Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, August 9, 2013

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
August 9, 2013

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 August 9, 2013

1) Motion - To endorse the composition of the Training and Certifiation Committee. Motion attached as **Appendix A**.
2) Motion - To accept the proposed Competencies document developed by the ALS Competency Workgroup. Motion and document attached as **Appendix B**.
3) Motion - To accept the proposed High Fidelity Simulation document developed by the ALS Competency Workgroup. Motion and document attached as **Appendix C.**
4) Motion - The Trauma System Oversight and Management Committee requests that the State EMS Advisory Board endorse the Virginia Statewide Trauma Registry Version 3 Minimum Data Set (VSTRv3). Motion and Version 3 dataset attached as **Appendix E**.

b) Karen Owens Accepts Emergency Operations Manager Position

Karen Owens has accepted the position of Emergency Operations Manager for the Virginia Office of EMS and will begin working in that position August 10, 2013. Karen has been in the EMS field since 1997, both as a volunteer and career provider for government and commercial ambulance services. She has worked at the Virginia Office of EMS since 2001 where she has served in various position including Emergency Operations Officer, Emergency Operations Training Coordinator, Emergency Operations Assistant Manager, and most recently, Emergency Operations Acting Manager. Karen received her Master's in Public Safety Leadership (2005) and Bachelors of Arts in Psychology (2001) with a minor in Childhood Studies from Christopher Newport University in Newport News, Virginia. Karen also holds certification as a Virginia

EMT-Intermediate and EMT-Basic Instructor, Virginia Firefighter I and II, and is a Certified Emergency Management Assistant.

Karen authored "Incident Command for EMS" published by Fire Engineering Books and has authored multiple articles for Fire Engineering on topics including Miscarriage, Burn Treatment, and Patient Care during Extrication. She has served as a presenter at Fire Department Instructor Conference (FDIC)-East and FDIC on topics including Mass Casualty, Rehab, EMS for ICS, and Triage systems.

In her free time, Karen is a Life Member at East Hanover Volunteer Rescue Squad where she has served in roles including EMT-B/Driver, Public Relations Officer, and President. She enjoys spending time with her husband and her two sons.

c) Delay in the implementation of changes to the recertification process for EMS providers in Virginia

Recently announced changes in the EMS recertification process pertaining to the elimination of testing requirements or the requirement to obtain a test waiver will be delayed. Originally scheduled to take effect July 1, 2013, changes to the EMS recertification process must be delayed until regulatory reviews can be completed.

During the 2013 session of the Virginia General Assembly, several bills (HB1622 and SB 790) were introduced and subsequently passed that amended §32.1-111.5 of the *Code of Virginia* by removing the requirement for EMS providers to take a written examination or obtain a waiver from testing from the relevant operational medical director (OMD) in order to recertify their EMS certification.

Before regulations can be adopted and put into effect, specific steps must be completed that are required by law and defined in the Administrative Process Act. Following the passage of HB1622 and SB790, the Office of EMS (OEMS) developed and submitted a regulatory package to request the adoption of certain changes to specific sections of the EMS Regulations related to the requirements for the recertification of EMS providers in order to conform to the new Code requirements.

One step in this regulatory review process requires the Office of the Attorney General (OAG) to ensure statutory authority for the proposed regulations. **The OAG has ruled and informed the OEMS that implementation of the changes to the EMS recertification process cannot take effect until after a "fast-track" regulatory process is completed.** A number of stages exist in the process and it will take additional time to complete before the changes in EMS recertification can take effect. **Therefore, in the interim, no changes in the EMS recertification process will occur. This means, in order to recertify your EMS certification, you must:**

Complete all continuing education (CE) requirements and submit the required documentation to the OEMS prior to the end of your certification expiration date. The OEMS must receive all required documentation no later than the close of business on the last day of your certification

period. If the last day of your certification period falls on a weekend, then documentation must be received no later than the last business day of the month your certification is set to expire.

Take the written examination for the level being recertified, or if affiliated with a Virginia licensed EMS agency, submit a test waiver signed by the agency's OMD prior to the end of your certification expiration date.

The OEMS apologizes for any inconvenience the delay in the implementation of these changes to the EMS recertification requirements may cause. The OEMS will provide regular updates to the EMS community through our website and social media outlets. **At this time, it is unknown how long it will take to "fast-track" the changes to the EMS regulations.**

The OEMS will do everything we can to expedite completion of the "fast-track" regulatory review process. Once we complete the regulatory process and are able to implement these changes to the EMS recertification process, notification will be widely disseminated announcing the date that the new procedures for EMS recertification will take effect.

d) Implementation of FBI Background Checks Delayed

The Office of EMS is working with the Virginia Department of Health (VDH) executive leadership and the Virginia State Police to obtain the necessary equipment, supplies and develop policies and procedures for the implementation of FBI background checks for each person who, on or after July 1, 2013, applies to be a volunteer with or employee of an EMS agency. Because these tasks are not complete, there will be a delay in the enactment of these new requirements in the law (§32.1-111.5).

Once the Office of EMS can implement the new requirements in the law each person who applies to be a volunteer with or employee of an EMS agency will be required to submit fingerprints and provide personal descriptive information (race, height, weight, eye color, hair color, etc.) to be forwarded by the Office of EMS through the Central Criminal Records Exchange (CCRE) of the Virginia State Police to the Federal Bureau of Investigation (FBI), for the purpose of conducting a state and national criminal history check.

There is no change in the background investigation policy at this time. The law does not require EMS agencies to submit fingerprints and personal descriptive information to the Office of EMS. EMS agencies may obtain state and national criminal history checks through other established processes, however, the cost to conduct these checks will not be covered by the state. *EMS Agencies should not change their practice until further notice. A notification will be generated by the Office of EMS when everything is in place to begin the new background check process.*

If there are any questions pertaining to an individual's eligibility for affiliation with a licensed EMS agency and/or their eligibility for EMS certification, please contact Mr. Michael Berg, Regulation and Compliance Manager, VA Office of EMS at 1-800-523-6019 or 804-888-9131 or by Email at Michael.Berg@vdh.virginia.gov.

e) Elimination of requirement to obtain medical practitioner signature on prehospital patient care report is delayed

The Office of EMS recently announced changes pertaining to the elimination of the requirement to obtain the signature of the medical practitioner who assumes responsibility for the patient at the hospital on the prehospital patient care report for an incident when a drug is administered or an invasive procedure is performed. Although the law is scheduled to take effect on July 1, 2013, changes to regulations are necessary.

During the 2013 session of the Virginia General Assembly, several bills (HB 1499 and SB 773) were introduced and subsequently passed that amended §54.1-3408 of the *Code of Virginia* permitting certified EMS personnel acting within their scope of practice to administer drugs and devices pursuant to an oral or written order or standing protocol.

Before the Office of EMS can remove language in the EMS Regulations that requires EMS personnel to obtain the signature of the medical practitioner who assumes responsibility for the patient, the Board of Pharmacy must remove language pertaining to medical practitioner signature in their existing regulations that appears in 12VAC110-20-500. The Board of Pharmacy met on June 18, 2013 and adopted changes in regulation that should be effective within the next two (2) months.

Until changes to the BoP Regulations occur, EMS personnel will continue to be required to obtain the signature of the medical practitioner who assumes responsibility for the patient at the hospital on the prehospital patient care report. If the patient is not transported to the hospital or if the attending medical practitioner at the hospital refuses to sign the record, a copy of this record shall be signed and placed in delivery to the hospital pharmacy who was responsible for that medication kit exchange by the agency's operational medical director within seven days (7) of the administration.

The OEMS apologizes for any inconvenience the delay in the implementation of these changes may cause. The OEMS will provide regular updates to the EMS community through our website and social media outlets.

Once the Board of Pharmacy regulations are effective and we are able to implement these changes to the EMS Regulations, notification will be widely disseminated announcing the date that the new procedures pertaining to medical practitioner signatures on patient care reports will take effect.

In the interim, if you have questions, please contact your area EMS Program Representative or Mr. Michael Berg, Regulation and Compliance Manager, VA Office of EMS at 1-800-523-6019 (toll free in VA), 804-888-9131 (direct) or by email at michael.berg@vdh.virginia.gov .

f) Model Interstate Compact for EMS Personnel Licensure for State Adoption

NASEMSO (National Association of State EMS Officials) has received funding from the Department of Homeland Security, Office of Health Affairs to develop a model interstate compact for states' legislative use to solve the problem associated with day-to-day deployment of EMS personnel across state boundaries in non-declared states of emergency. The goal of this project is to allow member states to honor licenses (certifications) by other states so long as the license is issued by another member state in a manner consistent with the compact terms.

The Model Interstate Compact will benefit EMS personnel who my work in cross border environments, EMS employers, state EMS offices and ultimately the patients served by EMS personnel and organizations working in more than one state. One of the important features of the compact will address EMS personnel practicing medicine in a state in which they are not technically licensed.

NASEMSO is proposing a system of self-regulation by the states through the use of interstate compacts whereby national policy can be put into place but remain flexible enough to change as change continues to occur in the EMS industry, preserving state sovereignty and collective control.

NASEMSO is receiving legal and technical assistance, and process guidance from the Council of State Governments (CSG) through its National Center for Interstate Compacts (NCIC).
The project is being closely coordinated with the National Governors Association, National Council of State Legislatures, Federal Interagency Committee on EMS (FICEMS), the National EMS Advisory Council (NEMSAC), and all federal agencies that employ EMS personnel.
The project started in October 2012 and will be complete by May 2014.
Project has four (4) phases. Two additional phases will follow (Phase III - Education and Enactment) and (Phase IV – Transition to Commission Administration)

Phase I: National Advisory Panel (NAP) (complete)

Examined current landscape of challenges and issues facing state EMS offices and the personnel they license and certify.

Present a set of solution-oriented recommendations for inclusion in a new model interstate compact.

1. EMS personnel must have a current, valid, unrestricted license to practice at or above the level of EMT issued by a state, US territory, or the District of Columbia.
2. EMS personnel must be at least 18 years old.
3. Authorized government agency by which the EMS personnel are licensed currently uses the minimum criteria outlined in the compact pertaining to individual licensure, to include, at a minimum:

    a) Requirement to pass a cognitive and psychomotor exam
    b) Requirement to pass a criminal background check

EMT – 56% of the states perform a state only check
44% of the states perform a FBI fingerprint criminal background check (CBC).
11% of the states perform both a state and FBI CBC.
PM – 59% of the states perform a state only check
41 % of the states perform a FBI fingerprint CBC
39 % of the states perform both a state and FBI CBC.

EMS personnel were requested or deployed by an agency having jurisdiction (AHJ), which includes, but is not limited to:

a) Incident commander
b) Medical care facility for a patient in their system
c) Employer with statutory or contractual authority to conduct operations in the geographical area.

Phase II: Eleven (11) member drafting team

Take theory-based NAP recommendations and make them operational by drafting draft legislation that can be adopted by states.
The drafting team had its initial meeting in Washington, DC on June 4 and 5. The second meeting of the drafting team is scheduled to be held in Baltimore, MD on August 20 and 21. The team will meet at total of four (4) times during the next seven (7) month period to draft a model interstate compact based on the recommendations of the advisory group and the expertise of the group.

Typical Compact provisions the team will discuss include:

- Purpose Statement
- Definitions
- General provisions and jurisdiction
- Governing structure and state administration
- Powers of compact (compliance, enforcement, rules, and discipline)
- General compact issues (activation, financing, etc.) - A minimum of 10 states are required to sign on to activate the compact.
- Member states will collectively share rule making related to the compact.
- Terms of compact language is contractual in nature upon promulgation as law, subordinate rules and processes associated with the day-to-day use of the compact are collaboratively negotiated by the states and administered by a national (administration body) organization or Commission, allowing for flexibility and change to accommodate contemporary demands and process efficiency.
- Compacts take precedence over conflicting statutes of the signatory states.

The key benefits of compacts are:

- Effectiveness and efficiency (economy of scale)
- Flexibility and autonomy compared to national policy which tends to take a one size fits all approach.
- Allows dispute settlement among the member states
- Collective cooperation among the states
- Facilitates cooperative behaviors leading to "win-win" situations

Some of the operational benefits include:

- National data and information sharing systems (Commission will develop a coordinated licensure database registry that will be shared between member states)
- Enhanced enforcement and compliance mechanisms (What about discipline? Bad Actors. Some level of review is necessary. Complaints. Who conducts investigation, who receives results of investigation, who enforces rules?)
- Uniform compact language and rules (uniformity at the lowest common denominator without compromising public health and safety)
- Uniform operations and procedures that will address items such as privilege to practice, scope of practice, medical direction, etc.)
- Effective governance structures
- Coordination with other interstate compacts (for example, EMAC)

g) Online EMS event notification system - EMS Voluntary Event Notification Tool (E.V.E.N.T.)

Within EMS, very little data exists about many aspects of the profession. In an effort to address this shortfall, NAEMT, in collaboration with the Center for Leadership, Innovation and Research in EMS, has developed an anonymous system for EMS practitioners to report near-miss and line of duty death (LODD) incidents by answering a series of questions in an online format.

The purpose of the system is to collect and aggregate data that will then be analyzed and used in the development of EMS policies and procedures, and for use in training, educating and preventing similar events from occurring in the future. No individual responses will be shared or transmitted to other parties. These Near Miss and LODD Online Reporting Tools and reports of the aggregate data collected are now live at www.emseventreport.org. These tools and reports, along with an already existing tool to report patient safety events, form the EMS Voluntary Event Notification Tool (E.V.E.N.T.).

The aggregated data collected is provided to state EMS offices and the appropriate federal agencies with jurisdiction over EMS on a quarterly and annual basis. Timely aggregated reports submitted through a variety of venues will make E.V.E.N.T. a living mechanism for change. It is envisioned that one of the primary end users of this data will be those responsible for the development of EMS policies at the state and federal levels.

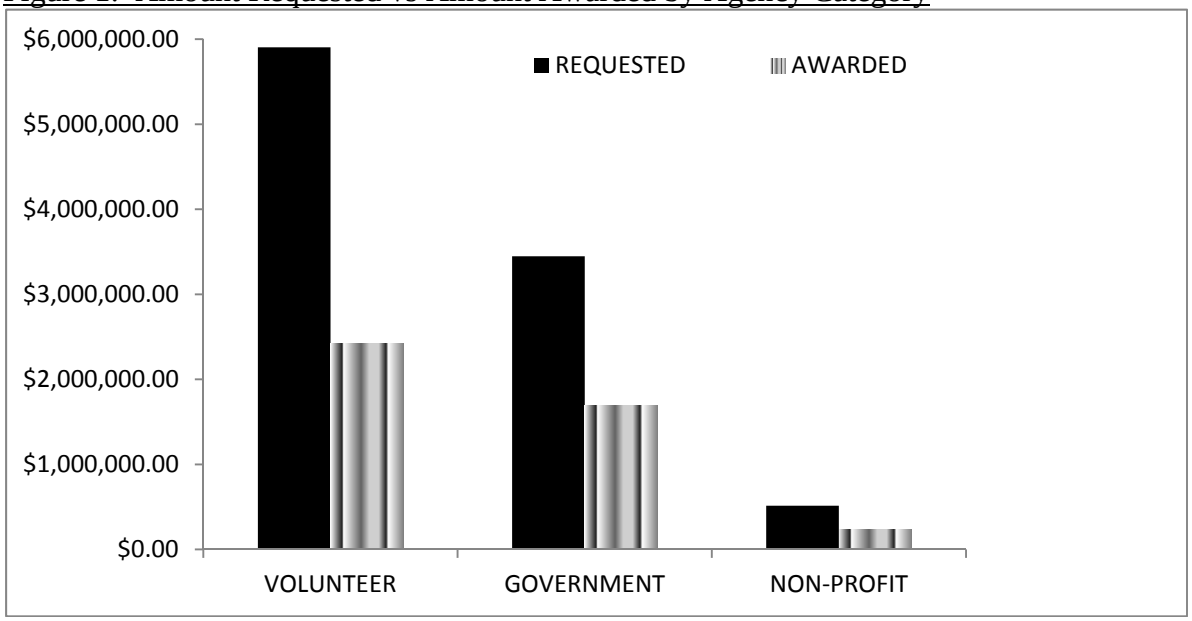
The Office of EMS encourages use of this online reporting tool by EMS agencies across the commonwealth. EMS agencies that already have internal reporting processes are asked to also submit their events into E.V.E.N.T. The Office of EMS was recently recognized as a site partner and is recognized by our logo posted on the E.V.E.N.T. site. A link to the E.V.E.N.T. site is currently posted on the OEMS Web site at:
http://www.vdh.virginia.gov/OEMS/EO/EMSSafety.htm.
Visit the E.V.E.N.T. system at www.emseventreport.org.

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

The Spring 2013 RSAF grant deadline was March 15, 2013; OEMS received 140 grant applications requesting $9,864,795.00 in funding. Grants were awarded on July 1, 2013 in the amount of $4,356,125.00 to 101 agencies. The following agency categories were awarded funding for this grant cycle:

- 60 Volunteer Agencies were awarded $2,421,376.00
- 30 Government Agencies were awarded $1,697,247.00
- 11 Non-Profit Agencies were awarded $237,503.00

Figure 1: Amount Requested vs Amount Awarded by Agency Category

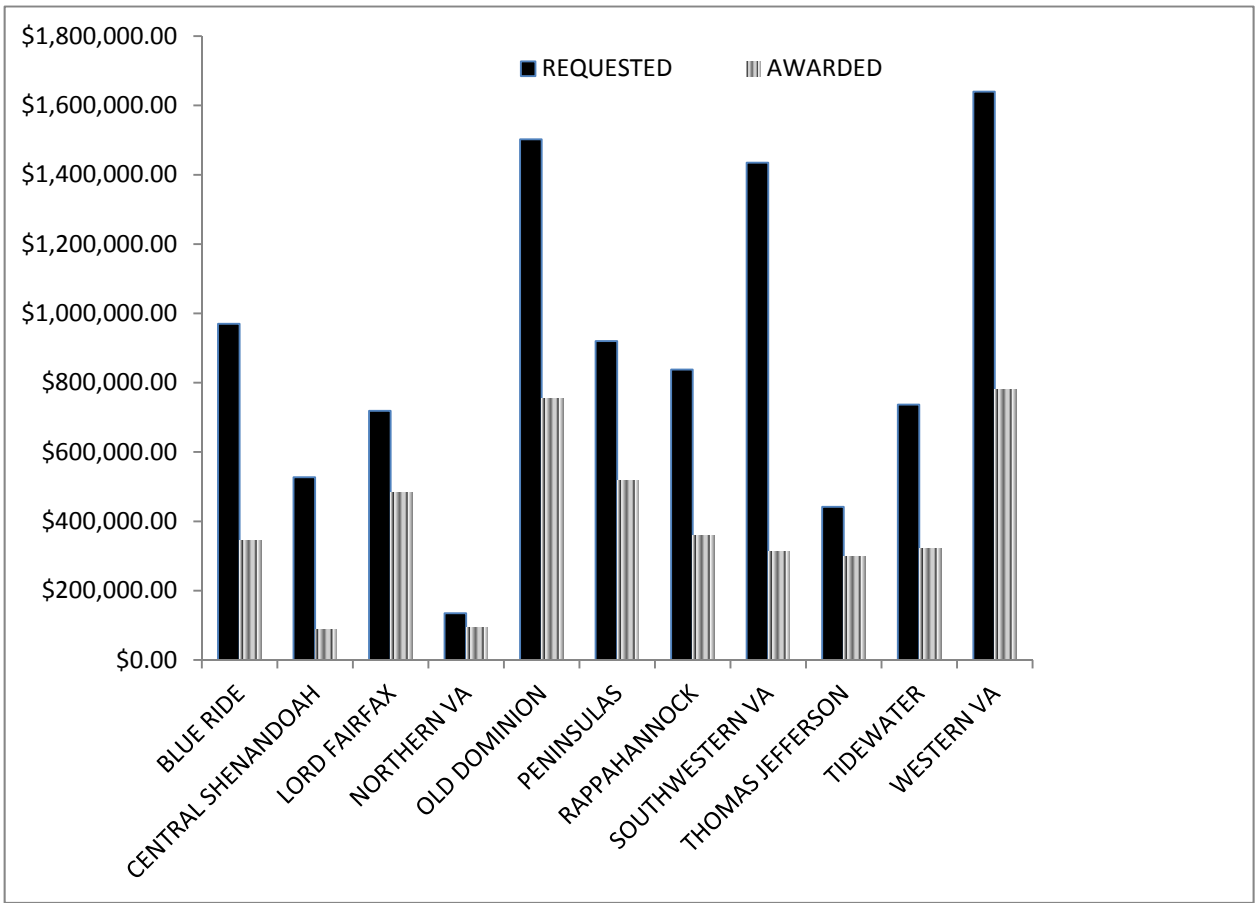


The following EMS regional areas were awarded funding in the following amounts:

- Blue Ridge EMS Council – 6 agencies awarded $346,021.00
- Central Shenandoah EMS Council – 7 agencies awarded $86,998.00
- Lord Fairfax EMS Council – 9 agencies awarded $483,246.00

- Old Dominion EMS Alliance – 17 agencies awarded $753,591.00
- Peninsulas EMS Council – 13 agencies awarded $518,226.00
- Rappahannock EMS Council – 8 agencies awarded $359,966.00
- Southwestern Virginia EMS Council – 14 agencies awarded $313,720.00
- Thomas Jefferson EMS Council – 4 agencies awarded $297,416.00
- Tidewater EMS Council – 5 agencies awarded $321,388.00
- Western Virginia EMS Council – 15 agencies awarded $781,233.00

Figure 2: Amount Requested vs Amount Awarded by EMS Regions



RSAF Grants Awarded by item categories:

- Audio Visual and Computers - $ 165,358.00
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - $ 185,157.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.

