Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, May 8, 2015

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
May 8, 2015

MISSION STATEMENT:

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

I. Executive Management, Administration & Finance

a) Action Items before the State EMS Advisory for May 8, 2015

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

b) Carol Morrow Retires from OEMS

On April 1, 2015 Carol Morrow retired from her position as Technical Assistance Coordinator at the Office of EMS . At the time of her retirement she was working on several important projects that included EMS Officer I training program and Standards for EMS agencies of Excellence. Carol has worked tirelessly with the sub-committee members of the EMS Workforce Development Committee to move these projects along and with some additional effort, both of these projects will be released in the near future.

Carol served on the Financial Assistance Review Committee before beginning her employment with the Office of EMS in 1990. She began her career at OEMS as the RSAF Grants Coordinator before transitioning into a position within Emergency Operations. While working in Emergency Operations she served as the Manager for Critical Incident Stress Management (CISM) and participated in responses to NC Hurricanes, 9-11 Pentagon and Virginia Tech mass shooting incident. She also helped coordinate 22 Post Critical Incident Seminars (PCIS's), a majority of which were arranged for 9/11 responders. In late 2008, Carol assumed the position of Technical Assistance Coordinator.

Carol has committed a significant amount of her lifetime to EMS beginning as a volunteer in Hanover County and for the last 25 years as a dedicated and committed employee of the Office

of EMS. Prior to her last day at OEMS, the staff held a reception for her and enjoyed talking about the people and things that have happened over the past quarter century that have helped shape EMS in Virginia. For those that wish to keep in touch with Carol, she can be reached by Email at carolspoonermorrow@gmail.com.

c) EMS Compass Initiative: EMS Performance Measures Project Aims to Help Local Systems

SAN ANTONIO, Texas, April 23, 2015– "EMS Compass, an initiative to improve systems of care though meaningful performance measures, is underway and will soon be looking for input from the public," said Nick Nudell, EMS Compass project manager, at Tuesday's closing session of the National Association of State EMS Officials Spring Meeting.

The initiative launched earlier this year with funding provided by the National Highway Traffic Safety Administration (NHTSA) through a cooperative agreement with the National Association of State EMS Officials (NASEMSO). EMS Compass brings together many of the nation's leading minds in EMS, healthcare and performance improvement, including the expertise of the Institute for Healthcare Improvement (IHI).

"EMS Compass is a national initiative that will support local communities in providing high-quality emergency care to patients," said Dia Gainor, executive director of NASEMSO. "We hope that the name, EMS Compass, will serve to differentiate this initiative from previous performance measurement efforts and regional activities and that it will communicate the goal of setting a course for continued performance measure development and implementation," Gainor continued. "Knowing what to measure and how to measure it is critical to helping our local and state EMS systems improve."

Although funded as a two-year project, the goal of EMS Compass is not just to create and evaluate performance measures, but to develop a system for designing performance measures that can live on well beyond the timeline of the current initiative. Measuring the quality of care in EMS has become more critical not only for quality improvement efforts, but also because healthcare financing is changing rapidly.

The EMS Compass performance measures will be based on the latest National EMS Information System (NEMSIS) version 3.0 data points and will allow EMS agencies to use local and state data meaningfully to improve care. In addition to the performance measure design system, EMS Compass will develop a guidebook to assist EMS providers and agencies in efforts to measure performance and make improvements.

"The project will facilitate an inclusive and open development process, with participation from dozens of EMS and healthcare experts and organizations and multiple opportunities for input and public comment, including a call for measures later this spring," said Nudell. "The call for measures, which is also used by the National Quality Forum (NQF) in its measurement design process, will allow anyone to submit performance measures to be considered by the EMS Compass committee members."

Other ways to be involved in EMS Compass will include:

- A series of webinars to discuss the prioritization of performance measures and solicit feedback
- from the EMS community
- Opportunities for EMS agencies to beta test and comment on the draft measures
- Public comment at future community and stakeholder meetings

The EMS Compass initiative is led by a steering committee of a diverse group of veteran EMS and performance measurement experts and chaired by the esteemed Bob Bass, MD, who recently retired as director of the Maryland Institute for EMS Systems (MIEMSS). "I am thrilled to be a part of one of the most important initiatives in EMS and excited to be working with some of the most thoughtful and innovative minds in the field," Bass said.

For more about EMS Compass or to volunteer to be involved in the national effort, sign up to receive updates at www.emscompass.org, and follow the initiative on Facebook and Twitter (@EMSCompass). Please see **Appendix A**.

d) EMS Voluntary Event Notification Tool: An EMS Culture of Safety Tool

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

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

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

Please see the following reports:

- **Patient Safety Events** reported to E.V.E.N.T. for calendar year 2014 – **Appendix B**
- **Provider Violence Events** reported to E.V.E.N.T. for calendar year 2014 – **Appendix C**
- **Near Miss** reported to E.V.E.N.T. for from calendar year 2014 – **Appendix D**

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

e) Legislation Introduced in the 2015 Virginia General Assembly Directly Impacting EMS

The final status of six (6) bills that the Office of EMS was assigned as lead agency:

HB1584 and SB 938 - Revises terminology related to fire services and emergency medical services and reorganizes provisions governing fire services and emergency medical services. The bill also contained technical amendments.

02/26/15 House: VOTE: ADOPTION (97-Y 0-N)
02/27/15 Senate: Conference report agreed to by Senate (37-Y 0-N)
03/23/15 Approved by Governor: Acts of Assembly Chapter text (CHAP0502)

HB1660 and SB877 - Recognition of EMS Personnel Licensure Interstate Compact. Creates the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact to (i) protect the public through verification of competency and ensuring of accountability for patient-care-related activities of licensed emergency medical services (EMS) personnel,(ii) facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority, and (iii) authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state.

HB1660

01/22/15 House: Subcommittee recommends laying on the table by voice vote
02/11/15 House: Left in Health, Welfare and Institutions

SB877

02/09/15 Senate: Passed Senate (38-Y 0-N)
02/17/15 House: Subcommittee recommends laying on the table by voice vote
02/24/15 House: Left in Health, Welfare and Institutions

SB837 and SB997 - Emergency medical services personnel; background checks; process. Creates an alternative method for national criminal history background checks for emergency medical services personnel, allowing local governments that have procedures in place for the collection of fingerprints and personal descriptive information and the forwarding of such fingerprints and information directly to the Federal Bureau of Investigation to do so instead of forwarding fingerprints and information through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the national criminal history background checks.

SB837

02/05/15 Senate: Incorporated by Education and Health (SB997-Stuart) (14-Y 0-N)

SB997

02/10/15 Senate: Passed Senate (38-Y 0-N)
02/20/15 House: Passed House with amendment (93-Y 1-N)
02/24/15 Senate: House amendment agreed to by Senate (39-Y 0-N)
03/19/15 Approved by Governor: Acts of Assembly Chapter text (CHAP0362)

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

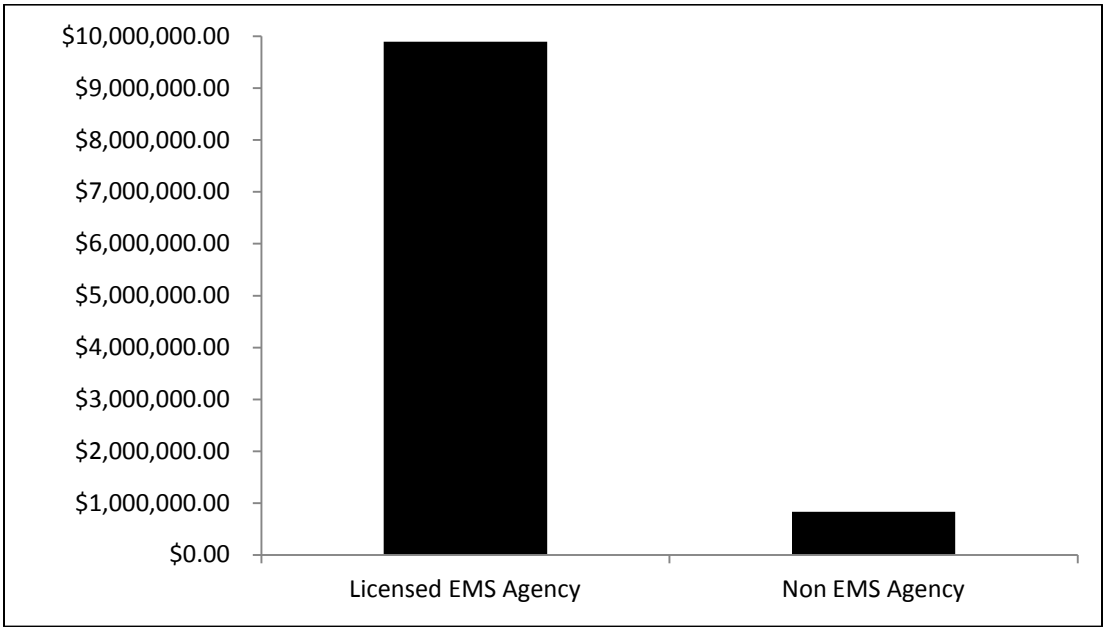
The implementation of the E-GIFT (EMS – Grant Information Funding Tool) is almost complete as Phase IV, Payments and Reports, is being finalized. Developing the web based program grant program has been highly successful and has been a major improvement to the RSAF grant program.

The RSAF grant deadline for the June 2015 grant cycle was March 16, 2015. OEMS received 152 grant applications requesting $10,724,108.00 in funding. This is the second cycle that the EMS Grant Information Funding Tool (E-GIFT) web-based application was required by all applicants.

Funding amounts are being requested in the following agency categories:

- 131 Licensed EMS Agencies requesting $9,894,198.00
- 21 Non EMS Agency requesting $829,910.00

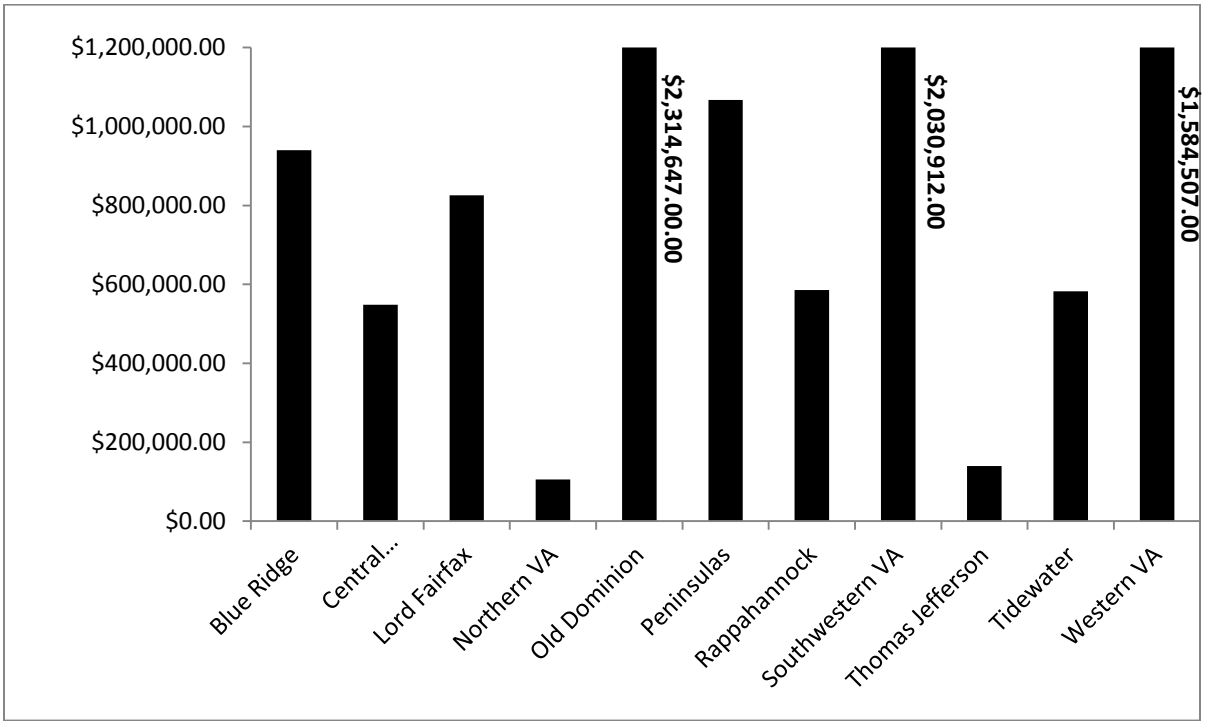
Figure 1: Agency Category by Amount Requested



Funding amounts are being requested in the following regional areas:

- Blue Ridge – Requesting funding of $939,747.00
- Central Shenandoah – Requesting funding of $548,227.00
- Lord Fairfax – Requesting funding of $825,485.00
- Northern Virginia – Requesting funding of $105,658.00
- Old Dominion – Requesting funding of $2,314,647.00.00
- Peninsulas – Requesting funding of $1,067,143.00
- Rappahannock – Requesting funding of $585,433.00
- Southwestern Virginia – Requesting funding of $2,030,912.00
- Thomas Jefferson – Requesting funding of $139,690.00
- Tidewater – Requesting funding of $582,659.00.00
- Western Virginia – Requesting funding of $1,584,507.00

Figure 2: Regional Area by Amount Requested



NOTE: Figure 2 has been altered to display regional areas requesting $1,200,000.00 or less to graphically represent a clearer graph of funds requested.

Funding amounts are being requested for the following items:

- 12 –Lead – $974,036.00
  - Includes all 12-Lead Defibrillators.

- Audio Visual/Computer Hardware - $ 222,861.00
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - $ 295,274.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.

- Emergency Operations - $ 90,563.00
  - Includes items such as Mass Casualty Incident (MCI), extrication equipment, rescue boat and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.

- Equipment - Basic and Advanced Life Support Equipment - $ 2,445,848.00

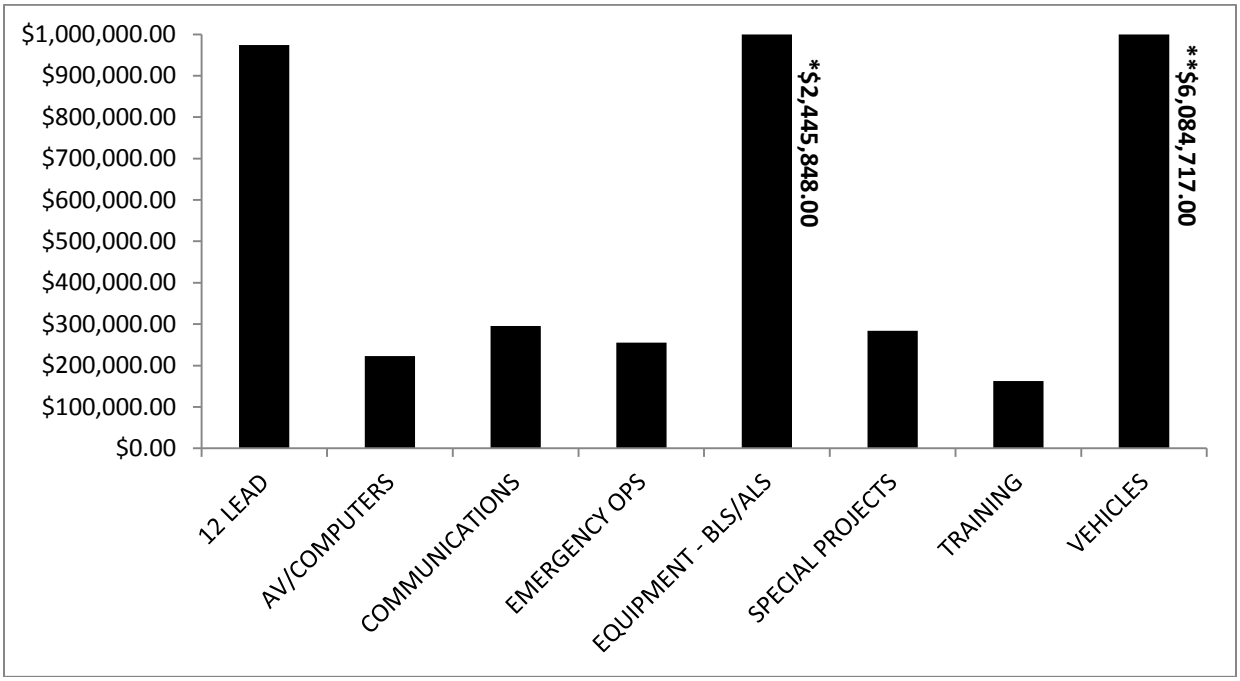
- Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.

- Special Projects - $ 448,400.00
  - Includes projects such as Special Project material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects, Protocol Projects and other innovative programs.

- Training - $ 162,409.00
  - 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 - $6,084,717.00
  - This category includes all vehicles such as ambulances, re-chassis, re-mounts and quick response vehicles.

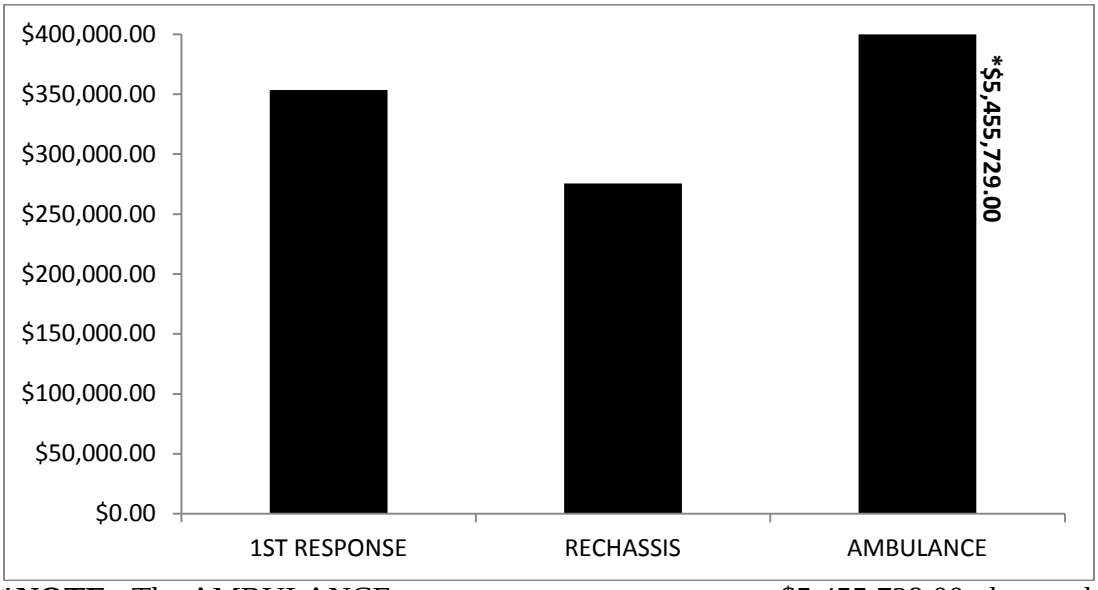
Figure 3: Item Requested by Amount Requested



***NOTE**: The EQUIPMENT – BLS/ALS category request amount was $2,445,848.00, the graph only represents items requested up to $1,000,000.00 to visually display other items requested.

****NOTE**: The VEHICLES category request amount was $6,084,717.00, the graph only represents items requested up to $1,000,000.00 to visually display other items requested.

Figure 4: Vehicle Category by Amount Requested



***NOTE**: The AMBULANCE category request amount was $5,455,729.00, the graph only represents items requested up to $400,000.00 to visually display other items requested.

The RSAF Awards Meeting will be held on June 5, 2015 and the Financial Assistance and Review Committee (FARC) will make recommendations to the Commissioner of Health. The grant awards will be announced on July 1, 2015. The next RSAF grant cycle will open on August 1, 2015 and the deadline will be September 15, 2015.

Rescue Squad Assistance Fund Emergency Grants

Appalachia Fire Departments was awarded 1 Rechassis at 100/0 (state/agency) funding for $89,945.00 on April 1, 2015. The grant was awarded based on the current ambulance taken out of service due to engine failure and metal shavings found in the oil. The agency was borrowing a loaner ambulance, but that unit needed to be returned to that agency. The ambulance was awarded on an emergency basis so patient care would not be impacted and the agency could continue to respond to calls for service.

EMS on the National Scene

II. EMS On the National Scene

National Association of State EMS Officials (NASEMSO)

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

a) NASEMSO Survey on EMS Specialty Certification Strategy Now Available

States and EMS stakeholders have identified that disparate approaches in definitions, the body of knowledge, skills, and evaluations suggested for various EMS specialties is a barrier to implementing EMS specialty practice nationwide. To help address this lack of consistency, NASEMSO envisions the use of multi-association and multi-disciplinary interactions to reach consensus on which potential EMS specialty areas should be recognized by the states as well as how such recognition should be accomplished. *A National Strategy for EMS Specialty Certification* proposes an approach to standardizing these elements and is now available on NASEMSO's web site. A needs assessment survey has been established to solicit stakeholder input on the viability and support for a collaborative effort to standardize the State approach to EMS specialties.

The survey for **STATE EMS OFFICIALS** is available at:
https://www.surveymonkey.com/s/WTQFYC2

The survey for **EMS STAKEHOLDERS** is available at:
https://www.surveymonkey.com/s/SPSWFF3

b) NASEMSO Letter to Nationwide Supports Controversial Super Bowl Ad

The NASEMSO Board of Directors recently approved a letter to Nationwide Insurance Headquarters from the Pediatric Emergency Care Council in support of a controversial ad that appeared during the 2015 Super Bowl. The ad depicts a child that dreams about the events in his life that he was unable to accomplish as the result of being killed in a preventable accident. Among the things the boy says he'll never experience: riding a bike, getting cooties, learning to fly, traveling the world in a boat with his dog and getting married. The ad ran afoul with some viewers as "depressing." A new app is available from Nationwide Children's Hospital in Columbus, OH developed by the safety experts in their Center for Injury Research and Policy. Caregivers are encouraged to make home safer with room-to-room safety checklists and links to

recommended products. Users can also create to-do lists, set reminders and track progress. Read the NASEMSO letter. For more information on the Nationwide Child Safety campaign "Make Safe Happen" go to: http://makesafehappen.com/.

c) NASEMSO Comments on Health IT Strategic Plan

NASEMSO responded to a request for comments from the Department of Health & Human Services' National Coordinator of Health on IT, in regard to its 2015-2020 strategic plan. Connecting EMS data with Health Information Exchanges is a stated priority for their office. This strategic plan will guide the programs and investments of $17 billion dollars in upcoming years related to health IT. The strategic plan can be accessed online at: http://www.healthit.gov/sites/default/files/federal-healthIT-strategic-plan-2014.pdf.

There is no reference to EMS in the draft strategic plan, and the draft plan does not include any specifics about ambulances, EMS, paramedics, or prehospital care, but it broadly includes emergency medical services under its definition of a health care provider. Go to: http://www.nasemso.org/Advocacy/Supported/documents/NASEMSO-Comments-to-ONCHIT-06Feb2015.pdf.

d) NASEMSO Endorses EMS Strong Campaign

The EMS Strong campaign seeks to celebrate, unify and inspire the men and women of our nation's emergency medical services. Created by the American College of Emergency Physicians (ACEP) in partnership with the National Association of Emergency Medical Technicians (NAEMT), EMS Strong brings together associations, EMS services, sponsors and national media to honor the dedication of EMS practitioners nationwide and to take National EMS Week into the future. NASEMSO is a proud sponsor of EMS STRONG. Learn more at www.emsstrong.org.

e) NEW!!! Look up an EMS License!

NASEMSO has added a new web page (https://www.nasemso.org/EMT-Paramedic-License-Verification.asp) that links to each U.S. state and territory website where verification of EMT and Paramedic licenses can be looked up online. The page is also linked from the Federation of Associations of Regulatory Board's (FARB) website at: http://www.imis100us2.com/farb/lookupalicense.

f) NASEMSO Introduces *Toward Zero Deaths* Efforts to Reduce Highway Fatalities

The NASEMSO joined the National Strategy on Highway Safety Toward Zero Deaths (TZD) effort, a vision of eliminating fatalities on our nation's roads. The National Strategy on Highway Safety Toward Zero Deaths effort was created by a steering committee cooperative that includes organizations representing our nation's highway safety system that have joined together to reduce annual traffic fatalities from more than 33,000 a year to zero. The TZD Steering Committee, which included **NASEMSO** as one of eight organizational members, rolled out the TZD plan that provides engineering, enforcement, education and EMS organizations with

initiatives, or safety countermeasures, that can be enacted by public agencies, businesses and individuals. Download the NASEMSO press release at: http://www.nasemso.org/documents/NASEMSO-TZD-Press-Release-10Mar2015.pdf.

g) NASEMSO Comments on NFPA Proposal to Develop CP Guide

The NFPA Technical Committee on Emergency Medical Services (EMS-AAA) convened a national emergency medical services (EMS) stakeholders meeting in April 2014 to discuss the subject of Mobile Integrated Healthcare/Community Paramedicine (MIH/CP). Previously, the EMS Technical Committee had reviewed a new project request for a MIH/CP document, though that request was later administratively withdrawn. At its October 2014 meeting, the NFPA Standards Council reviewed an International Association of Fire Fighters request that NFPA consider the establishment of a new document on fire-based community healthcare provider (FBCHP) program. After review of all the material before it, the Council voted to publish a notice to solicit public comments on the need for the project, information on resources on the subject matter, those interested in participating, if established, and other organizations actively involved with the subject. During this comment period, NASEMSO encouraged NFPA's efforts to be carried out within the context of numerous existing national initiatives rather than engaging the same people on parallel projects. No additional information is available at this time.

h) Utilization of the National Model EMS Clinical Guidelines Growing!

The success of the National Model EMS Clinical Guidelines continues to exceed NASEMSO expectations!

- 144,754 website hits and 3297 downloads since posted 10/23/14 through 3/3/15
- Jan 2015 – 4th most downloaded document
- Feb 2015 – 2nd most downloaded document

Most recently, we were extremely honored to share the document for use with the Public Authority for Civil Defense and Ambulance in the Sultanate of Oman. NASEMSO again takes this opportunity to thank the National Highway Traffic Safety Administration for the resources to complete this important project as well as the writing team and EMS community and stakeholders that continue to participate in its review and implementation!! Access the National Model EMS Clinical Guidelines at: http://www.nasemso.org/Projects/ModelEMSClinicalGuidelines/index.asp.

i) NASEMSO Announces Release of EMS Domestic Preparedness Strategy

NASEMSO has released the Emergency Medical Services Domestic Preparedness Improvement Strategy, consisting of goals, strategies, tasks, and activities to mitigate the ten most significant gaps in EMS preparedness and response. These goals, strategies, tasks and activities were structured to provide specific guidance and assign responsibilities to EMS organizations at the federal, national, state, tribal, and local levels. In an effort to bring solutions to published EMS domestic preparedness gaps, the Department of Homeland Security Office of Health Affairs

charged NASEMSO with leading a process to analyze and summarize specific published EMS preparedness reports and document implementable solutions to the identified gaps.

NASEMSO seated an EMS Domestic Preparedness Strategy Group consisting of representatives of thirteen EMS stakeholder organizations, representing EMS at the federal, national, state, tribal, and local levels. Represented constituencies included state EMS officials, EMS physicians, emergency managers, 911 communication center leaders, private- sector ambulance companies, fire chiefs, local EMS managers, and federal representatives from the departments and various programs that have EMS leadership responsibilities. The group identified and prioritized the most significant gaps in EMS domestic preparedness. The strategy group also identified general solutions to each of the ten most important gap areas.

j) NASEMSO Assists DHS Release of Updated 2014 National Emergency Communications Plan

The updated 2014 National Emergency Communications Plan (NECP) has been released by National Protection and Programs Directorate's (NPPD) Office of Cybersecurity and Communications (CS&C) and Office of Emergency Communications (OEC) with participation and input from NASEMSO President Paul Patrick and Program Manager Kevin McGinnis. This is the first update to the NECP since the original publication in 2008. The 2014 NECP provides information and guidance to those that plan, coordinate, invest in, manage, and use emergency communications systems. To help stakeholders prepare for the rapidly evolving emergency communications landscape, the NECP emphasizes the need to enhance and update the policies, governance structures, plans, and protocols that enable responders to communicate and share information under all circumstances.

As a stakeholder-driven plan, the NECP aims to maximize the use of all communications capabilities available to emergency responders—voice, video, and data—and to ensure the security of data and information exchange. Implementation of the NECP is a shared responsibility. Over the next several months, OEC will collaborate with its stakeholders across all levels of government and the private sector to assist in identifying NECP implementation activities aimed at ensuring emergency responders across the country can communicate effectively under all circumstances. For more information go to: http://www.dhs.gov/necp.

k) NASEMSO Submits Comments to NHTSA Federal Register Notice

Earlier this year in a Federal Register notice, the National Highway Traffic Safety Administration (NHTSA) proposed the collection of data from EMS agencies providing ambulance services and State offices responsible for overseeing training, licensing, and regulation of EMS agencies and their drivers to learn about the types of driver training required. NASEMSO was one of two respondents that responded for the docket, *Characterizing Ambulance Driver Training in EMS Systems*, which can be viewed at: http://www.regulations.gov/#!docketDetail;D=NHTSA-2014-0127.

l) NASEMSO Joins Letters to Support Key Federal Funding

NASEMSO has joined stakeholders in urging Congressional leaders to provide funding for the EMSC program. The letters states: "As organizations that care deeply about the health and safety of our nation's children, we write to request that you provide $21,116,000 in funding for the Emergency Medical Services for Children (EMSC) program at the Health Resources and Services Administration in the Fiscal Year (FY) 2016 Labor, HHS, Education (LHHS) appropriations bill.

In related news, NASEMSO joined the members of the CDC Coalition in sending letters urging Congressional leaders to provide $7.8 billion for the Centers for Disease Control and Prevention's programs in the FY 2016 Labor, Health and Human Services, Education and Related Agencies Appropriations bill. The letters noted that coalition members are pleased that President Obama's FY 2016 budget request would increase CDC's program level by $141 million over FY 2015.

NASEMSO has also joined stakeholders in a letter to the House and Senate Appropriations Committee leadership in support of FY 2016 funding for key federal programs aimed at addressing prescription opioid misuse and recovery. This effort is being organized by Trust for America's Health. For more information go to: http://www.nasemso.org/Advocacy/Supported/index.asp.

m) Dr. Douglas Kupas Named Among Top EMS Innovators of 2014

JEMS and Physio-Control, Inc. announce that PA State EMS Medical Director and NASEMSO member Dr. Douglas Kupas has been named one of the top 10 EMS Innovators of 2014. Individuals are nominated by their peers in recognition of their hard work, dedication and selfless efforts to make a difference in the delivery of EMS or in the lives of patients and providers. Dr. Kupas was recognized for his tireless efforts in implementing some of the Nation's first statewide EMS protocols including his efforts to establish high-functioning CPR teams in a pit crew approach to put emerging science into practice. This is the seventh year of the EMS 10 Innovators in EMS program, jointly sponsored by Physio-Control and JEMS. The program has a simple mission but a powerful objective: identify some of the best innovators in the EMS industry and alert the EMS community to their achievements to help providers and patients in the future. NASEMSO congratulates Dr. Kupas, a past chair of the Medical Directors Council on this well-deserved recognition!! For more information go to: http://www.jems.com/supplements/ems-10-innovators-ems-2014.html.

n) DHS S&T Shines Spotlight on Dr. Carol Cunningham for Women's History Month

The U.S. Department of Homeland Security (DHS) Science and Technology Directorate's (S&T) First Responders Group (FRG) helps S&T maintain focus on the top-priority needs of responders in the field. Their First Responder Spotlight Series highlights several FRRG members, offering a glimpse into their daily responsibilities, as well as their ongoing support of S&T technology development. In honor of Women's History Month (March 2015), DHS shone the spotlight on NASEMSO's own Dr. Cunningham. Way to go, Carol! Go to:

http://www.firstresponder.gov/Pages/Women%E2%80%99s-History-Month-First-Responder-Spotlight-of-Dr--Carol-A--Cunningham.aspx.

o) FirstNet Board Approves Release of 2nd Public Notice; Seeks Comments

As part of its ongoing efforts to consult with stakeholders, the First Responder Network Authority (FirstNet) Board recently approved for release a second Public Notice (Second Notice) seeking comment on important interpretations of FirstNet's enabling legislation, including public safety customer, operational, and funding considerations related to states or territories assuming responsibility for radio access network (RAN) deployment. The Middle Class Tax Relief and Job Creation Act of 2012 (Act) requires FirstNet to ensure the establishment of a nationwide public safety broadband network (NPSBN) based on a single national network architecture that evolves with technological advances over time. The Second Notice seeks feedback from all interested stakeholders, including public safety professionals from local, regional, tribal, and state jurisdictions, and vendors on a number of preliminary interpretations regarding key provisions of the Act, including:

- Technical requirements for equipment to be used on the network, including open standards for connectivity and device competition;
- The nature and application of FirstNet network policies, including those that aim to preserve interoperability in states and territories that assume responsibility for building and operating a RAN;
- The Governor's decision to assume RAN responsibility, and the roles and responsibilities of states and FirstNet throughout the process; and
- Customer, operational, and critical funding considerations regarding state or territory assumption of RAN responsibility.

