Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, May 18, 2012

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
May 18, 2012

MISSION STATEMENT:

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

I. Executive Management, Administration & Finance

a) Action Items before the State EMS Advisory for May 18, 2012

At the Executive Committee meeting of the State EMS Advisory Board held on Friday, April 27, 2012 a discussion between committee members and OEMS Executive Management resulted in a decision to list any motions that the Board will be asked to take action on be noted as the first item in the OEMS Quarterly Report to the State EMS Advisory Board. There are four action items the Board will be asked to vote on Friday, May 18, 2012:

- Action Item Number 1

The Training and Certification Committee, after reviewing all of the available options, proposes the following action item:

Certification candidates who have completed a Virginia approved initial certification Basic Life Support Training Program (FR/EMR and EMT-Basic/EMT) shall have their initial (first attempt) National Registry written certification examination fee paid from the portion of the EMS funds specifically earmarked in Code 46.2-694 (A.)(13.)(e.). A review of this process shall be conducted by the EMS Advisory Board every three (3) years or as warranted by changes in the Code of Virginia of Commonwealth of Virginia Budget pertaining to the funding of Emergency Medical Services.

Note: please refer to Section III, Division of Educational Development and Appendix B of this report.

- Action Item Number 2

The Training and Certification Committee recommends that the EMS Advisory Board support the policy for CE Web Casting.
Note: please refer to Section III, Division of Educational Development and Appendix C of this report.

- Action Item Number 3

The Medical Direction Committee moves that the EMS Advisory Board adopt the white paper titled "Roles and Responsibilities of Operational Medical Directors."
Note: please refer to Section III, Division of Educational Development and Appendix D of this report.

- Action Item Number 4

The Medical Direction Committee moves that the EMS Advisory Board adopt the white paper titled "Patient Non-Transport from Motor Vehicle Collisions."
Note: please refer to Section III, Division of Educational Development and Appendix E of this report.

b) Drug Shortages in Emergency Care

There continues to be discussions and meeting on the local, regional, state and federal levels involving all many stakeholder groups about the impact of drug shortages in emergency care. The purpose of these discussions and meetings are to obtain a better understanding of the magnitude and impact of shortages in drugs that are available for emergencies, the Federal efforts to reduce shortages, and to provide an opportunity for the emergency care community to discuss coping and mitigation strategies. There is also a continuing lack of medication availability for the regional medication boxes across the Commonwealth.

The Medical Direction Committee of the State EMS Advisory Board met on April 12, 2012. Dr. George Lindbeck, State EMS Medical Director provides the following summary of MDC's discussion drug shortages in emergency care:

> In many cases the medications involved in the shortages were surprising to the medical directors in that they were not expensive, newly introduced to practice, or infrequently used medications, but commonly used medications such as diazepam or morphine. In addition, a class of medications would be frequently be involved in the shortage, such as all injectable benzodiazepines or all injectable opiate pain medications, limiting options for substitutions. This would seem to be an area in which the FDA could provide some oversight, and if difficulties with an individual medication were encountered, e.g. midazolam, then there could be some compensation made by increasing the availability of diazepam or lorazepam for use.

Given that most EMS agencies participate in a drug kit exchange program with a local hospital, there have also been some concerns about the hospitals' needs for medication being out of "synch" with EMS needs – that hospitals have at times needed to conserve supplies of medication for in-hospital use and not have enough to stock EMS drug kits. At times hospitals have been able to change the form of the medication supplied in the drug kit, such as substituting a multi-dose vial for a unit dose formulation or changing the volume or concentration of the medication placed in the drug kit. In some cases, quickly implementing training for the new medication or formulation is challenging, and stocking the new formulation can increase the risk of dose calculation and administration errors. For example, many systems had moved to using ondansetron as an anti-emetic over promethazine, and had to quickly re-stock kits with promethazine and re-train providers on its use when ondansetron became unavailable.

Another common question was the use of out-of-date medications. Although conventional wisdom would seem to indicate that the use of a recently out-of-date medication would be preferable to not having any medication to use, medical directors are concerned about violation of BOP regulations as out-of-date medications are considered "adulterated" medications, and concerned about assuming liability for use of an out-of-date medication. Additional guidance from the FDA for extended use of medications involved in a shortage would be greatly appreciated. This may be an area in which state BOP's can be of assistance as well.

The National Association of State EMS Officials has developed an Issue Brief on the drug shortages and controlled substance regulation. Normally OEMS would place this information in the next section of the Quarterly Report titled "EMS on the National Level" however since this issue is affecting the entire nation and the Commonwealth of Virginia, this topic was moved to the Executive Management section to emphasize its importance. The NASEMSO Issue Brief is attached as **APPENDIX A.**

c) Enrolled Budget Bill

The Enrolled Budget Bill was delivered to the Governor on April 25, 2012. The governor said he was working quickly to finish his amendments to the recently passed state spending plan (Enrolled Budget Bill) and plans to send his amended version of the budget back to the General Assembly by May 4.

The following is included in the Enrolled Budget Bill for Emergency Medical Services:

	First Year FY 2013	Second Year FY 2014
Emergency Medical Services (40200)	$36,120,756	$36,120,756
Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	$28,648,150	$28,648,150
State Office of Emergency Medical Services (40204)	$7,472,606	$7,472,606
Fund Sources: Special	$17,847,721	$17,847,721
Dedicated Special Revenue	$17,867,452	$17,867,452
Federal Trust	$405,583	$405,583

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

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

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

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

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

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

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

R.1. Out of this appropriation, $500,000 the first year from the general fund shall be provided to fund two Poison Control Centers.

2. The State Health Commissioner shall report to the Chairmen of the Senate Finance and House Appropriations Committees by November 1, 2012 on the level of funding needed to support the operations and services of Poison Control Centers. The commissioner shall

assess the level of funding needed to provide statewide coverage of poison control services by two centers and the services that are required to be provided.

Transfers:

U. 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 the first year, and $9,055,000 the second year from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203).

BB. 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).

INTEREST EARNINGS

Notwithstanding any other provision of law, the State Comptroller shall not allocate interest earnings to the following agencies and funds in either the first year or the second year of the biennium. The estimated amount of interest earnings that shall remain in the general fund as a result of this provision is $11,389,754 the first year and $11,389,754 the second year of the biennium.

Department of Health 601 Trauma Center Fund 0902
Department of Health 601 Virginia Rescue Squads Assistance Fund 0910

§ 3-6.00 ADJUSTMENTS AND MODIFICATIONS TO FEES

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

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

§3-6.03 DRIVERS LICENSE REINSTATEMENT FEE
Notwithstanding §46.2-411 of the Code of Virginia, the drivers license reinstatement fee payable to the Trauma Center Fund shall be $100.

d) National EMS Memorial Service (NEMSMS) Announces 2012 Honorees

The National EMS Memorial Service has released the names of the 20 individuals from 13 states to be honored at the 2012 National EMS Memorial Service to be held Saturday, June 23 in Colorado Springs. The National EMS Memorial Service has, since 1992, been honoring America's EMS providers who have given their lives in the line of duty. The 20 individuals being honored this year join 581 others previously honored by the National EMS Memorial Service.

Each year, at a service held in Colorado Springs, 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 2012 National EMS Memorial Service will be conducted at the Pikes Peak Center in Colorado Springs. In addition to the presentations made during the Service, each honoree's name is engraved on a bronze oak leaf which is added to the "Tree of Life," the National EMS Memorial. Additional information on the National EMS Memorial Service is available from its web site at http://nemsms.org. 60% of the honorees were lost to on duty cardiac events. 20% were lost in medical aviation incidents, another 10% were MVA related, 5% rescue related, and 5% other. Our prayers go out to all honorees, crew members, families, and friends.

In related news, the National EMS Memorial Service also announced plans for the Fifteenth Annual National Moment of Silence, to be observed at 1930 hrs (MDT) on Saturday, June 23, 2012. This coincides with the National EMS Memorial Service to be conducted in Colorado Springs. The National Moment of Silence offers EMS providers and agencies around the nation the opportunity to join with those in attendance at the National EMS Memorial Service in honoring and remembering those members of our nation's Emergency Medical Services who have made the ultimate sacrifice and given their lives in the line of duty. The National EMS Memorial Service has prepared a "Suggested Script" which is available from the NEMSMS website at http://nemsms.org/silence.htm.

e) 2012 National EMS Memorial Bike Ride – EMS Week 2012

The National EMS Memorial Bike Ride (NEMSMBR) is gearing up for the 2012 Ride, with routes beginning in Boston, MA or Paintsville, KY on May 19, and both finishing in Alexandria, Virginia on May 25.

During the Ride, participants will travel through the states of Massachusetts, Kentucky, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Maryland, and Virginia.

“To see these parts of the United States on a bicycle is such a unique perspective” says Tim Perkins, NEMSMBR Public Information Officer. “It’s also great to interact with the providers and agencies along the route, not to mention the reason for the Ride: honoring over 30 individuals who have given the ultimate sacrifice providing EMS care.”

Additional rides are scheduled for Colorado in June and Louisiana in September. More information on the entire Bike Ride can be found at www.muddyangels.com. Contact: Tim Perkins, PIO, National EMS Memorial Bike Ride - pio@muddyangels.org

f) The Top 10 Innovators in EMS who Drove the EMS Practice Forward in 2011
(Reprint from the Journal for Emergency Medical Services -JEMS)

EMS has changed drastically over the years, with those changes driven by innovations from individuals looking to improve clinical or operational practice. No area has escaped their

creativity as they worked to bring EMS care to a higher level. As a result, the service now provides better care to more people in more ways than ever imagined. JEMS recently named the top 10 innovators in EMS who drove the EMS practice forward in 2011. Two of the ten are from Virginia:

- **Rider Alert Program – Rob Lawrence, Richmond, Virginia**

When Rob Lawrence, MCMI, initially started watching a motorcycle safety program develop and grow where he lived in the United Kingdom, he was intrigued. When he immigrated from the U.K. to Richmond, Va., in 2009, he brought his family, his worldly possessions, and this idea, which was started in Europe: that motorcycle riders and EMS could work together to help enhance motorcycle rider safety.

"I got in touch with a friend of mine who is the chairman of the United Kingdom Motorcycle Club and said, 'You've got a really good motorcycle safety program, could I borrow the concept?' From that point on we formed an international alliance supporting each other," says Lawrence, who is chief operating officer for the Richmond Ambulance Authority (RAA).

Birth of an Idea

It all started from that conversation, and now the Rider Alert program is growing into one of the most innovative and popular motorcycle safety alert programs in the country. In essence, motorcycle riders are issued a free card and decal. They fill out the card, listing their next of kin and any medical conditions. The cards are then placed inside their helmets. A free decal is also issued that alerts medical personnel or accident bystanders about the card inside the helmet and also states, "Do Not Remove Helmet." The decal is aimed to guide passersby or laypeople, who might try to force the helmet off while trying to help the rider in the event of an accident.

"It's a simple waterproof card that goes inside the helmet and contains key information about the rider," says Lawrence. "The decal alerts the medic that there is something in the helmet and warns a bystander not to meddle in helmet removal. That's how simple the concept is."

That simple concept has now swept six states and is spreading internationally. In the 11 months since its inception, Rider Alert has issued 125,000 free cards to motorcycle riders within Virginia, Maryland, West Virginia, North Carolina, New York and Arizona. It's also working with motorcycle clubs in Sweden and Australia to get the cards and decals approved in those countries. "The speed with which this has taken off has been phenomenal and life altering," says Lawrence.

When the program launched this past April, the chairman of the U.K. Motorcycle Club came to Virginia to help get the program off the ground. Because of the friendship between the European and Virginia motorcycle clubs, and because the program has been so unique and effective, Rider Alert was awarded the 2012 Prince Michael International Road Safety Award. "We've had international recognition, and we are very pleased with that," says Lawrence. Why the popularity? Lawrence suggests a number of reasons. "It's free to the rider, there is no requirement to register your decal, and there is no data held on you," he says. "The card is there

for when we need it to help the rider when they need us. The principles of that have been very well received."

The program is operated through what is now a Who's Who of corporate sponsors, including Bon Secours Richmond Health System, the American Automobile Association, GEICO, PHI Inc., and the public safety agencies of the Shenandoah Valley.

Going Viral

"We started off with Motorcycle Virginia, a not-for-profit organization, and then Bon Secours Virginia came on board and embraced the idea," says Lawrence. The hospital developed a website (www.rideralert.org), and issued a press release on the program. "We had almost overnight brand recognition," Lawrence says. "We started off with their sponsorship, and by day two, the program had gone viral on the Internet. The concept flew around the motorcycle community. The Virginia State Police and Virginia EMS are all supporters and distributors, as well as the motorcycle dealers in all the places we are operating."

Rider Alert also is using EMS to broadcast the details of the program internally, and periodically, e-mails are sent out to remind EMS personnel about the program.

"Now that we have brand recognition, we are going around to volunteer rescue squads," says Lawrence. "Not only will we give you a presentation on the card and how it works, but we will also give you a refresher in helmet removal." Rider Alert is trying to secure continuing education credits for these presentations.

"We want to continue to perpetuate the knowledge and understanding of getting the card out and removing the helmet effectively," Lawrence says. "Some volunteer rescue squads may not do this for months or years, so we want to increase the level of education that goes with it."

Lawrence hopes these volunteer rescue squads will not only be distributers of the cards and decals, but they will also use the presentations as a chance to go into communities to speak about rider safety while drawing attention to their own organizations. "That will help them raise their own awareness, as well," says Lawrence.

Costs for the program are low. Bon Secours picks up the marketing and website tabs, and the people running the organization give freely of their time. The sponsors pay for the cards and decals. "We are not making a profit," Lawrence says. "We are not trying to sell anything. We're just trying to promote motorcycle safety."

Increased Survival

Shortly after the program started in Virginia, a rider was thrown from her bike and knocked unconscious. Fortunately, she had a Rider Alert card in her helmet, which led to the saving of her life. In another case, a paramedic who arrived at the scene of a motorcycle accident might have begun treating the rider's trauma had they not seen the decal and retrieved the card instead. "The card identified that the rider had a medical condition, and the medic realized that the medical

condition had caused the accident," says Lawrence. The paramedic treated both the trauma and the medical condition, and the rider lived.

Rider Alert prefers that riders receive their cards and decals personally, as opposed to receiving them through friends or the mail. "We like people to individually hand the card out to the rider, and the reason for that is because it gives the rider a moment to think about their mortality," Lawrence says. "In that moment, they realize that the card is not a Kevlar-coated cloak of protection, but a piece of paper that may help them in an accident. It makes them think about their safety, the safety of their bike, their driving style, and the equipment they're wearing. It's an opportunity to talk about personal safety."

Feedback from the EMS community has been enthusiastic, to say the least. "We haven't had a bad word from the EMS or public safety community. We've had more positive feedback than I could have ever hoped for," says Lawrence. "The riders love it too because they realize it's something that will help us help them." In fact, the way Lawrence looks at it, the real owner of the card is EMS. And one day, if they need to, EMS will get the card back from the rider.

You'd think someone this passionate about motorcycle safety would be an avid motorcycle enthusiast and rider himself. But Lawrence is not. "I am not a motorcyclist; I've never ridden a motorbike," he says. "I lost a brother to a motorcycle accident decades ago, and the shock has never left the family."

The news of his brother's death arrived via a police knock on the family's door. "What I wouldn't want to wish on anyone is that knock on the door, and if I can reduce just one extra knock on the door, and then it's all worth doing," he says.

Sometimes, Lawrence is asked why a program like this hasn't been developed before now. His answer is straightforward: "It's probably because it's such a simple concept, and that makes it so popular," he says. "It's something everybody gets and everybody wants, so it makes our job a lot easier."

Lawrence is passionate about this program, although he worries about distracted drivers who don't pay attention around motorcycle riders. He worries about more and more drivers talking on cell phones, texting while driving and being less attentive overall. If this program can help those motorcycle riders stay safe, then he believes the program is doing its job.

"I have seen the carnage caused by motorcycle accidents, and doing something is better than doing nothing," he says. "This program has helped us to help many people. In 11 months, we have already seen that."

If Lawrence has his way, every motorcyclist in the world will carry a safety card inside their helmet; have a decal firmly affixed outside the helmet, and travel with his blessing for a safe journey.

- **Active Shooter Program - E. Reed Smith, MD, FACEP, Arlington County, Virginia**

No one in the nation will ever forget April 20, 1999, as the day that two students from Columbine (Colo.) High School opened fire and killed 12 fellow students and one teacher and injured more than two dozen others.

More than 10 years later, it's still a day that sticks in the mind of E. Reed Smith, MD, FACEP, the operational medical director for the Arlington County (Va.) Fire Department and an assistant professor of emergency medicine for George Washington University. Unfortunately, there have been many days, like Columbine, where active shooters position themselves on campuses or office buildings, with too many lives lost. Despite quick response by law enforcement and EMS in some of these situations, Smith thinks the response could be quicker and more effective. "We did an active shooter's drill here in Arlington County, with 20 or 30 students acting as victims," he says. "We staged, and two or three hours later, we were still staged and waiting. They had the shooters sequestered in the library, and the SWAT team was in negotiations, and we are still not in the building." Smith knew something had to change.

A Call for Change

Smith sat down with the Arlington County Fire Department Special Operations Battalion Chief Carl Lindgren, and they discussed developing better ways for EMS to respond more effectively in active shooter situations, while still protecting first responders. What they ultimately developed was the Rescue Task Force, one of the first active shooter response programs in the nation. The Task Force was based on the military's tactical combat casualty care (TCCC) guidelines and the military doctrine of combat medicine. The Rescue Task Force is so named to comply with National Incident Management System guidelines. "We are putting police and fire, which are two different entities with different resources, together toward a common goal of saving lives," says Smith. "That's where the name comes from."

Initially, basing the program on TCCC seemed to Smith to be the way to go. "TCCC is a phenomenal doctrine that has saved so many lives," he says. But then, he began to realize that the military basis of the doctrine didn't quite match up with the civilian situations that fire and rescue departments were encountering. "It's written for a military environment, with military participants, equipment and resources," he says. "It's not written for civilians, and it doesn't take into account the nuances of the civilian environment. I needed something written for the civilian environment, with civilian equipment and resources."

Translating the Doctrine

Although TCCC is based on solid battlefield medical procedures, it doesn't take into account the different scopes of practice between agencies, whether down the block or across the nation. It doesn't take into account the differing kinds of equipment EMS agencies may deploy. "And it doesn't take into account that I may be treating 5-year-olds and 65-year-olds," Smith says. "The bullets are the same; the weapons, the explosives, and a lot of the tactics are the same. But there are significant differences." So he and Geoff Shapiro, a colleague at George Washington University, sat down to begin the process of translating and redrafting TCCC into a civilian

format that EMS, fire and law enforcement agencies around the nation could use in all high-risk medical scenarios. They coined the term tactical emergency casualty care (TECC) and established a not-for-profit committee of nationwide experts to develop the civilian guidelines.

The goal of Rescue Task Force is aggressive forward deployment of medical assets into a non-secure scene. If someone is standing in a hallway shooting at people, EMS will not be deployed. But, after the police complete a primary sweep, when there is decreased risk with the scene not completely secure, the Rescue Task Force will be deployed.

“It takes four hours to secure an area, and we’re not going to wait that long,” says Smith. “It takes 10 minutes to do a primary sweep to make it safe, but not secure, and then we’re going to go to work. We use tactics and equipment to mitigate the threat.”

Creating a Plan

The first two arriving Arlington Fire paramedics now team up with two police officers. Once the initial police contact teams complete their sweep, the paramedics proceed. Wearing ballistic gear and carrying simple medical supplies, the Rescue Task Force group works rapidly in this “warm zone” to stabilize the wounded and evacuate to care.

“Before Columbine, police officers would show up to the scene of the shooting, surround the building, and secure the perimeter, so the bad guy couldn’t get out. Then they would wait for SWAT to show up. That was the old paradigm,” says Smith. “Now, across the country almost every patrol officer is trained that if there is an active shooter, the first three or four officers that show up immediately go after the bad guy. We wanted to deploy a similar paradigm for fire/EMS. The first few arriving EMS units can team up with police and move into the building to start rendering care without delay.”

Smith admits the selling of the idea initially encountered some pushback. But he was able to convince others that the idea was sound because the Task Force combination of police and fire working behind the initial contact teams allowed for the mitigation of risk, while saving lives. “You mitigate risk with tactics, good training, and good command,” he says. “It’s training, tactics, and equipment.”

Being on the Rescue Task Force also requires a different mindset. In a high-risk environment, first responders need to do things that are absolutely medically necessary, not things that are nice to do, says Smith. “In standard EMS, we do the things that need to be done, but we also do a lot of things that are nice to do. What we had to do in that high-risk situation in that hallway in a high school was define, ‘What needs to be done?’ Because every second you stay there you’re at risk. We based those medical recommendations on the tactical emergency casualty care guidelines.”

Going International

Smith's idea has been spreading. In this past year, the program has pushed into the regional level, with several agencies in the national capital region adopting the concept. The idea has gone international, as well. The London Fire Brigade met with Smith this past year.

They have taken some of the concepts and guidelines back with them and are now using them to form their own active shooter medical care and evacuation procedures. Which leads to a point that Smith wants to emphasize: Rescue Task Force is about concepts and guidelines that are flexible and adaptable to different agency and jurisdiction needs. "You can do this," he says. "You just don't have to do it the way I'm doing it. This works for my county. Bigger counties and bigger agencies need to figure it out."

The City of Fairfax Fire Department did just that. "They took the Rescue Task Force idea and made it appropriate for their system," Smith says. "The point is, the Rescue Task Force doesn't have to look in my agency the way it looks in your agency, as long as the goals are the same, which is to quickly get medicine at the point of wounding. If you want to send in 20 police officers with one medic, I'm fine with that, as long as we're getting medicine into that warm zone, which is key."

Smith says the idea of Rescue Task Force has been well accepted, although he admits getting the idea across has been a challenge at times. He doesn't seem to mind breaking down the "we've always done it this way" mindset, however, equating the process to how people used to think the Earth was flat.

"For a long time, we thought the world was flat," he says. "When we were presented with evidence that it was otherwise, it took time for people to change their view. Now, everyone knows the world is round. Just because we've always been doing something one way doesn't mean it's right."

Taking Risks

Smith feels the rescue paradigm in fire and EMS needs to change. He agrees that first responders need to be kept safe, but he also believes the job requires acceptance of risk. "We have to accept risk, but it has to be mitigated risk. It comes down to understanding risk and how you mitigate that risk, not being afraid to change the paradigm."

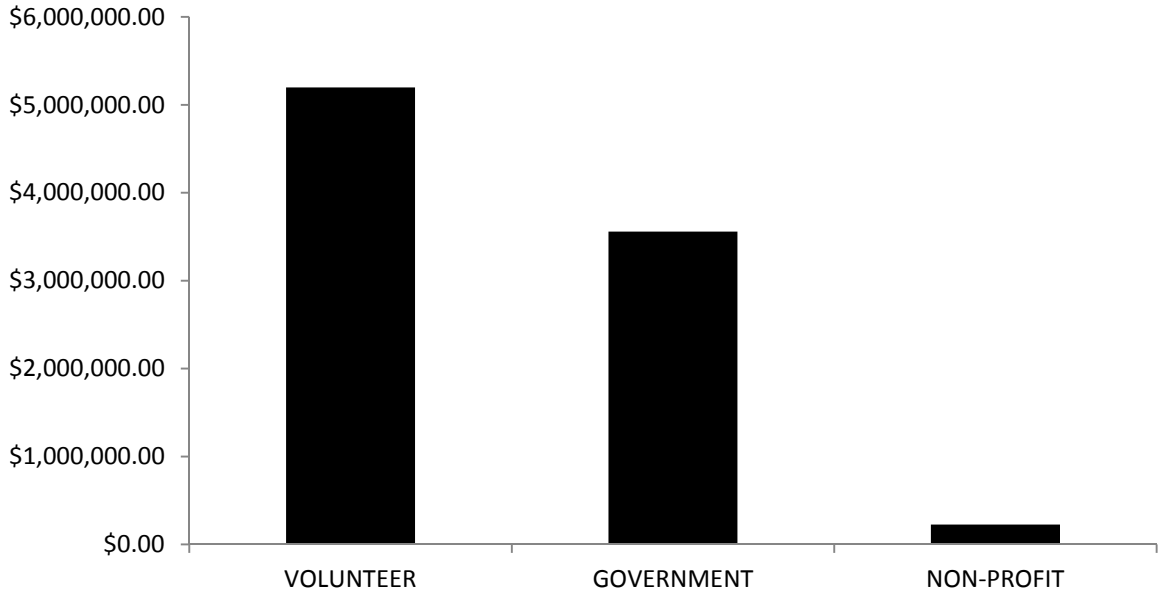
Smith is passionate about Rescue Task Force because he has children of his own and because he thinks it's a simple idea with huge ramifications. "I think this is a way we can make the world better," he says. "If we train thousands of hours and save just one child, then we've done good."

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

The RSAF grant deadline for the Spring 2012 cycle was March 15, 2012, OEMS received 135 grant applications requesting $8,983,448.00 in funding. Funding amounts are being requested in the following agency categories:

- 79 Volunteer Agencies requesting $5,197,735.00
- 44 Government Agencies requesting $3,558,768.00
- 12 Non-Profit Agencies requesting $226,945.00

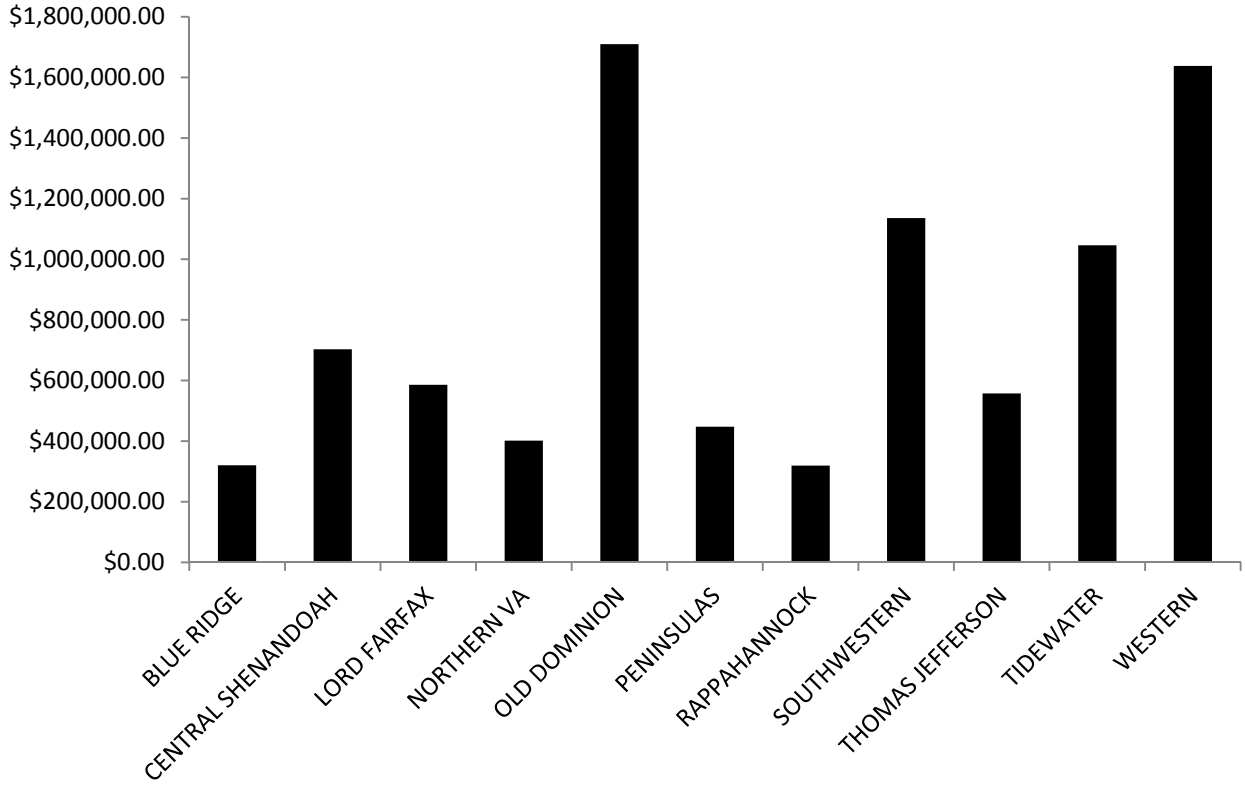
Figure 1: Agency Category by Amount Requested



Funding amounts are being requested in the following regional areas:

- Blue Ridge – 4 agencies requesting funding of $320,081.00
- Central Shenandoah – 11 agencies requesting funding of $703,086.00
- Lord Fairfax – 8 agencies requesting funding of $585,709.00
- Northern Virginia – 6 agencies requesting funding of $401,666.00
- Old Dominion – 26 agencies requesting funding of $1,709,882.00
- Peninsulas – 9 agencies requesting funding of $447,764.00
- Rappahannock – 6 agencies requesting funding of $319,217.00
- Southwestern Virginia – 15 agencies requesting funding of $1,135,820.00
- Thomas Jefferson – 5 agencies requesting funding of $557,238.00
- Tidewater – 17 agencies requesting funding of $1,046,423.00
- Western Virginia – 26 agencies requesting funding of $1,638,010.00
- Non-Affiliated Agencies – 2 agencies requesting funding of $118,552.00

Figure 2: Regional Area by Amount Requested

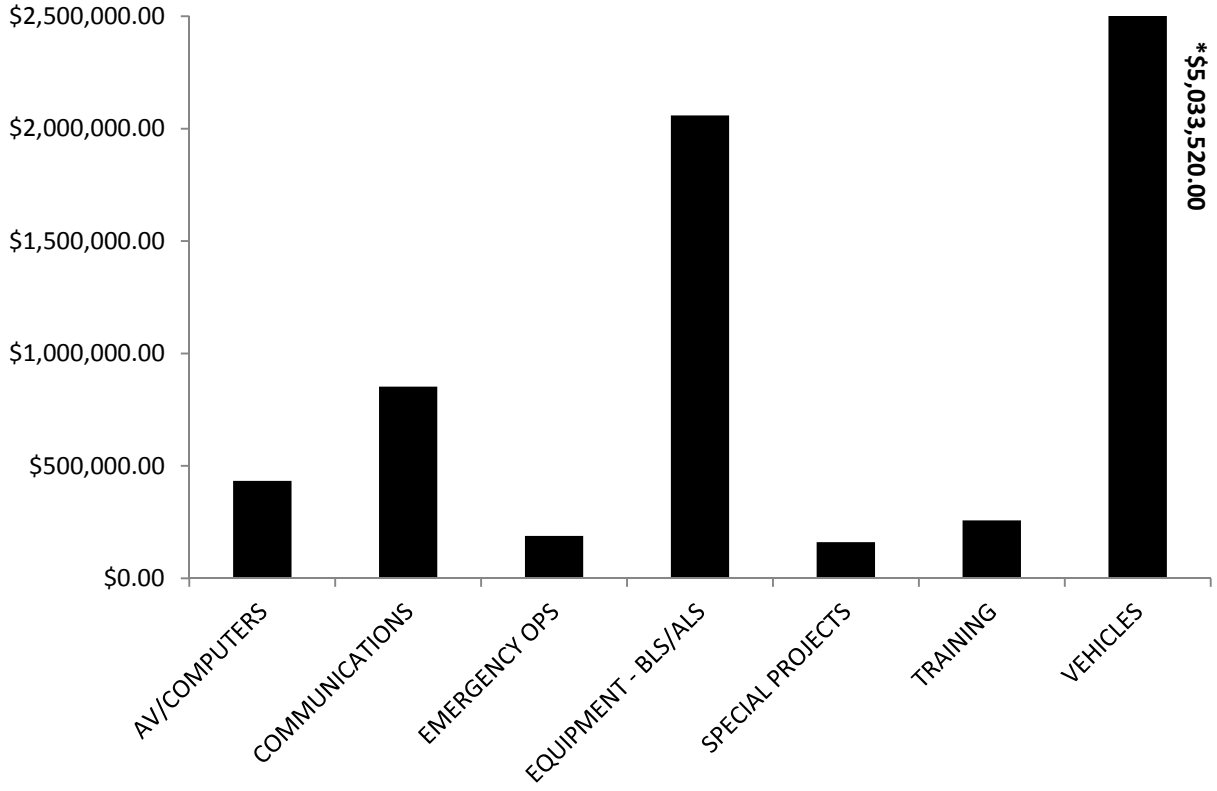


Funding amounts are being requested for the following items:

- Audio Visual and Computers - $ 432,824.00
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.
- Communications - $ 852,290.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.
- Emergency Operations - $ 188,640.00
  - Includes items such as Mass Casualty Incident (MCI) All Terrain Vehicle (ATV), extrication equipment and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.
- Equipment - Basic and Advanced Life Support Equipment - $ 2,058,453.00
  - Includes any medical care equipment for sustaining life, including defibrillation, airway management, and supplies.
- Special Projects - $ 160,665.00
  - Includes projects such as Recruitment and Retention, Special Events Material, regional drug box projects, Emergency Medical Dispatch (EMD) and other innovative programs.

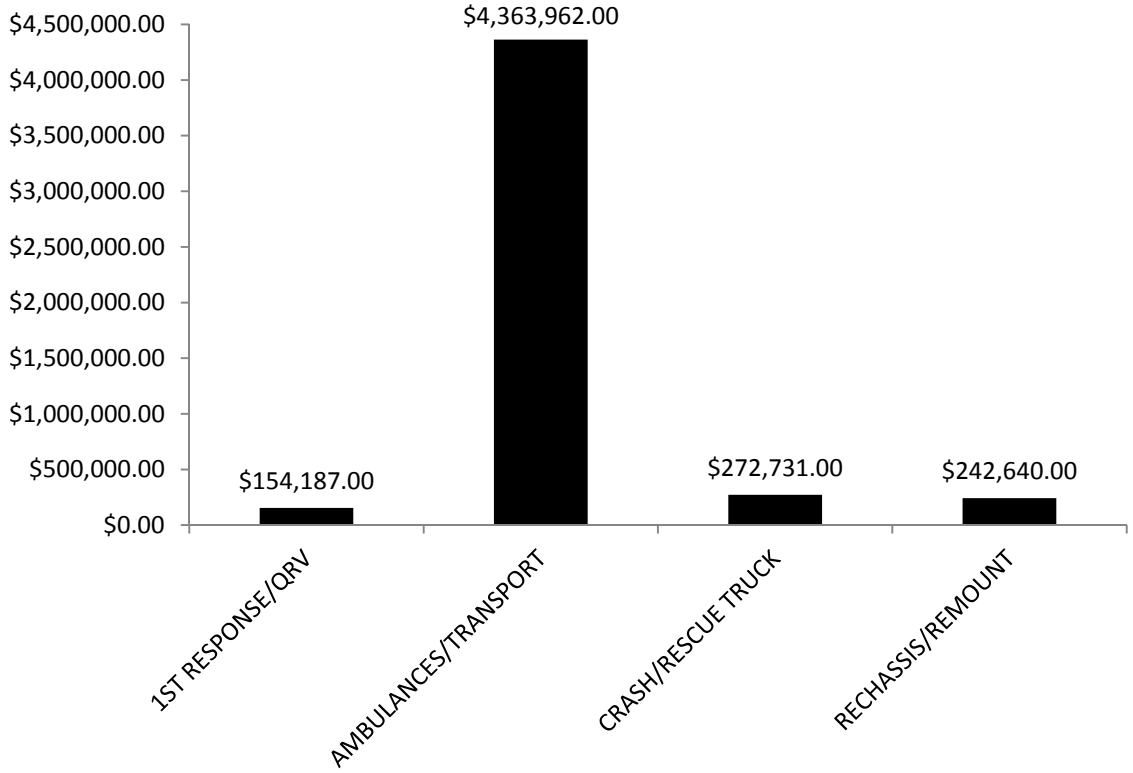
- Training - $ 257,055.00
    - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.
- Vehicles - $ 5,033,520.00
    - Includes ambulances, 1st Response/Quick Response Vehicles (QRV) and rechassis/remount of ambulances.

Figure 3: Item Requested by Amount Requested



*NOTE: The VEHICLES category request amount was $5,033,520.00, the graph only represents items requested up to $2,500,000.00 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 2012 grant cycle will be awarded on July 1, 2012. The next RSAF Grant cycle will open August 1, 2012 and close September 17, 2012.

h) Other Grant Programs

- OEMS – Advanced Life Support (ALS) Training Equipment Special Initiative Grant

OEMS announced a 100% funding level grant opportunity on March 15, 2012 to 28 eligible ALS Training Programs throughout the Commonwealth. The application deadline was April 16, 2012; OEMS received applications from 25 organizations requesting funding in the amount of $2,629,267.00 for ALS training equipment. Each grant applicant selected one out of five available ALS training packages available on the state procurement website (eVA.virginia.gov) ranging in pricing from $102,809.00 to $107,684.00. OEMS awarded 25 grants on April 19, 2012 for funding in the amount of $2,629,267.00 with all organizations required to submit a Purchase Order (PO) for the equipment and the Memorandum of Agreement (MOA) at the end of the grant cycle on May 15, 2012.

- Department of Homeland Security (DHS), State Homeland Security Grant Program (SHSGP)

OEMS did not receive funding for the 2011 DHS Grant Application that was submitted for the Virginia Emergency Medical Services Interoperable Communications (VEMSIC) Project. The 2012 State Homeland Security stakeholders meeting will take place on May 7 at Chesterfield

Fire and EMS. This meeting will outline the 2012 SHSGP application process and discuss the grant guidance for DHS and VDEM.

i) 26% Return to Localities Fund for EMS

$7,147,068 will be distributed to localities during this last quarter of Fiscal Year 2012. On March 21, 2012 a letter was sent to the County Administrator/City Manager informing them of the Fiscal Year 2012 funding. Funds cannot be transferred until they submit the Report of Expenditures for the previous fiscal year funds. That report summarizes the use of funds and distribution by EMS agency.

The purpose of these funds is to provide funding for:

- Training of volunteer or salaried emergency medical service (EMS) personnel of licensed, nonprofit emergency medical services agencies, and
- Purchase of necessary equipment and supplies for use in such locality by licensed, non-profit emergency medical and rescue services.

To learn more about this funding, please go to the OEMS website:

http://www.vdh.virginia.gov/OEMS/Agency/FundingEquipment.htm

EMS on the National Scene

II. EMS On the National Scene

a) USFA, Office of Health Affairs Release EMS Medical Directors Handbook

The Department of Homeland Security's U.S. Fire Administration (USFA), in partnership with the DHS Office of Health Affairs (OHA), has released a handbook for physician medical directors of local departments and agencies who are involved in Emergency Medical Services (EMS) response. The Handbook for EMS Medical Directors (PDF, 2.5 Mb) covers topics ranging from occupational health and safety to liability issues. Go to: http://www.usfa.fema.gov/downloads/pdf/publications/handbook_for_ems_medical_directors.pdf.

"This handbook provides an overview of key roles and responsibilities to assist current and prospective medical directors in performing their important missions," said U.S. Fire Administrator Ernest Mitchell.

The Handbook for EMS Medical Directors was developed by the International Association of Fire Chiefs (IAFC) as part of a cooperative agreement with the DHS OHA and USFA. Many national level EMS and fire organizations also contributed to the handbook's development.

"EMS medical directors are an essential component in local-level emergency response," said Dr. Alexander G. Garza, DHS Assistant Secretary for Health Affairs and Chief Medical Officer. "Their critical oversight and medical direction ensure that patients receive effective emergency medical care – a vital part of this nation's homeland security."

In addition to providing medical oversight and direction, EMS medical directors support EMS personnel and other first responders through training, protocol development, and resource deployment advice.

"The IAFC and its EMS Section were pleased to work in partnership with the USFA and DHS OHA on this project to support medical directors who are crucial to the effective delivery of EMS throughout this country," said IAFC President and Chief Al H. Gillespie.

Further information on USFA's EMS research initiatives may be found on the USFA website. Go to: http://www.usfa.fema.gov/fireservice/research/ems/index.shtm.

b) NASEMSO Releases "Rural Highway Mass Casualty Guidelines"

NASEMSO completed its project commitment to NHTSA's Office of Emergency Medical Services and the recommendations of the National Transportation Safety Board related to rural highway mass casualty readiness. The capstone document, "Rural Highway Mass Casualty Guidelines: Resources for State and Local Officials," was presented to and accepted by the Federal Interagency Committee on Emergency Medical Services. It is hoped that this document will be an asset in efforts to improve response in rural areas of state EMS systems and to further

collaboration with state offices of highway safety and state traffic safety engineering staff. View the document at: http://www.nasemso.org/documents/RuralHighwayMassCasualtyReadinessGuidelinesforStateEMSOfficialsFINAL.pdf.

c) Survey Says: NASEMSO I-Team Reports to NEMSAC

The results of NASEMSO's annual Education Agenda Implementation Survey were reported to the National EMS Advisory Council (NEMSAC) on March 28, 2012. Data collected in 2011 shows that the majority of states are actively engaged in implementing the *EMS Education Agenda of the Future: A Systems Approach*. 74% of states report that they will require national EMS program accreditation by December 31, 2012 while another 7% expect to have the requirement in place within 5 years. Since data collection began in 2007:

- Roughly 20% increase in states using SOP levels as a foundation at EMT and paramedic levels
- 18%- 22% increase in states planning to implement EMR and AEMT levels
- To date, NO state has indicated they will NOT implement National Models for EMT or Paramedic

No plan to implement level in state:

- EMR – 23%
- AEMT– 11%

At the moment 75% of the states indicate they will utilize the National Registry of EMT (NREMT) or a combination of the NREMT with state-specific components in the state licensure process at the EMT, AEMT, and paramedic levels in the future. This percent is expected to increase as National Registry has been unanimously approved by NASEMSO as the official organization for national EMS testing. The complete report can be downloaded from the NASEMSO web site at: http://www.nasemso.org/EMSEducationImplementationPlanning/Toolkit.asp.

d) FAA Reauthorization Overview

In early February, Congress enacted a Four-year Reauthorization of the Federal Aviation Administration (FAA). This is the first long-term authorization for the FAA since September 2007. Besides providing a framework for funding and program development at the FAA for the next several years, the legislation also included a number of provisions to require the FAA to move forward on helicopter EMS (HEMS)-specific safety regulations.