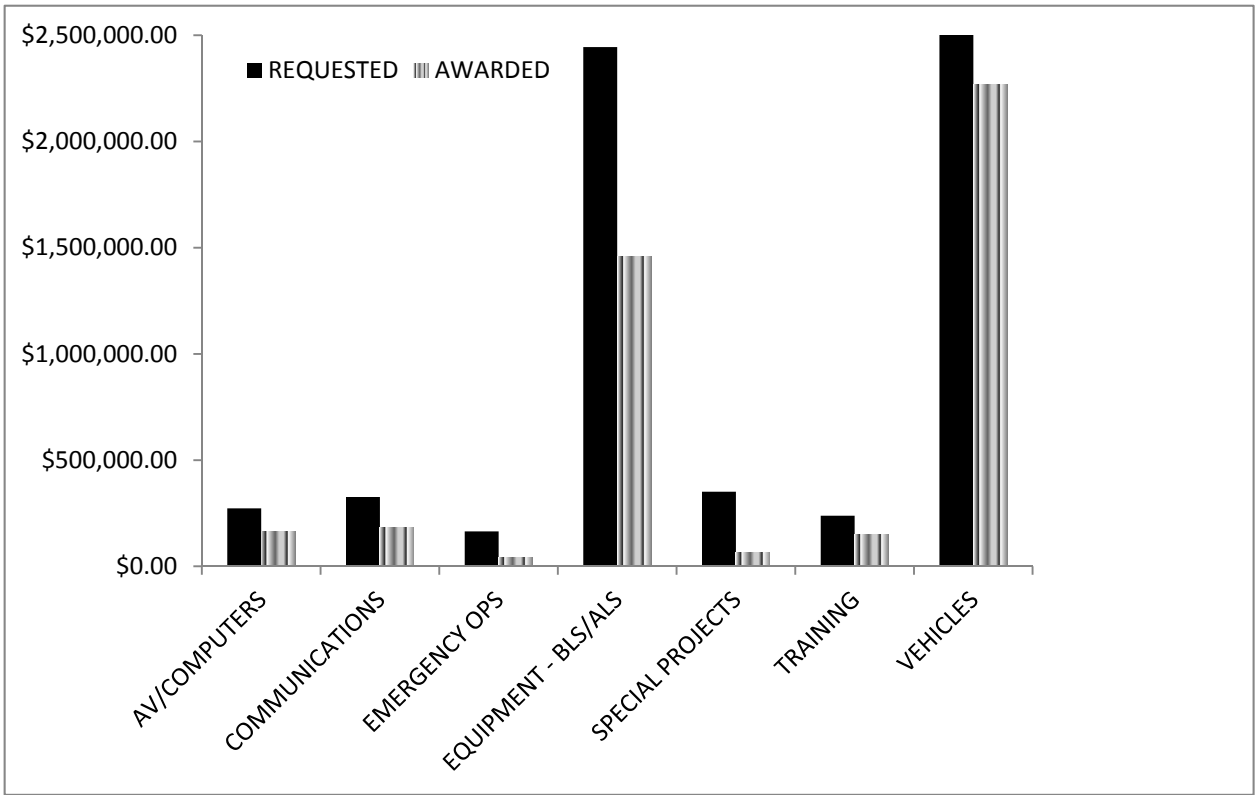
- Emergency Operations - $ 44,540.00
    - Includes items such as Mass Casualty Incident (MCI) All Terrain Vehicle (ATV), extrication equipment and personal protection equipment (PPE). The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.

- Equipment - Basic and Advanced Life Support Equipment - $ 1,459,367.00
    - Includes any medical care equipment for sustaining life, including defibrillation, airway management, and supplies.

- Special Projects - $ 67,538.00
    - Includes projects such as Recruitment and Retention, Special Events Material, Emergency Medical Dispatch (EMD), Virginia Pre-Hospital Information Bridge (VPHIB) projects and other innovative programs.

- Training - $ 151,404.00
    - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.
- Vehicles – 2,282,761.00
    - Includes ambulances, 1st Response/Quick Response Vehicles (QRV) and rechassis/remount of ambulances.

Figure 3: Awarded Requested vs Amount Awarded by Item



*NOTE: The VEHICLES category request amount was $6,068,010.00, the graph only represents items requested up to $2,500,000.00 to visually display other items requested.

The Fall 2013 grant cycle will begin on August 1, 2013 with a deadline of September 16, 2013; grants will be awarded January 1, 2014.

Rescue Squad Assistance Fund Emergency Grants

Boyce Volunteer Fire Company
2 LifePak 15 – (100/0) - $56,298.00
Request – Due to failure of device and not being able to replace parts to the older units.

John H. Enders Volunteer Fire & Rescue Squad Company
1 Hurst Extrication Tool System – (100/0) - $41,000.00
Request – Due to device breaking and too old for replacement parts.

2013 Department of Homeland Security Grant Program

The Secretary of Veteran's Affairs and Homeland Security and the Virginia Department of Emergency Management will hold regional meetings for the FFY 2013 State Homeland Security Grant Program. A stakeholder meeting for the Central Virginia area will be held on August 1, 2013 at 9:30am in Chesterfield County. OEMS will attend to get an update of the process for the 2013 application development, to include the timeline, project proposal outline and the grants management office updates.

EMS on the National Scene

II. EMS On the National Scene

a) AVL Committee Provides KKK-A-1822F Ambulance Specs Change Notice

The US General Services Administration has just issued a change notice to the KKK specs. The change notice affects the language in sections related to:

- Payload capacity, calculation and documentation
- Doors
- Oxygen system and suction
- Type II ambulance body

These changes are effective July 2, 2013. You can download the change notice at the NASEMSO Agency & Vehicle Committee "Current Resources" web page at: http://www.nasemso.org/Projects/AgencyAndVehicleLicensure/index.asp#Resources

b) FirstNet to Issue RFIs in Near Future

The First Responder Network Authority (FirstNet) plans to issue multiple requests for information (RFIs) within the next few weeks. The RFIs will request detailed information regarding potential deployment options for two crucial portions of the Long-Term Evolution (LTE) network: the radio access network (RAN) and core network. The RFIs will be posted on www.fedbizopps.gov. "The upcoming RFIs are an important step in the FirstNet information gathering process, which will enable us to continue toward our mission of delivering a nationwide network dedicated to public safety," said Bill D'Agostino, FirstNet General Manager. "I encourage all those interested in responding to be creative and detailed in their comments. As I have said in the past, achieving our mission will require an unprecedented amount of public and private partnership, and these RFIs will help lay the foundation for that to happen." All RFI responses, as well as information provided by stakeholders participating in the FirstNet ongoing series of regional workshops and the results of state consultations planned this fall, will be used to inform the development of FirstNet's nationwide deployment plan. This plan, in turn, will be presented to the states for their review and decisions.

c) ICD-10 Deadline is October 1, 2014

The compliance deadline for ICD-10 is October 1, 2014. CMS Administrator Marilyn Tavenner has affirmed the ICD-10 deadline and encourages providers, payers, and vendors across the health care industry to prepare to use the new codes for services provided on or after October 1, 2014. The CMS website offers a variety of resources targeted to payers, providers, vendors, and others to help you with your transition to ICD-10. Timelines, checklists, fact sheets, and in-depth guides are all available to help you and your organization plan for a smooth transition.
Keep Up to Date on ICD-10 Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the October 1, 2014, deadline at:
http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10.

d) WISER for Android 2.0 Now Available

The National Library of Medicine's Wireless Info System for Emergency Responders (WISER) for Android 2.0 is now available. WISER now fully integrates content from the Chemical Hazards Emergency Medical Management (CHEMM) website. This integration includes:

- New hospital provider and preparedness planner profiles
- Acute care guidelines for 6 known mass casualty agents/agent classes
- The addition of a wealth of CHEMM reference material
- CHEMM Intelligent Syndrome Tool (CHEMM-IST), a new help identify tool designed to diagnose the type of chemical exposure after a mass casualty incident
- Emergency Response Guidebook data is now updated to the ERG 2012.

WISER for Android includes a custom ERG 2012 tool. WISER for Android can be downloaded and installed directly from the Google Play Store.

e) New GAO Report Highlights the Needs of Kids in CBRN Incidents

In a new report to the House Committee on Energy and Commerce, the Government Accountability Office (GAO) was asked about efforts to address the needs of children in the event of a CBRN incident. This report examines (1) the percentage of CBRN medical countermeasures in the SNS that are approved for pediatric use; (2) the challenges HHS faces in developing and acquiring CBRN medical countermeasures for the pediatric population, and the steps it is taking to address them; and (3) the ways that HHS has addressed the dispensing of pediatric medical countermeasures in its emergency response plans and guidance, and ways that state and local governments have addressed this issue. View GAO-13-438 at: http://www.gao.gov/products/GAO-13-438.

f) IOM Focuses on Children and Families Needs Following Disaster

The Institute of Medicine's (IOM) Forum on Medical and Public Health Preparedness for Catastrophic Events recently hosted a workshop entitled "Preparedness, Response and Recovery Considerations for Children and Families after a Disaster". The public workshop assembled representatives from federal, state, local, public health and health care sectors, as well as schools, community organizations, and other non-traditional partners that have an interest in better preparing communities, especially children, for emergencies. The event focused on past highlighted gaps and recommendations and their progress, best practices, and emerging resilience strategies and recovery measures. The workshop also highlighted opportunities to improve partnerships and coalitions with a focus on the needs of children and families. Audio presentations and slides are now available on the Forum's web site at: http://www.iom.edu/Activities/PublicHealth/MedPrep/2013-JUN-10.aspx.

g) NOAA Predicts Active 2013 Atlantic Hurricane Season

NOAA's Climate Prediction Center is forecasting an active or extremely active Atlantic hurricane season this year. For the six-month hurricane season, which began June 1, NOAA's Atlantic Hurricane Season Outlook says there is a 70 percent likelihood of 13 to 20 named storms (winds of 39 mph or higher), of which 7 to 11 could become hurricanes (winds of 74 mph or higher), including 3 to 6 major hurricanes (Category 3, 4 or 5; winds of 111 mph or higher). These ranges are well above the seasonal average of 12 named storms, 6 hurricanes and 3 major hurricanes. NOAA's seasonal hurricane outlook is not a hurricane landfall forecast; it does not predict how many storms will hit land or where a storm will strike. Forecasts for individual storms and their impacts will be provided throughout the season by NOAA's National Hurricane Center.

h) Senate Hearing Focuses on Effectiveness of Preparedness Grants

Since September 11, 2001, the nation has invested almost $40 billion in equipment, training, and exercising and in order to enhance and sustain essential capabilities, assessments must be done to determine our current level of preparedness and identify gaps that will inform future investment of tax-payer dollars. A recent Senate hearing focused on measuring of the impact of FEMA grants since 9/11 and the role Federal, state, and local governments play in developing metrics to assess preparedness for natural and manmade events. FEMA Deputy Administrator Tim Manning, describes the Department's efforts to establish a National Preparedness Grant Program (NPGP) consolidate current State and local preparedness grant programs into one overarching program (excluding EMPG and Assistance to Firefighters Grants programs) to enable grantees to collaboratively build and sustain core capabilities towards achieving the National Preparedness Goal. The consolidated NPGP grant program would fund specific resources to meet 31 core capabilities described in the National Preparedness Goal and help FEMA measure progress toward achieving overall preparedness, and these hose core capabilities were developed against specific threats and hazards. The Department of Homeland Security (DHS) soon will send a formal legislative proposal to the House and Senate for implementation of the NPGP program. View the archived event and download individual testimonies for *Are We Prepared? Measuring the Impact of Preparedness Grants Since 9/11* at: http://www.hsgac.senate.gov/subcommittees/emdc/hearings/are-we-prepared-measuring-the-impact-of-preparedness-grants-since-9/11.

i) Interactive Map: State Laws Concerning Sport-Related Concussions among Youth

By the beginning of 2013, a total of 49 states and the District of Columbia had legislation to prevent concussions and to limit further injury to student athletes who sustain concussions, with most of these laws mandating that student athletes who experience a concussion be removed from play and obtain a health care provider's permission before returning to play. Go to: http://www.childrenssafetynetwork.org/publications/state-laws-concerning-sport-related-concussions-among-youth.

Please note: To see the components of your state's law, hover over it with your cursor. To read the law itself, click on the state to view the state's legislation page.

j) 2014 EMSC Meeting Marks Program's 30th Anniversary

Mark your calendars! The dates for next year's EMS for Children Program Meeting have been finalized. The meeting will be held Tuesday, July 28 through Friday, August 1, 2014, at the Renaissance Arlington Capital View Hotel. More information about the meeting and how to make hotel reservations will be released in the spring of 2014.

k) KidsAndCars.org Offers Practical Advice on Preventing Childhood Emergencies in Vehicles

According to the National Highway Traffic Safety Administration, heatstroke is the leading cause of non-crashrelated vehicle fatalities of children younger than 14. Summer hasn't even arrived, and yet already this year seven children have died of heat stroke after being left in vehicles. Through the "Look Before You Lock" educational campaign, the first of its kind, KidsAndCars.org has distributed more than 300,000 information cards to birthing hospitals nationwide. KidAndCars.org promotes awareness among parents, caregivers and the general public about the dangers to children, including backover and frontover incidents, and heat stroke from being inadvertently left in a vehicle. The organization works to prevent tragedies through data collection, education and public awareness, policy change, product redesign and survivor advocacy.

l) Motorcycle Deaths Climb as States Repeal Helmet Laws

The number of motorcyclists killed in traffic accidents jumped 9 percent last year, a disturbing increase in a 15-year trend. Warm weather in the spring of 2012 and a stronger economy likely prompted motorcyclists to hit the road more often, but the trend has seen motorcyclist deaths increase almost every year, wrote Dr. James Hedlund for the Governors Highway Safety Association, a group of state traffic safety agencies. To read the full article, please go to: http://www.pewstates.org/projects/stateline/headlines/motorcycle-deaths-climb-as-states-repeal-helmet-laws-85899470721.

m) IOM Research Agenda to Reduce the Threat of Firearm-Related Violence

In 2010, more than 105,000 people were injured or killed in the United States as the result of a firearm-related incident. Recent, highly publicized, tragic mass shootings in Newtown, CT; Aurora, CO; Oak Creek, WI; and Tucson, AZ, have sharpened the American public’s interest in protecting our children and communities from the harmful effects of firearm violence. While many Americans legally use firearms for a variety of activities, fatal and nonfatal firearm violence poses a serious threat to public safety and welfare. In January 2013, President Barack Obama issued 23 executive orders directing federal agencies to improve knowledge of the causes of firearm violence, what might help prevent it, and how to minimize its burden on public health. One of these orders directed the Centers for Disease Control and Prevention (CDC) to, along with other federal agencies, immediately begin identifying the most pressing problems in firearm violence research. The CDC and the CDC Foundation asked the Institute of Medicine (IOM), in collaboration with the National Research Council, to convene a committee tasked with

developing a potential research agenda that focuses on the causes of, possible interventions to, and strategies to minimize the burden of firearm-related violence. The committee's proposed research agenda focuses on the characteristics of firearm violence, risk and protective factors, interventions and strategies, the impact of gun safety technology, and the influence of video games and other media. For more information go to: http://www.nap.edu/catalog.php?record_id=18319.

n) NTSB Targets Impaired Driving

The National Transportation Safety Board (NTSB) recently released a set of targeted interventions to put the country on a course to eliminate alcohol-impaired driving crashes. The 19 recommendations call for stronger laws, swifter enforcement and expanded use of technology. Each year in the United States, nearly 10,000 people are killed in crashes involving alcohol-impaired drivers and more than 173,000 are injured, with 27,000 suffer incapacitating injuries. Since the mid-1990s, even as total highway fatalities have fallen, the proportion of deaths from accidents involving an alcohol-impaired driver has remained constant at around 30 percent. In the last 30 years, nearly 440,000 people have died in alcohol related crashes. The report, "Reaching Zero: Actions to Reduce Alcohol-Impaired Driving," is available at: http://go.usa.gov/TeQe.

o) Healthcare Workers: Protect Yourselves!

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. If you work directly with patients or handle material that could spread infection, you should get appropriate vaccines to reduce the chance that you will get or spread vaccine-preventable diseases. Protect yourself, your patients, and your family members. Make sure you are up-to-date with recommended vaccines. The term "healthcare workers" includes physicians, nurses, **emergency medical personnel**, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff. The CDC has recently updated its website on the topic and recommends the following vaccines for HCWs: Hepatitis B, Influenza, Measles Mumps and Rubella (MMR), Varicella, Tetanus, Diphtheria, and Pertussis, and Meningococcal (if routinely exposed to N. meningitides. For more information go to: http://www.cdc.gov/features/healthcareworkervaccines/index.html.

p) CP Survey Deadline Extended to July 1

Community Paramedic (CP) programs utilize EMS practitioners in an expanded role to increase patient access to primary and preventative care within the medical home model. CP programs work to decrease emergency department utilization, save healthcare dollars and improve patient outcomes. The introduction of CP programs within EMS agencies is a top trend in emergency medical care. To better understand the extent and characteristics of Community Paramedicine programs across the country, 16 national EMS organizations are conducting a survey to collect information about these programs. The information gathered will be vital in helping all to understand this trend and possibly to develop strategies and policies to support it. Readers are encouraged to complete this brief survey at your earliest possible convenience. It should take no

more than 20 minutes to complete. Here is the link to the survey: http://www.surveymonkey.com/s/communityparamedicine1.

q) NFPA 1710 Standard

Public comment was recently closed on NFPA Standard 1710 *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments.* The Scope of the document includes:

- 1.1* Scope. This standard contains minimum requirements relating to the organization and deployment of fire suppression operations, emergency medical operations, and special operations to the public by substantially all career fire departments.

- The requirements address functions and objectives of fire department emergency service delivery, response capabilities, and resources.

- 1.1.2 This standard also contains general requirements for managing resources and systems, such as health and safety, incident management, training, communications, and pre-incident planning.

- 1.1.3 This standard addresses the strategic and system issues involving the organization, operation, and deployment of a fire department and does not address tactical operations at a specific emergency incident.

http://www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=1710&docnum=1710&tab=docinfo.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The Training and Certification Committee met on Wednesday, July 10, 2013. There are three (3) action items for the State EMS Advisory Board:

1. **Appendix A** - Motion - TCC Composition 08-2013
2. **Appendix B** - Motion - ALS Competency and High Fidelity Allowance Standards
3. **Appendix C** - Motion - Use of High Fidelity Simulation

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 scheduled for Thursday, July 11, 2013 was cancelled.

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

National Registry of EMTs Certification Test

The office has published the latest National Registry Test results for all levels of certification. The statistics compare the national pass rates to the state's and then by individual program/instructor. The ALS statistics include data from January 1, 2007 into the second quarter of 2013. The BLS statistics include data from July 1, 2012 into the second quarter of 2013. The information is currently linked at the bottom of the "EMS Training Program Accreditation" page of the OEMS Web site at:
http://www.vdh.virginia.gov/OEMS/Training/Accreditation.htm

Advanced Life Support Program

A. Five (5) ALS Coordinator candidates attended the EMS Education Coordinator Institute held during June2013 at VAVRS Rescue College in Blacksburg, VA and four (4) are now certified as ALS Coordinators. The fifth did not finish due to a family emergency and will complete the process at the next Institute.

B. Seven (7) applications are currently pending for ALS Coordinator endorsement and applicants will be invited to the September 2013 Instructor Institute. No further applications are allowed and all candidates have been encouraged to pursue their Education Coordinator (EC) certification.

