Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Friday, August 8, 2014

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board
August 8, 2014

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 8, 2014

The Training and Certification Committee met on July 9, 2014. There are three (3) action items for the Board:

- **Appendix A** - RN Bridge to Paramedic Competencies
- **Appendix B** – CE Revision Proposal
- **Appendix C** – Experiential Learning Document

The Trauma System Oversight and Management Committee met on June 6, 2014. There is one action item for the Board:

- **Appendix F** – Recomposition of TSO&MC, staggered and term limits

b) State Emergency Medical Services Advisory Board Appointments

- **Michel. B. Aboutanos**, **MD MPH FACS** of Richmond, Professor and Chief, Division of Acute Care Surgery, Medical Director VCU Trauma Center, Virginia Commonwealth University Health System

  Representing the American College of Surgeons
  Term: 7/1/2014 - 6/30/2017
  Replaces Ajai Malhotra, M.D.

- **The Honorable Sherrin Cherrell Alsop** of Newtown, Member, Board of Supervisors, King and Queen County

  Representing the Virginia Association of Counties
  Term: 7/1/2014 - 6/30/2017
  Replaces Beau Blevins, III

- **Samuel T. Bartle, MD** of Richmond, Assistant Professor, Departments of Emergency Medicine and Pediatrics, Virginia Commonwealth University

  Representing the Virginia Chapter of the American Academy of Pediatrics
  Term: 7/1/2014 – 6/30/2017
  Replaces Robin L. Foster, M.D.

- **Gary Critzer*** of Waynesboro, Director, Department of Emergency Management and Emergency Medical Services, City of Waynesboro

  Representing the Central Shenandoah EMS Council
  Term: 7/1/2014 – 6/30/2017

- **Valeta C. Daniels** of Richmond, Emergency Medical Services Liaison, Henrico Doctors Hospital, Parham Doctors', Retreat Doctors Hospitals, West Creek and Hanover Emergency Centers

  Representing the Virginia Association of Volunteer Rescue Squads
  Term: 7/1/2014 – 6/30/2014
  Replaces Dreama Chandler

- **Lisa M. Dodd, DO** of Mechanicsville, Emergency Medicine Physician, Virginia Commonwealth University Health System

  Representing the Virginia Chapter of the American College of Emergency Physicians
  Term: 7/1/2014 – 6/30/2017
  Replaces James R. Dudley, M.D.

- **Stephen J. Elliott*, BAS, NREMT-P** of Palmyra, Battalion Chief/Shift Commander, Albemarle County Fire Rescue

  Representing the Thomas Jefferson EMS Council
  Term 7/1/2014 – 6/30/2017

- **Jason D. Ferguson** of Daleville, Division Chief, Fire and EMS Operations, County of Botetourt

  Representing the Western Virginia EMS Council
  Term: 7/1/2014 – 6/30/2017
  Replaces Dale Wagner

- **The Honorable Joan F. Foster** of Lynchburg, Member, Lynchburg City Council; Director of Development, Lynchburg Beacon of Hope

  Representing the Virginia Municipal League
  Term 7/1/2014 – 6/30/2017
  Replaces Andrea W. Oakes

- **S. Denene Hannon** of Salem, EMT-I and Paramedic Volunteer, Salem Rescue Squad

  Representing the Virginia Association of Volunteer Rescue Squads
  Term: 7/1/2014 – 6/30/2017
  Replaces Wayne Meyers

- **Jon Henschel** of New Market, Battalion Chief, Winchester Fire and Rescue Department

  Representing the Lord Fairfax EMS Council
  Term: 7/1/2014 – 6/30/2017
  Replaces Larry A. Oliver

- **H. David Hoback*** of Roanoke, Chief, CFOD, EFO Roanoke Fire-EMS Department

  Representing the Virginia Fire Chiefs Association
  Term: 7/1/2014 – 6/30/2017

- **Sudha Jayaraman, MD, MSc** of Richmond, Assistant Professor of Surgery, Division of Trauma, Critical Care and Emergency Surgery, Virginia Commonwealth University

  Representing the Medical Society of Virginia
  Term: 7/1/2014 – 6/30/2017
  Replaces Allen Yee, M.D.

- **Jason Jenkins** of Haymarket, Battalion Chief, Fairfax County Fire and Rescue Department

  Representing the Virginia Chapter of the IAFF
  Term: Unexpired - 7/1/2012 through 6/30/2015
  Replaces Gary Samuels

- **Cheryl Lawson, MD, FACEP** of Newport News, Medical Director of Peninsulas EMS Council

  Representing the Peninsulas EMS Council
  Term: Unexpired 7/1/2012 through 6/30/2015
  Replaces David Barrick

- **Marilyn McLeod*, MD, FACEP,** of Lynchburg, Medical Director of Centra One Air Services/Medflight, Regional Medical Director, Blue Ridge EMS Council

  Representing the Blue Ridge EMS Council
  Term: 7/1/2014 – 6/30/2017

- **Christopher L. Parker, BSN, RN, CEN, CPEN, NRP, CCEMTP** of Lynchburg, Lynchburg General Hospital; EMS Flight Nurse, Centra One; Educator, Faculty, Central Virginia Community College.

  Representing the Virginia Emergency Nurses Association and the Virginia Nurses Association
  Term: 7/1/2014 – 6/30/2017
  Replaces Cathy Fox, RN, CEN

- **Anita Perry*, RN, MSN, CEN, AAS/NREMT-P, CMTE** of Abingdon, System Director of Flight Services, Wellmont Health System

  Representing the Virginia Hospital and Healthcare Association
  Term: 7/1/2014 – 6/30/2017

- **José V. Salazar, MPH, NREMT-P** of Sterling, Deputy Chief of EMS and Training, Loudoun County Fire and Rescue.

  Representing the Northern Virginia EMS Council
  Term: 7/1/2014 – 6/30/2017
  Replaces Brian R. Hricik

- **Kelly G. Southard** of Orange, Rescue Chief, Orange County Rescue Squad; Senior Principal/ Partner, Gillum Architects, P.C.

  Representing the Rappahannock EMS Council
  Term 7/1/2014 – 6/30/2017
  Replaces R. Christian Eudailey

- **Daniel C. Wildman** of Fredericksburg, Vice President/Owner, LifeCare Medical Transports, Inc.

  Representing the Virginia Ambulance Association
  Term: Unexpired, 7/1/2012 through 6/30/2015
  Replaces Anthony D. Wilson

Denotes reappointment

c) Final Approved EMS Appropriation for FY2015 and FY2016

Department of Health (601)

		FY2015	FY2016
284.	Emergency Medical Services (40200)	42,620,756	42,620,756
	Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	35,148,150	35,148,150
	State Office of Emergency Medical Services (40204)	7,472,606	7,472,606
Fund Sources:	Special	17,847,721	17,847,721
	Dedicated Special Revenue	24,367,452	24,367,452
	Federal Trust	405,583	405,583

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

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

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

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

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

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

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

G. Out of this appropriation, up to $400,000 the first year and up to $400,000 the second year from the Virginia Rescue Squad Assistance Fund shall be used for grants to emergency medical services organizations to purchase 12-lead electrocardiograph monitors.

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

Poison Control Centers

(Financial Assistance to Community Human Services Organizations (49200). Budget Item 291)

Out of this appropriation, $1,000,000 the first year and $1,000,000 the second year from the general fund shall be used to support three poison control centers. The State Health

Commissioner shall review existing poison control services and determine how best to provide and enhance use of these services as a resource for patients with mental health disorders and for health care providers treating patients with poison-related suicide attempts, substance abuse, and adverse medication events. The Commissioner shall allocate the general fund amounts between the three centers. The general fund amounts shall be based on the proportion of Virginia's population served by each center.

Note: For FY2015 the distribution of funds for the three Poison Control Centers is as follows:

- Virginia Poison Center at VCU $387,700
- Blue Ridge Poison Center at UVa $311,200
- National Capital Poison Center $301,100

§3-1.01 Interfund Transfers Affecting the EMS Appropriation

T. The State Comptroller shall transfer quarterly, one-half of the revenue received pursuant to § 18.2-270.01, of the Code of Virginia, and consistent with the provisions of § 3-6.03 of this act, to the general fund in an amount not to exceed $9,055,000 the first year, and $8,055,000 the second year from the Trauma Center Fund contained in the Department of Health's Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203). It is the intent of the General Assembly that this transfer be phased-out over a multi-year period.

Y. On or before June 30 each year, the State Comptroller shall transfer $10,518,587 the first year and $9,518,587 the second year to the general fund from the $2.00 increase in the annual vehicle registration fee from the special emergency medical services fund contained in the Department of Health's Emergency Medical Services Program (40200). It is the intent of the General Assembly that this transfer be phased-out over a multi-year period.

d) Comprehensive EMS Bill to be Reintroduced During to 2015 Session of the Virginia General Assembly

During the 2014 session of the Virginia General Assembly HB581 and SB355 were introduced by Delegate Stolle and Senator Stuart, respectively to address the inconsistent use of terms and phrases in the *Code of Virginia* that refer to individuals, organizations, vehicles, medical directors, etc. as they relate to emergency medical services (EMS). For example, currently, EMS agencies are referenced by multiple terms in the code; i.e., rescue squad, life saving crews, first aid crew, volunteer sea rescue, etc. These bills, identical in nature, were also introduced to separate Fire and EMS in the code in an attempt to develop legal and operational clarity.

Because of the compressed time frame during the legislative session, there was not sufficient time for key stakeholder groups and other interested parties to review the changes proposed in HB581/SB355 to multiple sections of the Code. HB 581 was carried over to the Health, Welfare and Institutions Committee until the 2015 session of the Virginia General Assembly. SB 355

was carried over until 2015 with a request for the state EMS Advisory Board to review and make recommended changes to the existing bills. By not acting on these bills, the legislature gave key EMS stakeholder groups and other interested parties addition time to comment on the proposed code language changes.

It was felt the EMS community would be in a better position to understand the proposed changes to the Code if they had an opportunity to participate in drafting the language changes. At the direction of the state EMS Advisory Board Chairman, Mr. Gary Critzer, a workgroup of the Legislation and Planning committee was formed to review the existing code and with input from key EMS stakeholder groups and other interested parties, make recommendations for technical changes to the Code in order to reduce the ambiguity and confusion over the use of definitions and terms related to EMS. The workgroup includes representation from OEMS, VDFP, VFCA, VPFF, Virginia Firefighters' Association, VAA, VAVRS, VAGEMSA, regional EMS Councils, and the Division of Legislative Services.

The workgroup has met on March 14. April 18, and May 30 and will meet again on August 1. Following updates to the Code that will occur on July 1, 2014, the workgroup will finalize draft bill language at their August 1 meeting and request public comment. Following a public comment period, additional changes may be made to the draft bill language before presenting it to the state EMS Advisory Board on November 5, 2014. The draft bill language will then be available for interested legislators to pre-file in December for the 2015 session of the Virginia General Assembly that begins on January 14, 2015.

Individuals and organizations interested in providing comments related to the draft comprehensive EMS bill language should submit their remarks to Mr. Scott Winston, Asst. Director, VA OEMS at scott.winston@vdh.virginia.gov

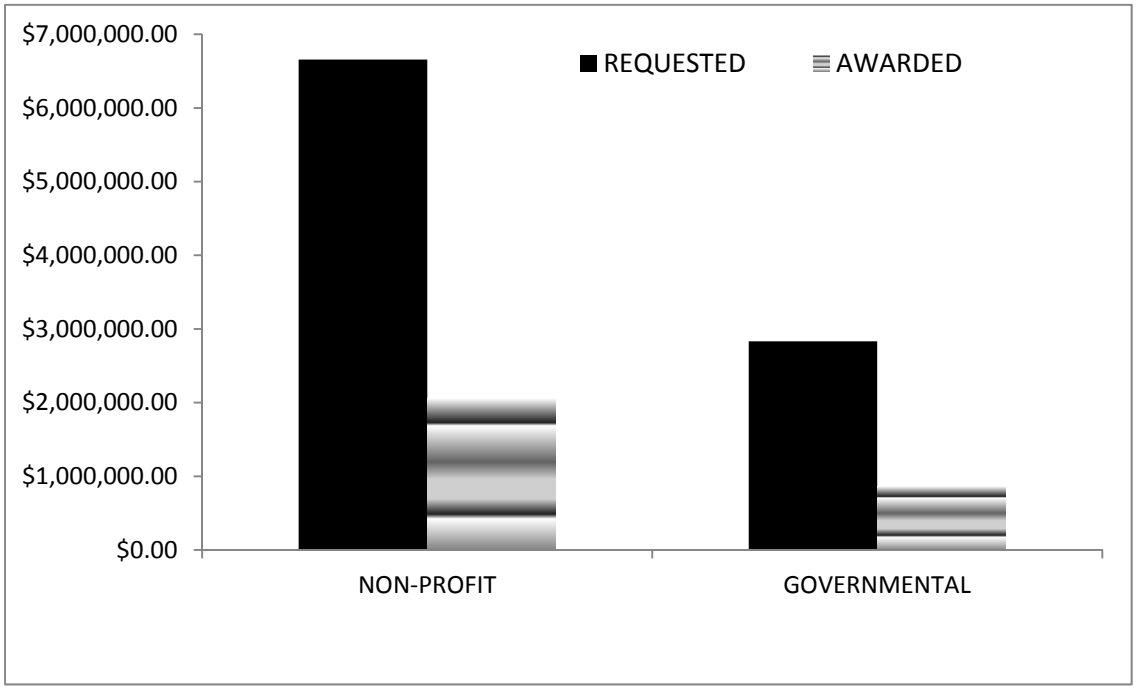
e) Financial Assistance for Emergency Medical Services Grant Program (FAEMS), known as the Rescue Squad Assistance Fund (RSAF)

The Spring 2014 RSAF grant deadline was March 17, 2014; OEMS received 111 grant applications requesting $9,340,665.00 in funding. Grants were awarded on July 1, 2014 in the amount of $2,926,806.00 to 87 agencies.