MedEvac professionals spent March 14, 2012 day in uniform on Capitol Hill to develop and strengthen ties with their Congressional representatives. Every day in Washington, law makers and federal administrators can potentially make decisions that have profound effects on patient care, flight regulations, hospital and EMS administration, funding and reimbursement.

This year, special legislative focus is being focused on the sustainability of Medicare for medevac providers. The Association of Air Medical Services (AAMS) is working to develop a legislative proposal to address Medicare sustainability in light of rapidly increasing costs. The current Medicare Fee Schedule rates were never based on costs. Since the passage of the Balanced Budget Act of 1997, the air ambulance fee schedule has only increased an average of 2% per year, while costs for providing services have increased at a substantially higher rate, due to aviation safety enhancements, and the rapidly escalating costs for such things as jet fuel, aircraft, aircraft parts, and insurance.

Emphasis will also be placed on the fact that the healthcare community is facing a serious and dangerous shortage of a number of medicinal drugs. These shortages are not only affecting hospitals, but have also trickled down to EMS providers, including air and critical care ground ambulance services. As a result, AAMS supports H.R. 2245 and S. 296, companion bills that seek to improve advance notices of potential shortages and better communication with the healthcare community.

e) D-Block Allocation to Public Safety is 'Done'

Allocation of the D-Block of 700 MHz spectrum for the purposes of building a nationwide, interoperable emergency communications network is all but sealed. Congress has agreed to allocate the D-Block to public safety and support the development of a mission-critical, nationwide public safety broadband network. The provisions are included in the conference report to the Middle Class Tax Relief and Job Creation Act of 2012 (H.R. 3630). A summary of the provisions included in Title IV of the conference report includes:

The D Block will be allocated to public safety. Governance of the network by a new First Responder Network Authority will be within the National Telecommunications and Information Administration of the Department of Commerce. Incentive auctions will provide $7 billion for construction of the network. In approximately 11 years, public safety organizations will be required to give back spectrum currently in use in the T Band. The agreement includes provisions to pay for their relocation to the 700 MHz band.

f) Directory Provides Links to Needed Public Safety Broadband Information

The long-awaited nationwide public safety broadband network is moving closer to reality with the passage of legislation giving public safety both the spectrum and funding needed to build the network. The Public Safety Broadband Directory has links to a wide range of current information on the nationwide efforts to bring broadband to public safety. The directory categorizes all resource links both by activities in broadband and, by the organizations integrally involved in the nationwide public safety broadband network. Go to:
http://www.npstc.org/broadbandDirectory.jsp.

g) IOM Report Provides Framework and Tools to Deliver Health Care Effectively During Catastrophic Disasters

While most areas of the country have systems in place to handle conventional disasters, such as a plane crash or building collapse, the infrastructure and systems to deliver health care during or following catastrophic situations, such as a widespread disease outbreak or a devastating earthquake, are rudimentary at best, says a new report from the Institute of Medicine. The report provides a resource manual to guide health care organizations, public health agencies, first responder teams, and government agencies in delivering care as effectively as possible to the greatest number of people when such disasters occur. Go to: http://iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response/Press-Release-MR.aspx.

h) EMS Near Miss and Line of Duty Death Online Reporting Tools Launched

NAEMT has been working with the Center for Leadership, Innovation and Research (CLIR) in EMS on the development of an anonymous system for EMS practitioners to report near-miss and line of duty death incidents by answering a series of questions in an online format. The purpose of the system is to collect and aggregate data that will then be analyzed and used in the development of EMS policies and procedures, and for use in training, educating and preventing similar events from occurring in the future. No individual responses will be shared or transmitted to other parties. The Near Miss and Line of Duty Death Online Reporting Tools were launched in March and is live at www.emseventreport.org. These tools, along with an already existing tool to report patient safety events, form the EMS Voluntary Event Notification Tool (E.V.E.N.T).

i) Study of Best Practices for Emergency Vehicle Visibility Initiated

The U.S. Department of Homeland Security's U.S. Fire Administration (USFA), supported by the U.S. Department of Justice National Institute of Justice (NIJ), and in partnership with the Cumberland Valley Volunteer Firemen's Association's (CVVFA) Emergency Responder Safety Institute, has initiated a study of emergency vehicle markings, lighting, and design to recommend best practices for increased visibility to approaching motorists. The goal of this study is to develop best practices in the application of various chevron patterns, creative use of reflective decal markings, new arrangements of warning lights and other innovative designs, all with the intent of increasing the visibility of the emergency vehicles to motorists approaching them. The study will focus on emergency vehicles not covered by existing standards in this area. Further information on USFA's emergency vehicle and roadway safety research initiatives may be found at: http://www.usfa.fema.gov/fireservice/research/safety/vehicle-roadway.shtm.

j) USFA, Federal Highway Administration Complete Study of Traffic Incident Management Systems

Updated *Traffic Incident Management Systems* manual contains technical information and training programs for fire and emergency service providers. The U.S. Fire Administration (USFA) and the U.S. Department of Transportation's (DOT) Federal Highway Administration,

working in partnership with the International Fire Service Training Association (IFSTA) have, through a study of current traffic incident management practices and policies, updated the 2008 edition of the Traffic Incident Management Systems (TIMS) manual. The 2012 edition provides the most current technical information and training programs in traffic incident management for fire and emergency service providers in this area as well as guidance to local fire departments on compliance with the latest edition of the DOT Manual of Uniform Traffic Control Devices (MUTCD). For further information about this study and other roadway safety projects go to: http://www.usfa.fema.gov/fireservice/research/safety/roadway.shtm.

k) May is National Trauma Awareness Month; Campaign is "Decide to Drive: Arrive Alive! "

The American Trauma Society, in collaboration with the Society of Trauma Nurses and the Emergency Medical Services for Children, every year convene a committee to develop materials for National Trauma Awareness Month. Committee members research current trends in traumatic injury, and based on this the committee selects one cause of major injuries to focus on during National Trauma Awareness Month. This year we are again focusing on the growing problem of distracted driving. We urge communities across the United States to focus on this problem in May 2012 and throughout the year. The National Trauma Awareness 2012 campaign materials created and selected by ATS, EMSC and STN. They include, but are not limited to, fact sheets, pamphlets, videos, and games directed at educating the public on distracted drivers and persons or things that will distract the driver. Go to: http://www.amtrauma.org/injury-prevention-programs/trauma-awareness-month-2012/index.aspx.

l) CDC announces launch of new Apps for 2011 Field Triage Guidelines

A new CDC smartphone application, available at no cost, is now available for EMS professionals. The goal of the app is to increase knowledge and awareness of 2011 Guidelines for the Field Triage of the Injured Patients. EMS professionals can use this app to test their knowledge and learn more about transport decisions for injured patients. Download it free from the Apple App Store. To learn more about the 2011 Guidelines for the Field Triage of the Injured Patients, visit www.cdc.gov/Fieldtriage.

m) MedPAC to Conduct a Study of the Medicare Ambulance Fee Schedule

The Medicare Payment Advisory Commission (MedPAC), an advisory agency to the U.S. Congress, has been tasked by the Congress to conduct a study of the Medicare ambulance fee schedule. The Middle Class Tax Relief and Job Creation Act of 2012 requires MedPAC to evaluate the Medicare ambulance payment system. Specifically, MedPAC's mandate is to assess the appropriateness of certain ambulance add-on payments, to determine their effect on providers' margins, and determine if there is a need to reform the Medicare ambulance fee schedule. The report is due June 15, 2013 but may be published earlier. Policy analyst staff of MedPAC made a preliminary presentation at the April 5, 2012 MedPAC meeting. The PowerPoint is available and it contains very interesting statistics based on a retrospective review of Medicare claims data:
http://medpac.gov/transcripts/Ambulance_presentation_April2012%20Final.pdf

A complete transcript of the presentation associated with the slides can be viewed at: http://www.medpac.gov/transcripts/0412%20MedPAC.pdf. (control-F and enter the word ambulance to jump to that portion of the meeting).

n) PSHSB Seeks Comment on Requests for Waiver

The Public Safety and Homeland Security Bureau (PSHSB) seeks comment on several requests for waiver of the Commission's January 1, 2013 VHF-UHF narrowbanding deadline, codified at 47 C.F.R § 90.209(b), which requires private land mobile radio licensees in the 150-174 MHz and 450-512 MHz bands to operate using channel bandwidth of no more than 12.5 kHz or equivalent efficiency by January 1, 2013. The listing for Virginia includes: Pittsylvania County, VA Date Filed: 12/12/2011. Requested Waiver Date: 8/30/2013

o) USDA Provides Interagency Helicopter Extraction Source List

The US Department of Agriculture (USDA) Forest Service has recently updated its "Interagency Emergency Helicopter Extraction Source List – 2012". The intent of this source list is to provide Incident Management Teams, Geographic Area Coordination Centers, and Forests access to the availability of helicopter resources on a state, geographical and national basis to conduct human extractions (hoist/short-haul) for emergency evacuations. Both insertion/extraction techniques are used to precisely place emergency response personnel and remove critically injured victims from normally inaccessible terrain or locations. The goal is to provide emergency response to the seriously injured and to respond as quickly as possible to life threatening situations occurring on agency and interagency incidents. Emergency helicopter extraction resources identified in this document have been compiled from federal, state, municipal governments, military, and Emergency Medical Response (EMS) programs throughout the country. Many factors may determine the availability and response time of requested resources. This updated 2012 publication provides a thorough listing of helicopter resources available to conduct human extractions for emergency evacuations throughout the United States. Go to:

p) SAMSHA Provides New Disaster Preparedness and Recovery Resource

The Substance Abuse and Mental Health Services Administration (SAMHSA) has published a new resource that lists disaster preparedness and recovery resources for range of professionals who assist individuals and communities in coping with disaster. Topics include emergency preparedness, training, disaster response, stress prevention and management, and suicide prevention. To download a copy, go to: http://store.samhsa.gov/product/Disaster-Behavioral-Health-Preparedness-and-Response-Resources/DTAC11-CATALOG?WT.ac=EB_20120202_DTAC11-CATALOG.

q) Draft 2 EMS Culture of Safety Draft Available for Comment

A three-year cooperative agreement between the National Highway Traffic Safety Administration (NHTSA), with support from the Health Resources and Services Administration's (HRSA) EMS for Children (EMSC) Program, and the American College of

Emergency Physicians (ACEP) has brought together representatives from national EMS and fire organizations to develop a national EMS "Culture of Safety" Strategy. Draft 2 of the document is now available for review: http://www.emscultureofsafety.org/

r) CDC Revises Field Triage Guidelines

CDC has released the Morbidity and Mortality Weekly Report: Recommendations and Reports on the 2011 Guidelines (2011 Guidelines) for Field Triage of Injured Patients. The 2011 Guidelines are an update of the guidance recommended in the 2006 Guidelines for Field Triage of Injured Patients. The new version provides changes to the decision scheme for EMS providers who care for and transport patients injured from motor vehicle crashes, falls, penetrating injuries, and other injury mechanisms each day in our nation's communities. Go to: http://www.nasemso.org/documents/RR6101FieldTriageebook.pdf.

s) NHTSA Concludes Defect Investigation on Chevy Volts

The National Highway Traffic Safety Administration (NHTSA) closed its safety defect investigation into the potential risk of fire in Chevy Volts that have been involved in a serious crash. Opened on November 25, 2011, the agency's investigation has concluded that no discernible defect trend exists and that the vehicle modifications recently developed by General Motors reduce the potential for battery intrusion resulting from side impacts. NHTSA remains unaware of any real-world crashes that have resulted in a battery-related fire involving the Chevy Volt or any other electric vehicle.

NHTSA continues to believe that electric vehicles show great promise as a safe and fuel-efficient option for American drivers. However, as the reports released in conjunction with the closure of the investigation indicate, fires following NHTSA crash tests of the vehicle and its battery components — and the innovative nature of this emerging technology — led the agency to take the unusual step of opening a safety defect investigation in the absence of data from real-world incidents. Based on the available data, NHTSA does not believe that Chevy Volts or other electric vehicles pose a greater risk of fire than gasoline-powered vehicles. For more information go to: http://www.nhtsa.gov/About+NHTSA/Press+Releases/2012/NHTSA+Statement+on+Conclusion+of+Chevy+Volt+Investigation.

t) NAEMT Advocacy Service Available to EMS Community

The National Association of EMTs has recently revised its web site to make it easier for NAEMT members to access services and information. However, any individual can use the NAEMT web site to access their EMS advocacy service powered by CapWiz. The site is designed to help you advocate for the passage of current federal legislation in support of EMS and EMS practitioners. There are many great features on this site, and we encourage you to familiarize yourselves with the following tools and resources:

- Find your elected representatives and the leaders of federal agencies that impact EMS in our country.

- View pending EMS-related legislation in Congress and look up how your Congressmen voted on the issues. The site includes voting records back to 1996.
- See who is running for office in your area. Check out recent polling information on the candidates.
- Register to vote in your state directly from this site.
- Search for media organizations and journalists in your area. Just go to www.naemt.org and look under the Advocacy tab to "contact Congress."

u) NFPA Standards Council Agrees to Immediate 1917 Revision Following Implementation

NASEMSO has learned that the NFPA Standards Council has approved the Committee's proposal to put the NFPA 1917 standard back into revision cycle immediately after the new standard becomes effective in January, 2013. The Report on Comments (ROC) was published in February, 2012, after which the public can only propose further changes through submission of a Notice of Intent to Make a Motion (NITMAM) to the NFPA Standards Council. NITAM's deadline for submissions was April 6, 2012. Any submissions will be considered at the NFPA General Membership Meeting in June, 2012. If no NITMAM is submitted, the current document would be submitted for NFPA approval as a "consent document." In its current cycle, the initial NFPA 1917 document will be effective on January 1, 2013. If the document is placed back in cycle immediately thereafter, the next version of the standard would be expected to become effective in January, 2015.

v) NREMT Launches National Certification EMR and EMT Exams

On January 1, the NREMT launched National EMS Certification examinations for the EMR and EMT levels. These examinations reflect content outlined in the National EMS Education Standards and National Scope of Practice model. Candidates who successfully pass their EMR and EMT certification examinations do not need to complete transitions previously outlined by the NREMT. The proper post nominal notations for the Scope of Practice Model provider levels are:

- NREMR - Emergency Medical Responder
- NREMT - Emergency Medical Technician
- NRAEMT - Advanced Emergency Medical Technician
- NRP - Paramedic

The recommended placement is following an educational notion: John Q. Smith, BS, NREMT. US Trademark applications were filed by the National Registry for each of these notations and they can be used by Nationally Certified EMS providers as long as they hold a current, valid certification.

w) Community Paramedicine Evaluation Tool

HRSA's Office of Rural Health Policy (ORHP) has announced the release of the 2012 Community Paramedicine Evaluation Tool. Strategic Partnerships, Inc., and the Critical Illness

and Trauma Foundation, along with an advisory committee comprised of key experts, interviewed five developed Community Paramedicine programs in both rural and urban settings to better understand the elements that have lead to their successes as well as the challenges they have faced in implementing a Community Paramedicine program.

Community Paramedicine is an emerging field in health care where EMS professionals operate in expanded roles to provide health care services where access to physicians, clinics, and/or hospitals may be difficult. There has been increasing interest in and movement towards the implementation of such programs, particularly across rural America.

This document stresses the need for each Community Paramedicine program to define its system-specific health status benchmarks and performance indicators and to use a variety of community health and public health interventions to improve the community's health status. The document also addresses reducing the burden of illness, chronic disease, and injury as a community-wide public health problem, not strictly as a patient care issue.

This tool is intended to be used to evaluate Community Paramedicine programs in a standardized manner. In communities where a Community Paramedicine program has already been developed, this tool can be used to assess the current status of their program, guide program enhancements, and then re-assess progress over time. This tool can also be used as a framework to guide the development of new Community Paramedicine programs.

The Community Paramedicine Evaluation Tool can be found on the ORHP website at: http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf. Please contact Megan Meacham (mmeacham@hrsa.gov) if you have any questions about this resource.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC) met at the Office of EMS, 1041 Technology Park Dr., Glen Allen, VA for a Special Call meeting on March 7, 2012 and the quarterly meeting on April 4, 2012.

1. There are two action items. See Motions in **Appendix B and C.**
2. Copies of past minutes are available on the Office of EMS Web page at: http://www.vdh.virginia.gov/OEMS/Training/Committees-PDC.htm

B. **The Medical Direction Committee (MDC)** meeting was held at the Office of EMS, 1041 Technology Park Dr, Glen Allen, Virginia on April 12, 2012. There are two action items to consider. See Motion in **Appendix D and E.**

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

National Registry of EMTs Certification Test Proposal

As indicated in the last quarterly EMS Advisory Board report, the Office of EMS is continuing plans to transition to National Registry testing for all EMS certification levels beginning July 1, 2012. Please review **Appendix B** for a motion from Training and Certification Committee and please discuss with the key stakeholders, call the office and speak with Mr. Warren Short or any Division of Educational Development staff and be prepared to discuss at the May 18 EMS Advisory Board meeting.

Advanced Life Support Program

A. There are currently 49 new applications pending for ALS Coordinator endorsement. The next Instructor Institute will be held in Blacksburg, VA from June 9-13, 2012 in conjunction with the VAVRS Rescue College.

B. The Office held an Instructor Institute February 11 – 15, 2012 in Hanover. Thirteen ALS Coordinator candidates attended and received endorsement. An additional four EMT Instructor candidates have requested and received ALS Coordinator certification from that institute.

Basic Life Support Program

A. Instructor Institutes

1. The Office held an EMT Instructor Institute February 11-15, 2012. 11 EMT-Instructor Candidates were certified and 7 ALS-Coordinators received endorsement.
2. The next EMT Instructor Practical is scheduled for May 12, 2012.
3. The next Instructor Institute will be held in Blacksburg, VA, in conjunction with the VAVRS Rescue College on June 9-13, 2012.
4. EMS Providers interested in becoming an Instructor or learning more about the process to become an Education Coordinator should contact Mr. Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov

B. VEMSES Exam

1. There have been 324 Initial test attempts and the pass rate is 55.25%. There have been 66 second attempts on the exam and the pass rate is 59.09%. Ten providers have attempted the exam a third time, and the pass rate is 40%. Two providers have attempted the exam a fourth time and the pass rate is 100%.
2. Although there has been vocal opposition to the administration of this exam to evaluate the continued competence of our Instructors to be able to teach the minimum required material, the results reinforce the need to continue to require this before an Instructor/Coordinator can implement the new Education Standards in their programs. It is important to note that the first time pass rate is not a reliable indicator because many Instructors/Coordinators have stated they did not study prior to taking the exam, but rather wanted to take it 'cold' to see what was on the exam. The low second time pass rate is somewhat concerning.
3. Current EMT-Instructors/ALS-Coordinators may schedule to take the exam at Regional Consolidated Test Sites (CTS) or at specified locations with the Training Staff after in-person updates and ALS-C meetings.

C. EMS Instructor Updates:

1. The Division of Educational Development continues to hold both online and in-person Instructor Updates.
2. Online Updates will be held on the second Thursday evening every other month, beginning January 2012. In-person updates have also been scheduled for 2012.
3. The schedule of future updates can be found on the OEMS Website at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

EMS Training Funds

FY12

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$790,719.00	$300,231.17	$490,487.83
BLS CE Course Funding	$117,600.00	$28,883.75	$88,716.25
ALS CE Course Funding	$268,800.00	$59,946.25	$208,853.75
BLS Auxiliary Program	$92,000.00	$7,920.00	$84,080.00
ALS Auxiliary Program	$326,000.00	$118,360.00	$207,640.00
ALS Initial Course Funding	$1,339,290.00	$487,162.06	$852,127.94
Totals	**$2,934,409.00**	**$1,002,503.23**	**$1,931,905.77**

EMS Education Program Accreditation

A. EMT accreditation program.
   1. Emergency Medical Technician (EMT)
      - No applications on file.
   2. Advanced Emergency Medical Technician (AEMT)
      - No applications on file.
   3. Intermediate – Reaccreditation
      a) John Tyler Community College
         Site visit completed in January, 2012
         Conditional Accreditation Awarded January 2012 – Expires February 28, 2013.
      b) WVEMS – New River Valley Training Center
         Site Visit scheduled for May 17/18, 2012.
   4. Intermediate – Initial
      - No applications on file.
   5. Paramedic – Initial
      - No applications on file.

B. For more detailed information about accredited EMS Education Programs in Virginia, please view 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) must 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
        (1) Correction from January report—this college is working toward completing their CoAEMSP Institutional Self-study Report (ISSR).
    b) Patrick Henry Community College
        (1) Status unknown.
    c) Rappahannock EMS Council Paramedic Program
        (1) Working toward completing their CoAEMSP Institutional Self-study Report (ISSR).
    d) Southside Community College
        (1) Submitted their self-study to CoAEMSP.
        (2) CoAEMSP site visit conducted on December 1/2, 2011.
        (3) Awaiting review and approval of accreditation by CoAEMSP/CAAHEP.
    e) Prince William County Paramedic Program
        (1) Working toward completing their CoAEMSP Institutional Self-study Report (ISSR).
    f) Center for EMS Training, Inc.
        (1) Submitted their self-study to CoAEMSP.
        (2) CoAEMSP site visit scheduled for June 26/27, 2012.

On Line EMS Continuing Education

Distributive Continuing Education

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 quality programs and the ability for 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

TRAINVirginia

Due to technical issues beyond our control, the Office has suspended all of our online CE programs posted on TRAINVirginia.

We hope to have a solution in the near future; however we cannot provide a specific date at this time.

If EMS Providers find themselves against a deadline for CE, we are encouraging them to visit our third party vendors located on the OEMS web site at: http://www.vdh.virginia.gov/OEMS/Training/WebBasedCE.htm.

EMSAT

A. For the May EMSAT, OEMS is partnering with several other agencies, including the Virginia Chief Medical Examiner's Office, to produce a program entitled "When a Child Dies". The format for this EMSAT is a panel discussion featuring a pediatric emergency specialist, a forensic pathologist and a prosecutor. This program on how EMS can work with other agencies in the event of a child's death will provide valuable information on dealing with this difficult situation.

B. EMSAT programs for the next four months include:
   1. May 16 When a Child Dies
   2. June 20 The Near Drowning Patient
   3. July 18 Infection Control Update 2012
   4. Aug. 15 Safe Vehicle Extrication: Understanding Hybrids and Other New Automotive Technologies

The EMS Portal

On December 5, 2011, the Office of EMS Portal initiated a new EMS Agency component. This new component allows an agency and designated officers the ability to update agency profile data, manage affiliation, and the ability to produce specific reports in various formats. Notices were sent to all agency CEOs in November concerning the deployment of the EMS Agency component of the Portal with instructions on how to activate their agency in the Portal.

These new agency specific features have been built into the existing EMS Portal—utilized by EMS Providers and Instructors alike—which will enable agency administrators to delegate authority and access to their affiliated personnel. The system allows for 'real-time' access to records and increases the security surrounding access to EMS provider and agency data. OEMS is moving away from a 'single login and password' shared by numerous personnel to unique user logins where transactions can be more easily tracked.

It is most important for all EMS agencies to activate their portal. All affiliations are now managed over the web via the Agency component of the EMS Portal. Through the Portal, anyone with an EMS number can request to be affiliated with an EMS Agency. Once the request is submitted, the agency representative must either accept or deny the request. All activity initiates emails between the agency and applicant indicating the status of the request. An agency can also submit a request to a provider, who also must either accept or deny the request. **EMS AGENCY AFFILIATION IS NO LONGER CONDUCTED USING THE BLUE EMS CERTIFICATION TEST FORM**. To

activate the Agency component of the EMS Portal, the CEO of the agency must contact their local OEMS Program Representative who can explain the process and assist in initiating an account. Once activated, please contact anyone in Training or Regulation and Compliance for assistance in navigating the component and extending access to other officers in your agency.

Test waivers must be completed on a blue bubble test form using a #2 pencil and list the OMD, OMD number and the level being waived. The system will process the waiver request by determining if the provider is affiliated with an EMS agency for which the waiving OMD is affiliated. If there is a match, the waiver is processed. For this reason, it is imperative that all providers and agencies activate their EMS portal. The office notified providers expiring in December and January to assure their affiliation was up to date in the portal as well as notifying agencies with affiliates whose certification was expiring to assure activation of their agency component of the portal.

As of April 27, 2012, Agency participation has grown from approximately 30% to 59% and provider participation has grown from 59% to 65%. Please pass the word so that we can be at 100% by the August Board meeting.

As a reminder, the EMS 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.

Consolidated Test Sites (CTS's)

A. As indicated in the last quarterly report, the Office was in the process of transitioning CTS from the Division of Regulation and Compliance to the Division of Educational Development. The transition is now complete. Mr. Peter Brown was hired as a part time employee to manage this program. Pete's goals are to organize, train and standardize EMS certification testing across the state. The office is continuing to advertise for test examiners as we have not yet filled all CTS examiner positions. Due to federal regulations, all CTS examiners must become employees and contracting this service is no longer permissible. Any questions pertaining to testing can be addressed by Pete.

Other Activities

- DED staff participated with the Central Shenandoah EMS Council's instructor workgroup on April, 30, 2012.
- Greg Neiman continues to participate with the Autism Public Safety Workgroup coordinated by the Commonwealth Autism Service.
- Warren participated in a conference call with the Atlantic EMS Council Training Coordinators Group in March and April.
- DED participated in the Virginia Community College System EMS Workgroup on March 29 and 30.
- Debbie Akers participated in the Tidewater EMS Expo on April 14.

Emergency Operations

IV. Emergency Operations

Operations

- **Battlefield Park Elementary School Evacuation**

Karen Owens, Emergency Operations Assistant Manger participated in the planning and exercise of the Battlefield Park Elementary School *Student Evacuation and Reunification Plan*. The exercise allowed teachers and administrators to determine if the evacuation plan for the school was adequate and appropriate.

- **Virginia 1 DMAT**

The Emergency Operations Manager and HMERT Coordinator attended the Virginia-1 DMAT meetings during this quarter. The February meeting was held in Yorktown and included a luncheon to celebrate the DMAT anniversary. The Emergency Operations Manager attended the April meeting which included hands-on training opportunities.

- **New HMERT Vehicle**

Frank Cheatham continued to work on completing the work on the new HMERT Vehicle. During this quarter Mr. Cheatham continued with lettering, radio and light installation to place the vehicle in service. The HMERT Coordinator completed the removal of all lettering and emergency equipment from the old truck and got it ready for surplus.

- **Statewide Tornado Drill**

On March 20, 2012, members of the Division of Emergency Operations, as well as all members of the Virginia Office of EMS, participated in the Statewide Tornado Drill.

- **Meeting with BREMS and WVEMS**

On February 16, 2012, Winnie Pennington, Emergency Planner attended a planning meeting in Salem, VA involving MCI stakeholders on both regions. The meeting started talks on developing cooperative agreements and plans to effectively use resources in both regions during an MCI event in either.

- **Meeting with VDH OEP staff for FAC Planning**

On April 16, 2012, the Emergency Planner teleconferenced with VDH Office of Emergency preparedness staff on changes VDH planned to submit to VDEM on the State FAC Plan. This meeting was in preparation for a meeting called by VDEM committee on May 1.

- **Fire Department Instructors Conference**

From April 17-21, 2012, the HMERT Coordinator and Emergency Operations Assistant Manager attended the national Fire Department Instructors Conference (FDIC) in Indianapolis, Indiana. The conference provides an opportunity to attend courses on Fire and EMS issues conducted by nationally recognized speakers. During the conference, Karen Owens, Emergency Operations Assistant Manager, presented a class on rehab and Frank Cheatham, HMERT Coordinator, presented a class on Electrical Emergencies.

Planning and Preparedness

- **Assisting Regions**

Planner continues to assist Regional Councils on a case-by-case basis to develop planning in MCI, COOP, and EMS medical Surge. Additional surge guidance is available for regions as requested. More will be developed throughout the coming year.

- **OEMS COOP**

Winnie Pennington, Emergency Planner, continues to review the COOP. During this quarter she received notification of new guidelines for COOP development. Ms. Pennington continues to await additional guidance from VDH on the revision

Committees/Meetings

- **Hurricane Evacuation**

Frank Cheatham, HMERT Coordinator, attended a meeting of the Hurricane Evacuation Committee on April 25, 2012. The meeting focused on all issues associated with I-64 lane reversal.

Frank also attended three meetings specific to the issue of communications issues on February 16, 2012, March 14, 2012, and April 30, 2012. These meetings were addressing the communications issues with state agencies being able to communicate in the event of a lane reversal.

- **EMS Emergency Management Committee Meeting**

The EMS Emergency Management Committee met on April 19, 2012. The meeting provided an opportunity to discuss the recommended national triage standard.

- **Virginia Strategic Highway Safety Plan Committee**

Frank Cheatham, HMERT Coordinator, attended several meetings of the Virginia Strategic Highway Safety Plan Committee. The meetings were dealing with the various aspects of the plan and completing a formal draft to be submitted for approval.

- **NASEMSO Domestic Preparedness Committee**

The Emergency Operations Manager participated in the teleconference call with the NASEMSO Domestic Preparedness Committee discussing the FEMA/National Ambulance Contract, update on the West Virginia Dam program, and the MUCC triage system.

- **EMS Communications Committee**

The EMS Communications Committee held its quarterly meeting February 10, 2012. Emergency Operations Division Manager, Jim Nogle, and Emergency Operations Assistant Manager, Karen Owens, attended the meeting. Discussion included the Virginia chapter of the National Emergency Number Association (NENA) endorsing the OEMS White Paper concerning local implementation of emergency medical dispatch protocols. Additional discussion included the committee's endorsement of any Rescue Squad Assistance Fund (RSAF) grant request for communications equipment must be P25 compliant as to be in agreement with federal mandates stating the same. OEMS Grants Manager Amanda Davis recommended any PSAP requesting RSAF funding must be accredited by OEMS or in the accreditation process.

- **NASEMSO Highway Incidents and Transportation Systems (HITS) Committee**

The HMERT Coordinator participated in the monthly teleconference with the NASEMSO HITS Committee. The HITS Committee looks at Highway Incidents and Transportation Systems.

Training

- **Tri-City Regional Training School**

On February 18, 2012, Karen Owens, Emergency Operations Assistant Manager, participated in the Tri-City Regional Training School in conjunction with the Department of Fire Programs. Karen taught a class on Mass Casualty Incident Management I and II and an Instructor course in the same program. The course was attended by 18 students.

- **Essex Regional School**

On Mary 18, 2012 the Division of Emergency Operations sponsored a Mass Casualty Incident management I and II Course in conjunction with the first annual Essex Regional School. The course, taught by adjunct instructor Thomas Schwalenberg, prepares students for response to an emergency where there are larger numbers of patients than responders.

- **EMSAT**

The Emergency Operations manager and HMERT Coordinator traveled to the Insurance Institute for Highway Safety to film some footage for an upcoming EMSAT Video.

- **HAM Radio Class**

On March 24-25, 2012 the Division of Emergency Operations sponsored an Amateur (HAM) Radio certification class. The class, held at the Office of EMS in Glen Allen was attended by 16 students.

- **VDEM COOP Workshop**

Winnie Pennington, Emergency Planner attended a COOP workshop showcasing the new format and new definitions of Mission Essential Tasking. The workshop was put on by VDEM who is responsible for making sure all executive branch agencies comply with the Governor's directives on developing a COOP.

- **Semi-Annual Training for OEMS VERT Staff**

The Division of Emergency Operations, Emergency Planner developed and facilitated a semi-annual training for OEMS Virginia Emergency Response Team (VERT) members. The training was conducted in the form of an Exercise for the VERT staff on February 28, 2012. An After-Action Report was developed and distributed.

Communications

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

Orange County 9-1-1, Brunswick County 9-1-1 and City Of Roanoke 9-1-1 have pending applications submitted electronically to OEMS. All required documentation has also been provided and will be reviewed by EMS Communications Committee at the next scheduled meeting.

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

OEMS was represented by Emergency Operations Division Manager Jim Nogle and Grants Manager Amanda Davis at the combined Virginia Chapter APCO/NENA Winter Meeting on Monday February 6, 2012 in Chesterfield. Presentations included OEMS continued support of emergency medical dispatch, PSAP accreditation and OEMS grant opportunities.

- **OEMS Wireless Service**

During this quarter, the Office of EMS switched the majority of blackberry and cellular users from Sprint/Nextel to Verizon. This was initiated due to rising wireless costs and less than satisfactory service at the OEMS Technology Park locations.

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

The Regional EMS Councils submitted Third Quarter contract reports throughout the month of April. Submitted deliverable items are under review by OEMS.

The EMS Systems Planner has been reviewing documents related to the re-designation of the Regional EMS Councils. Applications for designation/re-designation are due to OEMS on October 1, 2012. The next designation period begins on July 1, 2013.

The EMS Systems Planner attended meetings of the Old Dominion, Rappahannock, and Southwest Virginia EMS Councils in the quarter.

Medevac Program

The Medevac Committee met on May 17, 2012. The minutes were not available at the time of the submission of the state EMS Advisory Board quarterly report.

The Medevac WeatherSafe application continues to grow in the amount of data submitted. In terms of weather turndowns, there were roughly 491 entries into the WeatherSafe system in the first quarter of 2012. Two thirds of those entries were for interfacility transports, which is a continuing trend. This is also an increase from 390 entries in the first quarter of 2011…not only does this show continued dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

There is also a push to place Hospital Landing Zone (LZ) information on WeatherSafe, so crew can find specific information (Latitude/Longitude, radio frequencies, photos of landing pad, etc.) in a standard format, and in one location.

The EMS Systems Planner has begun making site visits to the medevac services in Virginia, to get a better understanding of how those services function, and to meet and interact with the flight crews. Site visits have been made to Carilion, LifeGuard, Fairfax County Police, and UVA Pegasus this quarter.

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.

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 March of 2011.

In the quarter, an effort was made by OEMS staff to provide updates on the action steps of each Strategic Initiative of the State EMS Plan. This information is included in this report as **Appendix F.**

The State EMS Plan continues to be available for download via the OEMS website.

Miscellaneous

During EMS Week, Tim Perkins will be joining dozens of other EMS providers from across the United States and Canada who are participating in the National EMS Memorial Bike Ride. Tim has been involved with the Ride since 2008, and is currently the Public Information Officer for the Ride.

This year, riders will be starting at either Boston, MA, or Paintsville KY, with both routes concluding in Alexandria. This is especially meaningful this year, given the recent line of duty death of Paramedic Joshua Weissman of the Alexandria Fire Department. Riders will also be riding to honor Timothy "Kyle" Southern, an EMT for Priority Patient Transport, and a volunteer EMT with the Waynesboro First Aid Crew, who died in the line of duty in January 2012.

In addition to Tim's participation, the EMS System in Virginia is well represented by Bryan Kimberlin of the Southwest Virginia EMS Council, who serves as route coordinator for the Kentucky Route, as well as VA providers Erik Hanna, Maggie Slocum, Karen Hamilton, Scott Davis, Jim Davis, DJ Robinson, Wayne Reisner, and Bryan Ekey.

All riders are dedicated to the mission of the Ride, to memorialize and celebrate the lives of those who serve every day, those who have become sick or injured while performing their duties, and those who have died in the line of duty.

Public Information & Education

VI. Public Information and Education

Marketing and Promotion

- **EMS Bulletin**

On March 6, 2012 the quarterly EMS Bulletin was posted on the OEMS website and was promoted via the Constant Contact list-serv and social media outlets (Facebook and Twitter). The following reflects statistical information related to "reach", which identifies how many people viewed, downloaded or forwarded the bulletin based upon email list-serv and social media marketing efforts.

The March WebTrends report reflected that the EMS Bulletin was the most downloaded item on our website with 37,439 downloads. The Constant Contact list-serv statistics showed that the newsletter had an open rate of 30.4 percent and a unique click-through rate of 941 clicks. Facebook statistics showed that the EMS Bulletin reached a total of 452 unique users, which is the number of unduplicated people that saw the post. And, it engaged 24 users, which is the number of people that clicked through to the EMS Bulletin link.

- **EMS Week**

The week of May 20-26, 2012 has been declared National EMS Week, with May 23 designated as EMS for Children Day. This year's theme is, "EMS: More Than A Job. A Calling." The Public Information and Education Division ordered EMS Week Guides from the American College of Emergency Physicians and mailed them out to all of the EMS agencies in Virginia.

The public information and education assistant received the Governor of Virginia's Proclamation for EMS Week in Virginia. This signed certificate of recognition recognizes May 20-26, 2012 as Emergency Medical Services Week in the Commonwealth of Virginia and calls this observance to the attention of the citizens. Gubernatorial proclamations are special commemorative documents issued to raise public awareness and support for a particular issue, cause or initiative. They are commonly issued in support of Virginia history and/or historical figures from Virginia, public health and safety, education, professions and/or occupations, state government initiatives, and issues the Governor would like be bring to the public's attention. Please see **Appendix G**.

- **Rider Alert Program**

The Rider Alert program celebrated their first birthday on April 12, 2012, and since their inception they have registered a total of 130,000 cards, received national and international recognition and assisted another country in the launch of its own cars safety program. On March 28, 2012 a photo shoot was held at the Office of EMS for the Rider Alert program to assist with their promotional campaign. On May 1, 2012 members of the Office of EMS attended the launch of National Motorcycle Safety Awareness Month (which takes place in May) at AAA Mid Atlantic Headquarters in Chesterfield, Va.

- **Promoted Events on Social Media Outlets**

In an effort to keep our Twitter and Facebook websites active, educational and relevant, the Public Information and Education Division updates these pages daily and/or weekly with important announcements and health-related topics to increase awareness and promote the mission of OEMS and VDH.

Website Statistics

Figure 1: This table represents the top five downloaded items on the OEMS website from January – March, 2012.

January	1. Training Catalog (11,483 Downloads) 2. Symposium 2010 Presentations – LMGT-732 (10,131 Downloads) 3. Durable DNR Form (7,606 Downloads) 4. Modifying Your TRAIN Account (4,799 Downloads) 5. Practical Exam User Guide (4,386 Downloads)
February	1. Symposium 2010 Presentations – LMGT-732 (14,755 Downloads) 2. Training Catalog (9,637 Downloads) 3. Modifying Your TRAIN Account (5,294 Downloads) 4. Practical Exam User Guide (5,059 Downloads) 5. Set Up your TRAIN Account (4,598 Downloads)
March	1. Winter 2012 EMS Bulletin (37,439 Downloads) 2. Symposium 2010 Presentations – LMGT-732 (10,600 Downloads) 3. Training Catalog (9,729 Downloads) 4. Symposium 2010 Presentations – MED-815 (4,588 Downloads) 5. Durable DNR Form (4,372 Downloads)

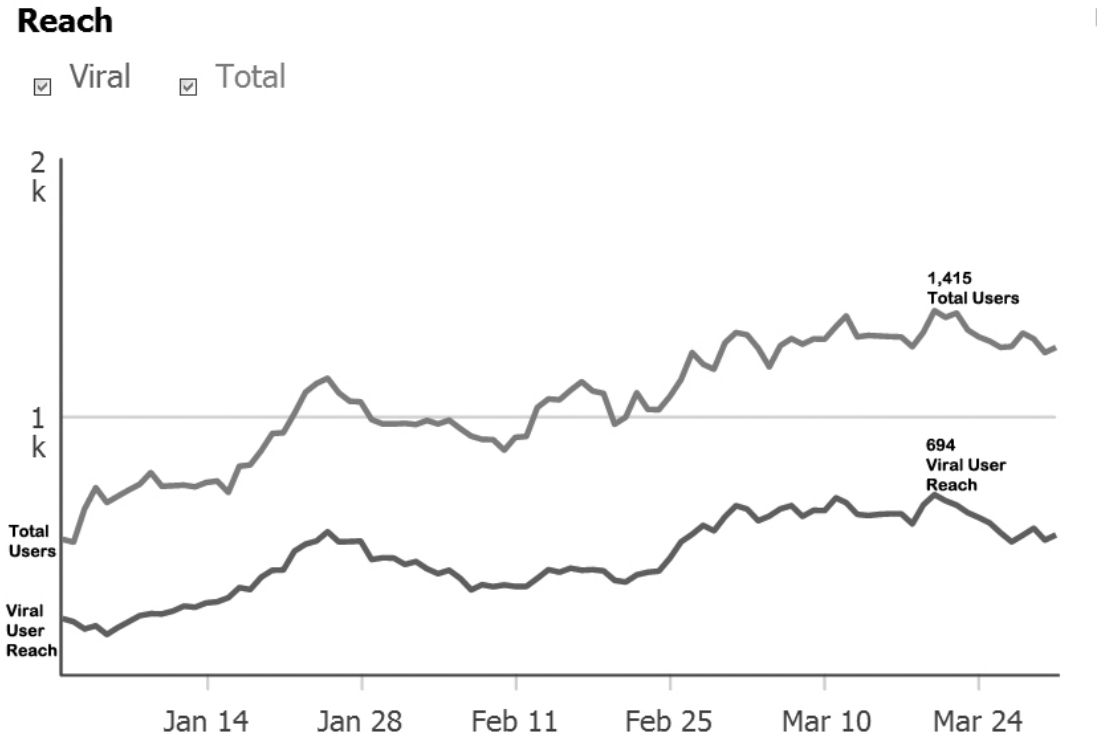
Figure 2: This table identifies the number of unique visitors, the average hits per day and the average visit length by minutes to the OEMS website from January – March, 2012. *Unique visitors* are defined as the number of unduplicated (counted only once) visitors to your website over the course of a specified time period, whereas the *average hits per day* include both unique visitors and repeat visitors:

Figure 2

	Unique Visitors	Average Hits Per Day	Average Visit Length (Minutes)
January	24,248	2,267	9:59
February	23,112	2,302	9:44
March	24,665	2,225	9:49

Figure 3: This graph shows how many unique users and viral users saw content from our Facebook page from January 1 – March 31, 2012. *Viral users* are defined as unique people that saw a story about our page published by a friend. The *total number* of unique users is defined as people who saw any content

associated with our page. Each point represents the unique people reached in the 7-day period ending with that day.
Figure 3



Symposium

- **Course Catalog**

The Symposium course catalog design is underway and will be completed by June. A limited number of catalogs will be sent to all EMS agencies, Regional EMS Councils and a list of predetermined individuals. It will also be available for download on the OEMS website.