The Second Notice aims to provide more clarity around important customer, operational, and funding considerations regarding state/territory planning for the NPSBN. It also addresses technical requirements required under the act for the NPSBN and the user devices accessing the network. The critical feedback received by the Board will inform FirstNet's implementation of the network in all states and territories, including those with substantial rural areas. FirstNet plans to address the conclusions resulting from the First Notice in upcoming releases. Learn more about FirstNet and Emergency Medical Services at: http://www.firstnet.gov/sites/default/files/firstnet-ems-factsheet.pdf.

p) NPSTC Survey Seeks to Study Prehospital Telemedicine

The EMS Working Group of the National Public Safety Telecommunications Council (NPSTC) is currently studying the use of prehospital (EMS) mobile telemedicine. A new nationwide public safety broadband network, called FirstNet, will allow EMTs and paramedics to access a dedicated high speed data network. This new network will allow secure live video, pictures, text and patient data or vital signs telemetry to be shared with receiving physicians, hospitals and

trauma centers, in addition to automated crash telemetry sensor data that is becoming standard on many vehicles. The EMS Working Group is examining the operational use cases for prehospital telemedicine (video and picture images). While the field of video conferencing and multi-media messaging technology is advancing quickly, there is no consensus in the healthcare community on how it should be used most effectively. This survey is one step to help determine how video and images might be used in the prehospital patient care setting.

q) FDA Approves Duo-Dote Date Extensions

The Food and Drug Administration (FDA) is alerting health care professionals and emergency responders of updated dates through which DuoDote auto-injectors, manufactured by Meridian Medical Technologies, may be used beyond the manufacturer's labeled expiration date. To help ensure patient safety, these products should have been — and should continue to be — stored as labeled. This posting updates FDA's May 13, 2014 alert, which notified health care professionals and emergency responders of a two-year extension of the labeled expiration dates of certain lots of DuoDote auto-injectors. The table on the FDA web site is an updated list of DuoDote auto-injector lots and new use dates. This new list, which replaces previously posted lists, includes each of the lots listed in FDA's May 13, 2014 posting, March 28, 2014 posting, December 24, 2013 positing and September 5, 2013 memorandum, as well as 10 new lots. For more information go to: http://www.fda.gov/Drugs/DrugSafety/ucm376367.htm.

r) NTAM 2015 Toolkit Now Available

The American Trauma Society, in collaboration with the Society of Trauma Nurses, is once again pleased to present National Trauma Awareness Month. This May, National Trauma Awareness Month celebrates its 27th anniversary with the campaign slogan, "3D Trauma Prevention" and focuses on contributors to motor vehicle crashes - Drugs/Drinking, Distraction and Drowsiness. This is an all too familiar list that makes driving in the United States a risky endeavor. In 2013, the US saw over 32,000 fatalities and over 2.3 million injuries from motor vehicle crashes. Of those, 31% involved an alcohol-impaired driver and 18% involved a distracted driver. While these numbers have decreased slightly over the past few years, the promotion of prevention strategies and education around risky behaviors must continue until these statistics are eliminated. Several new resources are now available at: http://www.amtrauma.org/?page=NTAM2015.

s) Researchers Evaluate Trauma Center Financial Impacts in a Statewide System

An article in the current issue of the Journal of the American College of Surgeons evaluates the financial impact (median costs per patient for TC response and verification) to hospitals in a statewide trauma system. According to the abstract, "Trauma financial impact includes the following costs: verification, response, and patient care cost (PCC). We conducted a survey of participating trauma centers (TCs) for federal fiscal year 2012, including separate accounting for verification and response costs. Patient care cost was merged with their trauma registry data. Seventy-five percent of the 2012 state trauma registry had data submitted. Each TC's reasonable cost from the Medicare Cost Report was adjusted to remove embedded costs for response and

verification. Cost-to-charge ratios were used to give uniform PCC across the state." Access the abstract at: http://www.journalacs.org/article/S1072-7515%2815%2900009-5/abstract.

t) Trauma Bill Moves to Senate

Following recent passage in the US House of Representatives, the Trauma Systems and Regionalization of Emergency Care Reauthorization Act has moved to the Senate as Senate Bill 763. S 763 would reauthorize two important grant programs: Trauma Care Systems Planning Grants, which support state and rural development of trauma systems, and Regionalization of Emergency Care Systems Pilot Projects, which provide funds to design, implement, and evaluate innovative models of regionalized emergency care. The bill would also direct states to update their model trauma care plan with the input of relevant stakeholders. The Bill has been referred to the Senate Committee on Health, Education, Labor, and Pensions. For more information go to: https://www.congress.gov/.

u) AHRQ Offers Innovations on Reducing Non-Urgent Emergency Services

The AHRQ Health Care Innovations Exchange is expanding efforts to scale up and spread innovations by sponsoring three Learning Communities that aim to improve the delivery of care. The Innovations Exchange has identified reducing the use of emergency services for non-urgent conditions as a high-priority area. For a variety of reasons, ranging from convenience to barriers in accessing primary care and other health care services, many patients seek treatment at the emergency department (ED) for non-urgent (often chronic) conditions that could be better handled in other settings. This pervasive issue results in unnecessarily high costs of care and has significant consequences for both the patient and the health care system. Patients often receive fragmented care and inadequate management of underlying medical, behavioral, and psychosocial needs, while emergency services are overburdened and struggling with allocating limited resources. The agency reports several innovations:

- Trained Paramedics Provide Ongoing Support to Frequent 911 Callers, Reducing Use of Ambulance and Emergency Department Services. Go to: https://innovations.ahrq.gov/profiles/trained-paramedics-provide-ongoing-support-frequent-911-callers-reducing-use-ambulance-and.

- Data-Driven System Helps Emergency Medical Services Identify Frequent Callers and Connect Them to Community Services, Reducing Transports and Costs. Go to: https://innovations.ahrq.gov/profiles/data-driven-system-helps-emergency-medical-services-identify-frequent-callers-and-connect

- Referral System Allows Responders to Connect 911 Callers to Needed Community-Based Services, Reducing Nonemergency Calls. Go to: https://innovations.ahrq.gov/profiles/referral-system-allows-responders-connect-911-callers-needed-community-based-services

- Specially Trained Paramedics Respond to Nonemergency 911 Calls and Proactively Care for Frequent Callers, Reducing Inappropriate Use of Emergency Services. Go to:

https://innovations.ahrq.gov/profiles/specially-trained-paramedics-respond-nonemergency-911-calls-and-proactively-care-frequent.

Suggested additional reading: 7 Best Practices to Reduce Emergency Department Misuse. Go to: http://www.acepnow.com/article/7-best-practices-reduce-emergency-department-misuse/.

v) GAO Report Addresses Federal Coordination of Drug Shortages

In the last decade, shortages of prescription drugs containing controlled substances, such as narcotics and stimulants, have increased nationwide, preventing providers and patients from accessing essential medications for treatment. Controlled substances are regulated by DEA because of the potential for abuse and addiction. To prevent diversion of controlled substances, DEA sets quotas that limit the amount of certain substances that are available in the United States. The Government Accountability Office (GAO) was asked to examine shortages of drugs containing controlled substances. This report examines (1) the trends in such shortages, (2) the effect on patients and providers, (3) DEA's administration of the quota process, and (4) coordination between DEA and FDA to prevent and mitigate shortages. GAO analyzed data from 2001 through 2013 from the University of Utah Drug Information Service, which is generally regarded as the most comprehensive source of drug shortage data, and from 2011 and 2012 from YERS/QMS, which is the official record for the quota process. GAO interviewed officials from DEA, FDA, organizations representing patients and providers, and drug manufacturers. GAO reviewed relevant statutes, regulations, and documents. For more information go to: http://www.gao.gov/assets/670/668252.pdf.

w) FCC Concludes AWS-3 Auction; Winning Bidders Announced

The Federal Communications Commission (FCC) recently concluded its most successful spectrum auction in history, known as the "AWS-3" auction, making 65 MHz of spectrum available for wireless services. Importantly, and pursuant to the same legislation that will lead to the deployment of the FirstNet nationwide public safety broadband network, the auction proceeds will fund several very important public safety initiatives:

- $7 billion to fund the FirstNet nationwide public safety broadband network;
- $300 million to conduct research and assist with the development of standards, technologies, and applications to advance wireless public safety communications; and
- $115 million for 9-1-1, E9-1-1, and Next Generation 9-1-1 implementation.

For more information go to: http://www.fcc.gov/document/auction-97-aws-3-winning-bidders.

x) FCC Adopts Rules to Help Better Locate Wireless 911 Callers

The Federal Communications Commission (FCC) has adopted new rules to help emergency responders better locate wireless callers to 911. These updates to the Commission's Enhanced 911 (E911) rules respond to Americans' increasing use of wireless phones to call 911, especially

from indoors where traditional 911 location technologies often do not work effectively or at all. The new rules establish clear and measureable timelines for wireless providers to meet indoor location accuracy benchmarks, both for horizontal and vertical location information. The Commission noted that no single technological approach will solve the challenge of indoor location, and no solution can be implemented overnight.

The new requirements will enable wireless providers to choose the most effective solutions and allow sufficient time for development of applicable standards, establishment of testing mechanisms, and deployment of new location technology. Four nationwide wireless carriers submitted a joint filing to the FCC that outlines changes to their previous proposal on location accuracy for indoor 911 calls, including new performance metrics, greater focus on the vertical Z-axis coordinate and a willingness to work on privacy issues associated with a proposed new database of Wi-Fi and Bluetooth beacon infrastructure. For more information go to: http://www.fcc.gov/document/fcc-adopts-rules-help-responders-better-locate-wireless-911-callers

y) CMS to Modify Requirements for Meaningful Use

The Centers for Medicare & Medicaid Services (CMS) has announced the intent to engage in rulemaking to update the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs beginning in 2015. These intended changes would help to reduce the reporting burden on providers, while supporting the long-term goals of the program. The new rule, expected this spring, would be intended to be responsive to provider concerns about software implementation, information exchange readiness, and other related concerns in 2015. It would also be intended to propose changes reflective of developments in the industry and progress toward program goals achieved since the program began in 2011. Advocates hope that this rulemaking opportunity will provide the opportunity to include EMS data systems into the bigger healthIT process that includes hospitals. For more information go to: http://blog.cms.gov/2015/01/29/cms-intends-to-modify-requirements-for-meaningful-use/.

z) LODD Report Highlights Need for Improved Awareness, Training, and Importance of Highway Design

The Alexandria (VA) Fire Department has released its findings of an investigation into an EMS Line of Duty Death (LODD) involving Paramedic Joshua Weissman who tragically fell to his death while traversing a highway barrier at an incident on Interstate 395 near the city in 2012. The report highlights the increased need for situational awareness, training, and highway design standards that could have prevented this fatality. We take note of this egregious observation from the report: “When a Firefighter Line of Duty Death occurs, NIOSH is the federal agency responsible for an investigation.

The Medic involved in this tragedy was hired and trained as a single role paramedic for the Alexandria Fire Department and was not cross-trained as a firefighter. Therefore NIOSH did not investigate the incident. There is no federal agency that is responsible for an EMS LODD unless those involved are also trained as firefighters.” The EMS community mourns the loss of Paramedic Weissman and we hope that the valuable lessons learned from this report will serve to

protect all responders to future highway incidents. For more information go to: http://www.alexandriava.gov/uploadedFiles/fire/info/Weissman%20LODD%20Report%20Final%20of%20Final%2012.22.2014.pdf.

aa) Resources for Optimal Care of the Injured Patient 2014 Now Widely Available from the COT

The American College of Surgeons Committee on Trauma (ACS-COT) has provided the final version (v1.1) of the 2014 Resources for Optimal Care of the Injured Patient document available for download. It has also created a resource repository, which is referred to in several places throughout the document. According to the ACS web site, the content related to the criteria is complete and the ACS does not envision any additional edits to the content until a formal process is developed for ongoing revision of the document. Verification applicants with any visits scheduled on or after July 1, 2015, will be required to meet the criteria contained in the Resources for Optimal Care of the Injured Patient 2014. Hard copies of the *Resources for Optimal Care of the Injured Patient 2014* manual are now available for purchase. For more information go to: https://www.facs.org/quality-programs/trauma/vrc/resources.

bb) NHTSA to Collect info on EMS Driver Training

In order to characterize ambulance driver training across the United States, the National Highway Traffic Safety Administration (NHTSA) proposes to collect information from EMS agencies providing ambulance services and State offices responsible for overseeing training, licensing, and regulation of EMS agencies and their drivers. NHTSA is interested in learning about what types of driver training are required, when the training is required (new drivers, continuing education, etc.), how driving incidents (crashes, moving violations, etc.) impact driving privileges, initial qualification standards (age, number of years with license, driving record, etc.), and other related topics.

Participation in the study will be voluntary and will only include State level agency representatives and representatives from EMS agencies that offer ambulance services. Data collection will be in the form of semi-structured interviews in-person or over the phone of contacts at State offices and an Internet-based survey of EMS agencies providing ambulance services. EMS agencies will be contacted via email, mail, or phone with a link to the Internet survey. State offices will be contacted via email or phone to participate in the semi-structured interviews. For more information go to: https://www.federalregister.gov/articles/2015/01/21/2015-00807/reports-forms-and-record-keeping-requirements#h-8.

cc) National Health Security Strategy and Implementation Plan Now Available

The U.S. Department of Health and Human Services' Assistant Secretary for Preparedness and Response has released the National Health Security Strategy and Implementation Plan 2015-2018. The goal of the plan "is to strengthen and sustain communities' abilities to prevent, protect against, mitigate the effects of, respond to, and recover from disasters and emergencies." Go to: http://www.phe.gov/Preparedness/planning/authority/nhss/Pages/default.aspx.

dd) Emergency Medical Response in Active-Threat Situations: Training Standards for Law Enforcement

Little is known about law enforcement medical training and response in the United States. The authors (in research now posted on the FBI web site) conducted a study that described levels of medical instruction provided to officers and evaluated the impact of specific training on selected medical decision-making skills. For the study they distributed an anonymous Internet-based survey through a law enforcement newsletter. In addition to demographic and training questions, they administered scenario-based survey questions developed by a panel of experts. In the absence of law enforcement-specific medical training, many agencies have turned to their military counterparts and their Tactical Combat Casualty Care (TCCC) curriculum.

This training emphasizes bleeding control based on data showing that the leading cause of preventable death in combat is extremity hemorrhage. Recently, a national law enforcement organization recommended that all officers receive training in these skills. In the authors' study, 54 percent of respondents indicated that they received additional departmental training in pressure dressings to control bleeding, while 49 percent reported training in tourniquet use, and 32 percent expressed that they had received instruction in advanced specialty hemostatic agents. Five hundred fifty-five respondents (42.4 percent) reported specific training in TCCC. For more information go to: http://leb.fbi.gov/2015/march/emergency-medical-response-in-active-threat-situations-training-standards-for-law-enforcement?utm_campaign=email-Immediate&utm_content=411623.

ee) Pennsylvania EMSC Offers New Video for Concussion Awareness and Emergency Response

The Pennsylvania EMS for Children is pleased to announce a new video for concussion awareness and emergency response. The video, entitled *Concussions: Be Aware, Be Prepared*, briefly discusses what a concussion is, signs and symptoms, when the 9-1-1 system should be activated, and what occurs when the ambulance arrives. The video was funded through a mini grant from the Pennsylvania Department of Health, Bureau of Family Health, which received its funding from a grant from HRSA. The video is currently on the front page of the Pennsylvania EMSC website (www.paemsc.org) and is available on their YouTube page here: https://www.youtube.com/watch?v=CrLvq9d1wlU.

ff) New ACS Position Statement on Trauma Center Designation Based on System Needs

The American College of Surgeons (ACS) recently released a statement emphasizing that the allocation of trauma centers should be based upon the needs of the population, rather than the needs of individual health care organizations or hospital groups. The position statement, *"Statement on trauma center designation based on system need,"* developed by the ACS Committee on Trauma's (COT) Trauma Systems Evaluation and Planning Committee was approved by the ACS Board of Regents last fall and recently published in the January issue of the *Bulletin of the American College of Surgeons.* The position statement is now available at:

http://bulletin.facs.org/2015/01/statement-on-trauma-center-designation-based-upon-system-need.

gg) ATS Updates TIEP, Launches New Trauma Maps

The American Trauma Society (ATS) announces that it has completed the 2014 revision of the Trauma Information Exchange Program (TIEP) and is now managing basic trauma maps based on the updated data from its own website at: http://www.amtrauma.org/?page=FindTraumaCenter.

The previous maps developed by the University of Pennsylvania's Cartographic Modeling Laboratory using the TIEP Database and other data sources to map trauma centers and hospitals across the country are still available but they have not been updated since 2010.

hh) FDA Approves Zoll CPR Devices

The U.S. Food and Drug Administration has approved the ResQCPR System, a system of two devices for first responders to use while performing cardiopulmonary resuscitation (CPR) on people whose hearts stop beating (cardiac arrest). The devices may improve the patient's chances of surviving cardiac arrest. The ResQCPR System consists of two devices that are intended to be used together to assist in performing CPR on adult patients with out-of-hospital, non-traumatic cardiac arrest.

The first device, the ResQPump Active Compression Decompression CPR Device, has a double-grip handle that attaches to the patient's chest with a suction cup, allowing the rescuer to push to deliver compressions and lift for decompressions, which is different than standard CPR. It also includes a pressure gauge to help rescuers maintain recommended compression depth and a timing mechanism to help the rescuer maintain the necessary compression rate.

The second device, the ResQPod 16.0 Impedance Threshold Device, fits onto a rescue facemask or breathing tube. When placed on the patient, it impedes airflow into the chest during chest decompression with the ResQPump, reducing the pressure inside the patient's chest and drawing more blood back to the heart, a concept known as preloading. A greater volume of blood being drawn into the heart can mean a greater volume of blood flowing out of the heart during the next compression, which may improve overall blood circulation as compared to standard CPR.

When used together, the two devices may increase the amount of oxygenated blood circulated through a patient's body during CPR. ResQCPR was developed by Advance Circulatory Systems, which was purchased by Zoll Medical in December 2014. For more information go to: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm437247.htm.

ii) Results of SUPER Project Now Available in PEC

The National Association of EMS Educators (NAEMSE) is pleased to announce that the results of the "Simulation Use in Paramedic Education Research (SUPER): A Descriptive Study" research project have been published early online by the Prehospital Emergency Care (PEC)

Journal. The purpose of this research was to characterize the use of simulation in initial paramedic education programs in order assist stakeholders' efforts to target educational initiatives and resources. PEC has offered early access to the article online if you are a subscriber.

NAEMSE would like to recognize and thank Laerdal Medical and the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) for their support of the Simulation Use in Paramedic Education Research (SUPER) project. For more information go to: http://informahealthcare.com/doi/abs/10.3109/10903127.2014.995845.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The Training and Certification Committee meeting was held on Wednesday, April 8, 2015. There is one (1) action items.

1. The Continuing Education has completed its work and submits the final proposed 2016 CE Plan for approval. This plan mirrors the National Registry at both the BLS and ALS level. Note: National Registry has not released the EMR breakdown, but Virginia will mirror their plan, when released.

Motion to accept the continuing education structure as exemplified in the attachment was approved unanimously by TCC. Please see **Appendix E.**

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

B. **The Medical Direction Committee (MDC)** The Medical Direction Committee meeting met on Thursday, April 9, 2015. The There are no action items for consideration.

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

Advanced Life Support Program

A. Virginia I-99 to Paramedic student's are continuing the transition process that allows them to gain certification at the Paramedic level after completion of a Virginia approved Intermediate-99 to Paramedic bridge program.

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

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

D. Virginia certified providers who also maintain their National Registry certification will be able to recertify by selecting the traditional refresher course option on their recertification application. A statement will appear on their CE report that verifies they have completed a Virginia approved refresher course that meets the requirements established by National Registry for recertification. The CE must be obtained during their two-year certification cycle with National Registry to take advantage of this option. More information will be released in the near future.

Basic Life Support Program

A. Education Coordinator Institute

1. The Office held the first Education Coordinator Institute for 2015, January 24-28 in the Tidewater Area. 23 Education Coordinators were certified.
2. The deadline to pass the EC Cognitive exam in order to be eligible for the next Institute was April 12, 2015. The next EC Psychomotor Exam is scheduled for May 9, 2015 in the Richmond Area.
3. The Next EC Institute is scheduled for June and will be held in Blacksburg in conjunction with the VAVRS Rescue College.
4. EMS Providers interested in becoming an Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
5. Schedule of the various deadlines and EC Institutes can be found on our website: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Educator Updates:

1. For 2015, the Division of Educational Development continued to provide in-person Educator Updates.
2. The Office conducted an in-person EMS Instructor Update on Saturday, February 21st at the PEMS Office, Saturday, March 21st at CVCC in the BREMS Region, Saturday, April 18th at the CSEMS Training Center and Saturday, May 2nd at Alexandria Fire Training Center in the NVEMSC Region.
3. We are adding a Friday afternoon update to the schedule. It will be held at Christiansburg Rescue Squad in the WVEMSC Region at 1pm on Friday, June 12th. We will also hold the scheduled update on Saturday, June 13th at the Inn at Virginia Tech/Skelton Conference Center beginning at 9am.
4. The schedule of future updates can be found on the Web at: http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm

EMS Training Funds

FY13

	Commit $	Payment $	Balance $
Emergency Ops Funding	$1,460.00	$755.00	$705.00
BLS Initial Course Funding	$729,348.00	$358,521.61	$370,826.39
BLS CE Course Funding	$125,160.00	$49,936.21	$75,223.79
ALS CE Course Funding	$297,360.00	$78,575.00	$218,785.00
BLS Auxiliary Program	$80,000.00	$18,280.00	$61,720.00
ALS Auxiliary Program	$350,000.00	$161,005.00	$188,995.00
ALS Initial Course Funding	$1,102,668.00	$591,256.40	$511,411.60
Totals	**$2,685,996.00**	**$1,258,329.22**	**$1,427,666.78**

FY14

	Commit $	Payment $	Balance $
Emergency Ops Funding	$1,120.00	$280.00	$840.00
BLS Initial Course Funding	$780,912.00	$375,809.00	$405,103.00
BLS CE Course Funding	$94,010.00	$37,100.00	$56,910.00
ALS CE Course Funding	$224,950.00	$79,520.00	$145,430.00
BLS Auxiliary Program	$130,000.00	$61,300.00	$68,700.00
ALS Auxiliary Program	$304,000.00	$180,640.00	$123,360.00
ALS Initial Course Funding	$1,188,504.00	$555,510.43	$632,993.57
Totals	**$2,723,496.00**	**$1,290,999.43**	**$1,432,496.57**

FY15

	Commit $	Payment $	Balance $
Emergency Ops Funding	$2,480.00	$540.00	$1,940.00
BLS Initial Course Funding	$708,484.50	$261,164.14	$447,320.36
BLS CE Course Funding	$56,780.00	$22,776.30	$34,003.70
ALS CE Course Funding	$139,370.00	$43,303.75	$96,066.25
BLS Auxiliary Program	$88,705.00	$9,760.00	$78,945.00
ALS Auxiliary Program	$526,176.00	$91,920.00	$434,256.00
ALS Initial Course Funding	$1,009,204.00	$351,486.24	$657,717.76
Totals	**$2,531,199.50**	**$783,092.43**	**$1,748,107.07**

EMS Education Program Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
   a) Frederick County Fire and Rescue's site visit was conducted in late March. The report is being finalized.
   b) Harrisonburg Rescue Squad site visit was conducted on April 20, 2015.
   c) Chesterfield Fire/EMS site visit was conducted on March 31, 2015. Site visit report is being finalized.

2. Advanced Emergency Medical Technician (AEMT)
   a) Frederick County Fire and Rescue's site visit was conducted in late March. Site visit report is being finalized.

3. Intermediate – Reaccreditation
   a) Roanoke Valley Regional Fire/EMS Training Center reaccreditation will be conducted in early June.

4. Intermediate – Initial
   a) Southwest Virginia EMS Council has been granted conditional accreditation with review. Their initial Intermediate course will begin in early spring.
   b) Paul D. Camp Community College initial accreditation visit was conducted in mid-March. Site visit report is being finalized.

5. Paramedic – Initial
   a) Germanna-Rappahannock EMS Council withdrew their self study with CoAEMSP due to changes required by SACS. They will be required to resubmit an application for evaluation when ready to move forward.
   b) Prince William County has completed their initial cohort class and their CoAEMSP self study visit has been scheduled.

6. Paramedic – Reaccreditation
   Piedmont Virginia Community College's CoAEMSP reaccreditation visit was held in January. They are awaiting their report from CAAHEP.

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

C. Beginning January 1, 2013, students must enroll in a nationally accredited paramedic program to qualify for National Registry certification. National accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).

National Registry

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

On Line EMS Continuing Education

Distributive Continuing Education

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

EMSAT

EMSAT programs for the next three months include:

May 20, The Domestic Abuse Scene
Instructor: Beth Bonniwell, Henrico County Police Division
Cat. 1 ALS, Area 78, Cat. 1 BLS, Area 02

June 17, Responding to a Patient who has Autism
Didi Zaryczny, Commonwealth Autism
Cat. 1, ALS, Area 89, Cat. 1 BLS, Area 02

July 15, Infection Control Update 2015
Katherine West, Infection Control- Emerging Concepts
Cat. 1 ALS, Area 89, Cat. 1 BLS, Area 06

The EMS Portal

The Office in conjunction with our IT support is updating the EMS portal to be multibrowser compatible by early summer. Once the new functionality is in place, the portal will no longer be limited to Internet Explorer and will no longer require using Internet Explore in compatibility mode. Future plans will include mobile compatibility.

CTS

A. There have been 40 - CTS, 4- EMT accredited course and 3- ALS psychomotor test sites conducted from January 14, 2015 through April 18, 2015.

B. No applicants met the requirements for the OEMS Test Examiner open position in Northern Virginia. The position will be re-advertised after the COV Online Employment System is upgraded on April 21, 2015

C. The updated CTS evaluator training program is complete and is available on CentreLearn.

D. The Psychomotor Examination Guide has been updated and is going through final review before being released.

Other Activities

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

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

- Debbie Akers attended the 2015 Stars of Life Event sponsored by the American Ambulance Association on Tuesday, April 14, 2015 in Washington, DC. 87 individuals were recognized for going above and beyond while performing their duties in EMS. This included three (3) providers from Virginia employed by Lifecare Ambulance.

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

- Warren participated in a meeting of the Atlantic EMS Councils EPSC committee on March 18th through March 20th..

- The Office discovered mid-March the Motorola CE Scanners would require a security update to continue functioning. This security update has to be applied by the Office at no cost to the instructor. Adam Harrell has been facilitating these updates, and currently has successfully updated 91 devices. The update has to be applied no later than August 1, 2015 to maintain functionality.

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

- Warren participated in the spring VAVRS Board of Governors' meeting held in Fredericksburg on April 18.

- Warren participated with the NASEMSO's Workforce Data Dictionary –Military Transition workgroup March 9 through March 11 in Alexandria Va.

Emergency Operations

IV. Emergency Operations

Operations

- **Ebola Preparedness and Planning**

The Division of Emergency Operations continues to be active in supporting VDH planning and preparedness efforts as it relates to Ebola. Activities include attending monthly meetings of the State Incident Management Team (IMT) and the VDH IMT. Additionally, Karen Owens, Emergency Operations Manager sent a survey to Virginia EMS agencies to determine their preparedness and involvement in local level planning.

The Emergency Operations Manager also participated in the Ebola Tabletop exercise on February 12, 2015. During the exercise discussion were held regarding the role of state and local assets to respond to potential EVD patients.

- **VOPEX**

Karen Owens, Emergency Operations Manager participated in the annual VOPEX Training exercise on February 10, 2015. The exercise which focused on an incident at the nuclear power stations provided an opportunity for OEMS to review VERT staffing and preparedness activities.

- **Virginia 1 DMAT**

Frank Cheatham, HMERT Coordinator continues to attend Va-1 DMAT meetings as a representative of the Office of EMS. The annual anniversary luncheon was held on March 17, 2015 in Williamsburg. A leadership meeting was held in conjunction with that luncheon.

- **COOP Updates**

Winnie Pennington, Emergency Operations Planner, completed the OEMS COOP updates to be included in the VDH COOP on March 31, 2015.

Committees/Meetings

- **EMS Communications Committee**

The EMS Communications Committee met on Friday, February 13, 2015. Discussion included the Virginia Information Technology Agency 911 Feasibility study and its potential impact on OEMS regarding oversight of emergency medical dispatch. OEMS PSAP Accreditation applications were reviewed from Dickenson and Madison Co. 911 centers. The two applications were also shelved until the next scheduled meeting. The committee agreed to replace outgoing committee member L.V. “Pokey” Harris with another representative from the southwestern part of Virginia.

- **Provider Health and Safety Committee**

Connie Green, Emergency Operations Assistant Manager, attended the Provider Health & Safety Committee meeting on February 13, 2015. The committee discussed the role that they should play in educating providers regarding abandonment and provider safety, reviewed the draft Safety Bulletins and assigned topics for the coming months and updated their agenda for the coming year.

- **Emergency Management Committee**

Connie Green, Emergency Operations Assistant Manager, attended the Emergency Management Committee meeting on February 12, 2015. The committee discussed the rollout of Mutual AidNet across the Commonwealth, the upcoming 11th anniversary of VA-1 DMAT, tactical medic training plans, the development of COOP training for agency heads, reviewed the goals of the *January 2015 NASEMSO Emergency Medical Services Domestic Preparedness Improvement Strategy*; and discussed the upcoming VEMA Symposium and VAVRS Conference.

- **Traffic Incident Management (TIM)**

The HMERT Coordinator continues to work with the TIM program. He held a meeting of the Best Practices workgroup to update them on the Job Aid and to also look at the next items that the group needed to consider. There was a first printing of the Job Aid and the distribution of the copies in possession was discussed.

- **Lane Reversal Coordination**

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

- **Task Force Meetings**

Over the past quarter, Frank Cheatham, HMERT Coordinator worked to continue the recruitment efforts for the Task Force teams. There are several agencies that are working on becoming one of the types of Task Forces to become a part of the system. He also had a meeting in Fredericksburg with one agency to assist with explaining the system and steps needing to be taken to become a Task Force. He also assisted several Task Forces by answering questions and offering suggestions to keep Task Forces viable and ready. He is also updating asset lists in preparation for the upcoming storm season.

- **Highway Owners Group**

Frank Cheatham attended a meeting of the Highway Owners Group for the Potomac Area of the I-95 Corridor Coalition. This group is made up of Virginia, Maryland, Delaware, and Pennsylvania. Various topics were discussed in regards to highway safety, response and training as well as other topics.

- **NASEMSO HITS Committee**

Frank Cheatham, HMERT Coordinator took part in NASEMSO HITS Committee conference calls in February and April.

- **Strategic Highway Safety Plan**

Frank Cheatham, HMERT Coordinator attended a Webinar on the Strategic Highway Safety Plan in February and also attended the Strategic Highway Safety Plan Steering Committee meeting in March.

