these improvements allow more than one OEMS staff person with access to requests for assistance so we can better cover when primary staff are on leave and respond to peak incidents.

The VPHIB Support Suite also allows staff and VPHIB users to monitor the status of all requests and ensure timeliness when possible. The support suite also includes a knowledge base and news section to provide up to date information and increased communication between OEMS and VPHIB users. Higher priority news articles are e-mailed to users to ensure those user that have not submitted a request will still receive important updates. Anyone can sign up to receive VPHIB News and TCC recently added the ability for anyone to receive RSS feeds for news items as well. The VPHIB Support Site is available at http://oemssupport.kayako.com/.

Figure 1



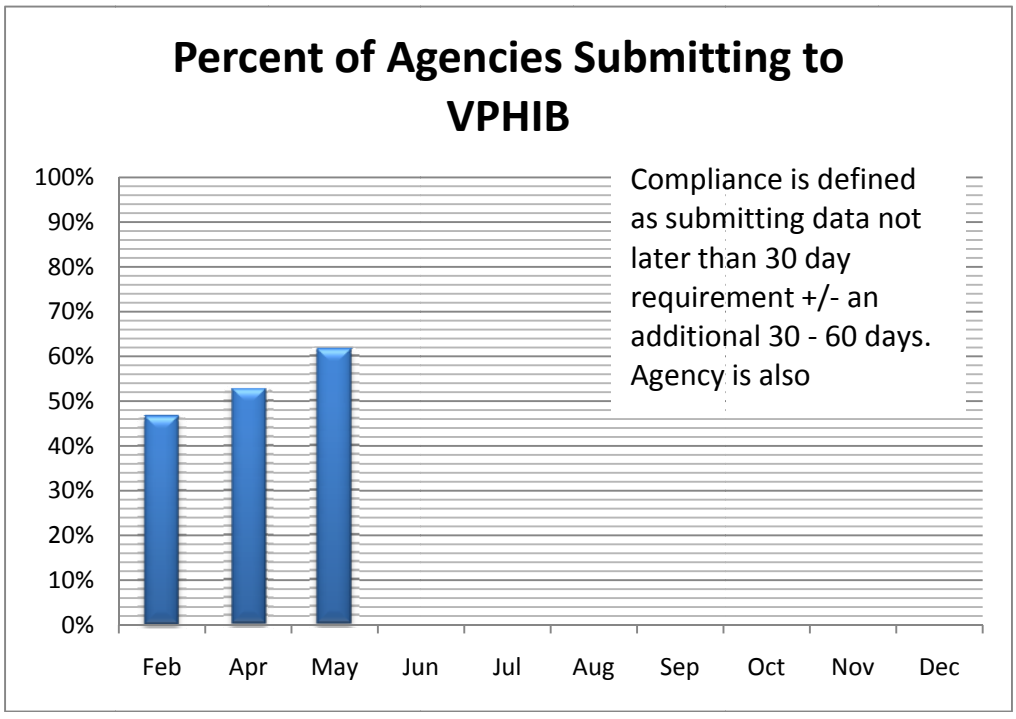
Data output: Report Writer 2 (RW2) has been updated to remove excess fields that are not used, reorganize the fields to a more logical order, and the addition of new datasets.

RW2 is available for use by all EMS agencies. The VPHIB agency administrator determines whether other users at their agency will have access RW2.

OEMS continues to evaluate data quality and compliance to asses our ability to produce statewide data reports. At this time, all agency demographic data has been reviewed and "cleaned" and is available for statewide use. Destination/hospital data was reviewed and it was discovered that significant quality issues existed with the hospital names. Third party vendor imports have been including hospital names spelled differently than prescribed by the VPHIB program. Corrections are being made to ensure data quality related to hospital names is being put into place. Notification has been made to all vendors and VPHIB users of a technical change to the XSD that will occur on June 30, 2011.

Compliance is a significant barrier to producing State-wide data. The compliance dashboard below (Figure 2) shows the current compliance rate with submission is 62%. A compliance rate of 90%, 95% optimally is needed to produce valid State-wide reports. In effort to remove the removing "I didn't know" factor wherever we can TCC has begun positing our monthly compliance report which was traditionally used internally only. The compliance report is posted to the State Bridge Knowledge Base and VPHIB Support Suite Knowledge base. To date the posting of the report has been well received.

Figure 2



Source: Virginia Pre-Hospital Information Bridge

NEMSIS Version 3 (Don't Say You Didn't Know): Within each quarterly report TCC will remind the system leaders and others who read our report that NEMSIS Version 3 is coming and IT WILL contain significant changes that will likely affect those agencies using third party

vendors. The best advice we can offer agencies is to **consider NEMSIS 3 when negotiating or re-negotiating the terms of service in contracts with EMS software vendors**.

Assure that your vendor is proactive with moving to NEMSIS V3 and that they intend to continue serving the EMS community when this change occurs. NEMSIS is no longer testing and certifying vendors at the current NEMSIS V2 level. As an example, OEMS' contract with ImageTrend requires them to provide a NEMSIS Gold Certified product at the most current version provided by NEMSIS. It is anticipated that some of the current EMS software vendors will choose not to continue to produce EMS software. No timeline currently exists that is reliable, but V3 is likely to be rolled in the next one to three years in Virginia.

NEMSIS information is available at http://www.nemsis.org/ and NEMSIS V3 is currently open for public comment at http://www.nemsis.org/v3/resources.html. There are several new requirements that will tighten down on data quality, increase the number of available data elements, and allow integration with other databases.

Virginia Statewide Trauma Registry (VSTR)

The fourth quarter's official audit for 2010 data submissions disclosed four facilities were not compliant and letters of non-compliance were sent to the Trauma Registrars with copies to the CEO. All four of these facilities are now back in compliance. Three other facilities were given extensions and we are currently working with them to get them back in compliance.

Our pre-audit conducted on 04/15/2011 disclosed 20 facilities have not submitted any data for the first quarter. Reminder notifications were sent out so they could ensure data was sent to the VSTR by May's official audit. One facility has already submitted data and we are working with the rest. Inova Alexandria and Inova Mount Vernon have switched their submission method to electronic and will be uploading their data the first week in May.

Our pre-audit also revealed four facilities were able to submit incorrect data with an arrival date many years before the Trauma Registry was created. We are in the process of correcting this information and submitted a defect to the Office of Information Technology to ensure this cannot happen during future data submissions.

Trauma System

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

The TSO&MC last met on March 3, 2011 and the draft minutes to this meeting can be found posted on the Virginia Town Hall website as required. Key items of the meeting included a presentation from the Medevac Committee's "Project Synergy" and discussion on the updating of two areas of the Trauma Center Designation Manual.

The two areas of the Trauma Center Designation Manual that are being revised are the centered around nursing criteria and burn criteria. The trauma coordinators/trauma managers presented their proposed revisions to the manual for approval. These revisions focused on nursing

education and trauma manager staffing. Details will be provided as an action item to approve the revision of the designation manual along with the burn criteria in the near future.

Burn criteria: Although burn trauma has been included in the trauma designation process, it has difficult to assess during Trauma Center site reviews due to the lack of criteria in the Trauma Center Designation Manual. The Committee is approaching the burn criteria revision by creating an additional designation level that will indicate that the hospital is Trauma and Burn Center. This effort has been performed in collaboration with the State's three Burn Centers. The final burn language is being incorporated into the Trauma Center Designation Manual now and should be available for Committee adoption at the June meeting. The nursing criteria, burn criteria and other clean-up and formatting of the manual should be available for the Advisory Board for their August meeting.

The State Trauma Triage Plan was approved by the State Board of Health (BOH) at their regular March 11, 2011 meeting. The plan has been posted and a standard report added to the VPHIB system so agencies can pull reports at the agency level to review possible patients that meet Step 1 of the plan. The final Statewide Trauma Triage Plan as adopted by the BOH can be found on-line at http://www.vdh.virginia.gov/OEMS/Files_page/trauma/StatewideTraumaTriagePlan.pdf

b) Trauma Center Fund

Below are the most recent distributions to designated Trauma Centers from the Trauma Center Fund.

Trauma Center & Level	Percent Distribution	Previous Quarterly Distribution	Dec. 2010 FY11	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	14.67%	$102,284.58	$197,397.63	$4,925,285.22
Inova Fairfax Hospital	13.65%	$95,172.77	$183,672.64	$9,642,046.15
Norfolk General Hospital	12.69%	$88,479.30	$170,755.01	$5,575,579.33
UVA Health System	13.91%	$96,985.59	$187,171.17	$5,725,013.65
VCU Health Systems	25.96%	$181,002.57	$349,314.42	$9,519,083.33
II				$0.00
Lynchburg General Hospital	3.28%	$22,869.35	$44,135.26	$1,103,885.97
Mary Washington Hospital	4.33%	$30,190.34	$58,263.92	$240,123.03
Riverside Regional Medical Ctr.	2.96%	$20,638.20	$39,829.38	$1,032,320.55
Winchester Medical Ctr.	3.61%	$25,170.23	$48,575.70	$1,451,841.18
III				$0.00
New River Valley Medical Ctr.	0.15%	$1,073.74	$2,072.20	$107,747.95
CJW Medical Ctr.	1.03%	$7,181.54	$13,859.55	$423,467.84
Montgomery Regional Hospital	0.25%	$1,770.98	$3,417.79	$128,849.96
Southside Regional Medical Ctr.	0.62%	$4,336.81	$8,369.55	$218,067.28
Virginia Beach Gen'l Hospital	2.88%	$20,080.41	$38,752.91	$1,544,855.25
Total			$1,345,587.13	$41,638,166.69

The most recent trauma fund distributions and more information on the Trauma Center Fund can be found on the OEMS Trauma System Web page at:
http://www.vdh.virginia.gov/OEMS/Trauma/TraumaSystem.htm

Emergency Medical Services for Children (EMSC)

Hospital and EMS Agency Surveys End *(Performance Measures 71, 72 and 73)*

The recent surveying required by the federal EMS for Children program has ended. Results are being compiled and findings will be shared as soon as practical.

Hospital Pediatric Emergency Department (PED) Designation *(Performance Measure 74)*

An EMSC Committee work group has been meeting and has now outlined draft criteria for three levels of pediatric ED designation as work continues to create a *voluntary hospital pediatric designation* program for Virginia. This work is in support of the OEMS EMSC program, which is expected to be administering the pediatric designation program once approved by VDH.

Pediatric Disaster Preparedness *(relates to Performance Measure 80)*

Virginia's EMSC Coordinator recently joined a group of select participants to work on creating a national curriculum for pediatric disaster preparedness. During two days of intensive meetings, hosted by the National Center for Disaster Medicine and Public Health (NCDMPH), members of assigned work groups identified the roles of those who needed to be trained and prioritized topics appropriate for that training from a comprehensive collection of resources. These efforts may eventually culminate in a stand-alone national course that addresses the needs of children during and after disasters that would be disseminated widely in the United States with federal support.

Site Visits for Small and Rural Hospital EDs *(Performance Measure 74)*

The EMSC Program is visiting a number of small and rural Virginia hospitals to assess their pediatric needs and capabilities in relation to the "Guidelines for Care of Children in the Emergency Department" document published in October of 2009. This document can be found at the following link: Joint Policy Statement - Guidelines for Care of Children in the Emergency Department, American Academy of Pediatrics, October 2009 .

The joint policy statement delineates "guidelines and the resources necessary to prepare hospital emergency departments (EDs) to service pediatric patients", and is endorsed by many organizations. A partial list of those endorsing these guidelines would include:

- American Academy of Pediatrics (AAP)
- American College of Emergency Physicians (ACEP)
- Emergency Nurses Association (ENA)
- American College of Surgeons (ACS)
- American Heart Association (AHA)

- American Pediatric Surgical Association (APSA)
- American Academy of Family Physicians (AAFP)
- National Association of Children's Hospitals and Related Institutions (NACHRI)
- National Association of EMS Physicians (NAEMSP)
- National Association of Emergency Medical Technicians (NAEMT)
- National Association of EMS Officials (NASEMSO)
- Children's National Medical Center
- Brain Injury Association of America (BIAA)
- Safe Kids USA
- National PTA, Society for Academic Emergency Medicine (SAEM)
- Joint Commission on Accreditation of Hospitals

The latest pediatric ED assessment was May 10th at Bath Community Hospital in Hot Springs, VA. Some other hospitals EMSC is currently working to schedule for assessments include:

- Carilion Stonewall Jackson Hospital (Lexington, VA)
- Carilion Giles Memorial Hospital (Pearisburg, VA)
- Dickinson Community Hospital (Clintwood, VA)
- Page Memorial Hospital (Luray, VA)
- Shenandoah Community Hospital (Woodstock, VA)

Grant-funded supplies/equipment being distributed to the EDs being assessed includes:

- Pediatric Broselow/Hinkle™ ALS System (portable supplies bag with essential color-coded pediatric emergency care supplies organized within it)
- Pediatric length-based resuscitation tapes (Broselow™)
- EZ-IO Intraosseous Infusion Systems (two power drivers, assorted IO needles, stabilizers, training bones)

EMSC Performance Measures Revisited

The EMSC National Performance Measures developed over the years by HRSA remain a work in progress; they were re-numbered and fine-tuned last year, and an updated list of the performance measures is shown below:

Performance Measure 71	*The percent of prehospital provider agencies in the state/territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.*
Performance Measure 72	*The percent of prehospital provider agencies in the state/territory that have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.*
Performance Measure 73	*The percent of patient care units in the state/territory that have essential pediatric equipment and supplies as outlined in national guidelines.*

Performance Measure 74	*The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.*
Performance Measure 75	*The percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.*
Performance Measure 76	*The percentage of hospitals in the state/territory that have written interfacility transfer guidelines that cover pediatric patients and that include pre-defined components of transfer.*
Performance Measure 77	*The percent of hospitals in the state/territory that have written interfacility transfer agreements that cover pediatric patients.*
Performance Measure 78	*The adoption of requirements by the state/territory for pediatric emergency education for license/certification renewal of BLS/ALS providers.*
Performance Measure 79	*The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by establishing an EMSC Advisory Committee, incorporating pediatric representation on the EMS Board, and hiring a full-time EMSC manager.*
Performance Measure 80	*The degree to which state/territories have established permanence of EMSC in the state/territory EMS system by integrating EMSC priorities into statutes/regulations.*

As part of the federal EMSC Progress Report due June 28th, EMSC programs will also be required to report on 5 additional MCHB Performance Measures (from HRSA) that previously were not required to be reported on by EMSC. These are shown below:

Performance Measure 7	*The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.*
Performance Measure 10	*The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training.*
Performance Measure 24	*The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.*
Performance Measure 33	*The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.*

Performance Measure 41	*The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.*

EMSC State Partnership Grant Update

OEMS started a new HRSA EMSC State Partnership Grant "year" on March 1 with funding of $130,000. HRSA, of course, stands for the *Health Resource and Services Administration*, and funding for EMSC is currently funneled through the *Maternal and Child Health Bureau* (MCHB) within HRSA.