- **Signage**

The public information and education assistant met with the director of the Office of EMS and the HMERT coordinator to discuss changes to Symposium signage that would better meet the needs of this annual event. Discussion included eliminating repetitive signage and reorganizing current signage for more appropriate use of space and posted information.

Governor's EMS Awards Program

The Public Information and Education Division posted downloadable PDF and Word versions of the award nomination forms on the OEMS website. Additionally, the Regional EMS Awards were promoted on Facebook and Twitter.

The regional EMS award nominations are due to the Office of EMS by Friday, July 20, 2012 and will be submitted via Lotus Notes, instead of previously being submitted on a CD via mail. The Governor's Awards Nomination Committee meeting will be held on August 17, 2012 to determine the winners of the 2012 Governor's EMS Awards. The winners of the Governor's EMS Awards will be announced at the 33rd Annual Virginia EMS Symposium Reception on Saturday, November 10, 2012.

Media Communications

- **Office of EMS Media Coverage**

The public information and education assistant worked with the Division of Regulations and Compliance on a media request for information about the licensed volunteer and commercial EMS services in Southwest Virginia and surrounding areas.

- **VDH Media Coverage**

The public information and education assistant fielded questions for requests related to other VDH programs on an interim basis while the Public Information and Education Coordinator position is vacant.

The public information and education assistant collects information on OEMS projects and programs for submission to the Commissioner's weekly e-mail update.

Regulation & Compliance

VII. Regulation and Compliance

Compliance

The EMS Program Representatives continue to conduct ongoing investigations pertaining to EMS agencies and providers. These investigations relate to issues concerning failure to submit prehospital patient care data (VPHIB), 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 criminal convictions. The following is a summary of the Division's activities for the first quarter of 2012:

Enforcement

Citations Issued:	15
EMS Providers:	12
EMS Agencies:	3

Compliance Cases

New Cases:	10
Cases closed:	21
Suspensions:	3
Temporary Suspensions:	2
Revocations:	0
Consent Order:	0

EMS Agency Inspections

Licensed EMS agencies:	683 Active
Permitted EMS Vehicles: (Active, Reserve, Temporary)	4,377

Recertification:

Agencies:	72
Vehicles:	656

New EMS agencies: 5

Spot Inspections: 86

Hearings (Formal, IFFC)

January 25, 2012: John Hunt, Bradley Gregory

Variances

Approved: 20
Disapproved: 14

OMD/PCD Endorsements

As of April 2012: 222 Endorsed

EMS Regulations

The final draft of the Virginia Emergency Medical Services Regulations 12VAC5-31 resides with Governor's Office awaiting his review and approval (8/16/2011).

Notable Information

Dr. Lindbeck along with Scott Winston, Charis Mitchell (OAG Liaison) and Michael Berg met with executive staff of the Board of Pharmacy to begin discussions on several pharmacy items to include practioner signatures, drug shortages and matters related to restocking medication kits. A work product will be forthcoming if approved by the Board of Pharmacy this summer.

Division Work Activity

1. Regulation and Compliance staff represented the Office of EMS in Fire/EMS studies conducted by the Virginia Fire Service Board. A study report will be presented to Amelia County on May 16, 2012. OEMS is participating in a Fire/EMS study for Fluvanna County with site visits set for June of this year.

2. Staff continues to offer technical assistance and educational opportunities to EMS agencies, entities and local governments as requested. The following is a listing of locations and dates for the first quarter of 2012:

   Jan 12 Matthews County Rescue Squad
   Jan 14 Appomattox County Rescue Squad
   Jan 18 Washington County
   Jan 21 Glade Spring Rescue squad, VAVRS District 9 meeting
   Jan 28 Henrico Fire CE Weekend, Keynote speaker
   Feb 3 ALS Coordinators Meeting, Charlottesville

Feb 8 Prince William EMS Advisory Council
Mar 13 Retreat Hospital, CE night, Richmond
Mar 17 March Medical Madness, Fluvanna
Mar 23 Lancaster County

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

4. The quarterly EMS Program Rep staff meeting was held in Charlottesville on February 29 – March 2, 2012. Inventory of all assigned equipment and work on updating Employee Work Profiles was completed.

5. OEMS staff is actively participating with Dr. Lindbeck to present OMD "Hot Topics" programs across the Commonwealth. The following locations and dates were completed during the first quarter:

Feb 8 TJEMS Council
Feb 13 Homestead, ACEP Winter Conference
Mar 7 REMS Council

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The Workforce Development Committee last met on January 27, 2012. The committee will meet on Thursday May 17, 2012.

WDC Sub-committee Reports:

a) Standards of Excellence (SoE)

The sub-committee met on March 27, 2012 to review the Recruitment and Retention and the Leadership and Management Self-Assessment Survey questions. The surveys can be found as **Appendix H.** The SoE survey has been significantly simplified – starting with the Core Areas.

Recruitment and Retention Survey Core Areas

1: Mission, vision, values
2: Recruitment
    Selection Process
    Expectation
    Orientation
3: Retention

EMS Leadership and Management Survey Core Areas

1: Agency Governance
    OEMS Rules and Regulations
    Policy and Procedures
2: Human Resources
3: Employee Development
    Training
4: Record Keeping
5: Asset Management
    Vehicles and Equipment
6: Financial Management

Phase I of the Standards of Excellence Process

I: Identify EMS agency (s) to pilot self-assessment surveys
II: Agency completes Recruitment and Retention self-assessment survey
III: Staff reviews survey, IDs areas of improvement

IV: Staff assembles assistance resource packet (sample forms, articles, web sites, classes, names of local experts)

V: Staff/Technical Assistance Team (TAT) meet with agency representatives to review assessment survey results– reviews packet of assistance materials

VI: Staff checks back in 30, 60, 90 days to check agency progress and assess if additional assistance is needed

VII: 6 months after original survey assessment, staff sends follow-up self-survey to assess progress

VIII: Based on survey assessment results –

No improvement and/or lack of interest – TAT visit
Improvement but more work needed -
Document

Goochland County EMS has agreed to pilot Phase I on the Standards of Excellence.

b) EMS Officer Standards

The sub-committee last met on March 27, 2012 and is scheduled to meet again on May 8, 2012. The sub-committee is currently collecting and comparing various job descriptions and guidelines for release of the attendant in charge to be used EMS Officer I.

c) EMS Officer Phase I – Steps to Certification (Draft)

(For individuals currently in a leadership position)

I: Individual develops portfolio that will demonstrate:
(based on requirements indicated in attached EMS Officer Matrix – See **Appendix I.**

A: Current formal documented EMS education, or
B: Comparable knowledge, experience and skills

II: Individual submits portfolio for EMS Officer I (majority of which is educational based)

II: ID # assigned by OEMS (remove all student identifiers)

IV: There will be 2 separate review panels: Practical and Written
These review panels will be staffed with a minimum of 3 subject matter experts (SME's) who have obtained at least 1 officer rank higher that they are reviewing (for EMS officer I – all reviewers will be qualified at the EMS Officer II or above level)

V: 2 of the 3 reviewers must be in agreement that the EMS Officer I candidate has met the educational requirements , as set out in the standards matrix. Once the requirement is met the candidate will be given a "conditional approval" as an EMS Officer I, good for a period of not more than 90 days. This will allow time for the evaluation process, return, evaluation and the final presentation of certification.

VI: The next step of the certification process consists of testing the candidate. There will be a minimum of 5 situational essay questions that the candidate will answer. These essay answers will be evaluated by a team of 3 different evaluators for consistence in management theory. As before, a simple majority of evaluators decides the outcome.

VII: Once candidate has been certified at the EMS Officer I level – the process may begin to apply for EMS Officer II.

The Virginia Recruitment and Retention (R&R) Network

The Recruitment and Retention Network met on April 13, 2012 in northern Virginia. The Recruitment and Retention Network and the Office of EMS are in the process of discussing plans for potential Virginia Recruitment and Retention Coordinators Summit to discuss the benefits of having a local government (and/or agency) R&R coordinator. More information will be available at the next meeting on June 22, 2012, at Forest View Volunteer Rescue Squad.

Volunteer Rescue Squad Assistance Work Group (VRSAWG)

The Volunteer Rescue Squad Assistance Work Group (VRSAWG) met last on April 13, 2012, in Richmond. The majority of the 6 VRSAWG Objective Sub-Groups have completed their assignments in preparation for the pilot project. Two volunteer rescue squads (in the western Virginia area) have been identified as having multiple problem areas that may benefit from assistance from VRAWG's Fix it Now (FIN) Teams.

VRSAWG representatives visited with these agencies in late January 2012 to explain the process and offer assistance. It was decided at the April VRSAWG meeting that a second visit will be completed to these agencies within 30 days (by May 13).

A Rescue Squad Assistance Fund (RSAF) grant application was re-submitted on March 15, 2012 for funds to continue the VRSAWG project. The original request was submitted in September 2011 but was not funded because sufficient information was not provided describing the scope of the project.

Trauma and Critical Care

IX. Trauma and Critical Care

This section includes:

- Poison Control Services
  - Legislative report on poison funding
- Stroke System
  - Virginia Stroke System Task Force
- Virginia Statewide Trauma Registry (VSTR)
  - VSTR data quality
  - VSTR submission compliance
  - Outside VSTR data requests
  - VSTR upgrade
- Virginia Pre-Hospital Information Bridge (VPHIB)
  - NEMSIS submission
  - Third party automatic uploading available
  - Migration to Virginia's version 3 EMS dataset (VAv3)
  - Data Quality Initiatives
  - VPHIB Data Validation Dashboard
  - OEMS' efforts to improve data quality
  - EMS Data Output
    - New access to statewide EMS data
    - New comparative analysis reports
  - VPHIB compliance remains high
  - On the Technical Side
    - Server environment
    - VPHIB application:
- Trauma System
  - TSO&MC March 1, 2012 meeting
  - Trauma Performance Improvement Committee
  - Trauma Center Designation Manual 2012 revision
  - Trauma Center Designation Manual 2014 revision
  - Trauma Center Fund
- EMS for Children
  - EMSC committee quarterly meeting
  - "Death of a Child EMSAT video in **production**
  - Transporting children safely in ambulances" DVD planned
  - Stakeholder input for hospital Pediatric Designation Program nears completion
  - Emergency Nurses Pediatric Course (**ENPC) at 2012 Symposium**
  - Regional pediatric symposiums
  - ED site visits continue

    - EMSC program ideas always welcome
- Durable Do Not Resuscitate
    - Downloadable DDNR well accepted
    - Reminder of new regulations

Poison Control Services

Legislative report on poison funding: OEMS' Division of Trauma/Critical Care (TCC) serves as the contract administrator for the three poison centers that make up the Virginia Poison Control Network (VPCN). Item 297 of the 2012 – 2014 Appropriations Acts states "The Commissioner of Health shall report to the Senate Finance and House Appropriations Committees by November 1, 2012 on the level of funding needed to support the operations and services of the Poison Control Centers."

As a result of this language OEMS began to contract with a neutral third party to perform the analysis of the funding needed to support the VPCN. The analysis would be limited to the minimum funding needed to meet the deliverables listed in the scope of work section of the most recent contract between the Commonwealth and the VPCN. This scope of work reflects the minimum requirements for American Association of Poison Control Centers (AAPCC) certification.

OEMS had been directed to establish a work plan on how it will complete this report by June 1, 2012 and have a draft of the completed study by August 15, 2012. Due to the aggressive nature of this timeline the firm of Clifton and Gunderson, which is already under contract with the OEMS to perform public audits, was engaged to create the report on the following timeline:

The goal timelines for the study:

- March 19, 2012 – VDH/OEMS drafts scope of work and distributes to VPCN for input;
- March 31, 2012 – VDH/OEMS provides a scope of work for the study to Clifton Gunderson;
- April 15, 2012 – Clifton Gunderson will provide a response (ability and cost) to the scope of work to the VDH/OEMS;
- May 1, 2012 – Appropriate procurement approvals and contract modifications completed by the VDH/OEMS.

Subsequent to the above efforts, the language relating to the poison center report changed to:

> *The State Health Commissioner shall report to the Chairmen of the Senate Finance and House Appropriations Committees by November 1, 2012 on the level of funding needed to support the operations and services of Poison Control Centers. The commissioner shall assess the level of funding needed to provide statewide coverage of poison control services by two centers and the services that are required to be provided.*

Since Virginia has maintained three poison centers since it has provided funding support for poison control services, OEMS has requested more information on the intent of the two center report. OEMS also placed the report development on hold until the final language is approved and further direction on the intent of the report is provided.

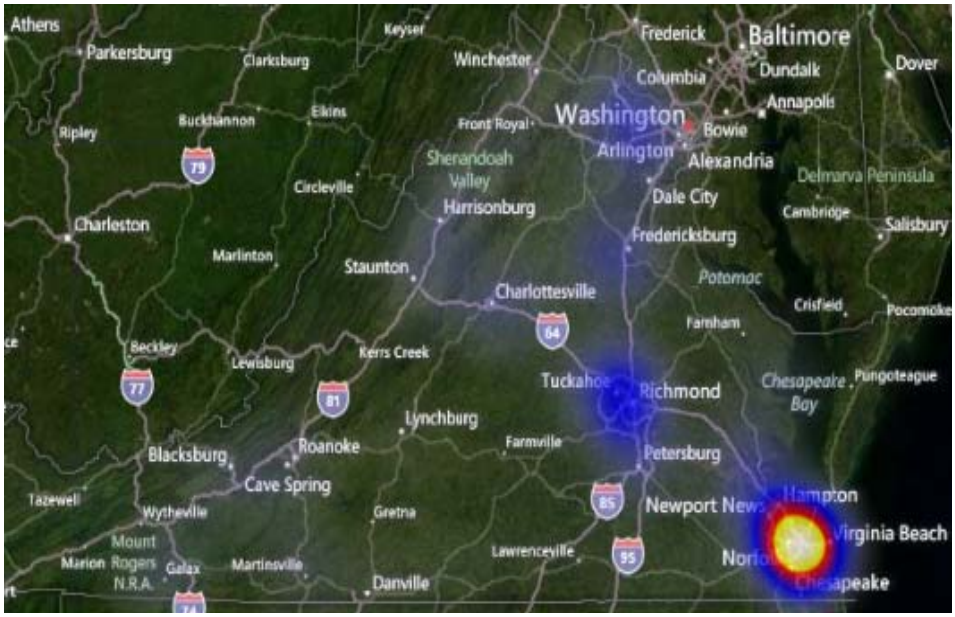
Stroke System

Virginia Stroke System Task Force: The last meeting of the Virginia Stroke System Task Force (VSSTF) was on Wednesday, April 18, 2012. OEMS staff was requested to provide a presentation on the status of the state and regional stroke triage plans, VPHIB as it relates to acute stroke, and other future EMS system plans.

The VSSTF was updated on the state of stroke triage plans which included the fact that the state plan and 10 out of eleven regional plans have been completed for some time. A summary of the greatest challenges observed with the regional plan development was the adherence to what hospitals are actually designated as stroke centers and the attempts to create "unofficial" levels of designation.

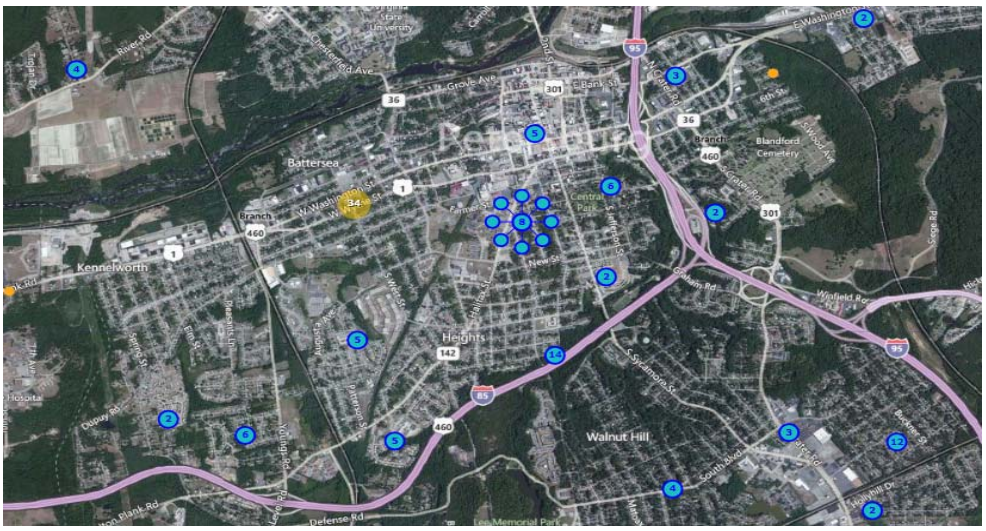
Some examples of stroke triage reports being developed using the VPHIB system were also presented. TCC Staff discussed the current trauma performance improvement reports being developed and how a similar process will be instituted once the 11 regional stroke triage plan had been implemented and enough time has passed to provide supportive data.

Figure 1 - "Heat Map" of Acute Stroke Patients in Virginia 2011



Source: 2011/9-1-1 responses/EMS impression of stroke or TIA/onset less than 3 hrs - VPHIB

Figure 2 - Acute Stroke Small Clusters (Petersburg) 2011



Source: 2011/9-1-1 responses/EMS impression of stroke or TIA/onset less than 3 hrs - VPHIB

Table 1 - Patient Complaint Upon Dispatch When AIC Suspected Stroke 2011

Dispatch_Complaint_Report

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Stroke/CVA	10111	58.4	58.4	58.4
	Unconscious/Fainting	1384	8.0	8.0	66.4
	Illness	1164	6.7	6.7	73.1
	Altered Mental Status	760	4.4	4.4	77.5
	Fall Victim	687	4.0	4.0	81.5
	Seizure/Convulsions	608	3.5	3.5	85.0
	Chest Pain	372	2.1	2.1	87.2
	Breathing Problem	357	2.1	2.1	89.2
	Other	344	2.0	2.0	91.2
	Diabetic Problem	281	1.6	1.6	92.8
	Unknown Problem/Man Down	273	1.6	1.6	94.4
	Headache	148	.9	.9	95.3
	Not Applicable	122	.7	.7	96.0
	Total	~	~	~	

Source: 2011/9-1-1 responses/EMS impression of stroke or TIA/onset less than 3 hrs - VPHIB

Patient Care Information System

Virginia Statewide Trauma Registry (VSTR)

VSTR data quality: Several efforts have been made throughout the quarter focused on correcting and/or improving VSTR data quality including:

- Worked with the VDH Office of Information Management (OIM) and Virginia Commonwealth University Health System's (VCUHS) Trauma Registrar to discover the source of several long standing data upload problems into the VSTR (primarily location where the injury occurred and blood alcohol values)
    - VCUHS has resolved all of its issues and is ready to replace all of its datasets (CY 2003 onward)
    - OIM is ready (late April) to test its repairs
    - Barring any unforeseen circumstances, all issues should be resolved by the end of 2nd Quarter CY 2012
- Created individual CY 2010 data files for all 14 designated trauma centers (DTC)
- Purpose of this project is to look for any additional data upload problems like those found in the VCUHS data
- Each DTC was asked to review a subset of their CY 2010 data for consistency with the data they had uploaded to VSTR
- Results are due on 04/30/12 and will be collated for discussion at the June Trauma System Oversight & Management Committee (TSO&MC) meeting

VSTR submission compliance: The fourth quarter 2011 official VSTR submission audit disclosed 100% compliance. Our next official audit for the first quarter of 2012 will be conducted on May 15, 2012.

Outside VSTR data requests: OEMS continues to offer data and data analysis for outside projects. Below are some examples of data requests that have occurred since our last quarterly report

- Pediatric traumatic brain injury analysis using 2005 – 2011VSTR data for Sara Tonizzo of VCUHS
    - Table 1. Pediatric Age Groups by Year
    - Table 2. VDH Regions by Year
    - Table 3. Admission Status by Year
    - Table 4. Discharge Status by Year
    - Table 5. Primary Brain Injury Diagnosis Code by Year
    - Table 6. Grouped ICD9-CM ECodes by Year
    - Table 7. VDH Region (Residence) and Age Group by Year
    - Table 8. VDH Region (Residence) and Discharge/Admission Status by Year
    - Table 9. VDH Region (Residence) and Primary Brain Injury Diagnosis Code by Year

    - Table 10. VDH Region (Residence) and ICD9-CM ECode Groups by Year

- Cardiac arrest data, using CY 2011 4th Quarter VPHIB data for Central Shenandoah EMS (CSEMS) Regional Council, requested by Matt Lawler of CSEMS. TCC staff was not able to come to an agreement on his desire for patient level data and my responsibilities under HIPAA. TCC Staff used the opportunity to pull the requested data elements and create an analysis data set which is being used for quality assurance analyses.
- Emergency department (ED) utilization data and patient characteristics for specific zip codes in the Fredericksburg, VA area, January 2010 through July 2011 for Karen Shiner of HCA Capital Division
    - Table 1. Overall Trauma ER Arrival Counts by Quarter
    - Table 2. Injury Location by County Counts by Quarter
    - Table 3. Transportation Mode Counts by Quarter
    - Table 4. Patient Transfer Status Counts by Quarter
    - Table 5. Patient Admission Status Counts by Quarter
    - Table 6. Revised Trauma Score (RTS) Counts by Quarter
    - Table 7. Patient Discharge Status Counts by Quarter
    - Table 9. Zip Code and County of Residence Counts by Quarter
    - Table 10. ICD9-CM Diagnosis Code Counts by Quarter

Work also continues on linking data from the VSTR with the Virginia Pre-Hospital Information Bridge (VPHIB). This effort will allow for a more complete evaluation of individual trauma patients' encounters with Virginia EMS agencies and hospitals. Data from the Center for Disease Control's injury related mortality statistics and National Trauma Center Maps, based on the Trauma Information Exchange Program, are also being integrated into the analyses.

The committee will continue work towards developing a more formal process to release trauma triage reports to hospitals, regions, and the public as these efforts evolve.

VSTR upgrade: OEMS is actively working towards upgrading the VSTR. The current VSTR was implemented in May of 2005 after nine years of development. Due to the lengthy development and now seven years of service the technology being utilized is essentially 1996 technology. With the planned national conversion from ICD9 coding to ICD10 coding in November 2013 it is an opportune time for upgrades.

Enhancements desired include:

- The elimination of disparate data from VPHIB and VSTR by combining the two systems.
- Add the ability of VPHIB's Report Writer to provide EMS with outcome data from the hospitals for trauma patients.
- Provide ad-hoc data reporting tool accessible by multiple levels of users.
- Add the ability to add and maintain data validation rules to rapidly respond to data quality issues.
- Detailed submission reporting back to hospitals to provide feedback on the quality of their data and success of an upload.

- The ability of the system to simultaneously collect ICD9 and ICD10 for a two year period from the November 2013 ICD10 implementation date.
- The ability of the system to map all ICD9 coded data to ICD10 format during the two year window.
- The ability for data owners to independently export raw data in a SAS format
- The ability to expand the use of electronic data transmission by hospitals.
- The ability to add data elements without costly and time consuming programming.
- The elimination of requiring that a costly developer must manually load any submitted electronic data
- Conversion of legacy data as practical
- Others items identified as the planning progresses.

Virginia Pre-Hospital Information Bridge (VPHIB)

NEMSIS submission: On April 25, 2012 Virginia began contributing its EMS data to the National EMS Database. TCC staff began by contributing all EMS responses for the year 2011 and will follow up with submitting 2010 responses also. TCC staff will likely begin contributing monthly at the same time it develops its monthly compliance and quality reports. NEMSIS maintains a publicly accessible data reporting tool at www.NEMSIS.org. Click on "reporting tools," then "national reports," and either "create a report" or "access reports."

Third party automatic uploading available: For agencies utilizing third party EMS software programs to submit to VPHIB; TCC staff has notified your vendor that it can now establish a web services connection so your submissions can occur automatically. TCC staff only requires that if a web services connection is setup, submissions must occur every two hours or less. It would be preferred that submissions occur every five to ten minutes. If EMS data could be moved to real-time, it could become one of the most power surveillance tools for health related incidents. TCC staff has begun discussions with the staff of VDH's bio-surveillance program.

Migration to Virginia's version 3 EMS dataset (VAv3): The draft EMS minimum dataset was posted for public comment from February 1, 2012 thru April 30, 2012. The move to VAv3 and its public comment period was announced at the majority of the EMS Advisory Board's standing committees, included in the OEMS quarterly report, e-mailed to all agency leaders within the OEMS licensure program, e-mailed to all VPHIB agency administrators, posted on the OEMS, VPHIB and VPHIB support main web pages, sent by U.S. mail to each agency, e-mailed, mailed, and faxed to all vendors serving Virginia, added to the OEMS newsletter, featured within the VAVRS' Virginia Lifeline periodical, posted on the VAGEMSA and PEMS websites, and included in multiple other reports.

The proposed minimum dataset is attached as **Appendix J**. This proposed document will be released for a final public comment period for the month of June. It is OEMS' intention to present a final draft to the EMS Advisory Board at its August 2012 meeting and ask for its endorsement. Our goal is to receive the State Board of Health's approval of the minimum dataset at its September 14, 2012 meeting.

OEMS will mirror the process used to roll out the national v3 data dictionary to allow maximum input from the entire system, affected vendors, and other entities, as well as maximize the use of our limited resources. The v2 to v3 migration goal timeline is the following:

- ~~February 1, 2012 – OEMS makes the Virginia Version 3.0 Data Dictionary (VAv3) available to the public by posting it on the VPHIB Support Suite Knowledgebase, VPHIB Knowledgebase, and the OEMS website.~~
- ~~February 1 – February 14 - OEMS will open a Wiki page to collect public comment. Details and instructions about how to use the VPHIB-VAv3 Wiki will be made available. **Note:** State, regional and local committees, EMS software vendors, EMS agencies, organizations, associations, providers, and all interested parties are highly encouraged to comment via the VAv3 Wiki.~~
- ~~February 1 – April 30 – If needed, "Town Hall" meetings will be scheduled using a webinar format to respond to concerns and questions.~~
- ~~April 30, 2012 – VAv3.0 comment period closed.~~
- May 18, 2012 - VAv3.1 exposure draft included in quarterly report to EMS Advisory Board
- June 1, 2012 - VAv3.1 posted for additional comment for final 30 days.
- June 30, 2012 – Vav3.1 Second comment period closed, minimum dataset locked down.
- August 10, 2012 – EMS Advisory Board asked to endorse VAv3.2 (final document)
- September 14, 2012 – State Board of Health requested to adopt VAv3
- September 15, 2012 – Final VAv3 document available publicly.
- January 1, 2013 – March 30, 2013 – OEMS opens collection of version 3 dataset to agencies (goal date).
- March 30, 2013 – last day to submit version 2 format and minimum dataset (goal date).

TCC staff continues to be very active on the national level participating in the development, review, and educational events on the NEMSIS version 3 products. Below are just some of the activities TCC staff has participated in.

- National Association of EMS Officials' (NASEMSO), Data Managers Council (DMC): The DMC has returned to meeting twice weekly to collaborate on creating unified suspected diagnosis, medication, procedure, and allergy lists to be used with version 3.
- NEMSIS software Developers weekly meeting: TCC staff continues to participate in the weekly NEMSIS software developer's webinar. This weekly meeting focuses on assuring consistency with migration to version 3 amongst all software vendors. The current focus of this group is achieving NEMSIS Version 3 compliance. As a state these conversations will hopefully prove invaluable with locking down our implementation timeline.
- NASEMSO's Mid-year Meeting provided time for all state data managers, NEMSIS, NHTSA, and other NASEMSO councils to further collaborate on the migration to NEMSIS' v3.
- ImageTrend State Data Managers Council: Since our last quarterly report this group has primarily been focused on assuring data quality, the move to NEMSIS 3, and developing

comparative analysis reports. TCC staff was invited to present its efforts with developing compliance and quality monitoring tools.

- NEMSIS Clinical Validation Rules workgroup: This group has not met at this time.

OEMS continues to be enthusiastic about the collaboration occurring regularly between NEMSIS, the states, and most EMS software vendors. The weekly communication between these groups should help to significantly mitigate technical issues moving Virginia to version 3.

Data Quality

VPHIB Data Validation Dashboard: Trauma staffs continue to move forward with working on improving VPHIB data quality. In April we announced and distributed our first monthly "VPHIB Data Validation Dashboard." This new tool uses a simple "stop light" style dashboard (see Figure 3) to provide agencies with a general idea about the quality of the data they are submitting to VPHIB by quantifying the frequency of validation errors. Agencies not achieving an "acceptable" level in the dashboard have access to detailed information as needed.

Two detailed reports are available, one for those who upload third party data and another for those that submit using the State system. Agencies submitting data using third party software can sign on to VPHIB, select "reports" on the "Modules" tab and click on "data transfer history. The data quality report is the last column on the left. A sample system generated quality report is attached as **Appendix K**.

TCC staff can also manually produce a similar report for agencies not using third party vendors or any agency upon request. A sample of the TCC developed "Date Validation Report" is included as **Appendix L**.

Figure 3 - Sample of Statewide Validity Dashboard

VPHIB Average Validity Scores by Agency April 2012 Averages derived from February 2012 submissions

FIELD REP	Agency Name	Agency #	Validity Status	Average	No. of Records Included
Fleenor	BOTETOURT COUNTY EMERGENCY SERVICES	01128		92.12	219
Burch	BOYDTON LIFE STATION INC	00553		99.97	33
Berry	BOYKINS VOLUNTEER FIRE DEPARTMENT & RESCUE SQUAD INC	00323		97.82	28
Daniels	BRANDY STATION VOLUNTEER FIRE DEPARTMENT	00607		100.00	10
Daniels	BRIDGEWATER VOLUNTEER RESCUE SQUAD	00247		64.48	56
Kendrick	BRISTOL LIFE SAVING CREW	00437		85.59	273
Daniels	BROADWAY EMERGENCY SQUAD	00049		61.06	35
McNeer	BROOKNEAL RESCUE SQUAD INC	00129		93.33	9

Figure 4 thru Figure 6 exhibits various EMS system demographics and allows TCC staffs with the ability to know where to focus on improvements.

Figure 4 – Validity Scores by Region

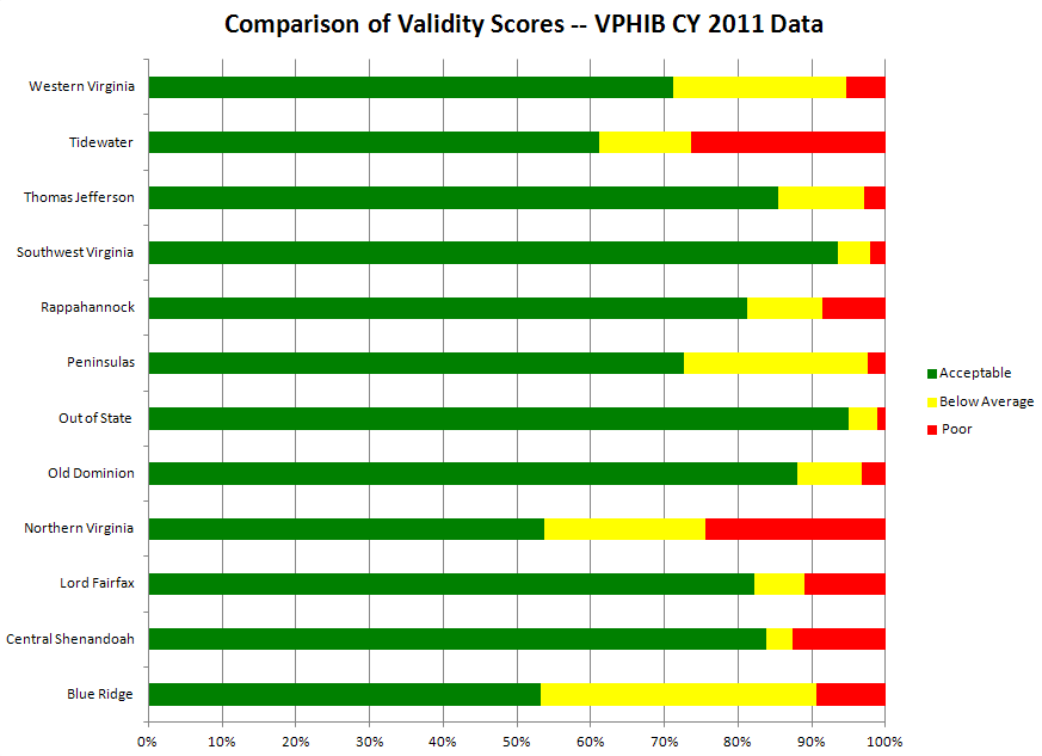


Figure 5 – Validity Scores by Agency Type

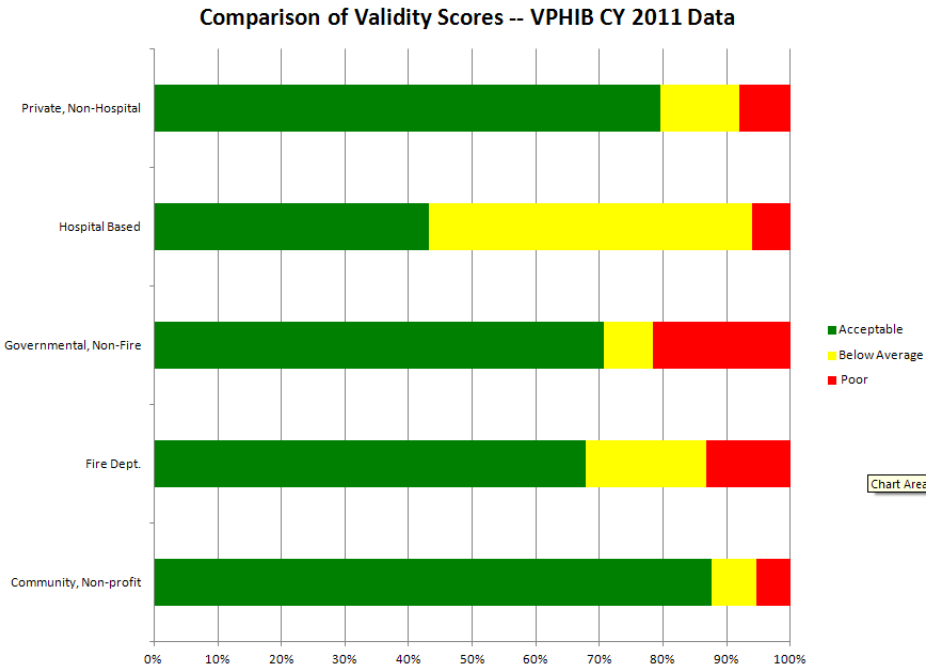
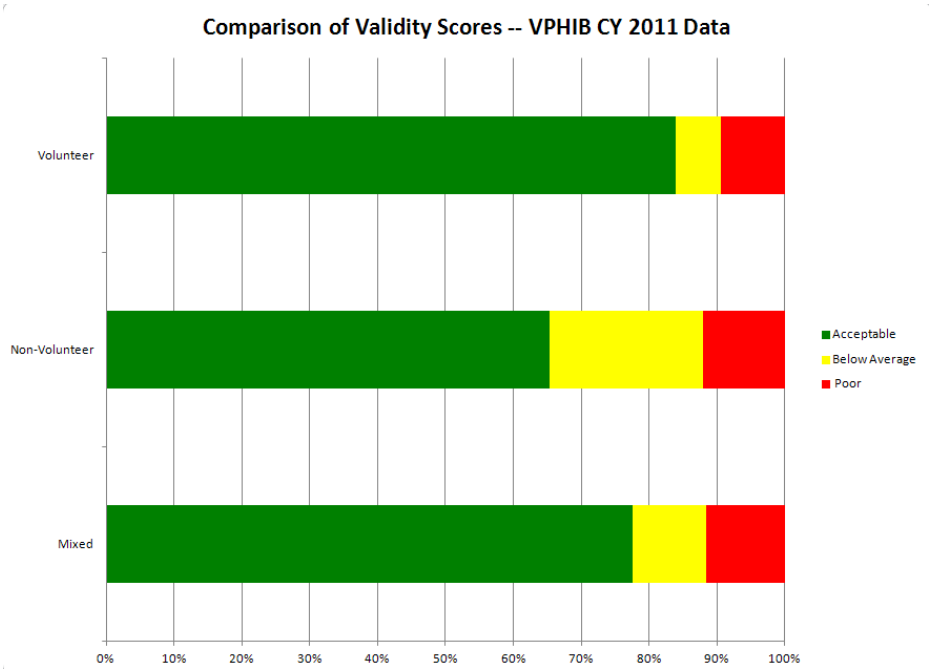


Figure 6 – Validity by Agency Status



OEMS' efforts to improve data quality: Finding and correcting EMS data quality does not fall on the EMS agencies alone. During this quarter the TCC Informatics Coordinator and Trauma/Critical Care Coordinator spent the bulk of their time assessing and creating fixes to prevent poor data. Through the increase of data request being received, each request provided an opportunity to identify areas of weaknesses. In addition, rolling out the validation dashboard allowed for dialogue between TCC staff and agencies which provided insight into ways to better help agencies see data quality issues. Several opportunities for improvement on how OEMS manages quality came to light.

TCC staff and ImageTrend spent many hours on web conferences performing data cleanup of data errors that primarily come from third party vendors (including our own). We continue to work alongside of ImageTrend to help identify how errors can occur despite systems being in place to prevent them.

TCC staff has worked directly and indirectly with several agencies to problem solve errors arising from the agency side of VPHIB data submission. One example of the benefit of meeting with an agency and their software vendor is shown below:

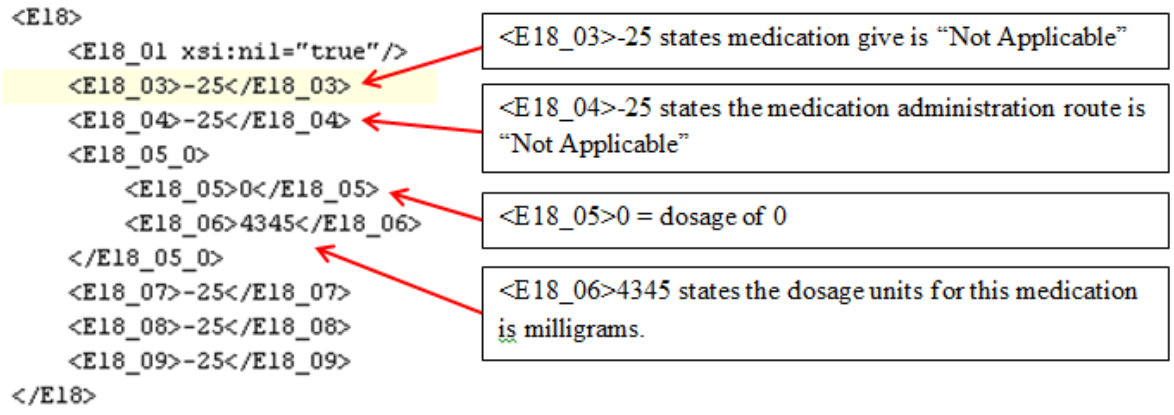
This agency was concerned because out of 2,437 records uploaded 2,014 had the below error with E18_03/medication name (Figure 7). The rule states that you cannot submit a record stating that the medication is not applicable, (they didn't give a medication) and then report, as in this case, that the administration of medication that was not given, was in milligrams. Figure 8 below shows the error coming from the agency's software in their XML file. The vendor will be able to correct the error which should benefit all of its customers.