- **VDH Patient Tracking Workgroup**

Winnie Pennington, Emergency Operations Planner, attended the VDH Patient Tracking Workgroup meeting on February 2, 2015. Winnie Pennington, Emergency Operations Planner, and Connie Green, Emergency Operations Assistant Manager, participated in a script review for the Patient Tracking Committee on March 30, 2015. Winnie Pennington, Emergency Operations Planner, participated in a second script review for Patient Tracking Committee on April 13, 2015.

- **VDH Ebola TTX Workgroup**

Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Operations Planner, participated in the VDH EVD TTX Planning Meeting for the first exercise on February 3, 2015 at VDEM. Connie Green, Emergency Operations Assistant Manager, participated in the EBOLA TTX After Action meeting on February 24, 2015 via conference call where the results of the first exercise were reviewed and discussed. Winnie Pennington, Emergency Operations Planner, participated in the initial planning meeting for second VDH EVD TTX on April 7, 2015. Winnie Pennington, Emergency Operations Planner, participated in the midpoint planning meeting for second VDH EVD TTX on April 21, 2015.

- **FirstNet Webinar**

Connie Green, Emergency Operations Assistant Manager, participated in the FirstNet EMS Webinar on February 19, 2015. The Webinar covered the impact on EMS that is expected to occur based upon the rollout of the national FirstNet communications system.

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

Karen Owens, Emergency Operations Manager, and Connie Green, Emergency Operations Assistant Manager, participated in planning meetings for the 2015 UCI Cycling race that will be held in September in the City of Richmond and surrounding jurisdictions.

Training

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

Frank Cheatham, HMERT Coordinator, helped instruct the April 90, 2015 Traffic Incident Management (TIM) Train the Trainer class in Fairfax. Nineteen (19) students attended representing EMS, Fire, Law Enforcement and the Towing industry. Instruction covered improving scene safety and reducing risk through effective management of traffic incidents and students participated in cross-discipline tabletop exercises in addition to lectures. Two adjunct instructors from the Office of EMS attended the training.

- **Tornado Preparedness Drill**

Winnie Pennington, Emergency Operations Planner, prepared information and the format for the Office yearly Tornado drill. The Annual Tornado Drill was conducted on March 17, 2015 in concert with the Statewide Tornado Drill. All Office of EMS employees and guests present participated in the Drill on March 17, 2015 at the Office of EMS in Glen Allen.

- **MCIM I & II Classes**

Karen Owens, Emergency Operations Manager, Connie Green, Emergency Operations Assistant Manager, and Frank Cheatham, HMERT Coordinator taught MCIM I and II and Train-the-Trainer classes on March 16, 2015 for Henrico Fire Department.

- **2015 Virginia EMS Symposium**

Frank Cheatham, HMERT Coordinator continues to address various logistical needs for the next Symposium as they arise. Planning and coordination of the various classes starts as soon as the classes are identified.

- **Vicarious Trauma Toolkit**

Karen Owens, Emergency Operations Manager continues to participate in the Vicarious Trauma Toolkit Grant Committee through Northeastern University. Serving as the NASEMSO representative, Karen traveled to Asheville North Carolina March 29-April 1, 2015 to train the pilot site in using the toolkit.

- **Vehicle Rescue Training**

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

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

Karen Owens, Emergency Operations Manager, attended the Fire Department Instructors Conference, April 21-24. During the conference Karen presented on the importance of Incident command for EMS. She also attended training classes that focused on EMS and Emergency Management topics.

Communications

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

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

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

On Tuesday, February 24, 2015 Ken Crumpler represented OEMS at the Winter APCO/NENA meeting held at Chesterfield Co. 911. Mr. Crumpler spoke regarding the current state of EMD in Virginia and continuing efforts by OEMS to support and promote EMD to include providing grant funding.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 12 events, including education sessions, training classes, and debriefings (both group and one-on-one).

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

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

Medevac Program

The Medevac Committee is scheduled to meet on May 7, 2015. The minutes of the February 12, 2015 meeting are available on the OEMS website.

The Medevac Helicopter EMS (HEMS) application (formerly known as WeatherSafe continues to grow in the amount of data submitted. In terms of weather turndowns, there were 513 entries into the Helicopter EMS system in the first quarter of 2015. 72% of those entries (373 entries) were for interfacility transports, which is a slight increase from information from previous quarters. The total number of turndowns is a decrease from 584 entries in the first quarter of 2014. This data continues to show a commitment to the program and maintaining the safety of medevac personnel and equipment in Virginia.

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

The EMS Systems Planner also participates on the NASEMSO Air Medical Committee. The committee met on April 10, 2015.

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

State EMS Plan

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

The current version of the State EMS Plan is available for download via the OEMS website. Later this year, OEMS will begin the process of reviewing the EMS Plan and assigning committees of the Board to look at key strategic initiatives and objectives that relate to their respective subject areas.

Public Information and Coordination

VI. Public Information and Education

Public Relations

Promotions

Via Constant Contact E-mail Listserv (January -March)
We are currently in the process of changing our listserv provider, so there are limited emails being sent via the listserv.

- February 18 – Egift webinar training
- February 24 – Egift webinar training

Via Social Media Outlets

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

- **January –** Health and wellness tips, Tidewater EMS Council's EMS/Nursing Education Expo registration, inclement weather delayed office opening, state holiday office closure, baby born on Northern Va. beltway article and the Charlottesville-Albemarle Rescue Squad for VEHEXT training.

- **February -** National Rural EMS Conference: Building Integration & Leadership for the Future registration, the Virginia Fire Chiefs Foundation's 5th Annual Virginia Fire Chiefs Golf Tournament, the Virginia Fire Chiefs Association training event, "Advanced Incident Command: Command Overload," winter weather extreme cold tips, car seat safety checks, observed holiday and inclement weather office closures, frostbite and hypothermia press release, RSAF E-Gift user webinar training, signs and symptoms of hypothermia and the 2015 Virginia Firefighter Games.

- **March -** EMS-Grant Information Funding Tool Web-based system, story about 12-year-old who saved her grandfather's life by performing CPR, which she learned at the Roanoke County Fire & Rescue Character Academy, AirCare 5 L.I.V.E 2015 registration, inclement weather office closure, 18th Annual Virginia Fallen Firefighters and EMS Memorial Service, Poison Prevention Week, March 15-21, Statewide Tornado Drill, CE Scanner Upload Portal is still down and the 3rd Annual PEMS Rural EMS Education Expo registration.

Customer Service Feedback Form (Ongoing)

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

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

Social Media and Website Statistics

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

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

***As of April 22, 2015, the OEMS Facebook page had 4,228 likes, which is an increase of 252 new likes since October 20, 2014. As of April 22, 2015, the OEMS Twitter page had 3166 followers, which is an increase of 278 followers since October 20, 2014.**

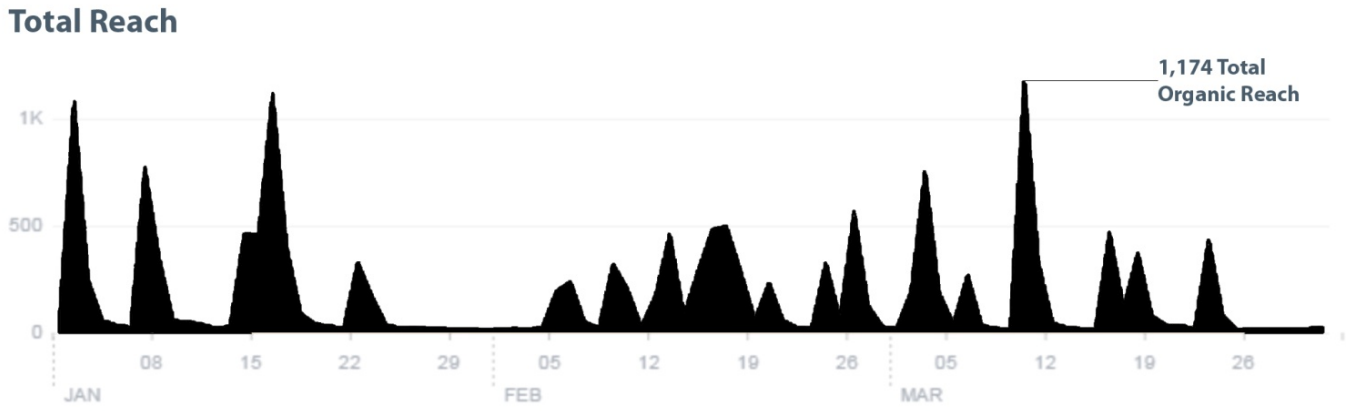


Figure 2: This table represents the top five downloaded items on the OEMS website from January – March.

January	1. EMSAT Centrelearn Instructions (27,139) 2. 2010 Symposium Presentation LMGT-732 (19,633) 3. Electronic Student Enrollment for Virginia EMS Certification Courses (17,243) 4. 2010 Symposium Presentation PREP-1013 (6,785) 5. Authorized Durable DNR Form (5,983)
February	1. EMSAT Centrelearn Instructions (25,644) 2. 2010 Symposium Presentation PREP-1013 (19,375) 3. 2010 Symposium Presentation LMGT-732 (19,002) 4. Electronic Student Enrollment for Virginia EMS Certification Courses (9,390) 5. 2009 Symposium Presentation SPE-1008 (6,364)
March	1. 2010 Symposium Presentation LMGT-732 (26,843) 2. EMSAT Centrelearn Instructions (26,030) 3. 2009 Symposium Presentation SPE-1008 (6,943) 4. 2010 Symposium Presentation PREP-1013 (6,690) 5. 2009 Symposium Presentation PREP-920 (6,049)

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

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
January	94,417	3,045	13:21
February	91,447	3,265	13:07
March	105,096	3,390	13:09

Events

EMS Week

- PR assistant coordinated the ordering and mailing of the American College of Emergency Physicians 2015 EMS Week Planning Guides to all affiliated EMS agencies.
- PR assistant submitted a proclamation request to the Governor's Office to recognize EMS Week in Virginia.

Fire and EMS Memorial Week

- PR coordinator promoted the Virginia Department of Fire Programs event flier on social media pages.
- PR coordinator will include the date for this event in the EMS Week press release, as well as additional information will be posted on the OEMS website.

EMS Symposium

- PR coordinator worked with Jennie Collins to update the Symposium Sponsorship Guide. Posted the updated sponsorship guide online April 14, 2015.
- PR coordinator started drafting Symposium Catalog, to be posted online prior to summer registration opening.

Governor's EMS Awards Program

- PR assistant prepared and submitted the 2015 Regional EMS Award nomination forms and guidelines to all Regional EMS Councils.
- PR assistant designed the 2015 Regional EMS Awards fliers and campaign posters to help promote the awards program.

Media Coverage

The PR coordinator and PR assistant were responsible for fielding the following OEMS media inquiries January - March:

- Jan. 7 – Received an inquiry from Scripps Washington Bureau regarding trauma transfer reports.
- March 10 – Received an inquiry from NBC 4 regarding billing for services for Medevac.
- March 13 – Received an inquiry from the News and Advance regarding regulations that limit the number of hours an EMT can work.
- March 16 – Received an inquiry from the Roanoke Times regarding EMS call data for the Roanoke area.

VDH Communications

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

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

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

- January 20 - OEMS Hosts Members of Ambulance Service Australia
  VDH's Office of Emergency Medical Services (OEMS), in coordination with the Richmond Ambulance Authority, recently welcomed Clinical Director Michael Rigo and Critical Care Paramedic Mick Hourigan to Richmond. Both guests are members of Ambulance Service Australia, based in Canberra. As a part of their four-day visit with different EMS organizations in Richmond, the guests were given a tour of OEMS by Ken Crumpler, emergency operations communications coordinator. They were provided an overview of the Virginia EMS system and discussed similarities and differences with that of the Australian system. Many thanks go to additional staff members who participated in the tour: Scott Winston, assistant director; Warren Short, EMS training manager; Terry Coy, media specialist III; Constance Green, emergency operations assistant manager; Winnie Pennington, emergency operations planner; Frank Cheatham, HMERT coordinator; Michael Berg, regulations and compliance manager; and Paul Sharpe, trauma and critical care manager.

- February 9 - OEMS Training Graduates Two Dozen Education Coordinators
  The Division of Educational Development within VDH's Office of Emergency Medical Services (OEMS) recently conducted an education coordinator institute session in Chesapeake. The program, which ran January 24-28, is the final stage for those who wish to conduct EMS education in the Commonwealth. The candidates who attended have completed a knowledge competency examination and a psychomotor examination. The Commonwealth graduated 24 education coordinators. OEMS staff participating in this program included Greg Neiman, BLS training specialist; Debbie Akers, Advanced Life Support training specialist; Adam Harrell, training and development specialist; and Warren Short, EMS training manager.

Regulation and Compliance

VII. Regulation and Compliance

EMS Agency/Provider Compliance

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

Compliance

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

Enforcement	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD	CY2014
Compliance Cases	**49**				**49**	**202**
Opened	38				38	140
Closed	11				11	62
Drug Diversions	**3**				**3**	**21**
Variances	**6**				**6**	**29**
Approved	2				2	16
Denied	4				4	13

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

Hearings

January 13 - Phillips; Kerns
February 23 - Morrison

Licensure

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

Background Unit

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

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

Background Checks	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD	2014
Processed	2,125				2,215	3,488
Eligible	1,380				1,380	2,683
Non-Eligible	18				18	19
Outstanding	726				726	546

Regulatory

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

- The Fast Track Regulatory Packet for changes to the Financial Assistance to EMS agencies (FARC) is within the regulatory process and currently is at the Office of the Attorney General for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6969)

- A Fast Track regulatory package to include the terminology of "affiliation" in the language of 12VAC-5-31-910 is within the regulatory process and currently resides in the Governors' Office for the analyst to review and approve, (http://townhall.virginia.gov/L/viewstage.cfm?stageid=7067)

- Staff will develop a Final-Exempt Regulatory Packet to address changes in definitions from 2015 General Assembly actions, SB938 and its companion bill, HB1584 Technical clean-up bill.

EMS Physician Endorsement

Endorsed EMS Physicians: As of April 21, 2015: 217

OMD Workshops continue as scheduled for 2015: February 10 (Hot Springs – 8 hour course), March 6 (Winchester – cancelled due to weather and one registration), March 11 (NOVA – 4 hour session), and March 18 (TJEMS - 4 hour session). Additional courses can be located at the following URL: http://www.vdh.virginia.gov/OEMS/MedicalDirectors/CEWorkshops.htm. Registration is not mandatory, but strongly encouraged.

Additional Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on February 18-20, 2015 in Lynchburg.

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

February 9, 2015 – Albemarle County Fire and Rescue
February 11, 2015 – VDFP – EVOC Curriculum rewrite (delayed)
March 1, 2015 – EMS Expo – Henrico Fire Training Center
March 7, 2015 – AirCare – F.A.C.T.S. – Fredericksburg
March 9, 2015 – Board of Supervisors and EMS agencies – Northumberland County
March 14, 2015 – March Medical Madness – Fluvanna
March 16, 2015 – Federal Bureau of Investigation – Chesapeake
March 19-22, 2015 – TEMS EMS Expo – Suffolk
March 28, 2015 – Charlottesville-Albemarle Rescue Supervisors Course - Charlottesville

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

Development of National Ambulance Standards

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

CAAS GVS 2015:

Work sessions were held on February 6 and 27 to review all submitted public comments. A conference call was conducted for a final review. A final product is still expected to be released and effective October 1, 2015.

NFPA 1917

Comments for the Second edition of the NFPA 1917 standards are being reviewed. Still expect a January 2016 release date.

KKK-1822-F (GSA)

Staff attended the Ambulance Manufacture's Division of the NTEA on March 19, 2015 where it was announced the current GSA document would remain valid until October 1, 2016. Change Notice 8 has been released for public comment (http://www.vdh.virginia.gov/OEMS/Agency/RegCompliance/FederalVehicleStandards.htm), and is expected to be implemented on July 1, 2015. The major change will be the implementation of SAE standards for the cot retention systems as previously announced.

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

Staff also continues to work with Dr. Mark Kirk (UVA) and Virginia Paramedic Rita Krenz as prehospital provider/reviewers with the National Library of Medicine/National Institute of Health in the development of a first responder/first receiver product with smart phone application. This team has meet via webinar and conference calls the following dates: January 9, and 30. It is anticipated this product will be released in 2015.

Additional Personnel Matters

The Office has been approved to hire an additional wage position to assist Mrs. Regina Garcia in the Background Unit. Applications are currently being reviewed to establish interviews. We anticipate filing the position by May 1, 2015.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee is scheduled to meet on May 7, 2015. The minutes of the February 12, 2015 meeting are available on the OEMS website. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

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

Pilots of the course were scheduled to begin in March and April of 2015. In mid-March, OEMS staff determined that the course content was not 100% complete, and made the decision to postpone the beginning of the pilot courses until the course content of EMS Officer I was complete. OEMS staff is continuing to review and revise all the modules of EMS Officer I, and ensuring that the finished product is beneficial to the individuals wishing to take the course. OEMS has not determined an anticipated timeline for implantation of the pilot courses.

Standards of Excellence (SoE) Sub-Committee

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

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

All documents related to the SoE program can be found on the OEMS website.
The sub-committee has identified EMS agencies in different parts of the Commonwealth who are willing to participate in the pilot phase of SoE. Completion of the self-survey by those agencies has taken place throughout the month of April, with site visits will be scheduled in May. The pilot phase is scheduled to be completed by October 2015 – at which time changes may be made to the process based on the outcome of the pilots.

The Virginia Recruitment and Retention Network

The Virginia Recruitment and Retention Network last met on February 20, 2015 at the Virginia Beach Volunteer Rescue Squad, Station 14. A motivational presentation was made by Mr. Mike Pibbs. The next meeting of the Virginia Recruitment and Retention Network is scheduled for Saturday, May 16, 2015. Location and time are to be determined.

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

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

Trauma and Critical Care

IX. Trauma and Critical Care

Division of Trauma/Critical Care Staffing

Its official, Dr. Carol Pugh has retired, but we are hoping to see here back in the future to do some part-time work for us. Some of the key projects Dr. Pugh developed were important reports on matters such as the morbidity and mortality rates by trauma level of hospitals. Dr. Pugh also developed a stakeholder driven trauma triage report for the State Health Commissioner (Commissioner). Dr. Michel Aboutanos delivered a presentation on that report to the EMS Advisory Board during its most recent meeting. The report was also included in our previous quarterly report and is posted on the Office of Emergency Medical Services (OEMS) website.

Dr. Pugh also attempted to work with the EMS Regional Councils and developed a customized dataset in our Virginia Pre-Hospital Information Bridge (VPHIB) system's Report Writer just for the regions to utilize EMS data. Dr. Pugh also provided monthly classes using her experience as a college professor to help the regional staff use VPHIB data for projects within their region. Unfortunately, the regional staff dwindled off and Dr. Pugh instead continued to provide assistance to the two remaining regions that were interested in using VPHIB data.

This has been Division of Trauma/Critical Care's (Div. of TCC) third major time consuming and costly attempts to provide regional access to our data to respond to comments stating "if we only had access to VPHIB and Virginia Statewide Trauma Registry (VSTR) data." As we begin to develop our new tools with an emphasis on data utilization the division will focus on direct to agency efforts and larger agency projects where we have greater success.

OEMS is in the process of filling Dr. Pugh's position, requesting to add an additional full-time FTE dedicated to data utilization, and a third part-time position also dedicated to data utilization. It is our desire to not only increase our data output on routine items of interest, but to also begin developing performance improvement (PI) toolkits, and stay ahead of the developing EMS performance measures (EMS PMs) initiative. One of our first areas of interest will be triage of time sensitive illnesses and injuries.

National Participation by Division of TCC Trauma System

National Participation

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

NASEMSO recently held its Spring Meeting in San Antonio, Texas and many important events took place, which are important to Virginia's EMS data program. The DMC voted to recommend to the National Highway Traffic Administration's (NHTSA) Office of Emergency Medical Services, which is the contract administrator for NEMSIS that no new major changes be implemented to the new version 3 national EMS dataset. The NASEMSO Board of Directors also voted to provide the same message to NHTSA.

This step was taken so states, vendors, and agencies can "jump on the version 3 train" while it is paused. This should provide agencies with a non-moving target to minimize training needs on the agency level and allow vendors to focus on implementation their products and not programming the next version. Minor updates will still occur annually, but the current two versions of version 3 will not be changed until 12/31/2017. On 1/1/2018 all vendors will need to be on v3.4.

Holding the version updates does not impact Virginia's timelines, but it does mean that major software updates that affect agencies and vendors will not occur allowing an easier transition. There is a downside to creating this pause and those are that as a new version we are bound to find issues. If the issues discovered require a major update we will all be forced to wait longer for a permanent resolution.

During the NEMSIS Steering Committee, which was held one evening during the San Antonio meeting, the committee advised NEMSIS to remove any software vendor that has applied for certification but has not many any efforts to go through actual compliance testing in 90 days. The Committee felt that having the vendor's name on the website indefinitely could be misleading to EMS agencies who may interpret this as a guarantee that the vendor would have an actual v3 product. Figure 1 illustrates the current list mentioned above. 23 vendors would be removed by this policy.

Figure 1 Non-NEMSIS compliant software products

Software Company	Capabilities	Component Validation^	Start Date	Pretesting*	Start Date	Active Testing**	Start Date	Passed Compliance	Completion Date
Application Data Systems Inc	Collect Data	✔	3/5/2015						
AngelTrack LLC	Collect Data	✔	10/7/2014						
Alpine Software Corporation	Collect Data	✔	2/20/2014						
American Ambulance	Collect Data	✔	8/15/2014						
American Ambulance	Receive & Process Data	✔	8/15/2014						
CollateUS Digital	Collect Data	✔	9/22/2014						
Consilience	Receive & Process Data	✔	9/26/2014	✔	2/3/2015	✔	3/16/2015		
Creative EMS Solutions	Receive & Process Data	✔	3/13/2015						
Creative EMS Solutions	Receive & Process Data	✔	3/13/2015						
Customized Computer Solution	Receive & Process Data	✔	4/1/2015						
Documed Systems International Inc.	Collect Data	✔	5/21/2014						
emsCharts, Inc	Collect Data	✔	10/6/2014						
EMS Data Systems, Inc.	Receive & Process Data	✔	10/1/2014						
Emergency Networking	Collect Data	✔	10/23/2014						
Emergency Networking	Receive & Process Data	✔	10/23/2014						
Emergency Reporting	Collect Data	✔	9/22/2014						
EmergiData Technologies	Collect Data	✔	4/6/2015						
ESO Solutions, Inc.	Collect Data	✔	10/21/2014						
FIREHOUSE Software, A Xerox Solution	Collect Data	✔	4/15/2015						
Forte Holdings, Inc	Collect Data	✔	12/9/2013						
Golden Hour Data Systems	Collect Data	✔	10/6/2014						
Intermedix	Collect Data	✔	12/15/2014						

The DMC also received an update on the EMS Compass project. The EMS Compass project is being managed by NASEMSO and is a two-year $2,000,000 project to design performance measures for the EMS community. It is believed that by 2018 reimbursement for EMS service will be very different and the current fee-for-service model will move to the quality of care provided model.

The DMC's representative to the National EMS Council (NEMSAC) shares some important information stating:

> "I suspect most of you are not aware of yet. This is partly as your representative to NEMSAC (we concluded today) and partly in my role as project manager for the EMS Compass Initiative.
>
> In 2018 at least 90% of ALL Medicare claims will be paid based on value rather than fee-for-service. DHHS [Department of Health and Human Services] Secretary Burwell announced it January 26th.
>
> That is the payment reform change we've [in EMS] have been (afraid of?) trying to stay ahead of for years, and it is now coming like a freight train with a short deadline and we're not ready for it today.
>
> What that means is (no particular order):
>
> 1) CMS will need performance measures approved to pay EMS providers for their performance;

2) Those performance measures need to be electronic and catalogued in the national eCQM database;
3) The EMS Compass Initiative is based on the v3 dataset;
4) The measures are not ready yet and may not be for another year or more. Over that time period we may discover the need for new elements or revisions to existing elements;
5) The measures need to go through an approval process by the NQF that takes 7-12 months before they're accepted, so that CMS can accept them,
6) Once the approvals are in place, agencies will need an electronic mechanism to report them to CMS.

From a rough EMS Compass timeline perspective, it would be the second quarter of 2017 before these measures could be approved for Medicare to use, **IF** the data supporting the measures is 'perfect'.

Once [the measures] are in place and being used, the data cannot change without also going through an extensive measure 'maintenance' process (not ad hoc but on a two-year schedule).

Experience tells me that even though we'll be taking great care to have the measures tested and validated, we're all going to discover new and interesting data collection practices or omissions from the data standard that are only discovered with good simulated testing OR widespread testing by our users.

Unless there is significant testing and/or implementation of version 3 this year, we could have agencies running into serious problems getting paid in 2018.

The Div. of TCC will pass on key national events related to the changes that are coming in EMS billing. However, EMS billing is not within our portfolio of responsibilities. As the program that manages EMS data collection we want to provide advice on the best way to collect EMS data to maintain or increase your ability to be reimbursed as well as documenting your patient care and performing quality assurance.

An extremely important tip is to not self-create elements and values in version 3 and make every effort to work within the boundaries of the national data standard as rolled out by the state. VPHIB staffs have been very involved the development of the version 3 national data standard (NDS) and make our policy decisions based on important issues such as the one above.

Trauma System

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

The Div. of TCC is pleased to announce that we have entered into a performance-based contract with the ACS for approximately $70,000 for an ACS State Trauma System Consultative Visit. The onsite portion of the assessment has been scheduled for September 1-4, 2015. Arrangements as to the location of the meeting are in process and will be shared as soon as possible.

Work continues on data collection for the Pre-review Questionnaire (PRQ) and will be ongoing until the document and supporting evidence is submitted to the ACS on July 1, 2015. To date, detailed information has been received from the Virginia Department of Health's Epidemiology office and a few of the EMS regional councils. This information along with data from other offices and groups from across the state will be complied into our application.

Over the next two months many individuals and groups can expect to be asked for assistance in completing the PRQ and in obtaining the needed documents to support the information provided to the ACS. The focus of this assessment includes but is not limited to:

- Injury epidemiology
- Statutory authority and administrative rules
- System leadership
- Coalition building and community support
- Lead agency and human resources within the lead agency
- Trauma system plan
- System integration
- Financing
- Prevention and outreach
- Emergency medical services
- Definitive care facilities
- System coordination and patient flow
- Rehabilitation
- Disaster preparedness
- System-wide evaluation and quality assurance
- Trauma management information systems
- Research

Our contract with the ACS was expanded to add an additional reviewer focused on assessing the needs of the pediatric population.

The final piece of the review process is the four-day meeting, where the ACS team comes to Virginia and conducts interviews with individuals, stakeholders, and groups involved in the trauma system. Invitations to this interview event will be forthcoming as the ACS develops a list of stakeholders they wish to meet with. At the completion of their evaluation a detailed report is provided outlining areas of strength in the trauma system and opportunities for growth.

Trauma System Oversight and Management Committee (TSO&MC)

The TSO&MC met on March 5, 2015. Because of weather there was not a quorum so the minutes from the December meeting have not been approved. The draft minutes to the meeting can be found on-line on the Virginia Regulatory Town Hall.

Dr. Forest Calland shared at the March meeting the continued work of the Trauma Performance Improvement Committee (TPIC) in the review of vital sign data submission in the pre-hospital setting and trauma triage. Currently, the team is working with the Peninsulas EMS council to fine tune the information that will be rolled out to the agencies in the community around trauma triage decisions and the completeness of vital sign documentation on trauma patients.

The committee heard from Dr. David Trump, Chief Deputy Commissioner, about the decision by the State Health Commissioner (Commissioner) to not submit the Trauma Center Designation Manual for approval at the March State Board of Health (BOH) meeting. Instead, the Commissioner decided the BOH should only receive the manual and education by OEMS staff and then be given time to review the manual prior to the June BOH meeting when it would be up for approval. Div. of TCC staff and the Chairman of the EMS Advisory Board, Gary Critzer, provided a working lunch presentation of the trauma system and the process used to revise the manual is created. See **Appendix G**.

There are two vacant positions on the TSO&MC; Citizen/Survivor Representative and a Level III trauma center position. Dr. Scott Hickey has joined the committee as the representative from the American College of Emergency Physicians, Virginia Chapter. Dr. Hickey is the Medical Director of the Emergency Department at Chippenham Medical Center, one of our Level II trauma centers.

Trauma Performance Improvement Sub-committee (TPIC)

The TPIC committee is in mourning over the retirement of Carol Pugh, and greatly misses her expertise in obtaining information from our data systems.

The TPIC committee continues to evaluate vital sign documentation and trauma triage based on these values. The 2014 data has been obtained and the documentation of vital signs by Prehospital providers shows improvement over the 2013 data. The most frequently omitted vital sign is the documentation of the Glasgow Coma Scale. The team is in review with the Peninsulas EMS council to develop the presentation of the data into its most useful and complete form, and to get all of the problems in data collection addressed prior to sharing the data with other groups.

Trauma Center Designation

No trauma verifications were conducted this quarter. The fall looks to be a busy designation/verification "season" as we have several facilities that have their regular site visit scheduled and have expressed interest in pursuing pediatric and/or burn designation.

The Virginia Trauma Center Designation Manual 2015 and the process by which it was vetted were reviewed with the State Board of Health (BOH) on March 19, 2015 and the BOH voted to approve the Trauma Designation Manual at that time with amendments. The TSO&MC would like to thank all of the individuals that worked on the manual for the last two years and the EMS Advisory Board for their support during this process. The current manual and the updated supporting documents needed for the review process are now posted on the OEMS website on the documents page.

The TSO&MC will be developing educational materials for site review team members now that the final approval has been obtained on the designation manual. The goal is to update current members of the site review team on changes to the standards, and to recruit and educate new individuals interested in participating in the review process.

Trauma Triage

The trauma nurse coordinators have two work groups working on major projects at this time. The first is the geriatric trauma workgroup that has finished its recommendations for geriatric triage and transfer guidelines which will be transferred to the trauma triage workgroup and the TSO&MC for review. The group is now working on geriatric trauma alert criteria and practice guidelines to share with their respective trauma programs. The second trauma program managers' workgroup is working on trauma triage and will take the geriatric recommendations under advisement as they continue their review of the state triage and transfer guidelines.

Trauma Center Fund

Trauma center funds were disbursed in both April and May. These funds are seen in Figure 2. Since 2006 when the trauma fund was instituted, OEMS has distributed over $86 million to the designated trauma centers.

Figure 2 Recent Trauma Center Fund Disbursement

Trauma Center & Level	Percent Distribution	April 2015 Distribution	May 2015 Distribution	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	14.26%	$ 286,621.15	$515,222.80	$10,916,544.67
Inova Fairfax Hospital	17.89%	$ 341,729.64	$614,284.41	$16,258,420.20
Norfolk General Hospital	9.31%	$284,375.99	$511,186.95	$10,561,240.78
UVA Health System	13.13%	$281,110.30	$505,316.63	$11,616,229.08
VCU Health Systems	27.66%	$553,795.31	$995,488.19	$20,567,898.70
II				
Lynchburg General Hospital	1.88%	$75,167.80	$135,119.70	$2,291,476.84
Mary Washington Hospital	4.38%	$118,029.97	$212,167.63	$2,254,206.59
Riverside Regional Medical Ctr.	3.32%	$85,168.97	$153,097.55	$2,681,997.77
Winchester Medical Ctr.	4.09%	$105,375.42	$189,420.15	$3,402,171.03
III				
New River Valley Medical Ctr.	0.40%	$105,375.42	$54,402.83	$481,855.44
CJW Medical Ctr.	0.95%	$47,001.24	$84,488.21	$1,079,514.20
Montgomery Regional Hospital	0.17%	$28,631.74	$51,467.67	$440,202.20
Southside Regional Medical Ctr.	0.62%	$99,864.57	$179,513.98	$914,506.14
Virginia Beach Gen'l Hospital	1.94%	$36,183.64	$65,042.78	$2,536,059.33
Total		$1,550,025.00	$4,266,219.48	$86,002,322.97

Patient Care Information System

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

"*Don't Say You Didn't Know*"

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

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

Figure 3 EMS Agency Implementation Packet

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

As a reminder we have revised our roll-ouot schedule providing extra time for those agencies that have an increasingly complex system to migrate as shown in Figure 4. These wll be firm deadlines and no further changes are anticipated. To find out deadline for any single agency you can go to our support suite at http://oemssupport.kayako.com/Knowledgebase/List/Index/47/timelinesdeadlines.