The following agency categories were awarded funding for this grant cycle:

- 62 Non-Profit Agencies were awarded $2,060,609.00
- 25 Government Agencies were awarded $866,198.00

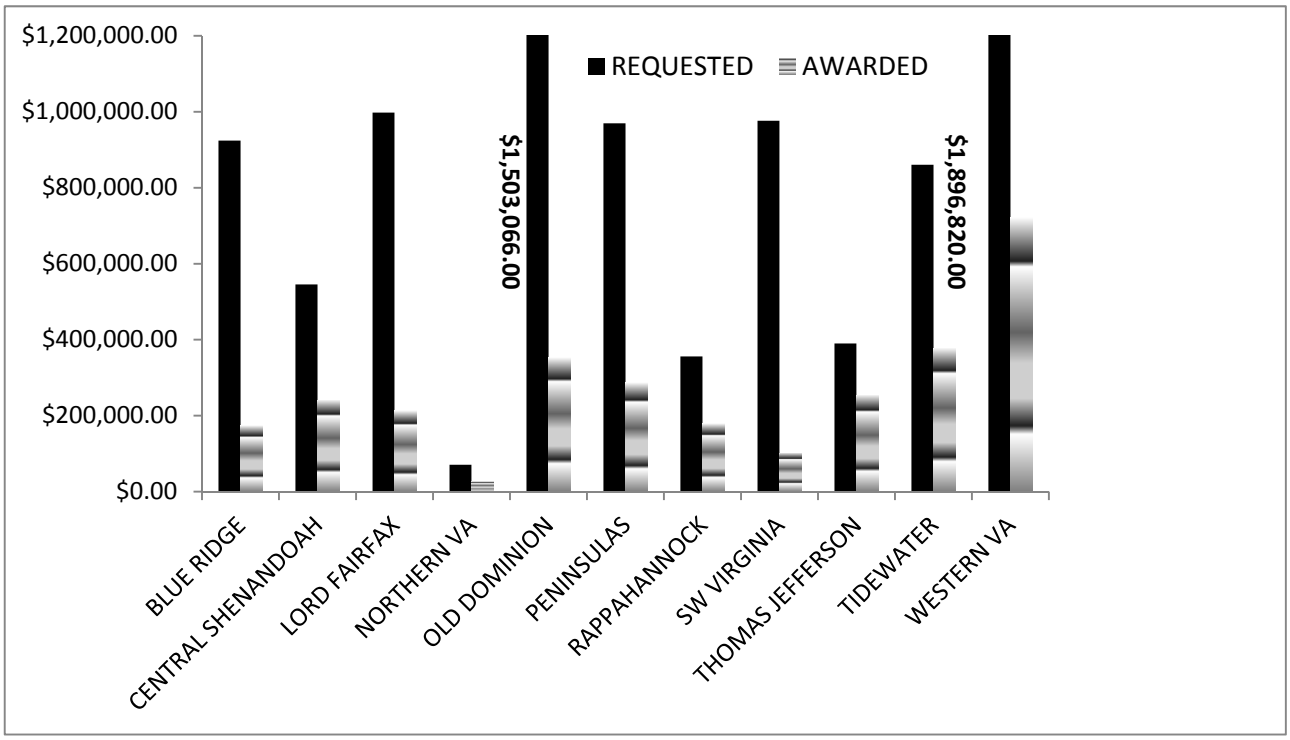
Figure 1: Amount Requested vs Amount Awarded by Agency Category



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

- Blue Ridge EMS Council – 8 agencies awarded $173,370.00
- Central Shenandoah EMS Council – 6 agencies awarded $240,784.00
- Lord Fairfax EMS Council – 5 agencies awarded $213,079.00
- Northern Virginia EMS Council - 2 agencies awarded $25,935.00
- Old Dominion EMS Alliance – 11 agencies awarded $353,621.00
- Peninsulas EMS Council – 10 agencies awarded $286,472.00
- Rappahannock EMS Council – 6 agencies awarded $178,802.00
- Southwestern Virginia EMS Council – 7 agencies awarded $101,859.00
- Thomas Jefferson EMS Council – 7 agencies awarded $253,731.00
- Tidewater EMS Council – 8 agencies awarded $377,778.00
- Western Virginia EMS Council – 17 agencies awarded $721,376.00

Figure 2: Amount Requested vs Amount Awarded by EMS Regions



RSAF Grants Awarded by item categories:

- 12 –Lead – $817,151.00
  - Includes all 12-Lead Defibrillators.

- Audio Visual and Computers - $ 109,233.00
  - Includes projectors, computer hardware/software, toughbooks, and other audio visual equipment.

- Communications - $ 304,399.00
  - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.

- Emergency Operations - $ 108,679.00
  - 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.

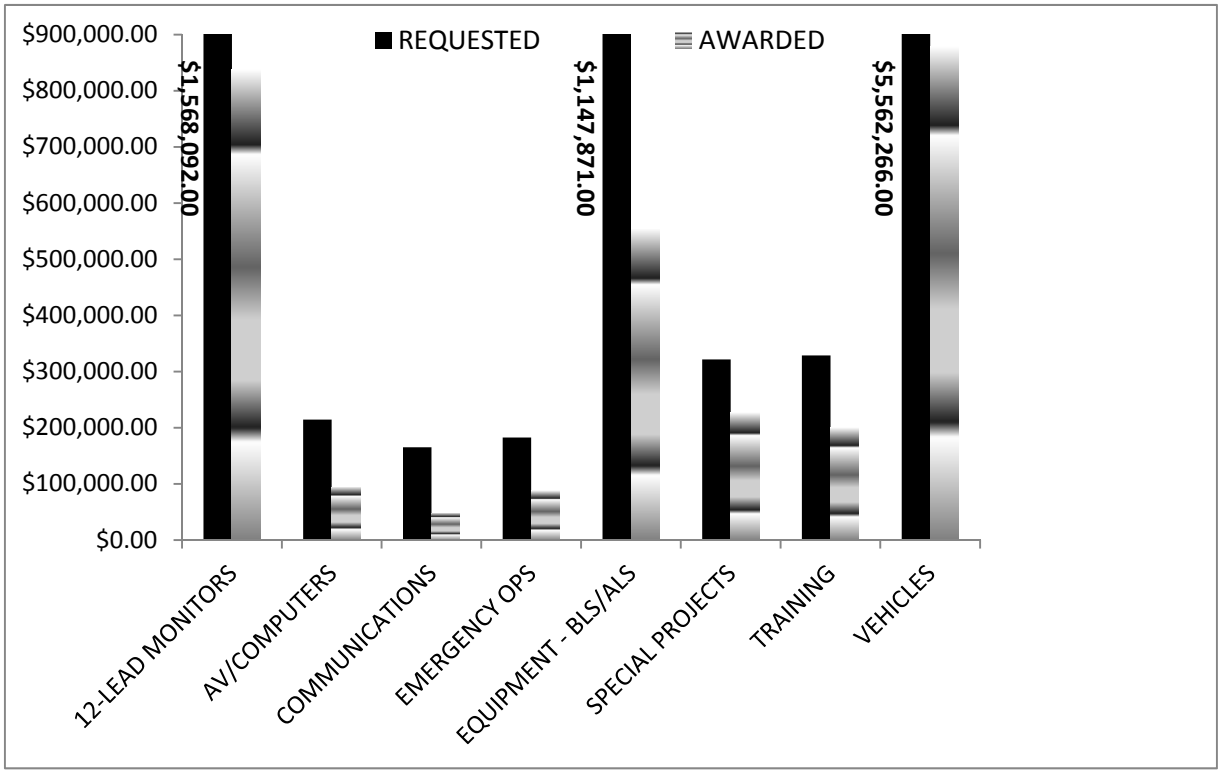
- Equipment - Basic and Advanced Life Support Equipment - $ 402,333.00
    - Includes any medical care equipment for sustaining life, airway management, and supplies, not including 12-Lead Defibrillators.

- Special Projects - $ 378,959.00
    - 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 - $ 121,495.00
    - 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 – 2,435,154.00
    - Includes ambulances, 1st Response/Quick Response Vehicles (QRV) and rechassis/remount of ambulances.

Figure 3: Awarded Requested vs Amount Awarded by Item



The Fall 2014 grant cycle will begin on August 1, 2014 with a deadline of September 15, 2014; grants will be awarded January 1, 2015.

Rescue Squad Assistance Fund Emergency Grants

South End Fire Company was awarded 1 Type III Ambulance (Ford E350) at 100/0 (state/agency) level funding for $172,500.00 on June 4, 2014. This agency was awarded an ambulance due one of their two ambulances remaining out of service due to the high amount of repairs and maintenance. This agency did not have the funding to repair the unit and the lack of use was detrimental to patient care.

EMS – Grant Information Funding Tool (E-Gift)

The OEMS Grants Unit and VDH Office of Information Management (OIM) continues to work on the web-based RSAF program to replace the CGAP software. Phase I, grant application, should be complete on August 1st for the Fall 2014 grant cycle, the following phases will include the grant review, meeting program, grant awards program and reporting. OEMS is in the process of beta testing the system with a selected user group, after beta testing OEMS will develop a training schedule and user guide to distribute to E-Gift users.

EMS on the National Scene

II. EMS On the National Scene

a) Equipment for Ground Ambulances Revision Now Available

The 2014 Joint Policy Statement (American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, Emergency Medical Services for Children, Emergency Nurses Association, the National Association of EMS Physicians, and the National Association of State EMS Officials) that informs and in some cases mandates equipment that must be available on ground ambulances has been published in final form and is now freely available in html and pdf versions on the publisher's web site. This information available without a subscription or fee. For more information go to: http://informahealthcare.com/doi/full/10.3109/10903127.2013.851312.

b) FAA Delays Helicopter Rule Implementation

The Federal Aviation Administration (FAA) is delaying the effective date of the Helicopter Air Ambulance, Commercial Helicopter, and Part 91 Helicopter Operations final rule published on February 21, 2014. In that rule, the FAA amended its regulations to revise the helicopter air ambulance, commercial helicopter, and general aviation helicopter operating requirements. The April 22, 2014 effective date does not provide an adequate amount of time for the affected certificate holders to implement the new requirements. By extending the effective date to April 22, 2015, the affected certificate holders will have sufficient time to implement the new requirements. This action will only affect the effective date of the provisions of the rule scheduled to take effect April 22, 2014. Other provisions in the rule with specified compliance dates will not be affected. For more information go to: https://www.federalregister.gov/articles/2014/04/21/2014-09034/extension-of-effective-date-for-the-helicopter-air-ambulance-commercial-helicopter-and-part-91.

c) NTSB Recommends FAA, NWS Improve Weather Forecast to Pilots

The National Transportation Safety Board (NTSB) recently issued nine recommendations addressing the need to provide more comprehensive preflight weather information to pilots. The recommendations were issued to both the Federal Aviation Administration (FAA) and the National Weather Service (NWS), who are jointly responsible for providing such information to pilots. Timely, detailed weather information is critical for enabling airmen to properly balance risks and make sound decisions when determining to fly. The recommendations are based on NTSB accident investigations involving aircraft encountering weather conditions, such as adverse surface wind, dense fog, icing, turbulence, and low-level wind shear. Currently, although information on these conditions may exist, it is not always provided to pilots through NWS

products during preflight weather forecasts. To view the NTSB's recommendations to the FAA and the NWS, click on the following links:

http://www.ntsb.gov/doclib/recletters/2014/A-14-013-016.pdf
http://www.ntsb.gov/doclib/recletters/2014/A-14-017-021.pdf

d) FirstNet Announces Plans for State Consultations

FirstNet officials plan to begin state consultations in July to determine the best way to deploy the portion of the nationwide broadband network for public safety within a give state or territory. Items on the final state checklist are supposed to ensure that state representatives are prepared for their consultation with FirstNet and should generate information that will be useful, whether the jurisdiction chooses to let FirstNet build the network or chooses to opt out and build its portion of the broadband system on its own. FirstNet recently delivered proposed checklists to the state points of contact (SPOCs) in the 56 states and territories impacted by FirstNet and sought additional input. That input was incorporated into the consultation package, which includes a six-point "readiness checklist" that states and territories need to complete before initiating talks with FirstNet and eight "discussion topics" that FirstNet would like submitted. To view the consultation package go to:
http://firstnet.gov/sites/default/files/Single%20Point%20of%20Contact%20%28SPOC%29%20Initial%20Consultation%20Package_04302014.pdf

e) Act of Congress Delays ICD-10 Implementation

Congress recently enacted the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93), which effectively delayed the implementation of ICD-10 to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. Physicians groups have expressed ongoing concern about rushing ICD-10 implementation while hospitals and the healthcare IT community are decrying the cost of the delay.

f) FDA Approves New Hand-held Auto-injector to Reverse Opioid Overdose

The U.S. Food and Drug Administration (FDA) recently approved a prescription treatment that can be used by family members or caregivers to treat a person known or suspected to have had an opioid overdose. Evzio (naloxone hydrochloride injection) rapidly delivers a single dose of the drug naloxone via a hand-held auto-injector that can be carried in a pocket or stored in a medicine cabinet. It is intended for the emergency treatment of known or suspected opioid overdose, characterized by decreased breathing or heart rates, or loss of consciousness. Evzio is injected into the muscle (intramuscular) or under the skin (subcutaneous). Once turned on, the device provides verbal instruction to the user describing how to deliver the medication, similar to

automated defibrillators. FDA Commissioner Margaret Hamburg supported the move in a statement, "For years, the lack of a lay-friendly delivery system has made it difficult to make naloxone broadly available to the public and to foster its use in non-medical settings, where it is often most urgently needed. [Evzio is] . . . an extremely important innovation that will save lives." For more information go to: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm391465.htm

g) NEW from the CDC!! Data on Injury-related ED Visits by Children and Adolescents

The Centers for Disease Control and Prevention (CDC) has recently posted NCHS Data Brief, No. 150 - Injury-related Emergency Department Visits by Children and Adolescents: United States, 2009–2010. Injury is the leading cause of death and a major source of morbidity among children and adolescents in the United States. This report examines nationally representative data on injury-related ED visits by children and adolescents aged 18 years and under in the United States during 2009–2010. Injury-related ED visit rates were also compared for the age groups 0–4, 5–12, and 13–18 years, as these correspond to the preschool, school-age, and teen life periods respectively. Key findings include:

- In 2009–2010, an annual average of 11.9 million injury-related emergency department (ED) visits were made by children and adolescents aged 18 years and under in the United States.
- The injury-related ED visit rate was 151 per 1,000 persons aged 18 years and under, and rates were higher for males than for females for all age groups (0–4 years, 5–12 years, and 13–18 years).
- The injury-related ED visit rates among persons aged 5–12 years and 13–18 years were higher for non-Hispanic black persons than for other race and ethnicity groups.
- Leading causes of injury-related ED visits among both males and females included falls and striking against or being struck unintentionally by objects or persons. Visit rates were higher for males than for females for both of these causes. For more information go to: http://www.cdc.gov/nchs/data/databriefs/db150.htm.

h) EMSC NRC Launches New Web Site

The Emergency Medical Services for Children (EMSC) National Resource Center's (NRC) website recently changed to **http://www.emscnrc.org**. The new URL features a new design, and much of the content has been reorganized. Please note that if your website or marketing materials currently link to the old website (**www.childrensnational.org/emsc)**, you will need to change those links as soon as possible. This includes all products or pdfs on your website that are hosted by **www.childrensnational.org**. The new URLs should be easy to find on the new site. If you cannot find the new URL for a specific page or product, please feel free to contact Suzanne Sellman, EMSC NRC senior communications specialist at: susellma@childrensnational.org.

i) FHWA Launches New Site to Assist State EMS Officials

The Federal Highway Administration (FHWA) has launched a new web site to encourage State EMS Offices to engage in the Strategic Highway Safety Plan (SHSP) process to reduce serious highway injuries and fatalities. The Strategic Highway Safety Plan (SHSP) is a data-driven, four to five year comprehensive plan that integrates the 4Es of highway safety:

- Engineering
- Education
- Enforcement
- Emergency Medical Services (EMS)

A new website is available to help EMS officials develop relationships and become involved in their State SHSP.