Basic Life Support Program

A. Education Coordinator Institute

1. The Office held an Education Coordinator (EC) Institute June 8-12, 2013 in conjunction with the VAVRS Rescue College in Blacksburg, VA. Thirteen (13) Candidates attended, Eight (8) EC Candidates and Five (5) ALS-C Candidates. Seven (7) EC Candidates were certified and one (1) was given Conditional Status. Four (4) ALS-C's were endorsed, one (1) had to leave early and will complete the training at a later date.
2. The next EC Institute will be held in the Richmond area in September of 2013.
3. EMS Providers interested in becoming an Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov
4. A schedule of various deadlines and EC Institutes can be found on our website at: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. Virginia EMS Education Standards (VEMSES) Exam

1. Scoring of the VEMSES exam was transitioned to the EMS Portal in late November/December 2012. Current Instructors/ALS Coordinators wishing to transition to Education Coordinator can access their scores and Letters of Eligibility online through their EMS portal.
2. Current EMT-Instructors/ALS-Coordinators may schedule to take the exam at Regional Consolidated Test Sites (CTS) or at specified locations with the OEMS Training Staff.

C. EMS Educator Updates:

1. For 2013 the Division of Educational Development is returning to the road to provide in-person Educator Updates. We will be arranging to include as many regions as possible.
2. Since the last EMS Advisory Board meeting, the Office conducted an in person EMS Instructor Update on May 11, 2013 at the PEMS Office and June 8th in Blacksburg during the VAVRS Rescue College.

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

EMS Training Funds

FY12

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$784,836.00	$416,282.42	$368,553.58
BLS CE Course Funding	$122,640.00	$43,898.75	$78,741.25
ALS CE Course Funding	$273,840.00	$85,776.25	$188,063.75
BLS Auxiliary Program	$94,000.00	$15,200.00	$78,800.00
ALS Auxiliary Program	$332,000.00	$182,910.00	$149,090.00
ALS Initial Course Funding	$1,342,350.00	$687,297.83	$655,052.17
Totals	**$2,949,666.00**	**$1,431,365.25**	**$1,518,300.75**

FY13

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$1,320.00	$675.00	$645.00
BLS Initial Course Funding	$720,780.00	$318,821.76	$401,958.24
BLS CE Course Funding	$120,120.00	$41,781.21	$78,338.79
ALS CE Course Funding	$295,680.00	$64,627.50	$231,052.50
BLS Auxiliary Program	$74,000.00	$12,520.00	$61,480.00
ALS Auxiliary Program	$344,000.00	$133,380.00	$210,620.00
ALS Initial Course Funding	$1,075,128.00	$432,075.36	$643,052.64
Totals	**$2,635,312.00**	**$1,006,807.33**	**$1,628,504.67**

EMS Education Program Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
   a) Navy Region has been granted provision accreditation at the EMT level.
   b) City of Virginia Beach Fire/EMS has been granted provision accreditation at the EMT Level.
   c) One (1) additional self study has been received and reviewed. Awaiting a date for the accreditation visit.

2. Advanced Emergency Medical Technician (AEMT)
   a) No applications on file.

3. Intermediate – Reaccreditation
   a) No applications on file.

4. Intermediate – Initial
   a) No applications on file.

5. Paramedic – Initial
   a) No applications on file.

6. Paramedic – Reaccreditation
   a) American National University (formerly National College) just completed their CoAEMSP reaccreditation site visit. Pending report.
   b) Southwest Virginia Community College will have their CoAEMSP reaccreditation visit from July 31-August 2, 2013.

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. Effective 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).

   1. All Virginia paramedic training programs in the Commonwealth have met the requirements making their students eligible to test NREMT as of January 1, 2013.

   2. The following programs must complete national accreditation through CoAEMSP/CAAHEP.

      a) Lord Fairfax Community College
         (1) Has received their Letter of Review from CoAEMSP. Initial CoAEMSP site visit is scheduled for October, 2013
      b) Patrick Henry Community College
         (1) Letter of Review has been submitted however the review is on hold pending the hiring of a new Program Director.
      c) Rappahannock EMS Council Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP.
      d) Prince William County Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP.
      e) Center for EMS Training, Inc.
         (1) Has been denied accreditation from CoAEMSP/CAAHEP and is not eligible to conduct Paramedic training.

On Line EMS Continuing Education

Distributive Continuing Education

EMSAT programs are now available FREE on CentreLearn! Virginia EMS providers can once again receive free EMSAT Continuing Education Courses on your home or station PCs. Fifty or more EMSAT programs are now available on CentreLearn Solutions LLC, at no cost to certified 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

A. EMSAT programs for the next three months include:

1. Aug. 21, Dealing with a Mentally Ill Patient
   Cat. 1 ALS, Area 89, Cat. 1 BLS, Area 05

2. Sept. 18, Virginia OEMS Rules and Regulations
   Cat. 2 ALS, Cat. 1 BLS, Area 07

3. Oct. 16, How Sweet it is: Diabetic Emergencies
   Cat. 1 ALS, Area 89, Cat. 1 BLS, Area 05

The EMS Portal

With the launch of the EMS Portal just over 4 years ago, the EMS community has embraced the ability to interact in real time with the Office. The Portal has provided a greater level of access to OEMS data than ever before. Starting with EMS instructors, adding EMS providers and with the agency installment launched on December 5, 2011, the Portal continues to grow. The goal is to enable agencies, providers and educators a more efficient process when interacting with the Office.

Future plans for the portal include but not limited to:

1. Provider directed recertification with the implementation of the new recertification process that eliminates the need for testing or a test waiver for those whose certification has not expired. This component of the portal is in the final testing phase and will be initiated upon the completion of the “fast track” regulatory changes.

2. Web based electronic course enrollment. This will reduce errors, the use of paper based forms and improve efficiency by allowing the option for all course enrollments to be recorded electronically. With this addition, the ability to gather emails and other demographic information will allow greater electronic communication, reducing printing and mailing costs. It may also provide a more accurate picture of how EMS is provided in Virginia. This component is ready for implementation. Instructional webinars are scheduled for August 2013 with email invites being extended to all Education Coordinators. The office anticipates this being activated mid August.

3. The opening of the EMS Physician Portal is in the near future. This will allow EMS physicians unprecedented access to the EMS system by providing electronic access to their agencies, providers, and educators. The EMS physicians have been very patient as the Portal was developing. With this access, the EMS physician will be better equipped to conduct business with the various EMS system components with which they participate. The office is in the final development phase. Testing will begin soon followed by EMS Physician orientation.

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

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

If your providers have not yet activated their portal, please encourage them to do so. The same goes for EMS agencies. We are beginning to utilize email more and the source for the email addresses comes from the portal. Please be sure to keep your email up to date and assure it is listed correctly in the portal.

CTS

A. The TCC has assigned a workgroup chaired by Tom Nevetral to update the psychomotor test evaluator training program.

B. OEMS Examiner Jessie Swinson resigned his position.

C. An initiative to replace optically scanned bubble forms with direct electronic input of psychomotor test results has begun. Implementation is expected next year.

D. There have been 38 psychomotor test sites conducted since your last meeting on May 10, 2013.

E. The EMSAT video "The Virginia Certification Experience" has been posted on the OEMS Web page in three segments. DVD's of this program for all Education Coordinators have been made and will be sent out soon.

Other Activities

- Debbie Akers was selected to participate on the Item Writing Committee with National Registry. She attended the session held from June 20-22 in Columbus, Ohio where her 25 submitted questions were reviewed by the committee and promoted to the pilot testing phase by National Registry.
- Debbie Akers will be serving as the Regional Chair person at the National Association of EMS Educators (NAEMSE) conference being held from August 4 – August 10, 2013 in Washington, DC.
- Greg Neiman continues to participate with the Autism Public Safety Workgroup coordinated by the Commonwealth Autism Service.
- A workgroup has been created by TCC to address HB1856 as it pertains to the "Training Disparities, Delivery and Availabiltiy of Training" component of this Section 1 bill. The workgroup is comprised of:

    - Dr. Charles Lane, MD
    - James Gower
    - James Larounis
    - Kathy Eubank
    - Michael Garnett
    - Greg Neiman
    - Pat Pope
    - Warren Short

- The committee had an initial meeting on April 14th. Due to vacation schedules, the next meeting will be planned for late August or early September 2013.

Emergency Operations

IV. Emergency Operations

Operations

- **Virginia 1 DMAT**

Frank Cheatham, HMERT Coordinator continues to attend the Va-1 DMAT team meetings as the Office of EMS representative.

- **HMERT Operations**

The Division of Emergency Operations provided logistical support to the Rivahfest event in Eastern Virginia the weekend of June 15, 2013. The Division supplied the supporting squad with misters and generators to provide heat relief to attendees.

- **Hanover Tomato Festival**

Karen Owens, Acting Emergency Operations Manager, and Frank Cheatham, HMERT Coordinator, assisted in the preparation and standby for the 35th annual Hanover Tomato Festival on July 13, 2013. The Division was asked to supply equipment for heat relief (misters, generators, and tents), as well as the command center.

- **Virginia Emergency Response Training Exercise (VERT)**

On May 21, 2013 the Office of EMS participated in the annual VERT event at the state Emergency Operations Center (EOC). The Emergency Planner served as a member of the Sim Cell, while the HMERT Coordinator and Emergency Operations Acting Manager worked to process EMS based requests in webEOC. The exercise provided an opportunity to test HMERT resources and their notification process.

- **Building Emergency and Evacuation Plan (BEEP)**

On July 3, 2014, the Emergency Planner conducted a fire drill of the Office of EMS as part of the Building Emergency and Evacuation Plan (BEEP).

Committees/Meetings

- **Resource Management Meeting**

Karen Owens, Emergency Operations Acting Manager, attended a state-level meeting of members of the Department of Emergency Management, Department of Fire Programs, and other agencies to discuss the problems of resource management during state emergency events, as well as the use of Statewide Mutual Aid.

- **Hurricane Evacuation**

The HMERT Coordinator continued to attend Lane Reversal Committee Meetings. He also participated in the state Lane Reversal Exercise on July 21, 2013. The exercise will test the ability to properly reverse lanes and communication capabilities. The HMERT Coordinator and

Emergency Operations Acting Manager also attended a meeting with Virginia State Police to finalize arrangements on the utilization of STARS radios and equipment for all Task Force deployments.

- **EMS Communications Committee**

The EMS Communications Committee met on Friday, May 10, 2013. Committee Chair Gary Critzer mentioned that there are issues going in the 9-1-1 industry concerning a the discontinuation of a communications product and the cost on the locality for the switch to a new system. The committee discussed the potential actions that could be offered to assist localities. The Committee also discussed the West Virginia EMD mandate.

- **EMS Emergency Management Committee**

The Division of Emergency Operations participated in the EMS Emergency Management Committee Meetings during this quarter. The meeting, held on May 9, 2013 focused on Business Risk assessment and planning for EMS agencies, as well as resources management at the state level.

- **Continuity of Operations Plan Committee**

Winnie Pennington, Emergency Planner held a COOP committee meeting on July 15, 2013. The committee worked on the development of an exercise for the Office of EMS to test the COOP.

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

Frank Cheatham, HMERT Coordinator will staff the NASEMSO Emergency Responder Safety committee. He continues to review documentation and send comments back for review. The final draft was completed in the middle of June.

- **Traffic Incident Management (TIM)**

The HMERT Coordinator serves on the group overseeing the deployment of the TIM Training program in the Commonwealth. The focus of the group is the SHRP 2 training curriculum that was developed by the Federal Government. Train the trainers will be held throughout the Commonwealth.

- **2013 Boy Scout Jamboree – West Virginia**

On June 28, 2013, Karen Owens participated in an information only conference call with members of the Eastern Region and representatives of the West Virginia department of Health and EMS office to review plans and expectations for the 2013 Boy Scout Jamboree. The conference call provided an opportunity for West Virginia officials to update those on the call of the plans in place and expected need.

- **Provider Health and Safety Committee**

On May 9, 2013 the Provider Health and Safety Committee met for their quarterly meeting. The team discussed the training programs available as well as the ability to track and manage information on line of duty injury and death.

Training

- **VDH-Preparedness Summit**

Winnie Pennington, Emergency Planner, attended the annual VDH Preparedness Summit on May 1-2, 2013. The summit provided an opportunity to attend various sessions on preparedness and planning issues in the state.

- **OEMS VERT Training**

The Office of EMS conducted annual training for the Virginia Emergency Response Team (VERT) members. The training, held on June 4, 2013, provided a review of the EOC procedures, webEOC access, and how to handle resource requests.

- **FEMA VTTX**

Winnie Pennington, Emergency Planner, participated in the FEMA VTTX exercise on June 26, 2013. The exercise focused on Mass Casualty response.

- **Hurricane Response Exercise**

On May 21, 2013 the Emergency Planner participated in the FEMA VTTX exercise on hurricane response.

Communications

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

PSAP Accreditation for the City of Colonial Heights was approved by the Communications Committee on May 10, 2013 at the regularly scheduled Communications Committee meeting. James City Co. 9-1-1 was re-accredited on June 6, 2013 after a scheduled site visit.

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

OEMS was represented by Communications Coordinator Ken Crumpler at the APCO/NENA Spring Conference in Virginia Beach. Mr. Crumpler spoke regarding EMD implementation with

Tazewell Co. 9-1-1 Director Derrick Ruble and PowerPhone Chair Chris Salafia and a second class on the subject of the role of the PSAP during Medevac operations.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

Regional CISM Team reports received by the date of this quarterly report include 12 calls for assistance.

Public Information and Education

V. Public Information and Education

Public Relations

Public Relations (April – June)
EMS Week, May 19 – 25

- Mailed out EMS Week planning guides to all affiliated EMS agencies in Virginia. Received proclamation from the to the Governor's recognizing EMS Week in Virginia.
- Prepared and distributed press release for EMS Week to all media. Received media coverage from two news radio outlets.
- Posted event information on the VDH and OEMS website, Facebook and Twitter pages and shared it via listserv. Information that was shared included the press release, Governor's proclamation, local promotions offered by area retailers and events occurring across the state in honor of EMS Week.

Fire and EMS Memorial Week, June 1 – 8

- Participated in the event marketing call hosted by VDFP and provided suggestions and tips as needed.
- Developed a marketing plan for OEMS' participation in the event, which included a mention about this event in the EMS Week press release, sharing various posts about the event on the OEMS social media pages and sent out an E-blast through our listserv.
- Worked with the informatics coordinator to provide current data to be included in the Governor's proclamation, which was prepared by VDFP.
- Attended an event at the Governor's Mansion to recognize the family members of providers who died in the line of duty.
- Prepared a donation letter regarding the Virginia Public Safety Memorial, to be sent to all EMS agencies.

EMS Bulletin

Completed and posted the Spring EMS Bulletin on the OEMS website April 1. Also promoted the bulletin through the OEMS listserv.

Promotions
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 April through June are as follows:

- **April –** National Public Health Week, Annual Hampton Roads Trauma Symposium, article about the rise in 911 call centers receiving telephony denial of service attacks, distracted driving awareness month, EMS Bulletin, Rider Alert program, Implementation Guide to Infection Prevention in EMS, National Volunteer Week.
- **May –** Fire & EMS Memorial Week, Mercedes-Benz new QR code safety schematic, EMS Week, EMS Memorial Bike Ride, Va. Beach Vol. Rescue Squad fundraising campaign, disaster response/emergency dispatch, National Nurses Week, PEMS Council training symposium, Stroke Awareness Month, Hurricane preparedness and Motorcycle Awareness Month.
- **June –** National EMS Memorial Service, provider portal and trauma registry maintenance, International Fire/EMS Safety and Health Week, severe weather warnings, Virginia Fallen Firefighter Memorial Service, delay in the implementation of changes to the recertification process for Virginia EMS providers, emergency preparedness, National CPR Week and Fire and EMS Memorial Week.

Via OEMS Website (April – June)

- **April** – Updated the OEMS website rotating news feature blocks with new information pertaining to National Public Health Week, National Distracted Driving Awareness Month and other awareness events that were going on during the month of April.
- **May** - Updated the OEMS website rotating news feature blocks with EMS Week, Fallen Firefighters Memorial Service, hurricane preparedness.
- **June** – Updated the EMS News section on the OEMS homepage with information pertaining Fire and EMS Memorial Week and a new safety feature from Mercedes-Benz that utilizes QR codes on windows which enables rescuers to pull up the car's schematic in case of an emergency when extrication is required.

Via Constant Contact E-mail Listserv (April - June)

- April 12 – Promoted the 2013 Spring EMS Bulletin.
- April 15 – Promoted Public-Safety Telecommunicators Week
- May 10 - Auvi-q new product info
- May 20 – EMS Week press release, proclamation and event info.
- May 21 – Reminder about disaster assistance and OEMS' rules regarding self-dispatching to disaster areas.
- May 31 – Fire and EMS Memorial Week
- June 4 - 2013 Virginia EMS Symposium Pre-Con Guide
- June 7 - Delay in Changes to Recertification Process
- June 21 - OEMS Portal Maintenance
- June 28 - Important Notice Regarding Practitioner Signature

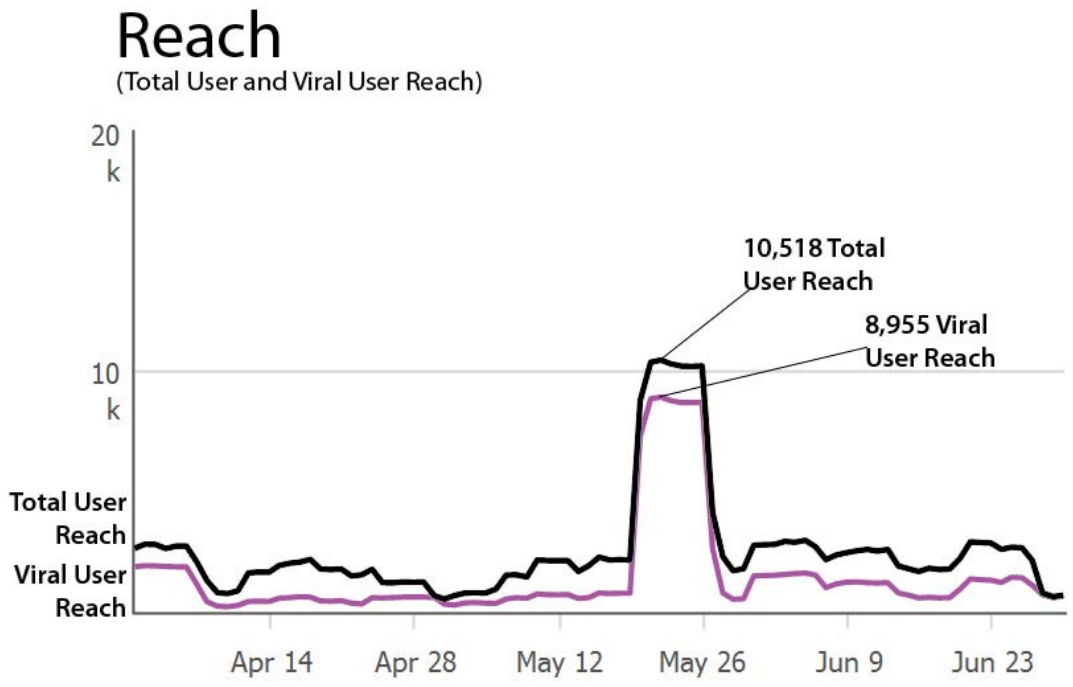
Training

The Public Information and Education Division participated in Virginia Emergency Response Team (VERT) Exercise conducted by OEMS on June 4.

Website Statistics

Figure 1: This graph shows how many unique users and viral users saw content from our Facebook page from April - June 2013. *Viral user reach* defines unique users that saw a story about our page published by a friend. The *total user reach* of unique users is defined as people who saw any content associated with our page. Each point represents the unique people reached in the 7-day period ending with that day.

***As of July 25, 2013 the OEMS Facebook page had 3,027 likes, which is an increase of 517 new likes since April 24, 2013. It's important to note that the OEMS Facebook page officially received over 3,000 likes in the month of July, 2013.**



Due to technical difficulties with the WebTrends reporting program, statistics pertaining to the OEMS webpage will be unavailable until further notice. These statistics include the top downloaded items, unique visitors, average hits per day and the average visit length by minutes to the OEMS website.

Governor's EMS Awards Program

- Created a promotional flier for the Regional EMS Council award deadlines and banquet dates, which was posted on the OEMS website April 15.
- Beginning May 31 – June 19, finalized the **TJEMS, PEMS, BREMS, WVEMS, NOVA and REMS** Regional EMS Council Awards press releases for distribution to local media contacts. Also posted these press releases on the VDH Regional Press Releases webpage.
- Coordinated office staff attendance at the Regional EMS Council award banquets.

EMS Symposium

- Posted the EMS Symposium Sponsor Guide on the OEMS Symposium webpage April 15.
- Designed and posted the Pre-Con Guide online and through social media and listserv promotions May 31.
- Started drafting and laying out the course catalog, to be completed in July.

Media Coverage

The PR coordinator was responsible for fielding the following OEMS and VDH media inquiries.