Beyond funding EMSC State Partnership Grants for all 50 states and 6 US protectorates (one per entity), HRSA also funds two support organizations for EMSC grantees, a number of EMSC Targeted Issues Grants and a research entity called the *Pediatric Emergency Care Applied Research Network* (PECARN). The two support organizations are the EMSC National Resource Center (NRC) based in Maryland and housed within the Children's National Medical Center, and the *National EMSC Data Analysis Resource Center* (NEDARC) based in Utah. The EMSC Targeted Issues Grants are competitively awarded, usually to academic centers that may or may not partner with others.

Historically HRSA has included FAN representatives, EMSC program Medical Directors, EMSC program Principal Investigators, state EMS representatives, NEDARC, NRC, PECARN and selected others in meeting with EMSC state managers at an *Annual EMSC Grantees Program Meeting*. This year HRSA has chosen to have only the EMSC managers gather in a focused 3-day meeting in Annapolis in early May. The assumption is that HRSA will again convene the larger group mentioned above in an *Annual EMSC Program Meeting* in 2012.

In review, the *EMSC Committee of the Governor's EMS Advisory Board* acts as an advisory committee to the Office of EMS *EMS for Children (EMSC) Program*, and the EMSC Manager for the Commonwealth sits as a member on the EMSC Committee (and provides staff support).

PEPP Training Follow-Up

A survey of *Pediatric Education for Prehospital Professionals* (PEPP) instructors trained with Virginia EMSC program federal grant funding will be conducted in May. The training was held in April of 2009 as part of the *Continuing Concepts for Prehospital Medicine Conference* hosted by the Tidewater EMS Council. 24 students were funded by the EMSC grant and about 16 others also attended (some from out of state). The sponsored participants received additional instructor toolkits resources on site and all participants were sent additional pediatric training resources from the EMSC program. The expectation (and hope) was that each of the new instructors would teach at least 2 courses in the next 2 years.

The purpose of the survey will be:

- to see how many of these instructors have been able to conduct and/or teach in PEPP courses since that time
- to identify what additional support may be needed to facilitate PEPP courses
- to encourage these instructors to go forward and promote additional PEPP training

Latest Version Length-Based Pediatric Tapes *(Performance Measure 73)*

Length-based pediatric resuscitation tapes are identified as "essential" equipment for ambulances in the consensus document from AAP and other national organizations, and by the federal EMSC program, but these items are not currently required in Virginia. Many ambulances do carry one of these tapes, but many are older versions and a number of them have been lost or worn significantly.

In order to assure that all BLS and ALS ambulances have access to the most recent version of a length-based tape, the EMSC program is using federal grant funding to purchase new Broselow™ pediatric tapes for distribution to all transport ambulances that need them.

Portable Pediatric Pulse Oximeters *(Performance Measure 73)*

Pulse oximeters were also identified as "essential" equipment for BLS ambulances in the consensus document from AAP and other national organizations, and by the federal EMSC program, but these items are also not currently required in Virginia. Most ALS ambulances already have access to pulse oximetry (at least for adults), but many BLS ambulances do not.

A limited number of portable pediatric pulse oximeters for BLS ambulances will be purchased soon by the EMSC program from this year's federal grant budget, and it is anticipated that additional numbers of these may be purchased from the 2012 EMSC program budget to provide to BLS transporting ambulances.

Transporting Children in Ambulances *(Performance Measure 80)*

The official release of the final version of the National Highway Transportation Safety Administration (NHTSA) recommendations on safely transporting children in ambulances is supposed to occur at any moment. For a DRAFT version of this report, visit the following link: DRAFT 2010 Recommendations for the Safe Transportation of Children in Ground Ambulances, NHTSA.

In additional the AAP and NHTSA both released new guidelines for securing children in automobiles on the same day in March. A web address for the NHTSA guidelines is http://www.nhtsa.gov/DOT/NHTSA/Traffic%20Injury%20Control/Articles/Associated%20Files/4StepsFlyer.pdf and a web address for the AAP guidelines is http://pediatrics.aappublications.org/cgi/reprint/peds.2011-0213v1. Both the AAP and NHTSA main websites can lead you to additional information on these topics.

EMSC Advisory Committee Update

The EMS for Children Committee of the EMS Advisory Board had its quarterly meeting April 7, 2011 and enjoyed as part of their program a special presentation by Dr. Alice Ackerman relating her experiences in southwest Virginia working to address pediatric disaster preparedness issues.

Four pediatric class topics discussed and submitted by the EMSC Committee have been accepted for the *2011 EMS Symposium*:

- *"The Choking Game—It's No Game"*
- *"Uncommon But Extremely Dangerous Ingestions in the Pediatric Patient"*
- *"Injury and Illness Prevention for EMS Agencies"* (includes *"Safe Sleep"*)
- *"Pediatric Readiness for EMS Agencies—Staying Prepared for Scary Kids"*

The EMSC Program will be providing fiscal support (nearly $10,000) for many additional pediatric topics being offered at the 2011 EMS Symposium with funding from the EMSC State Partnership Grant. This money will pay for instructor honorariums and travel expenses, books, supplies, room fees, technical support, etc. related to presenting pediatric topics.

The *Pediatric Emergency Department Designation Work Group* discussed its progress in finalizing draft criteria for the framework of the future voluntary designation program and the draft guidelines will be provided for comment at the next meeting.

All of the other items discussed in this report to the EMS Advisory Board were also discussed at the EMSC Committee meeting. The next meeting is scheduled for July 7, 2011 at 1041 Technology Park Drive in Glen Allen, VA.

Pediatric Toolkits Planned for Eventual Inclusion on the EMSC Website
Toolkits designed to assist EMS agencies, EMS providers and Virginia Hospitals in caring for children and promoting their wellness are being developed for inclusion on the EMSC website. A partial list of the toolkits being assembled would include:

- Inhalant Abuse
- Pediatric Emergency Transfer Guidelines
- Games Adolescents Shouldn't Play (GASP)
- Pediatric Disaster Preparedness
- Safe Sleep for EMS Providers
- Promoting Pediatric Training
- Pediatric Hospital ED Designation
- School Nurses and EMS
- Model Pediatric Protocols
- Transporting Children In Ambulances

Ideas are always being accepted for additional toolkits and should be directed to David Edwards, VA EMSC Coordinator, by email (david.edwards@vdh.virginia.gov) or by phone (804-888-9144).

NASEMSO--Pediatric Emergency Care Council (PEC)

The National Association of EMS Officials (NASEMSO) held its mid-year meetings in Annapolis, adjacent to the EMSC Program Managers Meeting the first week of May. The Pediatric Emergency Care (PEC) Council is a standing council of NASEMSO and met as part of

the mid-year meetings to discuss national issues concerning emergency care and children, and to provide input to NASEMSO in advising its federal partners and policymakers on pediatric issues.

The PEC Council is primarily composed of EMSC managers from all 50 states and 6 US protectorates. Virginia's EMSC Manager is the Vice-Chair of the PEC Council and co-chaired these meetings. The Atlantic EMSC Council (Virginia is a member) also participated in both of the national meetings last week in Annapolis.

Mandatory Reporting Update Sought

The EMSC program is requesting statistics from the Department of Social Services (DSS) to try and determine the number of EMS providers who have accessed the State Child Abuse Hotline (800-552-7076). This data will be shared when available.

Stroke System

There is nothing of significance from TCC to report on stroke at this time. TCC staff has reviewed many of the draft regional stroke triage plan and provided input to the OEMS systems planner. The due date for regional stroke plans to be given to VDH/OEMS for approval is 4/30/2011. There have been some concerns from key stroke stakeholders about the inclusion of stroke program staff with developing the regional plans and the content of draft plans.

STEMI System

OEMS continues to participate as an active member of the Virginia Heart Attack Coalition (VHAC) which functions in concert with the American Heart Association's (AHA) Mission Life Line (ML). Mr. John Dugan has joined the AHA as Virginia's STEMI Coordinator and has been transitioning into the role.

OEMS had previously agreed to purchase and perform data analysis from the National Cardiovascular Registry (NCDR) to evaluate our State's STEMI systems of care. OEMS staff, VHAC members and NCDR staff have met to work on the details of this data exchange.

The VHAC steering committee is working with the hospitals to establish the process of what type of data will be released.

Durable Do Not Resuscitate (DDNR)

The draft DDNR regulations continue to await the Governor's signature for approval. Once signed the draft regulations will be posted for public comment. Should little to no response occur during this public comment period the regulations will go into effect.
OEMS will provide education on the changes. Key items with the revised regulations include:

- Eliminate the need to print forms on unique distinctive paper (discontinuance of the yellow DDNR.

- The State will maintain a standardized form that can be downloaded by prescribing health care providers.

- Original copies of DDNR's will not be required; legible photo copies will be honored

- The lists of procedures and equipment that can or cannot be used to control an airway have been updated to reflect current practice.

Respectfully Submitted

OEMS Staff

Appendix A

Letter of Appreciation from the State EMS Advisory Board to GAYLORD W. RAY, MD, for his many years of personal and professional contributions and leadership within the Emergency Medical Services Systems of the Commonwealth of Virginia.

WHEREAS, Dr. Ray's involvement within the EMS Systems for the Commonwealth of Virginia and the Peninsulas Emergency Medical Services Council, Inc. began in 1977, when he was a resident at Riverside Hospital and began interacting with EMS providers presenting patients to the emergency Department; and in the late 1970's began an association with the volunteer EMS agencies in the Northern Neck of Virginia while practicing emergency medicine at Rappahannock General Hospital; And in the 1980's became Operational Medical Director for several volunteer EMS agencies of the Middle Peninsula and the Peninsulas EMS Council, Inc., and was active in the training of EMT-Cardiac Technicians and provided continuing medical education for the Basic and Advanced Life Support Providers while practicing emergency medicine at Riverside Walter Reed Hospital.

WHEREAS, In 1984 he was appointed to the State EMS Advisory Board and served on the key committees of Manpower & Training and Advanced Life Support and Medical Control, ultimately serving two consecutive three-year terms; and was asked to serve as the State EMS Medical Director for the Virginia Department of Health, which he accepted from 1990 to 1992.

WHEREAS, In 1994, Dr. Ray moved to Halifax Regional Hospital in South Boston in the Old Dominion Emergency Medical Services Alliance, Inc. region and continued the same level of commitment and involvement with the Office of EMS and EMS agencies within that region.

WHEREAS, In 2003, due to untimely and unforeseen events, which necessitated he retire from the practice of emergency medicine, he returned to the Peninsulas EMS Region where he again became active in providing and promoting EMS education and training opportunities for volunteer and career EMS personnel, and become the physician course medical director for EMS Programs at Rappahannock Community College; in late 2010, again due to unforeseen circumstances, Dr. Ray retired.

WHEREAS, During Dr. Ray's 33 year career (July 1, 1977 until November 30, 2010) as an emergency physician, he has been a dedicated and effective advocate for patients, volunteer and career emergency medical services providers of all levels, EMS, EMS systems and emergency medicine throughout the Commonwealth of Virginia and specifically the Peninsulas EMS Region;

*NOW, THEREFORE, BE IT RESOLVED, through this Letter of Appreciation, from the EMS Advisory Board this Thirteenth day of May, 2011 that **Dr. Gaylord W. Ray**, be and hereby is, thanked and commended for a lifetime of dedicated and exceptionally meritorious service to EMS in the Commonwealth of Virginia.*

_____

Jennie Collins, Chair
State EMS Advisory Board

Appendix B

RIDER ALERT CARD

EMS BRIEFING

RIDER ALERT CARD

Introduction

The concept of the Rider Alert Card is to place Next of Kin and contact details inside a motorcyclist's crash helmet to provide details to attending emergency services and or Emergency Department staff when a rider cannot communicate with first responders and beyond.