Figure 7 - Extract of VPHIB System Generated Data Quality Report

Total Records in File: 2437	Records Valid (0-39): 15
Records Imported: 2437	Your Avg Validity for last 90 days: 72
	System Avg Validity for last 90 days: 84

System Validation Issues	
Validation Error	Count
(E18_03) Medication name is missing when there is a dose, route, response, or complication given.	2014

Figure 8



EMS Data Output

Data requests: New data request sections were added to the VPHIB Support Suite and OEMS Web page. In addition to accessing the Data Request Form, other resource materials were added to assist requestors with understanding the limitations of access to trauma and EMS data. These resources include "FOIA & the EMS and Trauma Registries" (**Appendix M**)," VDH's Confidentiality Policy found on-line at http://oemssupport.kayako.com/Knowledgebase/Article/View/85/0/vdh-confidentiality-policy, and the procedure for obtaining an Institutional Review Board (IRB) approval. An IRB is required for accessing identifiable data and may also be found on-line at http://oemssupport.kayako.com/Knowledgebase/Article/View/84/0/identifiable-data-procedures---irb.

Figure 9 – New OEMS Webpage Data Request Page

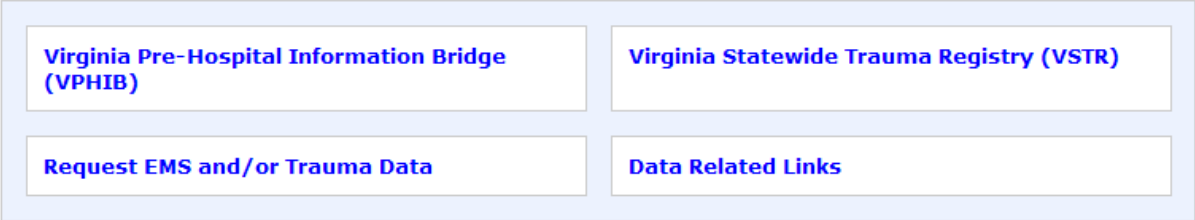
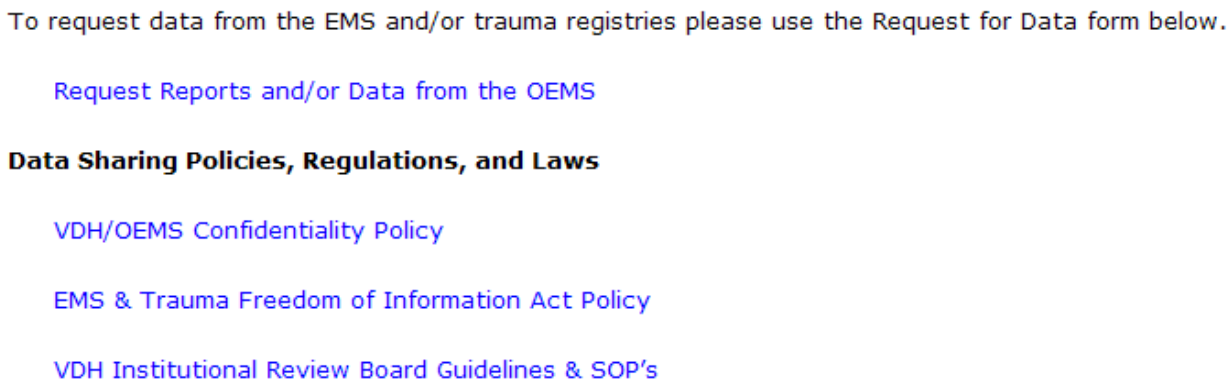


Figure 10 – Data Request Webpage Items



New access to statewide EMS data: A new VPHIB Report Writer user permission level has been added to the VPHIB system. The new role called **"local EMS system user"** provides limited access to statewide EMS data and has no true patient identifiable data elements included within its standard or ad-hoc reporting capabilities. Instructions for creating reports using the local EMS system user role are attached as **Appendix N**. However, used in conjunction with other data sources and/or other information the role has the potential to become identifiable.

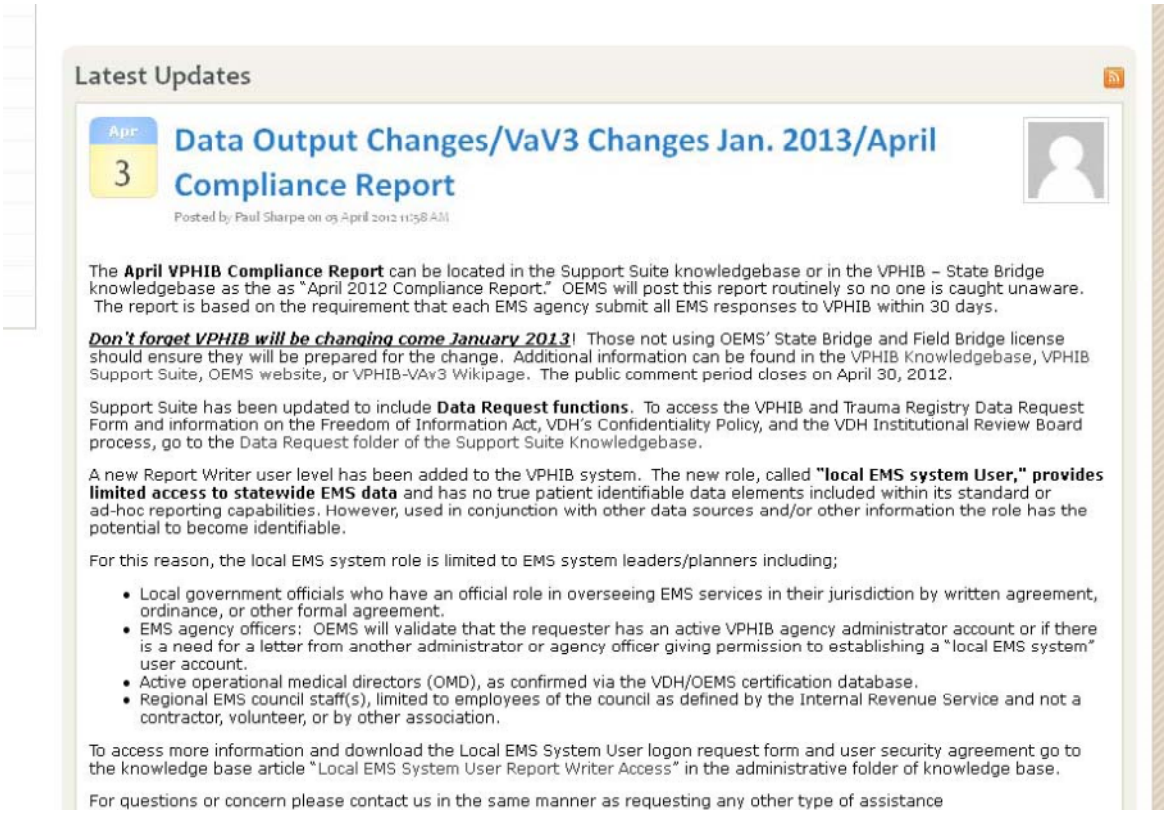
For this reason, the local EMS system role is limited to EMS system leaders/planners including;

- Local government officials who have an official role in overseeing EMS services in their jurisdiction by written agreement, ordinance, or other formal agreement.
- EMS agency officers: OEMS will validate that the requester has an active VPHIB agency administrator account or if there is a need for a letter from another administrator or agency officer giving permission to establishing a "local EMS system" user account.
- Active operational medical directors (OMD), as confirmed via the VDH/OEMS certification database.
- Regional EMS council staff(s), limited to employees of the council as defined by the Internal Revenue Service and not contractors, volunteers, or by others association.

To access more information and download the local EMS system user logon request form and user security agreement go to the knowledge base article "Local EMS System User Report Writer Access" in the administrative folder of knowledge base.

For questions or concern please contact us in the same manner as requesting any other type of assistance http//:support@OEMSSupport.Kayako.com or support@OEMSSupport.Kayako.com.

Figure 11 – New Data Output Changes Announced



Latest Updates

Apr 3

Data Output Changes/VaV3 Changes Jan. 2013/April Compliance Report

Posted by Paul Sharpe on 03 April 2012 11:58 AM

The **April VPHIB Compliance Report** can be located in the Support Suite knowledgebase or in the VPHIB – State Bridge knowledgebase as the as "April 2012 Compliance Report." OEMS will post this report routinely so no one is caught unaware. The report is based on the requirement that each EMS agency submit all EMS responses to VPHIB within 30 days.

Don't forget VPHIB will be changing come January 2013! Those not using OEMS' State Bridge and Field Bridge license should ensure they will be prepared for the change. Additional information can be found in the VPHIB Knowledgebase, VPHIB Support Suite, OEMS website, or VPHIB-VAv3 Wikipage. The public comment period closes on April 30, 2012.

Support Suite has been updated to include **Data Request functions**. To access the VPHIB and Trauma Registry Data Request Form and information on the Freedom of Information Act, VDH's Confidentiality Policy, and the VDH Institutional Review Board process, go to the Data Request folder of the Support Suite Knowledgebase.

A new Report Writer user level has been added to the VPHIB system. The new role, called **"local EMS system User," provides limited access to statewide EMS data** and has no true patient identifiable data elements included within its standard or ad-hoc reporting capabilities. However, used in conjunction with other data sources and/or other information the role has the potential to become identifiable.

For this reason, the local EMS system role is limited to EMS system leaders/planners including;

- Local government officials who have an official role in overseeing EMS services in their jurisdiction by written agreement, ordinance, or other formal agreement.
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- Active operational medical directors (OMD), as confirmed via the VDH/OEMS certification database.
- Regional EMS council staff(s), limited to employees of the council as defined by the Internal Revenue Service and not a contractor, volunteer, or by other association.

To access more information and download the Local EMS System User logon request form and user security agreement go to the knowledge base article "Local EMS System User Report Writer Access" in the administrative folder of knowledge base.

For questions or concern please contact us in the same manner as requesting any other type of assistance

Figure 12 and 13 below show samples of the local EMS system user role. There are currently 27 configurable standard reports and access to the VPHIB data cube.

Figure 12

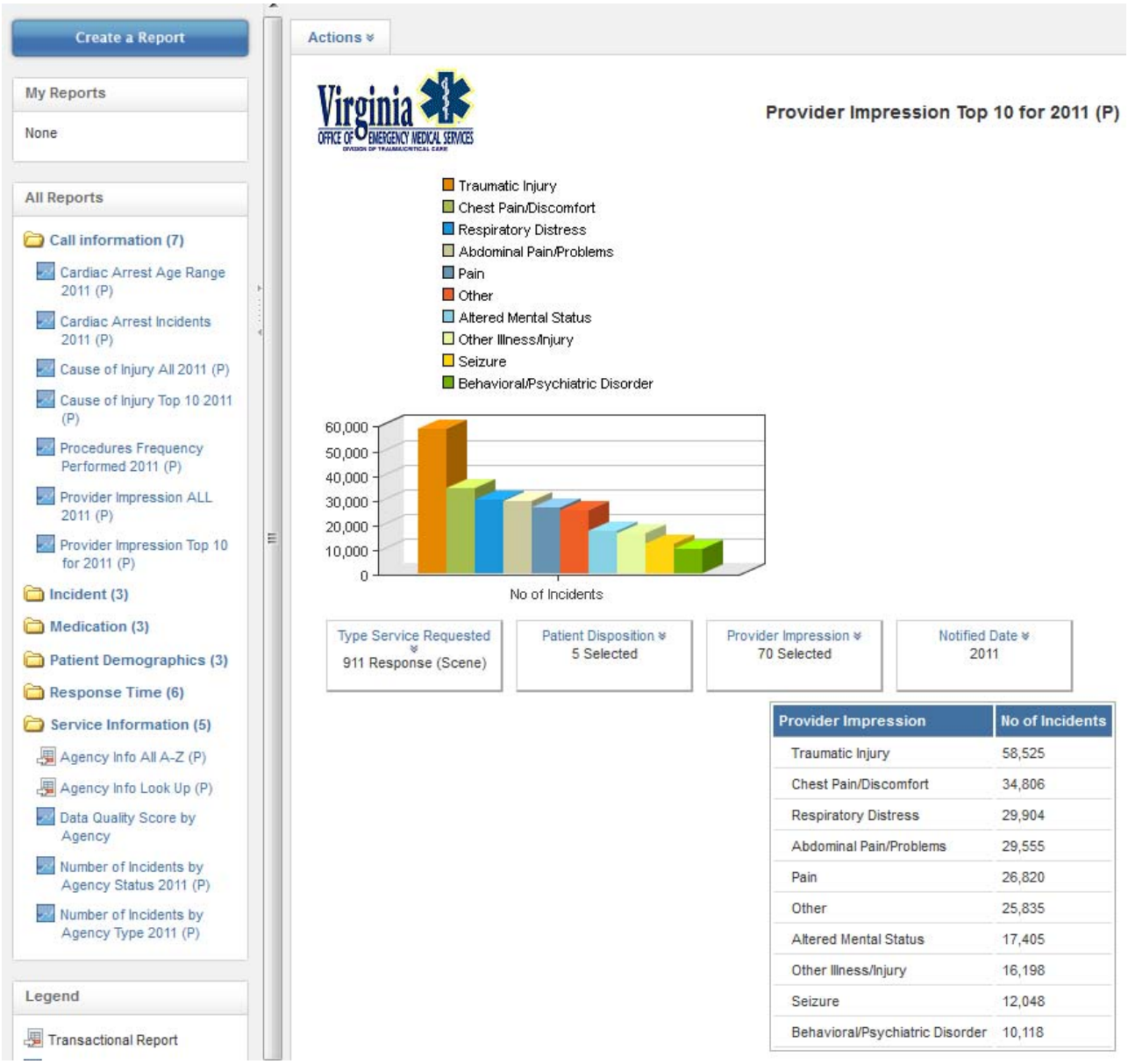
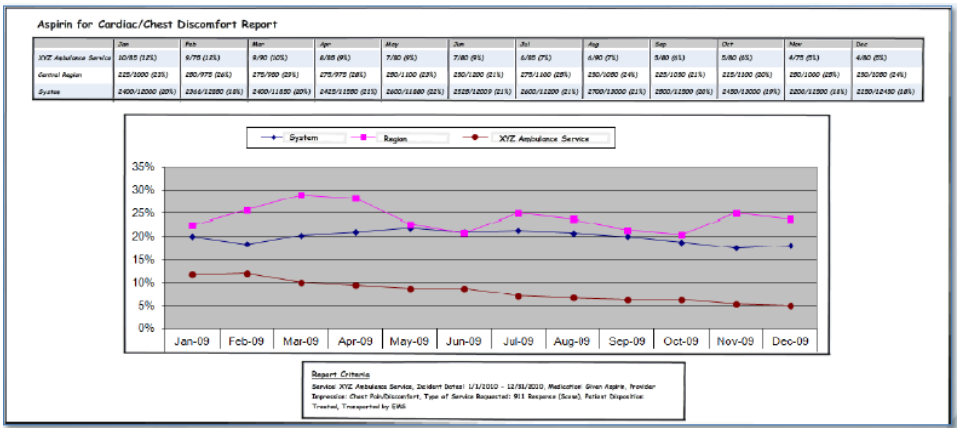

Create a Report
My Reports
None
All Reports
Call information (7)
Cardiac Arrest Age Range 2011 (P)
Cardiac Arrest Incidents 2011 (P)
Cause of Injury All 2011 (P)
Cause of Injury Top 10 2011 (P)
Procedures Frequency Performed 2011 (P)
Provider Impression ALL 2011 (P)
Provider Impression Top 10 for 2011 (P)
Incident (3)
Medication (3)
Patient Demographics (3)
Response Time (6)
Service Information (5)
Agency Info All A-Z (P)
Agency Info Look Up (P)
Data Quality Score by Agency
Number of Incidents by Agency Status 2011 (P)
Number of Incidents by Agency Type 2011 (P)
Legend
Transactional Report
Actions
Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Provider Impression Top 10 for 2011 (P)
Traumatic Injury
Chest Pain/Discomfort
Respiratory Distress
Abdominal Pain/Problems
Pain
Other
Altered Mental Status
Other Illness/Injury
Seizure
Behavioral/Psychiatric Disorder
60,000
50,000
40,000
30,000
20,000
10,000
0
No of Incidents
Type Service Requested
911 Response (Scene)
Patient Disposition
5 Selected
Provider Impression
70 Selected
Notified Date
2011
Provider Impression
No of Incidents
Traumatic Injury 58,525
Chest Pain/Discomfort 34,806
Respiratory Distress 29,904
Abdominal Pain/Problems 29,555
Pain 26,820
Other 25,835
Altered Mental Status 17,405
Other Illness/Injury 16,198
Seizure 12,048
Behavioral/Psychiatric Disorder 10,118

Figure 13

New comparative analysis reports: New comparative analysis reports will soon be added to participating states State Bridges. The new comparative analysis reports will allow individual EMS agencies to compare their own operational and clinical reports against their region, the state or to other similar EMS agencies within the state. Figure 14 shows a sample comparative analysis report where an agency compares its rate of aspirin administration to chest pain patients to its region's rate and that of the state.

Figure 14



Data Submission Compliance

VPHIB compliance remains high: With VPHIB compliance remaining generally high we will likely remove this as a standard item to report in the future. The only major VPHIB related compliance item during this period was VHD/OEMS' efforts to bring some long term VPHIB related compliance cases to a close. VDH/OEMS turned to local government to try and seek assistance with those agencies with long term compliance issues. This approach has helped resolve some cases and is hoped to be an additional step of assistance and encouragement prior to taking final compliance action.

On the Technical Side

Server environment: At the server level, on February 29th the VPHIB servers RAM were increased from 16GB each to 64 GB each. The increase was made to electively enhance VPHIBs response times, its upload speed, addition of web services, and provide extra power for the new local EMS system user role. Additional data storage space was also added during this reporting quarter. Recent challenges include an issue with one of the web servers which caused minor difficulties signing on to VPHIB and occasionally dropping sessions. It was also discovered that routine server defragmentation was not occurring and the indexing for these servers were reprogrammed to perform at an optimal level.

VPHIB application: During this quarter the VPHIB State Bridge and Field Bridge were updated to version 5.2 from version 5.1. Version five not only brought a new look to the programs, but provided significant improvements in the background. The validation tool has been greatly enhanced to allow us to create better data quality logic checks, the ability in the future for TCC staff to be able update the run form templates so that when providers enter a vital sign or procedure they will no longer have to separately document the skill as a procedure, and the addition of the data validation report card as described above.

Here are some important new features included in this release:

- **Field Bridge:**
  - The Last Name field will auto-search the repeat patient database

*<u>Note:</u> This functionality, as well as the Repeat Patient button, will be hidden if the Use Repeat Patients service setting is turned off. Previous versions of Field Bridge were *not* looking at this setting.*

  - The Dashboard will now show how many unread QA/QI messages you have (along with a link to your SB)
  - You now have the ability to hide/show any of the 4 CAD/Transfer buttons
- **EKG Integrations (w/i Field Bridge):**
  - Physio Code-Stat 9 is now supported
  - ZOLL 5.21 is now supported
  - The Import wizard window runs asynchronously (allowing the user to continue to enter data while the import is running)
- **Hospital Dashboard*:***
  - A new user management screen is now available which allows for a Hospital administrator to set up their own users
  - Batch printing now available
- **Inbox Enhancements:**
  - You will have the ability to send to all users in certain permission group(s)
  - The list of users to choose from now includes those users that have content rights to the given service (not just those listed in the Staff section)
  - When using the External Email checkbox within QA/QI notes, you can now choose to send a generic message instead of the actual QA/QI message
- **NEMSIS Import:**
  - Scorecard reports for NEMSIS Imports will be auto-emailed out to the person who imported the file -- once the imported file has gone through all of the steps (i.e. the last step being completion of validation)
- **Miscellaneous:**
  - Style changes (the I Want To menu from within Service Setup has been replaced by a searchable interface)
  - Many new data fields are available to be added to your run form layout
  - Ad hoc reports have been enhanced with several new fields to report on

Trauma System

TSO&MC March 1, 2012 meeting: The TSO&MC last met on March 1, 2012 and the draft minutes to this meeting can be found posted on the Virginia Town Hall website as required. The key items for this meeting included an update and further discussions on the direction of the Trauma Performance Improvement committee, organizing a new Trauma Center Fund Panel, providing additional funding to Level III centers, and organizing a full revision of the Statewide Trauma Center Designation Manual (this would be the 2014 revision).

Trauma Performance Improvement Committee: Work continues on performance improvement to support the *Statewide Trauma Triage Plan*. The initial data analysis has been updated as follows:

- Updated VSTR analyses from 4th Quarter CY 2011 meeting for 1st Quarter CY 2012 meeting
    - Trauma registry patients admitted to more than one hospital for a given injury. None found!
    - Destinations for patients meeting one or more step one trauma triage criteria
    - Comparison of patients taken to level I trauma center versus those taken to a hospital that is not designated as a trauma center
    - GIS maps created at the county and EMS regions levels
    - Transfers between trauma centers
    - Bar charts for overview and detailed analyses
- Performed new VSTR analyses for 1st Quarter CY 2012 meeting
    - Patient discharge status by trauma center designation level (patient count – column chart)
    - Deaths reported by trauma center designation level (facility count – column chart)
    - Death rates by trauma center designation level (overview – line chart)
    - Death rates by number of step 1 criteria met trauma center designation level (details – table)

Trauma Center Designation Manual 2012 revision: The pending 2012 version of the *Trauma Center Designation Manual* was scheduled to be presented for approval at the March 23rd State Board of Health meeting. VDH executive management elected to pull the manual from the agenda. The reasons for pulling the manual were primarily due to grammatical issues with language that was not part of the revised language. The 2012 revisions were limited to nursing education and burn center criteria and not a full revision.

TCC staff EMS has addressed the items identified by VDH executive management and requested the manual be presented to the June 15th State Board of Health meeting for approval. Centers undergoing verification this year are planning on be reviewed using the revised criteria.

Trauma Center Designation Manual 2014 revision: Five workgroups were established to work on revising focused areas of the trauma manual as shown in Figure 15. A project timeline for revising the trauma manual was set as follows:

- March 1 thru June 7 – Workgroups develop first draft of revised criteria assigned to their group;
- June 8 thru August 31 – Workgroups develop second draft of the revised criteria based on feedback from other groups;

- September 2012 – Trauma conference/retreat focused on trauma manual revision and performance improvement education.

The workgroups are meeting on schedules as needed to accomplish each individual groups objectives.

Figure 15

	Operational	Education/Credentialing	Performance Improvement	Special Needs	Administrative
	Equipment Requirements	TMD Credentials	PI Program Content	Pediatric Requirements	Designation Description
	Review Team Composition	TMD CE	Research	Geriatric Requirements	Organization Commitment
	Site Review Process	Physician Credentials		Bariatric Requirements	Program Leadership
	Review Team Orientation	Physician CE		Re-implantation	Trauma Team Alert
		Mid-level Credentials			Clinical Capabilities
		Mid-level CE			Ancillary Capabilities
		Outreach			Elec. Med Records
		Injury Prevention			follow up/transfer process
		EMS Outreach/Education			TSO&MC Attendance
					Designation Application
					Review Team Checklists
					Trauma Fund (report)
	Work Groups				
Co-Chair	L. Miller (2)	V. Mitchell (1)	F. Calland (1)	N. Martin (1)	A. Wright (1)
Co-Chair		L. Weireter (1)	K. Butler (1)		
	M. Carter (3)	E. Mabry (3)	E. Altizer (3)	M. Hall (2)	J. Gilley (3)
	M. Myers (1)	M. Hall (2)	M. Myers (1)	A. Turner (2)	A. Turner (2)
	R. Makhoul (3)	D. Taylor (1)	L. Wells (2)	EMSC Member (TBN)	B. Hawkins (n/a)
	L. Harris (3)		L. Harris (3)	Kelly Rumsey (1P)	D. Taylor (1)
					Susan Ward (n/a)

Trauma Center Fund: During the March 2012 TSO&MC a plan to appoint a new Trauma Fund Panel was made and a lengthy discussion held on providing additional financial support to Level III trauma centers. The panel advises on the Trauma Center Fund Distribution Policy. Revising the policy provides further guidance on how the funds are to be utilized in the future.

At the time of this report the next trauma fund distributions had not yet been made due to one of the funding sources not yet being received by OEMS fiscal. Table 2 below has the information available at this time.

Table 2

TRAUMA FUND REVENUES
CARS REPORTS

Month Collected	DUI Revenue Source Code 08192	DMV Revenue Source Code 02652	Interest Revenue 07108	Totals
Dist. Jan-12	3,875.45	$ 1,508,760.00	0.00	1,512,635.45
Dist. Feb-12	5,888.06	*$ 2,582,319.00*	0.00	2,588,207.06
Pending Mar-12	0.00	*$ 2,069,160.00*	0.00	2,069,160.00
	0.00	0.00	0.00	0.00
Quarterly Totals	9,763.51	6,160,239.00	0.00	6,170,002.51

Dist. = previously distributed and reported.
More information on the trauma fund can be found in the full trauma fund document, the "*Virginia Office of Emergency Medical Services Trauma Fund Grant Information and Disbursement Policy"*. This document and other trauma related documents can be found at: http://www.vdh.virginia.gov/OEMS/Trauma/index.htm

Emergency Medical Services for Children (EMSC)

EMSC committee quarterly meeting *(addresses Performance Measure 80)*: The EMS for Children (EMSC) Committee of the EMS Advisory Board had its quarterly meeting April 29, 2012 in Glen Allen, VA. The remaining 2012 meetings of the EMSC Committee are scheduled for July 12 and October 4.

"Death of a Child EMSAT video in production *(addresses Performance Measure 78)*: The education arm of the OEMS is moving ahead with a video training session relating to managing pediatric death scenes for May 2012. Members of the EMSC Committee, and especially Virginia Powell from the Office of the Chief Medical Examiner, have been integral to creating and producing this upcoming presentation.

Transporting children safely in ambulances" DVD planned *(addresses Performance Measure 80)*: The EMSC program is planning to create a DVD for Virginia EMS providers concerning the safe transport of children in ambulances, based upon the draft recommendations of the committee tasked with that objective for the National Highway Transportation Safety Administration (NHTSA). North Carolina (NC) recently accomplished a similar project, and NC's presentation would be customized to Virginia. For a draft version of the NHTSA report, visit the following web link: http://www.nasemso.org/Councils/PEDS/documents/EMS_Child_Transport_Working_Group_July_Final_Draft_7-2-20102.pdf.

Stakeholder input for hospital Pediatric Designation Program nears completion *(addresses Performance Measure 74)*: The Pediatric Emergency Department (PED) Designation Work Group met again March 11, 2012 and made further revisions to the draft criteria for three levels of a voluntary PED Designation program. The criteria are now undergoing discussions and review by the Virginia Hospital and Healthcare Association as the final step in procuring stakeholder input to the proposed program. Copies of **Version 031112** of the draft criteria are available upon request from David Edwards (david.edwards@vdh.virginia.gov) in pdf format.

PED designation in Virginia is just part of a nationwide effort to establish recognition programs for hospitals that can provide certain levels of emergency medical and/or trauma care for children. This was a major recommendation of the Institute of Medicine and is being facilitated through the EMSC program with funding from the Health Resource and Services Administration.

Emergency Nurses Pediatric Course (ENPC) at 2012 Symposium *(addresses Performance Measure 78)*: The EMSC Program is sponsoring an ENPC at the 2012 EMS Symposium, and there will be no additional charge to students beyond their Symposium registration. A limited number of paramedics will be accepted into the course for continuing education credit, but they will not be able to claim the certification. The ENPC course is being supported with federal EMS for Children funding awarded to Virginia.

Regional pediatric symposiums *(addresses Performance Measure 78)*: The EMSC Committee still plans to sponsor a series of regional one-day pediatric symposiums throughout the state in 2012 to increase the availability of pediatric education/training. The EMSC Program will work closely with EMS Regional Councils in spreading the word as these sessions become available, and in determining the best places in which to hold the training.

ED site visits continue *(addresses Performance Measure 74)*: The EMSC Program visits 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 web link: http://www.nasemso.org/Councils/EMSC/documents/Guidelines_for_Care_of_Children_in_the_ED.pdf. Grant-funded supplies are distributed to the EDs agreeing to be assessed.

EMSC program ideas always welcome: Ideas are always being accepted for EMSC toolkits for the EMSC website, and for any other aspect of Virginia's EMSC Program housed in the OEMS. Direct those ideas to David Edwards, VA EMSC Coordinator, by e-mail (david.edwards@vdh.virginia.gov), by phone (804-888-9144) or by mail (EMSC Program, Office of EMS, 1041 Technology Park Drive, Glen Allen, VA 23059).

Durable Do Not Resuscitate (DDNR)

Downloadable DDNR well accepted: OEMS has still received over 95% positive feedback about the new multi-part DDNR Order available for download on the Internet. Due to the number of requests for a Spanish version of the DDNR Order, OEMS has been in contact with

the Office of Minority Health and Public Health Policy in regards to getting the form translated. OEMS has been advised that VDH has a new vendor contract for interpretation and translation services, World Wide Interpreters, Inc. (WWI) located in South Houston, TX. No timeframe has been provided as to when they will complete the translations, have them reviewed, and approved by the appropriate authority.

Reminder of new regulations: The DDNR regulations were approved by the Governor and went into effect in July 2011. The OEMS website has been updated with a new multi-page DDNR Order form available for download and printing. The regulations also now allow for legible photocopies of DNR orders to be accepted by health care personnel. The new form can be seen on-line at http://www.vdh.virginia.gov/oems/ddnr/ddnr.asp.

Respectfully Submitted

Office of EMS Staff

Appendix

A

Issue Brief for NASEMSO Members:
Drug Shortages and Controlled Substance Regulation

Updated Apr. 13, 2012

Current national discussions about medication availability and controlled substance regulation revolve around two separate but interrelated categories of issues. These two issues are complicated, mutually exacerbating, and both are in dire need of resolution.

Drug Shortage Issue

In recent months, the issue of shortages of medications administered by EMS personnel has risen to the forefront.

- On February 29, 2012, the Joint National EMS Leadership Forum (JNEMSLF), with nine associations represented, identified "drug shortages" as an issue of national significance that warranted immediate attention.

- The JNEMSLF, which is facilitated by NASEMSO, agreed to work collaboratively to develop a white paper to capture a consensus based assessment of the problem and a call for action for a solution.

- Through a workgroup led by the International Association of Fire Chiefs on behalf of the JNEMSLF, letters were crafted and signed by NASEMSO and seven other national organizations and distributed to members of the House and Senate Committees expected to deliberate the bill once introduced. A list of members of Congress on the germane committees provided to us by IAFC can be found here.

An informational white paper recommending changes to a draft piece of federal legislation (being considered by the House Energy & Commerce Committee: https://www.nasemso.org/Members/documents/Title_IX_Drug_Shortages.pdf) was simultaneously circulated by the Association for Critical Care Transport (ACCT), including to all JNEMSLF participants. The draft has provisions related to drug manufacturers' and the Food & Drug Administration's duties and responsibilities. Fourteen national organizations including NASEMSO signed on to that white paper.

DEA Issue

In a separate but related initiative, Drs. Carol Cunningham [OH] and Joe Nelson [FL] represented NASEMSO on a multi-organization task force of EMS physician leaders led by the American College of Emergency Physicians. This group has focused on the Drug Enforcement Agency's (DEA) problematic and inconsistent application of DEA regulation as it relates to medical direction and controlled substances in the EMS environment.

- In advance of a March 13 briefing to the Federal Interagency Committee on EMS Medical Oversight Committee/Technical Working Group, NASEMSO participated in the

development of and signed on to correspondence (https://www.nasemso.org/Members/documents/DEA-FICEMS_DEALetter.pdf) sent to Dr. Rick Hunt MD in his capacity as Chair the committee.

- A white paper supporting the briefing outlines the issues, summarizes findings of a survey of state and local EMS medical directors illustrating the problems, and places a call to action to FICEMS to engage the DEA to resolve the issues related to EMS medical direction and controlled substance use.

NASEMSO staff, and leadership guided by the Medical Directors Council continue to be vigilant about emerging activities related to DEA regulation and acting on them accordingly. For example:

ACCT-ACEP White Paper

- On April 4, the Executive Director of the Association for Critical Care Transport (ACCT), who is also the chief lobbyist for Advocates for EMS, was invited to provide language for a fast moving piece of federal legislation related to the DEA to address the controlled substances regulatory issues.

- A white paper was rapidly crafted by ACCT over the ensuing weekend and NASEMSO leadership met by teleconference on Monday April 9 to deliberate the sign on invitation. So far, we are aware that ACCT, ACEP, the National EMS Management Association, IAFC, and the National Association of EMS Physicians have signed on to this initiative.

- NASEMSO leadership has declined the sign on invitation because it calls on Congress to mandate an attorney general review of the situation and underlying DEA regulations and policies.

- NASEMSO leadership is committed to engaging the DEA through FICEMS as described above, and believe that bypassing this critical first step of engagement and requesting federal legislation may be viewed as confrontational, premature, and contrary to the approach previously identified and potentially counterproductive. A complete explanation of our rationale is included in the correspondence sent to ACCT and ACEP leadership.

- ACEP and ACCT have been asked to join the JNEMSLF and use that platform for further deliberation of action steps.

White Paper
The Impact of Drug Shortages on
Patients with Emergency Medical, Critical and Life-Threatening Illness or Traumatic Injury

Background

The nationwide drug shortage problem has recently developed into alarming impact on patients with an emergency medical, critical and life-threatening illness or traumatic injury. Emergency medical services (EMS) encompasses emergency medical and trauma care provided to patients at any point in the continuum of health care services. "Field EMS" refers to emergency medical and trauma care provided *outside* of the hospital, most often prior to and during transport to a hospital. Field EMS providers conduct nearly 25 million transports for more than 8 percent of the US population per year, predominantly by ground, but also by air. Of those transports, patients who are critically ill or injured are transported by specialized critical care transport (CCT) providers by ground and air, including approximately 400,000 patients flown by fixed and rotor wing air ambulances every year. Field EMS and CCT providers administer life-saving care, often through the use of specialized equipment or drug therapies, while transporting a patient from the scene to a medically appropriate receiving hospital or between hospitals, typically moving patients to a higher tertiary care facility. While the drug shortage crisis emerged largely around sterile injectables, particularly in oncology, the crisis has spread to EMS, including emergency departments, CCT and Field EMS with a direct and adverse impact on extremely vulnerable patients with emergency medical and life-threatening critical care conditions.

At least 30 drugs on the FDA's current shortage list are commonly used as part of EMS, Field EMS and CCT. Among these drugs are ones used to treat cardiac, stroke, seizure, severe pain and high risk obstetrical patients in the field. If patients do not have access to these drugs within a very short time window, it can mean the difference between life and death or serious disability. In addition, certain sedatives that are used to treat combative patients are in short supply, putting the transport team and patient at risk as they attempt to treat and transport an agitated or noncompliant patient. Air ambulance providers have already had to turn away critical care patient transports due to their inability to secure and maintain life-saving drugs, putting patients at extraordinary risk.

Our nation depends upon EMS, CCT and Field EMS providers to be able to respond to mass casualty events, as well as individual emergencies. However, without the proper drug supply, these essential providers are severely limited in their ability to provide ample surge capacity or ensure that they will be able to meet the needs of patients with emergency and critical care conditions whose lives are literally and immediately at stake.

Limitations of Stop-Gap Measures

EMS, CCT and Field EMS providers are working to manage their drug supplies despite ongoing shortages as best they can, but certain stop-gap solutions are particularly difficult for medical and critical care transport providers to implement. Physician medical directors are now routinely facing difficult choices in directing nurses and paramedics in the utilization of suboptimal

substitute and expired drugs, as well as having to reserve limited and essential drug supplies for those patients in the greatest need. This puts patients at risk and physician medical directors in the untenable position of jeopardizing their medical licenses to best meet the needs of all of their patients with emergency medical, critical and life-threatening illness or traumatic injuries.

Substitutions

While therapeutic alternatives may exist for certain drugs, they are often in the form of non-preferred drugs and are sometimes only available in unfamiliar concentrations or vial sizes. Despite additional training, such substitutions can lead to dangerous situations involving medical errors of dosages when using different concentrations, especially in emergency situations when professionals are moving quickly, transport conditions are suboptimal, and time is of the essence.

Expiration Date Extensions

Under medical direction some providers are extending the expiration dates of select drugs for lack of a better alternative. There is no formal mechanism for extending medication shelf-life in the civilian environment. Therefore, medical directors are left to make individual decisions that may put their license on the line because they believe it is in the best interest of their patients to receive an expired drug instead of no drug.

Scope of Practice Issues

Certain substitutions may involve drugs that can only be administered by a specific type of trained professional. For example, in some states the scope of practice delineates the specific drugs an EMS provider may deliver. A substitute for that drug may not be included in that state's scope of practice, making it illegal for a paramedic to deliver that substitute drug. These and other “scope of practice” issues are of particular concern in the medical transport setting.

To illustrate further by example, in the State of Oregon, there are no injectable benzodiazepines available for purchase. These medications are used to stop active seizures (among other things). It is possible that a child could be left to seize for an entire transport because these drugs were unavailable. This could lead to significant disability or death of the patient. In addition, these medications are utilized for sedation to help EMS place breathing tubes into critical patients. Other drugs used to facilitate this procedure are also unavailable, putting our nation's trauma patients at risk.

Proposed Solutions

As Congress considers legislative options to address the drug shortage issue, our organizations stand ready to work with Members on a range of solutions to help improve the drug supply and mitigate the effects of shortages on patient care. We support Congressional efforts to require and expand advance notification systems so EMS, CCT and Field EMS providers are better able to manage potential shortages with additional lead time. We are concerned, however, that addressing drug shortages for pharmaceuticals that are "life-supporting, life-sustaining, or intended for use in the prevention of a debilitating disease or condition" does not adequately

capture the situation of drugs used for patients with emergency medical, critical and life-threatening illness or traumatic injury. In medical circles, the terms "life-sustaining and life-supporting" do not apply to acute emergency medical, critical and life-threatening conditions.

Thus, whatever solutions the Congress chooses to employ should specifically encompass and reference drugs used for treatment of patients with emergency medical, critical and life-threatening illness or traumatic injury, promote access to life-saving drugs where they are most needed by patients, and seek to identify and remove impediments to the ability of providers to compensate for lack of access to a preferred drug in the best interest of their patients.

In addition, we urge Congress to ensure that any stakeholder consultation process include representatives of the EMS, Field EMS and critical care transport communities. Accordingly, we recommend the following revisions to the legislative language that has been released to date:

I. House Energy & Commerce Committee's PDUFA discussion draft document:

- Page 193, Sec. 901 – Under SEC. 506C(a)(1) – add "(D): or intended for use in the treatment of an emergency medical, critical or life-threatening illness or traumatic injury
- Page 195, (B) – add "or intended for use in the treatment of an emergency, critical or lifethreatening illness or traumatic injury."
- Page 198, Sec. 904 – add "or intended for use in the treatment of an emergency medical, critical or life-threatening illness or traumatic injury" to the title of the Section.
- Page 201, (3) Amend to read "Is there a reason why drug shortages have occurred primarily in the sterile injectable market, and in certain therapeutic areas including drugs used for patients with emergency medical, critical and life-threatening conditions?"
- Page 201, add new (7) "How does the drug shortage crisis affect particular patient populations for whom lack of access to drugs can mean the difference between life, death or severe disability?"
- Page 201, add new (8) "How are providers, including hospitals, physicians and physician medical directors compensating for lack of access to preferred drugs in caring for their patients and are there impediments to their ability to adjust accordingly that can be ameliorated?"
- Page 201, (c) – add "emergency medical services and critical care transport providers."
- Page 205, (11) – add "emergency medical services and critical care transport providers."

II. Senate HELP PDUFA discussion draft on prescription drug shortages:

- Page 3 - following (1)(C) add "(D) drugs intended for use in the treatment of an emergency medical, critical or life-threatening illness or traumatic injury."