OEMS Media Inquires:

- April 1 - Karen Hopkins, reporter with 13NEWS WVEC-TV requested info about the OEMS audit and inspection process for EMS and fire trucks.

- May 21 - Alison Burns, reporter with the Virginia News Connection Public News Service conducted a taped interview regarding the EMS Week press release. Covered the number of EMS providers and agencies in Va. Also answered questions regarding calls for service and what they typically involved.

- May 21 - Ruthann Carr, reporter with the Fluvanna Review wanted to know about a report that several Fluvanna Rescue Squad vehicles didn't pass state inspection, and that they must comply with regulations by July.

- May 24 - Beverly Amsler, reporter with WVTF Public Radio & RADIO IQ and Virginia Public Radio conducted a live interview regarding EMS Week and the increase in EMS calls. Answered questions about volunteering in EMS, mentioned EMS Week information from the press release including facts about the number of EMS providers and agencies in Va. and that EMS week is recognizes the heroic efforts and dedication of Virginia's EMS providers. Also mentioned that out of the nearly 700 EMS agencies in Va. 447 of them are volunteer agencies.

- June 6 - Ruthann Carr, Fluvanna Review requested info regarding purported reports of Fluvanna EMS' out of service ambulance and unanswered calls.

- June 19 - Ruthann Carr, Fluvanna Review requested an update regarding Fluvanna Rescue Squad's permit.

- June 24 - Ruthann Carr, Fluvanna Review requested specific documentation pertaining to a provider's certification.

VDH Communications

VDH Communications Tasks– The PR coordinator was responsible for covering the following VDH communications tasks from April - June 2013.

- **April** – Coordinated and edited stories that highlighted VDH offices and programs for the Commissioner's Weekly Email during the month of April.

- **May** –Was responsible for the Team Editor task during the month of May, which involved editing various press releases, the Commissioner's weekly email and other documents for the PR team. Attended the Public Health Summit May 1-2. Also participated in the VERTEx training hosted by VDEM and held at the Virginia Emergency Operations Center Joint Information Center on May 22. I was a participant in this training on behalf of the VDH communications team.

- **June** – Coordinated and distributed Media Alerts during the month of June. In addition to the regularly scheduled monthly communications tasks, the PR coordinator is also responsible for updating the VDH Twitter page on a daily basis. This task began March 18 and will continue indefinitely. Also assisted as needed with tasks while fellow communication team members were out of the office.

Planning and Regional Coordination

VI. Planning and Regional Coordination

Regional EMS Councils

- **Regional EMS Council Designation**

The recommendation of the Regional EMS Council designation Site Reviewers to re-designate the current eleven Regional EMS Councils was unanimously approved by the Board of Health at their meeting on June 6. The current three year term of designation for the eleven Regional EMS Councils began on July 1, 2013. Each council received confirmation of designation from Dr. Romero prior to the beginning of the term.

- **Regional EMS Councils**

The Regional EMS Councils have submitted their FY13 Fourth Quarter contract reports throughout the month of July, and are under review. Most of the Regional Councils conducted their respective Regional EMS Awards programs throughout May, June, and July.

Medevac Program

The Medevac Committee is scheduled to meet on August 8, 2013. The minutes of the May 9, 2013 meeting are available on the OEMS website.

Additionally, the Medevac Committee met on August 7, to discuss the model State EMS Guidelines put forth by the Association of Air Medical Services (AAMS). The results of the meeting will be included in future quarterly reports.

The Medevac WeatherSafe application continues to grow in the amount of data submitted. In terms of weather turndowns, there were 607 entries into the WeatherSafe system in the second quarter of 2013. Roughly two thirds of those entries (372 entries) were for interfacility transports, which is a continuing trend. This is a decrease from 376 entries in the first quarter of 2012. This data continues to show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

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 in March of 2011.

As has been done in the past, the committees of the Advisory Board were tasked with evaluating the current Plan, and proposing additions and/or deletions, as well as a SWOT analysis, as it pertains to their particular subject area. Templates for these planning sessions were distributed in February, and proposed revisions were incorporated into the draft of the Plan.

Over the past few months, the subcommittees of the Governor's Advisory Board have met to update the plan. A draft for review by the Advisory Board has been provided as **Appendix D**, to be voted on at the November meeting. In the interim, the draft of the Plan will be posted to the OEMS website for public comment.

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

Regulation & Compliance

VII. Regulation and Compliance

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 (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 2nd quarter of 2013:

Enforcement

Citations Issued:	7
Providers:	4
EMS Agencies:	3

Compliance Cases

New Cases:	30
Cases closed:	19
Suspensions:	2
Temporary Suspensions:	4
Revocations:	5
Consent Order:	0

EMS Agency Inspections

Licensed EMS agencies:	685 Active
Permitted EMS Vehicles:	4,492 (Active, Reserve, Temporary)
Recertification:	
Agencies:	86
Vehicles:	561
New EMS agencies:	2
Spot Inspections:	156

Hearings (Formal, IFFC)

April 4, 2013 – Tomer
April 4, 2013 – Fluvanna Rescue Squad

April 4, 2013 – Nelson
April 4, 2013 – Feltner
May 31, 2013 – Hamilton VFD

Variances

Approved: 10
Disapproved: 6

OMD/PCD Endorsements

As of July 19, 2013: 223 Endorsed

Division Work Activity

Division Work Activity

Regulation and Compliance staff continues to represent the Office of EMS in Fire/EMS studies conducted by the Virginia Fire Service Board. The Wythe study was completed on June 2-4, 2013 and the Wise study was completed on July 14-17, 2013. The draft reports are being finalized before presenting them to the respective county governments. Amherst County has requested and subsequently granted approval by the Fire Service Board for a Fire/EMS study and Shenandoah County has submitted a similar request.

OEMS staff continues to offer technical assistance and educational presentations to EMS agencies, entities and local governments as requested. The following is a listing of locations and dates for the second quarter of 2013:

April 2, 2013 – Met with Delegate Orrock regarding HB 1856
April 3, 2012 – Met with VSP regarding FBI background checks
April 6, 2013 – VAVRS Spring BOG, Conducted EMS Regulations presentation
April 8, 2013 – Eastern Shore, Conducted EMS Regulations presentation
April 17, 2013 – Hardy, VA – OMD training class
April 24, 2013 – Cleveland Life Saving Crew – Conducted EMS Regs presentation
April 28, 2013 – Appomattox VRS – Conducted EMS Regulations presentation
April 29, 2013 – Medevac Committee Work session
May 10, 2013 – Stuart, Virginia – Conducted EMS Regulations presentation
May 29-30, 2013 – Baltimore, MD – NFPA 1917 workgroup (NASEMSO)
June 8, 2013 – VAVRS Rescue College, Blacksburg – OMD training class
June 18, 2013 – Attended Board of Pharmacy meeting

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.

A quarterly OEMS field staff meeting was held in Richmond, VA on June 5-7, 2013. The agenda for this meeting focused on routine operational and administrative functions of the work unit as well as meeting with the FARC committee a part of their grant review process.

Personnel Matters

The Office of EMS received permission to fill the vacant OEMS Program representative position previously held by Mr. Adam Harrell (NOVA). Interviews have been conducted and an offer has been made to the unanimous top candidate. It is anticipated this position will be filled the first week of August.

EMS Regulations

Staff is working with the various stakeholder groups (Medevac, Training and FARC) to review suggested revisions to sections of the current EMS Regulations. Once these reviews are complete, they will be directed through the Rules and Regulations Committee to be submitted as a regulatory review packet.

Recently announced changes in the EMS recertification process pertaining to the elimination of testing requirements for the requirement to obtain a test waiver will be delayed. Originally scheduled to take effect July 1, 2013, changes to the EMS recertification process must be delayed until regulatory reviews can be completed. The Fast Track regulatory package has been initated.
http://www.vdh.virginia.gov/OEMS/Files_Page/Training/NoticeofTestWaiverRemoval0613.pdf.

The Office of EMS is working with the Virginia Department of Health (VDH) executive leadership and the Virginia State Police to obtain the necessary equipment, supplies and develop policies and procedures for the implementation of FBI fingerprint background checks for each person who, on or after July 1, 2013, applies to be a volunteer with or employee of an EMS agency. Because these tasks are not complete, there will be a delay in the enactment of these new requirements in the law (§32.1-111.5). The needed equipment has been approved for purchase and OEMS is currently awaiting delivery, installation and training on the LiveScan program.
http://www.vdh.virginia.gov/OEMS/NewsFeatures/Implementation%20of%20FBI%20Background%20Checks%20Delayed.pdf.

DDNR – The periodic review is approaching. Input from OEMS staff for suggested changes to these regulations has been solicited. The process is to be completed by next spring.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The Workforce Development Committee (WDC) last met on May 14, 2013 – no business was conducted because a quorum was not present. The committee is scheduled to meet again on August 8, 2013.

WDC Sub-Committee Reports:

(a) Standards of Excellence

The sub-committee last met on April 24, 2013 and completed a final review of the material for all seven (7) Standards of Excellence Self-Assessment Surveys. The Operational Medical Direction portion of the Standards of Excellence program was assigned to Dr. George Lindbeck, State Medical Director for review and approval.

(b) EMS Officer Standards (I – IV)

The EMS Officer sub-committee last met in June, 2013. The EMS Officer Standards program was distributed to OEMS program staff for review. Those reviews are now under consideration by the subcommittee and will be forwarded to the Work Development Committee for final review and/or changes.

The Virginia Recruitment and Retention Network

The Recruitment and Retention Network has not met since the last State EMS Advisory Board. The next meeting is scheduled on August 16, 2013.

Trauma and Critical Care

IX. Trauma and Critical Care

Patient Care Information System

VDH Data warehouse development/linkage to hospital discharge data

We are very excited to announce that we have officially entered into a memorandum of understanding (MOU) between the OEMS and VDH's Office of Information Management (OIM). The data warehouse project will move us in the direction of linking VPHIB and VSTR with VDH's data warehouse that includes the State's hospital discharge data, vital statistics, and other health related data.

By participating in the VDH data warehouse we will have the unprecedented ability to access outcome data for EMS events in Virginia and also share our EMS and trauma data with other VDH programs to help influence other public health programs. We believe we are the first state in the country working on linking all EMS responses to hospital data. A small number of states perform some limited linkages to motor vehicle crash records and trauma data.

Agencies are encouraged to submit VPHIB data in real-time!

VDH/OEMS requests that agencies that have the ability to submit VPHIB data in real-time please do so. With the advances that have been made in EMS data collection, the EMS system could be the fastest resource for biosurveillance.

What is biosurveillance? Biosurveillance is a method of monitoring for biological agents used in terrorism, the spread of infectious diseases, and food-borne illnesses. Real-time data submissions can also assist local, regional, and state officials with rapid access to vital information about large scale incidents that have occurred in the Commonwealth. Early detection of these types of incidents could save lives, decrease the spread illness, and provide a means to rapidly intervene. Saving lives and rapidly intervening to prevent further illness and injury is the mission of EMS. Advances in technology now make it possible for the individual provider treating an individual patient to immediately affect a larger population of patients.

The most common issue VPHIB staffs hear from agencies is that they don't want to submit a patients EMS record until they are sure the record is complete and has the highest quality score possible. Agencies tell us that if a provider doesn't complete the EMS record during their shift that it may take to 30 days for providers to complete it. Along the same lines, agencies want to be able to perform QA on the record before it is submitted.

All of issues in the previous paragraph are still possible with real-time submission. When agencies establish web-services (automatic uploading) even if the initial EMS record that is submitted to VPHIB is incomplete; once the record is updated and is complete it will be resubmitted to VPHIB and replace/overwrite the incomplete record. VPHIB staff would not assess your agency's data quality compliance on records until they were over 30 days old. The initial data that is available in an incomplete record could be extremely valuable for

biosurveillance. The same process you are currently using to assure VPHIB receives high quality records should not have to be changed if you initiate real-time submission.

All agencies that use the State provided Field Bridge submit in real-time, as do all EMS Charts users in Virginia. EMS Charts was the first third party vendor to establish real-time submission and VPHIB receives their records within minutes. Many agencies with their own ImageTrend Service Bridges also submit in real-time just by clicking on auto-uploading in the administrators section of their Service Bridge. Zoll Inc. also has this functionality. Zoll users can contact Zoll support and request "web-services" be turned on to auto-submit to VPHIB. Zoll will work with ImageTrend to make the connection.

Don't believe us? Read the President's National Strategy for Biosurveillance released in July 2012.

Figure 1 - A sample of a biosurveillance report from the NEMSIS State Reports

The NEW! Virginia Statewide Trauma Registry (VSTR)

As previously reported, the Div. of TCC is in the process of replacing the existing VSTR with the Patient Registry product by ImageTrend. The new VSTR (using Patient Registry) will go live on or around January 1, 2014. The new VSTR, aka VSTRv3, has been installed on the same server cluster that the VPHIB system is installed on and the two systems will be integrated.

By having the two systems "integrated" hospital's will be able to pull EMS run information (up to 60 elements) directly into the hospital's trauma registry record. The ability of hospitals to populate fields in the trauma record they are creating will cut down on data entry time and help assure a higher level of quality. Likewise, the EMS record will have the ability to be backfilled

with “outcome” information that will help EMS agencies to be able to perform quality assurance initiatives on its trauma patients.

The new VSTR was installed in June and staff is actively setting up the new system. Most of the data entry pages have been drafted and the validation rules are in the final stages of testing. Once these two phases are complete, staff will setup the system’s different permission levels and begin distributing resource materials to hospitals throughout the Commonwealth. Training will be provided to hospital staffs during the mid to late fall.

Along with the software program change, the required minimum dataset was reviewed and revised. Div. of TCC staffs provided two public comment periods primarily focused towards all hospitals, the trauma centers, and the trauma registry vendors that serve Virginia. On June 6, 2013 the TSO&MC endorsed the revised VSTR minimum dataset. The revised VSTR minimum dataset is attached as **Appendix E** and is presented as an action item to the EMS Advisory Board for its endorsement. The State Board of Health (BOH) is the final promulgating body for the VSTR minimum dataset. If endorsed by the EMS Advisory Board the VSTR revised minimum dataset will be presented to the BOH in September 2013.

The Div. of TCC is happy to introduce the new VSTRv3. Even though the system is still being setup, below are screen shots to provide a glimpse of what the VSTRv3 homepage which includes customizable dashboards, data entry pages, a data exchange portal for hospitals that submit files from electronic medical record systems, and an analytics (reporting) page.

Figure 2 - VSTR Home Page with Individualized Hospital Dashboard.