For more information go to: http://safety.fhwa.dot.gov/hsip/shsp/ems/connection/

j) New NSADAD Report Includes Naloxone Distribution Data

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has released a new report, *Heroin and Prescription Drug Abuse*, that provides "the results of a membership inquiry describing the scope of the prescription drug abuse and heroin problem along with actions State substance abuse agencies are taking to address these challenges." The report finds that, "State substance abuse agencies are implementing a number of initiatives and strategies related to opioid issues. In turn, the report may serve as a "States-helping-States" tool. Information includes expanding access to naloxone as an “overdose prevention” strategy. For more information go to: http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf.

k) 9-1-1 Text Availability Now Live

For those who are nonverbal, deaf or otherwise have difficulty communicating via traditional telephone calls, a new option to seek emergency help is on the way. Starting this month, the nation’s four main wireless networks now have the capability to support text messages sent to 911. The move is a significant step toward making the service available on a broader scale. Text-to-911 is expected to be particularly meaningful to individuals who may have difficulty hearing or speaking. Currently, it is possible to text 911 in communities in 16 states where emergency call centers are set up to receive and respond to the messages, according to the Federal Communications Commission. Vermont recently became the first to deploy the service statewide with all four major wireless carriers. For more information go to: http://www.toptechnews.com/article/index.php?story_id=132009Y7Y0RC.

l) NHC to Issue Potential Storm Surge Flooding Maps

Beginning with the 2014 Atlantic hurricane season, NOAA's National Hurricane Center (NHC) will issue the Potential Storm Surge Flooding Map for those areas along the Gulf and Atlantic coasts of the United States at risk of storm surge from a tropical cyclone. Developed over the course of several years in consultation with emergency managers, broadcast meteorologists, and others, this new map will show:

- Geographical areas where inundation from storm surge could occur
- How high above ground the water could reach in those areas

The Potential Storm Surge Flooding Map is an experimental National Weather Service product that provides valuable new information on the storm surge hazard associated with tropical cyclones. For more information go to: http://www.nhc.noaa.gov/news/20140131_pa_stormSurgeGraphic.pdf.

m) CRS Issues Primer on Emergency Response

The Congressional Research Service (CRS) recently released a Congressional Primer on Responding to Major Disasters and Emergencies. The report provides an overview of disaster response and recovery responsibilities of the federal government and the requesting state or tribal government. The report also describe the roles for congressional offices to play in providing information to the federal response and recovery teams in their respective states and districts. Please go to: http://fas.org/sgp/crs/homesec/R41981.pdf.

n) Proposed Annotated CAAHEP Standards for EMSP Now Available

The draft of the proposed CAAHEP *Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions* has been approved by the CAAHEP Standards Committee and the CoAEMSP Board of Directors. The proposed *Standards* will be presented to the communities of interest. The CoAEMSP will hold listening sessions via web meeting and face-to-face sessions at EMS related meetings. In addition, comments will be accepted via an online comment tool.

VIEW the "Proposed Annotated CAAHEP Standards for EMSP" document at: http://origin.library.constantcontact.com/download/get/file/1103098668638-480/Proposed+Annotated+CAAHEP+Standards+for+EMSP+20140602.pdf.

SUBMIT COMMENTS: all comments must be received through the online survey at: http://www.surveymonkey.com/s/Standards_Comment.

Comments sent by U.S. Mail, email, and faxes are NOT accepted. Public comments intended for consideration by the CoAEMSP must be received no later than December 31, 2014.

Announcements will be made on the CoAEMSP web site at: www.coaemsp.org. The latest on the CAAHEP *Standards* revision process is also found on this web site. (Note: As of May 27, 2014, there are 12 programs "on hold" (awaiting fees, documents, etc), 276 possess a CoAEMSP Letter of Review, and 390 Accredited Paramedic Programs for a total of 678 in the CAAHEP process).

o) New Report Highlights Improved EMS Through Transportation Safety

Enhancing EMS to reduce mortality is one of the 22 goals identified in the American Association of State Highway and Transportation Officials (AASHTO) Strategic Highway Safety Plan (SHSP). A needs assessment was recently conducted by the Mountain-Plain Consortium at North Dakota State University for rural EMS in South Dakota to identify issues with respect to delivering quality EMS to rural residents. Although the EMS response time for fatal crashes is one of the most critical performance measures, the project targets a broader EMS 9-1-1 response with the attempt to address critical factors affecting the provision of EMS services. A new report, *"Improving Rural Emergency Medical Services through Transportation System Enhancement,"* highlights the findings of the research. For more information go to: http://www.mountain-plains.org/pubs/pdf/MPC14-267.pdf.

p) Federal Collaboration in EMS—The Four Priorities

The first webinar in a new, free series hosted by NHTSA's Office of EMS (OEMS) took place on June 2. EMS FOCUS: A Collaborative Federal Webinar Series, will provide a unique opportunity for Federal agencies to provide more information about EMS efforts and programs at the Federal level. FICEMS Chair Kathryn Brinsfield, MD, MPH, FACEP, and OEMS Director Drew Dawson discussed Federal efforts toward:

- Veteran to Civilian EMS Credentialing
- Evidence-Based Guideline Development
- EMS System Preparedness
- EMS Data Standardization

The session was recorded and will be archived at: wwww.ems.gov.

q) CMS Announces Resources on Comparative Billing Report on Ambulance: Ground Transportation

CMS issued a national provider Comparative Billing Report (CBR) on Ambulance: Ground Transportation on May 23, 2014. The CBR, produced by CMS contractor, eGlobalTech, contains data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers in the state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. (These reports are only available to the providers who receive them.) Providers are advised to

update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because fax is the default method of CBR dissemination. Providers should contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk or visit the CBR website.

r) Saline Shortage Likely to Stretch into 2015

Several news outlets are reporting that the shortages of IV saline solution may continue through early next year. Novation, a large, privately held group-purchasing organization based in Irving, TX recently convened a symposium for industry I.V. solution suppliers, hospital supply chain, clinical and pharmacy professionals, as well as representatives from the University of Utah Drug Information Service and the Food and Drug Administration (FDA).For more information go to: http://healthcare.dmagazine.com/2014/05/14/saline-shortage-industry-wide-baxter-hospira-iv/.

s) Field EMS Bill Introduced in Senate

S. 2400, the Field EMS Innovation Act (Field EMS Bill) was recently introduced in the U.S. Senate by Sen. Michael Bennet (D-Colo.), Sen. Mike Crapo (R-Idaho) and Sen. Tim Johnson (D-S.D.). This Senate bill is the companion to the Field EMS Bill introduced in the U.S. House of Representatives on February 26, 2013, as H.R. 809 by Congressman Larry Bucshon (R-Ind.). The Field EMS Bill addresses many of the challenges EMS systems face while trying to fulfill public expectations that all who need EMS can depend upon the highest quality of care and transport to the most appropriate clinical setting. The first bill to seriously look at EMS issues since the 1960s, the act would improve access to essential and life-saving EMS services and better integrate EMS within the larger health care system. The National Association of Emergency Medical Technicians (NAEMT) has taken the lead within the EMS community to support passage of this important legislation.

t) NEMA Issues Reports on States' Abilities to Deploy Private Sector and Volunteer Resources through EMAC

As states consider ways to increase their disaster response/recovery resource inventories, NEMA is releasing a new report on innovations and best practices in deploying private sector and volunteer resources through the Emergency Management Assistance Compact (EMAC). In partnership with the Stephenson Disaster Management Institute (SDMI), NEMA conducted a survey on these issues and received responses from 43 states and the U.S. Virgin Islands. Detailed follow-up interviews were conducted with 16 states. The report focuses on gaining insight into the experiences of states that have used the EMAC process to deploy private sector and volunteer resources to states with specific needs requested through EMAC. These states provided a wealth of information regarding their experiences, capabilities and concerns in deploying private sector and volunteer resources. This report provides specific examples of

solutions that can be replicated in other states interested in building these capabilities. For more information go to: http://www.emacweb.org/.

u) Trauma Bills Introduced in Congress

The "Improving Trauma Care Act" (H.R. 3548), introduced by Representative Bill Johnson (R-OH), amends the Public Health Service Act to improve the definition of trauma by including injuries caused by thermal, electrical, chemical, or radioactive force, commonly treated by burn centers. On May 22, Senator Jack Reed (D-RI) introduced the Senate companion (S. 2406). The "Trauma Systems and Regionalization of Emergency Care Reauthorization Act" (H.R. 4080), introduced by Representatives Michael C. Burgess (R-TX) and Gene Greene (D-TX), reauthorizes Trauma Care Systems Planning Grants, which support state and rural development of trauma systems. The bill also reauthorizes pilot projects to implement and assess regionalized emergency care models. Those grants and other federally supported activities relating to trauma would be authorized at the current level of $24 million annually for four years, through fiscal 2019.On May 22, Senators Jack Reed (D-RI), Susan Collins (R-ME), Johnny Isakson (R-GA), Mark Kirk (R-IL) and Patty Murray (D-WA) introduced the Senate companion (S. 2405).

v) NFPA Announces Next Meeting to Review 1917 Standard

The National Fire Protection Association (NFPA) has announced its next meeting to discuss NFPA 1917: Standard for Automotive Ambulances. The meeting will be held August 26-27, 2014 at the San Diego Marriott La Jolla. For more information go to: www.nfpa.org/1917next.

National Association of State EMS Officials (NASEMSO)

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

w) NASEMSO Joins EMS Organizations to Comment on FCC Proposed Rule Making

The National Association of State EMS Officials (NASEMSO), the National Association of EMS Physicians (NAEMSP), the National Association of EMTS (NAEMT), and the National EMS Management Association (NEMSMA) have collaboratively joined forces to support proposed rules by the Federal Communications Commission (FCC) to require indoor location accuracy as a means to enhance the E911 system. As part of the Federal Docket No. 07-114, the group submitted formal comment and continues to monitor the proposal. The document can ve viewed at: http://www.nasemso.org/Advocacy/Supported/documents/JointCommentsLocationAccuracyNASEMSO-NAEMT-NAEMSP-NEMSMA.pdf.

x) NASEMSO Congratulates Joe Schmider on State Director Appointment to FICEMS

Public Law 109-59 authorizes the Federal Interagency Committee on Emergency Medical Services (FICEMS), an entity that is tasked to ensure coordination among the Federal agencies involved with State, local, tribal, or regional EMS and 9-1-1 systems. NASEMSO member Joe Schmider has been appointed by Transportation Secretary Foxx to fill the position reserved for a State EMS Director. Schmider has been active in EMS for many years while serving in a variety of positions from Pennsylvania to Texas and is well qualified to fill the shoes of retired FICEMS member, Dr. Robert Bass.

y) NASEMSO Annual Report to NEMSAC Now Available

Since 2007, NASEMSO has collected annual data to chart the progress of implementing the EMS Education Agenda for the Future: A Systems Approach and developed a report to advise the National EMS Advisory Council (NEMSAC). Tremendous progress has been made moving the Nation to a common goal. Today, 76% of states intend to use the National EMS Scope of Practice Model as a foundation for State licensure at the EMR level; 100% at the EMT level, 88% at the AEMT level, and 100% at the Paramedic level. 90% of states require National EMS Program Accreditation at the Paramedic level. 92% of states use the National EMS Certification process at one or more levels for state licensure. The results of data collected in the fall of 2013 have been presented to NEMSAC and posted on the NASEMSO web site. NASEMSO expresses its gratitude to 50 states and Guam for participating in this survey! For more information go to: http://www.nasemso.org/EMSEducationImplementationPlanning/documents/Implementing-EMS-Education-Agenda-Report-to-NEMSAC-23Apr2014-FINAL.pdf

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The Training and Certification Committee met on July 9, 2014. There are three (3) action items for the Board:

- **Appendix A** - RN Bridge to Paramedic Competencies
- **Appendix B** – CE Revision Proposal
- **Appendix C** – Experiential Learning Document

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

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

B. **The Medical Direction Committee (MDC)** The Medical Direction Committee meeting met on Thursday, July10, 2014. There are no action items for consideration.

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

Advanced Life Support Program

A. ALS Coordinator re-endorsements are still being processed. All new individuals wishing to seek endorsement as an EMS educator are being offered guidance and direction on how to complete the Education Coordinator process.

B. As of July 1, 2014, the Office of EMS has issued certification to 177 Paramedics who have tested using the transition testing process implemented by National Registry. These providers were all NR I-99's who completed an Office of EMS approved Paramedic bridge course. This process will continue for eligible candidates until 2019 when National Registry will have completed the process to phase out all existing NR I-99 providers.

Basic Life Support Program

A. EMS Education Coordinator Institute

1. The Office was forced to cancel the June EC Institute usually held in conjunction with the VAVRS Rescue College due to the low number of eligible candidates. We anticipate having enough enrollees to hold the fall Institute.

2. The deadline to successfully pass the cognitive EC pretest to attend the fall Institute was on July 6, 2014. The next psychomotor exam is set for Saturday, August 9, 2014 in the Richmond area.

3. EMS Providers interested in becoming an Education Coordinator please contact Mr. Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov

4. Schedule of the various deadlines and EC Institutes can be found on the OEMS website at: http://www.vdh.virginia.gov/OEMS/Training/BLS_InstructorSchedule.htm

B. EMS Educator Updates:

1. For 2014, the Division of Educational Development will continue to provide in-person Educator Updates. We will be traveling to regional EMS council areas we did not see in 2013.

2. Since the last EMS Advisory Board meeting, the Office conducted in-person EMS Instructor Updates on May 17 in the LFEMS Council and June 7 in the WVEMS Council.

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

C. High School based EMT Programs

1. The Office of EMS recently completed revisions to the joint Department of Education/Office of EMS document governing High School EMT programs to bring it up to date with the current Virginia EMS Education Standards. In addition, the High School EMT I, II & III course competencies were streamlined and updated.

2. This document was reissued to all school systems and Guidance Counselors by the Department of Education and was accompanied by a Superintendent's memo reinforcing this joint document as the standards for any EMT course taught in the school system.