Figure 4 Vav2 to VAv3 Migration Deadlines

Virginia Timeline for Migration from Vav2 to VAv3

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

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

Key:

May be on v2:

Need to move to v3 during the time period:

V2 data no longer accepted v2 accounts killed:

Resources Available to Agencies and Vendors for VAv3

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

1) Schematron File – this is a file your vendor is required by NEMSIS certification to be able to import into their systems that contain most of the State's validation rules. Out of over 500 rules less than 20 are not in our Schematron file;
2) State File – This file is not mandatory for vendors to be able import, but most vendors encouraged its development and committed to its use. The state file is a file created by the state that contains:
    a. Any custom elements;
    b. All of our state required data elements;
    c. The certification levels accepted by VPHIB;
    d. The procedures that VPHIB will accept;
    e. The medications that VPHIB will accept;
    f. The protocols that VPHIB will accept;
    g. The list of all EMS agencies in VPHIB; and
    h. The facilities VPHIB will accept (this will be our hospitals).
3) EMS Electronic Medical Record (EMR) a.k.a. our run form. This is available to all ImageTrend Service Bridge and Rescue Bridge users. Importing our EMR may save ImageTrend users a lot of time preparing their own EMR from scratch. Once imported it can be customized if you have you own license.
4) Version 3 products should allow agencies to upload most agency and provider demographic information. It will not upload VPHIB user accounts. If user accounts are applicable to your agency they will need to be recreated.

5) VAv3 Data Dictionary – detailed information about the collection of VAv3 data. Maintained by VPHIB staffs and an official regulatory document.
6) VPHIB VAv3 Validation Rules – detailed information and list of the validation rules used in VPHIB. The document also breaks down the mandatory minimum dataset based on the phase of an EMS response, i.e. response, patient contact, and transport. Additional worksheets provide a list of data elements that are likely to be involved in certain call types, i.e. stroke, STEMI, and trauma. These were added because in v2 many agencies have built items into procedures to later find these call types. V3 does not allow this.
7) Suggested lists – These are based of the national suggested list which were developed by the data managers for each state and contain the below lists and the values accepted by VPHIB. Additions can be made upon request:
    a. Procedures
    b. Medications
    c. Cause of Injury
    d. Incident Location
    e. Protocols
    f. Impressions (primary & secondary)
    g. Symptoms (primary & associated)
    h. Hospitals

Virginia Statewide Trauma Registry (VSTR)

The VSTR has been functioning well with little to no technical issues. There continue to be some compatibility issues limited to a single third party trauma registry software vendor that are occurring on the vendor side. We had seen a significant dip in submission compliance as we transitioned, but as we improve our internal processes to be similar to the VPHIB system we have seen hospitals rapidly responding to our notice of missing information.

Staff feels behind in developing the quality process we use for VPHIB with the VSTR, but there have been several hot topics in trauma that have necessitated diverting staff time allotted for trauma activities away from the VSTR. These include the managing of the debate of implementing a certificate of public need process for trauma center designation and an alternative to achieving trauma designation outside the national and state designation process.

These issues also required additional staff time, as they intersected with the approval of the Trauma Center Designation Manual.

Emergency Medical Services for Children (EMSC)

EMS for Children Committee Update

The EMSC Committee of the State EMS Advisory Board met April 15, 2015. Beyond their usual business, the group spent considerable time discussing:

- The importance of the newly approved process for designating pediatric trauma centers.
- How to identify and recruit instructors for and facilitate consistent support for quality pediatric training/education topics for the Annual Virginia EMS Symposium Pediatric Track.
- Finding additional ways to meet the needs of Virginia EMS agencies in caring for pediatric patients. (It was suggested to collect anecdotes from EMS agencies that recently received pediatric immobilizers that illustrate the benefit of this distribution).
- Pediatric medical errors in Virginia, and how to constructively decrease the potential for these. The group explored the feasibility of proposing a pediatric medication errors study through the Pediatric Emergency Care Applied Research Network (PECARN), a national collaboration of major hospital centers on pediatric research projects in order to obtain the numbers needed to achieve statistical significance in pediatric scientific studies.
- Heat stroke awareness strategies to decrease preventable child deaths in Virginia.
- Next steps in helping improve the pediatric readiness of Virginia hospital emergency departments.
- Assisting the TSO&MC where appropriate in incorporating improvement into the trauma triage guidelines development process.
- Using the major bike race being held in Richmond this year as an opportunity for sharing injury prevention messages.

Purchasing Highlights of EMSC Program (with the HRSA State Partnership Grant funding):

- ***Child immobilization devices*:** After a formidable journey, the EMSC program has been able to purchase 160 devices to aid in the immobilization of injured children—129 have already been delivered and are in use. As part of the distribution process, each agency receiving one or more devices provided the EMSC program with the name of a designated pediatric contact/liaison for their agency. If you know of any volunteer agencies who still might have a need for this type of pediatric immobilizer, please contact David Edwards (david.edwards@vdh.virginia.gov) .

- ***iSimulate System for pediatric training*:** The purchasing process is almost complete for an i-Pad based advanced simulation system for pediatric

scenario training that will enable us to operate eight pediatric technical stations simultaneously if needed (as often is the case at the annual Virginia EMS Symposium).

The interactive system will allow scenario stations to be fully operational without the use of actual monitor/defibrillators and their inherent safety issues, logistical and connectivity problems, simplifying the effort and ability of educators and trainers to provide quality technical stations for courses like Pediatric Advanced Life Support, Pediatric Education for Prehospital Providers (PEPP), Emergency Pediatric Care (EPC), Advanced Pediatric Life Support, etc.

- ***Educational Support Materials:*** Textbooks, manuals, miscellaneous course fees, instructor support, and other items continue to be purchased to facilitate access to pediatric education and training in Virginia.

- ***Pediatric training manikins:*** Bids for multiple-use child and infant manikins will be going out within the next few weeks. These manikins will also be appropriate for use with the iSimulate "ALSi" simulation system described above (and for other training opportunities).

- ***Broselow™ Pediatric Emergency Tapes***: An additional order of 1,850 length-based pediatric emergency tapes is likely to be placed next week—we believe that this final distribution should complete the conversion of Virginia EMS ground ambulance agencies to the most current version of pediatric emergency tapes. If your agency does not yet have updated tapes for your transport ambulances, please contact David Edwards by phone (804-888-9144) or email (davidedwards@vdh.virgirnia.gov).

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

Heat Stroke Awareness and Prevention

The Virginia EMSC program is working closely with the national and Virginia chapters of SAFE KIDS and the Division of Prevention and Health Promotion in the Virginia Department of Health to raise awareness regarding the advent of warm weather and the associate risks of inadvertently leaving children in automobiles. There were more than 30 deaths from this cause last year.

In April, the Virginia EMSC program began using social media to send messages about heat stroke in children and how to prevent these deaths; the collaborative use of public service announcements and other materials will be tools as well in trying to assist in preventing these senseless tragedies.

EMSC Website Overhaul--Hospital and EMS Agency Sections Will Anchor

The EMSC website (within the OEMS website) is undergoing revision, and there will specific sections established for hospitals and EMS agencies.

- The hospital section will contain resources and toolkits developed as a direct result of data received during the Pediatric Readiness Assessment. 4,143 hospitals nationally (with 24/7 EDs that see children) participated in this assessment. Major topics will likely be the development of inter-facility transfer guidelines and agreements, incorporating pediatric quality/PI into hospital QI/PI efforts, and pediatric disaster planning and preparedness.

- The EMS agency section will contain resources and toolkits developed in part as a result of the national EMS assessment completed last year by more than 80% of EMS agencies that respond to 911 calls and may transport children. Appropriate equipment, supplies, policies, training/education and disaster preparation are just some of the areas covered.

Development of Quality Improvement (QI) Indicators

The Virginia EMSC program is developing sample QI markers/indicators for hospital emergency departments and EMS as a resource for evaluating and improving care. An example of areas covered might include these topics:

- asthma
- child maltreatment
- diabetic ketoacidosis (DKA)
- hematology/oncology
- head trauma
- length of stay in ED
- pain control
- medication administration
- recording/use of vital signs
- mock codes
- moderate sedation
- triage criteria

Additional QI indicators for EMS agencies seeking to evaluate and improve prehospital field care are also being developed, and at least some of these will be based upon data available though the VPHIB program. QI indicators are just one example of the kinds of items that will be available in both of the new sections planned for the EMSC website.

NASEMSO Pediatric Emergency Care Council (PECC) Update

The PEC Council is a standing council of the NASEMSO and works at a national level to facilitate improvement in pediatric emergency care, especially by working with federal partners

within the umbrella of the Health Resources and Services Administration (HRSA), the Department of Transportation, and Homeland Security.

EMS Education Toolkit for Pediatrics

Members of a special working group recently collaborated to compile education resources to assist in the education and re-licensure of practitioners related to pediatrics. The EMS Education Toolkit for Pediatrics is the result of a collaborative effort of the National Association of State EMS Officials (NASEMSO), the American Academy of Pediatrics (AAP), the EMSC National Resource Center (NRC), National EMSC Data Analysis Resource Center (NEDARC), the National Association of EMS Educators (NAEMSE), and the National Association of EMTs (NAEMT) with support from our federal partners at the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration EMS for Children Program (HRSA).

The toolkit is intended as a resource that can be used to inform the state EMS license renewal process to improve evaluation and performance related to pediatric skills competency although EMS Educators, EMS agencies, EMS practitioners, and others seeking information to improve pediatric education in emergency medical services will also find the information useful.

The toolkit is available at http://www.nasemso.org/EMS-Education-Toolkit-Pediatrics/.

Next Steps for Pediatric Facility Recognition

The work group which had been addressing a potential pediatric facility recognition program in Virginia is reorganizing to re-map a strategy toward improving emergency department pediatric readiness. The EMSC Committee will be instrumental in advising in this effort. We envision having additional hospital representatives join the group, as well as representation from the Virginia Hospital and Healthcare Association, American Academy of Pediatrics and other groups and individuals with expertise as we move forward. We plan to utilize electronic meetings for the first time to improve the frequency of meetings and numbers of stakeholders involved in this effort.

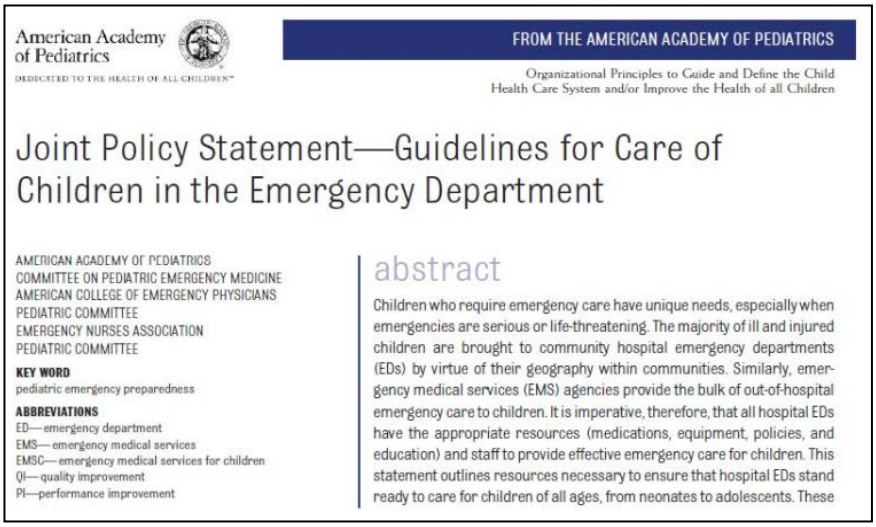
On-Site Pediatric Training

The Virginia EMSC program continues to facilitate access to pediatric education and training, especially in the form of EPC, ENPC, PALS, and PEPP courses around the Commonwealth, particularly in areas with historically difficult access to pediatric training.

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

Participation In On-Site ED Pediatric Assessments

Members of the EMSC Committee or others with expertise who wish to be involved in helping with on-site collaborative assessments of pediatric needs and capabilities of emergency departments should let David Edwards know, and should update their contact information.



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

Joint Policy Statement—Guidelines for Care of Children in the Emergency Department

AMERICAN ACADEMY OF PEDIATRICS
COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
PEDIATRIC COMMITTEE
EMERGENCY NURSES ASSOCIATION
PEDIATRIC COMMITTEE

KEY WORD
pediatric emergency preparedness

ABBREVIATIONS
ED—emergency department
EMS—emergency medical services
EMSC—emergency medical services for children
QI—quality improvement
PI—performance improvement

abstract

Children who require emergency care have unique needs, especially when emergencies are serious or life-threatening. The majority of ill and injured children are brought to community hospital emergency departments (EDs) by virtue of their geography within communities. Similarly, emergency medical services (EMS) agencies provide the bulk of out-of-hospital emergency care to children. It is imperative, therefore, that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children. This statement outlines resources necessary to ensure that hospital EDs stand ready to care for children of all ages, from neonates to adolescents. These

Program staff currently use the consensus document "*Joint Policy Statement - Guidelines for Care of Children in the Emergency Department", American Academy of Pediatrics, October 2009* as a guide to assess gaps in basic ED preparedness. The document delineates "guidelines and the resources necessary to prepare hospital EDs to service pediatric patients", and is endorsed by many respected organizations, and will probably be updated in the near future.

EMSC State Partnership Grant Notes

- We did receive word March 18, 2015 that funding for Virginia's March 2015-April 2016 EMSC grant cycle has been approved for $130,000. This will be the 3rd year of our approved 4-year grant cycle before completion is required for awarding of another EMSC State Partnership Grant.

- A webinar on the newly proposed "state snapshot tool" was held in mid-April. EMSC programs in all states are completing detailed surveys to populate a database resource for state EMSC programs. This may provide another means of evaluating progress nationally toward current performance measures and help determine what new EMSC performance measures should look like. New national EMSC performance measures will probably be announced/implemented in 2016.

- The first manuscript generated directly from the Pediatric Readiness Assessment of hospitals was accepted by the Journal of the American Medical Association and published April 13, 2015. There will be a link to this on the EMSC website shortly, and other manuscripts should follow soon.

- This year the single Annual EMSC Program Meeting is being replaced by four Regional EMSC Symposia that EMSC Program Managers and FAN (Family Advisory Network) representatives are required to attend (roughly specific to their geographic area). The

Regional Symposium applicable to Virginia will be held August 11-13 in Philadelphia, Pennsylvania.

- The Emergency Medical Services for Children National Resource Center has just released the Program Manager's Toolkit. This highly interactive tool is a helpful new resource for EMSC managers, and includes the updated interactive version of *Public Policy Primer: A Guide on the Legislative Process and Impacting Change at the Federal, State, and Local Levels*. Additionally, this toolkit is directly linked with *Getting Started, Staying Involved: An EMSC Toolkit for Family Representatives*.

- The EMSC Program is partnering with the American College of Emergency Physicians, the AAP, and the Emergency Nurses Association to celebrate "EMS for Children Day" on May 20, 2015.

- The EMSC program in Virginia welcomes Robin Donovan Pearce MSN, RN-BC to our EMSC Committee. Robin is the newly-appointed Trauma/Critical Care Coordinator within the OEMS, and a core position on the Committee since its inception has been reserved for the State Trauma Coordinator. Paul Sharpe has relinquished the Trauma Manager role in a planned expansion and reorganization of his managerial responsibilities.

Suggestions/Questions

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

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

Durable Do Not Resuscitate (DDNR)

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

Respectfully

Submitted

OEMS Staff

Appendix

A

EMS COMPASS

Improving Systems of Care Through Meaningful Measures

Improving Systems of Care Through Meaningful Measurement

EMS COMPASS

Acknowledgments

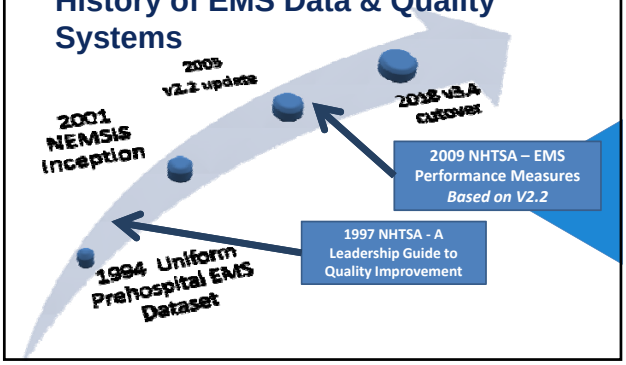
Thank you to the National Highway Traffic Safety Administration for funding and supporting this important work.

50 workgroup and committee members giving their time and expertise!

Public volunteers who will test and discuss draft measures prior to becoming final.

EMS COMPASS

History of EMS Data & Quality Systems



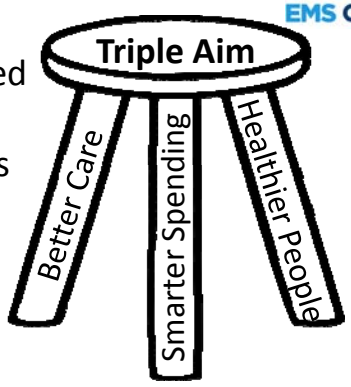
EMS COMPASS

NEMSIS Datasets Supporting Performance Measurement

What can you do with your data?

Patient Centered Health Systems

EMS COMPASS



EMS COMPASS

Pay For Performance is here!

- **Value**: CMS fee for service based payments tied to value for providers in alternative payment models (i.e. accountable care organizations, medical homes, bundled payments)
  1. 30% by 2016
  2. 50% by 2018
- **Quality**: CMS quality program (performance measures) participation
  1. 85% by 2016
  2. 90% by 2018

Health Care Learning & Action Network

- The Department of Health & Human Services is facilitating public-private partnerships to meet or exceed the CMS goals for value based payments

Medicare (CMS) Payment System Categories

	1. FFS with no link of payment to quality	2. FFS with a link of payment to quality	3. Alternative payment models built on FFS architecture	4. Population-based payment
Description	Payment is based on volume, not quality	A portion of payment vary based on quality or efficiency of health care delivery	Some payment linked to effective management of a population or episode of care. Still triggered by delivery of services.	Payment NOT directly linked to service delivery. Payment & responsibility for long term care of beneficiary (e.g. ≥ 1yr).
CMS FFS	• Limited in CMS FFS • Majority of CMS payments now linked to quality	• Hospital value-based purchasing • Physician value-based modifier • Readmission/Hospital Acquired Condition Reduction Program	• ACOs • Medical Homes • Bundled payments • Comprehensive primary care	• Eligible Pioneer accountable care organizations in years 3-5

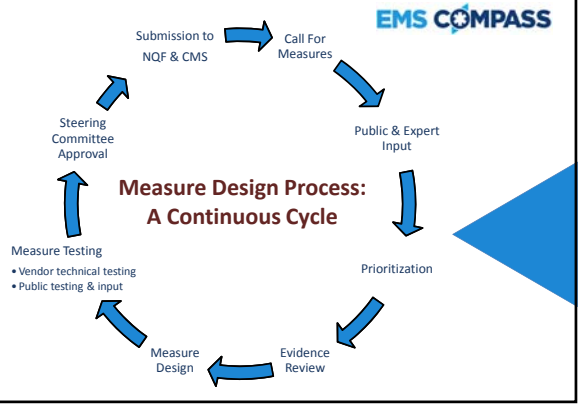
FFS= Fee For Service
ACO= Accountable Care Organization

CMS Quality Measures

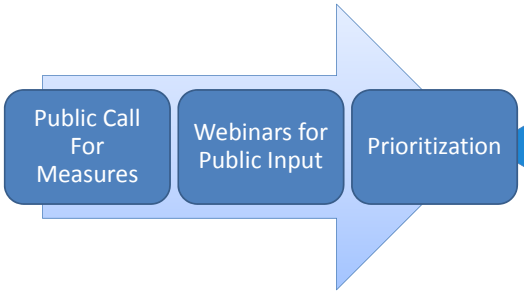
1. Developed by Measure Stewards (such as NASEMSO)
2. Submitted to National Quality Forum (NQF)
3. Extensive public evaluation of draft measures
4. NQF chooses to endorse measure (or not)
5. CMS chooses to accept measure (or not) for payment
6. Health care providers submit Measure Scores electronically to CMS

EMS Performance Measures

- EMS industry opportunity to develop measures from us and work for us!
- EMS Compass Initiative will:
  1. Develop a process for designing EMS specific performance measures.
  2. Design a family of structural, outcome, process, and balancing measures.
  3. Develop a guidance for EMS agencies and providers in how to use measures.

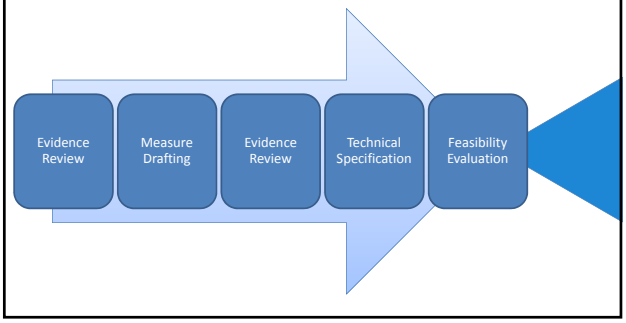


Measure Conceptualization



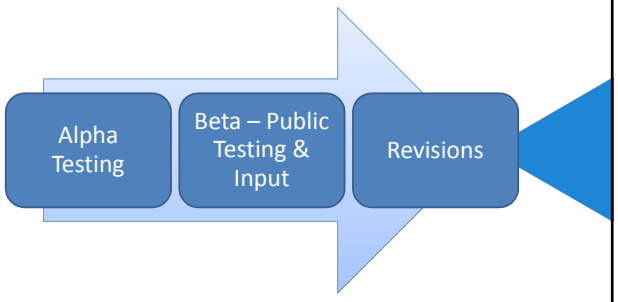
Measure Specification

EMS COMPASS



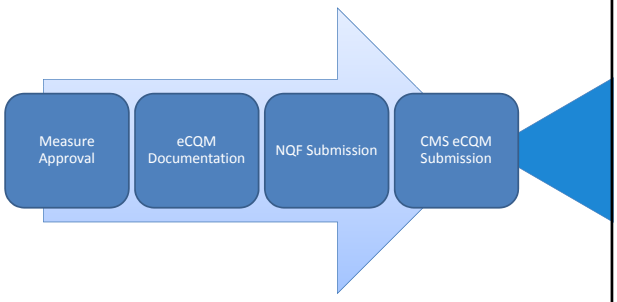
Measure Testing

EMS COMPASS



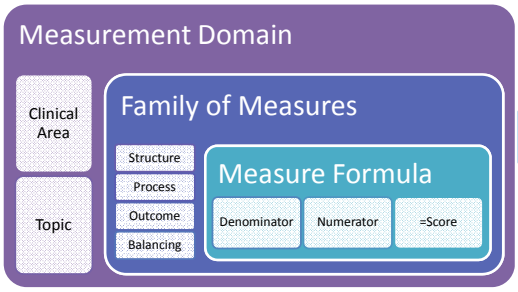
Measure Implementation

EMS COMPASS



What is a performance measure?

EMS COMPASS



EMS COMPASS

Domains	Example Possible Clinical Conditions & Topics
Patient and Family Engagement	Customer satisfaction, parent/family involvement, patient experience
Patient Safety	Stretcher drop rate, adverse event rate, ambulance crash rate, deteriorating patient (early warning), infection control/hand hygiene
Care Coordination	Matching care to need, access
Population/Public Health	Volumes, symptoms onset to 911, requests per capita
Efficient Use of Healthcare Resources	Cost per capita/patient, tax dollars per capita, patient utilization rate, patient contact time reliability, crash scene time
Clinical Process/Effectiveness	Stroke, STEMI, SCA, trauma, RAD, sepsis, CHF, pain management, hypoglycemia, seizures, COPD, mental health, anaphylaxis , provider skill success rate
EMS Workforce*	Turnover/Retention, vacancy rate, productivity, Compensation Comparator, injury rate, lost work days rate, education, R&R, certification & licensure, safety (near miss reporting, policies, etc), provider safety
EMS Fleet*	Vehicle miles traveled (VMT) rates
EMS Data*	NEMSIS submission rate, data integrity
EMS Finance*	Reimbursement rates

*EMS Convenience Domains that are outside the NQS/NQF original six but may prove to be necessary for EMS performance measurement.

EMS Measure Considerations

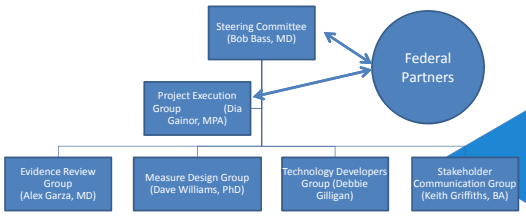
EMS COMPASS

- NQF Priority Criteria*
  - Importance to Measure and Report
  - Feasibility
  - Scientific acceptability of measure properties**
  - Usability and Use
  - Comparison to related or Competing measures.
- Data source from the National Emergency Medical Services Information System (NEMSIS) Version 3 generation data whenever possible.

* http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx

** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) grading definitions and methods, or Grading of Recommendations, Assessment, Development and Evaluation (GRADE) guidelines.

Overall Org Chart



Project Staff:
Nick Nudell, MS, NRP – Project Manager
Zoe Renfro, BA – Project Staff

EMS Compass Initiative Meetings

- Steering Committee:
  - 20 members 4 meetings
- Measurement Design Group:
  - 12 members 8 meetings
- Technology Developers Group:
  - 9 members 2 meetings
- Communications Group:
  - 6 members 4 meetings

Initiative Activity Schedule

- Oct. 2014: Project Started
- Jan. 2015-July 2016: 24 meetings & workgroups
- July 2016: Submit to peer review journal
- July-Aug. 2016: Conduct Blue Ribbon Panel
- Aug. 2016: Publish NASEMSO document
- Sept. 2016: Completion of this phase

For more information please contact:

Nick Nudell
Project Manager – EMS Compass Initiative
nick@nasemso.org
(760) 405-6869

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https://twitter.com/EMSCompass
#EMSCompass

EMS COMPASS
Improving Systems of Care Through Meaningful Measures

Appendix

B

CALENDAR YEAR 2014

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

Welcome!

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

This is an aggregate report of the near miss events reported to E.V.E.N.T. for calendar year 2014. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

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

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

This is the aggregate Near Miss E.V.E.N.T. summary report for Calendar Year 2014.

PROVIDED BY:

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada / Chefs Paramédics du Canada

National EMS Management Association

NAEMT

NASEMSO

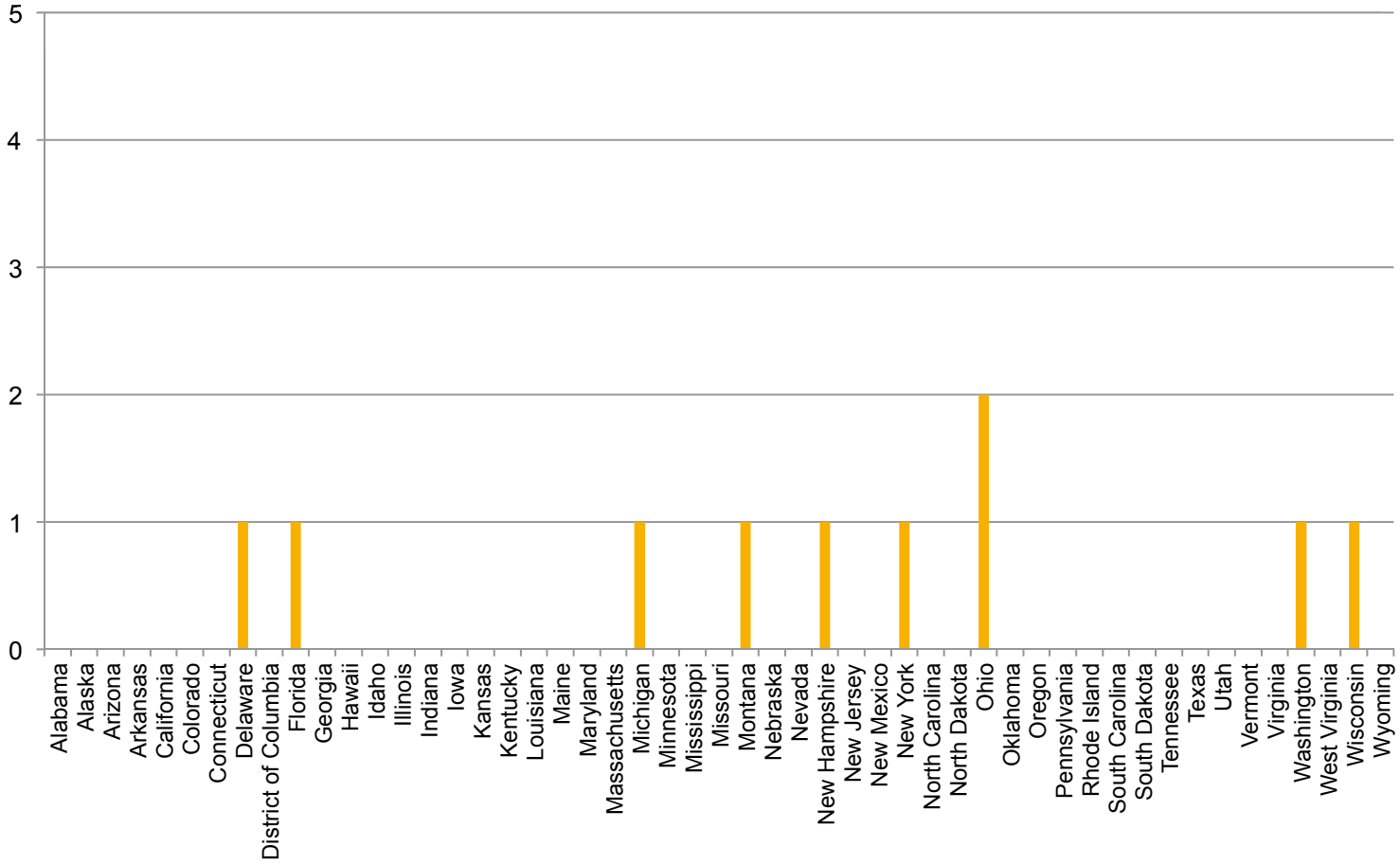
Table 1: Near Miss Events Quarterly

	2012	2013	2014
Jan - Mar	1	4	0
Apr - Jun	0	3	1
Jul - Sep	8	5	5
Oct - Dec	10	7	5
Total	19	19	11

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

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

Near Miss Events by State (United States of America)



FEMA Region Map of United States

Near Miss Events by FEMA Region

This period's US near miss event reports were in FEMA regions 1, 2, 4, 5, 8 and 10.

Figure 1.1 Notes: Map includes all Ten FEMA Regions as determined by Department of Homeland Security.


Alabama Emergency Medical Technicians Association


NAEMSP


CAA
HEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE


NAEMT


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


NATIONAL
EMS
MANAGEMENT
ASSOCIATION


National
EMS
Memorial
Service


NOSORH
national organization of state offices of rural health


NASEMSO


NATIONAL VOLUNTEER FIRE COUNCIL
ORG. 1976
Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
EMS
EMS ASSOCIATION


North Central
EMS Institute


Oregon
EMS Association
www.oregonems.org


Pennsylvania Emergency
Health Services Council
Your Voice In EMS.