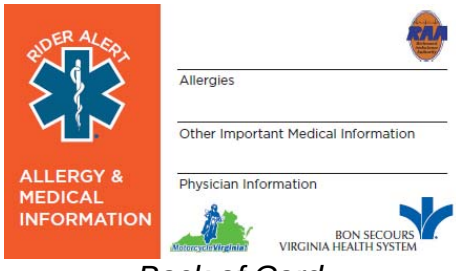
The idea came originally from the United Kingdom, where it began as a small project to distribute rider information cards in the county of Essex. The scheme's popularity soon meant that cards were available to riders across England and Scotland including the world famous road races at the Isle of Man TT. Since then, approximately 325,000 "CRASH Cards," as they are known in the UK, have been distributed.

Following initial meetings with the former Governor's Motorcycle Advisory Council, (now "Motorcycle Virginia") formal support and endorsement was offered to the evolving project. Generous sponsorship from Bon Secours Virginia Health System and the re-formed Motorcycle Virginia allowed the project to advance through the concept and design stages to its launch in April 2011.

Rider Alert Card

The card contains essential details and has the rider's name, emergency contact details, the relationship of the rider to the person at the contact number and any relevant medical details which can aid initial treatment. The card is produced on special waterproof paper that can be written on with a ballpoint pen and should be able to withstand the 'environment' inside a rider's helmet.

Front of Card



Back of Card

Rider Alert Decal

Accompanying the card, which will be placed inside the helmet, will be a decal that is to be applied to the exterior surface of the helmet or on the side of the visor. The decal will advise the presence of the card and is an integral part of the system.

The final design contains (with the kind permission of the Virginia Office of EMS) the 'EMS Star of Life' and the words '***Do Not Remove Helmet'***. This was placed as a safety advisory statement to bystanders who may be tempted to render assistance without the benefit of PHTLS training or skills.

Card containing decal sticker

Helmet Decal

Advice for EMS Agencies and First Responders

A FAQ received is 'what should arriving emergency services do on scene of a motorcycle related incident or accident'? The answer is to continue as your training and qualifications allow. **First Responders and beyond should continue to act to the limit of their protocols and training for dealing with helmets at all times** (in determining whether airway management requires the helmet be removed on scene or keeping it in place until the arrival of the patient at the Emergency Department).

Contained at the Annex below, is the extract from *NAEMT PHTLS Seventh Edition page 288&289*, covering helmet removal procedures. **The message to EMS providers remains clear however, act within stated protocols**, the Rider Alert Card provides additional information at the point the helmet is professionally and appropriately removed.

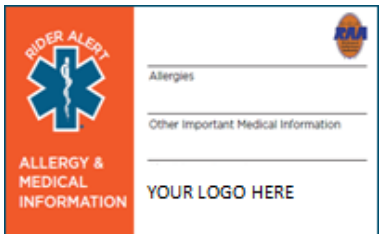
Developing Local Rider Alert Programs

The Rider Alert Program was initially developed for roll out in Virginia (and eventually beyond). The viral nature of the internet and news outlets, however, accelerated the program to the point that the Rider Alert team are now talking to many agencies across the USA and Canada in developing their own programs under the Rider Alert banner.

The key to success of the Program rests in one key area….Sponsorship! There is no state or federal funding for the program and, in Virginia, significant sponsorship has been received by Bon Secours Hospitals Virginia as well as Motorcycle Virginia. This has allowed (as at April 2011), 15,000 Rider Alert Cards to be placed for distribution at locations across the State, but primarily in the I64 Corridor from Virginia Beach to Charlottesville.

The Rider Alert Team is currently seeking further sponsors to help 'fill in' the remainder of the State. The key cost is the print production of cards and (given the waterproof nature of the paper) a run of 5000 Cards costs $1400. The print cost becomes cheaper as volume increases.

Should EMS, Public Safety or Hospitals wish to group together in current 'uncovered' parts of the state and can raise sufficient funds to purchase the cards, The Rider Alert team can facilitate a print run, along with the addition of local sponsor logos along the bottom white strip and top right hand corner of the cards



For local versions of the Rider Alert Card, the logos on the card can be changed out for new sponsor agencies

Further advice and assistance can be gained by contacting rideralert@raaems.org .

The current list of card distribution points is also available at www.rideralert.org

Conclusion

The Rider Alert card, while simple in concept, has already been proven in the UK and has gained a lot of attention across the USA and Canada in its short life. Responders are encouraged to look for the card decal on the helmet indicating the presence of the card, and indeed after helmet removal check the lining in case a card has been placed and not the decal.

As we have discovered, the card is relatively easy to produce and distribute, but local sponsorship is essential to keep the program rolling. It will provide many benefits to rider safety and aid responding emergency providers. Thank you for your support.

Rob Lawrence
Chief Operating Officer
Richmond Ambulance Authority
Chairman (Virginia) Rider Alert Project

April 27, 2011

NAEMT PHTLS Seventh Edition

NAEMT PHTLS Seventh Edition page 288&289 for helmet removal procedures. ..

Patients who are wearing full-face helmets must have the helmet removed early in the assessment process. This provides immediate access for the pre-hospital care provider to assess and manage a patient's airway and ventilator status. Helmet removal ensures that hidden bleeding is not occurring into the posterior helmet and allows the provider to move the head (from the flexed position caused by large helmets) into neutral alignment. It also permits complete assessment of the head and neck in the secondary survey and facilitates spinal immobilization when indicated. The pre-hospital care provider explains to the patient what will occur. If the patient verbalizes that the provider should not remove the helmet, the provider explains that properly trained personnel can remove it by protecting the patient's spine. Two providers are required for this maneuver.

1 - One provider takes position above the patient's head. With palms pressed on the sides of the helmet and fingertips curled over the lower margin, the first provider stabilizes the helmet, head, and neck in as close to a neutral in-line position as the helmet allows. A second provider kneels at the side of the patient, opens or removes the face shield if needed, remove eyeglasses if present, and unfastens or cuts the chin strap.

2 - The patient's mandible is grasped between the thumb and the first two fingers at the angle of the mandible. The other hand is placed under the patient's neck on the occiput of the skull to take control of manual stabilization. The provider's forearms should be resting on the floor or ground or on the provider's thigh for additional support.

3 – The first provider pulls the sides of the helmet slightly apart, away from the patient's head, and rotates the helmet with up-and-down rocking motions while pulling it off of the patient's head. Movement of the helmet is low and deliberate. The provider takes cares as the helmet clears the patient's nose.

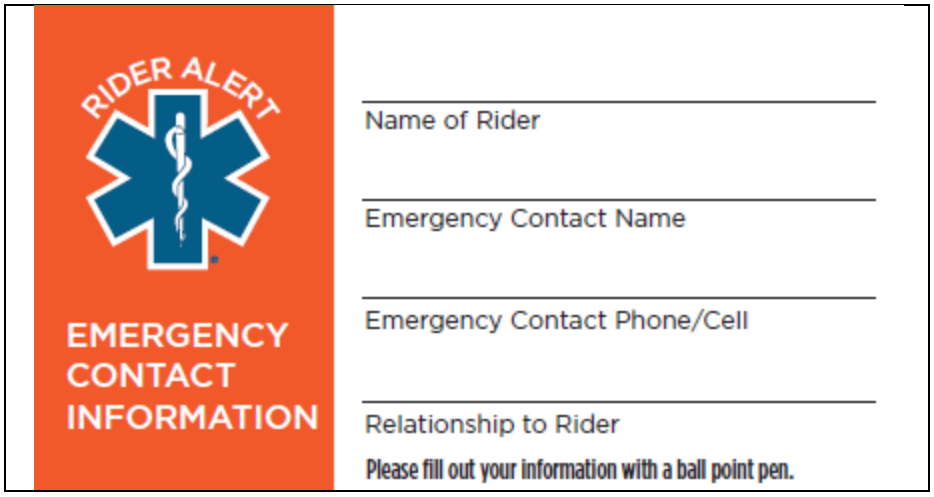
4 – Once the helmet is removed, padding should be placed behind the patient's head to maintain a neutral in-line position. Manual stabilization is maintained, and a properly sized cervical collar is placed on the patient.

Note – Two key elements are involved in helmet removal, as follows:

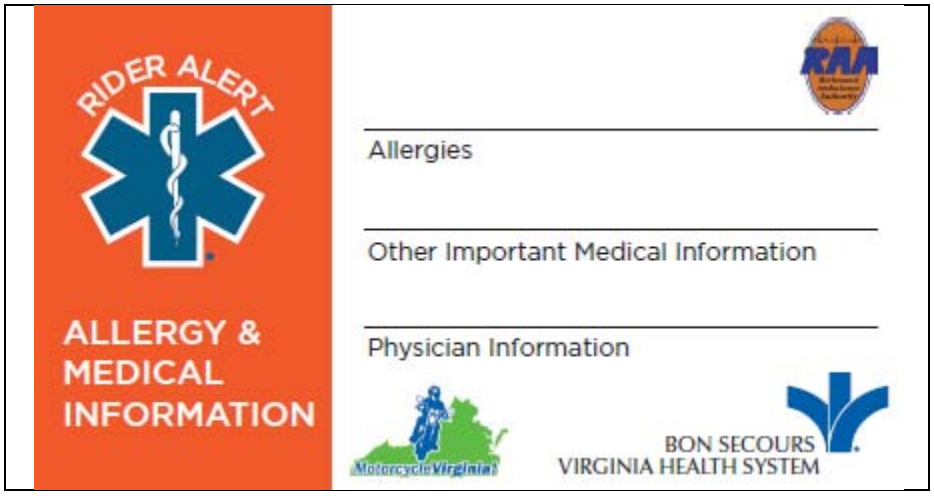
1. While one provider maintains manual stabilization of the patient's head and neck, the other provider moves. At no time should both providers be moving their hands.

2. The provider rotates the helmet in different directions, first to clear the patient's nose and then to clear the back of the patient's head.

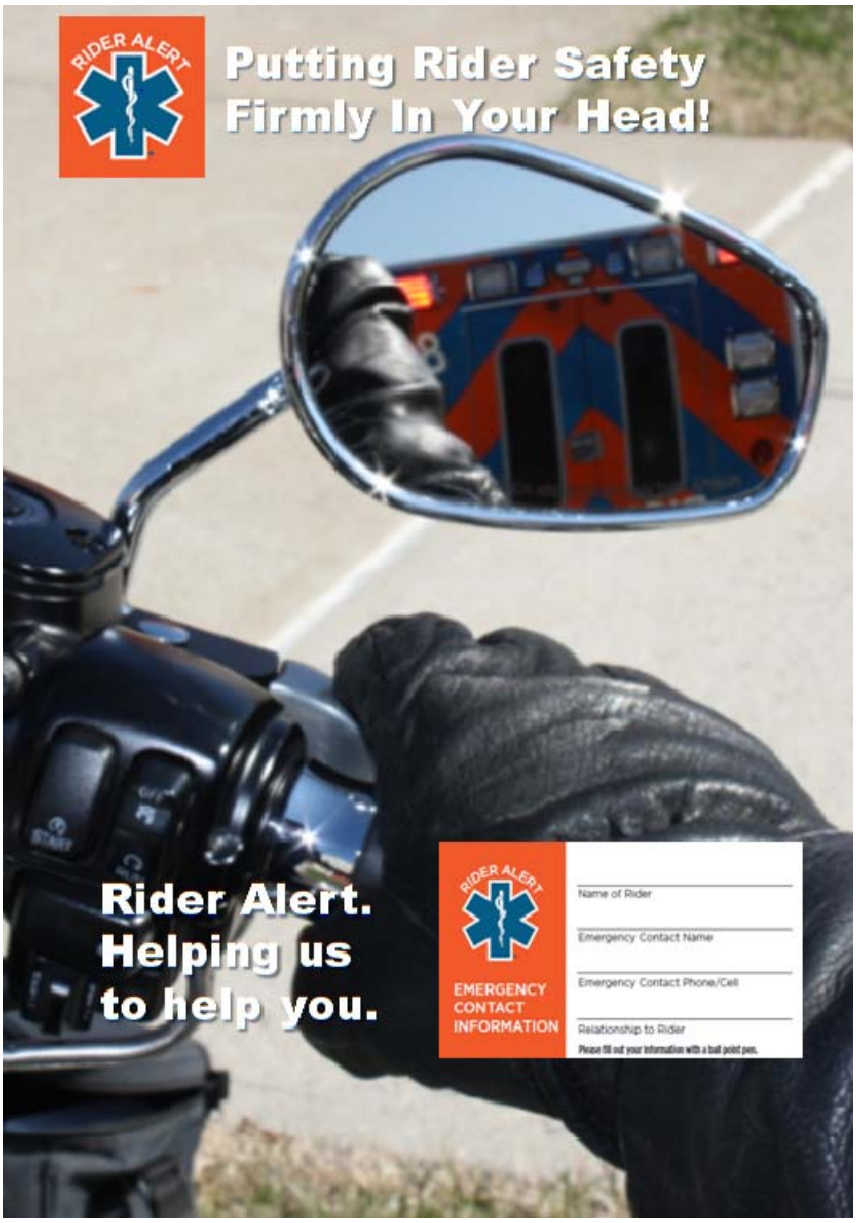
'Decal' Card



Front of Rider Alert Card



Back of Rider Alert Card



www.rideralert.org

Appendix C

Considerations for Virginia EMS Certification Testing

The Office presented to the EMS Advisory Board Executive Committee, Training and Certification Committee and the Medical Direction Committee a proposal to move toward a certification process that is congruent with the EMS Agenda for the Future and the EMS Education Agenda for the Future. These documents were produced back in the late 1990's as guidance for a maturing EMS System. The future is here and Virginia is very fortunate to have had the guidance and support of the various EMS system components that prepared the Commonwealth in a manner that over the years has placed us ahead of a majority of states and a leader in complying with the current EMS Systems' design as endorsed by the National Association of State EMS Officials (NASEMSO).