3. The document can be viewed here: http://www.doe.virginia.gov/instruction/career_technical/health_medical_sciences/emt_guidelines.pdf and the memo here: http://www.doe.virginia.gov/administrators/superintendents_memos/2014/165-14.shtml

EMS Training Funds

FY12

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$784,836.00	$416,612.42	$368,223.58
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	$734,067.66	$718,144.23	$15,923.43
Totals	**$2,341,383.66**	**$1,462,541.65**	**$878,842.01**

FY13

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$1,460.00	$755.00	$705.00
BLS Initial Course Funding	$729,348.00	$356,271.24	$373,076.76
BLS CE Course Funding	$125,160.00	$48,536.21	$76,623.79
ALS CE Course Funding	$297,360.00	$77,630.00	$219,730.00
BLS Auxiliary Program	$80,000.00	$18,120.00	$61,880.00
ALS Auxiliary Program	$350,000.00	$160,685.00	$189,315.00
ALS Initial Course Funding	$1,102,668.00	$577,479.49	$525,188.51
Totals	**$2,685,996.00**	**$1,239,476.94**	**$1,446,519.06**

FY14

	Commit $	*Payment $*	*Balance $*
Emergency Ops Funding	$1,120.00	$280.00	$840.00
BLS Initial Course Funding	$780,912.00	$350,058.04	$430,853.96
BLS CE Course Funding	$91,612.50	$32,217.50	$59,395.00
ALS CE Course Funding	$220,137.50	$67,112.50	$153,025.00
BLS Auxiliary Program	$130,000.00	$55,700.00	$74,300.00
ALS Auxiliary Program	$304,000.00	$152,000.00	$152,000.00
ALS Initial Course Funding	$1,188,504.00	$466,151.52	$722,352.48
Totals	**$2,716,286.00**	**$1,123,519.56**	**$1,592,766.44**

EMS Education Program Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)
   a) Navy Region's one year follow up will be conducted on July 30, 2014
   b) City of Virginia Beach Fire/EMS one year follow up will be conducted on July 23, 2014/
   c) Frederick County Fire and Rescue has submitted their self-study and it has been assigned to the accreditation team for review and the scheduling of a site visit.

2. Advanced Emergency Medical Technician (AEMT)
   a) Frederick County Fire and Rescue has submitted their self-study and it has been assigned to the accreditation team for review and the scheduling of a site visit.

3. Intermediate – Reaccreditation
   a) UVA Prehospital Program's site visit was held on June 19 & 20. The Office is awaiting the site team report findings.
   b) Danville Training Center re-accreditation visit will be conducted on July 16 & 17, 2014.

4. Intermediate – Initial
   a) Southwest Virginia EMS Council has been assigned to the site review team for review and the scheduling of a site visit.

5. Paramedic – Initial
   a) Patrick Henry Community College had their CoAEMSP initial accreditation visit in April and is awaiting their report of findings.
   b) Lord Fairfax Community College is awaiting their accreditation status from their accreditation visit held in October.
   c) Associates in Emergency Care has been granted full accreditation from CAAHEP.

6. Paramedic – Reaccreditation
   a) The reaccreditation visit for J. Sargeant Reynolds CC will be conducted by CoAEMSP on November 13 & 14, 2014.
   b) The reaccreditation visit for Central Virginia CCC will be conducted by CoAEMSP on November 19 & 20, 2014.
   c) The reaccreditation visit for VCU will be conducted by CoAEMSP on November 20 & 21, 2014.

C. 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

D. 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. 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 still need to obtain national accreditation through CoAEMSP/CAAHEP.
      a) Rappahannock EMS Council Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP and have completed their first cohort class. They are now required to submit their Initial-Accreditation Self Study Report (ISSR) within the next six months after which their initial site visit will be scheduled.
      b) Prince William County Paramedic Program
         (1) Has received their Letter of Review from CoAEMSP and have completed their first cohort class. They are now required to submit their ISSR within the next six months after which their initial site visit will be scheduled.

On Line EMS Continuing Education

Distributive Continuing Education

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

EMSAT

A. EMSAT programs for the next three months include:

Aug. 20, Behavioral Health and EMS: ECOs and TDOs
Cat. 1 ALS, Area 89, Cat. 1 BLS, Area 07

Sept. 17, The Pediatric Trauma Patient

Cat. 1 ALS, Area 87, Cat. 1 ALS, Area 08

Oct. 15, Respiratory Distress in the Adult Patient
Cat. 1 ALS, Area 88, Cat. 1 BLS, Area 05

Consolidated Test Sites (CTS)

A. There have been 39- CTS, 0- EMT accredited course site test administered and 12- ALS psychomotor test sites conducted since your last meeting on May 9, 2014.

B. Josh Wilkinson and Cody Jackson have been hired for the examiner positions that were open in the western and southwestern regions. Christopher Christensen has been hired as an examiner for the Blue Ridge and Central Shenandoah regions. Ksenia Stace has been hired as an examiner for the Tidewater and Peninsulas regions.

C. The TCC workgroup developing an updated CTS evaluator training program is progressing. A narrated PowerPoint presentation is nearly complete.

Other Activities

- Debbie Akers continues to participate in the bi-monthly NASEMSO webinars concerning Mobile Integrated Healthcare/Community Paramedicine.

- Debbie Akers is serving as the vice chair to the National Association of EMS Educators Recognition Committee. This committee is responsible for selecting the recipients of the HERO's award, the Legends that Walk Among Us and the James E Page Scholarship winner awarded annually by NAEMSE.

- Warren Short continues to participate with the Atlantic EMS Council Education and Professional Standards Committee (EPSC) in August.

- The office has completed interviews for the EM005 position and hope to have it filled by the end of August.

- Warren Short continues to participate on the National Governor's Association workgroup investigating the licensure, certification and other processes reviewing the integration of veteran's into the workforce. Debbie Akers has taken on the added responsibility of assisting Warren with this project.

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

- Greg Neiman continues his participation with the Commonwealth Autism Public Safety Workgorup.

- Greg Neiman represented OEMS while working with DOE to finalize the updated EMS/DOE High School EMT program guidelines.

Emergency Operations

IV. Emergency Operations

Operations

- **Hurricane Arthur**

The Division of Emergency Operations coordinated activities to prepare for the potential impacts of Hurricane Arthur. OEMS Staff that are trained to serve in the EOC were scheduled for shifts at the state EOC. Thankfully the path of the Hurricane impacted Virginia minimally and did not require OEMS activation.

- **Virginia 1 DMAT**

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

- **Vicarious Trauma Toolkit**

Karen Owens, Emergency Operations Manager, traveled to Boston, MA June 9-11, 2014 to participate in a two day planning conference for the Vicarious Trauma Toolkit Committee. The meeting provided an opportunity for committee members to discuss the focus and needs of the first response community regarding vicarious trauma, including the need to educate the community members on the definition of vicarious trauma. She also participated in a follow up conference call to ensure continued work and success of the project.

- **Mid-Atlantic EMAC Pre-planning**

Karen Owens, Emergency Operations Manager, continues to participate in the Mid-Atlantic EMAC pre-planning conference calls. The calls are designed to allow the Mid-Atlantic States to prepare for potential EMAC requests and assist in a smooth transition during emergency events. Connie Green and Frank Cheatham also participated in the July conference call.

- **Hanover Tomato Festival**

The Division of Emergency Operations supported the 36th Annual Hanover Tomato Festival with the deployment of support equipment (trailer, misters, tents, generators) and the Harrisonburg EMS Task Force. The teams provided patient care, treating multiple heat related emergencies.

- **Rural Access Medical Event**

EMS Task Force Thomas Jefferson 2 from Charlottesville deployed to the Rural Access Medical Event in far Southwest Virginia for three days in the month of July. The team supported the event with emergency care on site through a partnership with UVa Hospital.

Committees/Meetings

- **Provider Health and Safety Committee**

The Provider Health and Safety Committee held its quarterly meeting on May 8, 2014. While there are not enough members for a quorum, discussions were held regarding documents on ambulance safety and operations.

- **EMS Communications Committee**

The EMS Communications Committee met May 9, 2014. There were not enough members of the committee in attendance to have a quorum. Committee chair Gary Critzer led the discussion on having membership who can attend the meetings reliably. After the meeting, Ken Crumpler contacted members not in attendance to ask if they wished to continue being on the committee. The Virginia Chapter presidents of APCO and NENA were polled to get recommendations for someone to fill a position. The committee selected Melissa Wood (Fredericksburg 911) by a majority vote. Ms. Wood was contacted and is planning to attend the next scheduled meeting.

- **EMS Emergency Management Committee**

Winnie Pennington, Emergency Planner, attended the EMS Emergency Management Committee meeting on May 8, 2014. The committee reviewed a white paper regarding triage and presented it to the Advisory Board where it was accepted.

- **Traffic Incident Management (TIM)**

The HMERT Coordinator assisted with a Train the Trainer Class for the SHRP 2 Program held in Charlottesville in June. That was followed by a meeting of the Statewide TIM Committee on June 19, 2014. He reported on the work of the Best Practices workgroup of which he is chair.

- **Lane Reversal Coordination**

On May 8, 2014, Frank Cheatham and Karen Owens met with the New Kent County fire chief to discuss the process for HMERT support during Hurricane Evacuation Lane Reversal. During the meeting they reviewed the request process and the standard operating procedures. Emergency Operations Assistant Manager and HMERT Coordinator also attended a meeting in June with state agencies, including the National Guard and State Police regarding coordination of assets.

- **Task Force Meetings**

The HMERT Coordinator conducted a Task Force interest meeting held in Bristol, Va at the Southwest EMS Council office. It was well attended and there is a great deal of interest in developing a Task Force for that area. The HMERT Coordinator also provided some information for a meeting held in the Roanoke area to see if there is interest to holding a similar meeting that was held in the Southwest EMS Council area.

Frank Cheatham, HMERT Coordinator attended training held at Sterling Rescue for the Western Shelter System that their Task Force, NOVA 8 obtained with the help of a RSAF Grant. There was a great turnout of members and the training was very informative. This asset will be available to other Task Forces in the event of deployments.

- **Hurricane Evacuation Coordination Workgroup**

The HMERT Coordinator continues to attend these meetings which continue to look at the various aspects of evacuation and the effects on jurisdictions. Connie Green also attended the June meeting.

- **MutualAidNet Meeting**

Karen Owens and Winnie Pennington attended a meeting July 17, 2014 at the state EOC to review a new program that the Virginia Fire Chiefs are looking into. MutualAidNet will allow local emergency managers to request resources from area localities through the application.

Training

- **Mass Casualty EMSAT**

Karen Owens, Emergency Manager, led the June 18 EMSAT training on Mass Casualty Incident Management.

- **OEMS VERT Exercise**

Winnie Pennington, Emergency Planner, developed and conducted an annual training exercise for all OEMS staff that are trained to serve as members of the Virginia Emergency Response Team (VERT). The exercise, which was held on May 22, provided a reminder of the use of webEOC and determining appropriateness of ESF-8 requests.

- **VERTEX 2014**

Connie Green, Emergency Operations Assistant Manager, and Winnie Pennington, Emergency Planner, represented the Office of EMS at the 2014 VERTEX drill at the state EOC on June 25, 2014. The drill focused on the impact of a hurricane on the Commonwealth.

- **VOPEX 2014**

Connie Green and Winnie Pennington participated in the 2014 VOPEX exercise which focused on an event at North Anna Power Station.

- **SHRP 2 Train-the-Trainer**

Connie Green, Emergency Operations Assistant Manager attended a SHRP 3 Instructor Trainer course held in Charlottesville, Va. on June 18, 2014. also received her SHRP 2 Instructor certificate in June.

Communications

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

PSAP Accreditation for City of Staunton 911 was approved by the EMS Advisory Board on May 9th, 2014. Ken Crumpler, Communications Coordinator presented the accreditation before the Staunton City Council July 24, 2014.

- **Patrick County Presentation**

A presentation was given to the Patrick Co. Board of Supervisors on June 9, 2014 on the position of Virginia regarding Emergency Medical Dispatch and the OEMS accreditation program. This was at the request of Ms. Crystal Harris, Patrick Co. BOS Chair.

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

Ken Crumpler, communications Coordinator attended the Spring APCO/NENA conference in Virginia Beach, May 14-16, 2014. Mr. Crumpler instructed a course on the role of the PSAP during medevac operations.

Critical Incident Stress Management (CISM)

- **CISM Regional Council Reports**

During this reporting quarter Regional Council CISM teams reported 27 events, including education sessions, training classes, and debriefings (both group and one-on-one)

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

Regional EMS Councils

The Regional EMS Councils have submitted their FY14 Fourth Quarter contract reports throughout the month of July, and are under review.

OEMS has entered into a contract modification with all eleven Regional EMS Councils, to better define the scope of services related to Consolidated Testing Services.

The EMS Systems Planner attended the Lord Fairfax, and Old Dominion, Rappahannock, and Thomas Jefferson EMS Council award programs during the quarter.

Medevac Program

The Medevac Committee is scheduled to meet on August 7, 2014. The minutes of the May 8, 2014 meeting are available on the OEMS website.

The Medevac WeatherSafe application continues to grow in the amount of data submitted. In terms of weather turndowns, there were 480 entries into the WeatherSafe system in the second quarter of 2014. 62% of those entries (297 entries) were for interfacility transports, which is a continuing trend. The total number of turndowns is an increase from 604 entries in the first quarter of 2013. To date, there have been 1065 total entries into the system in 2014, a decrease from 1,233 entries for the same timeframe in 2013. This data continues to show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

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

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.

A draft was approved by the Advisory Board in November of 2013. OEMS is presented the plan to the Board of Health on June 5, and was unanimously approved.

The current version of the State EMS Plan is available for download via the OEMS website.

Public Information and Education

VI. Public Information and Education

Public Relations

Promotions

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

- **April 1** - Community Paramedicine Guidance Document
- **May 2 –** First Case of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Confirmed in U.S.
- **May 19** - EMS Week 2014
- **May 20** - Update: FBI Background Checks
- **May 28** - Project on Vicarious Trauma

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. Also regained access to the OEMS YouTube site in March, and posted new training videos courtesy of the Division of Educational Development. Some of the subjects that were featured from April - June are as follows:

- **April –** Community Paramedicine, National EMS Week, EMS for Children Day, Fallen Firefighter Memorial Service, 2014 Regional EMS Council Awards, National Public Safety Telecommunications Week, mosquito-borne viral diseases in Virginia, Virginia's Hurricane Preparedness Sales Tax Holiday, tornado preparedness tips and ideas for EMS Week including a community Hands-Only CPR training program.

- **May –** Middle East Respiratory Syndrome, Performance Maximizing Leadership" session, Peninsulas EMS Council's EMS Day at Busch Gardens, first two imported case of MERS-CoV infection identified in the U.S., EMS Week kick-off reminder, EMS Week press release and Governor's proclamation, VCU LifeEvac is at Southside Regional Medical Center today teaching Hands Only CPR, VCU LifeEvac EMS Week Open House, Bon Secours EMS Week activities, EMS Week events at University of Virginia Health System and its Medical Transport Network, FBI background checks, FEMA announces new Traffic Incident Management Train-the-Trainer program, EMS for Children Day, Bon Secours Richmond EMS Week activities, holiday office closures, Dumfries-Triangle Station 3F Basic Designated Officer training and National Hurricane Preparedness Week.
- **June –** Fairfax City Fire Dept. will host Basic Designated Officer training, article about a tool that can plug gunshot wounds in seconds, save the date and link to live broadcast of

the 2014 Fallen Firefighters Memorial, National CPR and AED Awareness Week, criminal history record program FAQs and Move Over Awareness Month.

Customer Service Feedback Form (Ongoing)

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

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

Training

- PR assistant completed the required online training for the Virginia Emergency Operations Center (VEOC) and the Virginia Emergency Response Team.