PAAW
PROFESSIONAL AMBULANCE
ASSOCIATION OF WISCONSIN


SOUTH CAROLINA
EMS ASSOCIATION

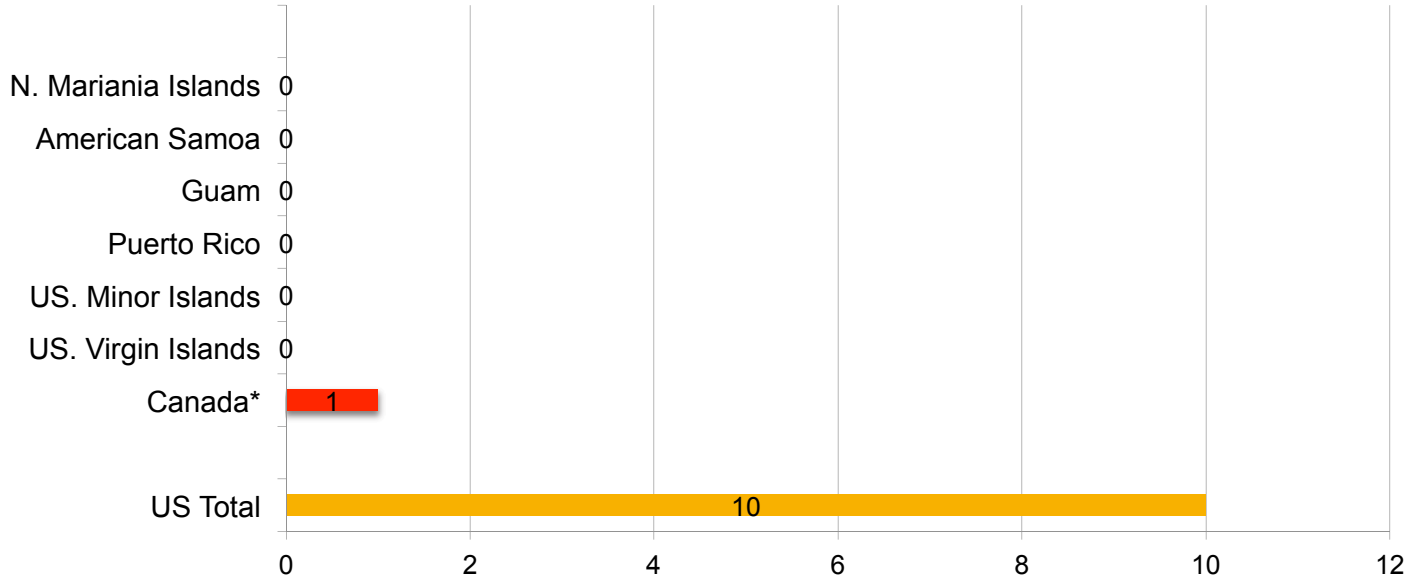

VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

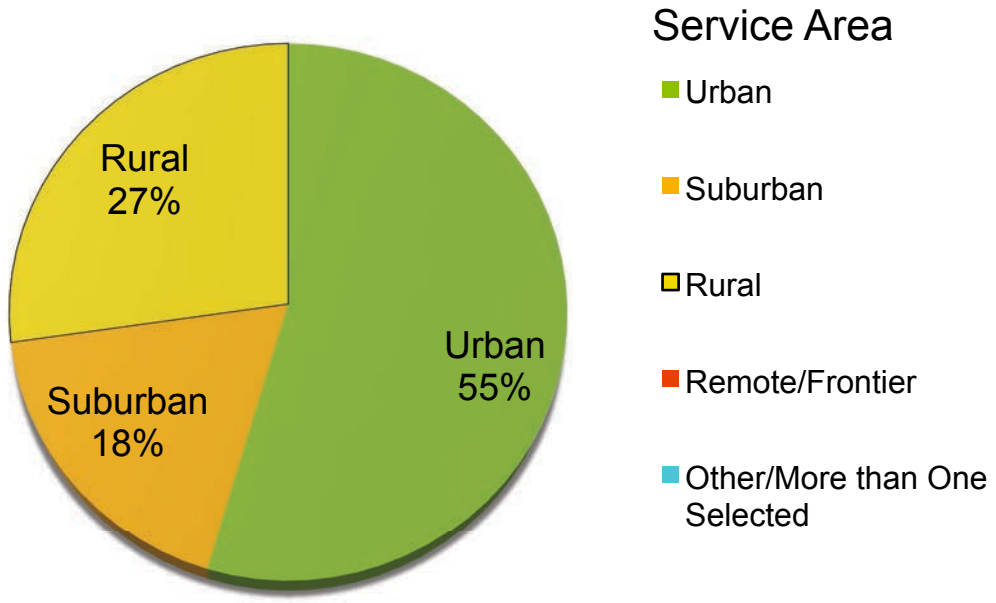

AAMS


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

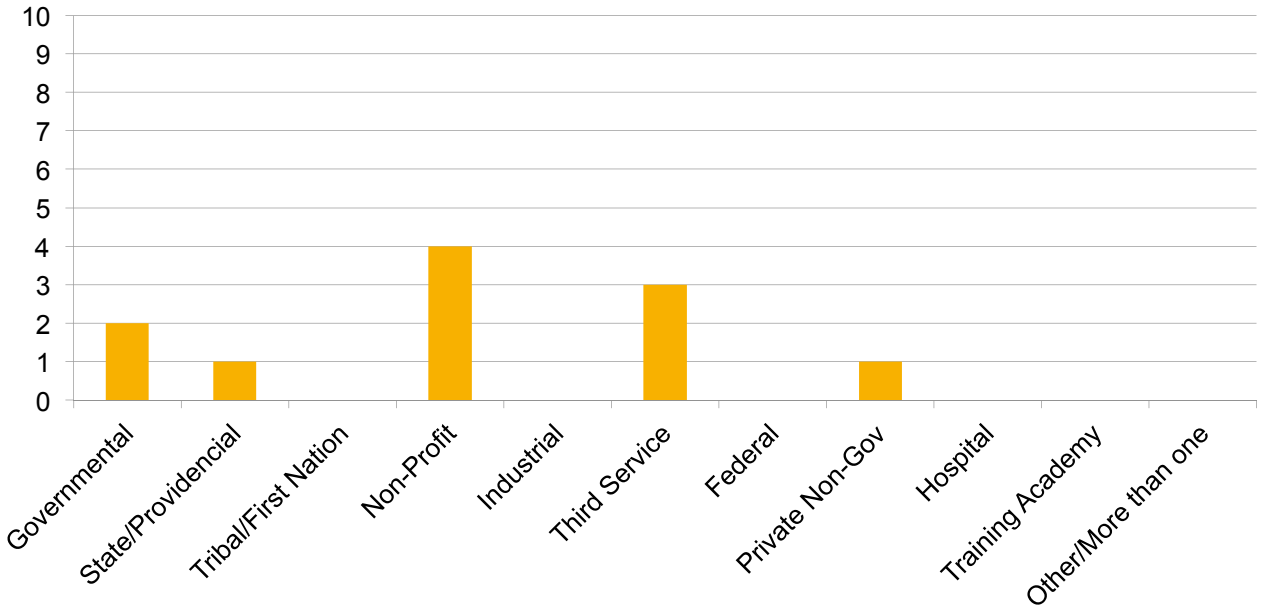
Annual Near Misses in Canada and U.S. Territories



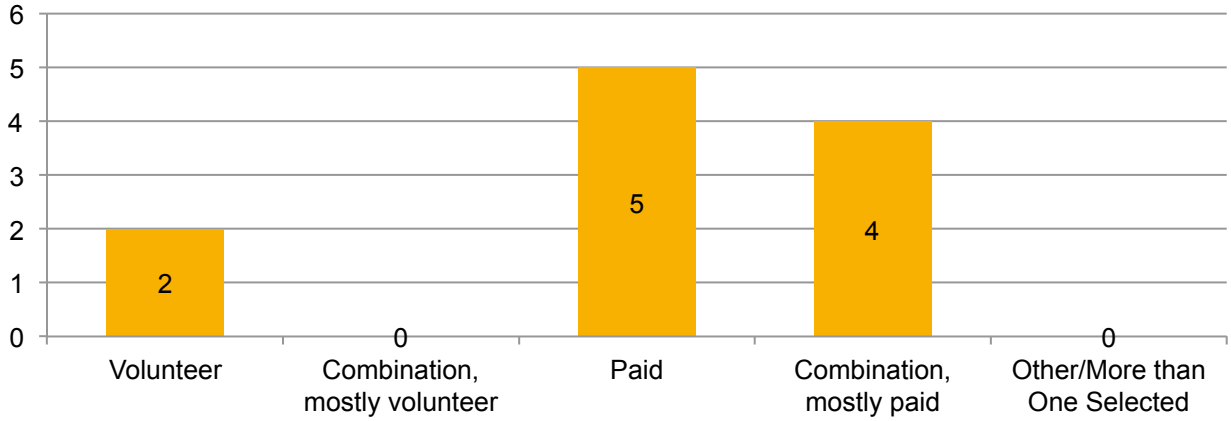
Annual Frequency of Near Miss Events Across Agency Characteristics



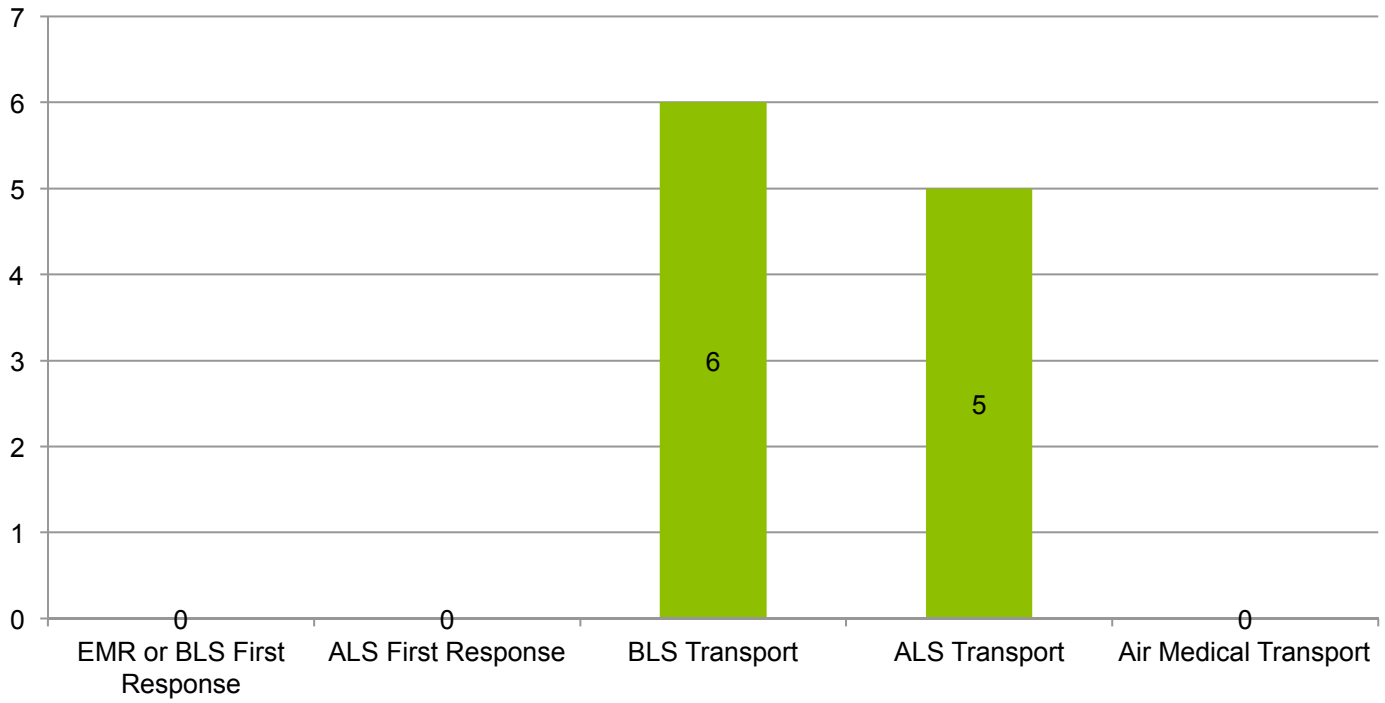
Frequency of NME by Agency Ownership



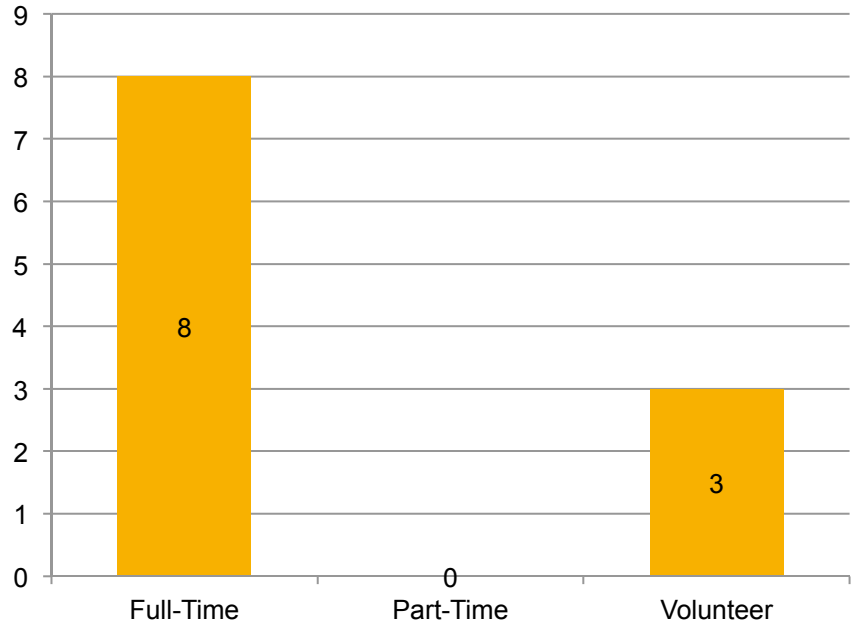
Department Type



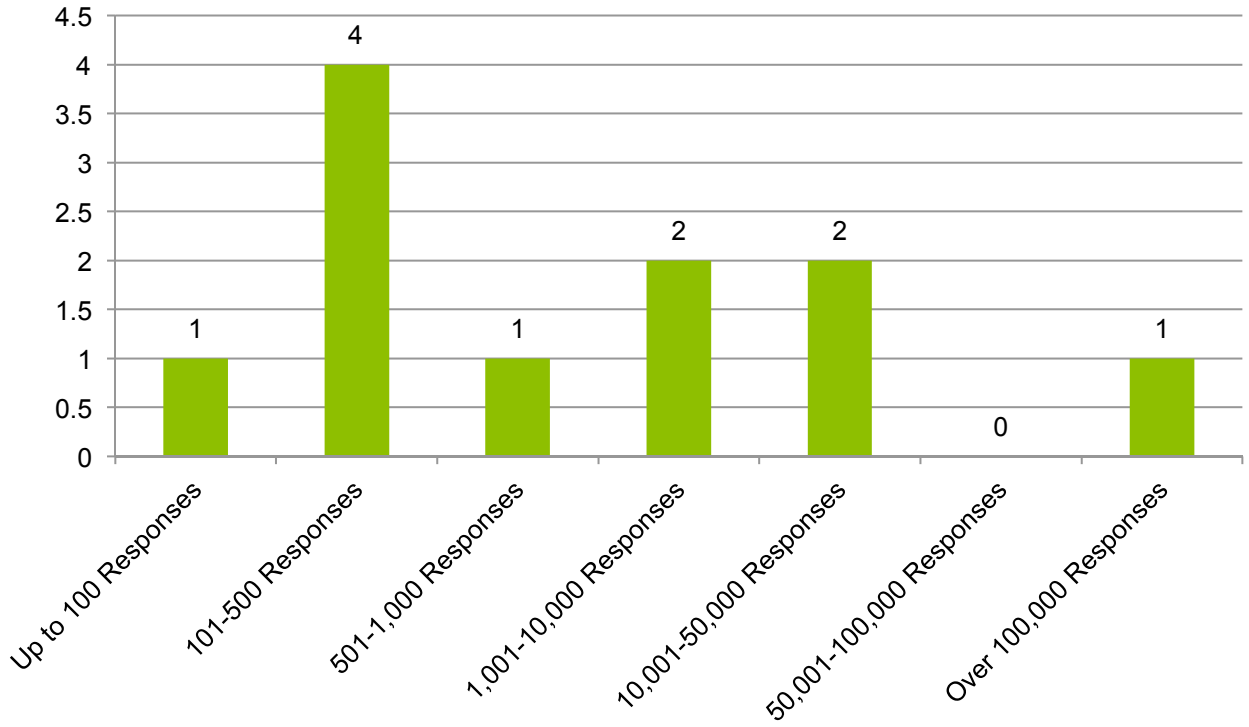
Level of Organization



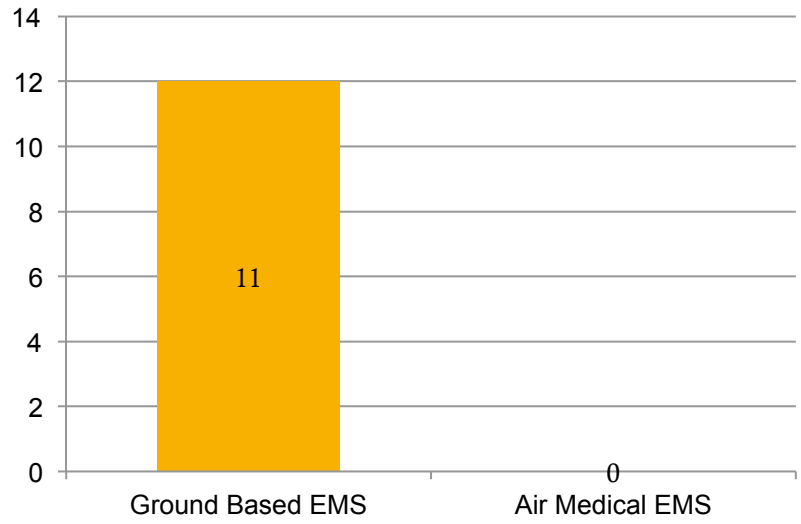
Employment



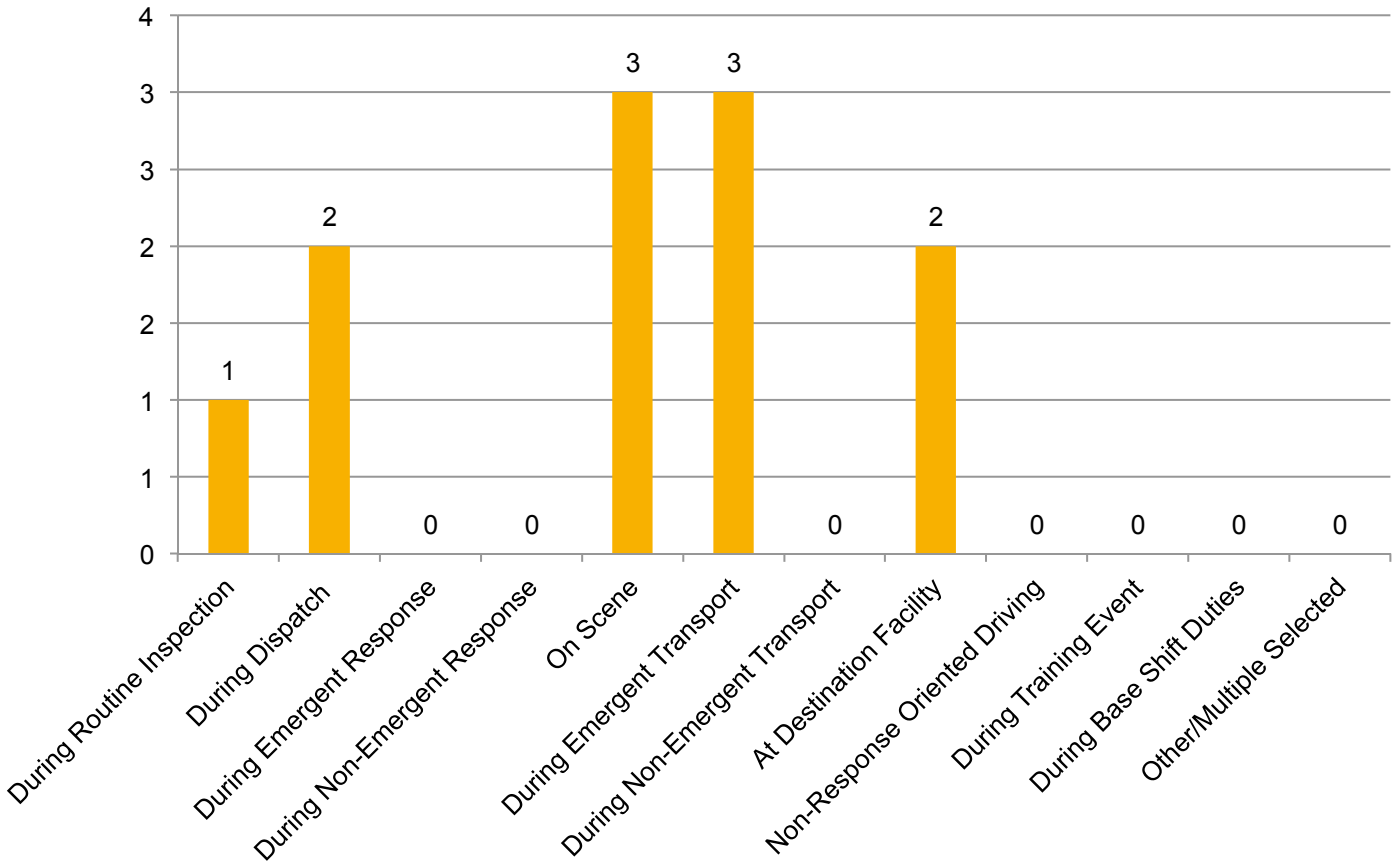
Annual Responses of NME Agency



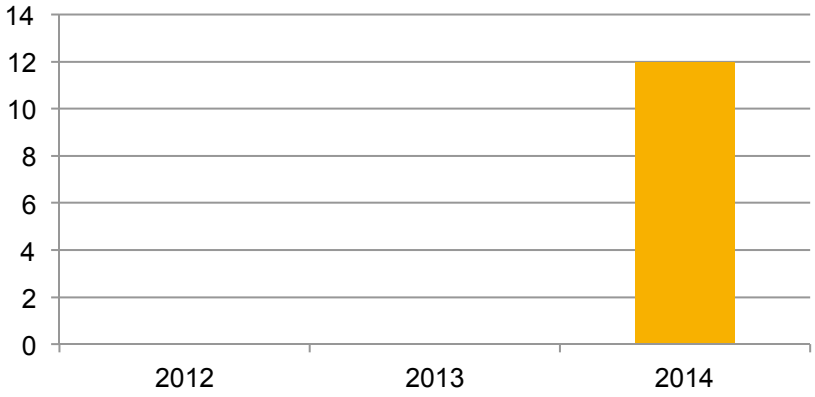
Near Miss Event Setting



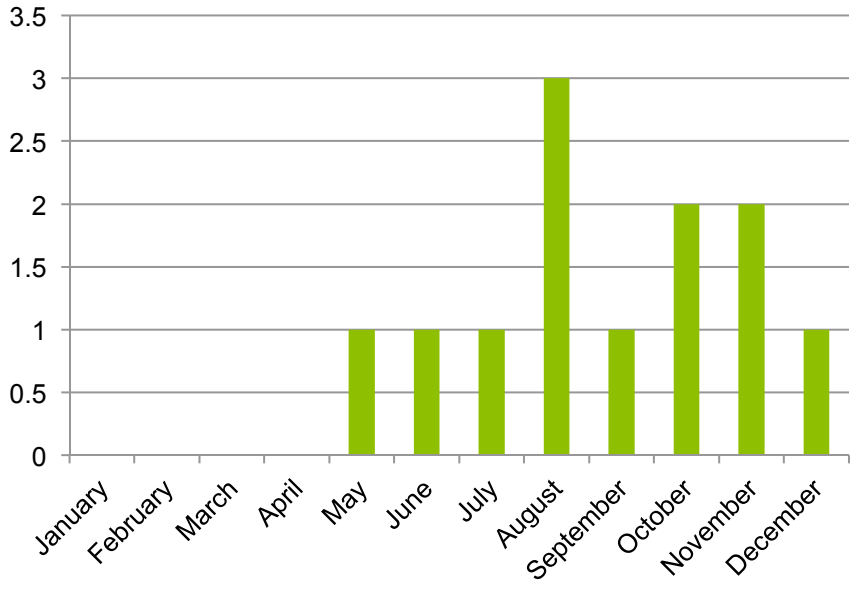
NME Occurrence During EMS Response Timeline



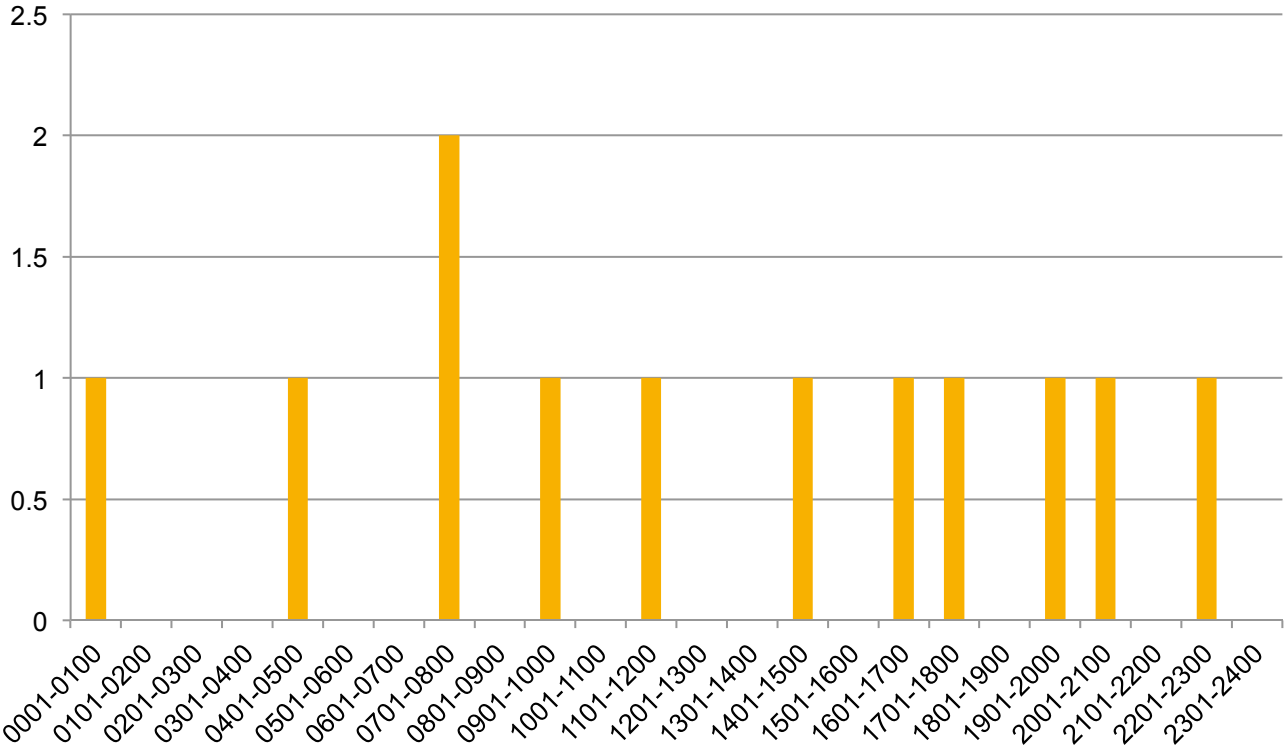
Year Reported Near Miss Event Occurred



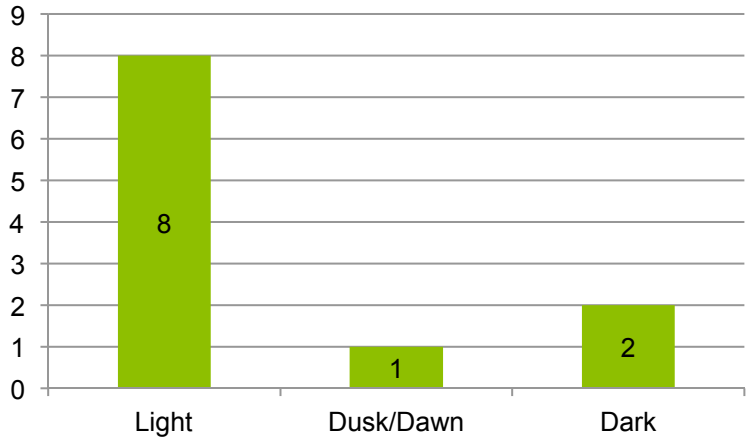
Month of Reported Near Miss Event



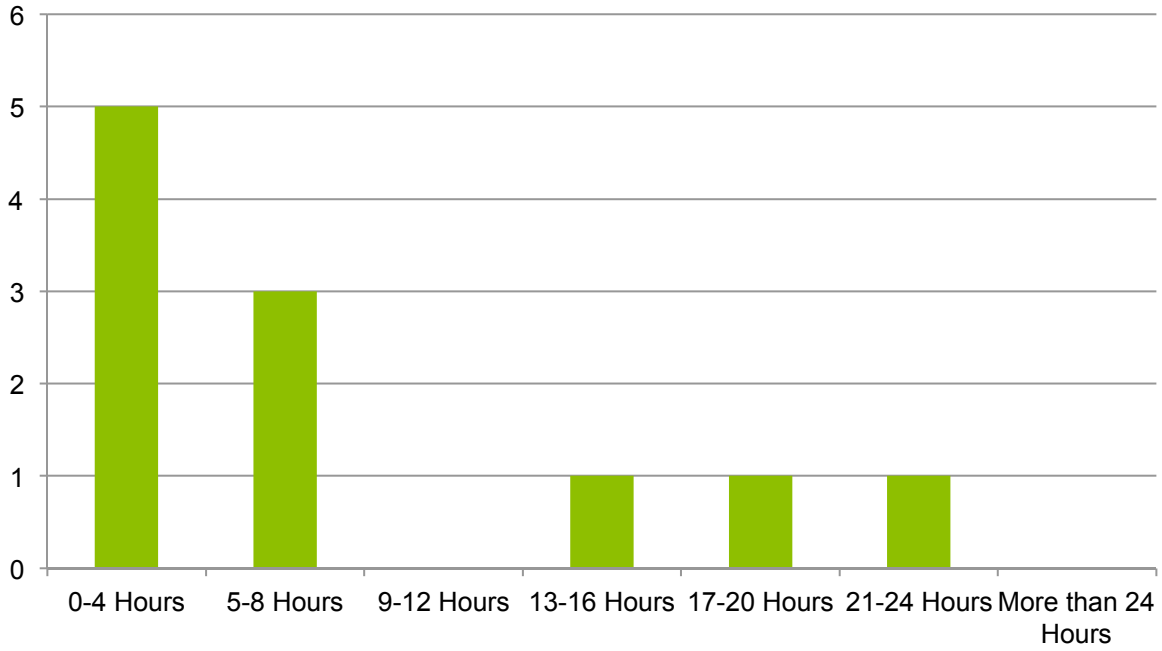
Time of Reported NME



Environmental Visibility During Near Miss Event



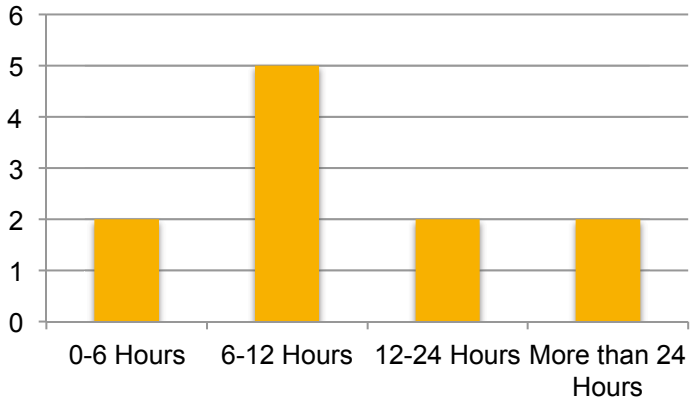
Hours into Shift at time of NME



Contributing Factors to Near Miss Events: As Reported by Providers

	Frequency		Frequency
Accountability	0	Situational Awareness	3
Command	1	SOP/SOG	0
Communication	1	Staffing	0
Decision Making	2	Task Allocation	0
Equipment	3	Teamwork	0
Fatigue	0	Training Issue	0
Distracted Driver/Pilot	0	Unknown	0
Horseplay	0	Weather	0
Human Error	0	Violent Patient	0
Individual Action	0	Violent Non-Patient	0
Procedure	0	Inadequate Lighting	1
Protocol	0	Other	0

Time off before beginning of shift with NME



#	Description	Lessons Learned/System Change
1	Was passenger while responding emergent to a call. Ambulance was travelling approximately 60 miles per hour in a 35 mile per hour zone. We were approaching a red light in which there was a left turn lane and two straightaways - all lanes were filled. Driver, while barely slowing, veered into the oncoming traffic's lane and proceeded to enter the intersection just as a car was also entering the lane and did not see the ambulance. Ambulance missed the other vehicle by inches.	The driver needs to slow down, stop at red lights, and be extremely cautious when entering another lane of traffic. Stricter tracking of vehicles and their speeds.
2	We were transporting a pt. code 3 and we were trying to hook up a 12 lead, capnography NC, and a NRB to the patient at the same time. The only way to achieve this was to stand. The driver was inexperienced. I only had 2 hours of sleep because of a previous call, and I was standing in the ambulance. The driver turned and hit his breaks and I was thrown into the side door entryway and would have fell if I had not grabbed the handrail in time.	Try to not stand up in the back of a moving ambulance or if absolutely necessary, stand during a straight stretch. Another possibility would be to communicate with my driver to take it easy and have my partner in the back spot me when I stand running hot or on bad roads. A centered cot would have made a big difference. I would not have had to stand up to reach the patient. A net in the front by the door would have helped me to steady myself or catch myself sooner. Wires from the 12lead, BP cuff, O2 tubing, pulse ox wires, and IV line were a distractions because it was difficult for me to safety work around the patient without disrupting any of the above.
3	A 1000 mL bag of Potassium Chloride (KCl) was recently discovered on an ambulance amongst the stored 1000mL Normal Saline bags during a routine check of the unit. KCl is not part of the services regular formulary. At this time we are still trying to determine how this potentially harmful medication made it on to one of our ambulances so as to ensure this does not inadvertently happen again. Thankfully, a diligent crew discovered the KCl bag and immediately alerted their supervisor. After a focused and deliberate examination we have currently not found any other bags of KCl in our supply chain. A week after this discovery we were made aware of an identical situation occurring approximately 3 months earlier on a different unit in another area. That event was not reported on at that time. An investigation in to both events has not yielded any answers in to how the KCl got in to our regular supply chain.	This event highlights several key elements: - The importance of deliberate and formal unit checks of equipment and medications. - It is extremely important that frontline crews report any identified threats to patient safety immediately. - EMS services should develop formal communication plans for emergent notification of issues. This should include Senior Leadership and frontline service providers as well as a fan out to other services when immediate actions are required. We do not know how the KCl bags have entered our supply chain. We are considering 3 possibilities right now: 1. The KCl is left over from a transfer and inadvertently tossed back in with the NaCl. 2. The crews are re-stocking off a cart in the hospitals or UCC's and accidently picking up a KCl instead of a NaCl. 3. The KCl is accidently being supplied to EMS from our supply chain or maybe even a supplier. Crews should be encouraged to always stock their units through regular supply processes and should not take items from facilities.