Figure 3 - Patient Demographic Data Entry Page

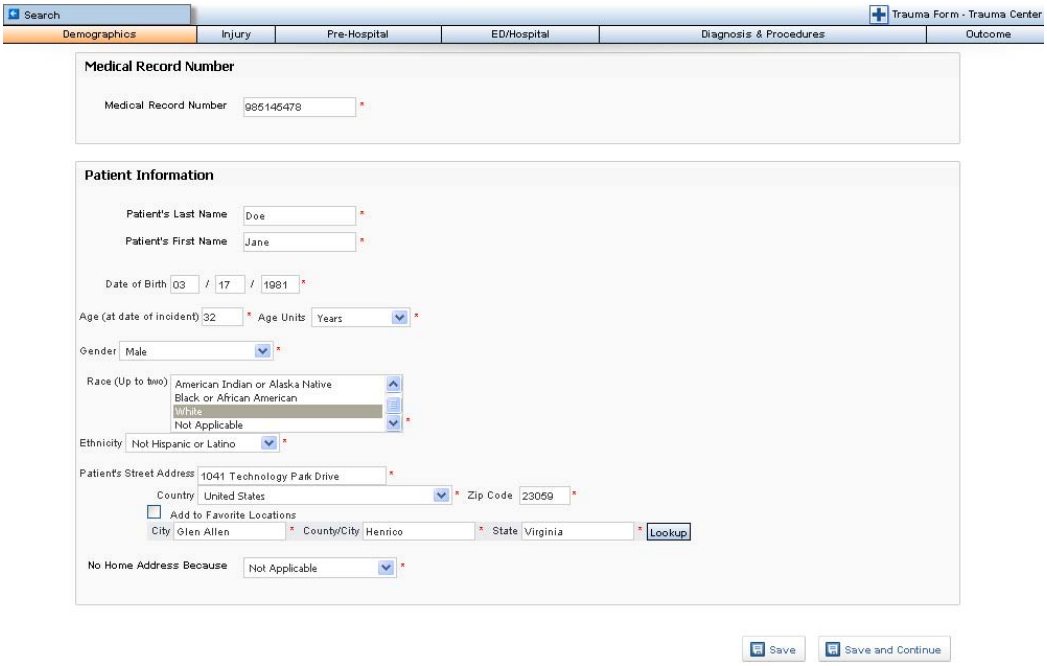


Figure 4 - Injury/Situation Data Entry Page

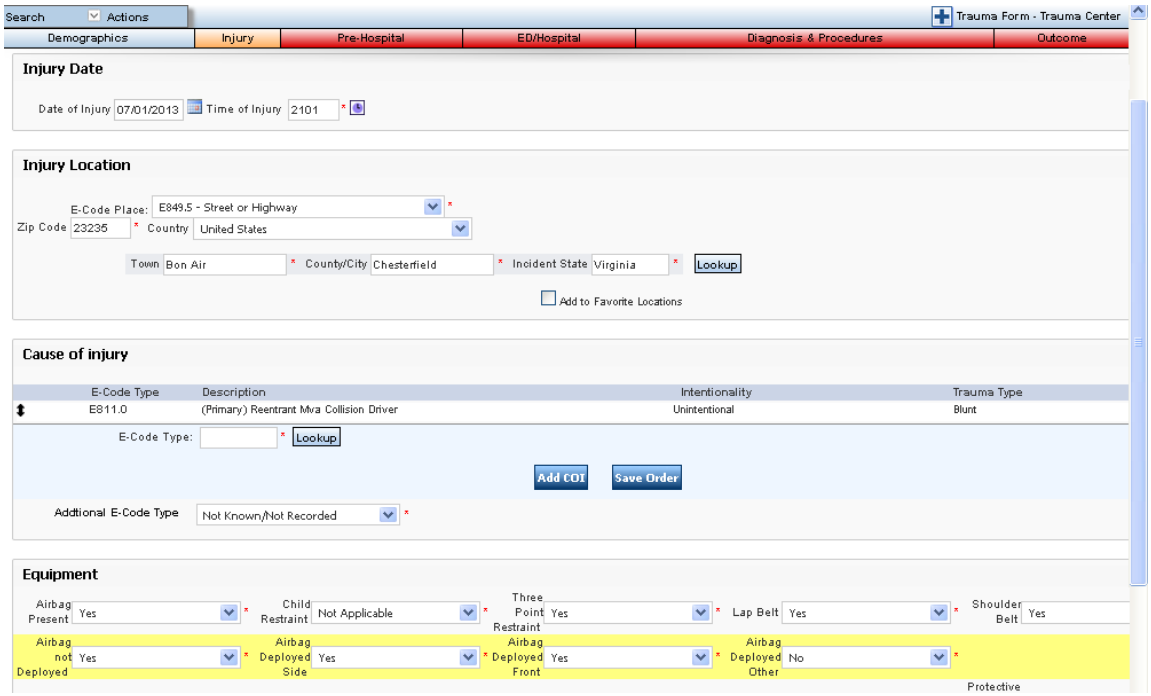


Figure 5 - Prehospital Data Entry Page with Prehospital Record Look-up

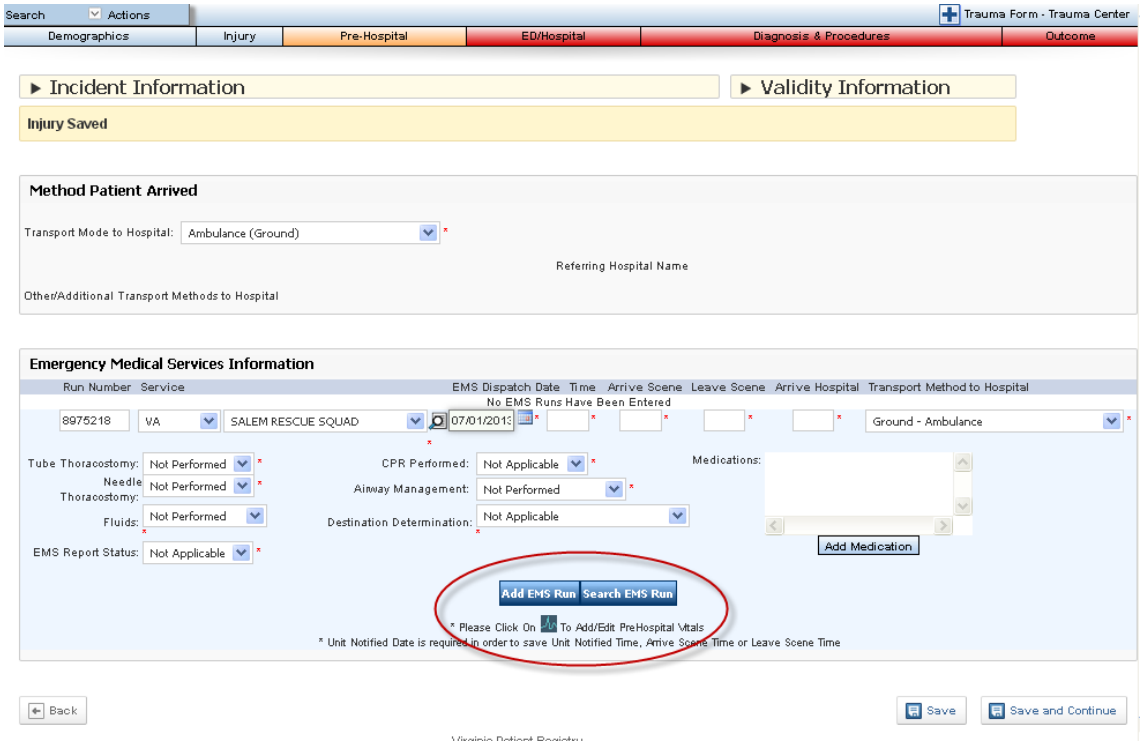


Figure 6 - Emergency Department Data Entry Page

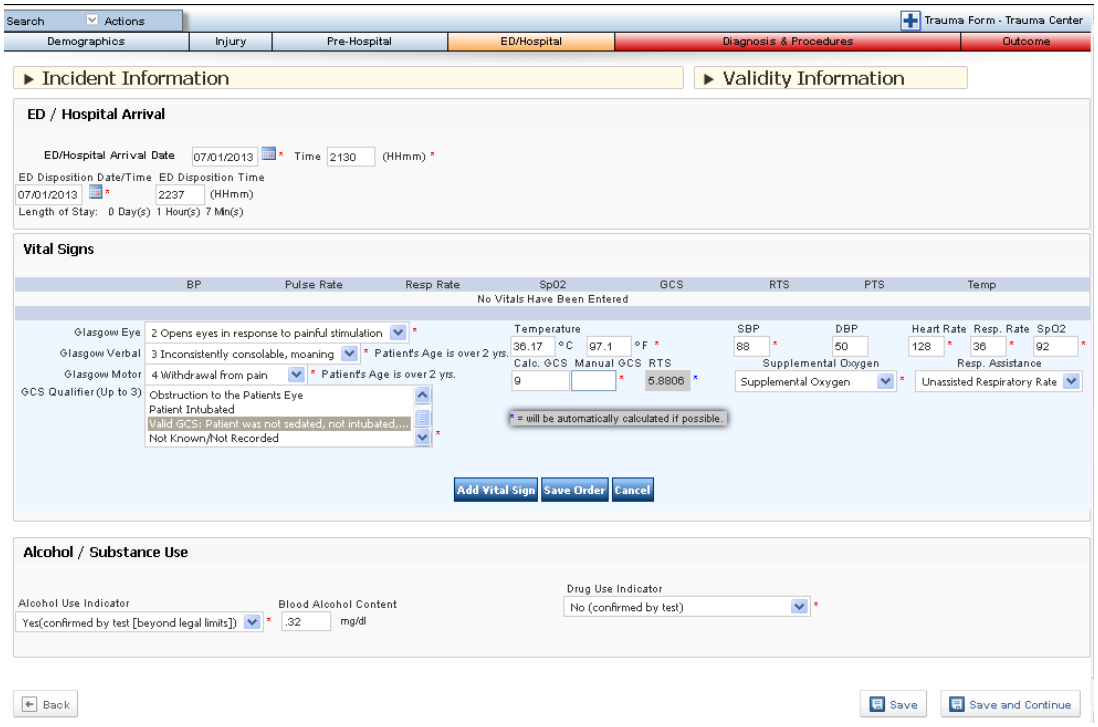


Figure 7 - Diagnosis, Injury Severity Scoring, Past Medical History, and Procedures Page

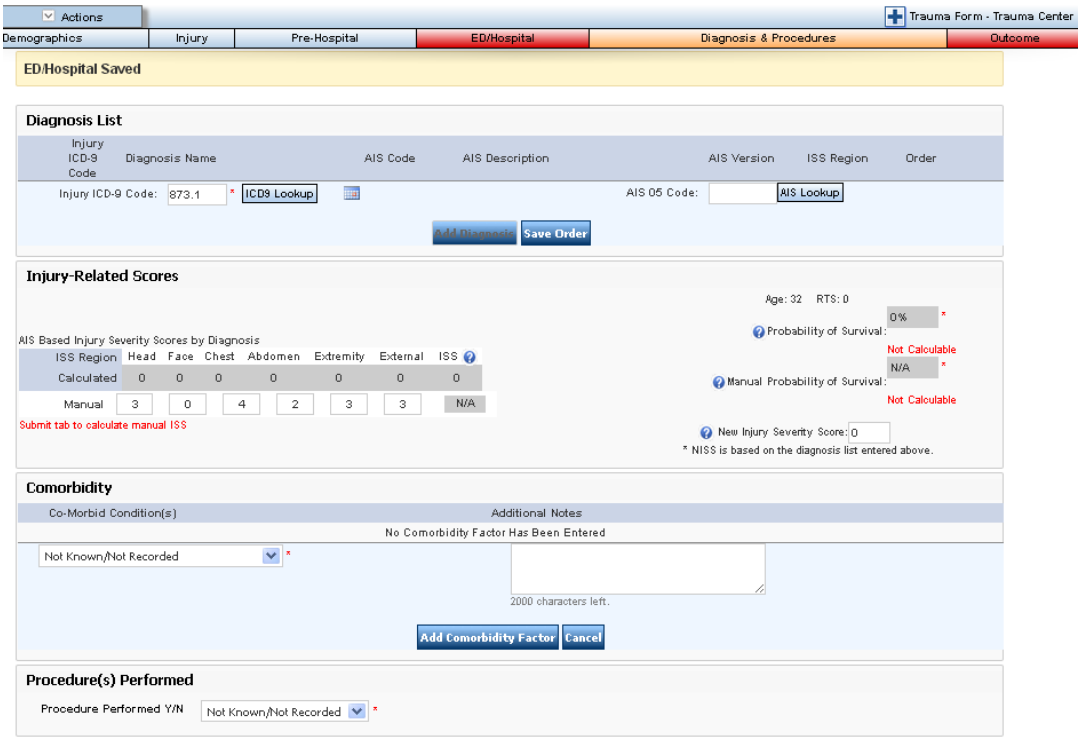


Figure 8 - Patient Outcome Data Entry Page

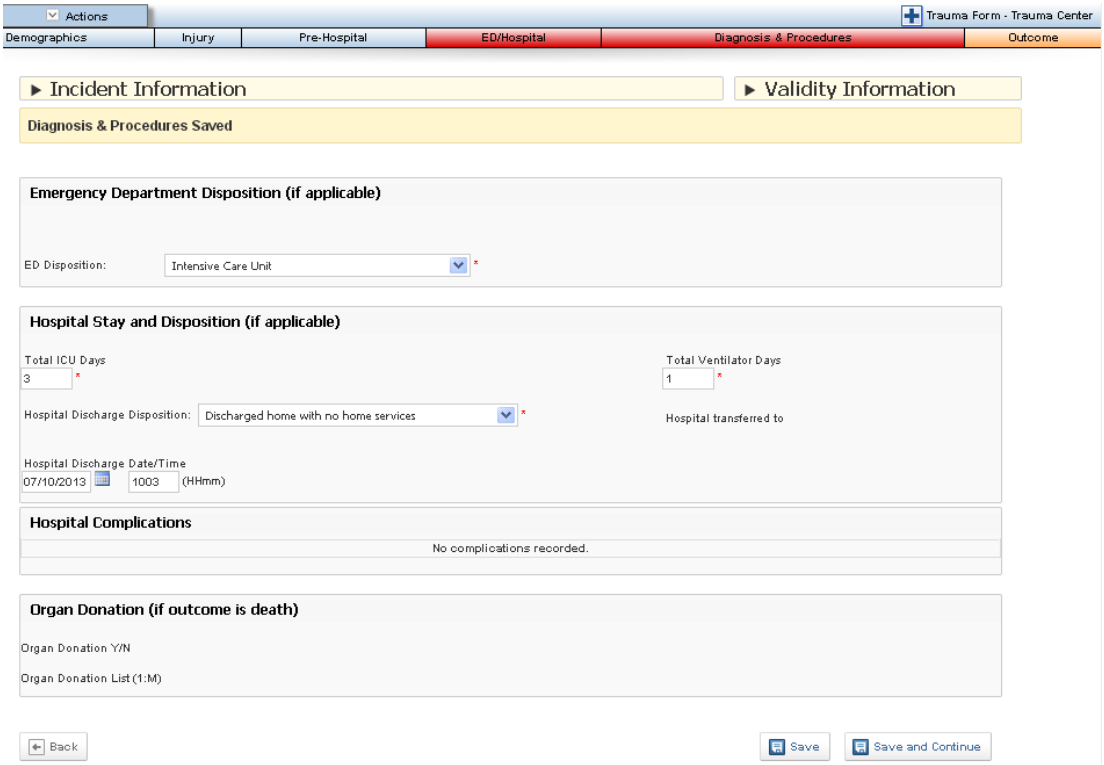


Figure 9 - Data Import Page

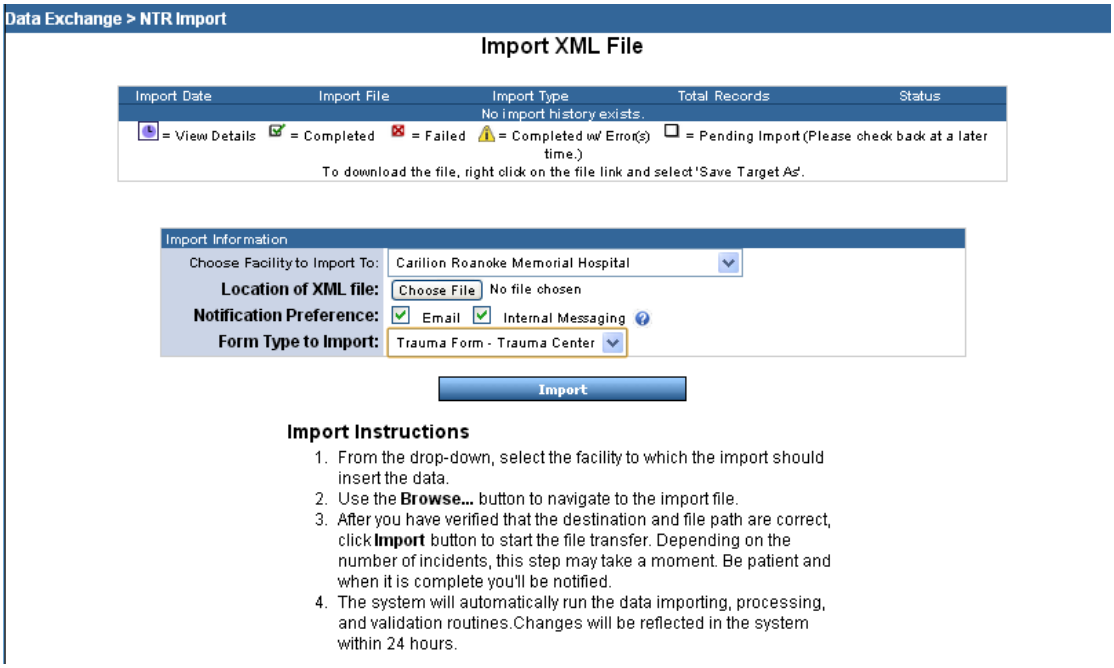
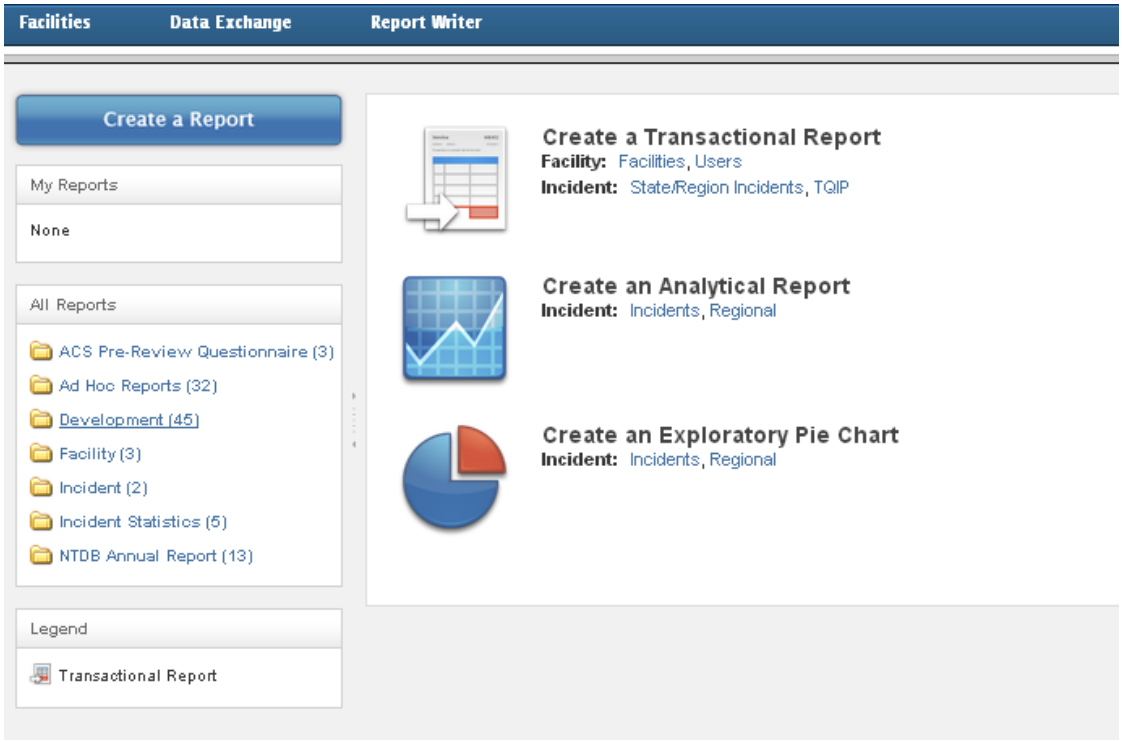


Figure 10 - VSTR Report Writer Page



Virginia Pre-Hospital Information Bridge (VPHIB)

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

As a reminder, the migration of VPHIB v2 dataset to the newVAv3 dataset is slated for 7/1/2014 thru 12/31/2014. All EMS agencies will be expected to move from v2 to VAv3 during this six-month window.

NEMSIS Related Items and Submission

During the June 23rd NASEMSO Data Managers Council meeting the NEMSIS Technical Assistance Center (TAC) announced it has its first vendors undergoing NEMSIS version 3 certification. The two vendors are:

- ImageTrend Inc.
- A/R Concepts Incorporated

There are also two vendors undergoing NEMSIS version 2 certification

- Harrison Software
- 1 Un-named vendor (asked not to be identified)

Virginia data is submitted by the Div. of TCC staff to NEMSIS each month when the Data Quality Dashboard and Compliance Report are developed. Data not submitted on time by Virginia EMS agencies will never get submitted to the national EMS database. We have seen a significant rise in the number of records being accepted by NEMSIS and have submitted an all time monthly high volume of 97,005 records. Figure 11 shows the number of records that have been accepted by NEMSIS for the most recent quarters.

Figure 11 - Number of Virginia EMS records accepted to date by the national EMS database.

Warehouse Summary for Your Sites							
	2011	2012				2013	
	Q4	Q1	Q2	Q3	Q4	Q1	Q2
test VIRGINIA	1	1	2	1	8	41	97,005
VIRGINIA	228,478	240,766	248,503	244,557	240,848	261,211	198,321

The bottom row shows the records accepted by NEMSIS. The top row is only a testing site.

As a reminder, NEMSIS maintains a public data "cube" that anyone can access to compare their own information to. Go to www.NEMSIS.org and click on the "Reporting Tools" tab.

VPHIB data quality compliance

The VPHIB program staffs thank all of our agencies for doing an amazing job over the last year improving the quality of data submissions. The improved submission compliance and improved data quality are why we continue to see our number of accepted records increase. We hope that agencies are also seeing the benefit of improving data quality when they work on performance improvement projects, develop reports, and see improved reimbursement for those that have fee for service in place.

Even though VPHIB data quality compliance has significantly improved, we continue to see some significant data quality issues exist with provider information such as EMS certification level, provider role, certification number, and similar provider demographic information. Our next significant validation rule update will focus on the provider demographic information and increasing the points deducted for logical rule errors.

Logical rules were scored very low to allow agencies and vendors with information about data quality weaknesses and allow time to make needed adjustments. Logical rules should be scored with the same weight as the element it is protecting. Incorrect data is more damaging to data quality than missing data.

Information will be distributed to inform the system of any needed changes and demonstrate why they are needed.

During this reporting quarter an additional VPHIB validation rules was implemented. As requested by system stakeholders, VPHIB staff provided a rationale when new validation rules are implemented. Below is the notice sent out via the VPHIB Support Suite and will be the template used for future changes.

NOTICE OF VALIDATION RULE CHANGE/ADDITION

Date: July 8, 2013

Data Element No.: E19_03 – Procedure

Rule Number: 1219

Rule Name: Procedure & Common Null Value (E19_03)

Error Message: E19_03 - Cannot have a valid procedure name and a null value (i.e. not applicable) at the same time.

Explanation: An additional validation has been added to identify when an EMS medical record reports that a procedure was performed AND at the same time reports not applicable, not reporting, not available, not recorded, or not known in the procedure field.

Figure 12 - below exhibits that 5.5 percent of Virginia's May 2013 records were rejected by NEMSIS due to this logic error. 5,608 records failed to make it into the National EMS Database for May alone. In total, Virginia has had 26,342 records rejected by NEMSIS due to this single error between 1/1/2013 and 5/31/2013.

Agencies please notify your EMS software vendor and providers to help avoid errors. Those with their own ImageTrend Service Bridge Figure 13 below shows you how you can set this rule up in your Service Bridge.

Figure 12 - NEMSIS Virginia Data Report Card (extract)

Section D. NEMSIS ETL Report Back to Top | Show/Hide Section D

Total Events: 101513

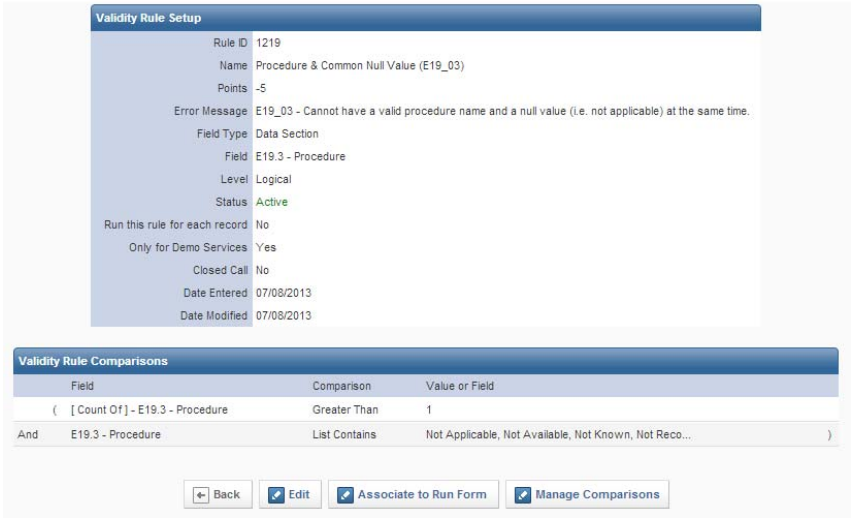
Hint: An element with color blue is a NEMSIS national element. To see the description of the element, simply hover over the blue element name with your mouse pointer.

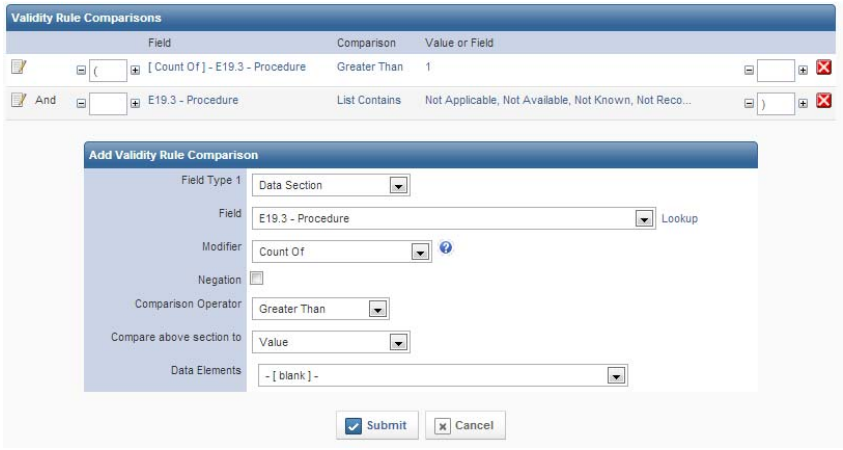
Note: The 'Violations' column reports how many individual EMS events in this submission violate a particular rule. For rules applying to the whole submission, 'Violations' and 'Percentage' columns will have no value. For example, if in this submission, greater than 30% of the field are populated with missing values, including nulls, blanks, and the null values, then violation of rule 114 will be reported in the table below. And the corresponding row's 'Violations' and 'Percentage' columns will be empty.