- PR coordinator will set up training for PR assistant at the VEOC Joint Information Center. Once completed, the PR assistant will be trained to respond to the VEOC or JIC in the event of an emergency.

Editorial Assistance

- As instructed by OEMS director, PR coordinator and assistant worked with Irene Hamilton on an editorial team that would provide assistance for OEMS documents that were sent up to VDH management.

- Utilizing guidelines from the VDH Correspondence Handbook, we offered edits and revisions for documents pertaining to the regulations and compliance division and the State EMS Plan.

Division Assistance

- PR assistant provided regulations and compliance manager with assistance editing and designing documents that covered the implementation of FBI Background Checks, which were posted on OEMS website.

- PR coordinator and assistant helped promote this information by sending info through listserv email and posting information on social media pages.

Social Media and Website Statistics

Figure 1: This graph shows the total organic reach of users who saw content from our Facebook page, April - June 2014. Each point represents the total reach of organic users in the 7-day period ending with that day.

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

***As of July 24, 2014 the OEMS Facebook page had 3,768 likes, which is an increase of 170 new likes since April 22, 2014. As of July 24, 2014, the OEMS Twitter page had 2,738 followers, which is an increase of 166 followers since April 22, 2014.**

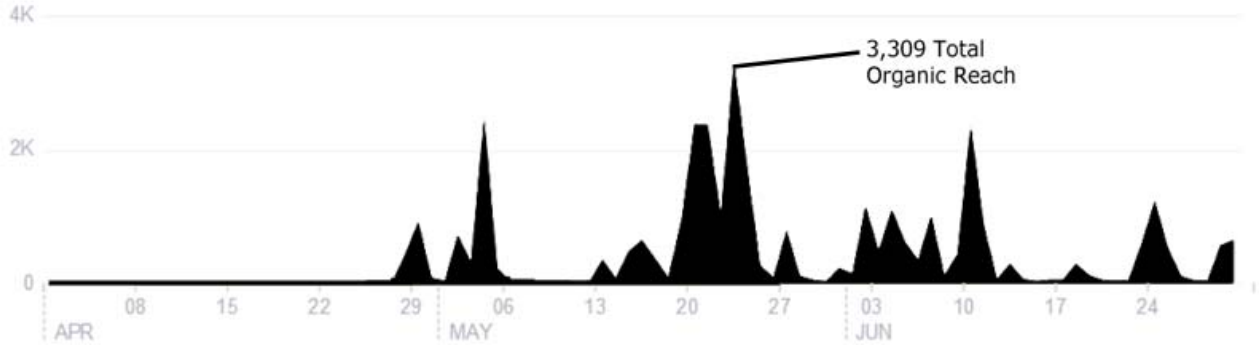


Figure 2: This table represents the top five downloaded items on the OEMS website from April – June.

April	1. 2010 Symposium Presentations LMGT-732 (31,994) 2. 2013 Symposium Presentations/AIR-202 (19,043) 3. EMSAT Centrelearn Instructions (18,165) 4. EMS Bulletin - Winter 2014 (11,494) 5. 2013Symposium Presentations OPE-4003 (8,740)
May	1. 2010 Symposium Presentations LMGT-732 (29,203) 2. EMSAT Centrelearn Instructions (14,982) 3. 2013 Symposium Presentations SPE-6003 (10,118) 4. EMS Bulletin – Winter 2014 (7,444) 5. 2012 Symposium Presentations OPE-4006 (7,393)
June	1. 2013 Symposium Presentations OPE-4003 (26,972) 2. 2010 Symposium Presentations LMGT-732 (22,510) 3. 2013 Symposium Presentations AIR-202 (17,030) 4. EMSAT Centrelearn Instructions (13,356) 5. 2012 Symposium Presentations OPE-4006 (8,129)

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

	Visitors	Average Hits Per Day	Average Visit Length (Minutes)
April	80,215	2,673	10:15
May	86,174	2,779	12:08
June	76,056	2,535	16:04

Events

Events

EMS Week, May 18 - 24

- PR assistant mailed out EMS Week planning guides to all affiliated EMS agencies in Virginia.
- PR assistant received proclamation from the Governor's office recognizing EMS Week in Virginia.
- PR assistant sent EMS Week info via listserv email. Information that was shared in the email included the press release and Governor's proclamation.
- PR coordinator prepared and distributed the press release for EMS Week to all media.
- PR coordinator posted event information on the VDH and OEMS website, Facebook and Twitter pages.
- PR coordinator shared various promotions on Facebook and Twitter that were being offered for EMS Week by area retailers, in addition to events occurring across the state in honor of this special week.

Fire and EMS Memorial Week, June 8-14

- PR coordinator continued to participate in event marketing meetings, hosted by VDFP.
- PR coordinator 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, posting a Fire and EMS Week webpage on the OEMS website and sending out an e-blast through our listserv.

- PR coordinator worked with the informatics coordinator to provide current data to be included in the Governor's proclamation, which was prepared by VDFP.

- PR coordinator and assistant reviewed and submitted suggested updates/changes for VDFP's proclamation from the Governor.

EMS Symposium

- PR coordinator sought out promotional ad quotes from national and local EMS publications.

- PR coordinator submitted promotional ads for the Symposium to the following publications: VAVRS Lifeline and the Virginia Fire Chiefs magazine.

- PR coordinator also reached out to local and national partners like the Virginia Department of Fire Program and NASEMSO for assistance in promoting the Symposium free-of-charge.

- PR coordinator continued drafting catalog design and began designing promo guide artwork.

- PR assistant designed the new name badge template that will be used for this year's Symposium.

- PR coordinator and assistant attended various planning meetings for the new Symposium registration program. Provided feedback on the design of the system and provided assistance with the beta testing of the system.

Governor's EMS Awards Program

- PR assistant continued to coordinate OEMS staff attendance at the Regional EMS Awards. PR assistant and PR coordinator attended Regional Awards at CSEMS, NOVA and TEMS.

- PR assistant designed 8x10 Regional EMS Council flier promoting the award deadlines and banquet dates, posted it on the OEMS website April 2014.

- PR assistant completed and submitted press releases that covered the Regional EMS Award ceremonies in April - June. Posted these press releases on the VDH Regional Press Releases webpage.

Media Coverage

The PR coordinator was responsible for fielding the following OEMS media inquiries April - June:

- **April 1** - Summer Ballentine with the Associated Press inquired about the AEMT program in Va. and the transition process to the National Registry. She had ques. about testing and if the Va. process involved legislators.

- **April 3 -** Jenna Zibton with WSLS needed background information for a story she was doing regarding the "phasing out" of EMT and intermediate certificates in Virginia.

- **April 7 -** Kris Hundley, Tampa Bay Times inquired about data pertaining to trauma activation fees from Va. hospitals.

- **June 10 -** Sydney Freedberg with the Bloomberg Press requested information regarding Trauma Center funding audits.

The PR coordinator was responsible for fielding the following VDH media inquiries April - June:

- **May 6** - Hospitals COOP Plan in case of State Gov't Shutdown - Virgil Dickson with Modern Healthcare inquired about what would happen in the event of a state government shutdown to the hospitals' continuity of operations. He also asked how it would impact operations at hospitals, especially those that have a high rate of Medicaid patients. I referred him to the Department of Medical Assistant Services and the Governor's office.

VDH Communications

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

- **April** –Responsible for the Team Editor task during the month of April, which involved editing various press releases, the Commissioner's Weekly email and other documents for the PR team. Attended The Academy aka Public Health Summit May 20-21.
- **May** – Responsible for editing and coordinating the Media Alerts during the month of May. Would send them out nightly to VDH management.

- **June** – Responsible for submitting any updates for the VDH website during the month of June. On June 11, attended an eight-hour training session on social marketing, focused on changing individual behaviors at the population level. This training was coordinated by VDH and was held at the Perimeter Center.

- **VDH Communications Conference Calls (Ongoing) -** The PR coordinator participates in bi-weekly conference calls and polycoms for the VDH Communications team.

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

April 7 - EMS Agencies Return Record Number of Responses in National Survey

David Edwards, EMS for Children (EMSC) coordinator for the Office of EMS, recently facilitated Virginia's response to the EMSC Reassessment Survey. The goal of this survey is to determine continuing progress toward certain national EMSC performance measures related to pediatric readiness. Virginia's survey response rate was 85.3 percent, well exceeding the threshold set by the federal government for considering the survey data valid. Three EMS Regional Councils achieved a 100 percent response rate: Blue Ridge EMS Council, Old Dominion EMS Alliance and the Western Virginia EMS Council. Congratulations to all partners who contributed to this important data collection, the results of which will translate into focused federal funding to help eliminate gaps in Virginia's pediatric emergency care readiness. Additional thanks go to Paul Sharpe, trauma and critical care manger; Tracy Mason, IT programmer; and Marian Hunter, public relations coordinator, for their assistance with the coordination and promotion of this survey.

Regulation and 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 and/or quality (VPHIB), violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to meet minimum staffing requirements for EMS vehicles and individuals with criminal convictions. The following is a summary of the Division's activities for the 2ndt quarter of 2014:

Enforcement

Verbal Warnings Issued:	14	Citations Issued:	20
Providers:	9	Providers:	8
EMS Agencies:	5	EMS Agencies:	12

Correction Orders Issued:	46
Providers:	0
EMS Agencies:	46

Compliance Cases

New Cases:	87
Cases closed:	22
Suspensions:	3
Temporary Suspension:	8
Revocations:	3
Consent Order:	0

Reported Drug Diversions 10

EMS Agency Inspections

Licensed EMS agencies:	674 Active	(7/2014)
Permitted EMS Vehicles:	4,455	(7/2014)

(Active, Reserve, Temporary)

Recertification:

Agencies:	85
Vehicles:	463
New EMS agencies:	1
Spot Inspections:	120

Hearings (Formal, Informal Fact Finding Conference)

April 8, 2014 – Klimenko

Variances

Approved:	4
Disapproved:	1

OMD/PCD Endorsements

As of July 23, 2014: 242 Endorsed EMS Physicians

EMS Regulations

OEMS Regulation and Compliance staff continues to work with the various stakeholder groups (Medevac and Training) to review suggested revisions to sections of the current EMS Regulations. Once completed, they will be directed through the Rules and Regulations Committee to be submitted as a regulatory review packet.

- The regulatory process to submit a Fast Track Regulatory Packet for changes to the Financial Assistance to EMS agencies (FARC) has been initiated and is currently at the Office of the Attorney General for their review and actions (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6969)
- The Fast Track Regulatory Packet for changes to "eliminate the required signature of the medical care practioner on patient care report" resides in the Governor's office for review and activity by office staff (http://townhall.virginia.gov/L/viewstage.cfm?stageid=6819).
- A Fast Track regulatory package to include the terminology of "affiliation" in the language of 12VAC-5-31-910 has been submitted to VDH administration for review and action.

The Office of EMS has begun the process of conducting criminal history records utilizing the FBI fingerprinting process through the Virginia State Police effective July 1, 2014. The OEMS website has a dedicated section on criminal background checks listing relevant information on this new process. Further information can be found at : http://www.vdh.virginia.gov/OEMS/Agency/RegCompliance/CriminalHistoryRecord.htm.

Division Work Activity

The Regulation and Compliance staff held their quarterly staff meeting on April 2-4, 2014. This was rescheduled from the original date of February 12-14, 2014 secondary to the weather event that affected the Commonwealth.

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

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.

Personnel Matters

The Division has requested the approval of a wage position in order to meet the additional work load anticipated by implementing the new criminal background check process.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee last met on May 8, 2014. The committee's primary goal is to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

The EMS Officer Sub-committee has met several times since the last EMS Advisory Board meeting. The last meeting was a work session on June 16, 2014. There are multiple work sessions scheduled for August and September 2014.

The sub-committee has been working on developing an EMS Officer I course based on the Fire Officer I course material in the Jones and Bartlett Fire Officer Principles and Practice (Third Edition). This course will require the student to do reading, homework assignments and projects prior to each class. The program is projected to take 24 hours of classroom time with another 24 -32 hours of out of classroom activities.

Two (2) pilot courses are tentatively scheduled to be held in October 2014 in the:

Central Shenandoah EMS Council region

Tidewater EMS Council region

A presentation on the EMS Officer I program is planned for the February 2015 EMS Advisory Board in order to obtain endorsement of the Board, before the program rolls out in March 2015. For additional information about the EMS Officer I program, please review the following documents attached to this report.

EMS Officer I Draft Syllabus – **Appendix D**

EMS Officer I Draft Course Schedule – **Appendix E**

Standards of Excellence Sub-Committee

A sub-committee meeting was held on July 16, 2014 to review and discuss the current status of the SoE program. After review and discussion – it was decided there needs to be more specific benchmarks and indicators identified for each Area of Excellence. In addition, a numerical system of "weight" will be provided on a 0 to 5 scale, for the most critical benchmarks. This will

result in a numerical score that will provide a definitive score in each area – thus assisting the agency to identify specific areas of improvement.

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

SoE Areas of Excellence

Leadership and Management

Recruitment and Retention

EMS Operational Readiness

Life Safety

Medical Direction

Clinical Care Measures/Standards

Community and local Government Involvement

Emergency Medical Dispatch

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

The Virginia Recruitment and Retention Network

Unfortunately, the Virginia Recruitment and Retention Network has not met since February.

The Network is considering changing the meeting day from Friday to Saturday in order to allow more volunteer EMS providers to attend and benefit from this great networking opportunity.

The next meeting will be at the Virginia State Fire Fighters Association Conference in Hampton, Virginia on Friday, August 15, 2014.

Trauma and Critical Care

IX. Trauma and Critical Care

Division of Trauma/Critical Care Staffing

We are very pleased to announce a couple of staffing updates for the Division of Trauma/Critical Care (Div. TCC). As mentioned in our May 2014 quarterly report, the second vacant support position for the Virginia Pre-Hospital Information Bridge (VPHIB) and the Virginia Statewide Trauma Registry (VSTR) that had been vacant had been successfully recruited. On May 27th Mr. Bryan Hodges joined the Div. TCC team. Bryan comes to us from a nationally known EMS patient care software company. In Bryan's last position he led the support and implementation program and brings his talents to our program. Bryan has a degree in information technology and a wealth of experience.

A new position has also been approved and will hopefully be recruited prior to the November 2014 quarterly report. This new position with serve as the Trauma Critical/Care Coordinator (TCCC) and assume responsibilities for managing the states trauma system. The TCCC will staff the Trauma System Oversight and Management Committee and manage the trauma designation program, trauma triage, and Trauma Center Fund. The TCCC will also represent the OEMS with other time-sensitive illness programs including stroke and STEMI.

Adding this new position will decompress the current division manager and allow existing programs to further develop and interact with other state programs and stakeholder groups.