The National EMS Education Agenda developed five integrated primary components. Listed below are those components and where Virginia's compliance with each component stands.

- National EMS Core Content – Compliant
- National EMS Scope of Practice Model – Compliant
- National EMS Education Standards – Compliant – Will be activated July 1, 2012
- National EMS Education Program Accreditation – Compliant – Well ahead of a majority of states.
- National EMS Certification – partially compliant –(Compliant at Intermediate and Paramedic) Need to add EMR, EMT, and AEMT.

As demonstrated, Virginia is well positioned for compliance with all the educational components. The last component is that of National EMS Certification.

The proposal staff presented will initiate the process of moving Virginia toward full compliance with the National EMS Agenda. Although not all the details have been fully addressed, this document is submitted to provide you with an overview of the project. The Training and Certification Committee is the lead on this project in association with the Medical Direction Committee.

The timing of this proposal has become somewhat of an urgent matter. The Atlantic EMS Council (AEMSC) was formed in 1974, comprised of six states and the District of Columbia. Since that time two additional members have joined. Original membership included Pennsylvania, New Jersey, West Virginia, Maryland, Delaware, Virginia, District of Columbia. North Carolina and South Carolina have joined over the last 10 years. One of the initial projects of the Council was to gather the training coordinators from each member state and develop a standardized, written certification examination. This process was designed to assure a valid, psychometrically sound and legally defensible written certification examination was developed and utilized in each member state. Those sound and guiding principles has been a guiding force for the member states ever since. Unfortunately, the process for developing certification examinations is no longer feasible. The ability to continue producing valid, psychometrically sound and legally defensible examinations will end January 2013 or possibly sooner. A discussion about the process of developing certification examinations by the AEMSC member states was held in December, 2010. The ability for Virginia and other member states to produce

certification examinations that meet current item response development requirements has become severely compromised. It is essential state EMS certification examinations be validated, psychometrically sound and legally defensible. As such an alternative must be sought. None of these alternatives are as cost efficient as the one we have utilized in Virginia over the past 30 plus years. Although there are several vendors capable of developing EMS certification examinations, only one can meet both Virginia EMS certification needs and has been endorsed by a national EMS organization as meeting the objectives of the National EMS Education Agenda. At the annual meeting of the National Association of State EMS Officials (NASEMSO) held in October 2010 in Norfolk, this organization went on record as recognizing the National Registry of EMTs (NREMTs) as the national testing service for EMS. The cost of testing, whether or not by the National Registry or other vendors is essentially the same, once you consider item response development, test production, test centers, all Virginia Certification levels (FR (EMR), EMT, Enhanced (AEMT), Intermediate (Intermediate 99) and Paramedic) and change in IT needs. After review of the various available options, the Division of Education Development submitted a proposal to OEMS executive management for review and consideration.

The proposal recommends use of the National Registry of EMTs certification examination process for all initial EMS certification levels recognized in Virginia. This would include EMR (our current First Responder), EMT, AEMT (our current Enhanced), Intermediate and Paramedic. The basic design mirrors the current practice for certification at the Intermediate and Paramedic level.

Several of the components we are investigating include the following:

1. Written test sites – The Office is currently in discussions with National Registry to determine locations and number of sites. We are using data from 2007, 2008, 2009, and 2010.
2. Cost of Exam – The Office is conducting discussions with National Registry to establish a billing process that allows the State to cover the cost of the initial written test attempt by EMRs and EMTs.
3. Automation of Reciprocity for Virginia programs – Discussions will involve National Registry and our Office of Information Technology to design and implement a process whereby we can automate reciprocity, thus removing the need for Virginia program graduates to apply for reciprocity.

Recertification would also take on a new process. Virginia would not require EMS providers maintain their National Registry although this option is available. This is the practice currently available for Intermediate and Paramedics. However, recertification in Virginia would require that providers at all levels comply with the Virginia continuing education program. Upon completion of the continuing education requirements, the provider would be eligible for recertification. The provider could recertify immediately or delay recertification until their anniversary month. The change being proposed is that recertification for eligible providers would be automatically processed during their certification anniversary month unless they requested electronically that it be done earlier. The proposal removes the requirement for an OMD waiver. Recertification for all EMS providers, regardless of agency affiliation, will be by

continuing education. Should a provider go into re-entry, the provider must pass the National Registry written test after they receive eligibility through Virginia continuing education. This test will be at the expense of the provider. Current re-entry regulations would apply.

In summary, the proposal being considered by the Training and Certification Committee in association with Medical Direction Committee will place all initial testing through the National Registry of EMTs. Initial certification test attempt costs will be covered by the Office for EMR and EMT. Recertification will continue to require compliance with the Virginia continuing education program but will remove the need for an exam waiver. Eligible providers who have completed the continuing education program will automatically be recertified during their anniversary month or at their discretion, upon their request if prior to this date. Implementing this remaining component places Virginia as 100% compliant with national standards for EMS Education.

This process will be posted on our web page so that all Virginia EMS System stake holders (EMS Agencies, OMD, Providers, Educators, and Regional EMS Councils) can follow. This proposal will surely raise many questions. You are encouraged to call the Office and/or contact any member of the Training and Certification Committee if you have further questions.

Regards,
The Division of Education Development

Appendix D

Virginia Department of Health's Office of Emergency Medical Services
State Strategic and Operational Plan 2010-2013
Executive Summary

§32.1-111.3 of the Code of Virginia requires the development of a comprehensive, coordinated, statewide emergency medical services plan by the Virginia Department of Health's Office of EMS (OEMS). The Board of Health must review, update, and publish the plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency care system. The objectives of the plan shall include, but not be limited to the seventeen objectives outlined in §32.1-111.3. For this reason, OEMS endeavored to review the existing State Emergency Medical Services Plan and incorporate information vital to the future of the Emergency Medical Services (EMS) System in Virginia.

In Virginia, EMS is the umbrella term for a continuum of health services including pre-hospital medical services and the trauma system. The EMS system in Virginia is a coordinated system of over 35,000 trained and certified providers, more than 4200 permitted EMS vehicles and greater than 650 licensed EMS agencies. This system provides ground and air emergency medical care to all citizens of the Commonwealth.

It is the mission of OEMS to reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide EMS system; and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need. Additionally, the vision of OEMS is to establish a unified, comprehensive and effective EMS system for the Commonwealth of Virginia that provides for the health and safety of its citizens and visitors.

The process utilized to revise and update the State EMS Plan (heretofore referred to as "The Plan") incorporated some new methods of gathering information. Each of the thirteen subcommittees of the EMS Advisory Board (Critical Incident Stress Management (CISM), Communications, Emergency Management, EMS for Children (EMSC), Financial Assistance and Review (FARC), Finance, Legislative and Planning, Medical Direction, Medevac, Professional Development, Regulation and Policy, Transportation, Trauma System Oversight and Management, and Workforce Development) were provided a standard planning template, identifying the: critical mission, commitment and values, vision for the future, existing strengths and weaknesses, and action strategies, and implementation steps and involved parties for their particular committee and/or discipline.

Using the information gathered from the committee planning templates, as well as current reference documents, including the EMS Agenda for the Future, and the EMS Education Agenda for the Future, among others, OEMS staff made revisions and updates to the State EMS Plan. ***The plan outlines the direction and defines the agenda of the EMS system for the future, incorporating Developing Partnerships, Creation of Tools and Resources, Developing Infrastructure, and Assuring Quality and Education as its core strategies*.** The specific changes/updates to the strategic initiatives within those core strategies are identified in a subsequent section of this document.

A draft of the Plan was approved by the Finance, Legislation and Planning Committee, presented to the EMS Advisory Board at their May 2010 meeting for approval in August 2010, and posted to the OEMS Website for public comment from June 1 to July 16, 2010. Forty seven comments were received, most of which were general comments on the EMS System as a whole, rather than specifically on the draft of the Plan. The plan was then unanimously approved by the EMS Advisory Board at their August 2010 meeting.

As mandated by the Code of Virginia, OEMS has presented the Plan to the Board of Health for approval.

Summary of changes/updates to State EMS Plan:

Core Strategy — Page in Plan

Core Strategy 1: Develop Partnerships

Collaboration and incorporation among all components and stakeholders are essential elements of a unified and comprehensive EMS system.

Strategic Initiative 1.1 – Promote Collaborative Approaches **Page 5**

Changes include: Focus on tracking traffic on websites and social media. Educating local government officials on EMS planning, coordination, benefits, and incentives for EMS personnel.

Strategic Initiative 1.2 – Coordinate responses to emergencies both natural and man-made **Page 6**

Changes include: Development/revision of guidance documents and planning templates for Emergency Response Teams and emergency planning. Focus recruitment of medical response resources in areas of the state lacking those services.

Core Strategy 2: Create Tools and Resources

The creation of tools and resources essential to ensure an up to date, progressive, and effective EMS System.

Strategic Initiative 2.1 – Sponsor EMS related research and education **Page 7**

Changes include: Creation of reporting tools within the Virginia Pre-hospital Information Bridge (VPHIB) designed to provide statistics on the EMS system. Evaluate reports from trauma centers related to over/under triage of trauma patients by EMS providers/agencies. Collection and assessment of EMS provider demographic information, specifically related to recruitment, retention, and the impact of an aging workforce on the provision of EMS.

Strategic Initiative 2.2 – Supply quality education and certification to EMS personnel. **Page 8**

Changes include: Incorporation of competency based standards for EMS training programs based on new EMS Regulations. Development of voluntary EMS Officer Standards. Implementation of new EMS education standards, based on national education standard documents.

Core Strategy 3: Develop Infrastructure

Continued efforts to develop and maintain the infrastructure of the EMS system ensures OEMS's ability to provide structure to the system in terms of training, regulation, emergency operations, trauma, and critical care. This will allow EMS providers and agencies to continue to be able to provide high quality services to the citizens of the Commonwealth.

Strategic Initiative 3.1 – EMS Regulations, Protocols, Policies, and Standards **Page 9-10**

Changes include: Development of guidelines for Air Medical Services (AMS) resource utilization, triage, and safety. Implementation of voluntary standards of excellence for EMS agencies. Revision of trauma center and regional EMS council designation criteria. Development of standard EMS agency and vehicle inspection checklist, and standard patient care guidelines and formulary.

Summary of changes/updates to State EMS Plan (Continued):

Strategic Initiative 3.2 – Focus recruitment and retention efforts **Page 11**

Changes include: Implementation of voluntary standards of excellence for EMS agencies. Expand existing recruitment and retention programs.

Strategic Initiative 3.3 – Upgrade technology and communication systems **Page 12**

Changes include: Ensuring emergency radio systems comply with related new state and federal regulations. Adoption of Emergency Medical Dispatch (EMD) as statewide standard for emergency medical radio systems. Establish statewide centralized AMS dispatch system.

Strategic Initiative 3.4 – Stable support for EMS funding **Page 13**

Changes include: Development of standard procurement and pricing standards for state grant funded EMS vehicles and equipment. Develop guidance documents to assist EMS agencies to account for use of state and other grant funds and donations.

Strategic Initiative 3.5 – Enhance regional and local EMS efficiencies **Page 14**

Changes include: Increase regulation and oversight of AMS statewide. Education of local government officials regarding the value of a high quality EMS system, especially in economically depressed areas as well as assuming a greater responsibility in their local EMS system.

Core Strategy 4: Assure Quality and Evaluation

Evaluation of every aspect of the EMS system ensures maintaining a high quality system, as well as identification of best practices, and/or areas of improvement to the system.

Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards. **Page 15-16**

Changes include: Maintaining performance improvement, trauma triage, and pre-hospital stroke standards. Develop and maintain statewide pre-hospital and inter-hospital ST Elevation Myocardial Infarction (STEMI) triage plan. Review and evaluate data collection and submission efforts through the VPHIB program. Review functional adequacy of EMS vehicles based on national/international standards.

Strategic Initiative 4.2 – Assess and enhance quality of education for EMS providers. **Page 17**

Changes include: Updating certification and quality improvement processes. Substitute practical examination with competency based training.

Strategic Initiative 4.3 – Pursue new initiatives that support EMS **Page 17**

Changes include: Engage EMS system in injury, illness and violence prevention efforts. Promotion of safety, wellness and physical health initiatives for Fire and EMS personnel.

VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES STATE STRATEGIC AND OPERATIONAL PLAN

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health
www.vdh.virginia.gov/oems

2010-2013

OEMS STATE STRATEGIC AND OPERATIONAL PLAN

Table of Contents

OEMS STATE STRATEGIC AND OPERATIONAL PLAN

INTRODUCTION

§32.1-111.3 of the Code of Virginia requires the development of a comprehensive, coordinated, statewide emergency medical services plan by the Virginia Office of EMS (OEMS). The Board of Health must review, update, and publish the plan triennially, making such revisions as may be necessary to improve the effectiveness and efficiency of the Commonwealth's emergency care system. The objectives of the plan shall include, but not be limited to the seventeen objectives outlined in §32.1-111.3.

Over the past few years, much attention has been paid to the development of the plan. Some of this is due to review reports, namely the Joint Legislative Audit and Review Commission (JLARC), and the Institute of Medicine (IOM) Report "EMS at the Crossroads". These recommendations made in these documents have assisted in driving the planning process forward.