Advocates for Emergency Medical Services
Air Medical Physician Association
American College of Emergency Physicians
American Heart Association/American Stroke Association
American Trauma Society

Association of Air Medical Services
Association of Critical Care Transport
International Association of Fire Chiefs
National Association of EMS Educators
National Association of EMS Physicians
National Association of State EMS Officials
National EMS Management Association
National Association of Emergency Medical Technicians
Trauma Center Association of America

DRUGS USED FOR EMS, FIELD EMS and CCT PATIENTS CURRENTLY IN SHORTAGE

- Amiodarone – for lethal heart arrhythmias that left untreated will stop the heart
- Atropine – to increase a heart rate which is too slow to sustain life
- Calcium Chloride and Calcium Gluconate – antidote for life threatening high potassium that threatens our dialysis patients
- Dexamethasone – for life threatening allergic reactions and asthma. Additionally for adrenal crisis that can lead to severe shock, death and disability
- Diazepam, Midazolam, Lorazepam – to stop active seizures and for sedation
- Diltiazem – to slow a very fast heart rate, which compromises cardiac function
- Diphenhydramine – for severe allergic reactions
- Epinephrine – (adrenaline) used for life threatening allergic reactions and acute pediatric asthma (intermittent shortages)
- Etomidate – sedative used to facilitate emergent intubation before placing someone on a ventilator
- Fentanyl – pain relief (similar to morphine)
- Forphenytoin – to prevent and stop seizures
- Furosemide – diuretic for serious heart failure
- Haloperidol – major sedative for combative patients
- Labetalol – to treat high blood pressure in patients with life threatening conditions
- Lidocaine – used in cardiac arrest - major stoppage of the heart as well as a local anesthetic
- Magnesium – to treat life threatening cardiac arrhythmias and also used as an adjunct in the treatment of emergent asthma conditions
- Mannitol – reduces brain swelling in serious head injury
- Morphine – pain medication
- Nicardipine – to treat dangerously high blood pressure in medical conditions such as stroke
- Nitroglycerin – used in the treatment of patients with heart attacks and angina
- Ondansetron – prevents vomiting. Significant during transport of a head injured patient
- Oxytocin – after delivery of a baby to prevent maternal uterine bleeding
- Phenylephrine – to increase blood pressure if the blood pressure is dangerously low
- Pancuronium – muscle relaxant used to facilitate ventilation and oxygenation in a patient with a breathing tube in place

- Phytonadione – to reverse the effects of oral blood thinning drugs in patients with life threatening bleeding
- Potassium – to increase the blood potassium level which left untreated can produce life threatening cardiac arrhythmias
- Procainamide – heart drug for life-threatening rhythm problems
- Prochlorperazine and Promethazine – to prevent vomiting
- Terbutaline – for pre-term labor and severe asthma
- Vasopressin – to restart the heart in cardiac arrest
- Vecuronium – muscle relaxant used to facilitate ventilation and oxygenation in a patient with a breathing tube in place

March 13, 2012
Briefing Regarding EMS Drug Enforcement Administration (DEA) Issues

Prepared by:

Jeffrey M. Goodloe, MD, NREMT-P, FACEP; ACEP EMS Committee, Medical Director, Medical Control Board, EMS System for Metropolitan Oklahoma City & Tulsa, Oklahoma

Sabina A. Braithwaite, MD, MPH, FACEP, NREMTP; ACEP EMS Committee Chair, Medical Director, Wichita- Sedgwick County EMS System, Wichita, Kansas.

Background:

The current practice of EMS medicine is of significant importance to a community's health and public safety. Thousands of physicians serving as EMS medical directors provide medical oversight to tens of thousands of EMS professionals, including over 72,500 Paramedics (source: 2010 Annual Report of National Registry of EMTs).

EMS providers routinely administer controlled substance medications to abate life-threatening seizures and control pain from traumatic injuries, such as fractures, burns, and amputations. To provide optimal patient care using these medications, a clear understanding of DEA regulations and expectations regarding the practice of EMS medicine is vital to promoting and ensuring the proper ordering, storing, supplying, administering, and disposal of these controlled substance medications. Physician medical directors of EMS agencies advocate appropriate controlled substance handling to maintain their EMS medical practice with regulatory and ethical integrity as well as to prevent diversion and abuse of these controlled substance medications.

Due to the routinely encountered clinical need for controlled substance medications in the practice of EMS medicine, all physician medical directors of EMS agencies desire to be in full compliance with DEA regulations. However, considerable confusion exists as to what practices properly fulfill the relevant DEA regulations and expectations regarding controlled substance medications in the EMS environment as noted from anecdotal discussions among EMS medical directors, EMS administrators, and officials at DEA offices across the United States. This

confusion may partly arise from the fact that the current regulations do not take into account the significant differences between EMS practice/work environment and that of other healthcare entities and individuals covered by the same regulations. To wit, a comprehensive review of the current DEA regulations (source 21 CFR Part 1300 to End, Revised as of April 1, 2011) yields no matches to searches for the following search terms: “emergency medical services”, “ambulance services”, or “paramedic”. (source: Dr. Sabina Braithwaite, January 12, 2012, Tucson, Arizona, Presentation at 2012 NAEMSP Annual Meeting)

Partnership:

To support the desire of EMS physicians to better understand the application of DEA regulation to their EMS practice and maintain compliance with said regulations, the ACEP EMS Committee was tasked by ACEP’s President (David C. Seaberg, MD, CPE, FACEP) with the following objective for the 2011-2012 year: *Explore ways to develop evidence-based resources for EMS system to address emerging operational issues.* (source: acep.org accessed March 13, 2012) Among the ACEP EMS Committee meeting attendees, the first subject identified for this objective by need and interest concerned DEA regulations and expectations in the EMS environment.

A multiple-step plan to address the objective was conceived by Jeffrey M. Goodloe, MD, NREMT-P, FACEP and supported by Dr. Braithwaite. The core components of that plan were:

a) Educate ACEP members serving as EMS medical directors on DEA regulations and expectations relevant to their practice of EMS medicine.
b) Engage DEA leadership in discussions advocating for clearer regulations and expectations relevant and appropriate to the practice of EMS medicine.
c) Assist DEA leadership in developing clearer regulations and expectations relevant and appropriate to the practice of EMS medicine.

In the effort to prepare educational materials, pervasive confusion and inconsistencies in the understanding and practices for the utilization of DEA regulations in the practice of EMS medicine were repeated obstacles to creating a clear guide for EMS physicians. Moreover, it became clear that not only was there lack of understanding on the part of physicians and EMS agencies, but there were significant inconsistencies in explanations and/or interpretations of existing regulation on the part of various DEA field offices across the country. It became clear that these inconsistencies in application of DEA regulations to the practice of EMS medicine were an insurmountable barrier to creating definitive guidance or reliable, national-level educational materials. Discussions with other organizations (NAEMSP, NASEMSO, AAEM) revealed shared concerns regarding these issues.

As a result, work on creating educational materials was suspended and a multi-organization task force of EMS physician leaders convened in Tucson, Arizona in January in conjunction with the 2012 NAEMSP Annual Meeting and Scientific Assembly to strategize on next steps. (See final page for organization and representative information) The task force agreed it would be best to survey membership of organizations with a large sector of physician EMS medical directors for specific information on experience with application of DEA regulation to EMS practice to

substantiate the issues, and specifically identify what common themes existed that required most urgent attention. An open-ended brief survey was designed by Dr. Goodloe and approved by the multi-organization task force. The survey was distributed to the membership of the ACEP's EMS Committee and EMS Section, NAEMSP, and the NASEMSO Medical Directors Council by their respective organizations. The survey asked respondents to anonymously answer the following questions:

> *1. What problems or concerns have you encountered in working with the DEA within your EMS practice of medicine? (e.g. inconsistencies of regulation explanations or applications--be specific, confusing explanations of regulations, inability to identify unique attributes of the practice of EMS medicine).*
>
> *2. What suggestions do you have to address the problems or concerns you identified in question 1?*
>
> *3. Are there additional questions or topics you would like us to raise with the DEA related specifically to the practice of EMS medicine? (e.g. issues you are unsure of the correct path to take based on regulation, but do not wish to raise through your agency for whatever reason) Please specifically indicate the DEA office you are working with in your practice of EMS medicine (e.g. Dallas, Washington D.C.).*

Over 100 respondents representing EMS agencies coast to coast, including urban and rural, volunteer and career, large and small agencies provided a broad view of the issue. A minority of respondents indicate no issues with DEA or simply a lack of personal investigation into whether their current practices are in compliance with DEA expectations and regulations. Of those who reported concerns, the following predominant issues with DEA regulations as applied to the practice of EMS medicine were identified by respondents:

1. Conflicts between DEA and state-level counterparts' regulations that are mutually exclusive.
2. Poor applicability to EMS. No specific language involving EMS is contained within existing DEA regulations and traditional mid-level practitioner model written for licensed individuals. The result is a poor fit to the agency model, deployment practices and delegated practice of medicine found in the practice of EMS medicine. Closely related to this, there is lack of specific EMS guidance/education on how to interpret the current regulations.
3. Inconsistent answers to the same questions within the same DEA office and between different DEA offices. While there is one set of federal regulations, the federal regional offices appear to have broad latitude and often inconsistent interpretative powers, complicated by the lack of specific EMS language already noted. Examples include whether individual EMS stations require separate DEA registrations, whether specific EMS registrations should be as practitioner or distributor, what locking mechanism(s) are required for controlled substances and what inventory practices are required for controlled substances.

4. Lack of a consistent authority to provide guidance for DEA-registered physician EMS medical directors and agencies on regulatory questions, to provide needed clarification of existing regulation, and to make this information available to others.
5. Inconsistency with long-standing, widely-used operational standards. A prime example is unused controlled substance being "wasted" at hospital with witnessing of said wastage as opposed to more recent interpretations requiring reverse distribution of previously opened containers of controlled substance pharmaceuticals.

Respondents indicated that the ideal resolution to their concerns might ultimately be best addressed by the promulgation of new DEA regulations or guidance that specifically address the unique environment of EMS medicine.

The multi-organization task force wrote a letter to the Dr. Rick Hunt, Chair of the Medical Oversight Committee of the Federal Interagency Committee on EMS based on the information above to request:

That FICEMS seek to initiate a dialogue with the DEA regarding how to most effectively mesh the patient care goals of EMS with the administrative and operational goals of the DEA for controlled substances. We believe the establishment of such a linkage would promote a partnership that would facilitate beneficial discussions. Topics might include:

1. *Creating a partnership with DEA to mutually identify how our nation's EMS community can best assure consistent compliance with existing regulations at the local, regional, and state levels. An option to explore may be providing an authoritative, nation-wide repository for EMS stakeholders' questions and DEA answers.*

2. *Determining areas of focus that would benefit from best practices that can be applied at a national level to promote local compliance.*

3. *3. Identifying key regulations needing clarification for EMS to facilitate compliance and enhance patient care.*

This request was officially presented to the FICEMS Technical Working Group (TWG) at their March 13, 2012 meeting. Our request was well received and TWG agreed that the proposed idea should be moved forward from the TWG to the full FICEMS with a recommendation that FICEMS seek out opportunities for a mutual dialogue with DEA not only on the issue at hand (inconsistent application of regulation) but also long term as the interface between DEA and EMS. It was recognized that a mutual understanding of each other's problems and priorities is important to ongoing coordination. Susan McHenry will be the primary TWG point of contact for the issue. The TWG is aware that our organizations stand ready to assist in any way we can. Representatives from the following organizations constitute the multi-organization task force:

American College of Emergency Physicians: Dr. Sabina A. Braithwaite
Dr. Jeffrey M. Goodloe
Dr. Craig A. Manifold
Dr. Joseph E. Holley, Jr.

American Academy of Emergency Medicine: **Dr. Allen Yee**
National Association of EMS Physicians: Dr. J. Brent Myers
National Association of State EMS Officials: Dr. Carol Cunningham and Dr. Joe Nelson

Information on each organization is as follows:

Founded in 1968, the **American College of Emergency Physicians** (ACEP) is based in Dallas, Texas and today represents more than 28,000 emergency physicians, residents and medical students. (source acep.org, accessed March 13, 2012)

Founded in 1993, the **American Academy of Emergency Medicine** (AAEM) is based in Milwaukee, Wisconsin and today represents more than 6,500 emergency physicians, resident and medical students. (source aaem.org accessed March 13, 2012)

Founded in 1984, the **National Association of Emergency Medical Services Physicians** (NAEMSP) is based in Lenexa, Kansas and today represents more than 1,200 physicians, paramedics, nurses, administrators, educators, researchers and key EMS personnel. (source naemsp.org accessed March 13, 2012)

Founded in 1980 , the **National Association of State Emergency Medical Services Officials** (NASEMSO) is based in Falls Church, Virginia and today its membership represents 56 state and territorial EMS directors, medical directors, training coordinators, data managers, trauma managers, and EMS for Children managers. (source nasemso.org accessed March 13, 2012)

Appendix

B

☒ Committee Motion: Name: Training and Certification Comittee

☐ Individual Motion: Name: _____

Motion:
The Training and Certification Committee, after reviewing all of the available options, proposes the following action item:
Certification candidates who have completed a Virginia approved initial certification Basic Life Support Training Program (FR/EMR and EMT-Basic/EMT) shall have their initial (first attempt) National Registry written certification examination fee paid from the portion of the EMS funds specifically earmarked in Code § 46.2-694 (A.)(13.)(e.).
A review of this process shall be conducted by the EMS Advisory Board every three (3) years or as warranted by changes in the Code of Virginia or Commonwealth of Virginia Budget pertaining to the funding of Emergency Medical Services.

EMS Plan Reference (include section number):

Strategic Initiative 4.2 – Assess and enhance quality of education for EMS providers.
4.2.1 Update the certification process to assure certification examinations continue to be valid, psychometrically sound, and legally defensible.
4.2.2 Update quality improvement process to promote a valid, psychometrically sound, and legally defensible certification process.

§ 32.1-111.5. Certification and recertification of emergency medical services personnel.

Committee Minority Opinion (as needed):

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☐ Approved ☐ Not Approved

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

Board Minority Opinion:

Meeting Date:

The Training and Certification Committee, after reviewing all of the available options, proposes the following action item:

Certification candidates who have completed a Virginia approved initial certification Basic Life Support Training Program (FR/EMR and EMT-Basic/EMT) shall have their initial (first attempt) National Registry written certification examination fee paid from the portion of the EMS funds specifically earmarked in Code § 46.2-694 (A.)(13.)(e.).

A review of this process shall be conducted by the EMS Advisory Board every three (3) years or as warranted by changes in the Code of Virginia or Commonwealth of Virginia Budget pertaining to the funding of Emergency Medical Services.

Unanimously Approved March 7, 2012 by the Training and Certification Committee

Supporting Points:

- EMS Regulations in Virginia establish EMT as the minimum required staffing level for an ambulance. If OEMS does not fund the initial cost of testing as a result of utilizing the National Registry (NR) certification examination, it is an unfunded mandate.

- Approximately 5,000 to 6,000 initial EMS certification written examinations are administered annually, at no cost to the candidate at the Basic Life Support (BLS) level. The cost of the National Registry written examination for EMR is $65 and $70 for EMT. The anticipated fiscal impact of utilizing the National Registry examination at the EMR and EMT level is between $325,000 and $420,000 on an annual basis.

  Initial start up costs to develop, administer and process a state developed EMS certification examination at five (5) separate levels will cost approximately $1M compared to the projected cost to utilize NR examinations. In addition, if NR examinations are utilized in Virginia, there will be less equipment and printing costs for OEMS and more time available for staff to serve our customers and constituents.

- Implementing National Registry testing in Virginia is the final step in meeting all objectives outlined in the *EMS Education Agenda for the Future: A Systems Approach.*

- Funding to cover the cost of initial NR testing at the EMR and EMT levels will come from the portion of the EMS funds specifically earmarked in Code (§ 46.2-694) to pay for the costs associated with the certification and recertification training of emergency medical services personnel. These funds were allocated as a result of HJR 743 (2007) which established the Joint Legislative Subcommittee Studying Incentives for Fire and Rescue Squad Volunteers. Members of the subcommittee recognized the importance of creating a consistent and reliable source of funding to promote the recruitment and retention of EMS personnel by enacting a $0.25 increase in the $4-for-life vehicle registration fee.

- The National Registry and Pearson Vue have agreed to open a minimum of 12 additional computer testing locations sites, for a total of 17 sites around the state, in order to reduce the amount of travel required by test candidates.

- As the source of these funds is paid by the citizens of the Commonwealth, and having certified EMS Providers, in either of these EMS levels, is a benefit to all of the citizens of the Commonwealth in the event of a medical, traumatic, natural or man-made emergency, the use of these funds should be available to all testing candidates and not just limited to those who are affiliated with licensed EMS Agencies.

- The State of Maryland, an original member of the Atlantic EMS Council, has implemented the process of paying for initial certification testing.

Appendix

C

☒ Committee Motion: Name: Training and Certification Comittee

☐ Individual Motion: Name: _____

Motion:
The Training and Certification Committee recommends that the EMS Advisory Board support the policy for CE Web Casting.

EMS Plan Reference (include section number):

Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel.
2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education.

§ 32.1-111.5. Certification and recertification of emergency medical services personnel.

Committee Minority Opinion (as needed):

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☐ Approved ☐ Not Approved

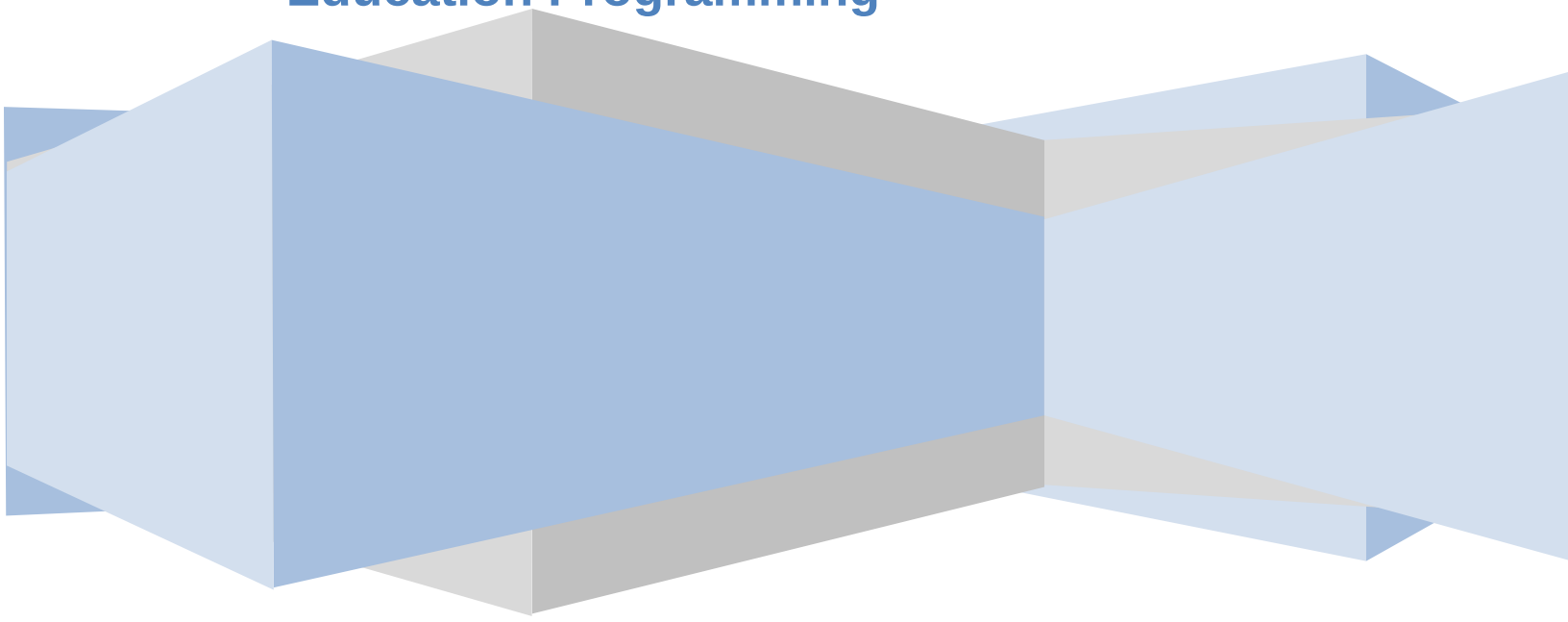
By Count: Yea: _____ Nay: _____ Abstain: _____

Board Minority Opinion:

Meeting Date:

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

Handbook for Webcasting of Continuing Education Programming



What is webcasting?

Webcasting is defined as the live broadcast of an educational event where the classroom is supplemented or replaced by the internet and occurs in a real-time synchronous format at designated training sites.

Becoming a Designated Webcast Receive Site

After reviewing this handbook, you must complete form TR-74 - *Application to be Designated as an Webcast Receive Site* and submit the form to the Office of EMS. This form is available on the OEMS web site.

To become a designated webcast receive site, you must have regular access to a building with a computer (laptop or moveable desktop) and high-speed internet access. A designated webcast site must have:

- A current generation computer connected to an LCD or DLP projector, regardless of the size of the group.
- A telephone (not cell) is also necessary.

Designated sites may be established at squad buildings, fire stations, hospitals, schools, or other community facilities. It is the responsibility of the applicant or applicants to contact the proposed facility to determine availability, as well as suitability for viewing live web-based classes.

Minimum Requirements for a Designated Webcast Receive Site

The site must, at a minimum have:

Room Requirements:

There must be adequate seating for the number of students registered for the course.

The site must, at a minimum have:

Computer:

- with high-speed internet access in the room.
- the latest version of software necessary to access the remote site and be connected to an LCD or DLP projector to project the image on a screen.
- connected to external speakers.

Telephone (not cell) shall:

- be positioned for easy access by the students.
- be located in the same room as the program being viewed.
- have speaker function with two way capability.

Room Acoustics shall:

- be in an area removed from high noise generating equipment or high activity sites such as fire or rescue traffic areas. Sound absorbent drapes, carpeting, cork bulletin boards, and acoustical ceiling tile will help minimize room noise.

Illumination shall be:

- controllable by the Site Proctor.
- of sufficient level to take notes.
- such that the seating arrangements avoid reflections from lighting fixtures, windows, etc.
- sufficient to allow if available, video viewing by the host site.

HVAC:

- The site must have adequate and functioning HVAC equipment which can be controlled by the Site Proctor.

Site Proctor Requirements

The site must designate responsible individuals who agree to function as primary and secondary Site Proctors. At least one Site Proctor must be at the site one (1) hour prior to the scheduled training session in order to set up the room and computer equipment. Proctors are responsible for:

- programming internet IP addresses,
- disseminating and collecting CE materials,
- and filling out evaluations. All of this information is contained in the following application form, which must be completed and approved by our office before any credit is given.

Site Proctors must be:

1. a minimum of 21 years of age and all appointments are subject to final approval by the Virginia Office of EMS.
2. Virginia certified EMS providers who are certified at the level of training being conducted or higher. (e.g. If the course is Intermediate level material, the proctor must be an Intermediate or Paramedic)
3. Appointed annually. There are no limits on appointments.

Proctor Responsibilities:

1. Is directly responsible to the EMT-Instructor/ALS-Coordinator whose program is being taught.
2. The primary proctor will attend all webcast classes unless arrangements are made to have the secondary proctor attend.
3. Will provide administrative assistance for the continuing education program as it pertains to completing the following:
    a. TR-06 – Course Roster
    b. Continuing education cards or electronic CE scanning
        i. Mailing or electronic transmission of continuing education forms to the Office of EMS
4. Will keep current phone numbers, addresses, and if available, e-mail addresses on file with the course coordinator.
5. Will remain at the site for the entire program
    a. Arriving one (1) hour early and remaining until the last person has left.
    b. Will assure site is left in an appropriate manner.
6. Will assure site is operational, that is, capable of receiving the webcast program.
    a. If site is not operational, the Proctor will provide cancellation notice to the course coordinator.

Guidelines for Webcasting of Continuing Education Programs

EMT-Instructors/ALS Coordinators (also referred to as a Course Coordinator) must follow these guidelines in order to conduct live webcast continuing education (CE) programs in Virginia.

These guidelines have been endorsed by the Training and Certification Committee. To assure compliance, this document must be signed by both the Course Coordinator and Physician Course Director (PCD) and accompany all Course Approval Request forms (TR-01) for which webcasting will be employed.

1. The Course Coordinator must ensure that the remote training site being used has applied for designation as a webcast receive site. Completion of OEMS form TR-74 is required for each remote site.
2. Self-study programs using electronic media such as web-based programs are not allowed. Only programs that use electronic transmission capabilities as real-time, two-way audio and video transmissions are eligible.
3. Remote webcast sites must have at a minimum the ability for one-way video and two-way audio streaming. Programs with one-way video and one-way audio will not be approved.
4. The Office of EMS will only approve synchronous programs for webcasting. Asynchronous CE programs are not allowed.
5. Individuals are not allowed to access this training via the Internet from their home and receive credit.
6. If a program chooses to use this learning modality, they must announce it to the Office of EMS with the Course Approval Request Form (TR-01). The Course Coordinator must include a signed copy of form (TR-75) with their submission of the Course Approval Request Form.
7. The Course Coordinator must assure that there is a Proctor present for the entire broadcast for all didactic portions of the program. The remote site Proctor is responsible for assuring the electronics are fully operational (both receiving and transmitting video and audio), must be familiar with operating the remote site electronic equipment and be responsible for having students sign the class roster for each session. The roster must be submitted to the Course Coordinator at the completion of the program.
8. Any lab activities at the remote site must have direct on-site supervision by an OEMS approved Proctor certified at or above the level of instruction and must follow the 6:1 student to instructor ratio.
9. In cases where the remote site Proctor is absent or when the remote site electronics fail to transmit and/or receive either video or audio, the students cannot receive continuing education credit. The class may be made up at a later date either in person or another video broadcast.
10. Remote sites will follow all course requirements, the *Handbook for Webcasting of Continuing Education Programming*, the Training Program Administration Manual and state regulations 12-VAC5-31.
11. The Course Coordinator and the Physician Course Director equally share responsibility for assuring the course complies with all appropriate Office of EMS standards, regulations, and policies.
12. The Course Coordinator must maintain records of student participation in the course and submit continuing education records for each involved student for programs.
13. Continuing education earned in webcast programs is considered to be distributive education for the purposes of National Registry recertification.

14. Non-compliance with these polices, the *Handbook for Webcasting of Continuing Education Programming,* the Training Program Administration Manual and/or state regulations 12-VAC5-31, will result in removal of Office approval and students will lose eligibility for certification testing at the level of certification the program is designed to deliver. Further, the Course Coordinator may face disciplinary action from the Office of EMS.

Acknowledgement of CE Webcasting Policies

Virginia Office of EMS
Division of Educational Development
1041 Technology Park Drive
Glen Allen, VA 23059

804-888-9120

Webcasting is defined as the live broadcast of an educational event where the classroom is supplemented or replaced by the internet and occurs in a real-time synchronous format at designated training sites. Following are the guidelines EMT-Instructors/ALS Coordinators (also referred to as a Course Coordinator) must follow in order to conduct live webcast continuing education (CE) programs in Virginia. These guidelines have been endorsed by the Training and Certification Committee. To assure compliance, this document must be signed by both the Course Coordinator and Physician Course Director (PCD) and accompany all Course Approval Request forms (TR-01) for which webcasting will be employed.

1. The Course Coordinator must ensure that the remote training site being used has applied for designation as a webcast receive site. Completion of OEMS form TR-74 is required for each remote site.
2. Self-study programs using electronic media such as web-based programs are not allowed. Only programs that use electronic transmission capabilities as real-time, two-way audio and video transmissions are eligible.
3. Remote webcast sites must have at a minimum the ability for one-way video and two-way audio streaming. Programs with one-way video and one-way audio will not be approved.
4. The Office of EMS will only approve synchronous programs for webcasting. Asynchronous CE programs are not allowed.
5. Individuals are not allowed to access this training via the Internet from their home and receive credit.
6. If a program chooses to use this learning modality, they must announce it to the Office of EMS with the Course Approval Request Form (TR-01). The Course Coordinator must include a signed copy of this form (TR-75) with their submission of the Course Approval Request Form.
7. The Course Coordinator must assure that there is a Proctor present for the entire broadcast for all didactic portions of the program. The remote site Proctor is responsible for assuring the electronics are fully operational (both receiving and transmitting video and audio), must be familiar with operating the remote site electronic equipment and be responsible for having students sign the class roster for each session. The roster must be submitted to the Course Coordinator at the completion of the program.
8. Any lab activities at the remote site must have direct on-site supervision by an OEMS approved Proctor certified at or above the level of instruction and must follow the 6:1 student to instructor ratio.
9. In cases where the remote site Proctor is absent or when the remote site electronics fail to transmit and/or receive either video or audio, the students cannot receive continuing education credit. The class may be made up at a later date either in person or another video broadcast.
10. Remote sites will follow all course requirements, the *Handbook for Webcasting of Continuing Education Programming*, the Training Program Administration Manual and state regulations 12-VAC5-31.
11. The Course Coordinator and the Physician Course Director equally share responsibility for assuring the course complies with all appropriate Office of EMS standards, regulations, and policies.
12. The Course Coordinator must maintain records of student participation in the course and submit continuing education records for each involved student for programs.
13. Continuing education earned in webcast programs is considered to be distributive education for the purposes of National Registry recertification.
14. Non-compliance with these polices, the *Handbook for Webcasting of Continuing Education Programming,* the Training Program Administration Manual and/or state regulations 12-VAC5-31, will result in removal of Office approval and students will lose eligibility for certification testing at the level of certification the program is designed to deliver. Further, the Course Coordinator may face disciplinary action from the Office of EMS.

Coordinator's
Printed Name: _____ Signature: _____ Date: _____

OMD/PCD
Printed Name: _____ Signature: _____ Date: _____

Virginia Office of Emergency Medical Services
www.vdh.virginia.gov/oems
EMS.TR.75
Revised: March 2012

Application to be Designated as an Webcast Receive Site

Virginia Office of EMS
Division of Educational Development
1041 Technology Park Drive
Glen Allen, VA 23059

804-888-9120

Following a review the *Handbook for Webcasting of Continuing Education Programming*, please complete this application with all of the appropriate signatures as indicated below.

Signatures on this page constitute agreement with the requirements as outlined in the *Handbook for Webcasting of Continuing Education Programming.*

After securing the appropriate signatures, return this form to the Office of EMS. We must have original signatures. You should maintain a copy of this application and the *Handbook for Webcasting of Continuing Education Programming* for your records. The Office will notify you of the status of your application within 30 business days of receipt.

FACILITY INFORMATION:

Facility Name _____

Facility Official Name _____ _____ _____
Last Name First Name MI

Mailing Address _____ _____ _____ _____
Number, Street, Apt. City State Zip +4

E-mail Address _____ Facility Phone # (for student contact) _____

Signature _____ Date _____

PRIMARY PROCTOR INFORMATION:

Name _____ _____ _____
Last Name First Name MI

Mailing Address _____ _____ _____ _____
Number, Street, Apt. City State Zip +4

Work Phone # _____ Home Phone # _____

E-mail Address _____ Cell Phone # _____

Signature _____ Date _____

Virginia Office of Emergency Medical Services
www.vdh.virginia.gov/oems
EMS.TR.74
Revised: March 2012

Application to be Designated as an Webcast Receive Site

Virginia Office of EMS
Division of Educational Development
1041 Technology Park Drive
Glen Allen, VA 23059

804-888-9120

SECONDARY PROCTOR INFORMATION:

Name

Last Name _____ First Name _____ MI _____

Mailing Address

Number, Street, Apt. _____ City _____ State _____ Zip +4 _____

Work Phone # _____ Home Phone # _____

E-mail Address _____ Cell Phone # _____

Signature _____ Date _____

REGIONAL COUNCIL INFORMATION:

Council Name _____

Council Official Name _____

Last Name _____ First Name _____ MI _____

Signature _____ Date _____

For more information about Webcast Sites, please contact Chad Blosser or Tracie Jones at the Virginia Office of Emergency Medical Services

Office of Emergency Medical Services
Division of Educational Development
1041 Technology Park Drive
Glen Allen, VA 23059
800-523-6019 (toll free)
804-888-9120 (Richmond)

Appendix

D

☒ Committee Motion: Name: Medical Direction Committee

☐ Individual Motion: Name: _____

Motion:
The Medical Direction Committee moves the EMS Advisory Board adopt the white paper titled "Roles and Responsibilities of Operational Medical Directors."

EMS Plan Reference (include section number):

2.2.3 Develop, implement and promote leadership and management standards for EMS agency leaders.

Committee Minority Opinion (as needed):

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☐ Approved ☐ Not Approved

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

Board Minority Opinion:

Meeting Date:

Roles and Responsibilities of Operational Medical Directors

Medical direction is an essential component of any EMS system. Medical directors shall meet qualifications as outlined in Virginia Office of EMS Rules and Regulations section 12VAC5-31-1810. Operational medical directors have specific responsibilities to the agency, EMS provider, and to the citizens within the jurisdictions which they serve. Roles and responsibilities include but are not limited to:

Administrative and regulatory

- be familiar with local, regional, and state, and Federal laws and regulations affecting EMS systems
- be knowledgeable about agency plans
  - Multiple casualty plans
  - Mass casualty plans
  - Mass gathering plans (if applicable)
- be knowledgeable about NIMS
- develop and/or approve field triage guidelines and protocols
  - periodically review and update field triage guidelines and protocols
  - monitor compliance with field performance guidelines
  - patient destination guidelines
- develop, actively participate, and/or provide medical oversight for an effective performance improvement program
- develop, actively participate, and/or provide medical oversight for a comprehensive mechanism for management of patient care incidents
  - complaints
  - allegations of substandard care
  - deviations from established protocols and patient care standards
  - be actively involved in auditing medical care provided by EMS professionals
    - random audits
    - other audits for cause

Educational

- develop and/or monitor counseling, retraining, testing, probation, and field preceptor ship of EMS providers and students
- develop and/or monitor continuing education of programs being delivered by their EMS agency to EMS personnel, other healthcare providers, and the public

Clinical

- be familiar with the medical literature which may impact EMS (directly or indirectly)
- be familiar with innovative medical devices which may impact EMS (directly or indirectly)
- provide direct patient care, if applicable to the EMS system
- be a medical resource for infection control issues
- be a medical resource for the design of a critical incident debriefing program
- be a medical resource for the design of a provider health and welfare program

Operational

- be knowledgeable about agency communications with EMS units

- be knowledgeable about agency dispatch (EMD)
  - be actively involved in the implementation, training, review, and revision of EMD protocols if EMD is under the oversight of the operational medical director
- approve the level of prehospital care provided by individuals within an agency
- approve the level of prehospital care provided by an EMS agency
- develop and/or approve appropriate EMS response times and intervals
- function as a liaison between the EMS agency and the medical community

Appendix

E

☒ Committee Motion: Name: Medical Direction Committee

☐ Individual Motion: Name: _____

Motion:
The Medical Direction Committee moves the EMS Advisory Board adopt the white paper titled "Patient Non-Transport from Motor Vehicle Collisions."

EMS Plan Reference (include section number):

3.1.8 Through a consensus process, develop a standard set of evidence-based patient care guidelines and standard formulary

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.

Committee Minority Opinion (as needed):

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☐ Approved ☐ Not Approved

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

Board Minority Opinion:

Meeting Date:

Patient Non-Transport from Motor Vehicle Collisions

Introduction

Obtaining patient refusals is an area that is often misunderstood by EMS providers. There are misperceptions about when a refusal is necessary and misunderstandings about the meaning of a refusal and the "protection" that such a refusal will provide an EMS provider from potential lawsuit.
This white paper addresses specific areas that frequently provide challenges to EMS providers and their agencies. Some providers feel the need to have all occupants in cars involved in motor vehicle crashes sign medical refusal paperwork. This is problematic in that it is time consuming and increases the time needed to clear the scene and increases the chance of secondary collision.

Appropriate Evaluation

EMS personnel are encouraged to identify every individual in a crash and ask if they would like evaluation. Persons involved in MVC's that are ambulatory at the scene, who appear to have normal mental status and decision making capacity (and are not intoxicated), who are ambulatory and do not appear to have external signs of injury (abrasions, contusions, or injury-related complaints such as headache or back pain) and who decline medical evaluation are not patients and do not require a signature for refusing transportation.

If any physical evaluation is performed (vital signs, examination, etc.) the person is to be considered a patient and complete documentation should be completed.
A person who has been involved in an MVC who has an apparent injury should be asked to sign a refusal if they decline evaluation or transport.

A person involved in a car crash involving high-risk mechanism of injury should be evaluated and documentation completed.

Appropriate documentation of the collision scene might include a summary of the number of total occupants and a statement about there being no complaints or reason to believe that any injury existed in situations where patients did not undergo medical evaluation.

Summary

Patients with normal mental status who are without complaint and who have no apparent injuries may decline medical evaluation at a car collision scene, and are not patients. As such, these individuals should not be required to sign a patient refusal form.

Appendix

F

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

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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 Initiative 1.1- 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 1.1 UPDATES:

1.1.1.1: Public Information and Education posts daily rather than monthly in order to keep stakeholders interested and engaged on a regular basis. While our goal is to raise awareness and keep interest high, we want to do so without bombarding our fan's newsfeed with superfluous info. Therefore, we'll post frequently when there's pertinent information to share.

1.1.2.1: Solicit input from EMS Workforce Development Committee and Virginia Recruitment and Retention Network and develop evaluation criteria for determining the effectiveness of recruitment and retention programs. Distribute to interested EMS agencies, organizations, associations and post on OEMS Web site. Review and update criteria and conditions for funding RSAF grants related to recruitment and retention. Review findings from International Association of Fire Chiefs/Virginia Fire Chiefs Association SAFER Grant "Volunteer Workforce Solutions" and identify key criteria for measuring the effectiveness of recruitment and retention programs.

1.1.2.2: Examine alternate educational methods such as Podcasts, Webinars and Video Streaming to deliver Keeping the Best courses to EMS agencies. Work with OEMS Public Relations coordinator to increase awareness of Keeping the Best program. Promote Keeping the Best program to Virginia Association of Counties (VACO) and Virginia Municipal League (VML). Include successful completion of a Keeping the Best program for all candidates in the EMS Officer Standards program.

1.1.2.3: Develop educational program and materials for local governments to increase awareness about the importance of leadership and management and recruitment and retention of EMS personnel. Continue providing information on the benefits and incentives that local government can provide for the EMS agencies

1.1.2.4: Promote greater involvement by local governments in the planning and coordination of emergency medical services and evaluate the effectiveness of their local delivery system. Present information at annual VML and VACO membership conferences

1.1.3.1: Public Information and Education encourages agencies and providers to visit the OEMS website and social media sites through promotional materials, List-serv emails and the e-newsletter.

1.1.3.2: Division of Educational Development has been encouraging providers to utilize the portal by a) Introducing all newly enrolled students to the portal via a letter with login and temporary passwords. b) Pushing the portal at all EMT updates. c) Contacting providers who have given e-mail addresses to OEMS. d) Emailing all Instructors and ALS Coordinators. e) Using the Regional EMS Councils as a conduit to disseminate information. f) Highlighting the portal on the OEMS website.

1.1.4.1: OEMS hosted the 2010 NASEMSO annual meeting in Virginia. Gary Brown, Director, Paul Sharpe, Division Manager for Trauma and Critical Care and Dave Edwards, EMS Coordinator attended the NASEMSO annual meeting in Madison, Wisconsin in October, 2011. Mr. Brown was elected to the NASEMSO Executive Committee. Mr. Sharpe represents OEMS on the Trauma Managers Council and Data Managers Council. Mr. Edwards represents OEMS on the Pediatric Emergency Care Council and is President Elect of the Council. Information is exchanged through state reports to NASEMSO and the East Region of NASEMSO, while information from these meetings are shared with OEMS staff respectively and is incorporated in policies and regulation as applicable. OEMS also incorporates an "EMS on the National Level" section in each Quarterly Report to the State EMS Advisory Board.

1.1.4.2: OEMS publishes all meetings of the State EMS Advisory Board and its 15 committees and all other workgroup(s) or subcommittee(s) meetings in the Commonwealth's Town Hall website and the OEMS website. OEMS actively participates with other state agencies on EMS and related matters on a routine basis with the VDFP, VDEM, Virginia State Police, the Board of Pharmacy as others as applicable. The 11 designated regional EMS councils and 15 other organizations are represented on the State EMS Advisory Board and routinely 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 1.2 UPDATES:

1.2.1.1: Revisions to the guidance document has been completed, and has been submitted to the Attorney General's office for approval.

1.2.1.2: Continuing to actively recruit new HMERT teams. One new team has been established in Harrisonburg.

1.2.1.3: Current recruitment is ongoing and updated based on needs.

1.2.2.1: This objective is ongoing, and continues to be met.

1.2.3.1: Final edits to a ChemPack Video are being completed and will soon be posted for online CE.

	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 2.1 UPDATES:

2.1.1.1: This area cannot be developed due to the elimination of the position that was to support this objective. Some active projects related this include a public access role has been developed to allow access to EMS data and is awaiting VITA/NG to perform work requested. OEMS has also begun contributing Virginia data to the National EMS Database. EMS and Trauma data has been linked to the DMV's motor vehicle crash to enhance both datasets. This too is pending full implementation until the VITA/NG work is performed. A SAS export has been written that allows OEMS to generate a raw file for IRB approved research projects. OEMS launched 130 standard reports accessible to all agencies and allows the reports to be exported in multiple formats including CSV, PDF, Word, PowerPoint, GIS, HTML, or printed. The reports can also be scheduled to run and be delivered via e-mail at the agency's discretion.

2.1.2.1: OEMS has worked with its vendor to make technical changes to provide access to the VPHIB's reporting tool. Permission roles have also been developed to support greater access. OEMS is awaiting the installation of server hardware by VITA/NG to further this project.

2.1.3.1: EMS Training Funds continue to fund initial and CE programs. Also, OEMS is researching a potential scholarship program and anticipate future planning on this program.

2.1.4.1: OEMS does not collect specific personal demographics. We do gather location, level, gender, etc. OEMS worked up a draft of data elements and presented to OEMS administration just over 2 years ago, but due to higher priorities, this was postponed until the portal was more complete in its development.

2.1.4.2: OEMS has responded to all requests from the workforce task groups for reports based upon data elements we do collect.

	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 2.2 UPDATES:

2.2.1.1: Regional CE program schedules are submitted to OEMS on a regular basis through regional EMS council contract deliverables.