Patient Care Information System

Patient Care Information System (VPHIB & VSTR)

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

"Don't Say You Didn't Know"

OEMS has been busy setting up the new VPHIB system that will house our VAv3 dataset. In addition to setting up the new application (ImageTrend Elite) product OEMS has also been working on the development of a new more robust server environment. The new server environment will be more robust to provide a stronger data output environment. The new environment will also allow OEMS to install SAS Visual Analytics. Visual Analytics will be a web-based robust data reporting system accessible at various permission levels. OEMS' goal is to provide more uses for EMS and trauma data.

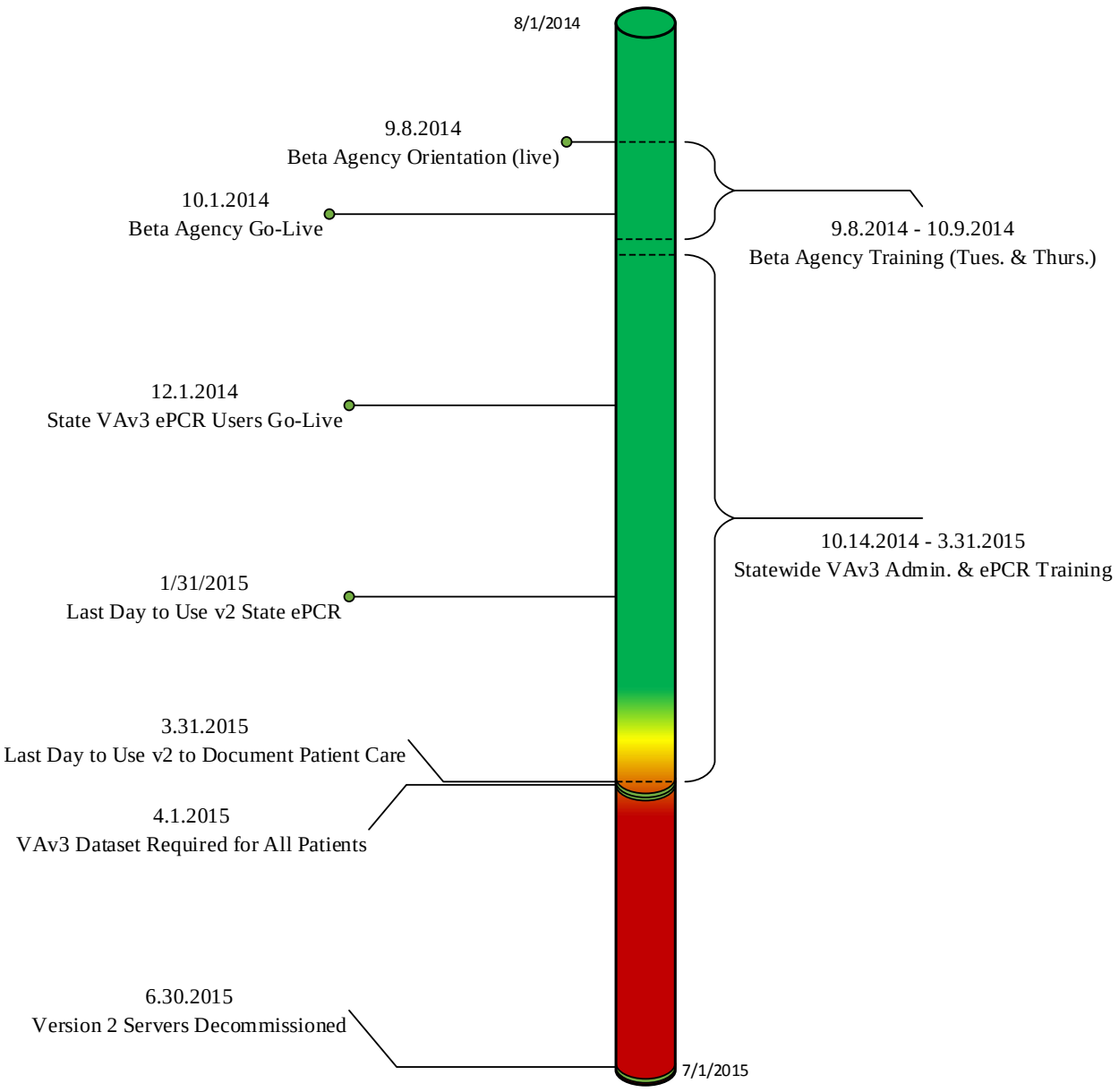
Implementing version 3:

OEMS is now in its active implementation window. To date we have not pushed implementation because it appears the vendors used the most in Virginia may be up to a quarter behind our spring assessments. Given that vendors appear to be generally on target but not quite ready to implement their products on July 1 OEMS is taking advantage of this time to setup the states VAv3 program slower with greater attention to detail. However, OEMS can make submission available for version 3 with little notice if needed.

Implementation Deadline Revised:

Given the current status being claimed by vendors, OEMS has revised its implementation timeline which includes the ability for agencies to collect version 2 patient data up to and including March 31, 2015, see Figure 1. However, a strong word of caution; this additional quarter was time already planned to be used by limited agencies due to extreme hardships. This will make the March 31, 2015 a hard deadline that will not allow for flexibility beyond that date. All patients responded to or transported beginning April 1, 2015 and later shall be collected and submitted using VAv3 standards.

Figure 1 Revised VAv3 Implementation Deadline



Beta Agencies: Approximately 10 EMS agencies have been identified to serve as VAv3 beta agencies. A live orientation and training day is being planned for September 8th at the OEMS. Beta agency training will also occur twice weekly throughout the VAv3 beta phase. These training sessions will be limited to beta agency leaders/trainers as the time will also be used to discuss issues surrounding testing the new program. Bryan Hodges will be serving as the point of contact for beta agencies.

VAv3 Statewide Training: OEMS has developed its training schedule and posted it for all to see. Training will be managed similar to the version 2 roll-out. Div. TCC staffs will provide train-the trainer level training for agency VPHIB administrators and leadership. Webinar training (live on-line) will be the primary method of delivering VAv3 education.

Beginning on Tuesday, October 14, 2014 there will be two classes held each Tuesday and Thursday. One class will address VPHIB administrator setup and the second class will focus on setup and use of the State's ePCR. The time of day (morning vs. afternoon) for each class will rotate to help accommodate attendees' schedules. The administrative classes will run through the 3/31/2015 deadline. The ePCR classes will end on 1/31/2015 when the State's current ePCR will be discontinued.

In-person training will be limited. Div. TCC staffs will perform ongoing administrator and ePCR training throughout the EMS symposium in November. These classes will be not be part of the regular symposium classes, but allow anyone interested to attend as their schedules allow.

OEMS is also finalizing having a two day VAv3 summit in cooperation with ImageTrend for ImageTrend Service Bridge and Rescue Bridge users. This opportunity would allow those agencies that have their own ImageTrend licenses to learn how to setup their v3 (Elite) systems in concert with the State's program. OEMS has also made this offer to other software vendors that have customers in Virginia.

Other VAv3 efforts during the past quarter include the finalization and installation of the validity rules that will be used to support the VAv3 minimum dataset. As anticipate and discussed there are over 600 individual initial validation rules for VAv3. This is in comparison to the just over 300 current rules.

Of the increased number of rules approximately 25 percent should not be applicable if the EMS software submitting them remains compliant with the NEMSIS standard. As an example in v3 none of the national elements should ever use "Not Reporting" and should never be blank / missing some type of response. Div. TCC staffs still put validation rules into place for elements that are missing data or using "Not Reporting."

Staffs also create the validation rules to a high level of detail. Using a similar example to the previous paragraph and using ePatient.13 – Gender, let's look at an example. Some who create a validation rule will write a more general rules such as ePatient.13 should be Male or Female or ePatient.13 cannot be a not value. Div. TCC staff prefers to write four rules: 1) ePatient.13 should not be "missing;" ePatient.13 should not be "not applicable;" ePatient.13 should not be "not recorded;" and ePatient.13 should not be "not reporting."

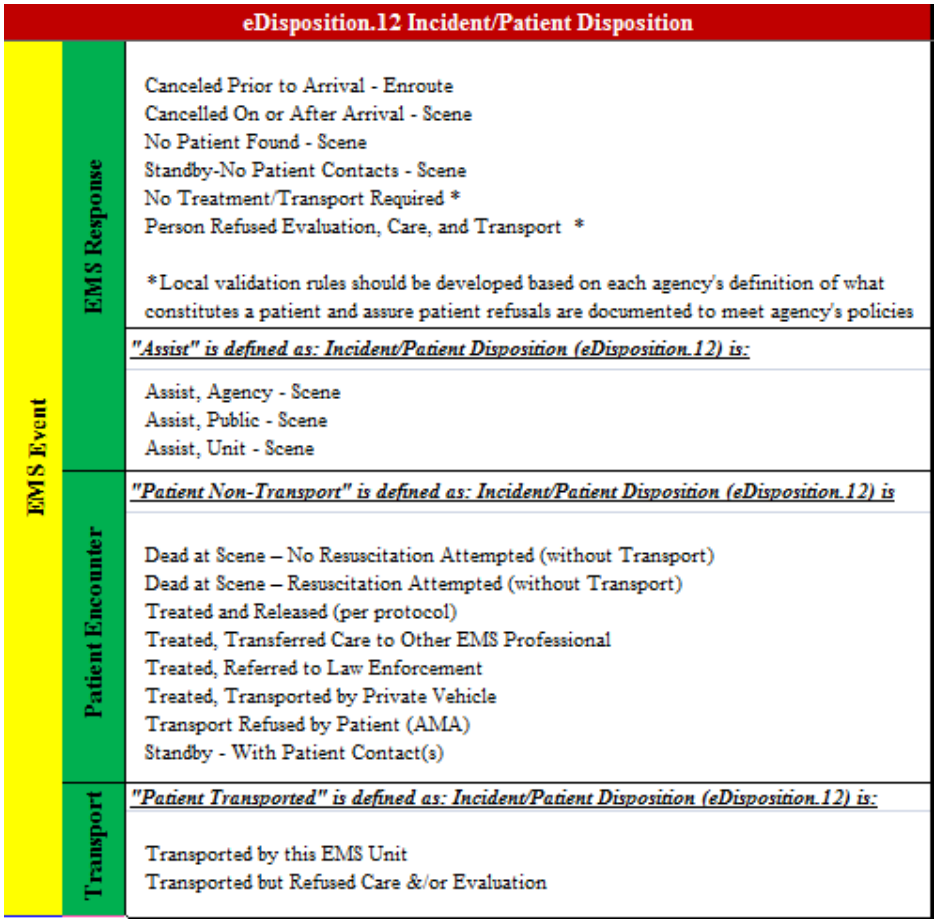
By creating Virginia's four rules providers know exactly which entry is incorrect. Additionally, agency VPHIB administrators and state staffs can better provide feedback and identify if the issue requires education, setting changes, or technical fixes to resolve. Having one rule that collects all will cause the agency or state to have to run reports to obtain more information.

The VAv3 Data Dictionary has been updated with a revision/update schedule, description of the new disposition codes, and all of the final validation information. The new components are also available as one page resource documents. The revised data dictionary will be released on August 4, 2014.

Finally, staff have been finalizing resource documents that move EMS data reporting from a unit based reporting (i.e. each unit completes its own PCR) to an event based reporting process. A couple other areas that will lessen the burden is limiting reporting requirements for cancelled calls and assist calls to data elements that could be collected solely by a CAD system and not a provider if an agency wants to explore this.

We believe this could lessen the burden of reporting to the provider and agency reporting. As part of this effort, staffs are trying to resolve current challenges faced by agencies using mixed crews (volunteer and paid providers).

Figure 2 Event Based Reporting and Phases



Schematron File Use in VAv3: Schematron is a rule-based validation language expressed in XML. NEMSIS introduced the use of Schematron for version 3 by requiring that each vendor being certified demonstrate their ability to utilize Schematron to perform validation checks prior to any electronic transfer of data i.e. from agency to state, agency to billing company, state to NEMSIS etc. Part of NEMSIS version 3 certification includes the requirement that data being transferred to NEMSIS run a national Schematron file.

OEMS had hoped to also utilize Schematron as part of our data quality program in a manner that would mirror our current method of validating data being imported to the state. At this time utilizing Schematron will not be part of our implementation and migration to VAv3. The State's

vendor had stated over the past year or more that the ability to auto-generate a Schematron file based on validations entered into our system utilizing the traditional method would be available. We have recently been informed that Schematron auto-generation will at some point in the future be made available, it is not currently on our vendor's migration plan.

Given the unexpected change in functionality by our vendor to generate a state level Schematron file, the fact that NEMSIS does not require EMS software vendors utilize, create, test or otherwise do anything with state level Schematron, and the fact that NEMSIS does not provide any support or education to states on Schematron VPHIB will not be utilizing a "state Schematron file." A national Schematron file is required, tested, and supported and will still need to be utilized by software vendors.

While we can't say this change will not affect EMS software vendors we believe the effects to our system to be minimal. VPHIB staff participated in the national workgroup that developed Schematron for EMS and it was clear that Schematron was not required for provider / point of entry level use for data validation. It was also clear that states were not required to utilize an additional state level Schematron, but only a national file. Our validation rules are available and can be used by vendors to assure what ever process they use to validate data entry can meet the required data quality standards.

We had skeptically hoped that theory behind Schematron would assist agencies when additional rules were added to the system by the state. We will duplicate our process to Schematron when it is made available to us and/or supported and required nationally.

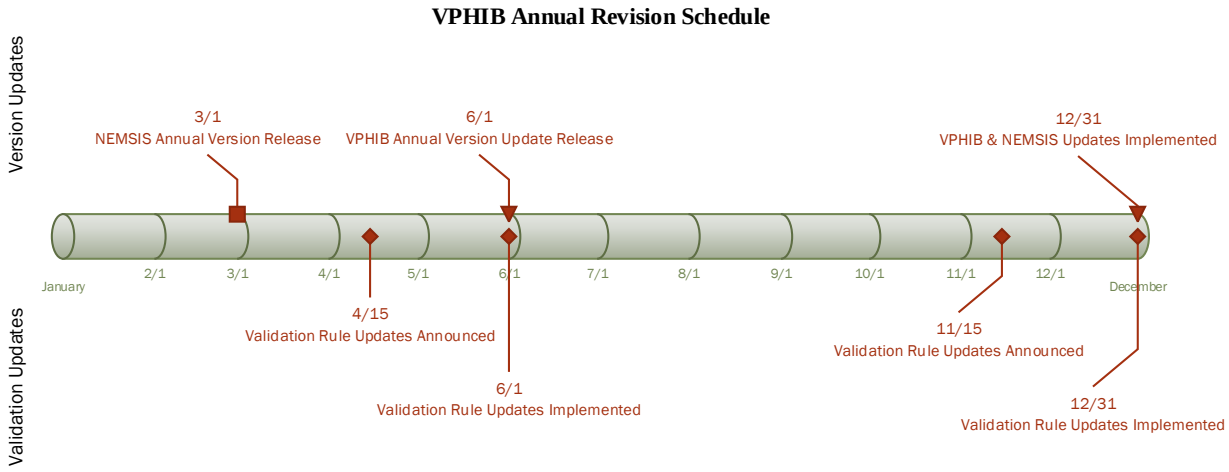
Version and Validation Rule Update Schedule: Prior to the implementation of version 3 updates to the VPHIB system were planned in batches and every attempt made to limit the frequency of change. It was still perceived that there were constant changes being made to the system. To help address this perception, Figure 5 below shows the schedule that will be followed to make version updates and validation rule updates.