As the Code of Virginia mandates, this plan must be reviewed, updated, and published triennially by the Board of Health. The Office of EMS appreciates the opportunity to present this document to the Board, and values any input that the Board provides, as well as the input of any other stakeholder, or interested party. Additionally, OEMS is prepared to report on the progress of the plan to the Board of Health or other interested parties upon request, and through the OEMS Annual Reports, and Service Area Plans as required by VDH, and the Code of Virginia.

This operational plan identifies the specific initiatives required of the OEMS staff in executing the 2010 – 2013 Strategic Plan. Each objective and action step is intended to accomplish those items most critical to the Strategic Plan in the given fiscal year. The Strategic Plan is designed to improve priority areas of performance and initiate new programs. Therefore, much of the routine, but important work of the OEMS staff is not included in the Operational Plan.

No later than 3 months prior to the end of a particular fiscal year the OEMS staff will evaluate progress on the plan and begin the process of creating the Operational Plan for the next fiscal year.

In most cases "accountability" should be the name of a person, division, or entity that has the lead responsibility for the implementation of the objective or action step. The plan will be reviewed quarterly, and the. Only those objectives and items relevant to the time frame will be a part of the review. Any changes in the objective or action steps should be noted in writing on the form at that time.

Virginia Office of Emergency Medical Services 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 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.

Virginia Office of Emergency Medical Services Vision Statement

To establish a unified, comprehensive and effective EMS system for the Commonwealth of Virginia that provides for the health and safety of its citizens and visitors.

What is the Emergency Medical Services system in Virginia?

The Virginia Emergency Medical Services (EMS) system is very large and complex, involving a wide variety of EMS agencies and personnel, including volunteer and career providers functioning in volunteer rescue squads, municipal fire departments, commercial ambulance services, hospitals, and a number of other settings to enable the EMS community to provide the highest quality emergency medical care possible to those in need. Every person living in or traveling through the state is a potential recipient of emergency medical care.

The Virginia Department of Health, Office of Emergency Medical Service (OEMS) is responsible for development of an efficient and effective statewide EMS system. The EMS System in Virginia is designed to respond to any and all situations where emergency medical care is necessary. This is accomplished through a coordinated system of over 35,000 trained, prepared and certified providers, over 4,200 permitted EMS vehicles, and over 650 licensed EMS agencies, to provide ground and air emergency medical care to all citizens of the Commonwealth of Virginia.

Appendix A – Planning Strategy Matrix

	Strategic Initiative1.1- Promote Collaborative Approaches		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 1: Develop Partnerships	1.1.1 Use technology to provide accurate and timely communication within the Virginia EMS System	OEMS, Regional EMS Councils	1.1.1.1 Track and report on amount, and general content of material posted to OEMS websites and social media on a monthly and annual basis.
	1.1.2 Promote collaborative activities between local government, EMS agencies, hospitals, and community colleges to support more community based EMS programs which lead to increased recruitment and retention of certified EMS providers.	OEMS, System stakeholders	1.1.2.1. Determine amount of new EMS providers recruited via recruitment and retention programs and activities. 1.1.2.2. Continue to schedule "Keeping The Best!' programs. 1.1.2.3. Develop informational items regarding benefits and incentives for local governments to provide to volunteer fire and EMS providers. 1.1.2.4. Educate and familiarize local government officials on the importance in taking a greater role in EMS planning and coordination.
	1.1.3 Provide a platform for clear, accurate, and concise information sharing and improved interagency communications between the Office of EMS, state agencies and EMS system stakeholders in Virginia.	OEMS, State Agencies (VDEM, OCP, VSP, VDFP), Regional EMS Councils, System Stakeholders.	1.1.3.1. Encourage agencies and providers to visit OEMS web page regularly, subscribe to OEMS e-mail list, and social media. 1.1.3.2. Encourage providers to utilize OEMS Provider Portal.
	1.1.4 Identify resources and/or opportunities to work collaboratively with other state agencies, organizations, and associations to improve processes and patient outcomes.	OEMS	1.1.4.1. Attend meetings of, and exchange knowledge with the National Association of State EMS Officials. 1.1.4.2. Encourage appropriate state agencies and organizations to participate in meetings and activities hosted or sponsored by OEMS.

	Strategic Initiative 1.2 – Coordinate responses to emergencies both natural and man-made.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 1: Develop Partnerships	1.2.1 Support, coordinate and maintain deployable emergency response resources.	OEMS, VDEM	1.2.1.1. Finalize Health and Medical Emergency Response Teams (HMERT) guidance document revision; implement new requirements based on revision. 1.2.1.2. Advertise and recruit new HMERT resources in areas lacking in those resources (Far SW, NW). 1.2.1.3. Create recruiting and selection process for resource management team.
	1.2.2 Increase knowledge of Emergency Operations capabilities with Emergency Managers, leaders, and supervisors on a local, regional, and state level.	OEMS	1.2.2.1. Continue to promote Emergency Operations resources, training courses, and abilities to localities across the Commonwealth.
	1.2.3 Assist EMS agencies to prepare and respond to natural and man-made emergencies by incorporating strategies to develop emergency response plans (the plan) that address the four phases of an emergency (preparedness, mitigation, response, and recovery) and to exercise the plan.	OEMS, VDEM	1.2.3.1. Create and promote planning templates aimed at EMS agencies, specifically related to COOP, Emergency Preparedness, and response concerns (MCI, Surge Planning, etc.)

	Strategic Initiative 2.1 - Sponsor EMS related research and education.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 2: Create Tools and Resources	2.1.1 Sponsor research and other projects that contribute to high quality EMS and improve patient outcomes utilizing data collected by the EMS Registries.	OEMS, AEMER	2.1.1.1. Create reporting tools within the VPHIB program that provide decision support statistics that can be used by committees staffed by VDH/OEMS
	2.1.2 Determine quality of EMS service and conduct analysis of trauma triage effectiveness.	OEMS, Designated Trauma Centers, TSO & MC, Regional EMS Councils	2.1.2.1. Trauma Performance Improvement Committee will provide quarterly reports to the regional trauma committees via their representative on the TSO&MC that identify over and under triage events.
	2.1.3 Establish scholarships for EMS provider education.	OEMS, FARC, AEMER, Regional EMS Councils.	2.1.3.1. Establish scholarship program for EMS education and research.
	2.1.4 Evaluate the impact of an aging workforce on service provision around the State.	OEMS, Workforce Development Committee, VAGEMSA	2.1.4.1. Assess demographic and profile characteristics of EMS Providers in Virginia through EMS Provider Portal. 2.1.4.2. Utilize EMS Provider Portal to collect information related to impact of aging workforce on provision of EMS service.

	Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 2: Create Tools and Resources	2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education.	OEMS, Professional Development Committee, Regional EMS Councils	2.2.1.1. Ensure regional training plans are submitted by the Regional EMS Councils to OEMS on an annual basis.
	2.2.2 Enhance competency based EMS training programs.	OEMS, Professional Development Committee, MDC	2.2.2.1. New EMS Regulations create optional EMT-Basic accreditation, which requires program applicants to use competency based training.
	2.2.3 Develop, implement and promote leadership and management standards for EMS agency leaders.	OEMS, Workforce Development Committee	2.2.3.1. Development of EMS Officer standards based on duties of crew chief position, supervisor, and director. 2.2.3.2. Test efficacy of standards through pilot program.
	2.2.4 Align all initial EMS education programs to that of other allied health professions to promote professionalization of EMS.	OEMS, Professional Development Committee, MDC, Board of Health Professions	2.2.4.1. New Education Standards, similar to that used in medical field, currently being implemented to all training/certification levels, and involves initial certification programs, as well as CE programs, to be completed in 2012
	2.2.5 Increase the amount and quality of pediatric training and educational resources for EMS providers, emergency department staff and primary care providers in Virginia.	OEMS, EMSC Committee, VHHA	2.2.5.1. Purchase pediatric training equipment for EMS agencies. 2.2.5.2. Sponsor pediatric training related instructor courses. 2.2.5.3. Provide support for speakers and topics at the VA EMS Symposium annually.
	2.2.6 Provide an increased number of training opportunities for EMS personnel in Emergency Operations methods and activities.	OEMS, VDEM	2.2.6.1. Creation of yearly training calendar for OEMS sponsored Em. Ops. Training offerings. 2.2.6.2. Review and update MCI management modules.

	Strategic Initiative 3.1 - EMS Regulations, Protocols, Policies, and Standards		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.1.1 Review and assess state and federal legislation related to the EMS system.	OEMS, Rules and Regulations Committee, Legislation and Planning Committee	3.1.1.1. Legislation review, determination of impact of legislation on VA EMS system. 3.1.1.2. Gather legislative news and interest items from NASEMSO, and EMS Advocates.
	3.1.2 Establish standards for the utilization of Air Medical Services (AMS).	OEMS, State Medevac Committee	3.1.2.1. Development of AMS guidelines for proper resource utilization. 3.1.2.2 Establish statewide AMS triage guidelines.
	3.1.3 Establish statewide Air/Ground Safety Standards.	OEMS, State Medevac Committee	3.1.3.1. Identify and adopt universal safety standards. 3.1.3.2. Implement and maintain weather turn down system. 3.1.3.3. Establish standard safety protocols and training based on protocols. 3.1.3.4. Standardize air/ground safety standards. 3.1.3.5. Standardize LZ procedures. 3.1.3.6. Develop process for consistent use of air to air communication.

	Strategic Initiative 3.1 - EMS Regulations, Protocols, Policies, and Standards (Continued)		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.1.4 Develop criteria for a voluntary Virginia Standards of Excellence Accreditation Program for EMS Agencies.	OEMS, Workforce Development Committee	3.1.4.1. Approval of first stage of voluntary accreditation standards by state EMS Advisory Board. 3.1.4.2. Implement program and market to interested agencies. 3.1.4.3. Evaluate efficacy of program based on feedback of EMS agency officials and Technical Assistance Teams.
	3.1.5 Maintain and enhance the Trauma Center designation process.	OEMS, Trauma System Oversight & Management Committee	3.1.5.1. Revise the trauma designation criteria to include burn criteria, pediatric criteria, nursing education requirements and infrastructure needs. 3.1.5.2. Conduct an analysis to determine the benefits of adding Level IV designation to our trauma care system.
	3.1.6 Maintain and enhance the Regional EMS Council designation process.	OEMS	3.1.6.1. Evaluate pros/cons of initial designation process. 3.1.6.2. Incorporate input of applicants and evaluators into next round of designations. 3.1.6.3. Conduct re-designation of councils on staggered basis in 2011 and 2012.
	3.1.7 Establish standardized methods and procedures for the inspection and licensing and/or permitting of all EMS agencies and vehicles, including equipment and supply requirements.	OEMS, Transportation Committee	3.1.7.1. Development of standard inspection checklist, to include all aspects of agency and EMS vehicle inspection.
	3.1.8 Through a consensus process, develop a standard set of evidence-based patient care guidelines and standard formulary.	OEMS, State EMS Medical Director, Medical Direction Committee, Patient Care Guidelines Committee, Drug Formulary Workgroup, Board of Pharmacy.	3.1.8.1. Resource document being developed to assist regional medical directors, agency medical director and agency personnel as patient care guidelines and protocols are produced.

	Strategic Initiative 3.2 - Focus recruitment and retention efforts		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.2.1 Develop, implement, and promote a comprehensive recruitment and retention campaign for EMS personnel and physicians, supporting the needs of the EMS system.	OEMS, State EMS Medical Director, Medical Direction Committee, Workforce Development Committee, FARC, Regional EMS Councils	3.2.1.1. Continue to support "EMS Jobs" website. 3.2.1.2. Develop and implement voluntary "Standards of Excellence" for EMS agencies. 3.2.1.3. Maintain Leadership & Management Track at the VA EMS Symposium, and recommend topics and presenters. 3.2.1.4. Continue to promote and support special RSAF applications related to recruitment and retention of EMS providers.
	3.2.2 Support and expand the Virginia Recruitment and Retention Network.	OEMS, Workforce Development Committee	3.2.2.1. Continue to support information and education for distribution. 3.2.2.2. Seek new avenues for EMS recruitment outreach. 3.2.2.3. Recommend strategies to expand existing programs and distribute to EMS stakeholders.
	3.2.3 Develop, implement, and promote the EMS Leadership and Management standards program.	OEMS, Workforce Development Committee	3.2.3.1. Provide Virginia's EMS agencies with the highest quality of leadership. 3.2.3.2. Develop and/or review leadership criteria and qualifications for managing an EMS agency. 3.2.3.3. Develop model job descriptions for EMS Officers. 3.2.3.4. Maintain Leadership & Management Track at the VA EMS Symposium, and recommend topics and presenters.

	Strategic Initiative 3.3 – Upgrade technology and communication systems		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.3.1 Assist with, and promote, the compliance of all emergency medical radio systems with state and federal regulations for narrow banding and interoperability.	OEMS, Communications Committee	3.3.1.1. Prior to 2013, ensure that all emergency medical radio systems meet FCC mandated narrow banding regulation. 3.3.1.2. Prior to 2015, ensure that all emergency medical radio systems meet state interoperability requirements.
	3.3.2 Promote emergency medical dispatch standards and accreditation among 911 Public Safety Answering Points (PSAPs) in Virginia.	OEMS, Communications Committee	3.3.2.1. Support concept of accredited PSAPs, operating with emergency medical dispatch (EMD) standards, and assist agencies in achieving accreditation, and/or adopting EMD as standard operating procedure.
	3.3.3 Provide technical assistance on wireless communication products available for use in the emergency medical community.	OEMS, Communications Committee	3.3.3.1. Continue to stay informed and up to date on new products and technologies, and serve as information conduit to communications entities.
	3.3.4 Establish statewide centralized dispatch system for air medical service.	OEMS, Communications Committee, State Medevac Committee	3.3.4.1. Evaluate existing centralized dispatch programs in other areas. 3.3.4.2. Develop initial role and expectations of centralized dispatch. 3.3.4.3. Develop system to determine availability of closest/most appropriately staffed AMS resource(s). 3.3.4.4. Identify minimum required information to be gathered when requesting AMS.