#	Description	Lessons Learned/System Change
4	Injury occurred - taken care of timely as far as documentation and treatment. Sprained ligament of left foot after rolling ankle on apparatus step off "running board". Missed five days of work.	Look before leaping... Was returning radio to truck, turned around and stepped off the second step down too quickly in a turning motion The truck is very large too many steps or not enough.
5	The procedure for obtaining blood glucose from a [manufacturer] safety needle involves first removing the cap, which covers the side of the device opposite the needle. Unfortunately, twisting this in the wrong way can easily cause the needle to slip out of the protective plastic sheathing.	Training - When these needles were placed in service they were so similar to the previously used catheters that no training was done. This ended up being a mistake as training might have prevented this incident. Equipment - [manufacturer] Safety Catheters might consider sealing the open slit in the bottom of the protective plastic that shields the needle. Procedure - By pinching the "handle" of the needle the cap can be removed easily which eliminates risk of the needle slipping out of the protective plastic.
6	My partner was walking out of the EMS doors into the EMS bay and an ambulance came up extremely close to the building. The squad was traveling at an excessive speed without lights or sirens and my partner never looked when he stepped out. I grabbed my partner's shirt and pulled him back. He almost walked right in front of the truck and got hit. He was inches away from the squad when they went by.	Do not trust that other trucks will see you, always have your partners back (literally) and always watch where you are walking. Have the trucks all pull in the bay the same direction at the hospital. Also, everyone drive with a responsible speed.
7	Crew was called to a sick person call. Patient began to become violent and crew fled the scene. During them leaving a crowbar was thrown threw the back window smashing it.	Leave the scene as soon as the situation escalates. Premise history and sending Police.
8	The patient was in police custody and had restraints as well as a "spit hood" on his head. When we refused to remove the cuffs or hood and explained it was for our safety the patient grew upset. I went to lift the stretcher into the ambulance and the patient kicked me in the face with a shoed foot. The patient had already been in an altercation with the police and was in custody for resisting arrest after domestic violence incident while intoxicated.	Be more cautious with an agitated patient and not leaving myself open to an opportunity for them to assault my partner or me. Have a law enforcement officers present to help mediate the situation quickly as there was not an officer close by. None that I can think of as this is outside what the system can monitor and enforce. Unless more law enforcement just transport these types of patients to the hospitals, but that will leave more liability upon them if something happens and the patient needs medical assistance.

#	Description	Lessons Learned/System Change
9	Called to scene of suicidal patient. Law Enforcement sent 7 squad cars and crew was cleared to go into residence. Once inside, patient eventually allowed brief assessment but then picked up a coffee table and almost threw at crew and officers inside. Patient was then calmed down and was escorted outside to ambulance. While near ambulance, patient swung around and was a able to grab an officer's holstered handgun. Patient was then taken down by LE and subdued without incident or injury to any party. Patient was restrained in ambulance using 4-point soft restraints and transported. Patient calm while enroute but then became very combative once in ER.	Even though law enforcement cleared scene as "safe" and crew initially staged a block away, it obviously was not safe to go in. This law enforcement group is experienced and surprised us with the lack of protection for patient and crew. 1) Even though scene is deemed safe, always assume it is not. 2) Request law enforcement physically restrain and cuff patient once there is a demonstration of violent intention, e.g., the coffee table. 3) Use chemical restraint, that's what it's for. Would have prevented additional issues in ambulance and at ER. 4) Ensure this address is flagged in CAD system for future responses. Training on appropriateness of scene safety, violent patients, and use of Geodon early.
10	Called to patient not breathing. Ambulance was improperly stocked with required supplies that could have possibly been detrimental to the outcome.	Properly stock and equip ambulance with required equipment.
11	While with a diabetic patient that was having seizures, Etomidate was drawn up and administered instead of D50. Medic who drew this medication up did not verify the drug prior to administering it.	Always check the 5 R's, Right Patient, Right drug, Right dose, Right route, Right time. We stressed this fact that if they had double-checked the bottle most likely this would not have happened. Our D50 and Etomidate come in a vial and both have blue tops on them, although the D50 is much bigger they are somewhat similar. We will in the future put a red label on the Etomidate over the cap and the D50 we will tape a 60cc syringe to it to better identify the medication.

Appendix

C

CALENDAR YEAR 2014

EMS Patient Safety Event Report

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

Welcome!

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

This is an aggregate report of the patient safety events reported to E.V.E.N.T. in the calendar year of 2014. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

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

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

This is the aggregate Patient Safety E.V.E.N.T. summary report for calendar year 2014.

PROVIDED BY:

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada
Chefs Paramédics du Canada

NATIONAL EMS MANAGEMENT ASSOCIATION

NAEMT

NASEMSO

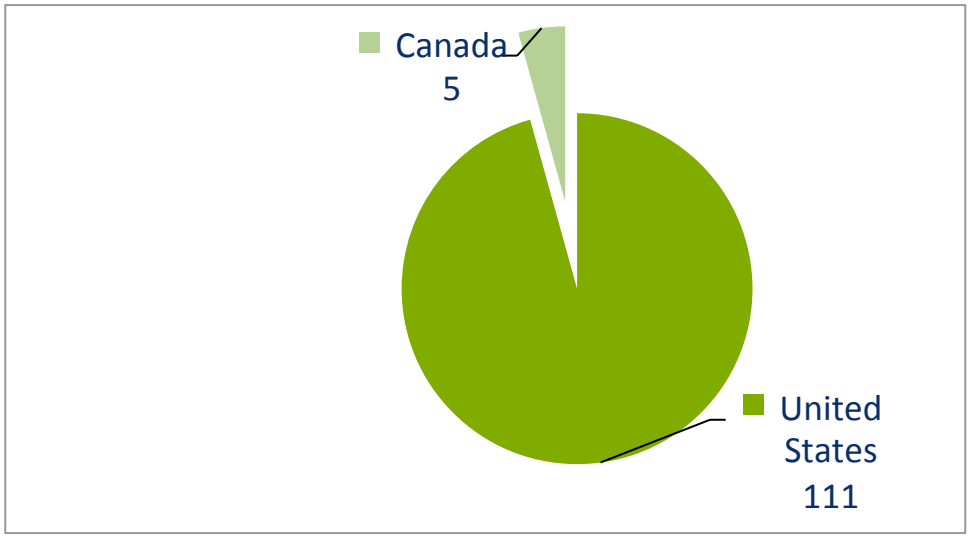
Patient Safety Event Reports Sorted Quarterly

	2012	2013	2014
Jan - Mar	6	31	30
Apr - Jun	9	39	32
Jul - Sep	13	35	24
Oct - Dec	6	32	30
Total	34	136	116

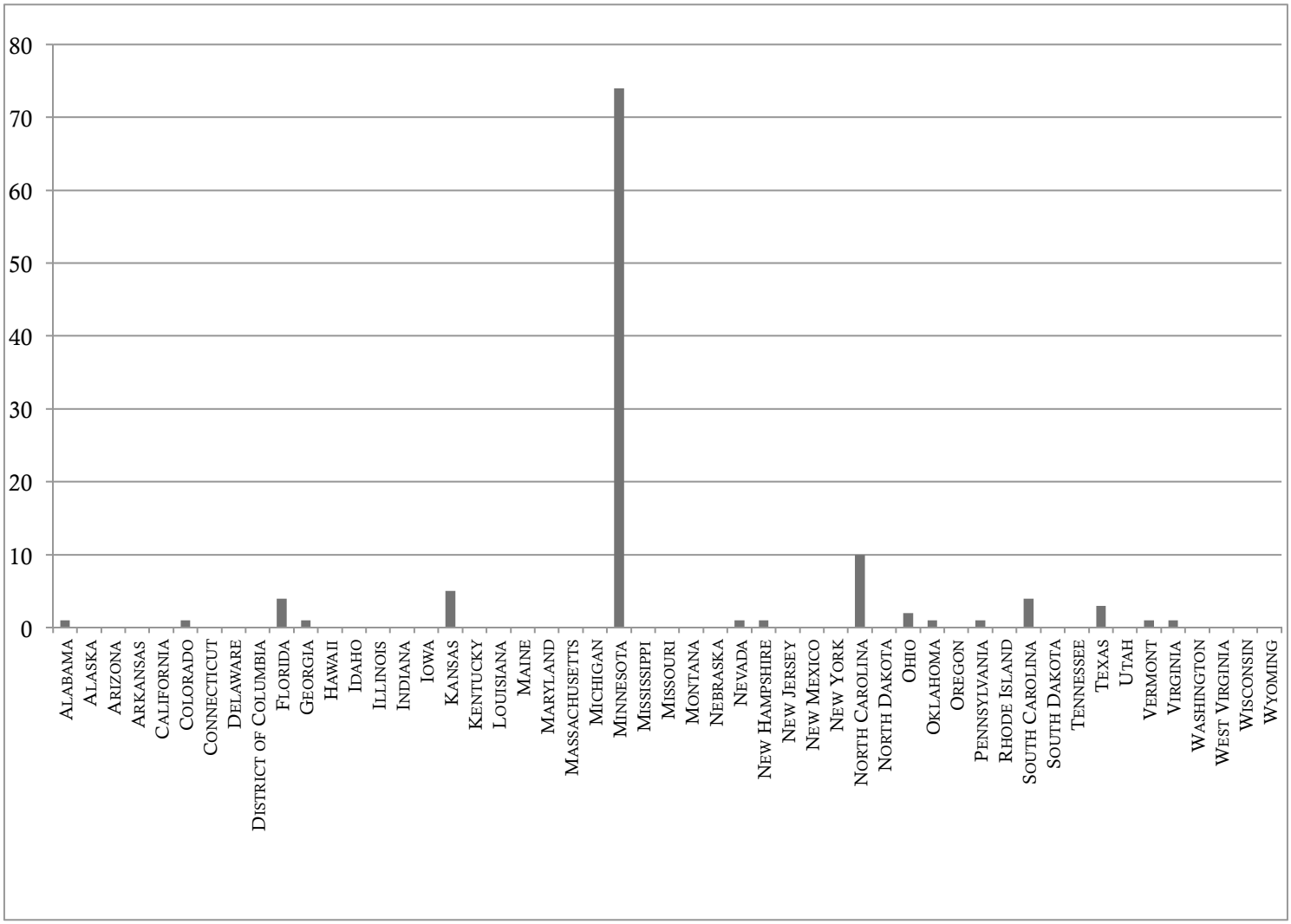
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

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

Quarterly Patient Safety Events by Country



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



Many of our reports this year have been generated from Minnesota. Thanks to the Minnesota agencies and practitioners for supporting this body of knowledge! Alabama, Colorado, Florida, Georgia, Kansas, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Vermont and Virginia were also contributors this year. If your EMS agency has an internal reporting system for patient safety events, we encourage you to have your staff member that receives those reports to also enter them into our anonymous system.


Alabama Emergency Medical Technicians Association


NAEMSP


CAAHEP


CECBEMS


CoAEMSP


HGH EMS
RESCUE


IEMSA
IOWA EMERGENCY MEDICAL SERVICES


NAED
National Academies of Emergency Dispatch


American College of Emergency Physicians
ADVANCING EMERGENCY CARE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National Registry of Emergency Medical Technicians
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national organization of state offices of rural health


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NATIONAL VOLUNTEER FIRE COUNCIL
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Supporting Those Who Serve


DEPARTMENT OF SAFETY
EMERGENCY MEDICAL SERVICES


VOLUNTEER AMBULANCE & RESCUE ASSOCIATION INC.
NEW YORK STATE


NORTH DAKOTA
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North Central
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Oregon
EMS Association
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SOUTH CAROLINA
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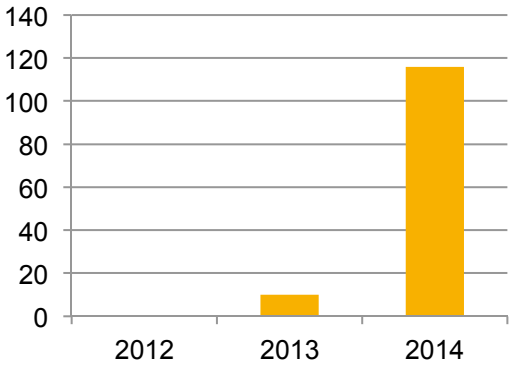
VFIS
A Division of Glatfelter Insurance Group


Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

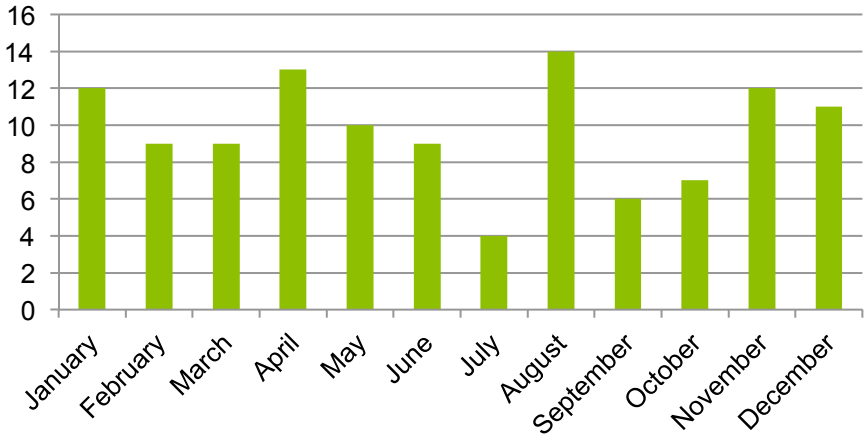

AAMS


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

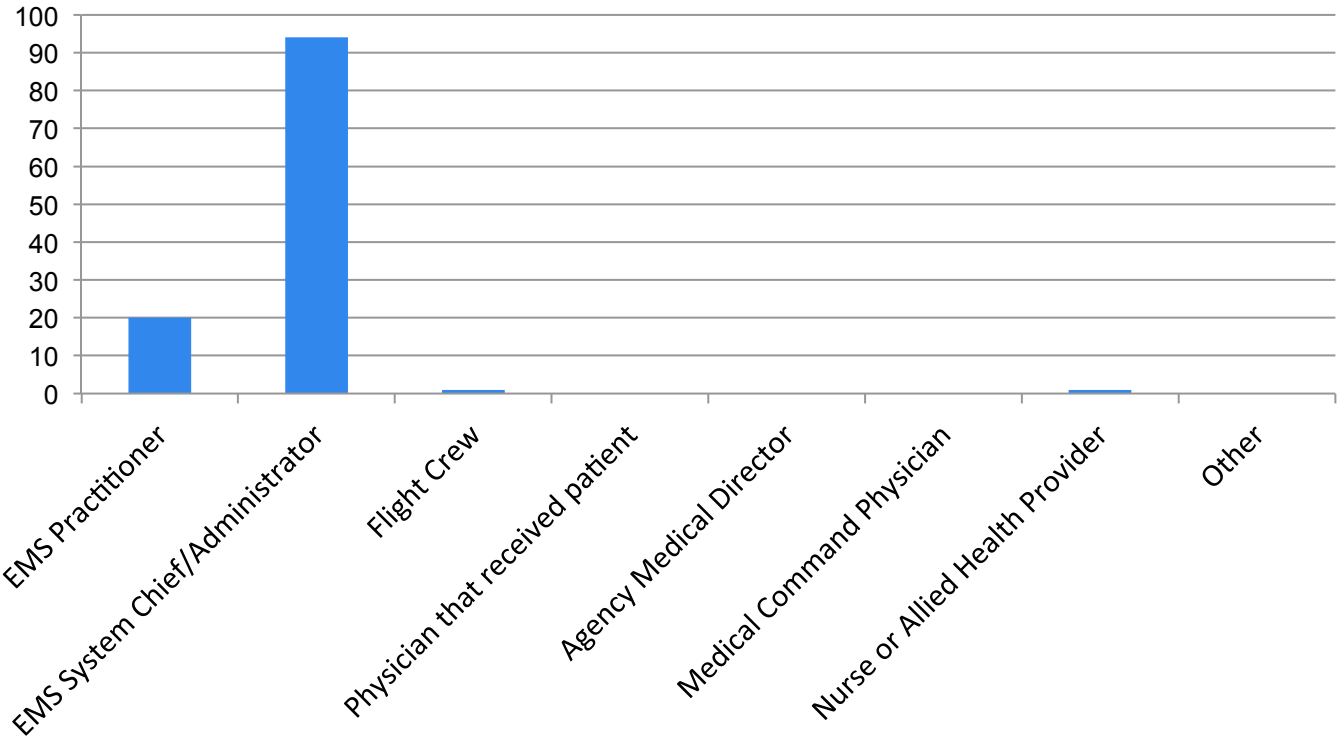
Year Reported Patient Safety Event Occurred



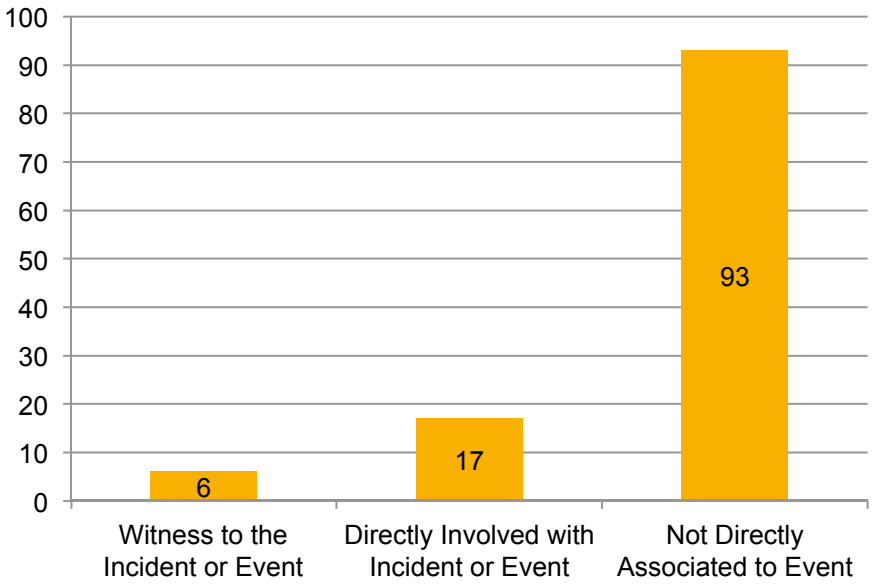
Month of Reported Patient Safety Event



Role of Person Reporting Incident

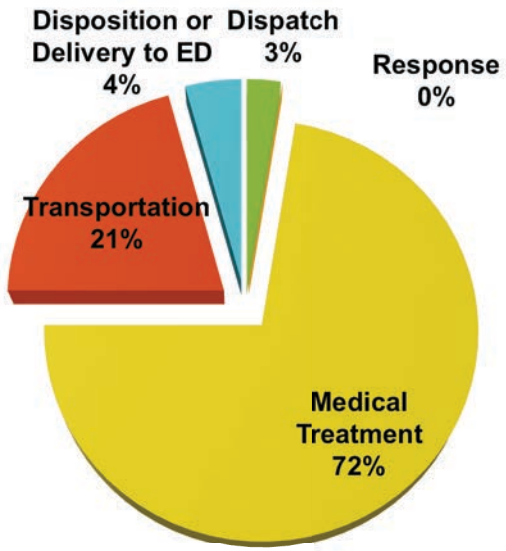


Involvement in Safety Event

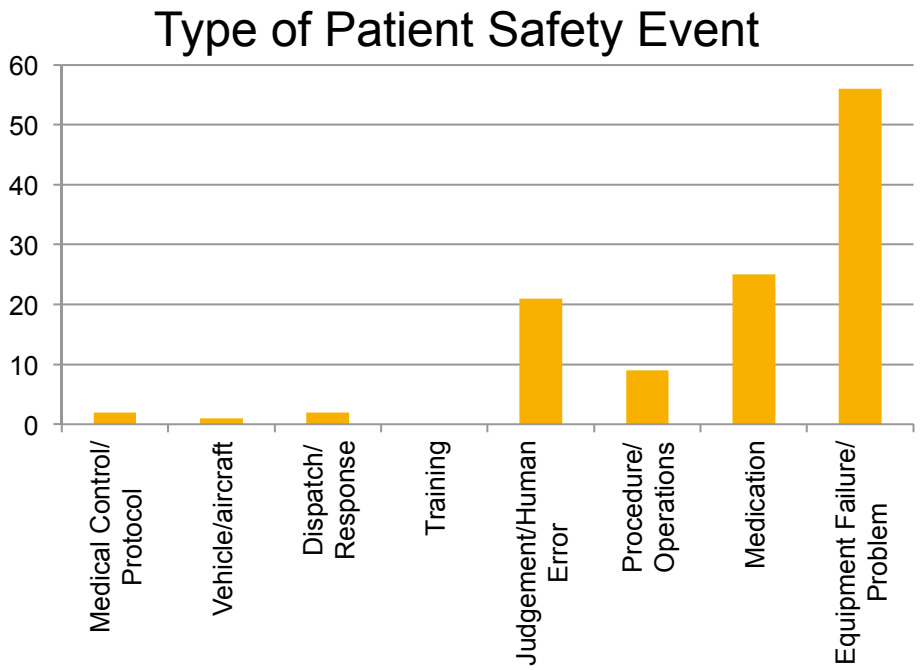


The reporters from this period are generally “not directly associated to the event”. The EMS system administrator dominates the “not directly associated” group.

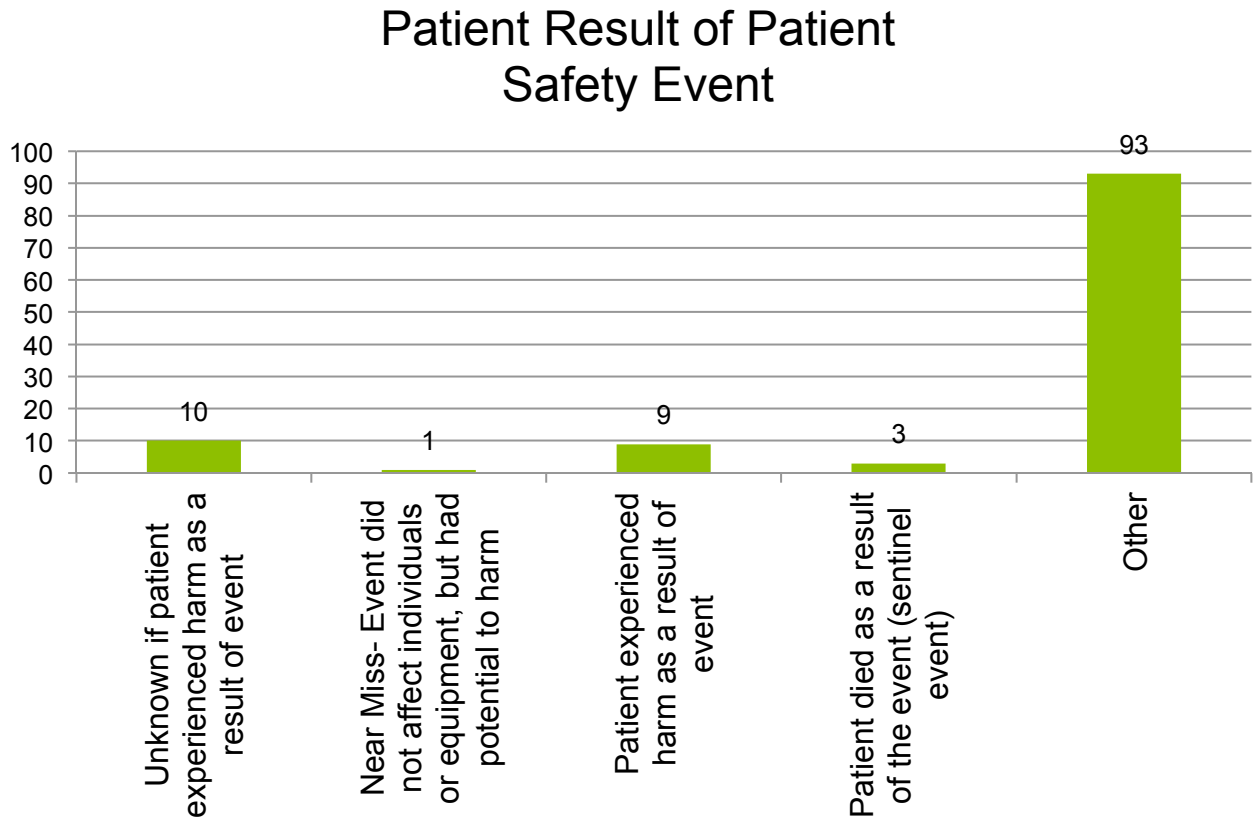
Category of Event



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



Equipment failures dominated the type of event, followed by medication event. Clinical judgment or human error, medical control, vehicle, dispatch and procedure events were also reported.



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

Appendix

D

CALENDAR YEAR 2014

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

Welcome!

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

This is an aggregate report of the provider violence events reported to E.V.E.N.T. for calendar 2014. We want to thank all of our organizational site partners. For a complete listing of site partners, see page 4.

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

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

This is the aggregate Provider Violence E.V.E.N.T. summary report for Calendar Year 2014.

PROVIDED BY:

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

IN PARTNERSHIP WITH:

North Central EMS Institute

Paramedic Chiefs of Canada / Chefs Paramédics du Canada

National EMS Management Association

NAEMT

NASEMSO

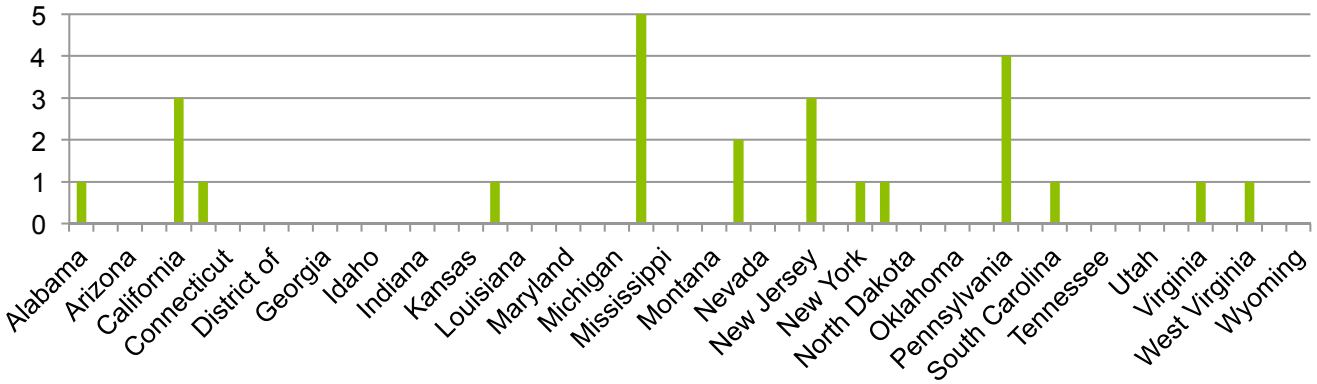
Table 1: Violence Events Quarterly

	2012	2013	2014
Jan - Mar	1	6	11
Apr - Jun	0	9	5
Jul - Sep	9	27	5
Oct - Dec	11	9	5
Total	21	51	26

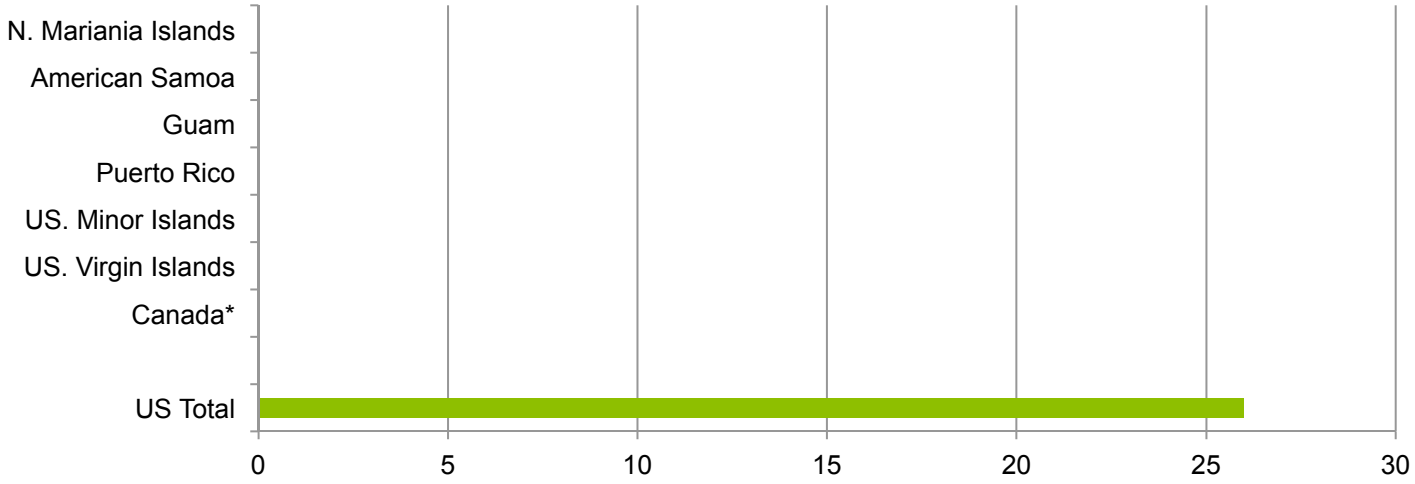
As you review the data contained in this report, please consider helping us advertise the availability of the report by pointing your colleagues to www.emseventreport.com.