Version updates include, but are not limited to, additional elements, values, and technical changes to the XML structure. The VPHIB program will work in synchronization with the NEMSIS revision process. NEMSIS will release its version updates on or around March 1st each year. Once available, VPHIB staffs will evaluate the NEMSIS release and post the Virginia specific updates by June 1st annually. NEMSIS requires software vendors to implement the

March 1st changes by the following January 1st. OEMS will align its revision updates to also occur on January 1st.

Validation rule updates will occur on an every six month basis. Updates will be posted and announced by April 15th and November 15th. Both cycles will provide a 45 day notice prior to implementing the new rules on June 1st and December 31st.

Figure 3 VAv3 Revision Schedule



Virginia Statewide Trauma Registry (VSTR)

The new VSTR application went live at the New Year. All non-trauma designated hospitals have been submitting to the new trauma registry since January. Designated trauma centers, which all use third party trauma registry software to submit, were required to upload by July 1st. It appears most, if not all, trauma centers have uploaded and the next step is for OEMS staffs to evaluate those submissions and identify technical or non-technical issues with their imports and provide feedback to the hospitals and their vendors.

After the trauma centers are provided with feedback on their submissions the next step will be to begin the process of providing a VSTR Data Quality Dashboard report routinely to the hospitals.

VDH Data Warehouse Development/Linkage **to Hospital Discharge Data Project (Output):**

The efforts to contribute EMS and trauma data to the VDH continue to make progress. The VDH data warehouse team was delayed by staffing changes and some earlier competing priorities. Their efforts have been back on track and they continue to develop the data cleaning routines that will be used, linkage to hospital data, and reports that will be generated by the warehouse.

From the OEMS Informatics Coordinator

Virginia Statewide Trauma Registry (VSTR)

- Continued to improve my skills in using the SAS ODBC connection and PROC SQL to extract data from VSTR
- Downloaded the data tables from the original VSTR in preparation for the development of the legacy data component of the new VSTR (VSTRv3)
- Began work on an analysis dataset using 2011 – 2013 data

TSO&MC Performance Improvement (PI) Committee

- The PI Committee's quarterly meeting was held in June. Much of what was planned for April and May could not be accomplished because of our short staffing situation. The work was rescheduled to be performed in July and August.

Virginia Pre Hospital Information Bridge (VPHIB)

- Continued to improve my skills in using the SAS ODBC connection and PROC SQL to extract data from VPHIB
- Began work on an analysis dataset based on 2013 data

EMS Councils Performance Improvement (PI)

- Continued to assist PI staff members with data analysis and reporting issues

VDH Data Warehouse (DW)

- Continued to work with Todd Nemanich (Office of Information Management, OIM) on the integration of the VPHIB data into the VDH DW

12 Lead ECG Survey

- Finished the data analysis, prepared slides, and made a presentation of the material for the Virginia Heart Attack Coalition's (VHAC) annual meeting on May 5th. The presentation can be found on-line by clicking here.
- Did some follow up data cleaning and clarifications, then distributed the information to:
  - Executive Directors and Performance Improvement staff for the 11 EMS Regional Councils
  - Members of VHAC who had worked on the development of the survey
- Provided an overview of the data to a fourth year medical student who will be working with his UVA faculty mentors over the summer to write an article for publication.

Data Requests

- Continued to work with Mary Kay Goldschmidt, a Doctorate in Nursing Practice student at UVA; Worked in conjunction with Ginny Powell of the Office of the Chief Medical Examiner (OCME) to provide additional details from the OCME's files in a way that was in keeping with HIPAA constraints.
- Worked with Rosie Hobron in the OCME to manage a complicated data request from the chief of a county level EMS agency.
- Provided summaries of EMS response time data for cardiac events 2011 – 2013 for the state and for several far southwestern Virginia counties for Nikki Morrison of Mountain Empire Community College. The data were incorporated into one of the required appendices for a Health Resources and Services Administration (HRSA) Rural Access to Emergency Devices Grant Program.
- Jay Collins MD of Eastern Virginia Medical School and Norfolk General Hospital asked for information on ISS values for Level 3 Trauma Centers. I provided a summary of 2011 – 2013 this data from the VSTR database for all levels of Trauma Centers.
- Provided a 2013 update for Greg Hudson (Valley Health System) of a 2011 – 2012 report I prepared earlier this year, containing destinations in their catchment area subdivided by: 1) ZIP code of origin (5 digits); 2) primary symptom type; and 3) reason destination was chosen.
- Suzanne Tolson, EMS Programs Clinical Coordinator at Rappahannock Community College, (RCC) asked for "call type" data for the EMS agencies in which their students

complete their clinical rotations. The information was needed for RCC's application for its Paramedic EMS Program by CoAEMSP (Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions). I provided counts for several call parameters (e.g., patient destination, provider's primary impression, destination type) for April 1, 2013 – March 31, 2014.

- Provided a summary of VPHIB overdose data for the Lord Fairfax Region for 4/1/2013 – 3/31/2014 for Special Agent Jay Perry of the Virginia State Police (VSP) to be used by a Lord Fairfax Region/VSP study group.
- Joel Michael MD, OMD for Carrollton Volunteer Fire Department asked for information on his agency's response times for the most recent 6 months. I provided a frequency distribution as well as the 90th percentile value. I also included an analysis of response delays in case they had an untoward impact on the data (for this time frame, they did not).
- Amanda Wahnich MPH from the Division of Surveillance and Investigation in the Office of Epidemiology asked for data on overdose cases assessed and/or treated and/or transported to the hospital. I was able to send her partially summarized 2013 counts so she could decide the final groupings she needed.
- Worked with James Schlitt, a computational epidemiologist with the Virginia Bioinformatics Institute's Network Dynamics and Simulation Science Laboratory at Virginia Tech. He is developing a Twitter surveillance system for emergency response and event detection and needed logs of real world events that could be used as a calibration set. I provided an EMS response dataset with date and time values and several broad call characteristics identified at the FIPS level for the Northern Virginia area.
- Provided an update to a dataset I created last year for Virginia Geriatric Education Center and VCU School of Medicine faculty member Pam Parsons PhD's HRSA Nursing Education, Practice, Quality and Retention-funded Richmond Health and Wellness Program for Older Adults, an interprofessional community based program targeting low-income seniors. One of their interventions focuses on EMS use by residents of two large geriatric apartment buildings in Richmond. I provided before and after counts of EMS calls to the two addresses (compared to the surrounding Zip Code) for 2012 and 2013. The crosstab summaries were detailed by disposition and whether or not the call type was an emergency.

Other Activities

- As noted last quarter, Russ Stamm retired in late January and Christy Shires left OEMS for another job in mid-February. This loss of staff resulted in the need to spend a considerable amount of time fielding support suite questions and assisting with other VPHIB and VSTR program activities.

- Served on the interview panel for the seven candidates invited for interviews for the two Patient Care Information System support staff positions.
- Helped to train our two new staff members – Karen Rice started on April 25th and Bryan Hodges started on May 27th.

Trauma System

Trauma System Oversight and Management Committee (TSO&MC)

With the recent appointments to the EMS Advisory Board by Governor McAuliffe; we wish to thank Dr. Malhotra for his time serving on the EMS Advisory Board and chairing the TSO&MC. Dr. Michel Aboutanos has been named to the EMS Advisory Board as the Virginia Chapter of the American College of Surgeons representative. This will leave the TSO&MC without a chair until at least the November EMS Advisory Board meeting.

The chair of the TSO&MC is elected by the full EMS Advisory Board. A nominating committee will be appointed at the August EMS Advisory Board meeting and bring forth a slate of nominees to the November meeting. Nominations from the floor will be taken and followed by a vote. The EMS Advisory Board Chair can appoint a board member to lead the committee in the interim.

The most recent TSO&MC meeting was held on March 5, 2014. The final agenda and draft minutes to the meeting can be found on-line on the Virginia Regulatory Town Hall. The key agenda items were to finalize the voting composition of the committee, how the name members will be determined, and updates on the draft Trauma Center Designation Manual.

The TSO&MC has been working towards defining its composition with the recent growth of the persons considering themselves as a committee membership, deviation from the bylaws it falls under, and accusations of not meeting FOIA laws. After great discussion, the committee passed a motion (**Appendix F**) establishing that the following positions would comprise the TSO&MC for two year terms, with the chair having the option to initially appoint members to a three year term to facilitate staggered terms in the future:

1. Chair (EMS Advisory Board Member)
2. Level I Designated Trauma Center Representative
3. Level I Designated Trauma Center Representative
4. Level I Designated Trauma Center Representative
5. Level I Designated Trauma Center Representative (at least one level I rep must be a Trauma Program Manager)
6. Level I Designated Trauma Center Representative (at least one Level I rep must be a Burn Surgeon)
7. Level II Designated Trauma Center Representative
8. Level II Designated Trauma Center Representative
9. Level III Designated Trauma Center Representative
10. Level III Designated Trauma Center Representative
11. Hospital Representative (non-trauma center / preferred not from health system with a trauma center)
12. Consumer / Trauma Survivor
13. Emergency Physician
14. EMS Provider (non-specific affiliation)
15. Pediatric Surgeon

The various levels of designation were challenged to work together to bring forth a slate of names to fill its representative's positions and an alternate. The VHHA will be reaching out to hospitals not designated as trauma centers to find a hospital representative. OEMS provided VHHA with a list of hospitals with a high volume of trauma patients and other information to assist with their recruitment. All committee members were going to communicate locally to make suggestions for the Consumer / Trauma Survivor and EMS representatives. Dr. Haynes was asked to work with pediatric surgeons for a recommendation to fill that position.

The process to revise the Trauma Center Designation Manual was not presented for action and will be moved forward when a clear voting membership for the committee exists. Given the political climate that has developed around the pediatric trauma criteria staff and the co-chairs for the special needs work grouped advised the document remain pending until a committee composition is correctly established.

Trauma Center Fund

Each July 1st the percentage of trauma funding each trauma center will receive during the upcoming year is recalculated. Based on the *Code of Virginia* the funding levels are set based on the number of admission days for patients of motor vehicle crashes. These percentages are typically representative of overall trauma patient volumes. Figure 4 below shows the revised trauma center fund percentages in comparison to last year's.

Figure 5 shows the Trauma Center Fund distributions since the last reporting period. Since our May report $7 million has been distributed to the designated trauma centers. Beginning in late 2006 OEMS has distributed over $77 million from the trauma fund to designated trauma centers.

Figure 4 Trauma Center Fund Distribution Percentages July 1, 2014

Trauma Center & Level	Percent Distribution FY14	# Qualified Admission Days CY 13	Percent Distribution FY15	Difference FY14 & FY15
I				
Roanoke Memorial Hospital	14.26%	3,687	12.88%	-1.38%
Inova Fairfax Hospital	17.90%	4,459	15.58%	-2.32%
Norfolk General Hospital	9.31%	3,654	12.77%	3.46%
UVA Health System	13.13%	3,609	12.61%	-0.52%
VCU Health Systems	27.67%	7,432	25.97%	-1.70%
II				
Lynchburg General Hospital	1.88%	721	2.52%	0.64%
Mary Washington Hospital	4.38%	1,323	4.62%	0.24%
Riverside Regional Medical Ctr.	3.32%	860	3.01%	-0.31%
Winchester Medical Ctr.	4.09%	1,146	4.00%	-0.09%
III				
New River Valley Medical Ctr.	0.40%	91	0.32%	-0.08%
CJW Medical Ctr.	0.95%	325	1.14%	0.19%
Montgomery Regional Hospital	0.17%	68	0.24%	0.07%
Southside Regional Medical Ctr.	0.62%	1,068	3.73%	3.11%
Virginia Beach Gen'l Hospital	1.94%	174	0.61%	-1.33%
Total		28,617	100.00%	

Figure 5 Trauma Center Fund Disbursements during the Reporting Period

Trauma Center Level	June FY14	July FY15	Percent Distribution FY15	Grand Total
I				
Roanoke Memorial Hospital	$550,209.89	$353,805.20	12.88%	$10,071,515.87
Inova Fairfax Hospital	$679,710.57	$421,831.14	15.58%	$15,250,918.17
Norfolk General Hospital	$373,618.05	$351,033.77	12.77%	$9,438,455.28
UVA Health System	$509,897.01	$347,002.60	12.61%	$10,506,337.32
VCU Health Systems	$1,028,256.48	$683,605.03	25.97%	$18,381,380.25
II				
Lynchburg General Hospital	$108,551.92	$92,787.15	2.52%	$1,994,696.10
Mary Washington	$197,739.72	$145,696.21	4.62%	$1,788,195.60
Riverside Regional Medical Ctr.	$159,924.09	$105,132.60	3.01%	$2,345,729.97
Winchester Medical Ctr.	$187,393.93	$130,075.44	4.00%	$2,986,123.26
III				
New River Valley Medical Ctr.	$55,752.74	$37,358.60	0.32%	$362,542.72
CJW Medical Ctr.	$75,374.06	$58,018.33	1.14%	$893,941.90
Montgomery Regional Hospital	$47,547.47	$35,343.02	0.24%	$355,788.89
Southside Regional Medical Ctr.	$63,601.27	$123,272.85	3.73%	$620,081.12
Virginia Beach Gen'l Hospital	$110,692.43	$44,665.09	0.61%	$2,429,381.16
Total	$4,148,269.63	$2,929,627.03	100.00%	$77,425,087.61

Trauma Center Designation

On July 2nd Johnson Willis Hospital in Chesterfield became the newest Level III designated trauma center. A trauma center site review team visited Johnson Willis hospital on June 25th with the purpose of evaluating the hospital for its readiness to serve as a provisional Level III trauma center. It was the team's recommendation to the State Health Commissioner that Johnson Willis possessed the resources and infrastructure needed to support being a Level III center.

Trauma Performance Improvement Committee (TPIC)

The trauma PI committee met on June 5, 2014 and continues to work toward providing state regional, and agency level reporting of potential missed-triages of trauma patients. Inter-facility transfer of trauma patients is also being developed. Step 1 of the Statewide Trauma Triage Plan, which are physiologically based, is being used to identify patients that should be transferred to designated trauma centers.

Virginia Stroke Systems Task Force

The Division of Trauma and Critical Care staff holds a seat on the Virginia Stroke Systems Task Force. The most recent VSSTF was held on July 18th. The July meeting is when members rotate on and off the task force and new members introduced themselves, provided background on their experience, and who they represent. A couple of new positions have been added to the task force to include the pharmaceutical industry and the medical equipment community.