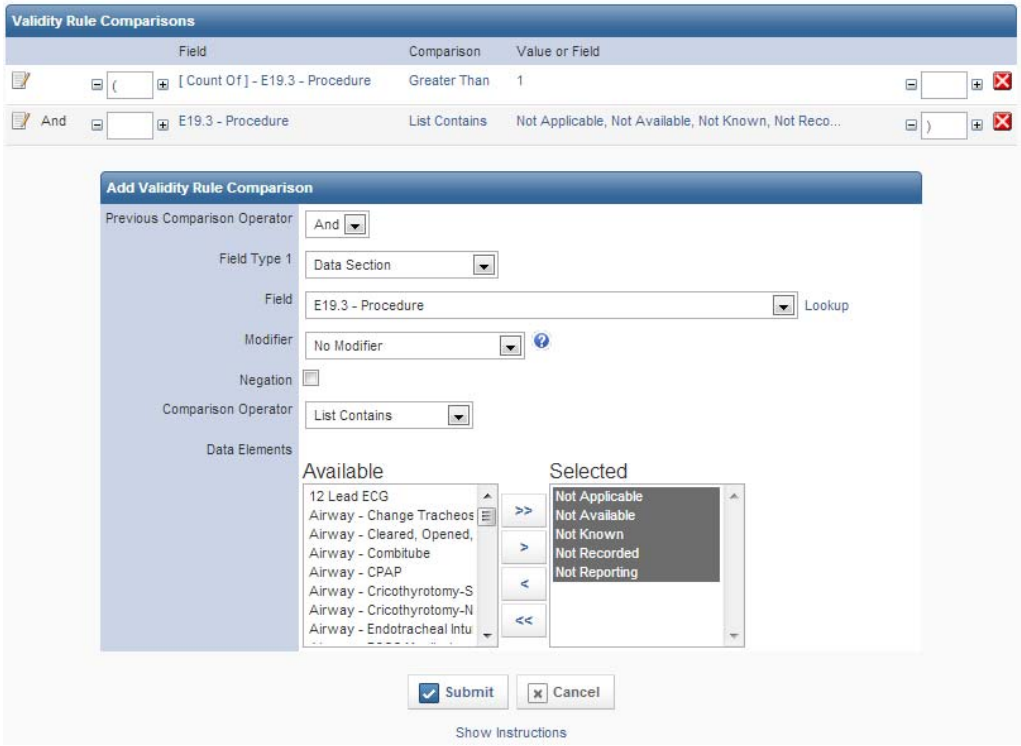
You can click on table headers (rule#, description, elements, action, violations and percentage) to sort the table.

Rule#	Description	Elements	Action	Violations	Percentage
191	A Null Value (-5, -10, -15, -20, -25) appears when a non-Null Value has also been submitted.	E19_03	Remove record/s reporting Null Values.	5608	5.5%

Figure 13 – Virginia E19_03 – Procedures & Common Null Value Rule (#1219)







Quarterly Update – What was done

During the last quarter the bulk of TCC staff time dedicated to VPHIB was focused on completing the move of VPHIB to its new server environment, which has been completed. Efforts to work with regional council PI staffs has continued including completing training on utilizing Report Writer and follow-up work sessions by webinar meetings. Additional time was dedicated to providing agency specific information from the small number of agencies having issues with data quality.

Quarterly Update – What will be done

Items that are on our short-list include addressing provider demographic information in the system as mentioned above, maximizing the upcoming features that will be installed with the next couple of upgrades from ImageTrend including Alerting, Automated data quality reporting, new QA/QI tools, and checklists. Time will be dedicated to integrating VPHIB and the VSTR. Finally, kicking off the data warehouse project linking EMS data to hospital discharge data and allow EMS data to be used by other areas of VDH.

On the technical side

TCC staff working with the VITA/NG partnership and ImageTrend finalized the move of VPHIB to a new server environment. The VPHIB and VSTR servers have been upgraded to MS SQL Server 2008 Enterprise (the most current available from NG.) Utilizing the enterprise version should allow some repairs and maintenance to occur without the system being required to go off-line. Adobe Cold Fusion v8 has been upgraded to v9 and v10 has also been installed and will be available when needed. Cold Fusion is used as the tool that allows the various severs to communicate with one another and function as a system.

Trauma System

Trauma System Oversight and Management Committee (TSO&MC)

The most recent TSO&MC meeting was held on June 6, 2013. The final agenda and draft minutes to the meeting can be found on-line on the Virginia Regulatory Town Hall. The key items from the June 6th meeting included endorsing the revised VSTR minimum dataset, finalizing the revised Trauma Center Fund Disbursement Policy, planning the wrap-up of the Trauma Designation Manual revision, and committee and center updates.

The proposed VSTR minimum dataset was endorsed by the TSO&MC and is to be presented to the EMS Advisory Board for its endorsement at the August 9, 2013. If endorsed by the EMS Advisory Board, the revised dataset will be presented to the State Board of Health for approval at its September 12, 2013 meeting.

The Trauma Center Fund Panel presented the final revised Trauma Center Fund Disbursement Policy revision. Key changes with this version of the policy included changing the methodology that defines what level of funding each center will receive. Beginning in July 2013 each center will receive one percent of available funding and from the remaining balance the traditional percentage based method is used. The percentage based portion is based on each center's proportion of admission days for victims of motor vehicle crashes.

Other minor adjustments to how the funds are utilized were made as well. The revised Trauma Center Fund Disbursement Policy, the revised trauma fund reporting tools, most recent distribution, and annual reports to the Senate and House Finance Committees and Governor can

be found on the Trauma Fund webpage at:
http://www.vdh.virginia.gov/OEMS/Trauma/TraumaCenterFund.htm

The TSO&MC discussed a plan to complete the revision of the Trauma Center Designation Manual. The plan includes the five workgroups (Operational, Education/Credentialing, Performance Improvement, Special Needs, and Administrative) submitting their final suggested updates by the September 5, 2013 meeting. The December 5, 2013 TSO&MC has been identified as the meeting that the revised Trauma Designation Manual will be presented to the committee for approval.

As a spin-off to the designation criteria discussion a temporary ad-hoc committee was established to explore whether a "needs based process" should be utilized to consider accepting applications for trauma center designation. A core group has been identified and meetings will be scheduled and run through the end of the year. More information will be available as this group begins its efforts.

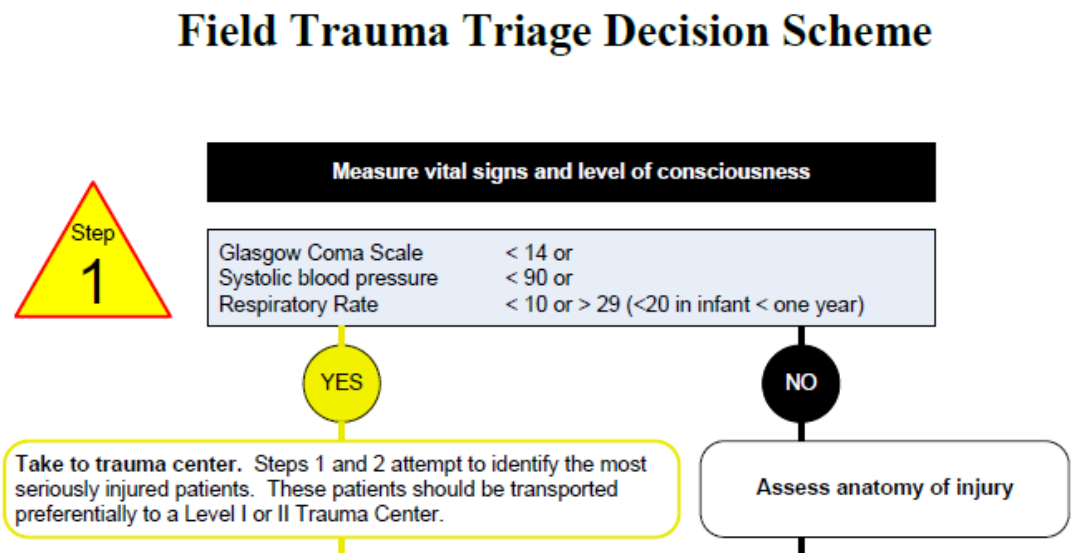
Trauma Performance Improvement Committee (TPIC)

The TPIC membership was reformed based on the formal composition decided on by the TSO&MC in December 2012. The new committee reviewed its charge and discussed where to begin and how to utilize its current resources. Two main foci were agreed upon; 1) initial triage by EMS to the appropriate facility and 2) transfer of hospital/trauma center patients to the same or higher trauma designation level after 24 hours.

Div. of TCC staff has already been working on developing a "missed triage" report that would be auto-generated and delivered to each EMS agency. This trauma triage report will identify injured patients that met "Step 1" of the Statewide Trauma Triage Plan that were not transported to a trauma center. The intent is to assure agency leadership is aware of patients that met trauma triage guidelines and were not transported to a trauma center.

The TPIC is focused on performance improvement and assisting the VDH/OEMS with meeting its *Code of Virginia* requirement to provide this information to EMS agencies, hospitals, and the State Health Commissioner. Regional reporting is not mandated, but is also part of the goal of this effort. It was staffs intention to have the process in beta format for the September TPIC's meeting. This goal deadline may be moved by two to three months. The reason for a delay is that ImageTrend unveiled a new "Alerting" capability being added to VPHIB this fall. This would better automate the process and use a function designed specifically to meet this type of need.

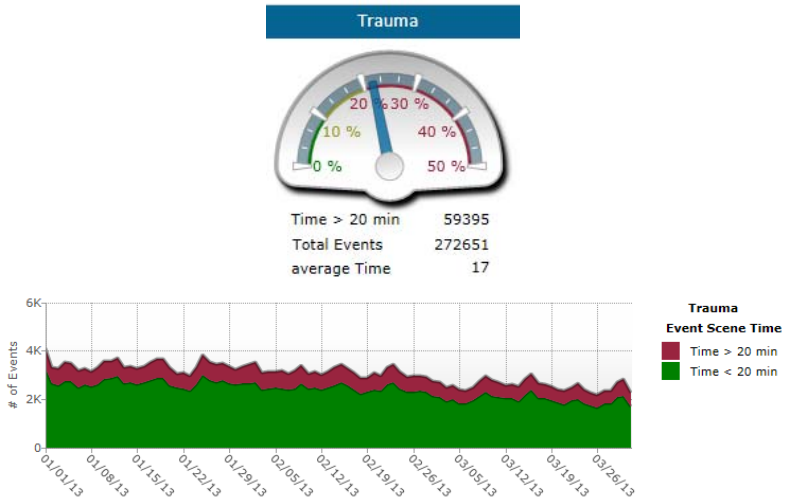
Figure 14 - Step 1 Virginia Field Triage Decisions Scheme



Trauma Triage

The National EMS Information System Technical Assistance Center (NEMSIS TAC) introduced its new EMS Performance Toolkit dashboard. One of the EMS performance measures is on scene time for the various time sensitive illnesses. Figure 15 below illustrates NHTSA performance measure 10.3 the "mean emergency scene interval" for trauma events. While the NEMSIS dashboard is based on 20 minutes scene times, many systems utilize a goal 10 minute on-scene time for major trauma. Figure ? below is for the first quarter of 2013.

Figure 15 - Exhibits the average on scene time by EMS crews for traumatic events

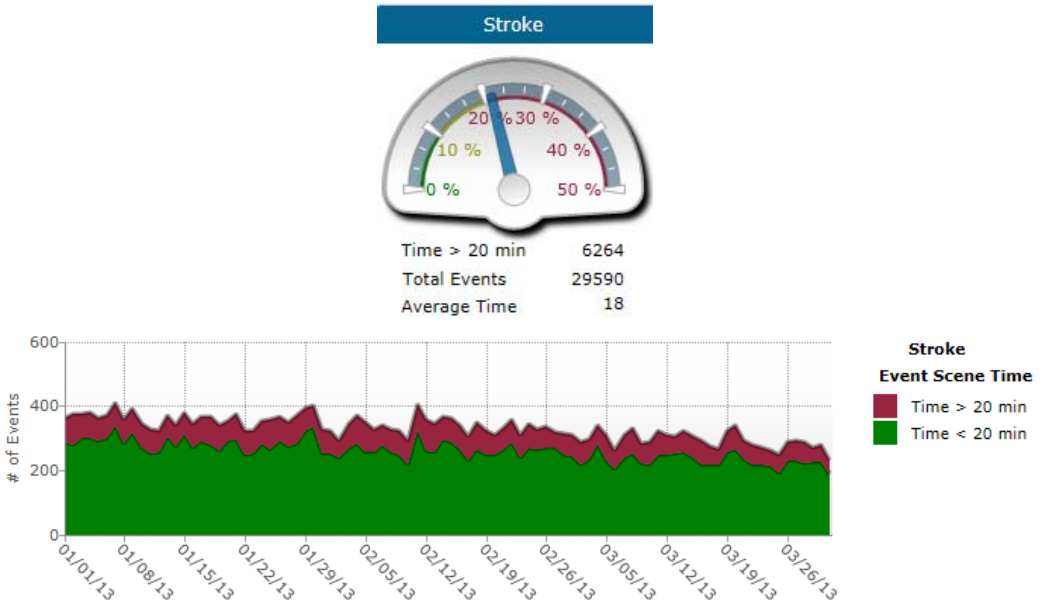


Virginia Stroke System

Stroke Triage

The NEMSIS TAC introduced its new EMS Performance Toolkit dashboard. One of the EMS performance measures is on scene time for the various time sensitive illnesses. Figure 16 below illustrates NHTSA performance measure 10.3 the "mean emergency scene interval" for acute stroke events.

Figure 16 - Exhibits the average on scene time by EMS crews for acute stroke events.



Emergency Medical Services for Children (EMSC)

National Pediatric Readiness Project (PRP)—Hospital Online Assessments Complete

The "National Pediatric Readiness Project" is an on-going quality improvement initiative, endorsed by a large cadre of national organizations (AAP, ENA, ACEP, HRSA, etc.), with the objective of assessing and improving the emergency care of children. The initial phase of this initiative, an online self-assessment of more than 5,000 hospitals, will be completed this month. Virginia hospitals were included in "Cohort 2" of 5 national cohorts—Cohort 2 began completing assessments in February and finished in mid-May. Cohort 5 is scheduled to end in mid-August.

The Virginia EMSC Manager was assigned as "pediatric champion" of the effort in Virginia and partnered with the Virginia Hospital and Healthcare Association (VHHA), the Emergency Nurses Association (ENA), the EMSC Committee of the EMS Advisory Board and others in an

effort to maximize the hospital response rate. The goal set by the PRP for considering the assessment to be valid in Virginia was participation by 80% of hospitals with a 24-hour emergency department that treats children.

In the end, Virginia achieved an official response rate of 97%, and an incredible *100% of civilian hospitals* in Virginia submitted assessments. Hospitals received immediate feedback in the form of a "gap analysis" when their assessments were submitted, and resources were provided to assist facilities in pursuing further improvement in their pediatric readiness

The results of the assessment are now being analyzed and a summary will be presented in the next Quarterly Report to the EMS Advisory Board.

Length-Based Pediatric Emergency Tapes Given to EMS Regional Councils for Distribution.

Each EMS Regional Council is receiving a number of the latest (Version 2011 Edition A) Broselow™ Pediatric Emergency Tapes (purchased with EMSC State Partnership funding through HRSA) to distribute to volunteer transport ambulances in their regions who need them. EMS Regional Council Directors are overseeing the distribution.

Full Funding Being Restored to EMSC State Partnership Grant

The Virginia EMSC program began a four-year continuation of its EMSC State Partnership Grant on March 1, 2013. The first year of funding from HRSA (Health Resources & Services Administration) had been reduced by $20,000 as a result of sequestration and congressional timing of continuing resolutions to fund the government. OEMS has received word from HRSA that full funding of the EMSC grant will soon be restored, and the original budget submitted will be reauthorized.

One benefit from this will be that a limited number of immobilization devices (probably 40) will be purchased for distribution to volunteer EMS agencies that indicate interest and a need (as resources will allow). If more requests are received than devices available, a drawing will be held to determine who will receive the items. We anticipate procuring about 20 LSP Pediatric Board and about 20 Pedi-Mates, and questions regarding these should be directed to David Edwards at the Office of EMS (see final paragraph).

Facilitating Access to Pediatric Education (PM78, 80)

The Virginia EMSC program is working to facilitate access to pediatric education and training, especially in the form of EPC (*Emergency Pediatric Care*) and *Emergency Nursing Pediatric Course* (ENPC) courses around the Commonwealth. The EMSC program plans to use its funding to continue supporting a number of these courses in areas with historically difficult access to pediatric training.

Pediatric On-Site ED Assessments to Resume (PM 74)

The Virginia EMSC program had not been making site visits to small and rural Virginia hospitals to assess their pediatric needs and capabilities while the National Pediatric Readiness Assessment (on-line survey) was in progress. Now that the initial online assessment phase has been completed, these visits will again be available to hospital EDs upon request.

EMSC Annual Program Manager's Meeting

The required annual meeting of EMSC state program managers was held in late April and early May. This year EMSC Family Representatives, who participate in the Family Advisory Network (FAN) were included and worked with other FAN reps and state EMSC Program Managers on strategies for meeting children's emergency care needs across diverse populations.

Pediatric Emergency Care Council (PECC)

The Pediatric Emergency Care Council (PECC) of the National Association of State EMS Officials (NASEMSO) met for two days upon conclusion of the EMSC Program Managers Meeting.

Some of the items the PECC is currently working on include:

- Creating a pediatric disaster readiness checklist tool for state EMS offices
- Maintaining federal recommendations for safe transport of children in ambulances as a "living document"
- Implementing the new national recommendations for equipment for ground ambulances soon to be published
- Determining evidence-based recommendations for minimum requirements to maintain pediatric care proficiency for recertification of EMS providers
- Including EMS agencies in illness and injury prevention strategies
- Providing support for the national Pediatric Readiness Project (PRP)

EDAP Designation Criteria Revised (PM 74)

Following the well-attended stakeholders meeting held in late 2012, the EDAP (Emergency Department Approved for Pediatrics) Work Group has made extensive revisions to EDAP criteria based upon the stakeholder suggestions received. The latest draft criteria are referred to as "Version 122712", when the newest revisions were incorporated.

Distribution of the revised draft criteria had been delayed pending conclusion of the National Pediatric Readiness Assessment that is now wrapping up. Additional stakeholder input will be solicited, and a draft of the current criteria will be available soon to those interested in being involved in this process.

The draft criteria will also be placed on the "members only" portion of the NASEMSO (National Association of State EMS Officials) website as a model pediatric resource for other facility

recognition programs begin developed throughout the country. The intended outcome from this process is to eventually implement a voluntary pediatric facility recognition program in Virginia to *recognize excellence and encourage improvement* in pediatric emergency medical care.

Suggestions/Questions

Suggestions or questions regarding the Virginia EMS for Children program should be submitted to David Edwards via david.edwards@vdh.virginia.gov or by calling the EMSC program within the Office of EMS at 804-888-9144. We welcome your interest and support.

Poison Control Services

OEMS' Div. of TCC serves as the contract administrator for the three poison centers that make up the Virginia Poison Control Network (VPCN). As a reminder, the 2012 – 2014 Appropriations Act had originally proposed to end State funding for poison control services for Virginia. The Act also limited the number of poison centers from the historical three centers to only two. Fortunately, the Virginia Poison Control Network has been restored to three centers and $1 million restored.

Div. of TCC staff will be hosting a planning meeting in late August 2013 aimed at planning on securing long-range funding security for the VPCN and develop a vision of what the future VPCN will look like. Further information will be shared as this project matures.

Durable Do Not Resuscitate (DDNR)

Div. of TCC staff continue to attend recent POST state meetings and continue to support their efforts to stream line issues surrounding living wills and DNR topics.

Downloadable DDNR: Just as a reminder the Durable Do Not Resuscitate form is available for download and printing on the OEMS website. The regulations also now allow for legible photocopies of DNR orders to be accepted by health care personnel. The new form can be seen on-line at http://www.vdh.virginia.gov/oems/ddnr/ddnr.asp.