	Strategic Initiative 3.4 – Stable support for EMS funding		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.4.1 Standardize EMS grant review and grading process by graders at regional and state level.	OEMS, FARC	3.4.1.1. Revise RSAF grant review sheet developed by FARC and OEMS Staff, and continue to evaluate for efficacy. 3.4.1.2. Solicit concerns/comments of regional EMS councils/stakeholders regarding the grant process.
	3.4.2 Develop a "Best Practices" resource guide on the procurement of EMS and rescue vehicles to include the use of existing or "cooperative" contracts in conjunction with the Department of General Services – Division of Purchases and Supply.	OEMS, FARC, Transportation Committee	3.4.2.2. Collaborate with DGS in developing resource guide, and distribute to grant applicants.
	3.4.3 Develop uniform pricing schedule for state funded items.	OEMS, FARC	3.4.3.1. Determine items that can be standardized. 3.4.3.2. Distribute schedule to grant applicants.
	3.4.4 Develop standard specifications for state grant funded equipment awarded to eligible non-profit EMS agencies.	OEMS, FARC, VDH Office of Purchasing and General Services	3.4.4.1. Standardize list of eligible equipment and vehicles that agencies are eligible for. 3.4.4.2. Utilize standard equipment and vehicle lists for future grant applications and cycles.
	3.4.5 Assist EMS agencies to identify grant programs and funding sources for EMS equipment, training, and supplies.	OEMS, FARC	3.4.5.1. Continue to promote RSAF program through Regional EMS Councils. 3.4.5.2. Identify grant opportunities that EMS agencies may be eligible for, distribute information to EMS system.
	3.4.6 Integrate state grant funding programs with other related grant funding programs.	OEMS, FARC	3.4.6.1. Continue to seek federal grant funds for items intended to improve the statewide EMS system .
	3.4.7 Develop guidance documents to assist EMS agencies account for the use of state grant funds and develop internal audit processes.	OEMS, FARC	3.4.7.1. Work with contracted audit firms and Office of Internal Audit to create reference documents to assist agencies to account for grant funds, and ensure sound auditing practices.

	Strategic Initiative 3.5 – Enhance regional and local EMS efficiencies		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.5.1 Standardize performance and outcomes based service contracts with designated Regional EMS Councils and other qualified entities.	OEMS, Regional EMS Councils	3.5.1.1. Maintain annual service contracts with Regional EMS Councils. 3.5.1.2. Provide standard contracts, plan templates, and other reference documents to Regional EMS Councils in each fiscal year. 3.5.1.3. Provide input on contract deliverables to Regional EMS Councils on a quarterly basis.
	3.5.2 Improve regulation and oversight of air medical services (AMS) statewide.	OEMS, State Medevac Committee, Rules & Regulations Committee	3.5.2.1. Revise/implement state AMS regulations. More clearly define licensure requirements for AMS agencies. 3.5.2.2. Develop a system for application as a new AMS service in Virginia. 3.5.2.3. Develop Certificate of Need process for new AMS services in Virginia. 3.5.2.4. Establish response areas for AMS agencies. 3.5.2.5. Develop standard process to address AMS issues. 3.5.2.6. Develop criteria for ongoing AMS performance improvement program.
	3.5.3 Educate local government officials and communities about the value of a high quality EMS system to promote development in economically depressed communities and the importance of assuming a greater responsibility in the planning, development, implementation, and evaluation of it's emergency medical services system.	OEMS, Professional Development Committee, Workforce Development Committee, OMHHE	3.5.3.1. Give presentations at Virginia Association of Counties (VACO) and Virginia Municipal League (VML) meetings, to educate local government officials about EMS. 3.5.3.2. Contribute EMS related articles and news items to monthly and quarterly publications of VACO and VML.

	Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 4: Assure Quality and Evaluation	4.1.1 Maintain statewide data-driven performance improvement process.	OEMS	4.1.1.1. Utilize epidemiology trained OEMS staff to conduct risk adjusted data analysis of trauma patients in cooperation with our stakeholders. 4.1.1.2. Develop an EMS performance improvement program.
	4.1.2 Maintain statewide pre-hospital and inter-hospital trauma triage plan.	OEMS, Trauma System Oversight & Management Committee, State EMS Medical Director	4.1.2.1. Maintain statewide trauma triage plan to support regional plan development and maintenance by regional trauma committees. 4.1.2.2. Supply state level data to assist with monitoring individual regional performance compared to state and national benchmarks.
	4.1.3 Maintain statewide pre-hospital and inter-hospital stroke triage plan.	OEMS, State Stroke Task Force	4.1.3.1. Actively participate on the Virginia Stroke System Task Force and develop and maintain a Statewide Stroke Triage Plan. 4.1.3.2 If available, provide funds for the development of regional stroke triage plans to ensure implementation is performed based on local resources.
	4.1.4 Develop and maintain statewide pre-hospital and inter-hospital ST Elevation Myocardial Infarction (STEMI) triage plan.	OEMS, Medical Direction Committee, State EMS Medical Director, VHHA, American Heart Association, Regional EMS Councils	4.1.4.1. Active OEMS participation on VHAC. 4.1.4.2. Development and implementation of State STEMI Triage Plan 4.1.4.3. Development of Regional STEMI Committees, and Regional STEMI Triage Plans, as a Regional EMS Council contract deliverable.

	Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards. (Continued)		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 4: Assure Quality and Evaluation	4.1.5 Review and evaluate data collection and submission efforts.	OEMS,	4.1.5.1. Develop standard reports within VPHIB that will allow individual EMS agencies to view the quality of data being submitted. 4.1.5.2. OEMS will provide quality "dashboards" where education can improve data quality and update validity rules within the application when education alone cannot correct poor data. 4.1.5.3. Provide quarterly compliance reports to the OEMS, Division of Regulation and Compliance and Executive Management.
	4.1.6 Review functional adequacy and design features of EMS vehicles utilized in Virginia and recommend changes to improve EMS provider safety, unit efficiency and quality of patient care.	OEMS, Rules & Regulations Committee, Transportation Committee	4.1.6.1. Evaluation of national/international documents and information related to vehicle and provider safety, with potential incorporation into EMS regulation and inspection procedure.
	4.1.7 Measure EMS system compliance utilizing national EMS for Children (EMSC) performance measures.	OEMS, EMSC Committee	4.1.7.1. Assist in assessing the pediatric emergency care readiness of Virginia CAH facilities.

	Strategic Initiative 4.2 – Assess and enhance quality of education for EMS providers.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 4: Assure Quality and Evaluation	4.2.1 Update the certification process to assure certification examinations continue to be valid, psychometrically sound, and legally defensible.	OEMS, Professional Development Committee	4.2.1.1. Revised process reduces subjectivity, tests random practical skills to ensure instructor accountability for training curricula content.
	4.2.2 Update quality improvement process to promote a valid, psychometrically sound, and legally defensible certification process.	OEMS, Professional Development Committee, Atlantic EMS Council (AEMS)	4.2.2.1. Virginia Scope completed, used with EMS Ed. Standards and AEMS Council Practice analysis, as well as subject matter experts to produce exams in order to promote valid, psychometrically sound, and legally defensible certification process.
	4.2.3 Explore substitution of practical examination with successful completion of a recognized competency based training program conducted by accredited training sites and using computer based technology for written examinations.	OEMS, Professional Development Committee	4.2.3.1. Identify tasks for Information Technology to perform to produce effective programming for online examination for written examinations. 4.2.3.2. Explore possibility of administering a program summative practical exam in lieu of state practical exam.

	Strategic Initiative 4.3 – Pursue new initiatives that support EMS		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 4: Assure Quality and Evaluation	4.3.1 Engage the EMS system in unintentional injury, illness, and violence prevention efforts.	OEMS, Health & Safety Committee, VDH – Div. of Injury and Violence Prevention	4.3.1.1. Participate in intentional and unintentional injury and illness prevention initiatives, and facilitate involvement for EMS agencies and providers.
	4.3.2 Develop, implement, and promote programs that emphasize safety, wellness, and the physical health of fire and EMS personnel.	OEMS, Health & Safety Committee, State EMS Medical Director	4.3.2.1. Creation of Health and Safety Committee of the state EMS Advisory Board, with quarterly meetings. 4.3.2.2. Maintain Health and Safety track at the VA EMS Symposium, and recommend topics and presenters. 4.3.2.3. Creation of Governor's EMS Award category for contribution to the EMS system related to the health and safety of EMS providers.

Appendix B – Sample Planning Matrix

	Strategic Initiative		
	Objectives	***Accountability***	***Action Steps***
Core Strategy			

Appendix C

Glossary of Terms

SWOT Analysis: An assessment of the internal strengths and weaknesses of the organization and the organization's external opportunities and threats.

Core Strategy: A main thrust or action that will move the organization towards accomplishing your vision and mission.

Strategic Initiative: An action that will address areas needing improvement or set forth new initiatives under the core strategy. This is the planning part of strategy that when combined with the vision, the mission and core strategies complete the strategic effort.

Operational Plan: This is the plan that implements the strategic intent of the organization on an annual basis.

Objective: A specific, realistic and measurable statement under a strategic initiative.

Action Step: A specific action required to carry out an objective.

Template: A guide and/or format that assists the user in accomplishing a task efficiently in a uniform and consistent manner.

Appendix C (Continued)

Glossary of Commonly Used Acronyms

VDH	Virginia Department of Health
OEMS	Virginia Office of EMS
VDEM	Virginia Department of Emergency Management
OCP	Virginia Office of Commonwealth Preparedness
VSP	Virginia State Police
VDFP	Virginia Department of Fire Programs
AEMER	Alliance for Emergency Medical Education and Research
TSO&MC	Trauma System Oversight and Management Committee (Subcommittee of state EMS Advisory Board)
FARC	Financial Assistance Review Committee (Subcommittee of state EMS Advisory Board)
VAGEMSA	Virginia Association of Governmental EMS Administrators
PDC	Professional Development Committee (Subcommittee of state EMS Advisory Board)
MDC	Medical Direction Committee (Subcommittee of state EMS Advisory Board)
WDC	Workforce Development Committee (Subcommittee of state EMS Advisory Board)
VHHA	Virginia Hospital and Healthcare Association
OMHHE	Virginia Office of Minority Health and Health Equity
AHA	American Heart Association
VHAC	Virginia Heart Attack Coalition
CAH	Critical Access Hospital
VPHIB	Virginia Pre Hospital Information Bridge
COOP	Continuity Of Operations Plan
MCI	Mass Casualty Incident
HMERT	Health and Medical Emergency Response Team
NASEMSO	National Association of State EMS Officials
LZ	Landing Zone
RSAF	Rescue Squad Assistance Fund
DHS	Department of Homeland Security
FCC	Federal Communications Commission
AEMS	Atlantic EMS Council (PA, WV, NJ, DE, MD, VA, DC, NC, SC)

Appendix D

Resources

In developing this plan several resources were used in addition to meetings and interviews with the Director and Assistant Director of OEMS.

- Code of Virginia: § 32.1-111.3. Statewide emergency medical care system. Requires a comprehensive, coordinated EMS system in the Commonwealth and identifies specific objectives that must be addressed.

- EMS Agenda for the Future: A document created by the National Highway Traffic and Safety Administration (NHTSA) that outlines a vision and objectives for the future of EMS. August 1996

- OEMS 5-Year Plan: July 1, 2007-June 30, 2010

- Service Area Strategic Plan State Office of Emergency Medical Services (601 402 04) which describes the statutory authority and expectations for OEMS and identifies the growing EMS needs of the citizens and visitors of Virginia.

- Service Area Strategic Plan Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (601 402 03) This service area includes Virginia Rescue Squads Assistance Fund grants program, Financial Assistance to Localities to support Non Profit Emergency Medical Service (EMS) agencies, and funding provided to support Virginia Association of Volunteer Rescue Squads (VAVRS).

- State Emergency Medical Services Systems: A Model: National Association of State EMS Officials – July 2008

- EMS at the Crossroads: Institute of Medicine - 2006

- Agency Planning Handbook: A Guide for Strategic Planning and Service Area Planning Linking to Performance-Based Budgeting: Department of Planning and Budget 2006-2008 Biennium, May 1, 2005

- Joint Legislative Action Review Commission (JLARC) Report – House Document 37, Review of Emergency Medical Services in Virginia. 2004.

- EMS Advisory Board Committee Planning Templates – Developed May-August 2009

- Regional EMS Council Process Action Team (PAT) Retreat Report - November 2008.

Appendix E

Virginia Department of Health
Prehospital and Interhospital
State Trauma Triage Plan

Virginia Department of Health
Office of Emergency Medical Services
Division of Trauma/Critical Care
1041 Technology Park Drive
Glen Allen, Virginia 23059
(804) 888-9100

Executive Summary

Under the *Code of Virginia* § *32.1-111.3*, The Virginia Department of Health (VDH), has been charged with the responsibility of maintaining a Statewide Trauma Triage Plan. EMS Regulation 12 VAC 5-31-390 states that all Emergency Medical Services (EMS) agencies shall participate in trauma triage plans. This plan is to include prehospital and inter-hospital patient transfers. All trauma triage plans must be submitted to the VDH Office of Emergency Medical Services, (OEMS) for approval.