2.2.2.1: Because this is optional, OEMS does not believe it will create much issue. Awaiting final approval of Regs. The content and self study has been on web site for over a year and a half.

2.2.3.1: Review NEMSMA Leadership Agenda and update competency criteria for all levels of EMS Officer standards. Continue work of EMS Workforce Development sub-committee to develop EMS Officer Standards for EMS officer II, III and IV.

2.2.3.2: Complete standards to evaluate the efficacy of EMS Officer I Program developed by sub-committee of EMS Workforce Development. Identify cadre of individuals from a diverse group of EMS agencies to pilot EMS Officer I Program by 12/31/12 and test the efficacy of the program.

2.2.4.1: Unless otherwise directed, DED is on schedule to implement the education standards for any program ending on or after July 1, 2012. This involves the VEMSES test. Initiation of National Registry testing for EMR and EMT and AEMT is planned to begin on July 1, 2012.. The AEMT is dependent on the Regs and may be delayed. DED continues to work with the Accreditation component of the national education agenda.

2.2.5.1: The EMSC program supports pediatric education by providing train-the-trainer (TtT) courses on a continuous basis, , training equipment, training resource materials, and coordination. EMSC also provides funding support for a pediatric track at the annual Virginia EMS Symposium.

2.2.5.2: EMSC has supported the implementation of regional based PEPP course instructors. Initially persons from each EMS region received instructor training at no cost including instruction, materials, travel and per-diem support. Each instructor was provided an initial cache of training equipment and supplies and the supplies are being maintained on an ongoing basis.

2.2.5.3: EMSC supports a pediatric track at the Virginia EMS Symposium by funding instructor fees, course fees, equipment and materials for multiple courses.

2.2.6.1: The yearly training calendar has been created, and is updated on a continual basis.

2.2.6.2: The MCI management modules are updated every five years. Date of next update is 2016.

	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 3.1 UPDATES:

3.1.1.1: OEMS is charged by VDH and the state to review legislation, prepare Legislative Action Summaries, Fiscal Impact Statements, and Talking Points and testify before committees of the Virginia General Assembly on EMS related legislation. OEMS sends out weekly legislative grids and reports to members of the State EMS Advisory Board, Regional EMS Councils and other stakeholder groups and individuals on a weekly basis when the Virginia General Assembly is convened.

3.1.1.2: Legislative news and interest items information from attending NASEMSO meetings, participating in NASEMSO conference calls and from NASEMSO email updates are shared with OEMS staff respectively and is incorporated in policies and regulation as applicable. OEMS also provides an "EMS on the National Level" section in each Quarterly Report to the State EMS Advisory Board.

3.1.2.1: The "Project Synergy" workgroup of the State Medevac Committee has been evaluating patient outcomes of patients brought in by AMS, with length of stay of less than 24 hours. This data, and the findings, should be the springboard to development of resource utilization guidelines. In addition, the "WeatherSafe" computer application helps AMS agencies determine if a mission has been turned down by another AMS agency.

3.1.3.1: The State Medevac Committee continues to remain current of universal safety standards implemented in other areas in hopes that similar standards may be implemented in Virginia.

3.1.3.2: The medevac WeatherSafe computer application has been up and running since it's launch in 2009. In 2011, there were 1,750 entries into the system, increased from 1,160 in 2011. OEMS continues to strongly encourage AMS agencies to submit data to WeatherSafe.

3.1.3.3: The State Medevac Committee continues to review information related to safety protocols, with the hope to standardize AMS safety protocols. When this is accomplished, an appropriate training program will be developed.

3.1.3.4: The AMS services in Virginia continue to promote safe practices for air and ground.

3.1.3.5: Landing Zone safety procedures continue to be reviewed and updated as needed, with training sessions for ground providers as needed.

3.1.3.6: Several advisory documents have been drafted and distributed regarding the use of standard radio frequencies for air to air communication between AMS aircraft.

3.1.4.1: Complete Standards of Excellence survey design and conduct pilot on a minimum of three EMS agencies using two (2) of the seven (7) areas of excellence by 7/1/2012. Leadership and Management and Recruitment and Retention areas will be examined. Revise standards and criteria for each area based on pilot program by 9/1/2012.

3.1.4.2: Implement full SoE program based on feed-back from pilots by 12/1/2012. Market program to regional EMS councils, EMS agencies, VAGEMSA, VAVRS and other interested parties.

3.1.4.3: Evaluate efficacy of the program based on improvement in areas of deficiency identified by EMS agencies completing the pilot program and other comments submitted by local government officials, regional EMS councils and others involved in process by 03/01/2013.

Strategic Initiative 3.1 UPDATES (Continued):

3.1.5.1: The Trauma Center Designation manual has been revised and approved by the TSO&MC and the State EMS Advisory Board. The revised criteria are on the agenda for the June 2012 State Board of Health (BOH) meeting and will be effective once approved by the BOH.

3.1.5.2: The State Trauma/Critical Care Coordinator has performed this analysis including literature research, survey of other state systems, and initiated the topic as a work session at the annual State Trauma Managers Council of NASEMSO for discussion. The item was brought to the TSO&MC meeting for discussion and consideration of need. The determination is that research to date has proven a less than one percent improvement to morbidity and mortality with the additional a Level IV centers to a mature trauma system. Combined with this information and the manpower reported to support Level IV centers in other states; there is no plan to pursue the addition of Level IV trauma centers at this time.

3.1.6.1: after the initial designation process, OEMS staff reviewed the process, and sought input from the designees, as well as reviewers, which will be incorporated into the next round of designation.

3.1.6.2: Input from staff of the designated regional EMS councils, as well as site reviewers, and OEMS staff are being incorporated into the next round of designation.

3.1.6.3: The Virginia EMS Regulations prevent designation of Regional EMS Councils on a staggered basis. Re-designation packets must be received by OEMS by 10/1/12 for re-designation by 7/1/13.

3.1.7.1: This information has been revised and placed on the OEMS website.

3.1.8.1: MDC has developed and published the Scope of Practice covering procedures and medications. Currently developing the patient care guidelines.

	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 3.2 Updates:
3.2.1.1: Evaluate use of "EMS Jobs" website. Revise "EMS Jobs" Website based on evaluation results.

3.2.1.2: Implement full SoE program based on feed-back from pilots by 12/1/2012. Market program to regional EMS councils, EMS agencies, VAGEMSA, VAVRS and other interested parties.

3.2.1.3: This continues to be part of the tracks offered at each Symposium.

3.2.1.4: Recruitment and retention grant requests are categorized during each grant cycle as a special priority, and given special consideration duing each grant cycle.

3.2.2.1: Technical Assistance Coordinator will attend all meetings of the Recruitment and Retention Network and disseminate information and educational opportunities to OEMS staff, regional EMS Councils, EMS agencies and other interested parties.

3.2.2.2: Encourage members of the Recruitment and Retention Network to participate in a R&R "think tank" to identify and develop new recruitment outreach opportunities. Identify other opportunities to work with offices with VDH and other state and federal agencies to develop EMS recruitment outreach programs.

3.2.2.3: Seek review and advice from Recruitment and Retention Network on all new OEMS R&R projects.

3.2.3.1: Advocate for opportunities to improve EMS agency leadership skills by enlightening local government officials
3.2.3.2: Develop a mentoring program for new EMS leaders by 12/31/12 (classes, resource materials, partnering with an experienced officer etc)

3.2.3.3: Publish information about the competencies contained in the EMS Officer Standards program

3.2.3.4: This track has been in place for several years now, and continues to bring in excellent speakers and topics.

	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 3.3 Updates:
3.3.1.1: FCC Narrowbanding mandate information is posted to the OEMS website, and distributed to system stakeholders.

3.3.1.2: OEMS, in cooperation with several other public safety communications agencies, has established policy, procedure, and education for agencies and jurisdictions on compliance with the State Interoperability Communications Plan.

3.3.2.1: OEMS continues to maintain the EMS and PSAP accreditation programs established in 2005.

3.3.3.1: OEMS maintains a relationship with the VITA public safety division and contracts for communications equipment, and is presented to agencies and jurisdictions that request assistance with equipment. The VITA contracts are also used as guidelines when RSAF grant applications are received.

3.3.4.1: the State Medevac Committee is considering other centralized dispatch programs across the country, but no specific planning related to this item is currently underway.

3.3.4.2: This item may be addressed in the future by the State Medevac Committee

3.3.4.3: A grid to determine the closest and most appropriately staffed aircraft is currently being developed in the Central Shenandoah area, with the collaboration of three AMS agencies in the area. It is the hope that this can be replicated on a statewide basis.

3.3.4.4: Much of the information required to be gathered when requesting AMS is already in place, but a training program for hospital personnel is currently being developed.

	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 3.4 Updates:

3.4.1.1: Development of a grant review worksheet has been piloted and is continually used each grant cycle by OEMS Staff, Regional EMS Councils, and OEMS Program Representatives. This worksheet helps document grader comments that are assessed by FARC in the final recommendations of grant requests

3.4.1.2: Changes are in the implementation process to make this a dynamic program and evaluation process.

3.4.3.1: The OEMS price list is updated each grant cycle to ensure consistency among like items purchased through RSAF.

3.4.3.2: The OEMS price list is available online through the grants section of the OEMS website.

3.4.4.1: Grant guidelines are updated bi-annually to ensure consistently of eligible items available for requesting agencies.

3.4.4.2: Guidelines are updated bi-annually to notify eligible agencies of Special Priority categories that are available through RSAF. Special Priority category grants receive precedence over other grant requests.

3.4.5.1: The grant program remains a deliverable item in the service contract between the OEMS and the Regional EMS Councils.

3.4.5.2: Grant information and guideline are distributed to stakeholders via e-mail and the OEMS website as identified.

3.4.6.1: OEMS staff have researched and applied for federal grants, as well as worked with other regional and state workgroups that have identified available federal grant funding.

3.4.7.1: OEMS has contracted with an independent audit firm to assist EMS agencies to account for the use of grant funds.

	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 3.5 Updates:

3.5.1.1: OEMS continues to enter into service contracts with the 11 regional EMS councils in Virginia on an annual basis.

3.5.1.2: OEMS also continues to develop and provide standard contracts, planning templates, and reference documents to help the regional EMS councils fulfill their contractual obligations.

3.5.1.3: OEMS provides input and feedback to the regional EMS councils regarding their contract deliverables each quarter, via a standard feedback form.

3.5.2.1: The draft AMS regulations are awaiting approval. These regulations will better define licensure requirements for AMS services.

3.5.2.2: Development of an application for new AMS services in Virginia is under consideration by the State Medevac Committee.

3.5.2.3: Planning for development of a standard Certificate of Need (CON) process for AMS services in Virginia is under consideration by the State Medevac Committee.

3.5.2.4: Response areas for AMS services are determined by radii based on flight time from a particular AMS base. PSAP's are encouraged to contact the closest and most appropriately staffed aircraft.

3.5.2.5: AMS issues are typically addressed on the agency level. System issues are vetted through the State Medevac Committee when they arise.

3.5.2.6: A workgroup entitled "Project Synergy" has been created to address AMS utilization, and will ultimately lead to better performance improvement programs among the AMS agencies.

3.5.3.1: There have been no presentations about EMS provided to VACO or VML in the past year. VACO and VML each have a representative on the State EMS Advisory Board. Both appointees are new to the board and appointed in 2011. OEMS provided an in-depth EMS orientation to both members in August of 2011. Both members are provided written Quarterly Reports to all members of the Board. These reports are also posted on the OEMS website. Both members were encouraged to report back to their respective organizations on EMS issues and matters and to share the quarterly reports.

3.5.3.2: In the past twelve months no EMS related articles or news items have been submitted to VACO or VML for publication in their respective monthly or quarterly publications.

	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 4.1 Updates:

4.1.1.1: A subcommittee of the TSO&MC was established to perform risk adjusted analysis of trauma data aimed at supporting trauma triage efforts. The subcommittee anticipates rolling out its results quarterly beginning in 2012. Reporting will include multiple levels of analysis designed to provide feedback to hospitals, EMS agencies, Regional EMS Councils, and the public.

4.1.1.2: The position that was created to develop and support a performance improvement (PI) program was eliminated. The only OEMS supported PI program is through the Regional EMS Council contract.

4.1.2.1: The Statewide Trauma Triage Plan was revised and rolled out in 2011. The plan is required to be reviewed triennially.

4.1.2.2: OEMS is working with the VPHIB vendor and other state data managers to develop comparative analysis reporting in VPHIB's report writer tool that will allow agencies to run reports that compare their compare their performance against statewide, regional, and agency level data. The information will remain blinded. All EMS agencies have access to ad-hoc and standard reporting of their own data to share and compare with other agencies and entities.

4.1.3.1: OEMS actively worked with the Virginia State Stroke Task Force (VSSTF) to develop a state stroke triage plan. OEMS attempts to serve as an active member of the VSSTF. The development of regional stroke triage plans was added to the Regional EMS Council contracts for the 2011 contract year, and implemented for use throughout the Commonwealth.

4.1.3.2: The Regional Stroke Triage Plans are supported financially through the Regional EMS Council contracts.

4.1.4.1: OEMS participates on the Virginia Heart Attack Coalition (VHAC).

4.1.4.2: Consideration of Development of a State STEMI Triage Plans may be considered in the future.

4.1.4.3: VHAC has implemented and supports regional STEMI committees. There are no plans currently to develop regional STEMI triage plans.

4.1.5.1: EMS Agencies have access to standard reports via VPHIB's report writer. They have the ability to develop customized reports, as well as some GIS reporting. Agency VPHIB administrators have the ability to provide access to any persons they deem appropriate, and the reporting tool provides multiple formats to export data.

4.1.5.2: As of 2011, all EMS agencies are able to access data quality report cards via the VPHIB system/ upon request from OEMS. OEMS has begun using the VPHIB e-mail list serve to send out tips to encourage agencies to utilize existing tools to evaluate their data. A statewide quality comparison report is projected to be released in Spring of 2012.

4.1.5.3: VPHIB staff provide a detailed monthly compliance report. The compliance report is sent to the Director of OEMS, and copied to the Regulation and Compliance Division and Fiscal Staff for RSAF qualification. The compliance rate for agencies submitting to VPHIB in February '11 was 52%, in February '12, the rate was 95.75%.

4.1.6.1: This is a new agenda item for the Transportation Committee to look not only NFPA recommendations for ambulance design but any other items from recognized bodies of science.

4.1.7.1: The EMSC on an ongoing basis, provides site visits to CAH and SHP facilities to assess their pediatric care capabilities. A workgroup has developed a draft Pediatric Emergency Department Designation (PEDD) program. The PEDD manual is in it's final revisions, and will be introduced to applicable stakeholders prior to formalization and implementation

	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 4.2 Updates:

4.2.1.1: The Office of EMS is working toward administering all EMS certification examinations via the National Registry of EMT's.

4.2.2.1: In compliance with the National EMS Education Agenda, OEMS is moving all certification examinations to the National Registry of EMT's. Additionally, OEMS is in position for accreditation compliance with the National Registry in 2013.

4.2.3.1: Online examinations will occur with National Registry testing.

4.2.3.2: With approval of the draft EMS Regulations, an avenue will be provided to explore administration of a summative practical examination.

	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.

Strategic Initiative 4.3 Updates:
4.3.1.1: Provider Health and Safety Committee began meeting in March of 2012. The committee is tasked with injury prevention and safety awareness activities.

4.3.2.1: Provider Health and Safety Committee began meeting in March of 2012. The committee is tasked with injury prevention and safety awareness activities.

4.3.2.2: The Health and Safety track has continued to be part of the Virginia EMS Symposium annually. There are several presentations on varied related topics each year.

4.3.2.3: 2011 marked the first year that nominations were submitted for the Governor's EMS award in the category of Outstanding Contribution to EMS Health and Safety. This award will continue to be given annually to entities committed to programs related to the health and/or 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

G

CERTIFICATE of RECOGNITION

By virtue of the authority vested by the Constitution in the Governor of the Commonwealth of Virginia, there is hereby officially recognized:

EMERGENCY MEDICAL SERVICES WEEK

WHEREAS, the health, safety and well-being of all Virginians is important to the prosperity, livelihood and happiness of the Commonwealth's citizens, families and communities; and

WHEREAS, emergency medical services (EMS) providers are the first to arrive upon the scene of disasters, be they medical, natural or manmade, to provide immediate and often life-saving assistance while fulfilling their mission to provide the best pre-hospital care; and

WHEREAS, emergency medical services (EMS) providers participate in numerous hours of rigorous training and continuing education in order to enhance their life-saving skills and thereby dramatically improve the survival and recovery rate of their patients; and

WHEREAS, the citizens of our great Commonwealth are thankful for the work of more than 36,000 emergency medical services providers and over 600 agencies, who provide for the well-being and safety of our Commonwealth's families and communities; and

WHEREAS, emergency medical services (EMS) providers and agencies demonstrate a high level of commitment and dedication to their communities and the citizens of the Commonwealth by providing training, health screenings and other life-safety awareness programs in their respective localities;

NOW, THEREFORE, I, Robert F. McDonnell, do hereby recognize the week of May 20-26, 2012 as **EMERGENCY MEDICAL SERVICES WEEK** in our **COMMONWEALTH OF VIRGINIA**, and I call this observance to the attention of our citizens.

Governor

Secretary of the Commonwealth

Appendix

H

YOUR LOGO HERE

Standards of Excellence Survey

EMS Agency Name:

EMS Agency Number:

EMS Agency Address:

Person Completing Survey:

E-mail address:

Contact Telephone #

Name of local government official you deal with:

Date of Survey:

Signature of agency leader:_____

Recruitment and Retention			
Mission, Vision, Values			
	Yes	**No**	**Comments**
Does your agency have a mission statement?	☐	☐	
When was the last time the mission statement for your agency reviewed?			
Does the service provided by your EMS agency support your mission?	☐	☐	
Are your values documented and made available to your members?	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
Recruitment			
Selection Process	**Yes**	**No**	**Comments**
How does your agency recruit new members?			

Does your agency have a recruitment officer?	☐	☐	
Does your agency recruit members all year long ?	☐	☐	
Is your agency membership reflective (diverse) of the community that you serve?	☐	☐	
Does your recruitment process appeal to interested parties of various backgrounds, skill sets and experience – that could result in a diverse agency?	☐	☐	
Expectations			
Does your agency have written job descriptions?	☐	☐	
Does your agency document and clearly communicate Member Expectation (what member is required to do ie: training, minimum of hours/week etc) to new members?	☐	☐	
Does your agency document and clearly communicate Agency Expectation (what agency will provide is: uniforms, equipment, etc to new members?	☐	☐	
Orientation			
Does your agency have a new member orientation program?	☐	☐	
What are the key components of the orientation program – equipment operation, safety, driving (EVOC)			
Does your orientation have a formal evaluation process (after the class)?	☐	☐	
Does you agency have a probationary membership period?	☐	☐	
Retention	**Yes**	**No**	**Comments**
Is there an agency program to retain members?	☐	☐	
Does your agency provide retention incentives (pay for training, uniforms, recognition)	☐	☐	
Does your agency have a program that recognizes members for their years of service?	☐	☐	
Does your agency have a series of planned events for members – summer picnic, Christmas party, etc?	☐	☐	
Does your local government provide	☐	☐	

members with retention incentives (lower property tax, county tags)?			
Does your agency encourage member participation in the decision making process?	☐	☐	
What is your agency doing to assist members to reach their potential and achieve goals important to them?			
Do you have a mechanism for members to make improvement suggestions?	☐	☐	
Have your agency's officers taken the Keeping the Best – Retention Program class?	☐	☐	
Do you know about the Virginia Recruitment and Retention Network (meets 6 times a year)?	☐	☐	
What is the process for asking a member to leave the agency/ be dismissed?			
Does your agency conduct an exit interview when a member leaves your organization?			
Does your agency track why members leave your agency – family, moved, infractions?	☐	☐	
Project Estimates			
	Yes	**No**	**Comments**
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

General Observations

[Replace this text with information regarding the overall readiness of project initiation. This must be filled-in by the Facilitator.]

Actions

ID	Action Item	Assigned To	Due By
			[mm/dd/yyyy]
			[mm/dd/yyyy]

YOUR LOGO HERE

Standards of Excellence Survey

EMS Agency Name:

EMS Agency Number:

EMS Agency Address:

Person Completing Survey:

E-mail address:

Contact Telephone #:

Name of local government official you deal with:

Date Survey Completed:

Signature of agency leader:_____

EMS Leadership and Management			
Agency Governance			
OEMS Rules and Regulations	**Yes**	**No**	**Comments**
Do you have a standard procedure for preparing for a state EMS inspection? Provide copy	☐	☐	
Policy and Procedures			
Does your agency have a set of Standard Operating Procedures/Guidelines (SOP) documented? Provide copy	☐	☐	
Is a copy of the SOP document given to every new member?	☐	☐	
Do you have agency By-Laws documented? – Provide copy	☐	☐	
Human Resources (HR Policies, Employee Relations, Coaching)			
	Yes	**No**	**Comments**
Does your agency have Human Resources (HR) policies? Provide copy	☐	☐	
Do you have a dedicated position that maintains & secures HR records?	☐	☐	
If you do not have an HR officer – how do you communicate with members on employee relations, human resource			

polices and coaching?			
Do you have a training program/material that relates to handling HR functions?	☐	☐	
Is there a coaching program for members? Provide copy	☐	☐	
Employee Development			
Training	**Yes**	**No**	
Is there an established training officer position in your agency?	☐	☐	
Is there a regular training program established to maintain provider skills and competencies? Provide copy	☐	☐	
Clinical development – do you have a clinical preceptor program? Provide copy	☐	☐	
Does your agency have a **succession** planning process?	☐	☐	
Does your agency have a Personal Development Plan for the Executive Officer position? Provide copy	☐	☐	
Does your agency have a Personal Development Plan for Front Line Supervisors? Provide copy	☐	☐	
Record Keeping			
	Yes	**No**	
Does your agency maintain any type of Training Records for your members?	☐	☐	
Does your agency maintain Infection Control Records (exposure records) for your members?	☐	☐	
Does your agency maintain Medical Treatment Protocols?	☐	☐	
Are the medical records for agency personnel kept separate from the agency personnel files?	☐	☐	
What agency position is responsible for maintaining these records?			
Are checks and balances in place to ensure these files are current and correct – in compliance with HIPPA?	☐	☐	
Are all records maintained in a confidential manner?	☐	☐	
Is your agency current on VPHIB records submission to OEMS?	☐	☐	
Asset Management (vehicles, equipment and financials)			

Vehicles and Equipment	**Yes**	**No**	
Does your agency have a vehicle and equipment maintenance program? Provide copy	☐	☐	
Does your agency have a vehicle replacement program ? Provide copy	☐	☐	
Is your communication equipment compliant with the FCC narrow banding mandate and P25 compliant?	☐	☐	
Financial Management	**Yes**	**No**	
Does your agency develop and approve an annual budget?	☐	☐	
Is your agency a 501c3 (IRS designation)?	☐	☐	
Does you agency file an IRS 990 every year?	☐	☐	
What agency position is responsible for maintenance of financial records?			
Are checks and balances in place to ensure these files are current and correct?	☐	☐	
Are the financial records of your agency audited on a regular basis?	☐	☐	
How often are the financial records of your agency audited?			

Actions

ID	Action Item	Assigned To	Due By
			[mm/dd/yyyy]
			[mm/dd/yyyy]
			[mm/dd/yyyy]

Appendix

I

EMS Officer I Matrix – Multiple Options (VDFP, VCCS, and NFA)

EMS Officer I Standards	Suggested Combined Requirements	Education to Meet Requirement
General Prerequisites		
Current Virginia EMS certification	?? certification level	EMT - B Or EMS 111, 112, 113, and 120
Field Experience	Minimum of 2 years of experience	EMT – B Or EMS 111, 112, 113, and 120
Experience as a trainer	Complete a Field Training Officer program	FO 1 (Chapter 12 Company Level Training) Or Fire Instructor I Or FST 135 (Instructor I) Or SPD 100 (Principle of Public Speaking)
Job Performance Prerequisites		
	Basic computer understanding and skills	FO 1(Demonstrated by activities) Or ITE 115 Or Basic Computer Class
	Knowledge of EMS agency structure, geographical area, policies and procedures of agency	FO 1 (Chapter 11 Organizational Structure) Or FST 100 Or EMS 111, 112, 113, and 120 Or Local Policies and Procedures (tested)
	Ability to communicate effectively (verbally and written), computer skills including spreadsheets	FO 1 (Demonstrated in activities) Or SPD 100 and ITE 115 Or Basic Business Writing
	Incident Management	FO 1 (Chapter 18 Inc Scene Management)

		Or NFA ICS Or NFA ICS for EMS Or ICS 100 and 200
	Write prose	FO 1 (Chapter 8 Written Communications) Or Eng 111 (College Composition) Or Basic Business Writing
	Basic interpersonal communication skills	FO 1 (Chapter 6 Interpersonal Communications) Or Social Science Elective Or NFA Leadership III
	Business communications – written word	FO 1 (Chapter 8 Written Communications) Or Eng 111 (College Composition) Or Basic Business writing Or NFA Leadership II
	Understanding of basic math models	FO 1 (Demonstrated in activities) Or MTH 1203 (Introduction to Mathematics)
EMS Officer I Standards	**Suggested Combined Requirements**	**Education to Meet Requirement**
Human Resources Management	***This duty involves leading the EMS unit team (2-3 persons) in the performance of daily duties, and the one-on-one training, development, and evaluation of new members of the EMS agency***	
Communications	Must be able to assign clear, concise tasks and responsibility, instructs and orients new members, verbal communications to enhance learning	FO 1 (Chapter 6 and 7 Interpersonal and Oral Com.) Or FST 100 Or NFA Preparation for Initial Company Operations
	Evaluates performance of new members and provide	FO1 (Chapter 12 & 13 HRM and Company Training)

	daily feedback on clinical and administrative performance matters, develops improvement plans for new members, including reading assignments, scenario based exercised and drills	Or FST 100 Or NFA Preparation for Initial Company Operations And NFA Strategies and Tactics for initial Co. Ops
	Principles of supervision and basic human resource management; ability to set priorities, plan and observe plan in action	FO1 (Chapter 13 & 14 HRM and Labor Relations) Or FST 100 Or NFA Leadership III
	Understanding of basic psychology, personality and mental health	FO1 (Chapter 4 & 10 Safety and Health Issue and ethi) Or FST 120 Or NFA Leadership I And NFA Leadership II
	Understating of social groups	FO1 (Chapter 6 Interpersonal Communications) Or FST 100 Or Leadership III
	Basic understanding of human resources	FO1 (Chapter 13 Human Resource Management) Or FST 100 Or Local Personnel Policies and Procedures (tested)
	Coaching, counseling and mentoring	FO 1 (Chapter 2 Leadership) Or FST 100 And SPD 100 Or NFA Leadership I
	Basic EMS supervisors – patient care, delegation and leadership	FO1 (Chapter 3 Supervision) Or FST 100 Or VDH Mass Casualty Incident Mgt I and II
	Discipline with due process	FO1 (Chapter 13 Human Resource Management)

		Or FST 100 Or NFA Leadership III
	Concept of research	Nothing in Fire officer I Or ENG 112 Or Nothing from NFA
Community and Government Relations	***This duty involves dealing with inquiries of the community and projecting the culture of the agency to the public and delivering safety, injury, and illness prevention education programs, according to the following job performance requirements***	
	Interpersonal communication skills, policies and procedures, familiarity with public relations and ability to respond to public inquiries	FO 1 (Chapter 15 Community Relations) Demonstrated in activities Or ENG 111 And SPD 100 Or NFA Leadership II
EMS Officer I Standards	**Suggested Combined Requirements**	**Education to Meet Requirement**
Administration	***This duty involves performing routine administrative duties in connection with the operation of an EMS unit, the response to EMS dispatches of all types, and the ability to manage unit level administrative work including documentation associated with the agency's field training program.***	
	Execute routine multi-unit administrative functions – forms, record management systems. Maintain administrative policies and procedures	FO 1(Chapt 3 Supervision and Chapter 9 Admin Funct) Or FST 100 Or NFA Preparation for Initial Company Operations
Emergency Service Delivery	***This duty involves responding to requests for service, managing smaller scope incidents completely, and managing the initial aspects of an incident of any size, while providing appropriate coordination and***	

	supervision to other members of the assigned unit.	
	Functions as primary clinical responder normally assigned, knowledge of EMS system protocols and procedures; ability to perform all medical procedures appropriate for certification level	Nothing in Fire Officer I Or EMS 111, 112, 113, and 120 Or Nothing from NFA
	Knowledge of incident Command, functions within ICS at appropriate level	FO 1 (Chapter 18 Inc Scene Management) Or NFA ICS 100 and 200 Or NFA ICS for EMS
	Serves a new member preceptor, coach, evaluator of new members	FO 1 (Chapter 3 Supervision) Or FST 100 Or NFA Preparation for Initial Company Operations
	Intro EMS Sys	Nothing in Fire Officer I Or EMS 111 Or Nothing from NFA
	History and development of EMS	Nothing in Fire Officer I Or EMS 111 Or Nothing from NFA
	Knowledge of special operations	FO 1 (Chapter 17 Pre-incident Planning) Or FST 100 Or VDH Mass Casualty Incident Mgt I and II
EMS Officer I Standards	**Suggested Combined Requirements**	**Education to Meet Requirement**
Health and Safety	***This duty involves serving as a role model, teacher, and evaluator of safe work practices, and preparing new members to work unsupervised in a safe manner.***	
	Applies safety regulations, practices and procedures and unit level	FO 1 (Chapter 10 Safety and Health) Or

		FST 120 Or NFA Incident Safety Officer
	Be familiar with most common causes of personal injury, accidents and advocate an infectious disease control program.	FO 1 (Chapter 10 Safety and Health) Or FST 120 Or NFA Incident Safety Officer
	Basic principles of health and wellness	FO 1 (Chapter 10 Safety and Health) Or FST 100 Or NFA Health and Safety Officer
Quality Management	***This duty involves conducting, demonstrating, and teaching basic quality management practices at the unit level***	
	Perform a complete and accurate chart review	FO 1 (Chapter 21 & 16 is Post-inc act & Records Mgt) Or EMS 111, 112, 113, and 120 Or FST 100
	Provide feedback to unit personnel concerning a quality management issue.	FO 1 (Chapter 20 Incident Scene Operations) Or FST 100 Or NFA Strategies for Company Success
	Know agency policies and procedures including awards, recognition and corrective action.	FO 1 (Demonstrated in activities/homework) Or FST 100 Or NFA Strategies for Company Success
Benchmark:	Associates in EMS Management/Administration	

Appendix

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
dAgency.02	EMS Agency Number	National	State	No	No	No	1	1	D01_01
dAgency.03	EMS Agency Name		State	No	No	No	0	1	D01_02
dAgency.04	EMS Agency State	National	State	No	No	No	1	1	D01_03
dAgency.05	EMS Agency Service Area States	National	State	No	No	No	1	1	n/a
dAgency.06	EMS Agency Service Area County(s)	National	State	No	No	No	1	M	D01_04
dAgency.08	EMS Agency Service Area ZIP Codes	National	State	No	No	No	1	M	n/a
dAgency.09	Primary Type of Service	National	State	No	No	No	1	1	D01_05
dAgency.10	Other Types of Service		State	No	Yes	No	0	M	D01_06
dAgency.11	Level of Service	National	State	No	No	No	1	1	D01_07
dAgency.12	Organization Status	National	State	No	No	No	1	1	D01_09
dAgency.13	Organizational Type	National	State	No	No	No	1	1	D01_08
dAgency.14	EMS Agency Organizational Tax Status	National	State	No	No	No	1	1	n/a
dAgency.15	Statistical Calendar Year	National	State	No	No	No	1	1	D01_10
dAgency.18	911 EMS Call Center Volume per Year	National	State	No	Yes	Yes	1	1	D01_04
dAgency.19	EMS Dispatch Volume per Year	National	State	No	Yes	Yes	1	1	D01_15
dAgency.20	EMS Patient Transport Volume per Year	National	State	No	Yes	Yes	1	1	D01_16
dAgency.21	EMS Patient Contact Volume per Year	National	State	No	Yes	Yes	1	1	D01_17
dAgency.25	National Provider Identifier	National	State	No	Yes	No	1	M	D01_21
dAgency.26	Fire Department ID Number	National	State	No	Yes	Yes	1	M	n/a
dContact.01	Agency Contact Type		State	No	No	No	0	1	n/a
dContact.02	Agency Contact Last Name		State	No	No	No	0	1	D02_01
dContact.03	Agency Contact First Name		State	No	No	No	0	1	D02_03
dContact.10	Agency Contact Phone Number		State	No	Yes	Yes	0	M	D02_08
dContact.11	Agency Contact Email Address		State	No	No	No	0	M	D02_10
dConfiguration.01	State Associated with the Certification Levels	National	State	No	No	No	1	1	n/a
dConfiguration.02	State Certification Licensure Levels	National	State	No	No	No	1	M	D04_01
dConfiguration.05	Protocols Permitted by the State	National	State	No	Yes	Yes	1	M	n/a
dConfiguration.06	EMS Certification Levels Permitted to Perform Each Procedure	National	State	No	No	No	1	1	D04_05
dConfiguration.07	EMS Agency Procedures	National	State	No	No	No	1	M	D04_04

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
dConfiguration.08	EMS Certification Level Permitted to Administer Each Medication	National	State	No	No	No	1	1	D04_07
dConfiguration.09	EMS Agency Medications	National	State	No	No	No	1	M	D04_06
dConfiguration.10	EMS Agency Protocols	National	State	No	No	No	1	M	D04_08
dConfiguration.11	EMS Agency Specialty Service Capability	National	State	No	No	No	1	M	n/a
dConfiguration.12	Billing Status			No	No	No	0	1	n/a
dConfiguration.13	Emergency Medical Dispatch (EMD) Provided to EMS Agency Service Area	National	State	No	No	No	1	1	n/a
dConfiguration.14	EMD Vendor		State	No	Yes	No	0	M	D04_17
dConfiguration.15	Patient Monitoring Capability(s)	National	State	No	No	No	1	M	n/a
dConfiguration.16	Crew Call Sign	National	State	No	No	No	1	M	D04_02
dLocation.01	EMS Location Type			No	No	No	0	1	n/a
dLocation.02	EMS Location Name			No	No	No	0	1	D05_01
dLocation.03	EMS Location Number						0	1	D05_02
dLocation.04	EMS Location GPS			No	No	No	0	1	D05_04
dLocation.06	EMS Location Address			No	No	No	0	1	D05_05
dLocation.08	EMS Location State			No	No	No	0	1	D05_07
dLocation.09	EMS Station or Location ZIP Code			No	No	No	0	1	D05_08
dLocation.10	EMS Location County			No	No	No	0	1	n/a
dVehicle.01	Unit/Vehicle Number		State	No	No	No	0	1	D06_01
dVehicle.02	Vehicle Identification Number			No	No	No	0	1	n/a
dVehicle.03	EMS Unit Call Sign			No	No	No	0	1	
dVehicle.04	Vehicle Type		State	No	No	No	0	1	D06_03
dVehicle.05	Crew State Certification/Licensure Levels			No	No	No	0	1	D06_04
dVehicle.10	Vehicle Model Year		State	No	No	No	0	1	D06_07
dPersonnel.01	EMS Personnel's Last Name		State	No	No	No	0	1	D08_01
dPersonnel.02	EMS Personnel's First Name		State	No	No	No	0	1	D08_03
dPersonnel.22	EMS Personnel's State of Licensure		State	No	No	No	0	1	n/a
dPersonnel.23	EMS Personnel's State's Licensure ID Number		State	No	No	No	0	1	D07_02
dPersonnel.24	EMS Personnel's State EMS Certification Level		State	No	No	No	0	1	D08_15

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
dPersonnel.31	EMS Personnel's Employment Status		State	No	No	No	0	1	D07_03
dFacility.03	Facility Location Code			No	No	No	0	1	D04_12
eRecord.02	Software Creator	National	State	No	No	No	1	1	E01_02
eRecord.03	Software Name	National	State	No	No	No	1	1	E01_03
eRecord.04	Software Version	National	State	No	No	No	1	1	E01_04
eResponse.01	EMS Agency Number	National	State	No	No	No	1	1	D01_01
eResponse.02	EMS Agency Name		State	No	No	No	0	1	n/a
eResponse.03	Incident Number	National	State	No	No	No	1	1	E02_02
eResponse.04	EMS Response Number	National	State	Yes	Yes	Yes	1	1	E02_03
eResponse.05	Type of Service Requested	National	State	No	No	No	1	1	E02_04
eResponse.07	Primary Role of the Unit	National	State	No	No	No	1	1	E02_05
eResponse.08	Type of Dispatch Delay	National	State	No	No	No	1	M	E02_06
eResponse.09	Type of Response Delay	National	State	No	No	No	1	M	E02_07
eResponse.10	Type of Scene Delay	National	State	No	No	No	1	M	E02_08
eResponse.11	Type of Transport Delay	National	State	No	No	No	1	M	E02_09
eResponse.12	Type of Turn-Around Delay	National	State	No	No	No	1	M	E02_10
eResponse.13	EMS Vehicle (Unit) Number	National	State	No	No	No	1	1	E02_11
eResponse.14	EMS Unit Call Sign	National	State	No	No	No	1	1	E02_12
eResponse.15	Level of Care of This Unit	National	State	No	No	No	1	1	n/a
eResponse.16	Vehicle Dispatch Location			No	Yes	Yes	0	1	E02_13
eResponse.23	Response Mode to Scene	National	State	No	No	No	1	1	E02_20
eResponse.24	Additional Response Mode Descriptors	National	State	No	Yes	No	1	M	n/a
eDispatch.01	Complaint Reported by Dispatch	National	State	No	No	No	1	1	E03_01
eDispatch.05	Dispatch Priority (Patient Acuity)			No	No	Yes	0	1	n/a
eCrew.01	Crew Member ID		State	No	No	No	0	1	E04_01
eCrew.02	Crew Member Level		State	No	No	No	0	1	E04_03
eCrew.03	Crew Member Response Role		State	Yes	Yes	Yes	0	M	E04_02
eTimes.01	PSAP Call Date/Time	National	State	No	Yes	Yes	1	1	E05_02
eTimes.03	Unit Notified by Dispatch Date/Time	National	State	No	No	No	1	1	E05_04
eTimes.05	Unit En Route Date/Time	National	State	No	Yes	No	1	1	E05_05

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
eTimes.06	Unit Arrived on Scene Date/Time	National	State	No	Yes	No	1	1	E05_06
eTimes.07	Arrived at Patient Date/Time	National	State	No	Yes	No	1	1	E05_07
eTimes.08	Transfer of EMS Patient Care Date/Time		State	No	Yes	Yes	0	1	E05_08
eTimes.09	Unit Left Scene Date/Time	National	State	No	Yes	Yes	1	1	E05_09
eTimes.10	Arrival at Destination Landing Area Date/Time			No	No	Yes	0	1	
eTimes.11	Patient Arrived at Destination Date/Time	National	State	No	Yes	No	1	1	E05_10
eTimes.12	Destination Patient Transfer of Care Date/Time	National	State	No	Yes	Yes	1	1	
eTimes.13	Unit Back in Service Date/Time	National	State	No	No	No	1	1	E05_11
eTimes.14	Unit Cancelled Date/Time		State	No	No	Yes	0	1	E05_12
ePatient.02	Last Name		State	Yes	Yes	Yes	0	1	E06_01
ePatient.03	First Name		State	Yes	Yes	No	0	1	E06_02
ePatient.06	Patient's Home City		State	No	Yes	Yes	0	1	E06_05
ePatient.07	Patient's Home County	National	State	No	Yes	Yes	1	1	E06_06
ePatient.08	Patient's Home State	National	State	No	Yes	Yes	1	1	E06_07
ePatient.09	Patient's Home ZIP Code	National	State	No	Yes	Yes	1	1	E06_08
ePatient.13	Gender	National	State	No	Yes	No	1	1	E06_11
ePatient.14	Race	National	State	No	Yes	No	1	M	E06_12
ePatient.15	Age	National	State	No	Yes	No	1	1	E06_14
ePatient.16	Age Units	National	State	No	Yes	No	1	1	E06_15
ePatient.17	Date of Birth		State	Yes	Yes	Yes	0	1	E06_16
ePayment.01	Primary Method of Payment	National	State	No	Yes	Yes	1	1	E07_01
ePayment.50	CMS Service Level	National	State	No	Yes	Yes	1	1	E07_34
eScene.01	First EMS Unit on Scene	National	State	No	Yes	No	1	1	n/a
eScene.04	Type of Other Service at Scene			No	No	No	0	1	E08_02
eScene.06	Number of Patients at Scene	National	State	No	Yes	No	1	1	E08_05
eScene.07	Mass Casualty Incident	National	State	No	Yes	No	1	1	E08_06
eScene.08	Triage Classification for MCI Patient	National	State	No	Yes	Yes	1	1	n/a
eScene.09	Incident Location Type	National	State	No	No	No	1	1	E08_07
eScene.15	Incident Street Address		State	No	No	No	0	1	E08_11
eScene.17	Incident City		State	No	Yes	Yes	0	1	n/a