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

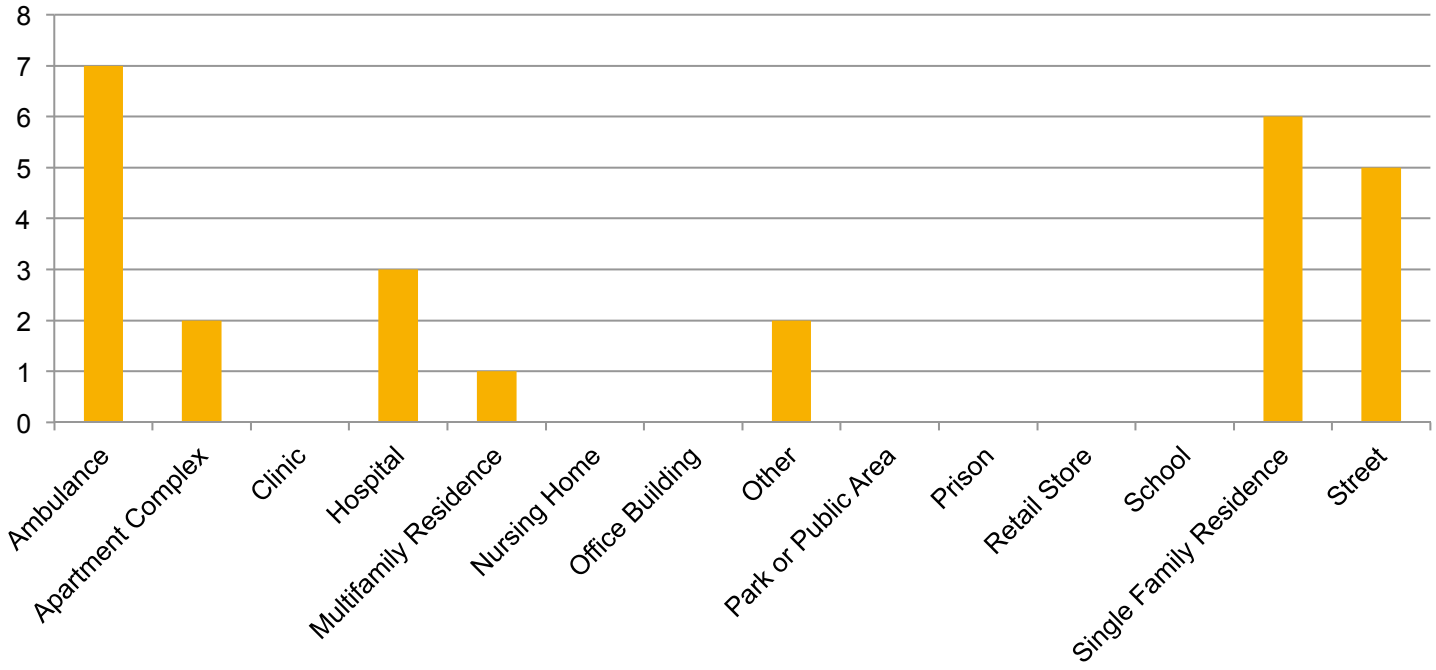
Violence Events by State (United States of America)



Quarterly Violence Events in Canada and U.S. Territories



Place Violence Occurred

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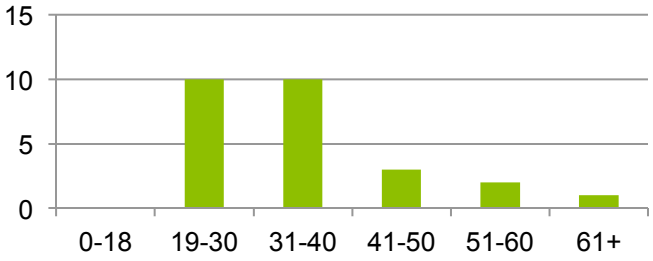
Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

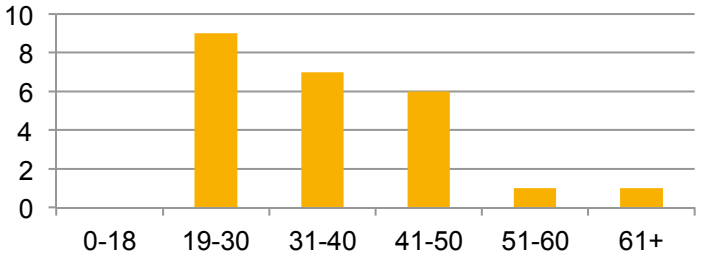

AAMS


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

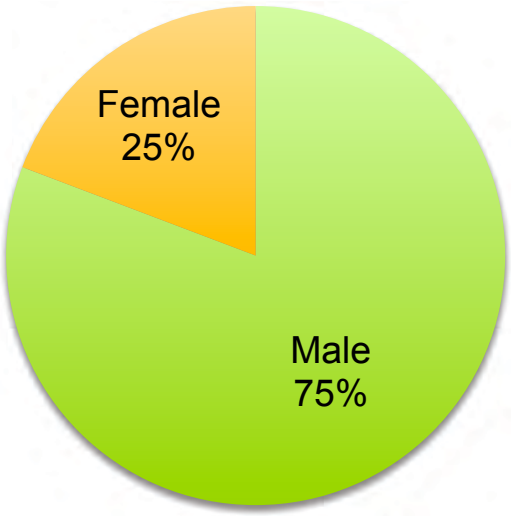
Victim Age



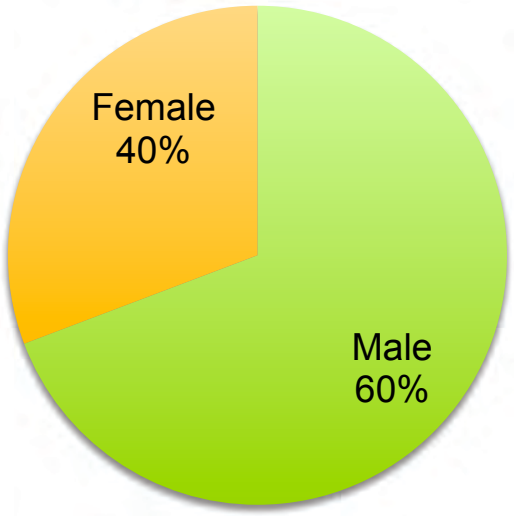
Assailant Age



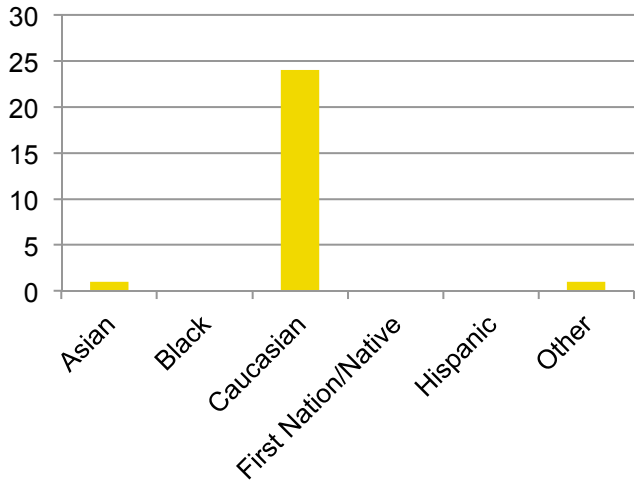
Victim Gender



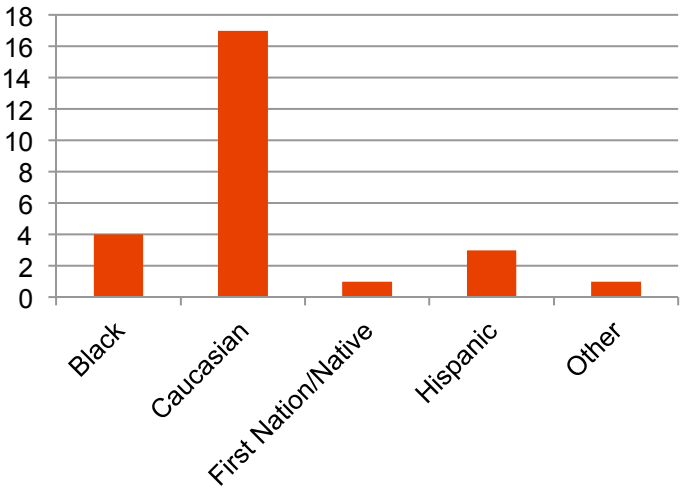
Assailant Gender



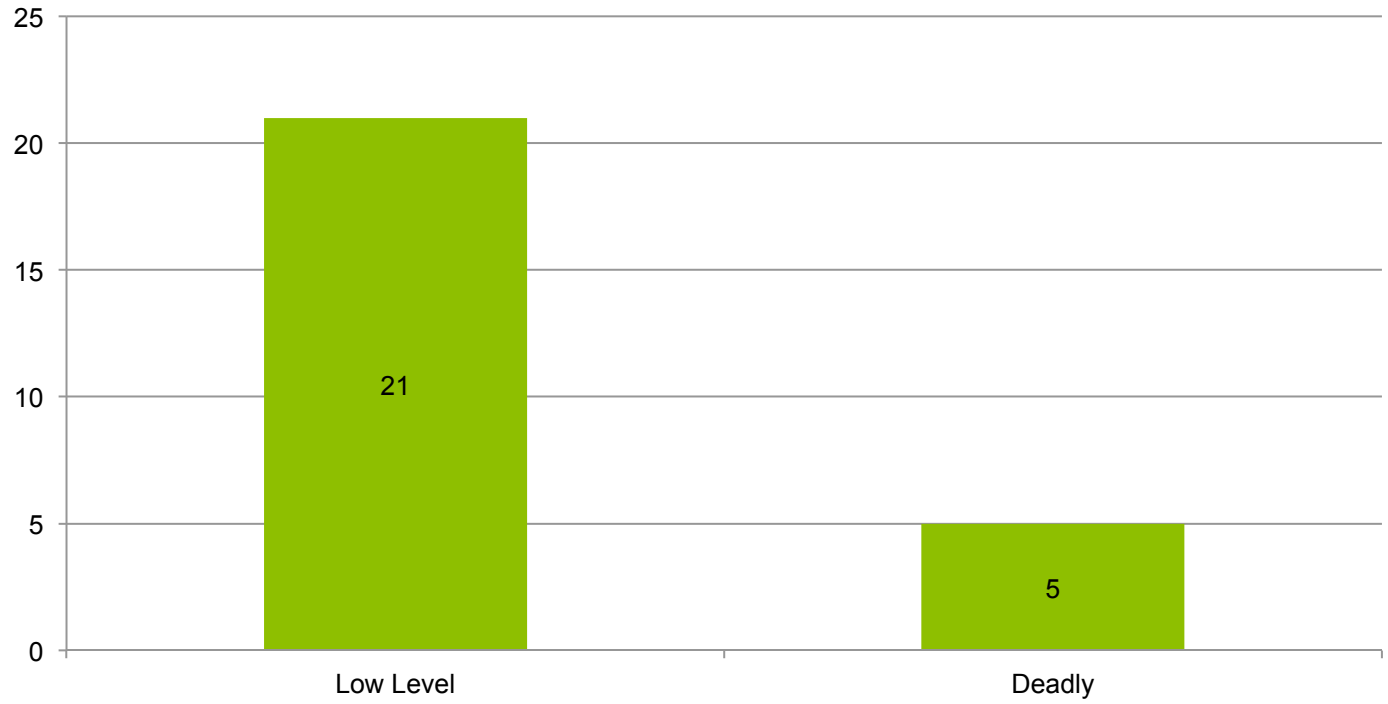
Victim Race



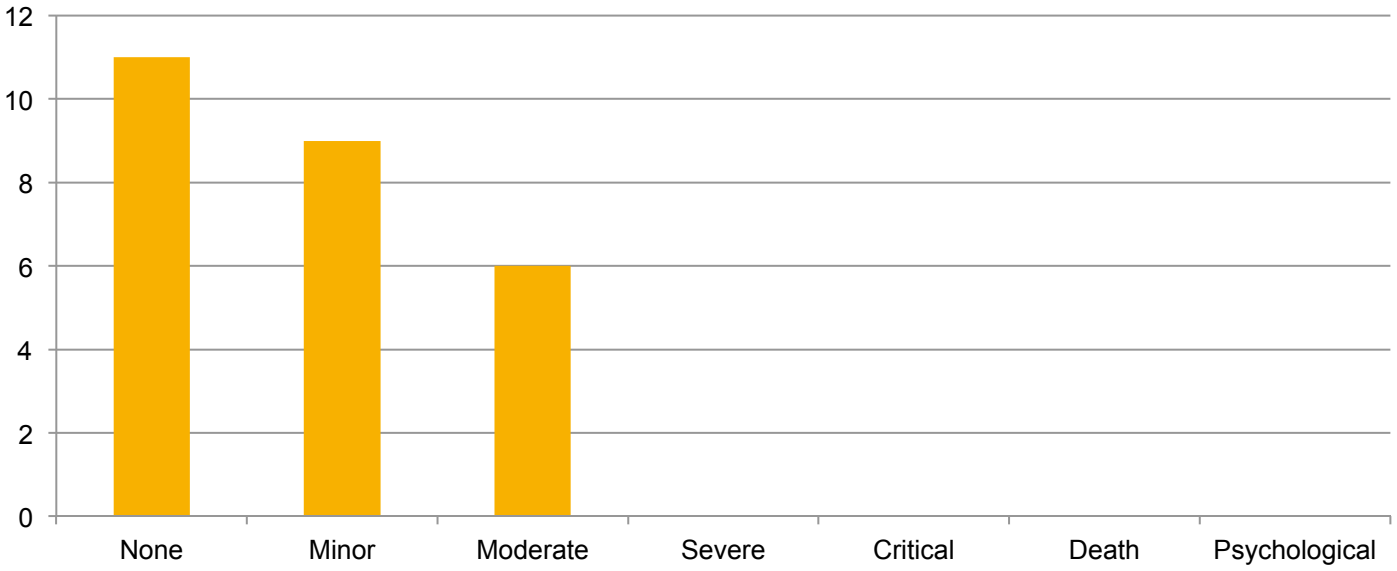
Asssailant Race



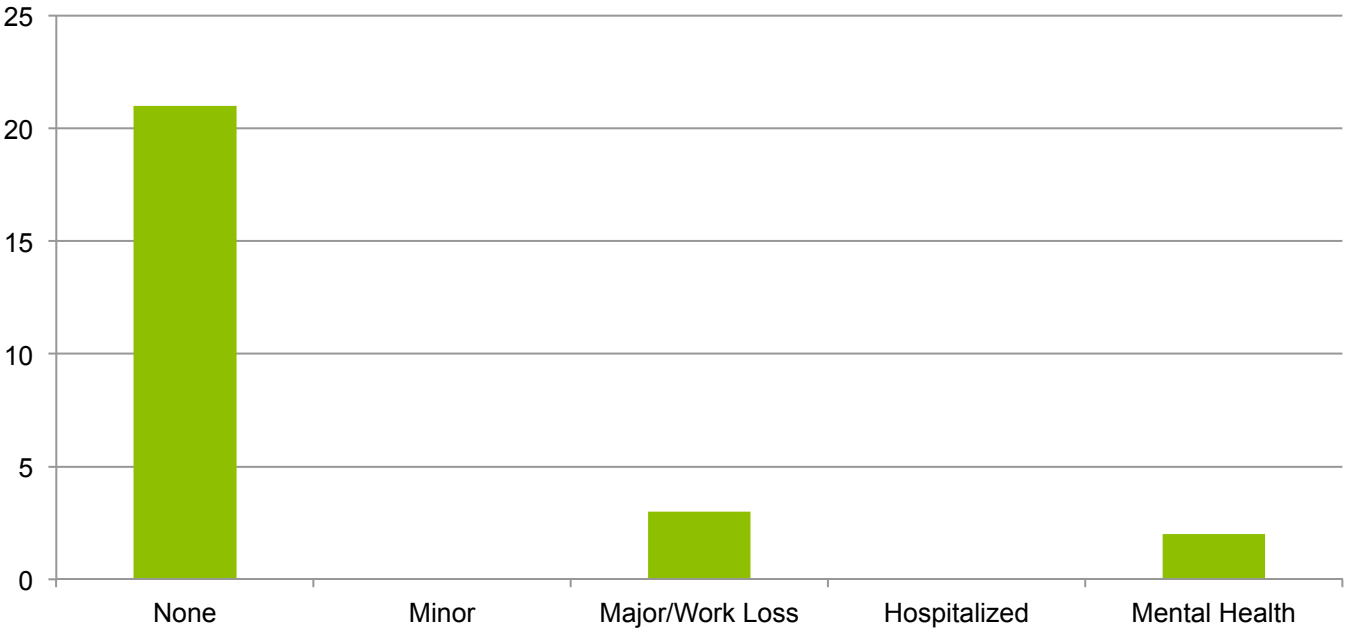
Paramedic's Perception of Harm



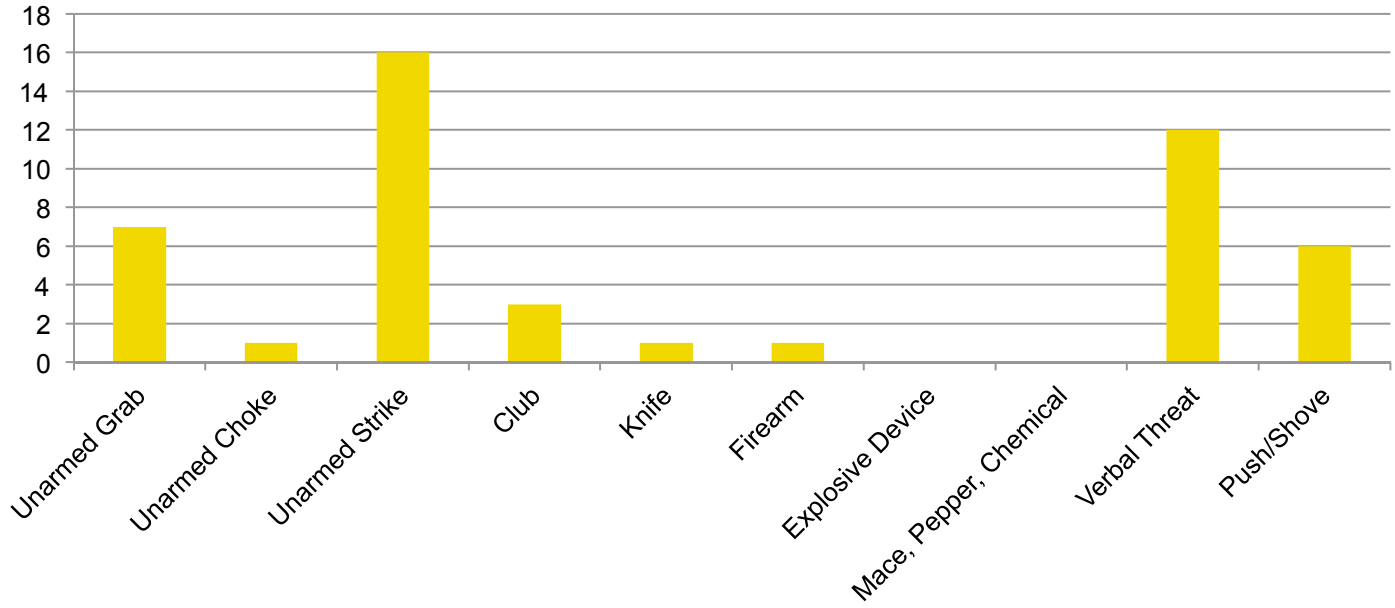
Type of Victim Injury



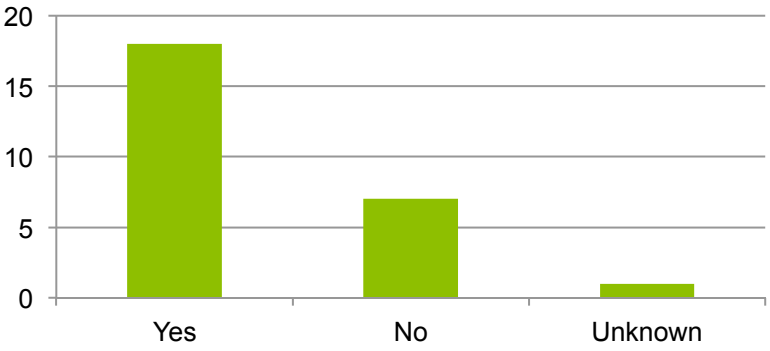
Type of Victim Treatment



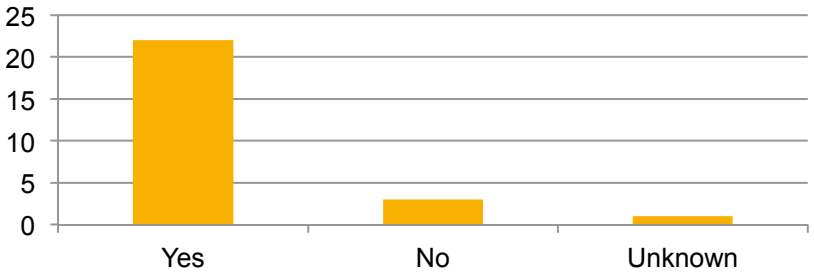
Method of Assault
Note: Multiple Options Reported



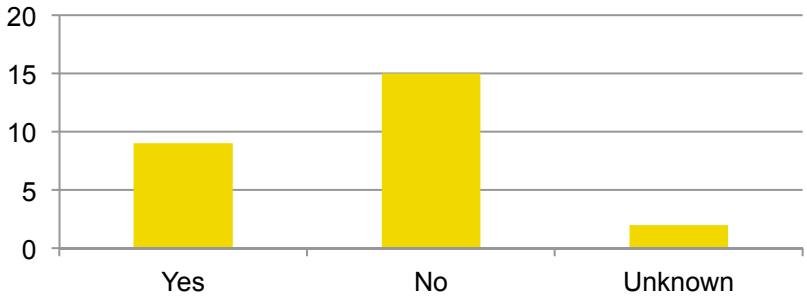
Internal Agency Report Filed



Law Enforcement Present or Notified



Assailant Arrest



Appendix

E

☒ **Committee Motion:**	**Name:**	Training And Certification Committee
☐ **Individual Motion:**	**Name:**	

Motion:

The Training and Certification committee moves to accept the continuing education structure as exemplified in the attachment.

EMS Plan Reference (include section number):

12VAC5-31-1419. Continuing education programs.
The programs must utilize the approved format for the corresponding level of certification as designed by the Office of EMS:
1. Category 1 (required) are topic areas that are required as part of the recertification criteria.
2. Category 2 (approved) are topic areas that support EMS activities.
3. Category 3 are topic areas that are delivered through a multimedia format as approved by the Board of Health.
2.2.1 - Ensure adequate, accessible, and quality EMS provider Training and continuing education exists in Virginia.
2.2.4 Align all initial EmS education programs to that of other allied helath professions to promote professionalism of EMS.

Committeee Minority Opinion (as needed):

None submitted.

For Board's secretary Use only:

Motion Seconded by:				
Vote:	**By Acclamation:**	☐ **Approved**	☐ **Not Approved**	
	By Count	**Yea:** ☐	**Nay:** ☐	**Abstain:** ☐

BLS Recertification Requirements

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

804-888-9120

Area #	Required Topics (Category 1) National Continued Competency Requirements (NCCR)	Hours Required EMR	 EMT
Airway, Respiration and Ventilation			
11	Ventilation		3.0
12	Oxygenation		1.0
13	Post-Resuscitation Care		0.5
14	Ventricular Assist Devices (VADs)		0.5
15	Stroke		1.0
16	Pediatric Cardiac Arrest (Lecture)		1.0
17	Pediatric Cardiac Arrest (Skills)		1.0
18	Chest Pain From Cardiovascular Disease		1.0
19	Cardiac rate disturbance (Pediatric)		1.0
Trauma			
20	Central Nervous System (CNS) Injury		0.5
21	Tourniquets		0.5
22	Field Triage		1.0
Medical			
23	Special Healthcare Needs		1.0
24	OB Emergencies		1.0
25	Communicable Diseases		0.5
26	Psychiatric & Toxicology Emergencies		1.0
27	Endocrine		1.0
28	Immunologic Diseases		1.0
Operations			
29	At-Risk Populations		0.5
30	Pediatric Transport		0.5
31	Affective Characteristics		0.5
32	Role of Research		0.5
	TOTAL CATEGORY 1 (NCCR)HOURS	8	20
	Flexible Topics (Category 2) **Local Continued Competency Requirements (LCCR)** **Individual Continued Competency Requirements (ICCR)**		
	TOTAL CATEGORY 2 (LCCR/ICCR)HOURS	8	20
	TOTAL HOURS	16	40

Illustration of New Proposed CE Structure

Virginia ALS Continuing Education Requirements – All Levels

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

804-888-9120

AREA #	DIVISION HOURS PER CERTIFICATION LEVEL			NCCR Section 1A—Mandatory Core Content
	Paramedic E	Intermediate I	AEMT C	Airway, Respiration, Ventilation
40	2	2	3	Artificial Ventilation
41	1	1	0	Capnography
42	1	0	0	Advanced Airway Management in the Perfusing Patient
				Cardiovascular
43	2	2	0.5	Post-Resuscitation Care
44	0.5	0.5	0	Ventricular Assist Devices (VADs)
45	1.5	1.5	1	Stroke
46	2	2	0.5	Cardiac Arrest
47	0.5	0.5	0	Congestive Heart Failure
48	2.5	2.5	2	Pediatric Cardiac Arrest
49	1	1	0	Acute Coronary Syndrome
50	0	0	1	Chest Pain from Cardiovascular Disease
51	0	0	1	Cardiac Rate Disturbance
				Trauma
52	2	1	0.5	Central Nervous System (CNS) Injury
53	0.5	0.5	0.5	Tourniquets
54	1	1	1	Field Triage
55	0.5	0.5	0	Fluid Resuscitation
				Medical
56	2	2	0.5	Special Healthcare Needs
57	1	1	1	OB Emergencies
58	1	1	1	Communicable Diseases
59	1	1	0	Medication Delivery
60	1	1	0	Pain Management
61	1	1	0.5	Psychiatric Emergencies
62	0	0	1	Toxicological Emergencies
63	0	0	1	Endocrine
64	0	0	1	Immunological Diseases
				Operations
65	1	1	1	At-Risk Populations
66	0.5	0.5	0.5	Pediatric Transport
67	0.5	0.5	0.5	Culture of Safety
68	1	1	1	Affective Characteristics
69	1	1	0	Crew Resource Management
70	1	1	1	Role of Research
	30	***28***	***20 +5***	**MANDATORY CORE CONTENT TOTAL**
	30	**28**	**20**	**NCCR HOURS REQUIRED PER LEVEL**
			5	**Additional NCCR hours from Paramedic List**
	30	**27**	**25**	**LCCR + ICCR Hours**
	60	**55**	**50**	**TOTAL HOURS REQUIRED PER LEVEL**

The National Continued Competency Program: The "New" Recertification Model

Since the 1980s, national EMS recertification has consisted of 72 clock hours of continuing education for each nationally certified EMS provider level. Recently, the EMS community across the nation has been changing entry requirements with the adoption of the new National EMS Scope of Practice and implementation of the EMS Education Guidelines. Because entry level requirements have changed, it was necessary to evaluate continued competency requirements.

In 2012, the NREMT introduced a new recertification model, the National Continued Competency Program (NCCP). Constructed using methodology similar to that of the American Board of Medical Specialty requirements, the new NCCP model streamlines the recertification process into three strategic categories of continuing education: National, Local, and Individual.

The NCCP offers numerous improvements that will impact EMS for the better for years to come. These changes allow a platform for evidenced-based medicine to reach EMS professionals all over the country, give state and local agencies the freedom to dictate a portion of the recertification requirements and provide a foundation for the EMS professional to embrace life-long learning through self-assessment.

The national component of the NCCP will constitute 50% of the new recertification requirements at each level and will replace the traditional DOT refresher. Topics will be updated and will reflect current trends in evidence-based medicine, scope of practice changes and position papers from numerous associations involved with EMS research. It will also focus on those patient presentations that have a low frequency but high criticality. The national component will be developed by a panel of experts assigned by the NREMT Board of Directors and will be updated every five years. After content has been selected, educational materials will be developed and disseminated to training officers, medical directors and program directors free of charge.

The local component of the NCCP will constitute 25% of the new recertification requirements at each level. The requirement for these hours will be decided by local entities, including the state, region or agency. These topics can include state or local protocol changes, tasks that require remediation based on QA/QI and topics chosen from run reviews. The local component allows national recertification requirements to be adapted to the needs of the state and local agencies. Methods to provide current continuing education such as monthly training, conferences, and in-service training will stay the same.

Finally, the individual component of the NCCP will constitute the last 25% of the new recertification requirements at each level. Within this component, an individual is free to take any EMS-related education. New to this recertification model will be a self-assessment tool. This self-assessment tool will provide feedback and recommendations for individual learning needs for the next recertification period.

As a result of the new NCCP recertification model, the total continuing education hours needed to recertify a national EMS certification have been reduced for EMTs, AEMTs and Paramedics (Table 1). As this model is implemented throughout the country, more information regarding the transition to the new recertification model will be provided.

Table 1. NCCP CE Hour Requirements by Level (Every 2 Years)

	National (50%)	Local (25%)	Individual (25%)	Total Hours
Paramedic	30	15	15	60
AEMT	25	12.5	12.5	50
EMT	20	10	10	40
EMR	8	4	4	16

Appendix

F

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

NREMT Initial Certification Fees effective January 1, 2017

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

NREMT Initial Certification Fees effective January 1, 2017

NREMT Level	Current Fees	Fees Effective 1/1/17	Change
EMR	$65	$75	$10
EMT	$70	$80	$10
AEMT	$100	$115	$15
Intermediate/99	$100	$125	$25
Paramedic	$110	$125	$15

If you have any questions please contact the NREMT at 614-888-4484.

Appendix

G

Virginia Trauma System Overview

Gary P. Critzer, NRP, CCEMTP
Chair, State EMS Advisory Board
Director
Department of Emergency Management and EMS
City of Waynesboro

Robin Pearce MSN, RN-BC
Trauma/Critical Care Coordinator
Virginia Department of Health's
Office of Emergency Medical Services

In the beginning…

- *Accidental Death and Disability: The Neglected Disease of Modern Society* .
  - Published in 1966 by the National Academy of Sciences.
    - No government oversight.
    - No accident prevention.
    - Poor communication.
    - 50% of the ambulances were provided by morticians.
    - Only 7,000 Emergency rooms in the United States.

Milestones in Virginia's Trauma System

1968 Board of Health vested with authority to set standards for and to license EMS agencies and to certify EMS providers.

1973 Federal EMS Systems Act (Title XII of the Public Health Service Act) - addressed the development of comprehensive EMS systems nationally to improve the quality of patient care and reduce morbidity and mortality. EMS system components included:

- Facilities;
- Critical Care Units; and
- Patient Transfers.

Milestones in Virginia's Trauma System

1980 Virginia's Trauma Center Designation process was initiated.

1981 First Level I trauma center designated.

1986 HJR No. 65 established a joint subcommittee to study the needs of Virginia's trauma care system including, but not limited to, trauma data collection, trauma triage, evaluation and research, and the economic impact of trauma.