The Statewide Trauma Triage Plan establishes minimum criteria for identifying trauma patients and the expectation that these patients shall enter the "trauma system" and receive rapid definitive trauma care at appropriate hospitals. Regional trauma triage plans may augment the Commonwealth's minimum trauma triage standards by providing additional point of entry information such as hospital capabilities, air medical services and others. At no time shall a regional or local plan set standards lower than prescribed by the state trauma triage plan or trauma center criteria. Individual regional and local systems may adapt the trauma triage plan to reflect the operational context in which they function.

VDH and Trauma System Oversight and Management Committee (TSO&MC) endorse the January 23, 2009; Centers for Disease Control (CDC) *Field Triage Decision Scheme: The National Trauma Triage Protocol* and its accompanying document the *Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage* and utilized these documents as the basis for this plan. The CDC is now home to the national trauma program and has assumed responsibility for establishing the national standard for trauma triage in cooperation with the American College of Surgeons (ACS) who has traditionally developed these criteria. Table 1 lists the organizations that endorse the *Guidelines for Field Triage of Injured Patients; Recommendations of the National Expert Panel on Field Triage* (Centers for Desease Control and Injury Prevention, 2009).

Table 1

List of Organizations that have Endorsed the CDC Trauma Triage Scheme
• Air and Surface Transport Nurses Association • Air Medical Physician Association • American Academy of Pediatrics • American College of Emergency Physicians • American College of Surgeons • American Medical Association • American Pediatric Surgical Association • American Public Health Association • Commission on Accreditation of Medical Transport Systems • International Association of Flight Paramedics • National Association of Emergency Medical Technicians • National Association of Emergency Medical Services Educators

- National Association of Physicians
- National Association of State Emergency Medical Service Officials
- National Native American Emergency Medical Services Association
- National Ski Patrol
- The Joint Commission
- With concurrence from the National Highway and Traffic Safety Administration

Source: Centers for Disease Control and Prevention (Prevention, 2009)

The Virginia Trauma System is an inclusive system; therefore, all hospitals are required to participate in the Trauma Triage Plan. Establishing a comprehensive statewide emergency medical care system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system serves to improve the delivery of EMS and thereby decrease morbidity, hospitalization, disability, and mortality. This document will provide a uniform set of criteria for prehospital and inter hospital triage and transport of trauma patients.

Definition of a Trauma Victim

The Virginia Trauma System defines a "trauma victim" as a person who has acquired serious injuries and or wounds brought on by either an outside force or an outside energy. These injuries and or wounds may affect one or more body systems by blunt, penetrating, or burn injuries. These injuries may be life altering, life threatening or ultimately fatal wounds.

Trauma patient recognition and triage is a two-tiered system:

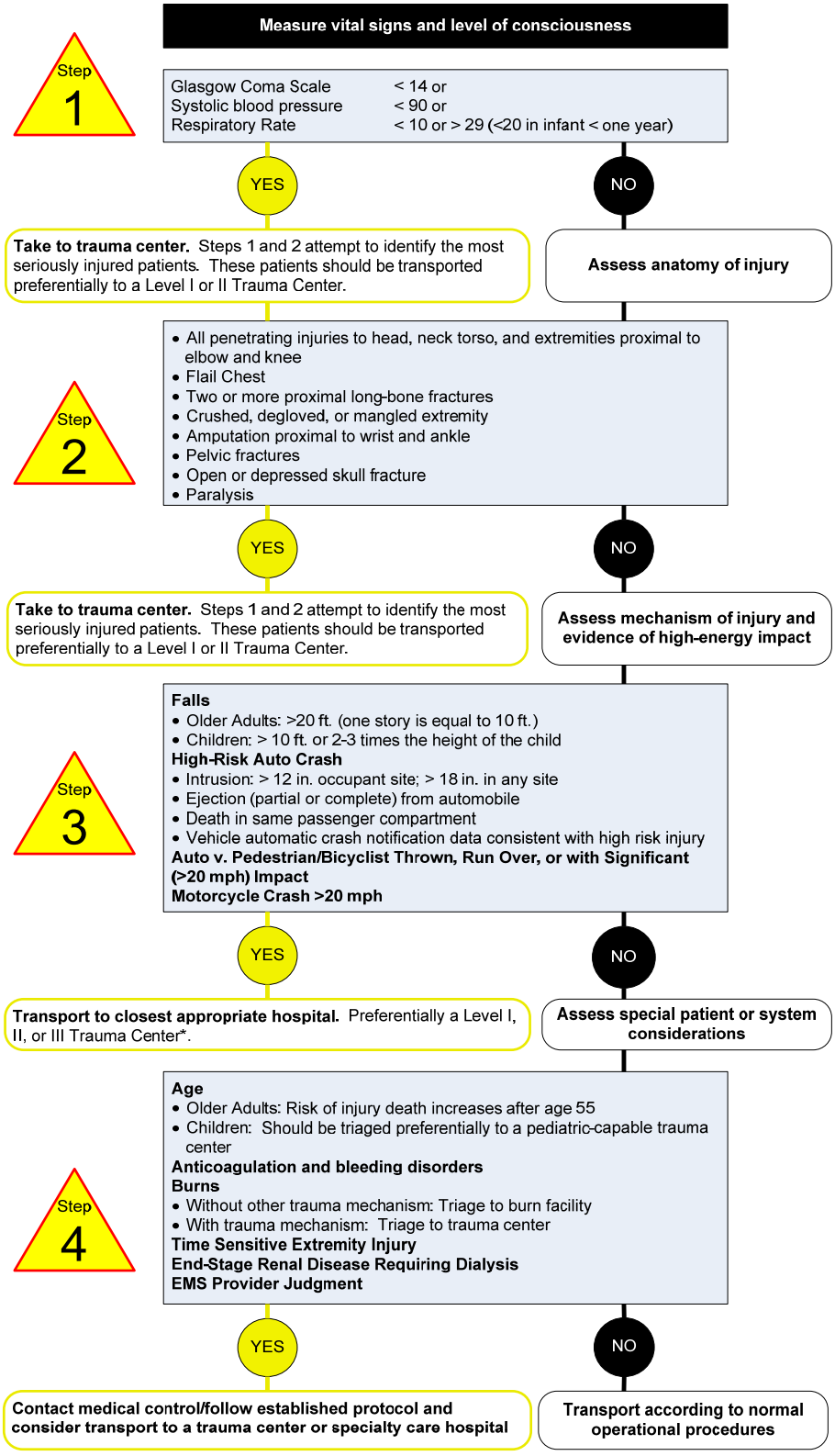
- Initial field triage in the prehospital environment (pre-hospital criteria), and;
- Secondary triage or trauma patient recognition and appropriate timely triage by all Virginia hospitals

Field Trauma Triage Decision Scheme

Diagram 1 illustrates the Virginia Trauma Triage Decision Scheme. The Virginia scheme was developed by members of the Emergency Medical Service Advisory Board's (EMS Advisory Board), TSO&MC (Committee, 2009) with input from the Medical Direction Committee. The CDC *Field Triage Decision Scheme: The National Trauma Triage Protocol* was utilized as the basis for the development of the Virginia scheme.

The Virginia scheme differs from the CDC scheme in two ways. First, Steps One and Two replace the term "transported preferentially to the highest level of care within the trauma system with Level I and Level II trauma center. Level I and Level II trauma centers are the highest level of trauma care in Virginia. The second difference is between Steps Three and Four. The CDC language that states; "transport to the closest appropriate trauma center" was changed to "transport to the closest appropriate hospital." This was done to accommodate for the fact that the CDC document was created with consideration for systems that have Level IV and Level V trauma centers, which Virginia does not have.

Figure 1 Virginia Field Trauma Triage Decision Scheme



Note: Prehospital providers should transfer trauma patients with uncontrolled airway, uncontrolled hemorrhage, or if there is CPR in progress to the closest hospital for stabilization and transfer.

The Medical Direction Committee of the EMS Advisory Board requested that the following statement from page 23 of the CDC's *Guidelines for Field Triage of Injured Patients; Recommendations of the National Expert Panel on Field Triage* be included in this document:

> Transition from Step Three to Step Four of Field Trauma Triage Decision Scheme: The answer of "yes" at Step Three of the Decision Scheme mandates transport of the patient to the closest appropriate trauma center, not necessarily to a center offering the highest level of trauma care available, as is the case in Steps One and Two. Which center is the most appropriate at any given time will depend on multiple factors, including the level of trauma center readily available, the configuration of the local or regional trauma system, local EMS protocols, EMS system capacity and capability, transport distances and times, and hospital capability and capacity. Patients whose injuries meet mechanism-of-injury criteria but not physiologic or anatomic criteria do not necessarily require the highest level of care available. At the time of evaluation, these patients are hemodynamically stable, have a GCS of >14, and have no anatomic evidence of severe injury. Their risk lies only in the mechanism by which they were injured. Thus, they require evaluation but do not need immediate transport by EMS providers to a Level I or Level II facility. If a severe injury is identified at the initial hospital evaluation, these patients may be transferred subsequently to a higher level of trauma care. For patients who do not meet Step Three criteria, the EMS provider should proceed to Step Four of the Scheme (Centers for Desease Control and Injury Prevention, 2009, p. 23).

To review the above information, the evidence supporting the guideline and other detailed information about the rationale for field trauma triage the reader is referred to the document "*Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel of Field Triage.*" The document was released by the Centers for Disease Control and Injury Prevention via the Morbidity and Mortality Weekly Report (MMWR) on January 23, 2009 / Vol. 58 / No. RR-1. This report and other resource materials are available on-line at http://www.cdc.gov/FieldTriage/.

Trauma Patient Transport Considerations

EMS Patient Care Protocols must address transport considerations. Each jurisdiction is unique in its availability of trauma resources. Consideration should be given to the hospital(s) that is/are available in the region and the resources that they have available to trauma patients when developing a point of entry plan. Pre-planning for times when the primary hospital is not available to receive trauma patients because of multiple patients, diversion, or loss of resources such as electric power need to be made in advance of being on scene with a critical trauma patient.

Consideration should also be given to prehospital resources including the level of care available by the ground EMS crews, the closest appropriate Medevac service [Helicopter EMS (HEMS)] available at the time of the incident, and other conditions such as transport time and weather conditions. Use of Medevac services can assist with trauma patients reaching definitive trauma care in a timely fashion.

The developers of this plan identified the following criteria to initiate field transports by helicopter of trauma patients as defined in this plan. Field transport of trauma patients by helicopter would be expected to:

1. Lessen the time from on scene to a hospital compared to ground transport;
2. Bypass a non-trauma designated hospital to transport directly to a trauma center in not greater than 30 minutes;
3. Meet the clinical triage criteria for transport to the closest Level I Trauma Center, or when appropriate the closest Level II Trauma Center;
4. Meet the greater level of care needed by the patient, provided that the Medevac unit can be on scene in a time shorter than the ground unit can transport to the closest hospital; and/or,
5. Document extenuating circumstances such as safety, egress/access similar to other "extraordinary" care scenarios.

EMS Mass Casualty Incident (MCI) Plans and Disaster/Weapons of Mass Destruction (WMD) Plans

Both prehospital and hospital providers should become familiar with other related plans. These plans represent a tiered response to a growing numbers of patients:

- MCI Plan;
- Disaster/WMD Plans; and
- Surge Capacity Plans.

The plans build upon one another. The Trauma Triage Plan is intended to guide treatment for a smaller number of patients that can be managed by resources available during normal day to day operations. MCI Plans provide additional guidance to agencies, municipalities and medical facilities when their normal resources are being strained. Surge plans are developed to meet the need of large scale events that may require caring for hundreds or even thousands of patients. The Trauma Triage Plan is intended for incidents that occur during normal EMS operations.

INTER-HOSPITAL TRIAGE CRITERIA

Hospitals not designated by VDH as a trauma center should expeditiously transfer injured patients who meet the physiological and/or anatomic criteria in Table 2 to an appropriate trauma center.

Table 2

Adult Criteria: Based on the Resources for Optimal Care of the Injured Patient: 1999 (American College of Surgeons, 1999) and adapted by the TSO&MC.