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
eScene.18	Incident State	National	State	No	No	No	1	1	E08_14
eScene.19	Incident ZIP Code	National	State	No	No	No	1	1	E08_15
eScene.21	Incident County	National	State	No	No	No	1	1	E08_13
eSituation.01	Date/Time of Symptom Onset/Last Normal	National	State	No	Yes	Yes	1	1	E05_01
eSituation.02	Possible Injury	National	State	No	Yes	No	1	1	E09_04
eSituation.03	Complaint Type		State	No	Yes	No	0	1	n/a
eSituation.04	Complaint		State	No	Yes	Yes	0	1	E09_05
eSituation.05	Duration of Complaint		State	No	Yes	Yes	0	1	E09_06
eSituation.06	Time Units of Duration of Complaint		State	No	Yes	Yes	0	1	E09_07
eSituation.07	Chief Complaint Anatomic Location	National	State	No	Yes	No	1	1	E09_11
eSituation.08	Chief Complaint Organ System	National	State	No	Yes	No	1	1	E09_12
eSituation.09	Primary Symptom	National	State	No	Yes	Yes	1	1	E09_13
eSituation.10	Other Associated Symptoms	National	State	No	Yes	Yes	1	M	E09_14
eSituation.11	Provider's Primary Impression	National	State	No	Yes	No	1	1	E09_15
eSituation.12	Provider's Secondary Impressions	National	State	No	Yes	No	1	M	E09_16
eSituation.13	Initial Patient Acuity	National	State	No	Yes	Yes	1	1	n/a
eInjury.01	Cause of Injury	National	State		NV	Nil	1	M	E10_01
eInjury.03	Trauma Center Criteria	National	State	No	Yes	Yes	1	M	n/a
eInjury.04	Vehicular, Pedestrian, or Other Injury Risk Factor	National	State	Yes	Yes	Yes	1	M	E10_04
eInjury.05	Main Area of the Vehicle Impacted by the Collision		State	No	No	Yes	0	1	E10_05
eInjury.06	Location of Patient in Vehicle		State	No	No	Yes	0	1	E10_06
eInjury.07	Use of Occupant Safety Equipment		State	No	Yes	Yes	0	M	E10_08
eInjury.08	Airbag Deployment		State	No	No	Yes	0	M	E10_09
eInjury.09	Height of Fall (feet)		State	No	No	Yes	0	1	E10_10
eArrest.01	Cardiac Arrest	National	State	No	Yes	Yes	1	1	E11_01
eArrest.02	Cardiac Arrest Etiology	National	State	No	Yes	Yes	1	1	E11_02
eArrest.03	Resuscitation Attempted By EMS	National	State	No	Yes	Yes	1	M	E11_03
eArrest.04	Arrest Witnessed By	National	State	No	Yes	Yes	1	M	E11_04
eArrest.05	CPR Care Provided Prior to EMS Arrival	National	State	No	Yes	Yes	1	1	n/a
eArrest.06	Who Provided CPR Prior to EMS Arrival		State	No	No	No	0	M	n/a

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
eArrest.07	AED Use Prior to EMS Arrival	National	State	No	Yes	Yes	1	1	n/a
eArrest.08	Who Used AED Prior to EMS Arrival		State	No	No	Yes	0	M	n/a
eArrest.09	Type of CPR Provided	National	State	No	Yes	Yes	1	M	n/a
eArrest.10	Therapeutic Hypothermia Initiated	National	State	No	Yes	Yes	1	1	n/a
eArrest.11	First Monitored Arrest Rhythm of the Patient	National	State	No	Yes	Yes	1	1	E11_05
eArrest.12	Any Return of Spontaneous Circulation	National	State	No	Yes	Yes	1	M	E11_06
eArrest.14	Date/Time of Cardiac Arrest	National	State	No	Yes	Yes	1	1	E11_08
eArrest.15	Date/Time Resuscitation Discontinued		State	No	Yes	Yes	0	1	E11_09
eArrest.16	Reason CPR/Resuscitation Discontinued	National	State	No	Yes	Yes	1	1	E11_10
eArrest.17	Cardiac Rhythm on Arrival at Destination	National	State	No	Yes	Yes	1	M	E11_11
eArrest.18	End of EMS Cardiac Arrest Event	National	State	No	Yes	Yes	1	1	n/a
eHistory.01	Barriers to Patient Care	National	State	No	Yes	Yes	1	M	E12_01
eHistory.08	Medical/Surgical History		State	Yes	Yes	Yes	0	M	E12_10
eHistory.12	Current Medications		State	Yes	Yes	Yes	0	1	E12_14
eHistory.17	Alcohol/Drug Use Indicators	National	State	Yes	Yes	No	1	M	E12_07
eNarrative.01	Patient Care Report Narrative		State	No	Yes	Yes	0	1	E13_01
eVitals.01	Date/Time Vital Signs Taken	National	State	No	Yes	Yes	1	1	E14_01
eVitals.02	Obtained Prior to this Units EMS Care	National	State	No	Yes	Yes	1	1	E14_02
eVitals.03	Cardiac Rhythm / Electrocardiography (ECG)	National	State	Yes	Yes	Yes	1	M	E14_03
eVitals.04	ECG Type	National	State	No	Yes	Yes	1	1	n/a
eVitals.05	Method of ECG Interpretation	National	State	No	Yes	Yes	1	M	n/a
eVitals.06	SBP (Systolic Blood Pressure)	National	State	Yes	Yes	Yes	1	1	E14_04
eVitals.07	DBP (Diastolic Blood Pressure)		State	Yes	Yes	Yes	0	1	E14_05
eVitals.08	Method of Blood Pressure Measurement	National	State	No	Yes	Yes	1	1	E14_06
eVitals.10	Heart Rate	National	State	Yes	Yes	Yes	1	1	E14_07
eVitals.12	Pulse Oximetry	National	State	Yes	Yes	Yes	1	1	E14_09
eVitals.14	Respiratory Rate	National	State	Yes	Yes	Yes	1	1	E14_11
eVitals.15	Respiratory Effort			No	No	Yes	0	1	E14_12
eVitals.16	Carbon Dioxide (CO2)	National	State	Yes	Yes	Yes	1	1	E14_13
eVitals.18	Blood Glucose Level	National	State	Yes	Yes	Yes	1	1	E14_14

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V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
eVitals.19	Glasgow Coma Score-Eye	National	State	Yes	Yes	Yes	1	1	E14_15
eVitals.20	Glasgow Coma Score-Verbal	National	State	Yes	Yes	Yes	1	1	E14_16
eVitals.21	Glasgow Coma Score-Motor	National	State	Yes	Yes	Yes	1	1	E14_17
eVitals.22	Glasgow Coma Score-Qualifier	National	State	No	Yes	Yes	1	M	E14_18
eVitals.23	Total Glasgow Coma Score		State	Yes	Yes	Yes	0	1	E14_19
eVitals.26	Level of Responsiveness (AVPU)	National	State	No	Yes	Yes	1	1	E14_22
eVitals.27	Pain Score	National	State	Yes	Yes	Yes	1	1	E14_23
eVitals.29	Stroke Scale Score	National	State	Yes	Yes	Yes	1	1	E14_24
eVitals.30	Stroke Scale Type	National	State	No	Yes	Yes	1	1	n/a
eVitals.31	Reperfusion Checklist	National	State	Yes	Yes	Yes	1	1	E14_25
eVitals.32	APGAR			Yes	No	Yes	0	1	E14_26
eExam.01	Estimated Body Weight in Kilograms		State	Yes	Yes	Yes	0	1	E16_01
eExam.04	Skin Assessment			Yes	No	No	0	M	E16_04
eProtocols.01	Protocols Used	National	State	No	Yes	Yes	1	1	E17_01
eProtocols.02	Protocol Age Category	National	State	No	Yes	Yes	1	1	n/a
eMedications.01	Date/Time Medication Administered	National	State	No	Yes	Yes	1	1	E18_01
eMedications.02	Medication Administered Prior to this Units EMS Care	National	State	No	Yes	Yes	1	1	E18_02
eMedications.03	Medication Given	National	State	Yes	Yes	Yes	1	1	E18_03
eMedications.04	Medication Administered Route		State	No	Yes	Yes	0	1	E18_04
eMedications.05	Medication Dosage	National	State	No	Yes	Yes	1	1	E18_05
eMedications.06	Medication Dosage Units	National	State	No	Yes	Yes	1	1	E18_06
eMedications.07	Response to Medication	National	State	No	Yes	Yes	1	1	E18_07
eMedications.08	Medication Complication	National	State	No	Yes	Yes	1	M	E18_08
eMedications.09	Medication Crew (Healthcare Professionals) ID		State	No	Yes	Yes	0	1	E18_09
eMedications.10	Role/Type of Person Administering Medication	National	State	No	Yes	Yes	1	1	n/a
eMedications.11	Medication Authorization			No	No	Yes	0	1	E18_10
eProcedures.01	Date/Time Procedure Performed	National	State	No	Yes	Yes	1	1	E19_01
eProcedures.02	Procedure Performed Prior to this Units EMS Care	National	State	No	Yes	Yes	1	1	E19_02
eProcedures.03	Procedure	National	State	Yes	Yes	Yes	1	1	E19_03
eProcedures.04	Size of Procedure Equipment			No	No	Yes	0	1	E19_04

PN = Pertinent Negatives; NV = Not Values; Nil = Can be blank

V3 Element Number	V3 Element Name	NEMSIS Suggested Use		PN	NV	Nil	Recurrence Min	Recurrence Max	V2 Number
eProcedures.05	Number of Procedure Attempts	National	State	No	Yes	Yes	1	1	E19_05
eProcedures.06	Procedure Successful	National	State	No	Yes	Yes	1	1	E19_06
eProcedures.07	Procedure Complication	National	State	No	Yes	Yes	1	M	E19_07
eProcedures.08	Response to Procedure	National	State	No	No	Yes	1	1	E19_08
eProcedures.09	Procedure Crew Members ID		State	No	Yes	Yes	0	1	E19_09
eProcedures.10	Role/Type of Person Performing the Procedure	National	State	No	Yes	Yes	1	1	n/a
eProcedures.13	Vascular Access Location		State	No	Yes	Yes	0	1	
eAirway.01	Indications for Invasive Airway		State	No	Yes	Yes	0	M	n/a
eAirway.02	Date/Time Airway Device Placement Confirmation		State	No	Yes	Yes	0	1	n/a
eAirway.04	Airway Device Placement Confirmed Method		State	No	Yes	Yes	0	1	n/a
eAirway.07	Crew Member ID		State	No	Yes	Yes	0	1	n/a
eAirway.08	Airway Complications Encountered		State	No	Yes	Yes	0	M	n/a
eAirway.09	Suspected Reasons for Failed Airway Procedure		State	No	No	Yes	0	M	n/a
eDisposition.02	Destination/Transferred To, Code		State	No	Yes	Yes	0	1	E20_02
eDisposition.11	Number of Patients Transported in this EMS Unit		State	No	Yes	Yes	0	1	n/a
eDisposition.12	Incident/Patient Disposition	National	State	No	No	No	1	1	E20_10
eDisposition.16	EMS Transport Method	National	State	No	Yes	Yes	1	1	n/a
eDisposition.17	Transport Mode from Scene	National	State	No	Yes	Yes	1	1	E20_14
eDisposition.18	Additional Transport Mode Descriptors	National	State	No	Yes	Yes	1	M	n/a
eDisposition.19	Condition of Patient at Destination	National	State	No	Yes	Yes	1	1	E20_19
eDisposition.20	Reason for Choosing Destination	National	State	No	Yes	Yes	1	M	E20_16
eDisposition.21	Type of Destination	National	State	No	Yes	Yes	1	1	E20_17
eDisposition.22	Hospital In-Patient Destination	National	State	No	Yes	Yes	1	1	n/a
eDisposition.24	Destination Team Pre-Arrival Activation	National	State	No	Yes	Yes	1	1	IT10_02
eDisposition.25	Date/Time of Destination Prearrival Activation	National	State	No	Yes	Yes	1	1	n/a
eOther.08	Crew Member Completing this Report		State	No	Yes	Yes	0	1	n/a

PN = Pertinent Negatives; NV = Not Values; Nil = Can be blank

Appendix

K

ImageTrend EMS Service Bridge

Data Quality Report

Report Printed On: 04/26/2012

Report Summary

Primary Service:	[redacted]	**Avg Validity for Imported Data:**	80
User:	[redacted]	**Records Valid (80-100):**	27
Date Uploaded:	04/19/12 11:07:58 AM	**Records Valid (60-79):**	14
Software Vendor:	[redacted]	**Records Valid (40-59):**	9
Total Records in File:	50	**Records Valid (0-39):**	0
Records Imported:	50		
		Your Avg Validity for last 90 days:	83
		System Avg Validity for last 90 days:	84

System Validation Issues

Validation Error	Count
Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.	46
Logic E18_01) - Cannot have a medication and common null value entered at the same time.	46
Logic E19_03 - Cannot have a procedure and a common null value entered.	38
E06_13 - Patient's ethnicity is required.	17
E12_10 - The patient's medical/surgical history is missing.	16
E05_09 - Leave Scene date/time is missing.	14
E09_06 - The duration of the patient's chief complaint is missing.	14
E09_07 - Chief complaint duration missing a unit of time.	14
E09_04 - Possible injury is missing.	13
E09_13 - Primary symptom is missing	12
E19_03 - Procedure name is missing.	12
E09_07 - Chief complaint duration missing unit of time.	7
IT8.19 - AMA type is missing and response disposition is patient refusal!	6
IT8_21 - The patient's stated reason for refusing care is missing!	6
(E18_04) Medication administration route is missing.	4
E05_07 - Arrive Patient Side date/time is missing.	4
E06_12 - Patient's Race is required.	3
Logic E19_01 - Date Proc Performed is before Arrived Patient Date.	3
E06_14 - Patient's age is missing.	2
E10_01 - Cause of injury is missing!	2
Logic E09_04 - A Cause of Injury should not exist when possible injury is 'No'.	2
E06_01 - Patient's last name is missing	1
E06_02 - Patient's first name is missing	1
E06_16 - Patient DOB is missing	1
E06_16 - Patient's DOB is missing	1
E10_04 - Vehicle Injury Indicators should exist when possible injury is 'Yes' and there is a vehicle involved.	1
E10_09 - Indication of airbag deployment during a MVC should exist when injury indicated.	1
E14_01 - A set of vitals is required for this type of call	1
E18_07 - The patient's response to medication administration is missing.	1

System Validation Issue Details				
Incident #	**Call #**	**PCR #**	**Incident Date**	**Error**
FR110406009225	-5	FR110406009225.A31.1	04/06/11	E05_09 - Leave Scene date/time is missing.
FR110406009225	-5	FR110406009225.A31.1	04/06/11	E06_12 - Patient's Race is required.
FR110406009225	-5	FR110406009225.A31.1	04/06/11	E09_04 - Possible injury is missing.
FR110406009225	-5	FR110406009225.A31.1	04/06/11	E09_07 - Chief complaint duration missing unit of time.
FR110406009225	-5	FR110406009225.A31.1	04/06/11	E09_13 - Primary Symptom is missing
FR110406009225	-5	FR110406009225.A31.1	04/06/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR110406009225	-5	FR110406009225.A31.1	04/06/11	IT8_21 - The patient's stated reason for refusing care is missing!
FR110406009225	-5	FR110406009225.A31.1	04/06/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110406009225	-5	FR110406009225.A31.1	04/06/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E06_13 - Patient's ethnicity is required.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E09_04 - Possible injury is missing.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E09_06 - The duration of the patient's chief complaint is missing.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E09_07 - Chief complaint duration missing a unit of time.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E09_13 - Primary symptom is missing
FR110506011947	-5	FR110506011947.A332.1	05/06/11	E12_10 - The patient's medical/surgical history is missing.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110506011947	-5	FR110506011947.A332.1	05/06/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110508012123	-5	FR110508012123.M31.1	05/08/11	E05_09 - Leave Scene date/time is missing.
FR110508012123	-5	FR110508012123.M31.1	05/08/11	E06_13 - Patient's ethnicity is required.
FR110508012123	-5	FR110508012123.M31.1	05/08/11	E09_04 - Possible injury is missing.
FR110508012123	-5	FR110508012123.M31.1	05/08/11	E09_13 - Primary Symptom is missing
FR110508012123	-5	FR110508012123.M31.1	05/08/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110430011386	-5	FR110430011386.A332.1	04/30/11	E05_09 - Leave Scene date/time is missing.
FR110430011386	-5	FR110430011386.A332.1	04/30/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110430011386	-5	FR110430011386.A332.1	04/30/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110430011386	-5	FR110430011386.A332.1	04/30/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E05_09 - Leave Scene date/time is missing.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_01 - Patient's last name is missing
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_02 - Patient's first name is missing
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_12 - Patient's Race is required.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_13 - Patient's ethnicity is required.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_14 - Patient's age is missing.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E06_16 - Patient DOB is missing
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E09_04 - Possible injury is missing.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E09_07 - Chief complaint duration missing unit of time.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	E09_13 - Primary Symptom is missing
FR110704017742	-5	FR110704017742.A31.1	07/04/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR110704017742	-5	FR110704017742.A31.1	07/04/11	IT8_21 - The patient's stated reason for refusing care is missing!
				Logic E10_03 - For Mechanism of Injury, a common null value

FR110704017742	-5	FR110704017742.A31.1	07/04/11	and another value cannot be selected together.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110704017742	-5	FR110704017742.A31.1	07/04/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110704017742	-5	FR110704017742.A31.2	07/04/11	E05_09 - Leave Scene date/time is missing.
FR110704017742	-5	FR110704017742.A31.2	07/04/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110704017742	-5	FR110704017742.A31.2	07/04/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110704017742	-5	FR110704017742.A31.2	07/04/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	E05_09 - Leave Scene date/time is missing.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	E06_13 - Patient's ethnicity is required.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	E09_04 - Possible injury is missing.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	E09_07 - Chief complaint duration missing unit of time.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	E19_03 - Procedure name is missing.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR110721019572	-5	FR110721019572.A31.2	07/21/11	IT8_21 - The patient's stated reason for refusing care is missing!
FR110721019572	-5	FR110721019572.A31.2	07/21/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110721019572	-5	FR110721019572.A31.2	07/21/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110716019039	-5	FR110716019039.A31.1	07/16/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110716019039	-5	FR110716019039.A31.1	07/16/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110716019039	-5	FR110716019039.A31.1	07/16/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110718019259	-5	FR110718019259.A31.1	07/18/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110718019259	-5	FR110718019259.A31.1	07/18/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110718019259	-5	FR110718019259.A31.1	07/18/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110507012087	-5	FR110507012087.M31.1	05/07/11	E05_09 - Leave Scene date/time is missing.
FR110507012087	-5	FR110507012087.M31.1	05/07/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110507012087	-5	FR110507012087.M31.1	05/07/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110507012087	-5	FR110507012087.M31.1	05/07/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110320007672	-5	FR110320007672.A31.1	03/20/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110320007672	-5	FR110320007672.A31.1	03/20/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110320007672	-5	FR110320007672.A31.1	03/20/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110715018974	-5	FR110715018974.A232.1	07/15/11	E05_09 - Leave Scene date/time is missing.
FR110715018974	-5	FR110715018974.A232.1	07/15/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110715018974	-5	FR110715018974.A232.1	07/15/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.

FR110715018974	-5	FR110715018974.A232.1	07/15/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E06_13 - Patient's ethnicity is required.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E09_04 - Possible injury is missing.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E09_06 - The duration of the patient's chief complaint is missing.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E09_07 - Chief complaint duration missing a unit of time.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E12_10 - The patient's medical/surgical history is missing.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	E19_03 - Procedure name is missing.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	Logic E09_04 - A Cause of Injury should not exist when possible injury is 'No'.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110702017505	-5	FR110702017505.A31.1	07/02/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110727020255	-5	FR110727020255.A31.3	07/27/11	E06_13 - Patient's ethnicity is required.
FR110727020255	-5	FR110727020255.A31.3	07/27/11	E09_07 - Chief complaint duration missing unit of time.
FR110727020255	-5	FR110727020255.A31.3	07/27/11	E10_04 - Vehicle Injury Indicators should exist when possible injury is 'Yes' and there is a vehicle involved.
FR110727020255	-5	FR110727020255.A31.3	07/27/11	E10_09 - Indication of airbag deployment during a MVC should exist when injury indicated.
FR110727020255	-5	FR110727020255.A31.3	07/27/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR110727020255	-5	FR110727020255.A31.3	07/27/11	IT8_21 - The patient's stated reason for refusing care is missing!
FR110727020255	-5	FR110727020255.A31.3	07/27/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110725019921	-5	FR110725019921.A31.1	07/25/11	E09_13 - Primary symptom is missing
FR110725019921	-5	FR110725019921.A31.1	07/25/11	E10_01 - Cause of injury is missing!
FR110725019921	-5	FR110725019921.A31.1	07/25/11	E12_10 - The patient's medical/surgical history is missing.
FR110725019921	-5	FR110725019921.A31.1	07/25/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110725019921	-5	FR110725019921.A31.1	07/25/11	Logic E19_01 - Date Proc Performed is before Arrived Patient Date.
FR110828024093	-5	FR110828024093.A232.1	08/28/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110828024093	-5	FR110828024093.A232.1	08/28/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110828024093	-5	FR110828024093.A232.1	08/28/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110827023535	-5	FR110827023535.M32.1	08/27/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110827023535	-5	FR110827023535.M32.1	08/27/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110827023535	-5	FR110827023535.M32.1	08/27/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110825023042	-5	FR110825023042.M31.1	08/25/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110825023042	-5	FR110825023042.M31.1	08/25/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110825023042	-5	FR110825023042.M31.1	08/25/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110828024096	-5	FR110828024096.A232.1	08/28/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110828024096	-5	FR110828024096.A232.1	08/28/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110828024096	-5	FR110828024096.A232.1	08/28/11	Logic E19_03 - Cannot have a procedure and a common null value entered.

FR110409009465	-5	FR110409009465.M31.1	04/09/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110409009465	-5	FR110409009465.M31.1	04/09/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110409009465	-5	FR110409009465.M31.1	04/09/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	(E18_04) Medication administration route is missing.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	E09_13 - Primary symptom is missing
FR110928027471	-5	FR110928027471.M31.1	09/28/11	E12_10 - The patient's medical/surgical history is missing.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	E18_07 - The patient's response to medication administration is missing.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	E19_03 - Procedure name is missing.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110928027471	-5	FR110928027471.M31.1	09/28/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110930027615	-5	FR110930027615.A31.1	09/30/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110930027615	-5	FR110930027615.A31.1	09/30/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110930027615	-5	FR110930027615.A31.1	09/30/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E05_07 - Arrive Patient Side date/time is missing.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E06_13 - Patient's ethnicity is required.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E09_07 - Chief complaint duration missing a unit of time.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E09_13 - Primary symptom is missing
FR111018029492	-5	FR111018029492.A31.1	10/18/11	E12_10 - The patient's medical/surgical history is missing.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111018029492	-5	FR111018029492.A31.1	10/18/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110923026971	-5	FR110923026971.A32.1	09/23/11	E05_09 - Leave Scene date/time is missing.
FR110923026971	-5	FR110923026971.A32.1	09/23/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110923026971	-5	FR110923026971.A32.1	09/23/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110923026971	-5	FR110923026971.A32.1	09/23/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110923026968	-5	FR110923026968.M31.1	09/23/11	E05_09 - Leave Scene date/time is missing.
FR110923026968	-5	FR110923026968.M31.1	09/23/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110923026968	-5	FR110923026968.M31.1	09/23/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110923026968	-5	FR110923026968.M31.1	09/23/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110716019024	-5	FR110716019024.A32.1	07/16/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110716019024	-5	FR110716019024.A32.1	07/16/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110716019024	-5	FR110716019024.A32.1	07/16/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110917026395	-5	FR110917026395.M31.1	09/17/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110917026395	-5	FR110917026395.M31.1	09/17/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.

FR110917026395	-5	FR110917026395.M31.1	09/17/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	E06_13 - Patient's ethnicity is required.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	E09_07 - Chief complaint duration missing a unit of time.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	E09_13 - Primary symptom is missing
FR111112031948	-5	FR111112031948.A31.1	11/12/11	E12_10 - The patient's medical/surgical history is missing.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111112031948	-5	FR111112031948.A31.1	11/12/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110908025409	-5	FR110908025409.A31.1	09/08/11	E06_13 - Patient's ethnicity is required.
FR110908025409	-5	FR110908025409.A31.1	09/08/11	E09_06 - The duration of the patient's chief complaint is missing.
FR110908025409	-5	FR110908025409.A31.1	09/08/11	E09_07 - Chief complaint duration missing a unit of time.
FR110908025409	-5	FR110908025409.A31.1	09/08/11	E12_10 - The patient's medical/surgical history is missing.
FR110908025409	-5	FR110908025409.A31.1	09/08/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E06_14 - Patient's age is missing.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E06_16 - Patient's DOB is missing
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E09_04 - Possible injury is missing.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E09_06 - The duration of the patient's chief complaint is missing.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E09_07 - Chief complaint duration missing a unit of time.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E12_10 - The patient's medical/surgical history is missing.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	E19_03 - Procedure name is missing.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110918026437	-5	FR110918026437.A31.1	09/18/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111017029432	-5	FR111017029432.A32.1	10/17/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111017029432	-5	FR111017029432.A32.1	10/17/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111017029432	-5	FR111017029432.A32.1	10/17/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	E05_09 - Leave Scene date/time is missing.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	E09_04 - Possible injury is missing.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	E09_07 - Chief complaint duration missing unit of time.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	E09_13 - Primary Symptom is missing
FR111105031264	-5	FR111105031264.A31.1	11/05/11	E19_03 - Procedure name is missing.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	Logic E09_04 - A Cause of Injury should not exist when possible injury is 'No'.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111105031264	-5	FR111105031264.A31.1	11/05/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	E06_12 - Patient's race is required.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	E06_13 - Patient's ethnicity is required.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	E09_04 - Possible injury is missing.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	E09_06 - The duration of the patient's chief complaint is missing.

FR111129033515	-5	FR111129033515.A31.1	11/29/11	E09_07 - Chief complaint duration missing a unit of time.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	E12_10 - The patient's medical/surgical history is missing.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111129033515	-5	FR111129033515.A31.1	11/29/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	E06_13 - Patient's ethnicity is required.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	E09_07 - Chief complaint duration missing a unit of time.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	E09_13 - Primary symptom is missing
FR111128033509	-5	FR111128033509.A31.1	11/28/11	E12_10 - The patient's medical/surgical history is missing.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111128033509	-5	FR111128033509.A31.1	11/28/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E05_07 - Arrive Patient Side date/time is missing.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E06_13 - Patient's ethnicity is required.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E09_07 - Chief complaint duration missing a unit of time.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E12_10 - The patient's medical/surgical history is missing.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	E19_03 - Procedure name is missing.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111218035471	-5	FR111218035471.A31.1	12/18/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111220035619	-5	FR111220035619.A31.1	12/20/11	E05_09 - Leave Scene date/time is missing.
FR111220035619	-5	FR111220035619.A31.1	12/20/11	E06_13 - Patient's ethnicity is required.
FR111220035619	-5	FR111220035619.A31.1	12/20/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR111220035619	-5	FR111220035619.A31.1	12/20/11	IT8_21 - The patient's stated reason for refusing care is missing!
FR111220035619	-5	FR111220035619.A31.1	12/20/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111220035619	-5	FR111220035619.A31.1	12/20/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	E05_09 - Leave Scene date/time is missing.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	E06_13 - Patient's ethnicity is required.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	E09_07 - Chief complaint duration missing unit of time.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	E09_13 - Primary Symptom is missing
FR111229036537	-5	FR111229036537.A32.1	12/29/11	IT8.19 - AMA type is missing and response disposition is patient refusal!
FR111229036537	-5	FR111229036537.A32.1	12/29/11	IT8_21 - The patient's stated reason for refusing care is missing!
FR111229036537	-5	FR111229036537.A32.1	12/29/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111229036537	-5	FR111229036537.A32.1	12/29/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111111031821	-5	FR111111031821.A31.1	11/11/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111111031821	-5	FR111111031821.A31.1	11/11/11	E09_07 - Chief complaint duration missing a unit of time.
FR111111031821	-5	FR111111031821.A31.1	11/11/11	E10_01 - Cause of injury is missing!
FR111111031821	-5	FR111111031821.A31.1	11/11/11	E12_10 - The patient's medical/surgical history is missing.

FR111111031821	-5	FR111111031821.A31.1	11/11/11	E19_03 - Procedure name is missing.
FR111111031821	-5	FR111111031821.A31.1	11/11/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111111031821	-5	FR111111031821.A31.1	11/11/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111223035966	-5	FR111223035966.A231.1	12/23/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111223035966	-5	FR111223035966.A231.1	12/23/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111223035966	-5	FR111223035966.A231.1	12/23/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111229036456	-5	FR111229036456.A31.1	12/29/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111229036456	-5	FR111229036456.A31.1	12/29/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111229036456	-5	FR111229036456.A31.1	12/29/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111222035867	-5	FR111222035867.A231.1	12/22/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111222035867	-5	FR111222035867.A231.1	12/22/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111222035867	-5	FR111222035867.A231.1	12/22/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111027030369	-5	FR111027030369.A231.1	10/27/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111027030369	-5	FR111027030369.A231.1	10/27/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111027030369	-5	FR111027030369.A231.1	10/27/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR110924027001	-5	FR110924027001.M31.1	09/24/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR110924027001	-5	FR110924027001.M31.1	09/24/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR110924027001	-5	FR110924027001.M31.1	09/24/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111225036108	-5	FR111225036108.A31.1	12/25/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111225036108	-5	FR111225036108.A31.1	12/25/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111225036108	-5	FR111225036108.A31.1	12/25/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111231036647	-5	FR111231036647.A31.1	12/31/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111231036647	-5	FR111231036647.A31.1	12/31/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111231036647	-5	FR111231036647.A31.1	12/31/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	E05_07 - Arrive Patient Side date/time is missing.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	E05_09 - Leave Scene date/time is missing.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	E06_13 - Patient's ethnicity is required.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	E09_04 - Possible injury is missing.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	E09_07 - Chief complaint duration missing unit of time.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111205034123	-5	FR111205034123.A31.1	12/05/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	E06_13 - Patient's ethnicity is required.

FR111105031250	-5	FR111105031250.A31.1	11/05/11	E09_04 - Possible injury is missing.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	E09_07 - Chief complaint duration missing a unit of time.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	E12_10 - The patient's medical/surgical history is missing.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111105031250	-5	FR111105031250.A31.1	11/05/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	E09_04 - Possible injury is missing.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	E09_07 - Chief complaint duration missing a unit of time.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	E12_10 - The patient's medical/surgical history is missing.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111205034124	-5	FR111205034124.M31.1	12/05/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E05_07 - Arrive Patient Side date/time is missing.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E06_13 - Patient's ethnicity is required.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E09_04 - Possible injury is missing.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E09_07 - Chief complaint duration missing a unit of time.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E12_10 - The patient's medical/surgical history is missing.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	E19_03 - Procedure name is missing.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111012028857	-5	FR111012028857.A31.1	10/12/11	Logic E19_03 - Cannot have a procedure and a common null value entered.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E09_06 - The duration of the patient's chief complaint is missing.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E09_07 - Chief complaint duration missing a unit of time.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E09_13 - Primary symptom is missing
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E12_10 - The patient's medical/surgical history is missing.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E14_01 - A set of vitals is required for this type of call
FR111211034795	-5	FR111211034795.A231.1	12/11/11	E19_03 - Procedure name is missing.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	Logic E10_03 - For Mechanism of Injury, a common null value and another value cannot be selected together.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	Logic E18_01) - Cannot have a medication and common null value entered at the same time.
FR111211034795	-5	FR111211034795.A231.1	12/11/11	Logic E19_03 - Cannot have a procedure and a common null value entered.

Schema Validation or Import Processing Issues					
Record Number	**Call #**	**PCR #**	**Incident #**	**Error Message**	**Detail Message**
No Schema Validation or Import Processing Issues Detected					

Appendix

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Sample Fire & Rescue Frequency of Validation Errors 2/1/2012 – 2/29/2012

The purpose of this Data Validation Report (DVR) is to provide feedback to individual agencies on the rate of validation errors occurring with their VPHIB data submissions for the time period noted above. Validation rules are used to check data entries for accuracy. Our validation rules are either based on logic or the state's minimum data standard. For example, a logic rule will identify that an "enroute to the hospital time" cannot occur prior to arriving on scene.

Validation rules that protect the state's minimum standard will identify when an item that is required to be submitted is missing or does not contain a valid answer. Individual elements may appear more than once. It is our hope that once you know what items are frequently not being reported correctly, that you will be able to educate your providers or work with your IT staff to make corrections to improve the quality of information you are submitting. For the purposes of this report we only include detailed information on errors that are occurring in 5 percent or greater of the time period reviewed.

Please contact VPHIB Support at http://oemssupport.kayako.com/, Support@OEMSSupport.Kayako.com, or (804) 888 – 9149 with any questions you may have or technical support needed to correct data your data quality issues.

Quick Facts
Data Collection Method: EMS Data Systems v3.7
Number of Incidents for report: 747
Number of Records by Scoring Groups

- 100 (all validity rules met) - 515
- 90 – 99 (acceptable) = 129
- 80 – 90 (below average) = 45
- 0 - 80 (poor) = 39

Avg. Score: 93.34
Minimum Score: 38.0
Maximum Score: 100.0

Figure 1

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Distribution of Validity Scores February 2012

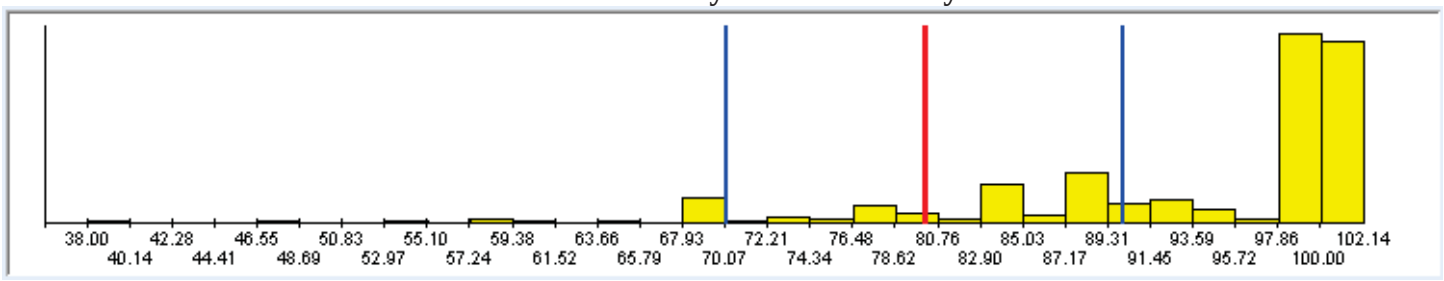


Figure 2

Frequency of Validation Errors February 2012

Error Name & Number	Number of Records with this Error	Percentage of Agency's Records with this Error	Current Value of Error
(total number of records submitted)	**747**		
Logic E18_01: Cannot have a medication and common null value entered at the same time. (See below)	474	63.45%	-1
Logic: E19_03 Cannot have a procedure and a common null value entered. (See below)	312	41.77%	-1
E05_09 - Leave scene date/time is missing	148	19.81%	-5
E08_07 - Location type is missing	97	12.99%	-10
E09_07 - Chief complaint duration missing unit of time!	87	11.65%	-1
E06_13 - Patient's ethnicity is required	75	10.04%	-1/-10
E09_04 - Possible injury is missing.	74	9.91%	-10
E18_09 - The provider ID is needed when a procedure has been performed.	60	8.03%	-5
E05_07 - Arrive patient side date/time is missing	58	7.76%	-5
E06_16 - Patient DOB is missing	58	7.76%	-1/-5
E06_02 - Patient's first name is missing	57	7.63%	-1/-10
E05_06 - Arrive on scene date/time is missing	53	7.10%	-5
E09_06 - The duration of the patient's chief complaint is missing!	38	5.09%	-5
E09_13 - Primary symptom is missing	29	3.88%	-5

Error Comments:

Logic E18_01 and Logic E18_01 errors are occurring because a medication was given or a procedure performed and one of the associated required fields was answered with a null/not value. As an example your incident number **12102051** has procedure 6830/Other performed at 18:02 and E19_09.Provider ID is -25/not applicable (see figure 3 below). This error is caused because the provider ID is missing.

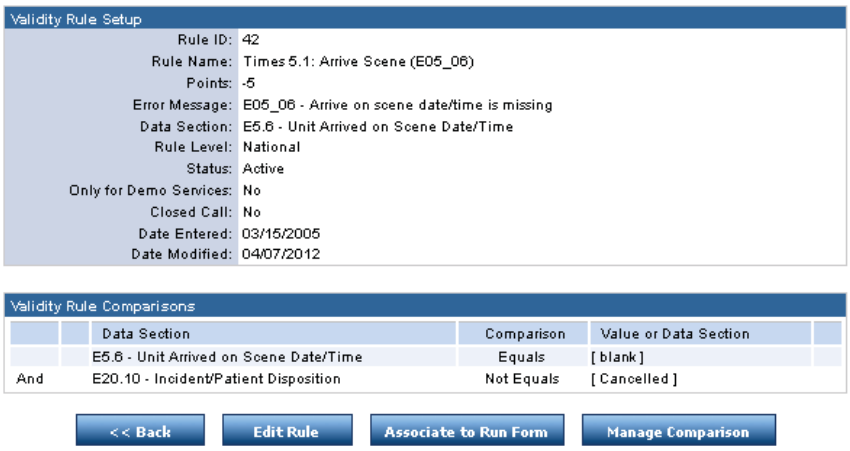
It is also concerning that two procedures were reported as “6830/Other.” If there are procedures your agency is performing and we do not have them in our list of procedures please let us know and we will add them or provide you with the correct mapping for that procedure.

Figure 3

```
- <E19>
  - <E19_01_0>
      <E19_01>2012-02-24T17:32:00.0Z</E19_01>
      <E19_03>6830</E19_03>
      <E19_05>1</E19_05>
      <E19_06>1</E19_06>
      <E19_07>4500</E19_07>
      <E19_09>E042616104</E19_09>
    - <IT07_00_19>
        <IT07_24>963026</IT07_24>
      </IT07_00_19>
    </E19_01_0>
  - <E19_01_0>
      <E19_01>2012-02-24T18:02:00.0Z</E19_01>
      <E19_03>6830</E19_03>
      <E19_05>1</E19_05>
      <E19_06>1</E19_06>
      <E19_07>4500</E19_07>
      <E19_09>-25</E19_09>
```

E05_06 – Arrive on scene date/time is missing

This error is triggered if the response disposition is anything except cancelled and the arrive on scene time is blank.



Validity Rule Setup

Rule ID:	42
Rule Name:	Times 5.1: Arrive Scene (E05_06)
Points:	-5
Error Message:	E05_06 - Arrive on scene date/time is missing
Data Section:	E5.6 - Unit Arrived on Scene Date/Time
Rule Level:	National
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	03/15/2005
Date Modified:	04/07/2012

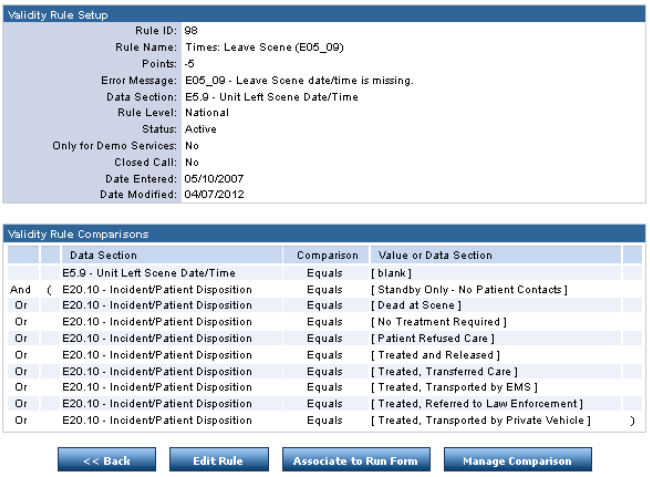
Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
		E5.6 - Unit Arrived on Scene Date/Time	Equals	[blank]	
And		E20.10 - Incident/Patient Disposition	Not Equals	[Cancelled]	

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E05_09 – Leave scene date/time is missing

This error is triggered if the response disposition indicates that the unit would have had to arrive on scene and the leave scene time is blank.