Milestones in Virginia's Trauma System

1997 Trauma triage protocols initiated.

2004 JLARC Study "The Use and Financing of Trauma Centers in Virginia" released.

2005 HRSA's State trauma system assessment piloted in Virginia.

2006 Virginia Trauma Center Fund created.

The Burden of Trauma

Injury is the leading cause of death for children and adults ages 1 – 44.

Injury is the 5th leading cause of death for all U.S. residents.

Treatment of the severely injured person at a trauma center can lower the risk of death by 25%.

Trauma has a profound effect on individuals, their families and society because of the tremendous medical, psychosocial, and financial burdens.

The Burden of Trauma

Crash-related death costs in Virginia 2005 - $863 million.

- $9 million medical costs.
- $854 million work loss costs.

A non-fatal hospitalization following a motor vehicle accident in 2010 in the United States.

- Average medical cost- $54,197.
- Average work loss cost - $119,618.

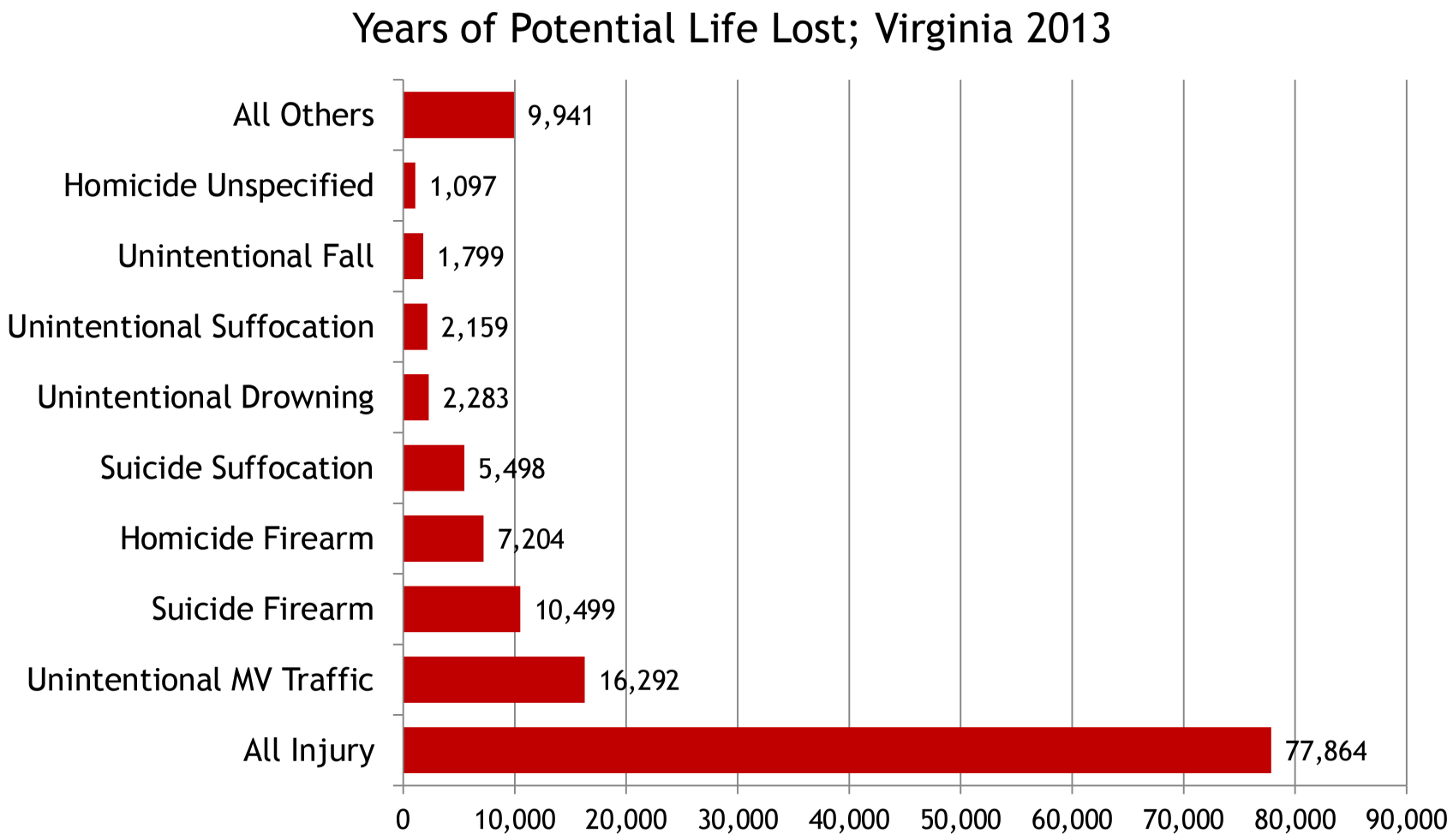
The Burden of Trauma

In 1975 993 individuals died as a result of a motor vehicle crash in Virginia.

In 2012 777 individuals died as a result of a motor vehicle crash in Virginia.

These numbers are not adjusted to account for the increase in Virginia's population or the number of vehicles on the road.

The Burden of Trauma



The Burden of Trauma

10 Leading Causes of Death by Age Group, United States – 2012

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,939	Unintentional Injury 1,353	Unintentional Injury 743	Unintentional Injury 807	Unintentional Injury 11,908	Unintentional Injury 15,851	Unintentional Injury 15,034	Malignant Neoplasms 48,028	Malignant Neoplasms 113,130	Heart Disease 477,840	Heart Disease 599,711
2	Short Gestation 4,202	Congenital Anomalies 501	Malignant Neoplasms 440	Malignant Neoplasms 472	Suicide 4,872	Suicide 6,216	Malignant Neoplasms 11,337	Heart Disease 35,265	Heart Disease 71,228	Malignant Neoplasms 403,497	Malignant Neoplasms 582,623
3	SIDS 1,679	Malignant Neoplasms 392	Congenital Anomalies 167	Suicide 306	Homicide 4,614	Homicide 4,342	Heart Disease 10,489	Unintentional Injury 20,394	Unintentional Injury 15,822	Chronic Low. Respiratory Disease 122,375	Chronic Low. Respiratory Disease 143,489
4	Maternal Pregnancy Comp. 1,507	Homicide 339	Homicide 138	Homicide 173	Malignant Neoplasms 1,574	Malignant Neoplasms 3,674	Suicide 6,758	Liver Disease 8,877	Chronic Low. Respiratory Disease 15,212	Cerebro-vascular 109,127	Cerebro-vascular 128,546
5	Unintentional Injury 1,169	Heart Disease 154	Heart Disease 67	Congenital Anomalies 160	Heart Disease 956	Heart Disease 3,231	Homicide 2,705	Suicide 8,862	Diabetes Mellitus 12,553	Alzheimer's Disease 82,690	Unintentional Injury 127,792
6	Placenta Cord. Membranes 1,018	Influenza & Pneumonia 93	Chronic Low. Respiratory Disease 63	Heart Disease 108	Congenital Anomalies 423	HIV 652	Liver Disease 2,469	Diabetes Mellitus 5,747	Liver Disease 11,230	Diabetes Mellitus 52,881	Alzheimer's Disease 83,637
7	Bacterial Sepsis 566	Septicemia 62	Benign Neoplasms 47	Chronic Low Respiratory Disease 56	Diabetes Mellitus 196	Diabetes Mellitus 646	Diabetes Mellitus 1,867	Cerebro-vascular 5,654	Cerebro-vascular 11,070	Unintentional Injury 44,698	Diabetes Mellitus 73,932
8	Respiratory Distress 504	Cerebro-vascular 56	Influenza & Pneumonia 44	Cerebro-vascular 51	Cerebro-vascular 183	Liver Disease 597	Cerebro-vascular 1,730	Chronic Low. Respiratory Disease 4,533	Suicide 6,929	Influenza & Pneumonia 43,355	Influenza & Pneumonia 50,636
9	Circulatory System Disease 492	Benign Neoplasms 55	Cerebro-vascular 34	Influenza & Pneumonia 41	Complicated Pregnancy 169	Cerebro-vascular 535	HIV 1,345	HIV 2,582	Septicemia 4,982	Nephritis 37,740	Nephritis 45,622
10	Neonatal Hemorrhage 422	Chronic Low Respiratory Disease 51	Septicemia 26	Benign Neoplasms 40	Influenza & Pneumonia 147	Congenital Anomalies 401	Septicemia 757	Septicemia 2,340	Nephritis 4,765	Septicemia 27,022	Suicide 40,600

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

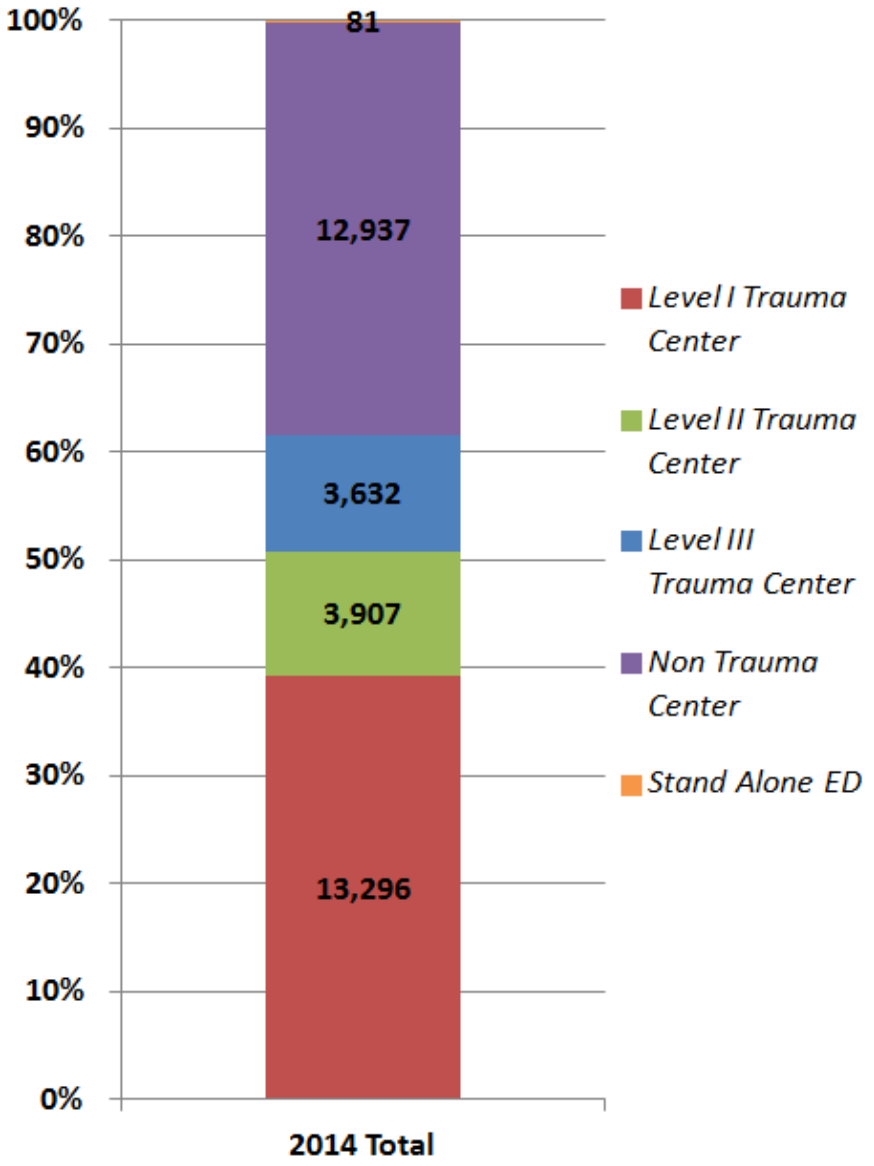
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Trauma Cases Reported during CY 2014 by Type of Facility Patient Admitted

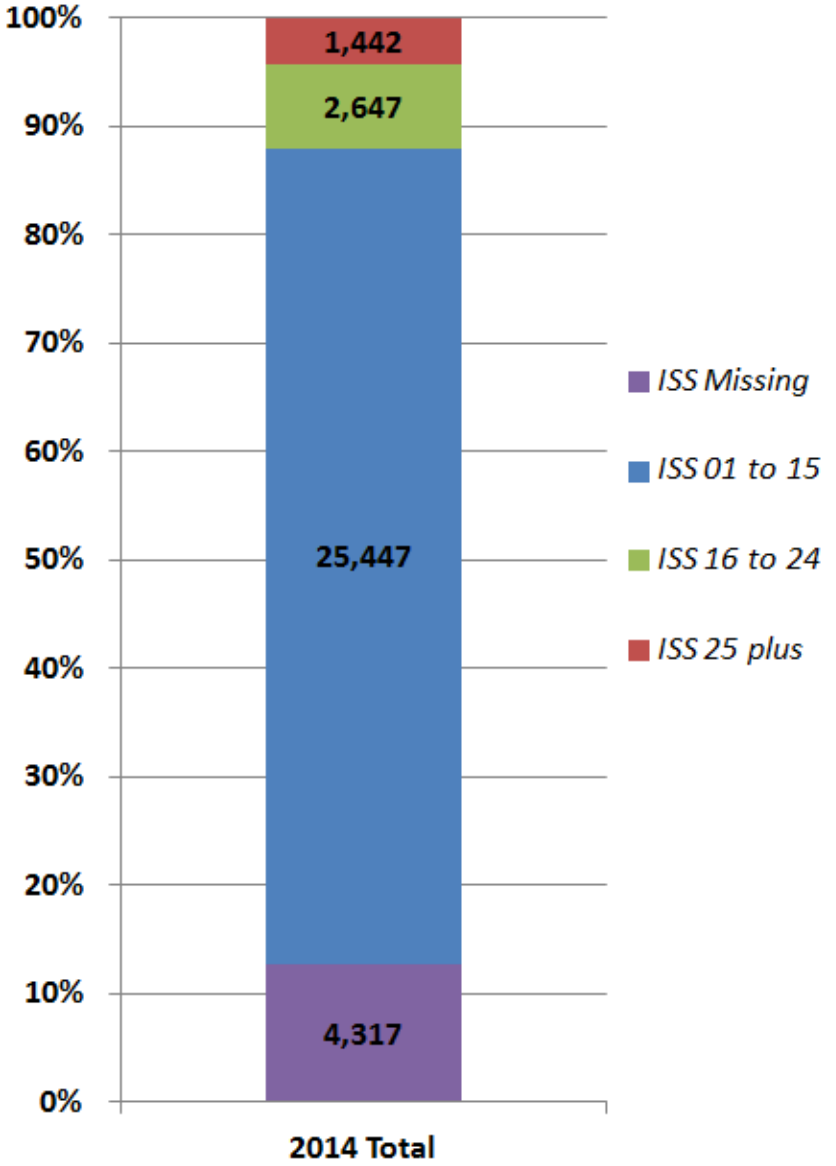
(N = 33,853)

9% of all EMS assessments

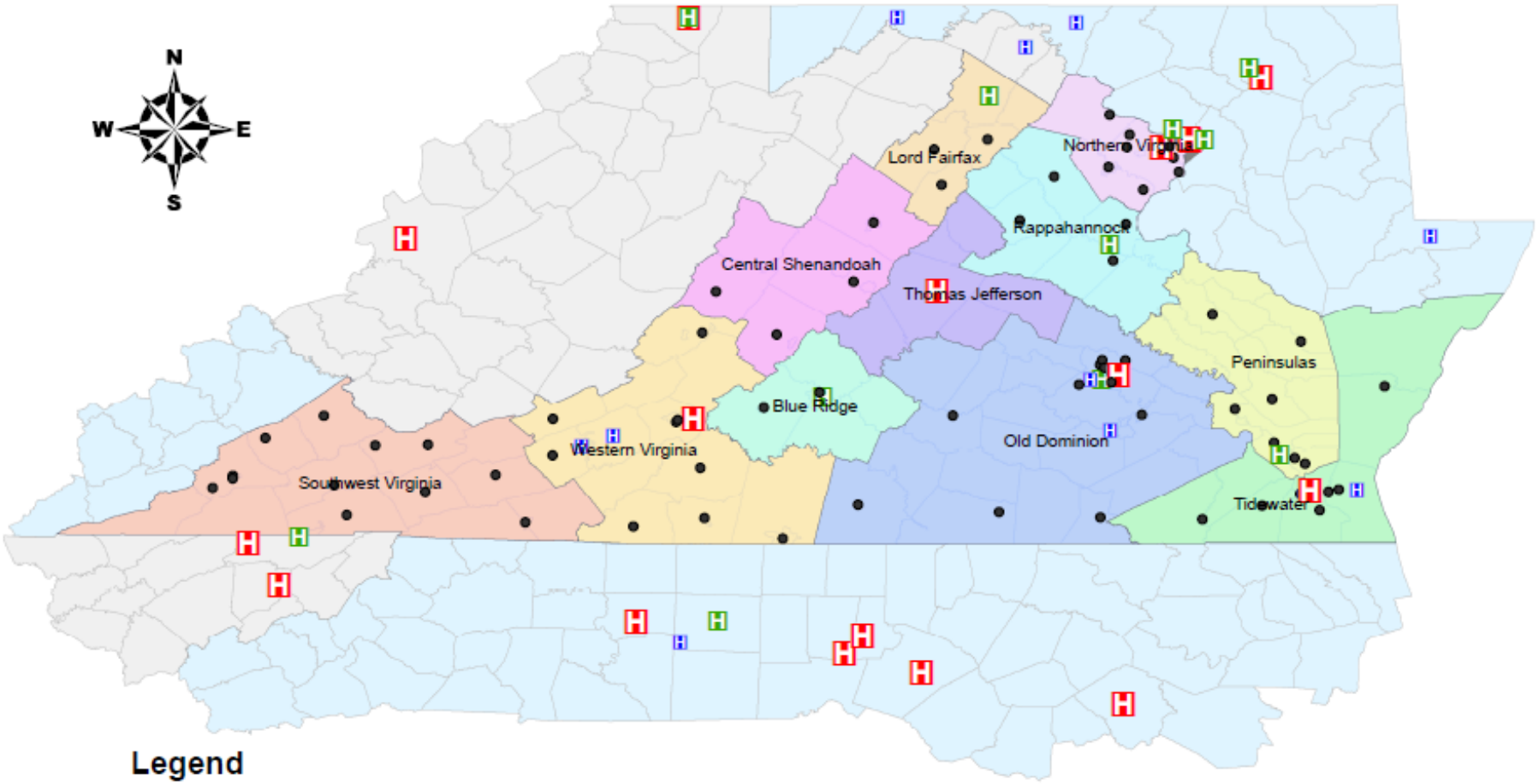


Trauma Cases Reported during CY 2014 by Injury Severity Scale (ISS) Value

(N = 33,853)



Map 1. Location of Trauma Centers and Hospitals in Virginia and Nearby Trauma Centers in Surrounding States - 2015



Legend

Hospitals

- Non Trauma Centers

Trauma Center Designation

- Level I
- Level II
- Level III

EMS Council Regions

Names of Regions

- Blue Ridge
- Central Shenandoah
- Lord Fairfax
- Northern Virginia
- Old Dominion
- Peninsulas
- Rappahannock
- Southwest Virginia
- Thomas Jefferson
- Tidewater
- Western Virginia

Components of our Trauma System

Trauma Triage

Trauma Registry

Trauma Performance and Improvement

Trauma Fund

Trauma Designation

Trauma Triage

State trauma triage plan is based on the Center for Disease Control and Prevention's *Guidelines for the Field Triage of Injured Patients*.

Criteria for this plan is developed by the Trauma System Oversight and Management Committee (TSO&MC) and approved by the State Emergency Medical Services (EMS) Advisory Board. Consultants include:

- Virginia Chapter of American College of Surgeons;
- Virginia College of Emergency Physicians;
- Virginia Hospital and Healthcare Association; and
- Prehospital care providers.

Virginia Statewide Trauma Registry

Utilized as decision support statistics for trauma system development.

Collects injury data from all hospitals in the Commonwealth.

Based upon the National Trauma Data Standard.

Data are collected on all injured patients admitted to a hospital, died in a hospital, or were required to be transferred to a higher level of care.

Trauma Performance and Improvement

Performed though out the trauma system:

- Individual pre-hospital agencies.
- Each EMS region via a performance based contract with the OEMS.
- Each trauma center has a robust PI program.
  - Most significant piece of the designation process
- TSO&MC's Trauma PI Sub-committee.
  - Looks at the system as a whole
  - Recent activities evaluating Trauma Triage located on the Virginia Town Hall and http://www.vdh.state.va.us/OEMS/Trauma/LinksDocuments.htm

Trauma System Funding

2004 – HB 1143 amended the *COV* § 18.2-270.01 and created the Virginia Trauma Center Fund.

The purpose of the Trauma Center Fund is to offset the cost to Virginia Trauma Centers associated specifically with being designated. Trauma funds focus on the readiness costs that hospitals cannot seek reimbursement for.

Trauma Designation

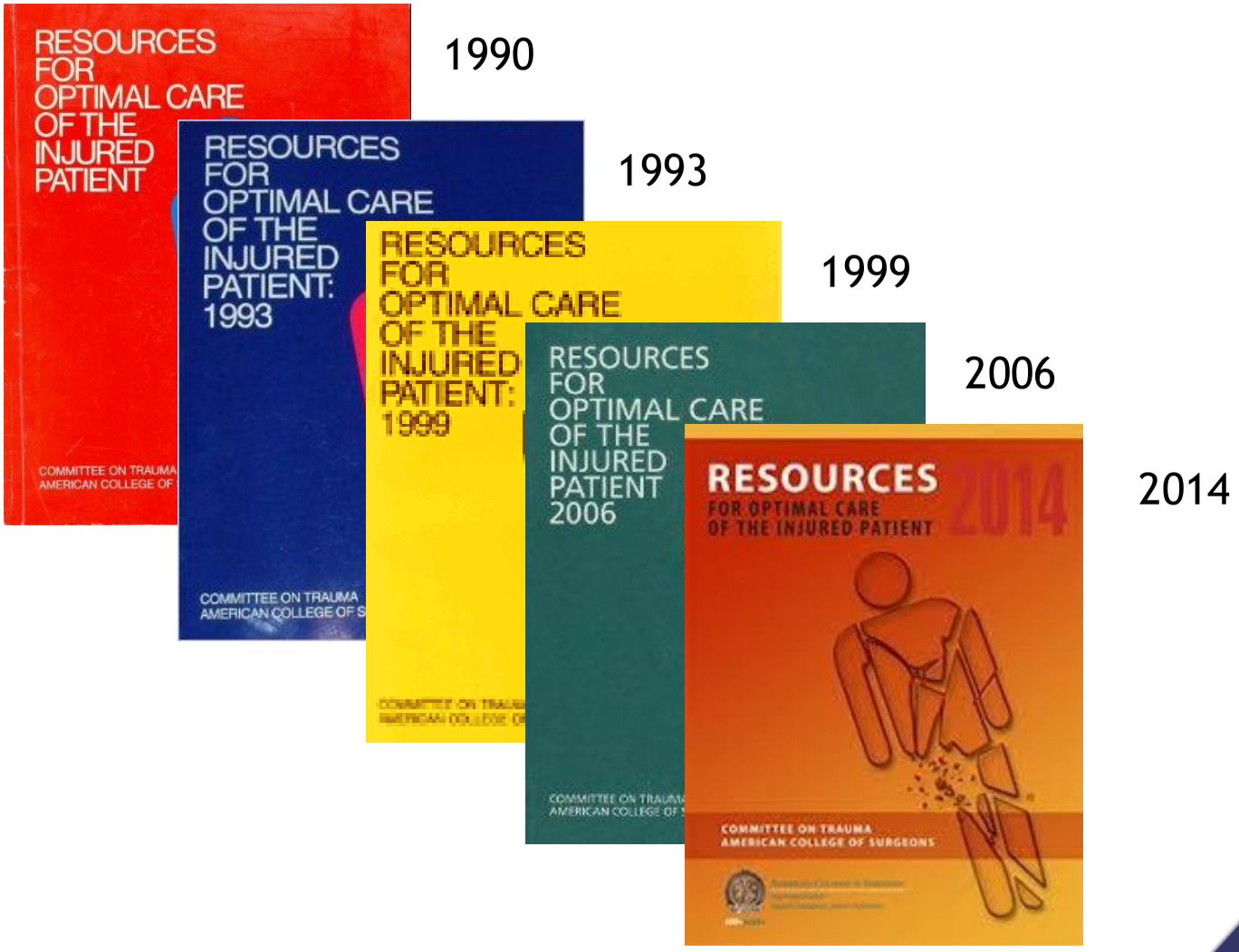
Based on national standards.

Stakeholder driven:

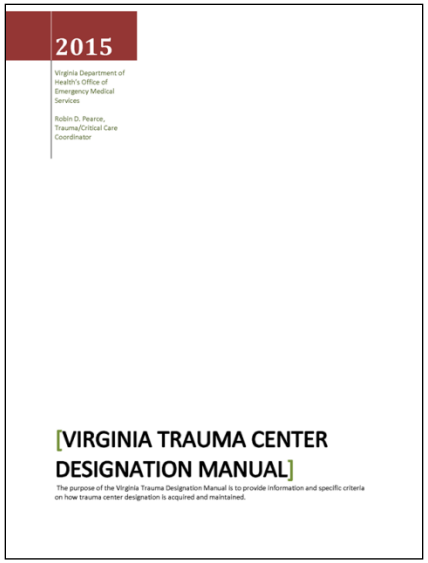
- Trauma System Oversight & Management Committee;
- EMS Advisory Board; and
- State Board of Health

Designation process

National Trauma Center Designation Standard

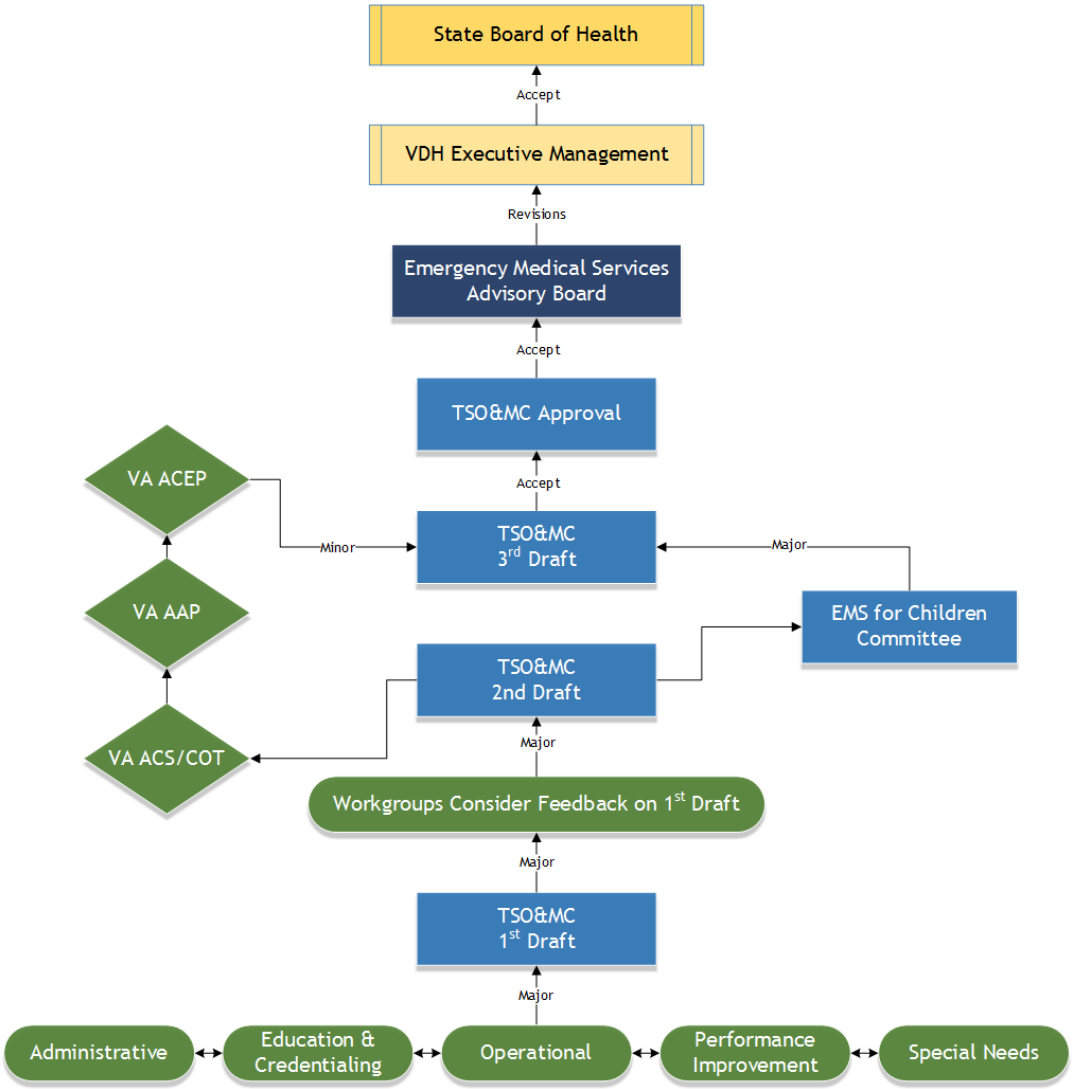


Virginia Trauma Center Designation



The *Code of Virginia* §32.1-111.3 Requires Virginia Trauma Center Designation Criteria be "based upon a national evaluation system".

Designation Criteria is Stakeholder Driven



State Emergency Medical Services Advisory Board (§ 32.1-111.10)

- Enabling legislation passed in 1968.
- Members appointed by the Governor.
- Liaison between Office of Emergency Medical Services (OEMS) and the public.
- Ensures that the OEMS understands and responds to public concerns.
- Ensures that the activities of the OEMS are communicated to the public.
- Provides advice and counsel regarding methods and procedures for planning, developing and maintaining a statewide emergency medical services (EMS) system to the OEMS and the State Board of Health.

EMS Advisory Board Composition

- VA Hospital & Healthcare Assoc.
- Medical Society of VA
- VA Chapter of American College of ED physicians
- VA Chapter of the American College of Surgeons
- VA Municipal League
- VA Chapter of the American Academy of Pediatrics
- Emergency Nurses Assoc. or VA Nurses' Assoc.
- A consumer that has nothing to do with the system in anyway
- VA Assoc. of Counties

Board continued

- One member from each of the 11 regional EMS councils
- VA Ambulance Assoc.
- VA Assoc. of Governmental EMS administrators
- 2 reps. From VA Assoc. of Volunteer Rescue Squads
- VA state Firefighters Assoc.
- Virginia Fire Chief's Assoc.
- A VA professional firefighter
- VA Assoc. of Public Safety Communication Officials

State Emergency Medical Services Advisory Board

14 Standing Committees, three of interest for today

- Medical Direction
- EMS for Children (EMSC)
- Trauma System Oversight and Management Committee (TSO&MC)

Trauma System Oversight & Management Committee (TSO&MC Core Objectives

Advise the VDOH/OEMS on matters relating to:

- Maintaining a statewide pre-hospital and inter-hospital trauma triage plan. (§32.1-111.3:19.B)
- Maintaining a performance improvement process that supports the trauma center designation process, trauma triage plan, and improves trauma care throughout Virginia. (§32.1-111.3:B.3)
- Maintaining a process for designation of hospitals as trauma centers. (§32.1-111.3:A.10)

EMS for Children Committee Members

- American Academy of Pediatrics
- American College of Emergency Physicians
- Community Pediatrician
- EMSC Medical Director
- American Academy of Pediatrics
- Emergency Nurses Association
- VDH Division of Injury and Violence Prevention
- VA DMV
- VDH/OCME Child Death Review
- VA Assoc. of School Nurses
- Family Rep
- EMSC Principle Investigator

EMSC Committee Members continued

- EMS Agency Rep.;
- State EMSC Manager;
- EMS Regional Council Director; and
- Pediatric Rep. to EMS Advisory Board.

Medical Direction Committee

Regional Medical Directors for all 11 EMS regions in the State all of whom are physicians;

Physician from the EMS for Children Committee;

OEMS EMS/Trauma Operational Medical Director;

Two members at large:

- Trauma Surgeon; and
- Emergency Medicine Physician.

Questions

robin.pearce@vdh.virginia.gov

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