Respectfully Submitted

OEMS Staff

Appendix A

State EMS Advisory Board
Motion Submission Form

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

Motion:

Move to endorse the composition of the Training and Certifiation Committee to reflect the following:
1.EMS Advisory Board Member - TCC Chair
2. EMS for Children
3. VAGEMSA
4. VAVRS
5. Regional EMS Council Executive Directors Group
6. Virginia Community College System (VCCS)Accredited Institution
7. Non-VCCS Accredited Program
8. Education Coordinator
9. Education Coordinator
10. EMS Physician from MDC
11. Member at Large - EMS Advisory Board Appointments

EMS Plan Reference (include section number):

2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia
§ 32.1-111.3. Statewide emergency medical care system.
§ 32.1-111.4. Regulations; emergency medical services personnel and vehicles; response times; enforcement provisions; civil penalties

Committeee Minority Opinion (as needed):

None

For Board's secretary Use only:

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

Board's Minority Opinion:

Appendix B

State EMS Advisory Board
Motion Submission Form

☒ **Committee Motion:**	**Name:**	Training and Certification Committee (TCC)
☐ **Individual Motion:**	**Name:**	

Motion:

Move to accept the proposed ALS Competencies document developed by the ALS Competency Workgroup attached to this document.

EMS Plan Reference (include section number):

2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia
2.2.2 Enhance competency based EMS training programs
4.2.2 Assure adequate and appropriate education of EMS students
§ 32.1-111.5. Certification and recertification of emergency medical services providers; appeals process.
§ 32.1-111.3. Statewide emergency medical care system.

Committeee Minority Opinion (as needed):

None

For Board's secretary Use only:

Motion Seconded by:

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

Board's Minority Opinion:

V
sion of Educational
1041 Technolo Drive
Glen All 23059
3-9120

	Column A	Column B	Column C	Column D	Column E	Column F
1	AREAS	EMT to AEMT	AEMT to I Bridge	EMT to INTERMEDIATE	I to P Bridge	EMT to PARAMEDIC
2	CLINICAL REQUIREMENTS:					
3	Emergency Department[1]	12 hrs	6 hrs	12 hrs	12 hrs	24 hrs
4	Critical Care Area[2]	-	4 hrs	4 hrs	4 hrs	8 hrs
5	Pediatrics[3]	-	4 hrs	4 hrs	4 hrs	8 hrs
6	Labor & Delivery[4]	-	4 hrs	4 hrs	4 hrs	8 hrs
7	OR/Recovery	-	4 hrs	4 hrs	4 hrs	8 hrs
8	Other Clinical Settings[5]	prn	prn	prn	prn	prn
9	TOTAL MINIMUM CLINICAL HOURS[6]	36 hrs	36 hrs	72 hrs	72 hrs	144 hrs
10	ALS Medic Unit (Field Internship)	12 hrs	12 hrs	24 hrs	24 hrs	48 hrs
11	TOTAL MINIMUM FIELD/CLINICAL	48 Hours	48 Hours	96 Hours	96 Hours	192 Hours
12	TOTAL PATIENT CONTACTS[6]	30	30	60	60	120
13	COMPETENCIES:					
14	Trauma Assessment, pediatric[7]	2	3	5	5	10
15	Trauma Assessment, adult	2	3	5	5	10
16	Trauma Assessment, geriatric	2	3	5	5	10
17	Medical Assessment, pediatric[7]	2	3	5	5	10
18	Medical Assessment, adult	2	3	5	5	10
19	Medical Assessment, geriatric	2	3	5	5	10
20	Cardiovascular distress[8]	5	5	10	10	20
21	Respiratory distress	5	5	10	10	20
22	Altered Mental Status	5	5	10	10	20
23	Obstetrics: delivery	-	-	-	2	2
24	Neonatal Assessment/care	-	-	-	2	2
25	Obstetrics Assessment	-	5	5	5	10
26	Med Administration	15	15	30	30	60
27	IV Access[9]	25	-	25	-	25
28	Airway Management[10]	20[8]	15[6]	25[10]	25[10]	50[20]
29	Ventilate Non-Intubated Patient [9, 11]	20	-	20	-	20
30	Endotracheal Intubation[12]	-	1 real Patient	1 real Patient	1 real Patient	1 real Patient
31	Team Leader on EMS Unit[13]	10 (6)	15 (8)	25 (15)	25 (15)	50 (30)

[1] May be free-standing ED. However, clinics, urgent care centers, physician offices, etc. may not be substituted.
[2] CCU, ICU, CC xport team, Cath Lab, etc.
[3] PICU, PEDs ED, Pediatrician Office, Peds Urgent Care, Ped clinic.
[4] Prefer L&D unit, but can be satisfied with OB Physician Office or OB clinic.
[5] Use of non-traditional clinical sites is encouraged to allow the student to meet the minimum clinical hour requirements and allow them to see a variety of patients
[6] The minimum hours/patients/complaints is not meant to equal the total. The minimums must be met in each area, but the student has flexibility to meet the total.
[7] The student should attempt to complete one in each age group: Neonate, Infant, Child, and Adolescent.
[8] Cardiac Arrest, Chest pain/pressure, STEMI, dysrythmia, etc.
[9] Although students in bridge programs do not have minimums, the program must ensure continued skill competency.
[10] Refer to CoAEMSP interpretation of what constitutes Airway Management "Airway Management Recommendation" http://coaemsp.org/Documents/Intubation%20Subcommittee%20FINAL%20revised%202013-02-1.pdf In order to demonstrate airway competency, the student should be 100% successful in their last attempts at airway management. The number required is listed inside the brackets.
[11] Ventilation may be accomplished utilizing any combination of live patients, high fidelity simulations, low fidelity simulations, or cadaver labs.
[12] AEMT –I: older than 12 years; Intermediate: older than 12 years; I-P: any age group, P: any age group.
[13] The number in parentheses is the maximum number of Team Leader calls that can be BLS. The program must establish, in writing, what constitutes an ALS call.

NOTE: The above listed clinical hours/competencies are minimum mandatory. Programs may set higher minimums or add to this list.

Appendix C

State EMS Advisory Board
Motion Submission Form

☒ **Committee Motion:**	**Name:**	Training and Certification Committee (TCC)
☐ **Individual Motion:**	**Name:**	

Motion:

Move to accept the proposed High Fidelity Simulation document developed by the ALS Competency Workgroup attached to this document.

EMS Plan Reference (include section number):

2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia
2.2.2 Enhance competency based EMS training programs
4.2.2 Assure adequate and appropriate education of EMS students
§ 32.1-111.5. Certification and recertification of emergency medical services providers; appeals process.
§ 32.1-111.3. Statewide emergency medical care system.

Committeee Minority Opinion (as needed):

None

For Board's secretary Use only:

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

Board's Minority Opinion:

Virginia EMS Clinical Education Requirements

Addendum A: The Use of High Fidelity Patient Simulation

DRAFT: May 29, 2013

Background in Simulation

Simulated experiences provide the student with the opportunity to be involved in patient care experiences they may otherwise not experience in actual clinical settings (e.g., emergency childbirth, tension pneumothorax, VT requiring synchronized cardioversion)

These patient situations are low frequency, high impact events they may otherwise not experience. Simulation offers an avenue to assess clinical judgment and critical thinking without jeopardizing patient safety. A simulated experience allows students to critically analyze their own actions (or failure to act), reflect on their own skill sets and critique the clinical decisions of others. Simulation promotes active learning and participation, to enhance students' critical thinking skills. Educators can apply well-founded simulation approaches to help students in clinical rotations to attain educational goals.

Definitions:

Clinical simulation - An active event in which students are immersed into a realistic clinical environment or situation. During this authentic clinical experience learners are required to integrate and synthesize core concepts and apply appropriate interpersonal and psychomotor skills. Students must incorporate critical thinking and decision-making skills in the assessment and management of simulated sick and injured patients.

Fidelity - The degree to which a simulation and/or a simulation device accurately reproduces clinical and/or human parameters; realism.

Low-Fidelity (LF) Technologies – A device that does not respond to interventions or is unable to be altered in real time to create a response.

High-Fidelity (HF) Technologies – A device (manikin) with lifelike features, either whole body or partial body, which is able to respond to a learner's actions or interventions. Response of the manikin to the student's performance is computer-controlled by the instructor. High-Fidelity Patient Simulator (HFPS) sessions must be scenario-based with clear performance objectives. The simulation must be recorded (i.e. audio and video) and culminate with a formal audio/visual review and debriefing.

HF Manikin capabilities: Vital signs, ECG, advanced airway procedures, vascular access, lungs sounds, electrical therapies (i.e. synchronized & unsynchronized defibrillation, transcutaneous pacing)

Key Components in Simulation

Integral components of a simulated learning experience include:

1. The educator must be trained and comfortable using the HFPS.

2. Students must come into the simulated clinical environment prepared for the simulation with a basic knowledge of the material and dressed appropriately for the clinical experience. The student will be expected to actually perform, not verbalize, the required skills.

3. Learning occurs when the environment accurately reflects reality and both the student and educator are actively engaged.

4. Simulated patient experiences must include the following to be a successful teaching tool:

    - Comprise the simulation exercise, debriefing, and evaluation.
    - Have clearly stated objectives that are presented to the student prior to engaging in the simulation experience (See addendum B).
    - Student requirement to prepare for the simulation in the same manner as they would prepare for an EMS call (pre-dispatch equipment check, etc.)
    - An orientation to both the HFPS and simulation lab area.
    - Challenge the student to use problem solving and critical reasoning skills to assess and manage the situation.
    - The educator assumes the role of facilitator, providing cues when necessary, but is not an active participant in the simulation.
    - Both the educator and the student participate in an active debriefing. Facilitated by the educator, the debriefing should challenge the student to think critically about his/her practice and clinical judgment. The debriefing session should occur immediately after the simulation is completed so the thoughts and feelings of the learner are not forgotten and do not get distorted over time. Video/Audio recording of the simulation must be utilized as a tool to provide objective data for review.
    - Each simulation session should also include an evaluation of the overall experience by both the educator and student.

Rationale for Using High-Fidelity Simulation to meet EMS Clinical Requirements

Based on the information and research presented thus far, HFPS is best accomplished as part of the clinical component of an EMS educational program. Rationale for this includes:

1. For all students to be actively engaged in a HFPS scenario there must be a maximum of four students.
2. For the team of students to cohere and maximize the HFPS learning experience, more than one scenario must be worked at a time. Six to eight hour sessions, working 3 to 4 scenarios work best.
   NOTE: Manikin/scene prep, execution, debriefing / video review, and evaluation takes 1.5 to 2 hours per scenario.
3. The VEMSES hourly breakdown for course content is structured for the traditional use of LF skills training. The time and resource intensive nature of HFPS does not lend itself to be incorporated into a regular class session.

Standards and Guidelines for the use of HFPS as part of EMS Clinical Education

1. HFPS used to meet competency/assessment requirements must adhere to the standards set forth in this document.
2. No more than 20% of the required competencies may be through HFPS.
3. HFPS scenarios should involve high criticality patients. See Addendum C.
4. HFPS does not replace the minimum clinical hour requirements of the program level.
5. HFPS scenarios cannot be used in place of required team leader calls.

References

Billings, D.M., & Halstead, J.A. (2005). *Teaching in Nursing: A Guide for Faculty* (2nd ed.). Philadelphia: W.B. Saunders.

Jefferies, P.R. (Ed.) (2007). *Simulation in Nursing Education: From Conceptualization to Evaluation.* New York, NY: National League for Nursing.

Kyle, R. R., Murray, W.B. (Eds.) (2008). *Clinical Simulation: Operations, Engineering and Management.* Burlington, MA: Academic Press.

Morton, P.G. (1995). Creating a laboratory that simulates the critical care environment. *Critical Care Nurse*, *16*(6), 76-81.

Virginia State Simulation Alliance (2008). *Use of Clinical Simulation Experiences in Nursing Education: The Virginia State Simulation Alliance Position Statement* (Unpublished).

Virginia Board of Nursing (2009). Guidance Document # 90-24: The Use of Simulation in Nursing Education (Unpublished).

Addendum B: Example of HFPS Learning Objectives

Adult Cardiac Field Simulation leading to Cardiac Arrest

Simulation Objectives:
General:

1. Student will perform a physical assessment based on the information obtained in the patient history and understand the significance of its findings.

2. Student will demonstrate knowledge, skills and abilities consistent with those identified in the National and/or Virginia Scope of Practice.

3. Student demonstrates proper skill techniques and attempts these when the situation arises.

4. Student will demonstrate effective teamwork in the simulation center setting in care of the simulated patients.

5. Student will demonstrate the ability to obtain patient history appropriate to chief complaint on critical patients.

6. Student will demonstrate the ability to be responsible for patient management on critical patients while enroute to the hospital.

7. Student will demonstrate the ability to handle stressful situations effectively.

8. Student will demonstrate the ability to direct the team, delegating tasks appropriately.

Suggested Review: Adult patient assessment, ACLS algorithms, IV insertion and fluid management, medication administration, airway management and oxygen administration, use of cardiac monitor/ defibrillator, ACLS medications, cardiac rhythm recognition

Dispatch information: You are dispatched to a local apartment complex for an unresponsive person.

Addendum C: Examples of high criticality scenarios

Airway, Breathing and Cardiology o Provide ventilatory support for a patient o Attempt to resuscitate a patient in cardiac arrest o Provide care to a patient experiencing cardiovascular compromise o Provide post resuscitation care to a cardiac arrest patient
Medical Emergencies o Assess and provide care to a patient experiencing an allergic reaction o Assess a patient with possible overdose o Assess and provide care to a near-drowning patient
Trauma o Perform a rapid trauma assessment o Assess a patient with a head injury o Assess and provide care to a patient with a suspected spinal injury o Provide care to a patient with a chest injury o Provide care to a patient with an open abdominal injury o Provide care to a patient with shock/hypoperfusion o Assess and provide care to a patient with a burn injury
Obstetrics and Pediatrics o Assess and provide care to an infant or child with cardiac arrest o Assess and provide care to an infant or child with respiratory distress o Assess and provide care to an infant or child with trauma o Assess and provide care to an infant or child with shock/hypoperfusion o Assess and provide care to an obstetric patient o Provide care to a newborn o Provide care to a mother immediately following delivery of a newborn

Appendix D

VIRGINIA OFFICE OF EMERGENCY MEDICAL SERVICES STATE STRATEGIC AND OPERATIONAL PLAN

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

2013 Updates to State Plan – Recommendations from Committees

OEMS STATE STRATEGIC AND OPERATIONAL PLAN

Table of Contents

OEMS STATE STRATEGIC AND OPERATIONAL PLAN

INTRODUCTION

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

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

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

This operational plan identifies the specific initiatives required of the OEMS staff in executing the 2013 – 2016 Strategic Plan. Each objective and action step is intended to accomplish those items most critical to the Strategic Plan in the given fiscal year. The Strategic Plan is designed to improve priority areas of performance and initiate new programs. Therefore, much of the routine, but important work of the OEMS staff is not included in the Operational Plan.

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

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

Virginia Office of Emergency Medical Services Mission Statement

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

Virginia Office of Emergency Medical Services Vision Statement

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

What is the Emergency Medical Services system in Virginia?

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

The Virginia Department of Health, Office of Emergency Medical Service (OEMS) is responsible for development of an efficient and effective statewide EMS system. The EMS System in Virginia is designed to respond to any and all situations where emergency medical care is necessary. This is accomplished through a coordinated system of over 35,000 trained, prepared and certified providers, nearly 4,500 permitted EMS vehicles, and over 680 licensed EMS agencies, to provide ground and air emergency medical care to all citizens of the Commonwealth of Virginia.

Appendix A – Planning Strategy Matrix

	Strategic Initiative 1.1- Promote Collaborative Approaches		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 1: Develop Partnerships	1.1.1 Use technology to provide accurate and timely communication within the Virginia EMS System	OEMS, Regional EMS Councils	1.1.1.1 Track and report on amount, and general content of material posted to OEMS websites and social media on a monthly and quarterly basis.
	1.1.2 Promote collaborative activities between local government, EMS agencies, hospitals, and increase recruitment and retention of certified EMS providers.	OEMS, System stakeholders	1.1.2.1. Determine amount of new EMS providers recruited via recruitment and retention programs and activities. 1.1.2.2. Continue to schedule "Keeping The Best!' programs. 1.1.2.3. Maintain informational items regarding benefits and incentives for local governments to provide to volunteer fire and EMS providers. 1.1.2.4. Educate and familiarize local government officials on the importance in taking a greater role in EMS planning and coordination.
	1.1.3 Provide a platform for clear, accurate, and concise information sharing and improved interagency communications between the Office of EMS, state agencies and EMS system stakeholders in Virginia.	OEMS, State Agencies (VDEM, OCP, VSP, VDFP), Regional EMS Councils, System Stakeholders.	1.1.3.1. Encourage agencies and providers to visit OEMS web page regularly, subscribe to OEMS e-mail list, and social media. 1.1.3.2. Encourage providers to utilize OEMS Provider Portal.
	1.1.4 Identify resources and/or opportunities to work collaboratively with other state agencies, organizations, and associations to improve processes and patient outcomes.	OEMS	1.1.4.1. Attend meetings of, and exchange knowledge with the National Association of State EMS Officials. 1.1.4.2. Encourage appropriate state agencies and organizations to participate in meetings and activities hosted or sponsored by OEMS. 1.1.4.3. Collaboration among AMS entities to ensure systems enhancements.
	1.1.5 Promote data sharing projects which benefit internal and external projects	OEMS	1.1.5.1. Further data sharing efforts with the highway safety community. 1.1.5.2 Establish data use agreements with bordering states to share EMS data on a regional level utilizing the national EMS database. 1.1.5.3 Provide a means for VDH bio-surveillance programs to utilize VPHIB data.

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

	Strategic Initiative 2.1 - Sponsor EMS related research and education.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 2: Create Tools and Resources	2.1.1 Sponsor research and other projects that contribute to high quality EMS and improve patient outcomes utilizing data collected by the EMS Registries.	OEMS	2.1.1.1. Revive "Trends in Trauma and Emergency Medicine" as a web based product • Begin with Statewide summaries from VSTR and VPHIB for 2007 – 2011 by end of CY 2013 • Add Regional EMS Council level summaries by end of FY 2014 2.1.1.2. Expand "Trends in Trauma and Emergency Medicine" to include • Measures based on combined VSTR and VPHIB data to be available to the public by the November EMS Advisory Board meeting annual beginning in CY 2014. 2.1.1.3. Develop VSTR and VPHIB research data set to be available for entities upon request and that have obtained an institutional review board approval by the end of 2015.
	2.1.2 Determine quality of EMS service and conduct analysis of trauma triage effectiveness.	OEMS, Designated Trauma Centers, TSO & MC, Regional EMS Councils	2.1.2.1. Trauma Performance Improvement Committee and/or EMS staffs will provide quarterly reports to the regional trauma committees via their representative on the TSO&MC that identify over and under triage events due on the established schedule that OMS staff submits its contribution to the EMS Quarterly Report to the EMS Advisory Board. The statewide version of this quarterly report shall be included in the quarterly report and posted on the OEMS Web site. 2.1.2.2. Develop and implement OEMS component of VDH Data Warehouse (DW) by end of CY 2014 • Use DW to integrate VPHIB and VSTR data by the end of 2015. • Use DW to access and integrate VHI and Vital Statistics data OEMS databases. • Provide agency-wide access to EMS data to be used in other public health efforts. 2.1.2.3. Use the DW to support bio-surveillance projects being performed within the VDH.
	2.1.3 Establish scholarships for EMS provider education and EMS specific research.	OEMS, FARC, Regional EMS Councils. Other EMS Stakeholders	2.1.3.1. Establish scholarship program for EMS education. 2.1.3.2. Establish funding program for EMS research.
	2.1.4 Evaluate the impact of an aging workforce on service provision around the State.	OEMS, Workforce Development Committee, VAGEMSA, VAVRS	2.1.4.1. Assess demographic and profile characteristics of EMS Providers in Virginia through EMS Provider Portal. 2.1.4.2. Utilize EMS database to evaluate information related to impact of aging workforce on provision of EMS service.