Validity Rule Setup

Rule ID:	98
Rule Name:	Times: Leave Scene (E05_09)
Points:	-5
Error Message:	E05_09 - Leave Scene date/time is missing.
Data Section:	E5.9 - Unit Left Scene Date/Time
Rule Level:	National
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	05/10/2007
Date Modified:	04/07/2012

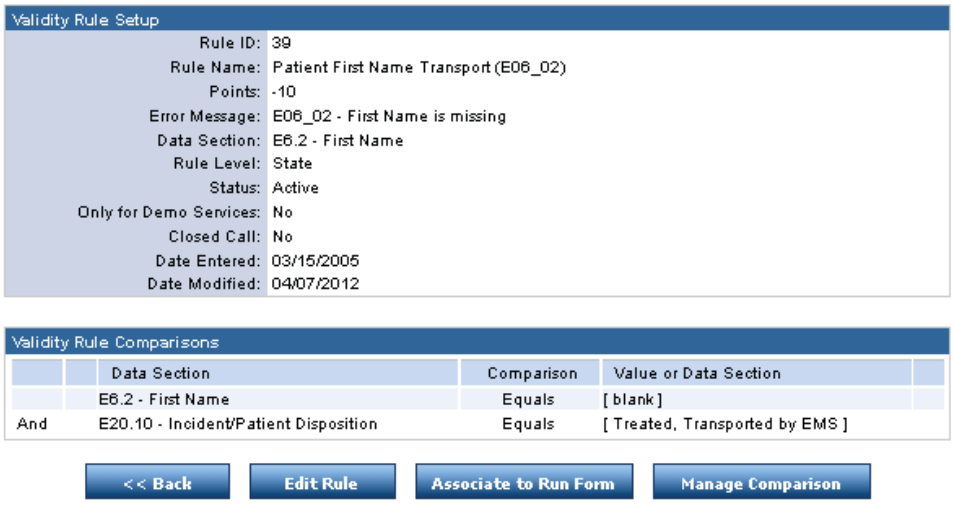
Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
		E5.9 - Unit Left Scene Date/Time	Equals	[blank]	
And	(	E20.10 - Incident/Patient Disposition	Equals	[Standby Only - No Patient Contacts]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Dead at Scene]	
Or		E20.10 - Incident/Patient Disposition	Equals	[No Treatment Required]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Patient Refused Care]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated and Released]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transferred Care]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Referred to Law Enforcement]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by Private Vehicle]	)

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E06_02 – Patient first name is missing

This rule is triggered if the incident disposition is treated and transport and no first name was given. It is weighted more heavily for transport units compared to non-transport.



Validity Rule Setup

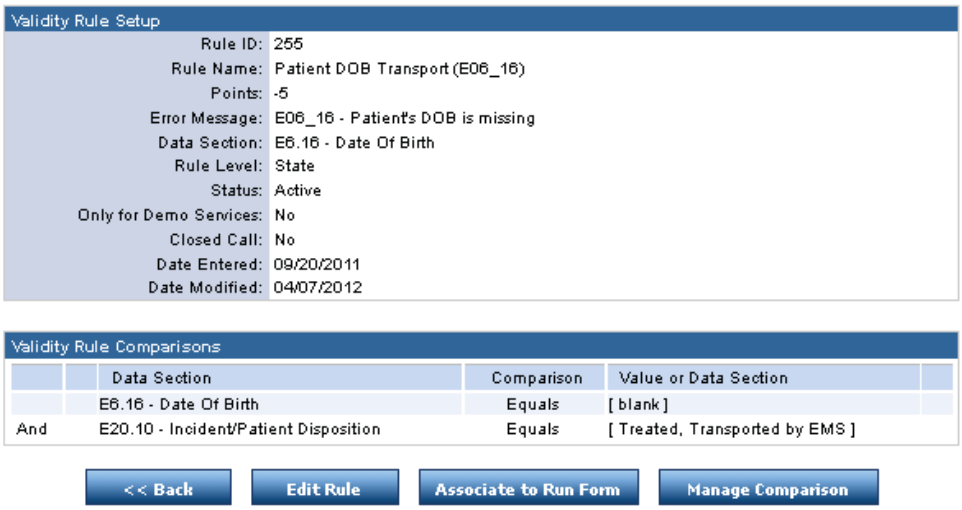
Rule ID:	39
Rule Name:	Patient First Name Transport (E06_02)
Points:	-10
Error Message:	E06_02 - First Name is missing
Data Section:	E6.2 - First Name
Rule Level:	State
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	03/15/2005
Date Modified:	04/07/2012

Validity Rule Comparisons

	Data Section	Comparison	Value or Data Section
	E6.2 - First Name	Equals	[blank]
And	E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]

E06_16 – Patient DOB is missing

This rule is triggered if the incident disposition is treated and transport and no DOB was given. It is weighted more heavily for transport units compared to non-transport.



Validity Rule Setup

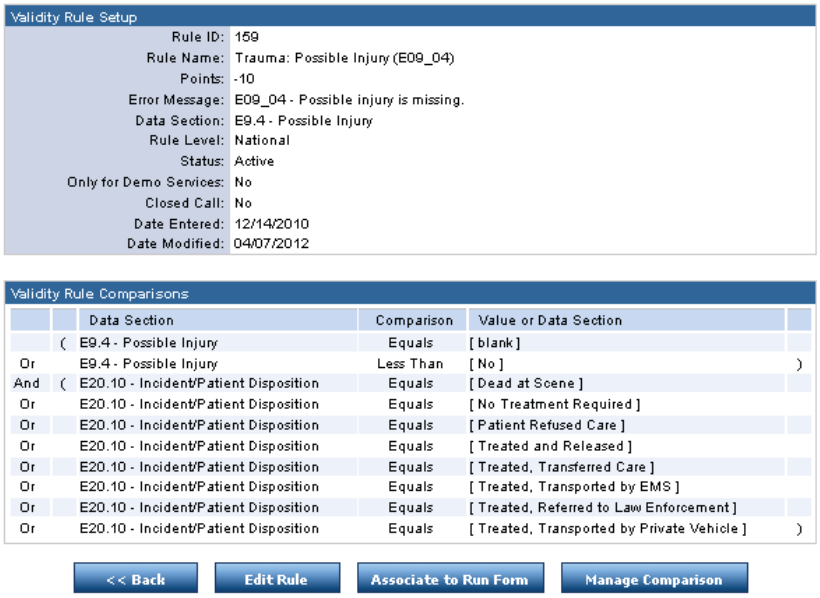
Rule ID:	255
Rule Name:	Patient DOB Transport (E06_16)
Points:	-5
Error Message:	E06_16 - Patient's DOB is missing
Data Section:	E6.16 - Date Of Birth
Rule Level:	State
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	09/20/2011
Date Modified:	04/07/2012

Validity Rule Comparisons

	Data Section	Comparison	Value or Data Section
	E6.16 - Date Of Birth	Equals	[blank]
And	E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]

E09_04 - Possible Injury is missing

This error is triggered if the patient disposition reflects there was patient contact and possible injury is blank/missing. OEMS would rather just utilize the provider impression for this, but Nationally this is a significant field that reports are developed with.



Validity Rule Setup

Rule ID:	159
Rule Name:	Trauma: Possible Injury (E09_04)
Points:	-10
Error Message:	E09_04 - Possible injury is missing.
Data Section:	E9.4 - Possible Injury
Rule Level:	National
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	12/14/2010
Date Modified:	04/07/2012

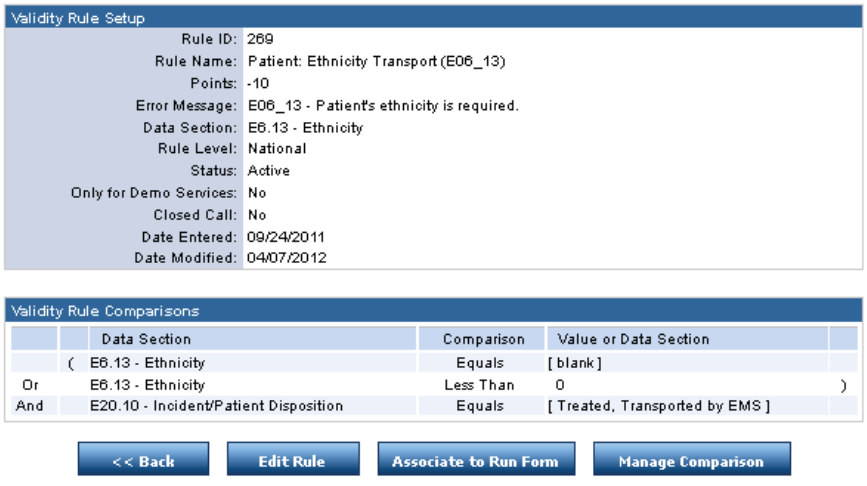
Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
	(	E9.4 - Possible Injury	Equals	[blank]	
Or		E9.4 - Possible Injury	Less Than	[No]	)
And	(	E20.10 - Incident/Patient Disposition	Equals	[Dead at Scene]	
Or		E20.10 - Incident/Patient Disposition	Equals	[No Treatment Required]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Patient Refused Care]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated and Released]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transferred Care]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Referred to Law Enforcement]	
Or		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by Private Vehicle]	)

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E06_13 – Ethnicity is missing

This error triggers when the response disposition is treated and transported and ethnicity is either blank or a not value. The scoring is weighted higher for transport units.



Validity Rule Setup

Rule ID:	269
Rule Name:	Patient: Ethnicity Transport (E06_13)
Points:	-10
Error Message:	E06_13 - Patient's ethnicity is required.
Data Section:	E6.13 - Ethnicity
Rule Level:	National
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	09/24/2011
Date Modified:	04/07/2012

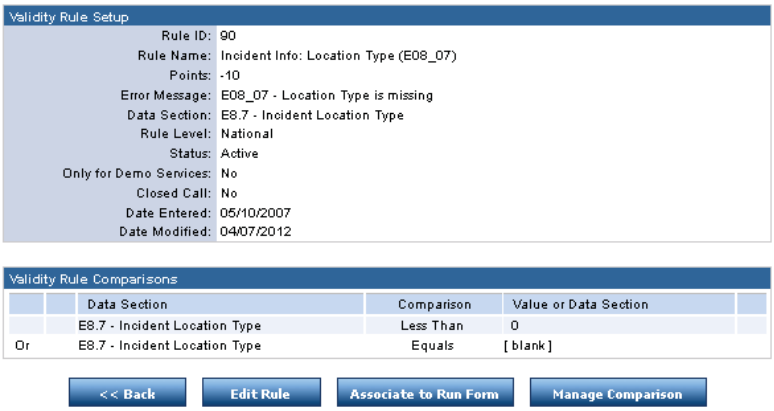
Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
	(	E6.13 - Ethnicity	Equals	[blank]	
Or		E6.13 - Ethnicity	Less Than	0	)
And		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]	

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E08_07 – Location type is missing

This error is triggered when the incident location is blank or a null/not value for all incidents.



Validity Rule Setup

Rule ID:	90
Rule Name:	Incident Info: Location Type (E08_07)
Points:	-10
Error Message:	E08_07 - Location Type is missing
Data Section:	E8.7 - Incident Location Type
Rule Level:	National
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	05/10/2007
Date Modified:	04/07/2012

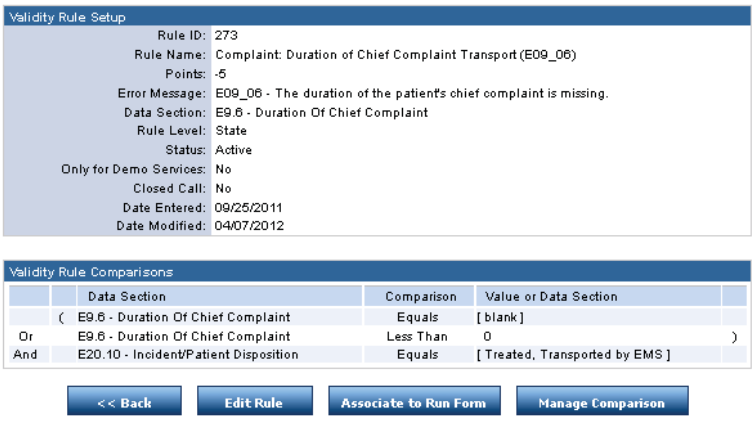
Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
		E8.7 - Incident Location Type	Less Than	0	
Or		E8.7 - Incident Location Type	Equals	[blank]	

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E09_06 – Duration of chief complaint

This error is triggered when incident disposition is treated and transported and by EMS and the duration of the chief complaint is blank or uses a null/not value.



Validity Rule Setup

Rule ID:	273
Rule Name:	Complaint: Duration of Chief Complaint Transport (E09_06)
Points:	-5
Error Message:	E09_06 - The duration of the patient's chief complaint is missing.
Data Section:	E9.6 - Duration Of Chief Complaint
Rule Level:	State
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	09/25/2011
Date Modified:	04/07/2012

Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
	(	E9.6 - Duration Of Chief Complaint	Equals	[blank]	
Or		E9.6 - Duration Of Chief Complaint	Less Than	0	)
And		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]	

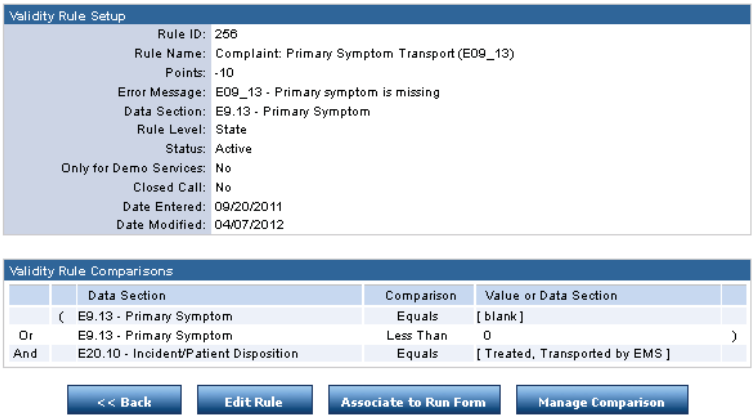
<< Back | Edit Rule | Associate to Run Form | Manage Comparison

E09_07 – Chief complaint duration is missing unit of time

This error triggers when the time unit (seconds, minutes, etc.) of the duration of the chief complaint is missing.

E09_13 - Primary symptom is missing

This rule is triggered when the patient was treated and the primary symptom is blank or uses a null/not value.



Validity Rule Setup

Rule ID:	256
Rule Name:	Complaint: Primary Symptom Transport (E09_13)
Points:	-10
Error Message:	E09_13 - Primary symptom is missing
Data Section:	E9.13 - Primary Symptom
Rule Level:	State
Status:	Active
Only for Demo Services:	No
Closed Call:	No
Date Entered:	09/20/2011
Date Modified:	04/07/2012

Validity Rule Comparisons

		Data Section	Comparison	Value or Data Section	
	(	E9.13 - Primary Symptom	Equals	[blank]	
Or		E9.13 - Primary Symptom	Less Than	0	)
And		E20.10 - Incident/Patient Disposition	Equals	[Treated, Transported by EMS]	

<< Back | Edit Rule | Associate to Run Form | Manage Comparison

Appendix

M

Rights & Responsibilities:

The Rights of Requesters of EMS and Trauma Data and the Responsibilities of the Virginia Department of Health's Office of Emergency Medical Services (VDH/OEMS) under the Virginia Freedom of Information Act

Purpose of this document: Technically any request made to the VDH/OEMS for information is considered a Freedom of Information Act (FOIA) request. This document is a modified version of the VDH FOIA document and its purpose is to focus on data requests from the Trauma and EMS Registries. VDH maintains a list of common exemptions to FOIA which includes the Trauma and EMS Registries, which are exempt from FOIA by law.

VDH/OEMS generally will provide data from these sources if the request is de-identified and is determined to be valid. VDH/OEMS does retain the right to recuperate costs as allowed by FOIA and cannot guarantee the availability of statistical analysis. To obtain identifiable data, the requestor will need to obtain approval of the VDH Institutional Review Board.

The Virginia Freedom of Information Act (FOIA), located § 2.2-3700 et. seq. of the Code of Virginia, guarantees citizens of the Commonwealth and representatives of the media access to public records held by public bodies, public officials, and public employees.

A public record is any writing or recording -- regardless of whether it is a paper record, an electronic file, an audio or video recording, or any other format -- that is prepared or owned by, or in the possession of a public body or its officers, employees or agents in the transaction of public business. All public records are presumed to be open, and may only be withheld if a specific, statutory exemption applies.

The policy of FOIA states that the purpose of FOIA is to promote an increased awareness by all persons of governmental activities. In furthering this policy, FOIA requires that the law be interpreted liberally, in favor of access, and that any exemption allowing public records to be withheld must be interpreted narrowly.

To request data from the EMS and/or trauma registries please use the Request for Data from the Office of EMS form and submit the request to Support@OEMSSupport.Kayako.com or go to http://oemssupport.kayako.com/ and navigate to Data Request in the sites Knowledgebase and complete the form on-line. You may also mail your request to 1041 Technology Park Drive, Glen Allen, Virginia 23059 or call (804) 888-9149.

For other VDH request, go to http://www.vdh.virginia.gov/Administration/FOIA/

Your FOIA Rights

- You have the right to request to inspect **or** receive copies of public records, or both.
- You have the right to request that any charges for the requested records be estimated in advance.

- If you believe that your FOIA rights have been violated, you may file a petition in district or circuit court to compel compliance with FOIA.

Commonly Used Exemptions

The Code of Virginia allows any public body to withhold certain records from public disclosure. VDH/OEMS commonly withholds records subject to the following exemptions:

- Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1. (§ 2.2-3705.5(5) of the Code of Virginia);
- Personnel records (§ 2.2-3705.1 (1) of the Code of Virginia);
- Records subject to attorney-client privilege (§ 2.2-3705.1 (2)) or attorney work product (§ 2.2-3705.1 (3));
- Vendor proprietary information (§ 2.2-3705.1 (6));
- Records relating to the negotiation and award of a contract, prior to a contract being awarded (§ 2.2-3705.1 (12));
- Medical and mental records (§ 2.2-3705.5(1) of the Code of Virginia);

Costs

- You may have to pay for the records that you request from VDH. FOIA allows us to charge for the actual costs of responding to FOIA requests. This would include items like staff time spent searching for the requested records, copying costs or any other costs directly related to supplying the requested records. It cannot include general overhead costs.
- If we estimate that it will cost more than $200 to respond to your request, we may require you to pay a deposit, not to exceed the amount of the estimate, before proceeding with your request. The five days that we have to respond to your request does not include the time between when we ask for a deposit and when you respond.
- You may request that we estimate in advance the charges for supplying the records that you have requested. This will allow you to know about any costs upfront, or give you the opportunity to modify your request in an attempt to lower the estimated costs.
- If you owe us money from a previous FOIA request that has remained unpaid for more than 30 days, VDH may require payment of the past-due bill before it will respond to your new FOIA request.

VDH's Responsibilities in Responding to Your Request

- VDH must respond to your request within five working days of receiving it. "Day One" is considered the day after your request is received. The five-day period does not include weekends or holidays.

- The reason behind your request for public records from VDH is irrelevant, and we cannot ask you why you want the records before we respond to your request. FOIA does, however, allow VDH to ask you to provide your name and legal address.

- FOIA requires that VDH make one of the following responses to your request within the five-day time period:

    - We provide you with the records that you have requested in their entirety.

    - We withhold all of the records that you have requested, because all of the records are subject to a specific statutory exemption. If all of the records are being withheld, we must send you a response in writing. That writing must identify the volume and subject matter of the records being withheld, and state the specific section of the Code of Virginia that allows us to withhold the records.

    - We provide some of the records that you have requested, but withhold other records. We cannot withhold an entire record if only a portion of it is subject to an exemption. In that instance, we may redact the portion of the record that may be withheld, and must provide you with the remainder of the record. We must provide you with a written response stating the specific section of the Code of Virginia that allows portions of the requested records to be withheld.

    - If it is practically impossible for VDH to respond to your request within the five-day period, we must state this in writing, explaining the conditions that make the response impossible. This will allow us seven additional working days to respond to your request, giving us a total of 12 working days to respond to your request.

- If you make a request for a very large number of records, and we feel that we cannot provide the records to you within 12 days without disrupting our other organizational responsibilities, we may petition the court for additional time to respond to your request. However, FOIA requires that we make a reasonable effort to reach an agreement with you concerning the production or the records before we go to court to ask for more time.

Appendix

N

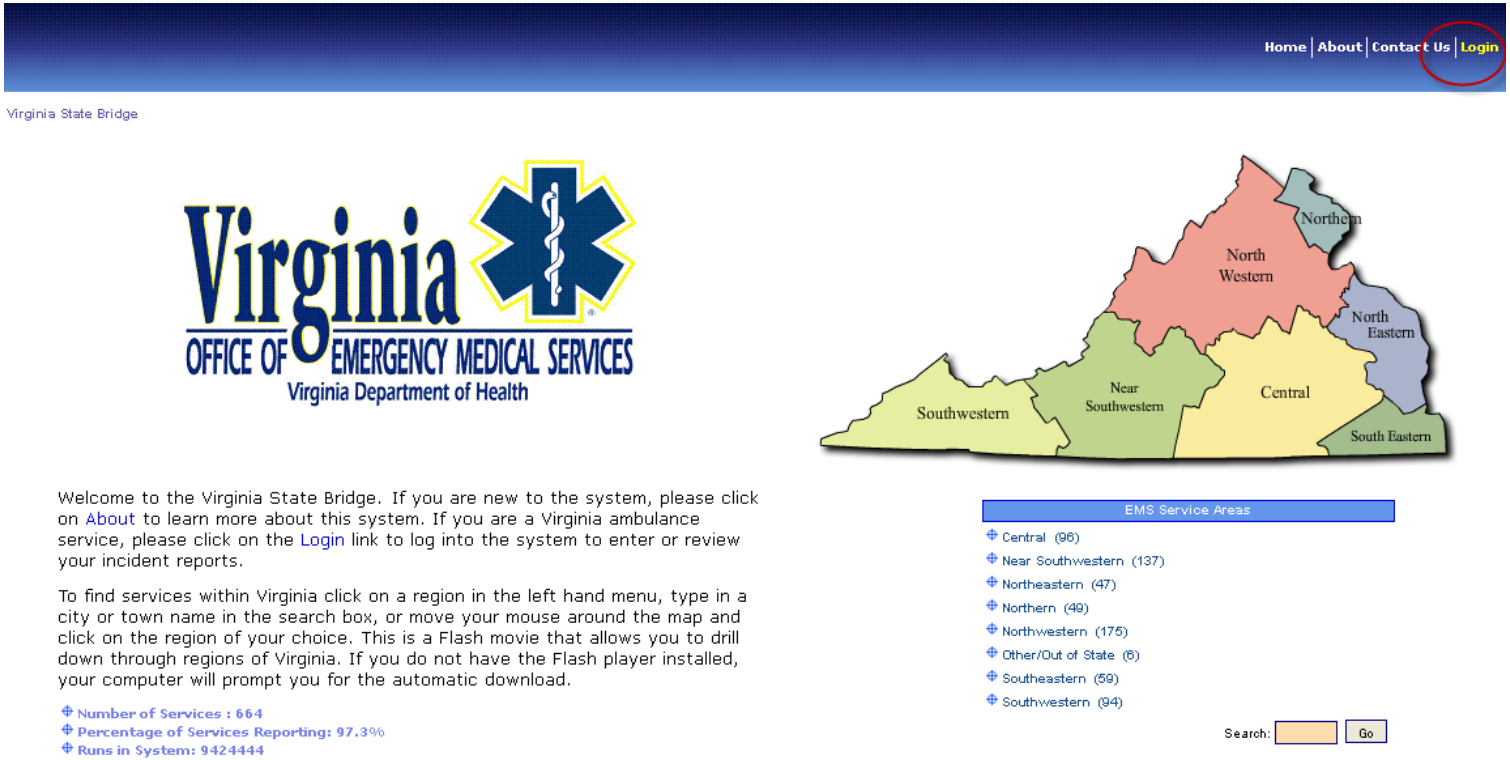
Local EMS System Report Writer User Instructions

The Local EMS System Report Writer role is a single user security role. As such, users must have a unique user ID and password which are assigned by the Office of Emergency Medical Services (OEMS.)

To request a Local EMS system account fill out and submit a "Logon Request – Local EMS System" and a Local EMS System use Security Agreement. This can be found in the VPHIB Support Suite located at http://oemssupport.kayako.com. The forms are located in the "Administrative" folder of the Knowledgebase.

- Once you have an account go to https://vphib.vdh.virginia.gov/ and click on the Login link (Figure 1).

Figure 1

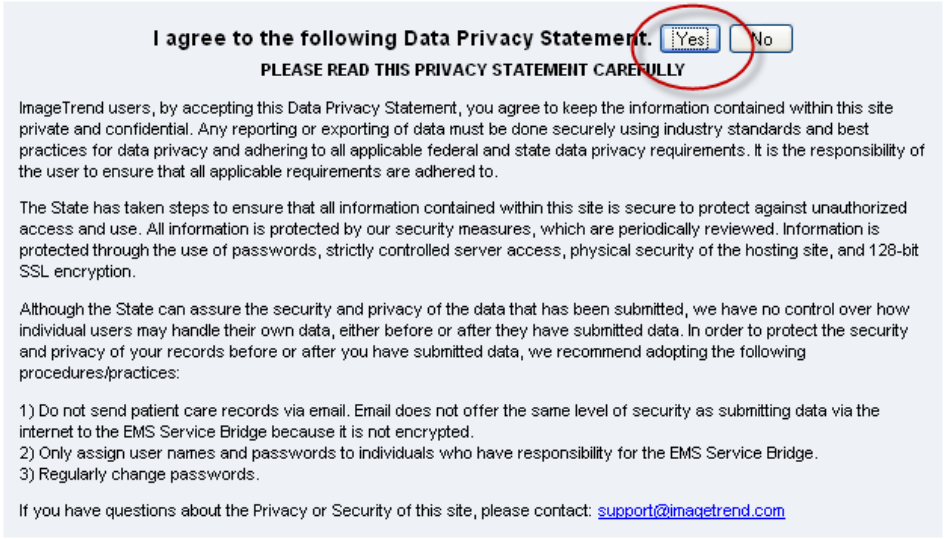


- Once you click on the login link you will see the username and password page (Figure 2). Enter your user name and password. You will be required to change your password the first time you sign on and periodically after.

Figure 2

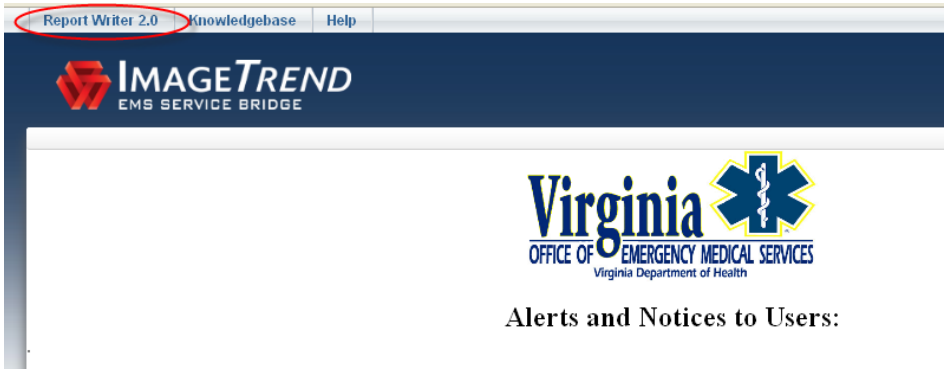
- Even though you will not be able to access HIPAA level data you will be required to agree to the HIPAA privacy statement (Figure 3).

Figure 3



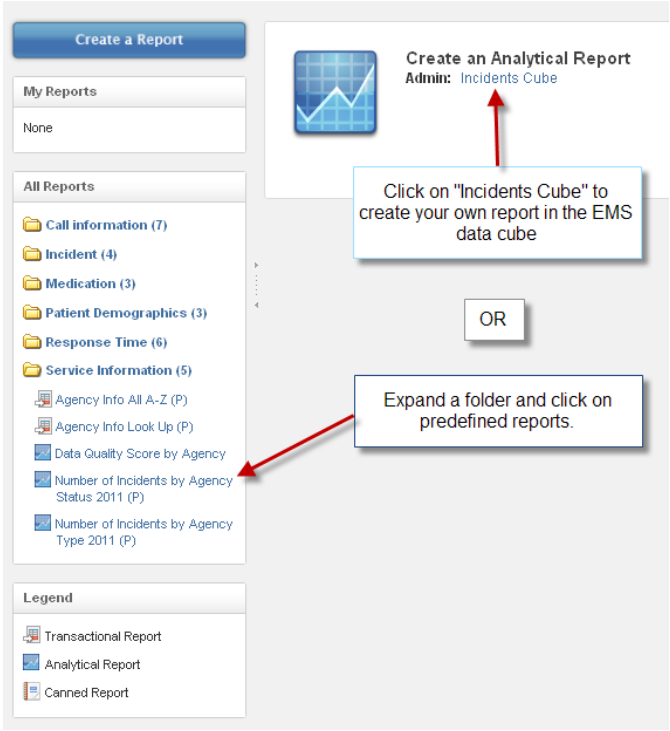
- Once signed in, you will be brought to the home page (Figure 4). To access EMS data click on the "Report Writer 2.0" tab. Note you will also see current announcements and have access to the users documents and other information posted for all users.

Figure 4



- Once on the Report Writer 2 menu, you will have the choice of predefined reports (left) and entering the "Incidents Cube."

Figure 5



- As shown in Figure 5 above, when you expand the folders in the left hand menu you can choose a predefined report. Figure 5 illustrates selecting the number of incidents by injury status report.
- The report will return with a graph and/or table (Figure 6.)
- As shown below the report can then be further "drilled down" by click on the filters and selecting and deselecting the fields included in each element.
- Also shown below, by clicking on the "Export" button, the report can be printed and exported. Figure 7 illustrates the export formats available for this report.

Figure 6

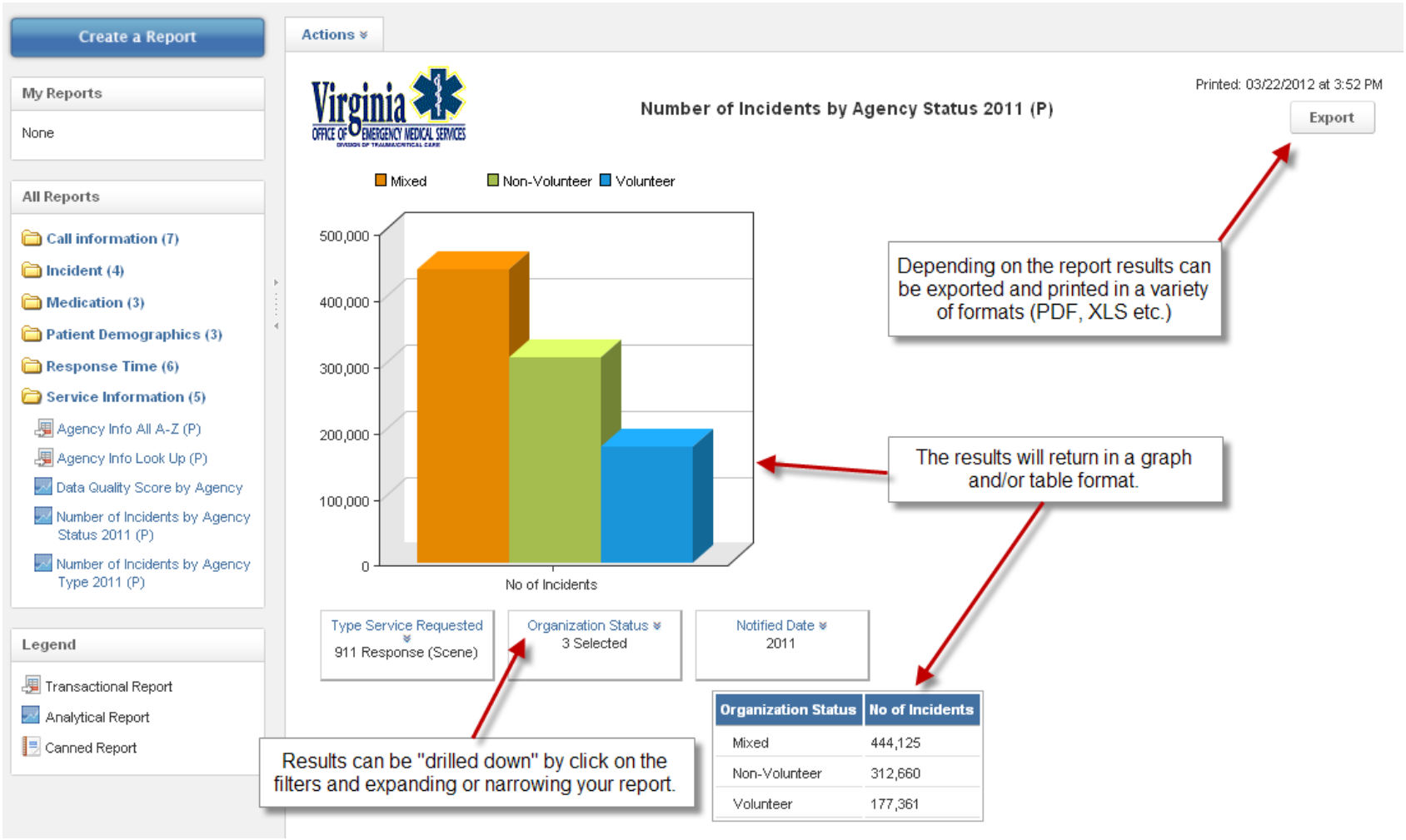
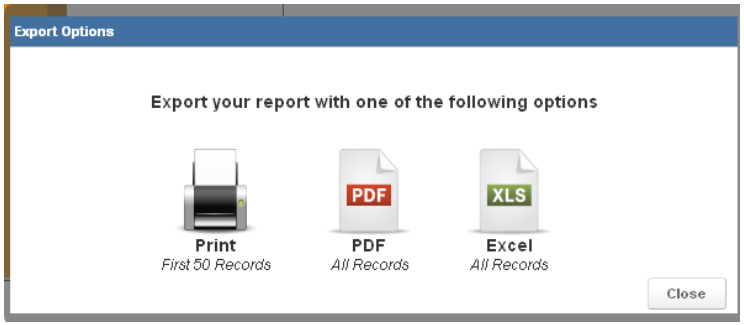
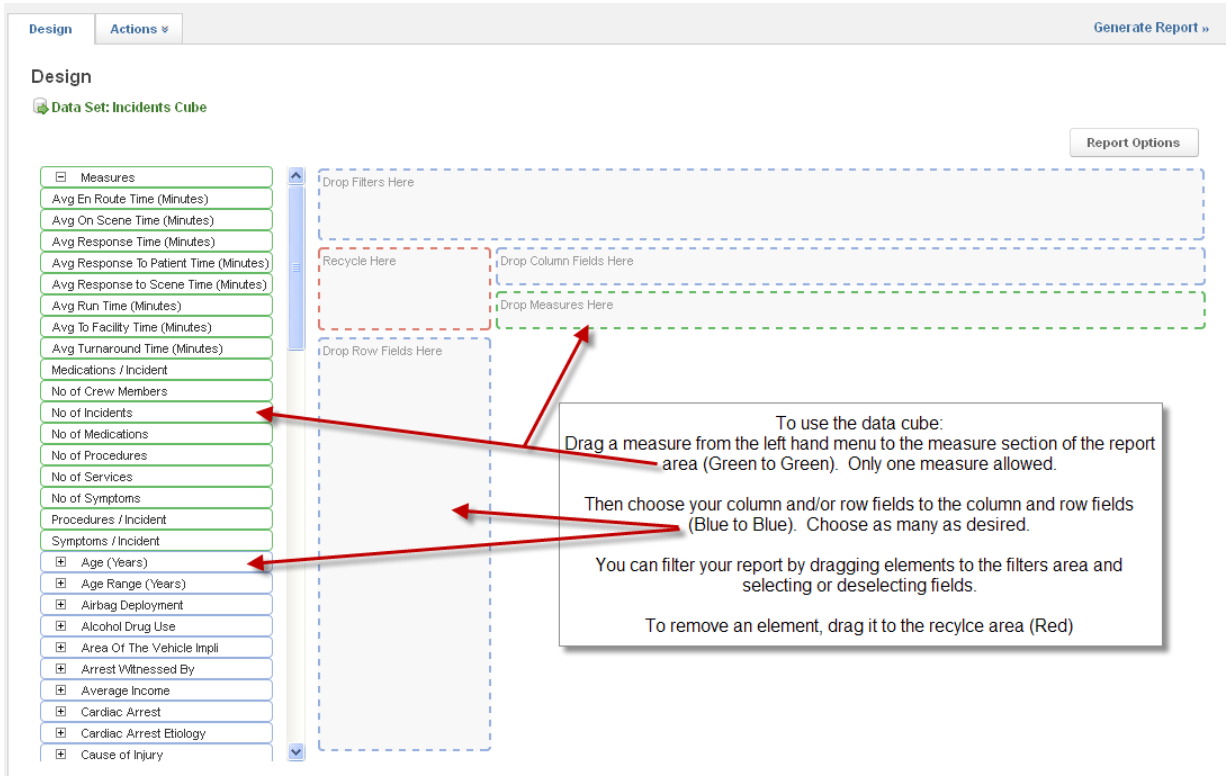


Figure 7



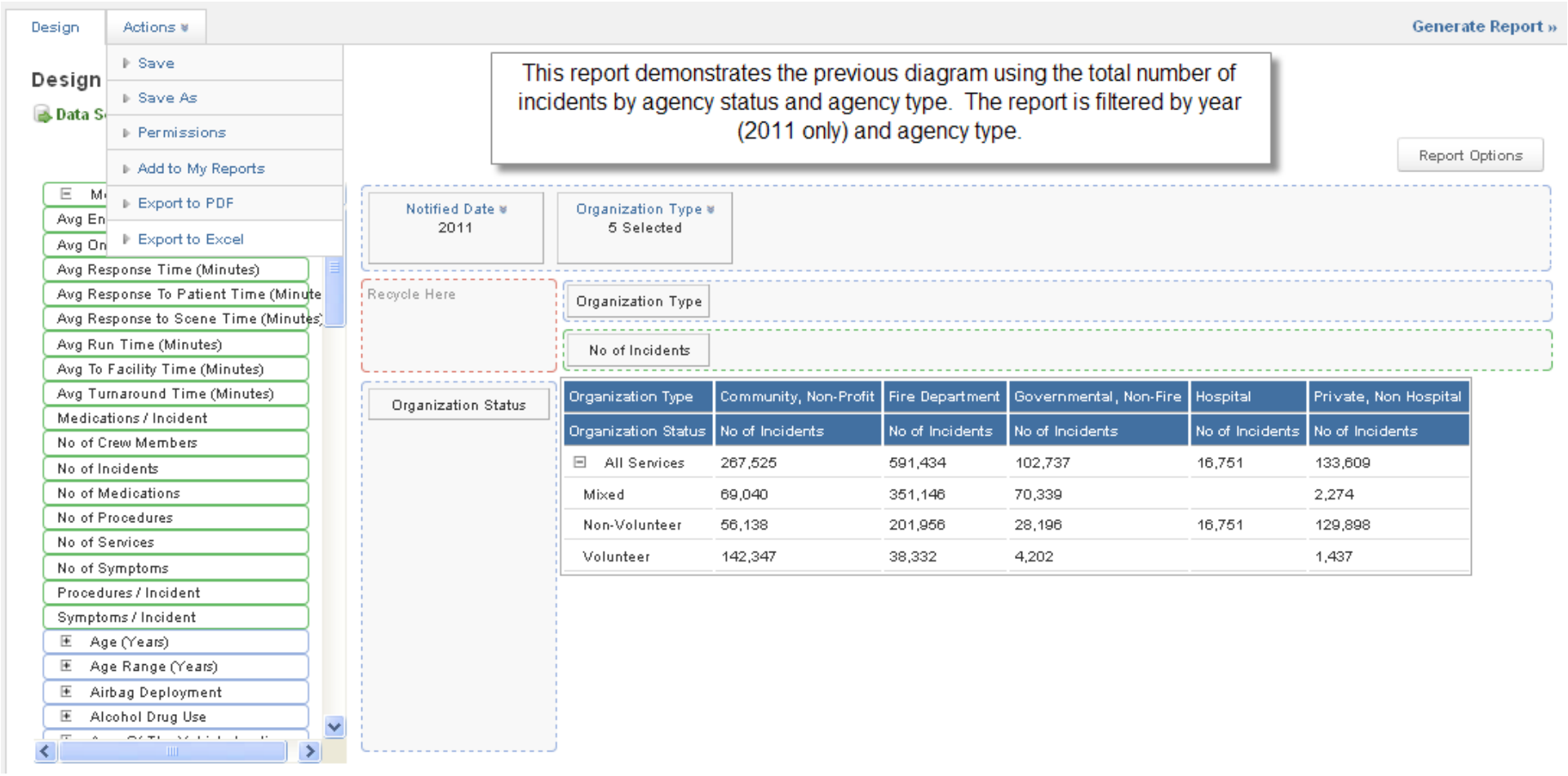
- To develop your own report click on the "Incidents Cube" link as shown in Figure 5.
- By dragging elements into the report area reports can also created. Figure 8 below demonstrates how to include elements in your report.

Figure 8



- Figure 9 illustrates a basic report and the use of filters needed to create a report on the number of incidents in 2011 by agency status and type. Without using filters your results will come from over 9,000,000 records from 12 years and include two different minimum datasets. This will likely cause a report of poor quality.
- The "Actions" tab will provide your options for exporting your results, when available.

Figure 9



Organization Type	Community, Non-Profit	Fire Department	Governmental, Non-Fire	Hospital	Private, Non Hospital
Organization Status	No of Incidents	No of Incidents	No of Incidents	No of Incidents	No of Incidents
All Services	267,525	591,434	102,737	16,751	133,609
Mixed	69,040	351,146	70,339		2,274
Non-Volunteer	56,138	201,956	28,196	16,751	129,898
Volunteer	142,347	38,332	4,202		1,437