Respiratory

- Bilateral thoracic injuries
- Significant unilateral injuries in patients under age 60 (e.g. pneumothorax, hemo-pneumothorax, pulmonary contusion, >5 rib fractures)
- Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease
- Respiratory compromise requiring intubation
- Flail chest

Central Nervous System

- Unable to follow commands
- Open skull fracture
- Extra-axial hemorrhage on CT, or any intracranial blood
- Paralysis
- Focal neurological deficits
- Glasgow Coma Scale (GCS) ≤ 12

Cardiovascular

- Hemodynamic instability as determined by the treating physician
- Persistent hypotension
  Systolic B/P (<100) without immediate availability of surgical team

Injuries

- Any penetrating injury to the head, neck, torso or extremities proximal to the elbow or knee without a surgical team immediately available.
- Serious burns/burns with trauma (see Table 5)
  Significant abdominal to thoracic injuries in patients where the physician in charge feels treatment of injuries would exceed capabilities of the medical center

Special Considerations

- Trauma in pregnancy (≥ 24 weeks gestation)
- Special needs individuals
- Geriatric
- Bariatric

Table 3

Pediatric Criteria: Based on the Resources for Optimal Care of the Injured Patient: 1999 (American College of Surgeons, 1999) and adapted by the TSO&MC.
All pediatric patients with Pediatric Trauma Scores ≤ 6 * See pediatric trauma score on the following page **Respiratory** • Bilateral thoracic injuries • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease • Flail chest **Central Nervous System** • Open skull fracture • Extra-axial hemorrhage on CT Scan • Focal neurological deficits **Injuries** • Any penetrating injury to the head, neck, chest abdomen or extremities proximal to the knee or elbows without a surgical team immediately available • Combination of trauma with burn injuries • Any injury or combination of injuries where the physician in charge feels treatment of the injuries would exceed the capabilities of the medical center

Pediatric Trauma Score

Table 4

COMPONENT	+2	+1	-1
Size	Child/adolescent, >20 Kg.	Toddler, 11-20 Kg.	Infant, <10 Kg.
Airway	Normal	Assisted O2, mask, cannula	Intubated: ETT, EOA, Cric
Consciousness	Awake	Obtunded; loss of consciousness	Coma; unresponsiveness
Systolic B/P	>90 mm Hg; good peripheral pulses, perfusion	51-90 mm Hg; peripheral pulses, pulses palpable	<50 mm Hg.; weak pulse rate; no pulses
Fracture	None seen or suspected	Single closed fracture anywhere	Open, multiple fractures
Cutaneous	No visible injury	Contusion, abrasion; laceration <7 cm; not through fascia	Tissue loss; any GSW/Stabbing; through fascia

Source: The Pediatric Trauma Score was first released as an accurate predictor of injury severity in pediatric trauma patients in 1987 (Tepas, 1987)
Key for Pediatric Trauma Score

B/P – Blood Pressure	Cm – centimeter	ETT – Endotracheal tube
mm – millimeter	Kg - kilogram	EOA – Esophageal Obturator Airway
Hg – mercury	O2 – oxygen	GSW – gunshot wound

BURN-RELATED INJURIES

Table 5

The American Burn Association has identified the following injuries that usually require referral to a burn center.
• Partial thickness and full thickness burns greater than 10 percent of the total body surface area (BSA) in patients under 10 or over 50 years of age. • Partial thickness burns and full thickness burns greater than 20 percent BSA in other age groups. • Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints. • Full-thickness burns greater than five percent BSA in any age group. • Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications). • Significant chemical burns. • Inhalation injuries. • Burn injury in patients with pre-existing illness that could complicate management, prolong recovery, or affect mortality. • Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center. • Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities. • Burn injury in patients who will require special social and emotional or long term rehabilitative support, including cases involving child abuse and neglect.

Inter-Hospital Transports by Helicopter

The developers of this plan identify that any one or more of the following criteria should exist to initiate inter-hospital transports by helicopter of trauma patients as defined in this plan:

1. All trauma patients meeting the inter-hospital triage criteria as indentified in Table 2 and being transported by helicopter must be transferred to the closest appropriate Level I or Level II trauma center or burn center.

2. Patient requires a level of care greater than can be provided by the local hospital.
3. Patient requires time critical intervention, out of hospital time needs to be minimal, or distance to definitive care is long.
4. Utilization of local ground ambulance leaves local community without ground ambulance coverage.

Trauma Triage Quality Monitoring

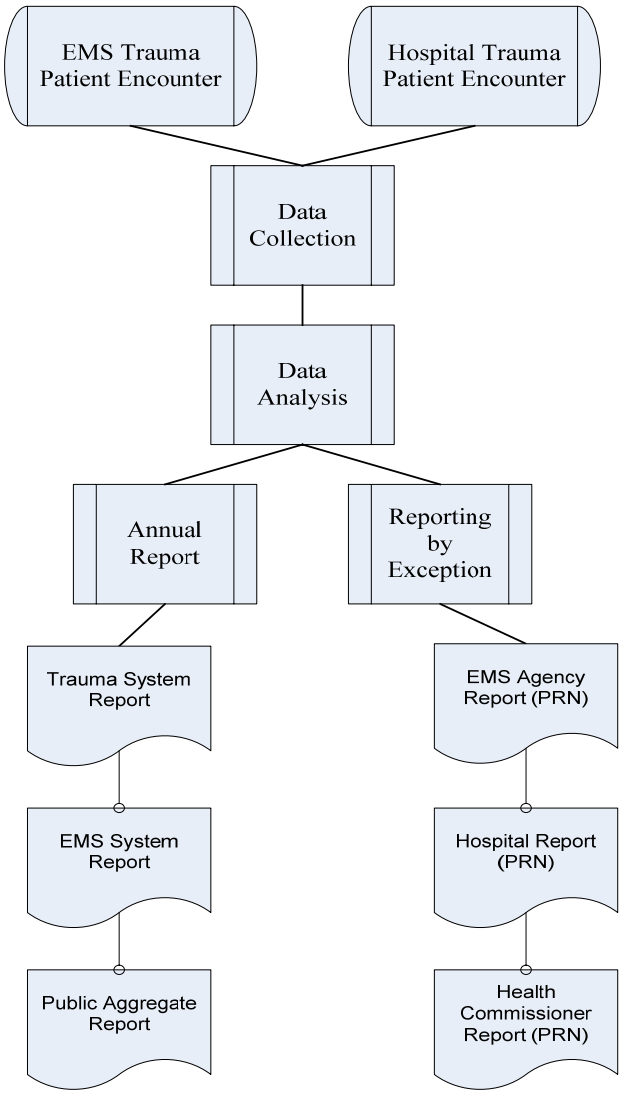
VDH's OEMS is responsible for monitoring and ensuring the quality of trauma care and trauma triage in the Commonwealth. Quality monitoring and assurance is accomplished through several means including, but not limited to, the trauma center designation process, analysis of data from the Emergency Medical Services Patient Care Information System (EMS and Trauma Registries) and from other existing validated sources, the trauma performance improvement committee, feedback mechanisms, and performance improvement groups throughout the Commonwealth.

The Commissioner of Health will report aggregate trauma triage findings annually to assist the EMS and Trauma Systems to improve local, regional and statewide trauma triage programs. A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

The program will ensure that each EMS director or hospital is informed of any patterns of incorrect prehospital or interfacility missed triage, delayed or missed interfacility transfer, as defined in the statewide plan, specific to the provider. The program will also give the entity an opportunity to correct any facts on which such a determination is based, if the entity or its providers assert that such facts are inaccurate.

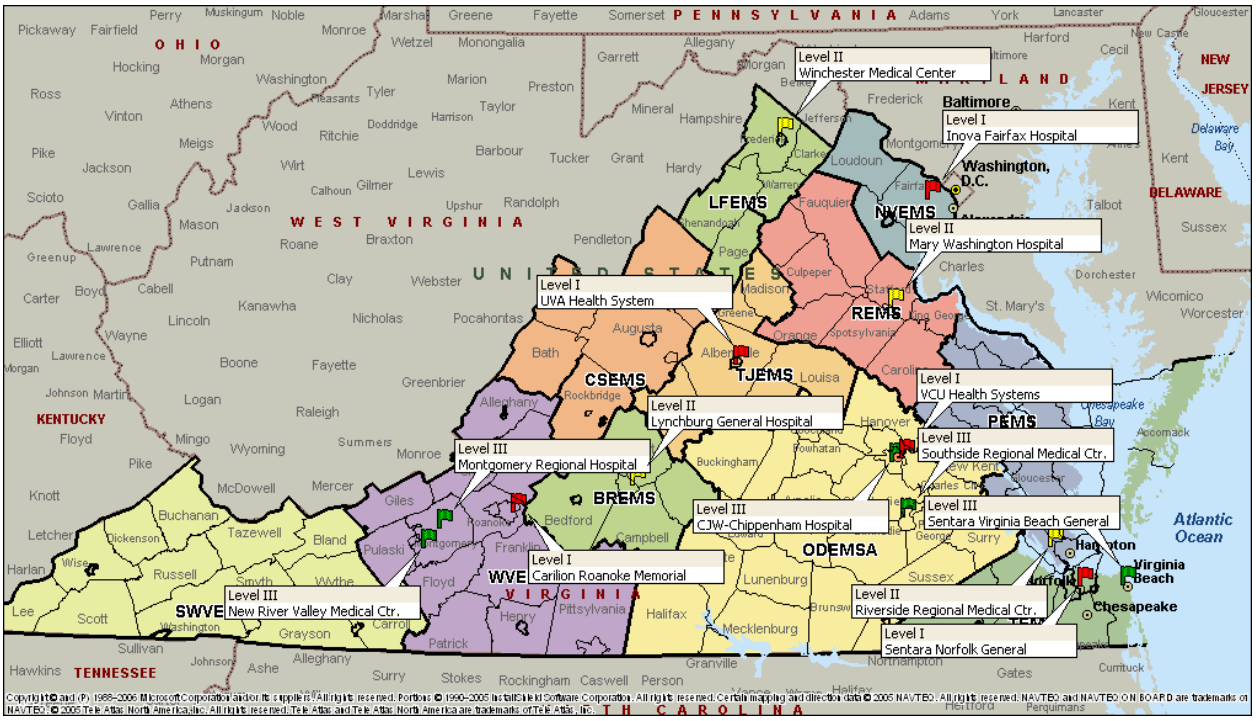
The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.1. Such data or information in the possession of or transmitted to the Commissioner, the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings as is written in the *Code of Virginia*, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data (Virginia, 2008) .

Figure 2 Trauma Triage Quality Monitoring and Assurance Process



Virginia Designated Trauma Centers and Designation Level Description

Figure 3 Map of Virginia Trauma Centers



Trauma Center Designation Levels Defined

Level I Trauma Centers

Level I trauma centers have an organized trauma response and are required to provide total care for every aspect of injury, from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research, and system planning.

Carilion Roanoke Memorial Hospital
Bellevue @ Jefferson Streets, Roanoke

Inova Fairfax Hospital
3300 Gallows Road, Falls Church

Sentara Norfolk General Hospital
600 Gresham Drive, Norfolk

UVA Medical Center
1224 West Main Street, Charlottesville

VCU Medical Center
12th & Marshall Streets, Richmond

Level II Trauma Centers

Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. The specialty requirements may be fulfilled by on-call staffs that are promptly available to the patient. Due to some limited resources, Level II centers may have to transfer more complex injuries to a Level I center. Level II centers should also take on responsibility for education and system leadership within their region.

Lynchburg General Hospital
1901 Tate Springs Road, Lynchburg

Mary Washington Hospital
1001 Sam Perry Boulevard, Fredericksburg

Riverside Regional Medical Center
500 J. Clyde Morris Boulevard, Newport News

Winchester Medical Center
1840 Amherst Street, Winchester

Level III Trauma Centers

Level III centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, emergency operations and also arrange for the transfer of the patient to a facility that can provide definitive trauma care. Level III centers should also take on responsibility for education and system leadership within their region.

Carilion New River Valley Medical Center
2900 Lamb Circle, Christiansburg

CJW Medical Center, Chippenham
7101 Jahnke Road, Richmond

Montgomery Regional Hospital
3700 South Main Street, Blacksburg

Sentara Virginia Beach General Hospital
1060 First Colonial Road, Virginia Beach

Southside Regional Medical Center
200 Medical Park Blvd, Petersburg

Minimum Surgical Specialties for Trauma Designation by Level of Designation

Table 6

Surgical Clinical Capabilities: (On call and promptly available)	**Level of Designation**		
	I	**II**	**III**
Trauma/General Surgery	**X**	**X**	**X**
Anesthesiology	**X**	**X**	**X**
Orthopedic Surgery	**X**	**X**	**X**
Thoracic Surgery	**X**	**X**	
Cardiac Surgery	**X**		
Pediatric Surgery	**X**		
Hand Surgery	**X**		
Microvascular/Replant Surgery	**X**		
Neurological Surgery	**X**	**X**	
Plastic Surgery	**X**	**X**	
Maxillofacial Surgery	**X**	**X**	
Ear, Nose & Throat Surgery	**X**	**X**	
Oral Surgery	**X**		
Ophthalmic Surgery	**X**	**X**	
Gynecological Surgery/Obstetrical Surgery	**X**	**X**	

Source: Virginia Statewide Trauma Center Designation Program Hospital Resource Manual (Health, 2006)

Minimum Medical Specialties for Trauma Designation by Level of Designation

Table 7

Medical Clinical Capabilities: (On call and promptly available)	**Level of Designation**		
	I	**II**	**III**
Cardiology	**X**	**X**	
Pulmonology	**X**		
Gastroenterology	**X**		
Hematology	**X**		
Infectious Disease	**X**		
Internal Medicine	**X**	**X**	**X**
Nephrology	**X**		
Pathology	**X**	**X**	**X**
Pediatrics	**X**		
Radiology	**X**	**X**	**X**
Interventional Radiology.	**X**		

Source: Virginia Statewide Trauma Center Designation Program Hospital Resource Manual (Health, 2006)

Trauma Triage Related Resources

Virginia Office of EMS Trauma Web page:
http://www.vdh.virginia.gov/OEMS/Trauma/index.htm

Centers for disease Control and Injury Prevention
CDC Field Triage Main page: http://www.cdc.gov/fieldtriage/
CDC National Trauma Triage Protocol Podcast:
http://www2a.cdc.gov/podcasts/player.asp?f=10649
CDC Field Triage PowerPoint:
http://search.msn.com/results.aspx?q=CDC+Trauma+triage&FORM=CBPW&first=1

American College of Surgeons – Committee on Trauma
http://www.facs.org/trauma/index.html

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