	Strategic Initiative 2.2 - Supply quality education and certification of EMS personnel.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 2: Create Tools and Resources	2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia.	OEMS, Training and Certification Committee,	2.2.1.1. Ensure regional training plans are submitted by the Regional EMS Councils to OEMS on an annual basis. 2.2.1.2. Review student disposition on a bi-annual basis; identifying areas of concern for TCC input and possible corrective action.
	2.2.2 Enhance competency based EMS training programs.	OEMS, Training and Certification Committee, MDC	2.2.2.1. Compare and contrast traditional versus competency based programs. 2.2.2.2 Identify and document aspects from competency based programs that directors feel enhance their programs as compared to the traditional approach.
	2.2.3 Develop, implement and promote leadership and management standards for EMS agency leaders.	OEMS, Workforce Development Committee	2.2.3.1. Development of EMS Officer standards based on duties of Attendant in Charge position, supervisor, and director. 2.2.3.2. Test efficacy of standards through pilot program annually.
	2.2.4 Align all initial EMS education programs to that of other allied health professions to promote professionalism of EMS.	OEMS, Training and Certification Committee, MDC, Board of Health Professions	2.2.4.1. Proactively promote Advanced Level EMT Training (AEMT)
	2.2.5 Increase the amount and quality of pediatric training and educational resources for EMS providers, emergency department staff in Virginia.	OEMS, EMSC Committee, VHHA	2.2.5.1. Purchase and distribute pediatric training equipment for EMS agencies. 2.2.5.2. Sponsor pediatric training related instructor courses. 2.2.5.3. Provide support for speakers and topics at the annual VA EMS Symposium.
	2.2.6 Provide an increased number of training opportunities for EMS personnel in Emergency Operations methods and activities.	OEMS, VDEM	2.2.6.1. Create a yearly training calendar for OEMS sponsored Em. Ops. Training offerings. 2.2.6.2. Review and update MCI management modules.
	2.2.7. Assure an adequate amount and quality of geriatric training and educational resources for EMS providers, emergency department staff and primary care providers in Virginia.	OEMS, TCC, MDC	2.2.7.1. Sponsor geriatric training related instructor courses. 2.2.7.2. Provide support for speakers and topics at the annual VA EMS Symposium.

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

	Strategic Initiative 3.1 - EMS Regulations, Protocols, Policies, and Standards (Continued)		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.1.4 Develop criteria for a voluntary Virginia Standards of Excellence Recognition Program for EMS Agencies.	OEMS, Workforce Development Committee	3.1.4.1. Approval of first stage of voluntary accreditation standards by state EMS Advisory Board. 3.1.4.2. Implement and market program to interested agencies. 3.1.4.3. Evaluate efficacy of program based on feedback of EMS agency officials and Technical Assistance Teams.
	3.1.5 Maintain and enhance the Trauma Center designation process.	OEMS, Trauma System Oversight & Management Committee, EMSC	3.1.5.1. Revise the trauma designation criteria to include burn criteria, pediatric criteria, nursing education requirements and infrastructure needs. 3.1.5.2. Conduct an analysis to determine the benefits of adding Level IV designation to our trauma care system.
	3.1.6 Maintain and enhance the Regional EMS Council designation process.	OEMS	3.1.6.1. Evaluate pros/cons of initial designation process. 3.1.6.2. Incorporate input of applicants and evaluators into next round of designations. 3.1.6.3. Conduct re-designation of councils on staggered basis in 2013 and 2014.
	3.1.7 Establish standardized methods and procedures for the inspection and licensing and/or permitting of all EMS agencies and vehicles, including equipment and supply requirements.	OEMS, Transportation Committee	3.1.7.1. Development of standard inspection checklist, to include all aspects of agency and EMS vehicle inspection.
	3.1.8 Through a consensus process, develop a recommendation for evidence-based patient care guidelines and formulary.	OEMS, State EMS Medical Director, Medical Direction Committee, Patient Care Guidelines Ad-hoc Workgroup, Drug Formulary Ad-hoc Workgroup, Board of Pharmacy.	3.1.8.1. Resource document being developed to assist regional medical directors, agency medical director and agency personnel as patient care guidelines and protocols are produced.

	Strategic Initiative 3.2 - Focus recruitment and retention efforts		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.2.1 Develop, implement, and promote a comprehensive recruitment and retention campaign for EMS personnel and physicians, supporting the needs of the EMS system.	OEMS, State EMS Medical Director, Medical Direction Committee, Workforce Development Committee, FARC, Regional EMS Councils	3.2.1.1. Continue to support "VA EMS Jobs" website. 3.2.1.2. Develop and implement voluntary "Standards of Excellence" for EMS agencies. 3.2.1.3. Maintain Leadership & Management Track at the VA EMS Symposium, and recommend topics and presenters. 3.2.1.4. Continue to promote and support special RSAF applications related to recruitment and retention of EMS providers. 3.2.1.5 Review and promote the OMD Workshop Curriculum 3.2.1.6 Promote and develop an ongoing relationship with EMS Fellowship Programs
	3.2.2 Support and expand the Virginia Recruitment and Retention Network.	OEMS, Workforce Development Committee	3.2.2.1. Continue to support information and education for distribution. 3.2.2.2. Seek new avenues for EMS recruitment outreach. 3.2.2.3. Recommend strategies to expand existing programs and distribute to EMS stakeholders.
	3.2.3 Develop, implement, and promote the EMS Officer standards program.	OEMS, Workforce Development Committee	3.2.3.1. Provide Virginia's EMS agencies with the highest quality of leadership. 3.2.3.2. Develop and/or review leadership criteria and qualifications for managing an EMS agency. 3.2.3.3. Develop model job descriptions for EMS Officers.

	Strategic Initiative 3.3 – Upgrade technology and communication systems		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 3: Develop Infrastructure	3.3.1 Assist with, and promote, the compliance of all emergency medical radio systems with state and federal regulations for narrow banding and interoperability.	OEMS, Communications Committee	3.3.1.1. Continue to ensure that all emergency medical radio systems meet FCC mandated narrow banding regulation. 3.3.1.2. Prior to 2015, ensure that all emergency medical radio systems meet state interoperability requirements.
	3.3.2 Promote emergency medical dispatch standards and accreditation among 911 Public Safety Answering Points (PSAPs) in Virginia.	OEMS, Communications Committee	3.3.2.1. Support concept of accredited PSAPs, operating with emergency medical dispatch (EMD) standards, and assist agencies in achieving accreditation, and/or adopting EMD as standard operating procedure.
	3.3.3 Provide technical assistance on wireless communication products available for use in the emergency medical community.	OEMS, Communications Committee	3.3.3.1. Continue to stay informed and up to date on new products and technologies, and serve as information conduit to communications entities.

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

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

	Strategic Initiative 4.1 – Assess compliance with EMS performance driven standards.		
	Objectives	***Accountability***	***Action Steps***
Core Strategy 4: Assure Quality and Evaluation	4.1.1 Maintain statewide data-driven performance improvement process.	OEMS, MDC	4.1.1.1. Utilize epidemiology trained OEMS staff to conduct risk adjusted data analysis of patients in cooperation with our stakeholders. 4.1.1.2. Develop an EMS performance improvement program.
	4.1.2 Maintain statewide pre-hospital and inter-hospital trauma triage plan.	OEMS, Trauma System Oversight & Management Committee, State EMS Medical Director, MDC	4.1.2.1. Maintain statewide trauma triage plan to support regional plan development and maintenance by regional trauma committees. 4.1.2.2. Supply state level data to assist with monitoring individual regional performance compared to state and national benchmarks.
	4.1.3 Maintain statewide pre-hospital and inter-hospital stroke triage plan.	OEMS, State Stroke Task Force, MDC	4.1.3.1. Actively participate on the Virginia Heart Attack Coalition and develop and maintain a Statewide Stroke Triage Plan. 4.1.3.2 If available, provide funds for the development of regional stroke triage plans to ensure implementation is performed based on local resources.
	4.1.5 Review and evaluate data collection and submission efforts.	OEMS, MDC	4.1.5.1. Develop standard reports within VPHIB that will allow individual EMS agencies to view the quality of data being submitted. 4.1.5.2. OEMS will provide quality “dashboards” where education can improve data quality and update validity rules within the application when education alone cannot correct poor data. 4.1.5.3. Provide quarterly compliance reports to the OEMS, Division of Regulation and Compliance and Executive Management.
	4.1.6 Review functional adequacy and design features of EMS vehicles utilized in Virginia and recommend changes to improve EMS provider safety, unit efficiency and quality of patient care.	OEMS, Rules & Regulations Committee, Transportation Committee	4.1.6.1. Evaluation of national/international documents and information related to vehicle and provider safety, with potential incorporation into EMS regulation and inspection procedure.
	4.1.7 Measure EMS system compliance utilizing national EMS for Children (EMSC) performance measures.	OEMS, EMSC Committee	4.1.7.1. Assist in assessing the pediatric emergency care readiness of Virginia Emergency Departments.

Core Strategy 4: Assure Quality and Evaluation	Strategic Initiative 4.2 – Assess and enhance quality of education for EMS providers.		
	Objectives	***Accountability***	***Action Steps***
	4.2.1 Update the certification process to assure certification examinations continue to be valid, psychometrically sound, and legally defensible.	OEMS, Training and Certification Committee	4.2.1.1. Review and revision of psychomotor examination by TCC as needed. 4.2.1.2. Review statistical data and make recommendations for the EC recertification exam.
	4.2.2 Assure adequate and appropriate education of EMS students.	OEMS, Training and Certification Committee , Atlantic EMS Council (AEMS)	4.2.2.1. Review state statistics for certification rates and assist in determining avenues to improve outcomes and implement new processes. 4.2.2.2. Improve instructor compliance with student registration process.
	4.2.3 Explore substitution of practical examination with successful completion of a recognized competency based training program conducted by accredited training sites and using computer based technology for written examinations.	OEMS, Training and Certification Committee	4.2.3.1. Explore possibility of administering a program summative practical exam in lieu of state practical exam.

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

Appendix B – Sample Planning Matrix

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

Appendix C

Glossary of Terms

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

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

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

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

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

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

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

Appendix C (Continued)

Glossary of Commonly Used Acronyms

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

Appendix D

Resources

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

- Code of Virginia: § 32.1-111.3. Statewide emergency medical care system. Requires a comprehensive, coordinated EMS system in the Commonwealth and identifies specific objectives that must be addressed.
- EMS Agenda for the Future: A document created by the National Highway Traffic and Safety Administration (NHTSA) that outlines a vision and objectives for the future of EMS. August 1996
- OEMS 5-Year Plan: July 1, 2010-June 30, 2013
- Service Area Strategic Plan State Office of Emergency Medical Services (601 402 04) which describes the statutory authority and expectations for OEMS and identifies the growing EMS needs of the citizens and visitors of Virginia.
- Service Area Strategic Plan Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (601 402 03) This service area includes Virginia Rescue Squads Assistance Fund grants program, Financial Assistance to Localities to support Non Profit Emergency Medical Service (EMS) agencies, and funding provided to support Virginia Association of Volunteer Rescue Squads (VAVRS).
- State Emergency Medical Services Systems: A Model: National Association of State EMS Officials – July 2008
- EMS at the Crossroads: Institute of Medicine - 2006
- Agency Planning Handbook: A Guide for Strategic Planning and Service Area Planning Linking to Performance-Based Budgeting: Department of Planning and Budget 2006-2008 Biennium, May 1, 2005
- Joint Legislative Action Review Commission (JLARC) Report – House Document 37, Review of Emergency Medical Services in Virginia. 2004.
- EMS Advisory Board Committee Planning Templates – Developed May-August 2009
- Regional EMS Council Process Action Team (PAT) Retreat Report - November 2008.

Appendix E

State EMS Advisory Board
Motion Submission Form

Committee Motion: Name: _____

√ **Individual Motion**: Name: Trauma System Oversight & Management Committee (TSO&MC)

Motion:

The TSO&MC requests that the EMS Advisory Board endorse the Virginia Statewide Trauma Registry Version 3 Minimum Data Set (VSTRv3).

EMS Plan Reference (2013 version used) (include section number):

1.1.5 – Promote data sharing projects which benefit internal and external projects.

2.1.1 – Sponsor research and other projects that contribute to high quality EMS and improve patient outcomes utilizing data collected by the EMS Registries 2.1.1 – Determine quality of EMS service and trauma triage analysis.

2.1.2 Determine quality of EMS service and conduct analysis of trauma triage effectiveness..

4.1.1 – Utilize epidemiology trained OEMS staffs to conduct risk adjusted data analysis of patients.

4.1.2 – Support the maintenance of the statewide and inter-hospital trauma triage plan.

4.1.5 – Review and evaluate data collection and submission efforts.

Committee Minority Opinion (as needed):

Not applicable

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

_____

Vote: _____ YEA _____ NAY _____ ABSTAIN

Board Minority Opinion:

_____
_____
_____

Meeting Date: _____

Code of Virginia 32.1-116.1 The Prehospital patient care reporting procedure: trauma registry; confidentiality

In order to collect data on the incidence, severity and cause of trauma, integrate the information available from other state agencies on trauma and improve the delivery of prehospital and hospital emergency medical services, there is hereby established the Emergency Medical Services Patient Care Information System. The Emergency Medical Services Patient Care Information System shall include the Virginia Emergency Medical Services (EMS) Registry and the Virginia Statewide Trauma Registry.

States: "*All licensed hospitals which render emergency medical services shall participate in the Virginia Statewide Trauma Registry by making available to the Commissioner or his designees abstracts of the records of all patients admitted to the institutions' with diagnoses related to trauma. The abstracts shall be submitted in the technical format prescribed by the Department and shall include the minimum data set prescribed by the Board.*"

VDH/OEMS has not revised its trauma registry minimum dataset or technical format since 2004. VDH/OEMS has attempted to be conservative in the number of data elements it collects with the goals of moving closer to the national trauma standard, meet its mandates for trauma triage monitoring, trauma center designation, performance improvement, and allow for linkage to other applicable databases.

The proposed Virginia Statewide Trauma Registry Minimum Dataset version 3 (VSTRv3) was distributed to Virginia hospitals, trauma centers, third party trauma registry software vendors serving Virginia hospitals, the Department of Rehabilitative Services, and the general public. Approximately 25 notices have been sent to these entities using U.S. Mail, e-mail list serves, and during standing committee meetings, Web site postings, and other venues. The Trauma System Oversight and Management Committee of the EMS Advisory Board endorsed the revised minimum dataset at its June 5, 2013 meeting.

Public comment occurred via a Wiki page dedicated to this project. Google Analytics was used to monitor the Wiki page to assure that the target audience was being reached. Two public comment period were held with a moderate amount of input received. Public comment for each comment period was compiled ad distributed. Most comments led to requested changes or by adding additional information to the resource materials that are being developed to support the program.

Table 1 below exhibits the proposed revised Virginia Statewide Trauma Registry minimum dataset and if the element is a national element and if it will be collected by designated trauma centers, acute cares hospitals, or both.

Table 1 Proposed Trauma Registry Minimum Dataset

Proposed Trauma Registry Data Element Number and Name (VSTRv3)	NTDB	Trauma Ctrs	Hospitals
Demographic_01 – Patient's Home ZIP Code	Y	Y	Y
Demographic_02 – Patient's Home Country	Y	Y	Y
Demographic_03 – Patient's Home State	Y	Y	Y
Demographic_04 – Patient's Home County/City	Y	Y	Y
Demographic_05 – Patient's Home Town	Y	Y	Y
Demographic_06 – Alternate Home Address	Y	Y	Y
Demographic_07 – Patient's Date of Birth	Y	Y	Y
Demographic_08 - Age	Y	Y	Y

Demographic_09 – Age Units	Y	Y	Y
Demographic_10 - Race	Y	Y	Y
Demographic_11 – Ethnicity	Y	Y	Y
Demographic_12 - Gender	Y	Y	Y
Demographic_13 - Medical Record Number (MRN)	N	Y	Y
Demographic_14 - Last Name	N	Y	Y
Demographic_15 - First Name	N	Y	Y
Demographic_16 - Patient's Street Address	N	Y	Y
Diagnosis_01 - Co-Morbid Conditions	Y	Y	N
Diagnosis_02 – Injury Diagnosis	Y	Y	Y
ED/Hospital_01 – ED/Hospital Arrival Date	Y	Y	Y
ED/Hospital_02 – ED/Hospital Arrival Time	Y	Y	Y
ED/Hospital_03 – Initial ED/Hospital SBP (Systolic Blood Pressure)	Y	Y	Y
ED/Hospital_04 – Initial ED/Hospital Heart Rate	Y	Y	Y
ED/Hospital_05 – Initial ED/Hospital Temperature	Y	Y	Y
ED/Hospital_06 – Initial ED/Hospital Respiratory Rate	Y	Y	Y
ED/Hospital_07 – Initial ED/Hospital Respiratory Assistance	Y	Y	Y
ED/Hospital_08 – Initial ED/Hospital Pulse Oximetry	Y	Y	Y
ED/Hospital_09 – Initial ED/Hospital Supplemental Oxygen	Y	Y	Y
ED/Hospital_10 – Initial ED/Hospital Glasgow Coma Score - Eye	Y	Y	Y
ED/Hospital_11 – Initial ED/Hospital Glasgow Coma Score - Verbal	Y	Y	Y
ED/Hospital_12 – Initial ED/Hospital Glasgow Coma Score - Motor	Y	Y	Y
ED/Hospital_13 – Initial ED/Hospital Total Glasgow Coma Score	Y	Y	Y
ED/Hospital_14 – Initial ED/Hospital Glasgow Coma Score - Qualifier	Y	Y	Y
ED/Hospital_15 – Alcohol Use Indicator	Y	Y	Y
ED/Hospital_16 – Drug Use Indicator	Y	Y	Y
ED/Hospital_17 – ED Discharge Disposition	Y	Y	Y
ED/Hospital_19 – ED Discharge Date	Y	Y	Y
ED/Hospital_20 – ED Discharge Time	Y	Y	Y
Financial_01 – Primary Method of Payment	Y	Y	Y
Injury_01 – Injury Incident Date	Y	Y	Y
Injury_02 – Injury Incident Time	Y	Y	Y
Injury_03 – Work-Related	Y	Y	Y
Injury_04 – Patient’s Occupational Industry	Y	Y	Y
Injury_05 – Patient’s Occupation	Y	Y	Y
Injury_06 – Primary E-Code Type	Y	Y	Y
Injury_07 – Injury E-Code Place	Y	Y	Y
Injury_08 – Additional E-Code	Y	Y	Y
Injury_09 - Incident Location ZIP Code	Y	Y	Y
Injury_11 - Incident State	Y	Y	Y
Injury_12 - Incident County or City	Y	Y	Y
Injury_13 - Incident Town (if applicable)	Y	Y	Y
Injury_14 - Use of Protective Devices/Safety Equipment	Y	Y	Y
Injury_16 - Airbag Deployment	Y	Y	Y
Organ_01 - Organs Donated	N	Y	Y
Outcome_01 – Total ICU Length of Stay	Y	Y	Y

Outcome_02 – Total Ventilator Days	Y	Y	Y
Outcome_03 – Hospital Discharge Date	Y	Y	Y
Outcome_04 – Hospital Discharge Time	Y	Y	Y
Outcome_05 – Hospital Discharge Disposition	Y	Y	Y
Outcome_06 - Name of Facility Transferred To Code	N	Y	Y
Prehospital_01 – EMS Dispatch Date	Y	Y	N
Prehospital_02 – EMS Dispatch Time	Y	Y	N
Prehospital_03 – EMS Unit Arrival Date at Scene or Transferring Facility	Y	Y	N
Prehospital_04 – EMS Unit Arrival Time at Scene or Transferring Facility	Y	Y	N
Prehospital_05 – EMS Unit Departure Date From Scene or Transferring Facility	Y	Y	N
Prehospital_06 – EMS Unit Departure Time From Scene or Transferring Facility	Y	Y	N
Prehospital_07 - Transport Method to Hospital	Y	Y	Y
Prehospital_08 – Other/Additional Transport Methods to Hospital	Y	Y	Y
Prehospital_09 – Initial Field SBP (Systolic Blood Pressure)	Y	Y	N
Prehospital_10 – Initial Field Heart Rate	Y	Y	N
Prehospital_11 – Initial Field Respiratory Rate	Y	Y	N
Prehospital_12 – Initial Field Pulse Oximetry	Y	Y	N
Prehospital_13 – Initial Field Glasgow Coma Score - Eye	Y	Y	N
Prehospital_14 – Initial Field Glasgow Coma Score - Verbal	Y	Y	N
Prehospital_15 – Initial Field Glasgow Coma Score - Motor	Y	Y	N
Prehospital_16 – Initial Field Total Glasgow Coma Score	Y	Y	N
Prehospital_17 – Interfacility Transfer	Y	Y	Y
Prehospital_18 - Name of Facility Transferred From	N	Y	Y
Prehospital_19 - Name of EMS Agency Received From	N	Y	Y
Procedures_01 – Hospital Procedures	Y	Y	Y
Procedures_02 – Hospital Procedure Start Date	Y	Y	N
Procedures_03 – Hospital Procedure Start Time	Y	Y	N
Quality_01 – Hospital Complications	Y	Y	N
Severity_01 – AIS Code	Y	Y	N
Severity_02 – AIS Severity	Y	Y	N
Severity_03 – ISS Score	Y	Y	N
Severity_04 – AIS Version	Y	Y	N
Severity_05 – Locally Calculated ISS	Y	Y	N