Dr. Solenski gave a presentation on a HRSA grant that has been submitted which would study the effectiveness of telemedicine use in stroke care. Dr. Tim Sheppard also presented and updated the task force on critical changes occurring in stroke care, stroke designation, and future stroke system changes being considered. From this presentation and discussion members will be looking at the benefits and challenges of stroke centers seeking "comprehensive stroke centers" and consider how the task force can provide evidence of the benefits implementing a stroke system in Virginia have made.

There were also project team updates / reports given. The current workgroups include the stroke coordinators group, identification of stroke rehabilitation service availability in Virginia, telehealth mapping, and identifying evidence based support for the utilization of diagnostics for stroke evaluation.

The next meeting will be held on October 17, 2014.

Division of Trauma/Critical Care on the National Scene

Data Managers Council (NASEMSO)

The Data Managers Council (DMC) is primarily a "working" committee where all states collaborate to establish consistency in EMS data collection throughout the country. Virginia trauma staff serves as Chair of the DMC. Current projects underway include state data manager mentor program, NEMSIS version 3 extended definitions workgroup, a data quality workgroup, and one final workgroup reviewing the comments received during the NEMSIS open public comment period which collects suggested changes for the next NEMSIS version update.

The DMC membership as provide a liaison to national committees in areas such as helicopter EMS, community paramedicine, NEMSAC, and a data integration workgroup. DMC members regularly attend NEMSIS lead meetings such as the EMS software developers' bi-weekly meeting, CAD integration workgroup, and medical device integration workgroup.

NASEMSO will soon begin receiving funding from NHTSA in the amount of $1.5 million to develop EMS performance measures utilizing the NEMSIS version 3 dataset. We look forward to providing updates on this project and utilizing its end product on a state level.

State Trauma Managers Council

The Division of Trauma and Critical Care staff is also a member of NASEMSO's State Trauma Managers Council. Since the current FTE serves as both the Virginia data manager and the state trauma manager our participation with the trauma managers is currently less active with the trauma managers. OEMS does actively utilize and contribute to national trauma system development with the trauma council. The Trauma Managers Council formulates recommendations on policies and positions specific to EMS trauma systems. These recommendations are considered by the NASEMSO Executive Committee, and positions are taken by the association as a whole (not by individual councils), to represent consensus of all state and territorial EMS offices, nationwide.

The Trauma Managers Council provides a forum for communication, interaction, and networking between peers, other national organizations and federal agencies with similar missions. This forum allows for the sharing of best practices; developing and encouraging mentoring programs; the joint resolution of obstacles and challenges; and the nationwide promotion of evidence-based decision making.

NEMSIS Steering Committee

As Chair of the DMC Div. TCC staff holds one of eight positions on the NEMSIS Steering Committee. The NEMSIS steering committee helps provide stakeholder input to NEMSIS and provides assistance in forming the short and long term plans / goals. The steering committee did not meet this quarter and our next meeting will be during the October annual meeting.

Emergency Medical Services for Children (EMSC)

Initial Feedback a from Survey of EMS Agencies (*PM 71,72,73)**:** During 2013-14, 48 states, the District of Columbia, and 5 territories participated in an EMS for Children (EMSC) assessment for three federal, Emergency Medical Services (EMS)-related performance measures about pediatric medical direction and equipment.

Virginia had 425 responses from EMS agencies (the most nationally), achieving a response rate of 85.3%. Nationally, over 8,000 EMS agencies responded; an 83.1% response rate.

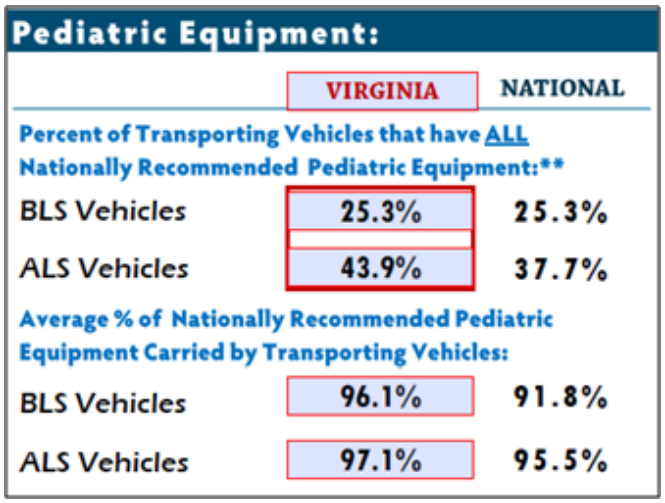
Figure 6 below shows the availability of online pediatric medical direction and written pediatric protocols. Virginia falls a little below the national average for on-line pediatric medical direction and above average with written pediatric protocols. We are above average with the availability of those protocols during an EMS response.

Figure 7 exhibits the availability of the nationally recommended pediatric equipment for EMS units by BLS versus ALS units.

Figure 6 Availability of Pediatric Medical Direction

Online Medical Direction:		
	VIRGINIA	NATIONAL
Online Medical Direction Available to Give Medical Advice When Treating a Pediatric Patient:		
BLS Agencies	85.7%	90.1%
ALS Agencies	83.9%	89.5%
Offline Medical Direction:		
	VIRGINIA	NATIONAL
Have Written Pediatric Protocols Available:		
BLS Agencies	96.2%	93.0%
ALS Agencies	99.5%	98.7%
Protocols Always or Almost Always Available During an EMS Call:		
BLS Agencies	81.1%	72.0%
ALS Agencies	96.7%	93.5%

Figure 7 Availability of Nationally Recommended Pediatric Equipment



Pediatric Equipment:	VIRGINIA	NATIONAL
Percent of Transporting Vehicles that have ALL Nationally Recommended Pediatric Equipment:**		
BLS Vehicles	25.3%	25.3%
ALS Vehicles	43.9%	37.7%
Average % of Nationally Recommended Pediatric Equipment Carried by Transporting Vehicles:		
BLS Vehicles	96.1%	91.8%
ALS Vehicles	97.1%	95.5%

Figure 8 Five Least Carried Types of Pediatric Equipment - BLS

The Five Least-Carried Pieces of BLS Equipment	
ITEM	% CARRY
Mask for bag-valve mask - neonate size	60%
Extremity immobilization device -medium	76%
Pulse oximeter with pediatric probes	78%
Length/weight-based tape or appropriate reference material for pediatric equipment sizing and drug dosing	86%
Mask for bag-valve mask - child size	89%

Figure 8 Five Least Carried Types of Pediatric Equipment - ALS

The Five Least-Carried Pieces of ALS Equipment	
ITEM	% CARRY
Mask for bag-valve mask - neonate size	74%
Magill forceps - pediatric size	85%
Lower extremity (femur) traction device - child size	85%
Meconium aspirator adaptor	86%
Pulse oximeter with pediatric probe	89%

A good survey response like this makes it very likely that continued significant EMSC funding will be received by the Virginia Office of EMS. These amounts are passed on to EMS agencies, hospitals and EMS providers in multiple supportive ways (supplies, training, technical assistance, etc.).

Initial Feedback from Survey of Virginia Hospitals (PM 76, 77)

During 2013-14, 49 states, the District of Columbia, 5 territories, and 3 freely associated states participated in an EMS for Children (EMSC) assessment for two federal hospital-based performance measures about pediatric inter-facility transfer agreements and guidelines.

Virginia had 90 responses from hospitals with 24-hour Emergency Departments (EDs). This represented 100% of civilian hospitals, and an overall response rate of 96.8%. 3 military hospitals declined to participate.

Figure 9 Percent of Hospitals that have Pediatric Transfer Agreements in Place

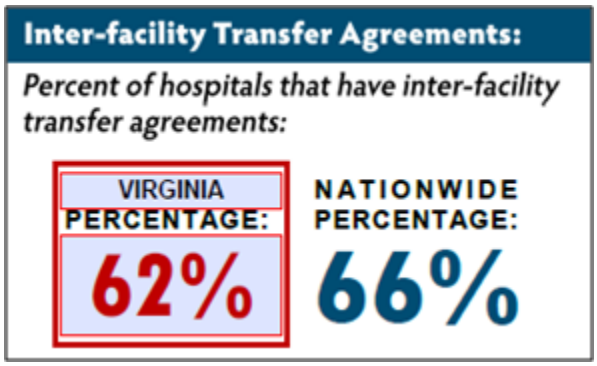
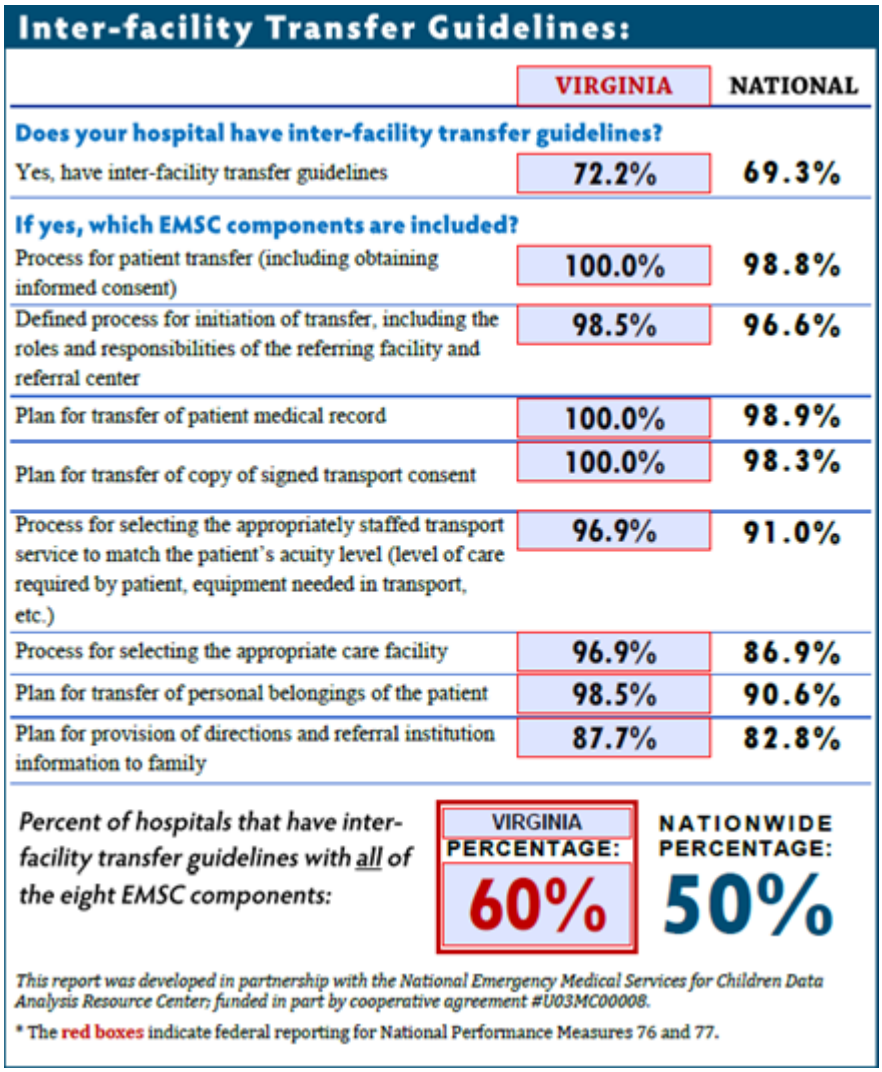


Figure 10 Breakdown of Pediatric Transfers Agreements by Eight National Components



Pediatric Track for 2014 EMS Symposium (PM 78)

The Virginia EMS for Children program has been using federal EMSC grant resources received from the Health Services and Resources Administration (HRSA) to support pediatric training opportunities in Virginia for several years now. This year EMSC funding will provide a *dedicated pediatric track* at the 2014 EMS Symposium in Norfolk in November. Please take the time to review all the choices that are available for those who wish to improve their knowledge and skills related to the emergency care of children.

Child Immobilization Devices (PM 73)**:** EMSC program is using federal funds to purchase a limited number of infant/pediatric immobilization devices for distribution to volunteer EMS agencies who signed up for them at the EMS booth at last year's Symposium (on a first-come, first-served basis).

Additional devices will be purchased this fall, and a request for interested agencies will be circulated in September to develop a list for this purchase. Or, if preferred, volunteer EMS agency leaders interested in having their agency be considered when the EMSC program distributes these devices should contact David Edwards at the Office of EMS by phone (804-888-9144) or email (david.edwards@vdh.virginia.gov). If more requests are received than devices available, a drawing will determine which agencies will receive the devices.

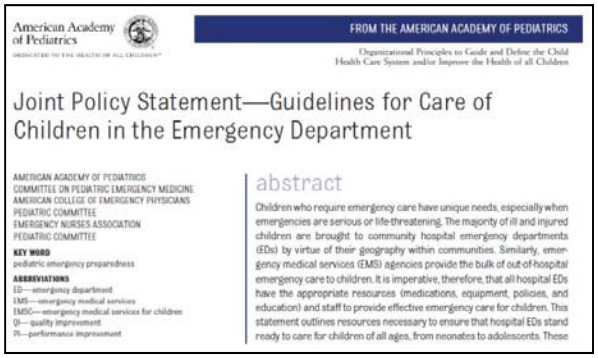
The EMSC Committee discussed the issues of "immobilization" due to injury and "safe restraint" of children being transported in ambulances at their July 10, 2014 meeting. There are two related but distinct issues, which require different solutions. This will be a major focus of both the Committee and the EMS for Children program (within the Office of EMS) and will require on-going discussion to assure that limited federal grant funding be appropriately educate EMS agencies and assist in addressing the equipment issues directly.

More On-Site Pediatric Training/Education Requests Being Accepted (PM 78,80)

EMS agencies interested in on-site pediatric training should contact David Edwards at 804-888-9144 (david.edwards@vdh.virginia.gov) or Dr. Robin Foster (rlfoster@hsc.vcu.edu). The Virginia EMSC program facilitates access to pediatric education and training, especially in the form of EPC (*Emergency Pediatric Care*), *Emergency Nursing Pediatric Course* (ENPC), and

PEPP (Pediatric Education for Prehospital Professionals) courses around the Commonwealth, particularly in areas with historically difficult access to pediatric training. Again, federal EMSC funding will be used for purchasing some pediatric training manikins to aid in this effort.

On-Site Emergency Department Pediatric Assessments (PM 74)**:** The Virginia EMS for Children program is once again accepting requests from Virginia hospital emergency departments to provide on-site assessments of their pediatric needs and capabilities (at no cost to the hospital).


American Academy of Pediatrics

FROM THE AMERICAN ACADEMY OF PEDIATRICS

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

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

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

KEY WORD
pediatric emergency preparedness

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

abstract

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

Program staff use the consensus document *"Joint Policy Statement - Guidelines for Care of Children in the Emergency Department", American Academy of Pediatrics, October 2009* as a guide to assess gaps in basic ED preparedness. This document delineates "guidelines and the resources necessary to prepare hospital emergency departments (EDs) to service pediatric patients", and is endorsed by many organizations. For additional information please contact David Edwards at 804-888-9144 or by email (david.edwards@vdh.virginia.gov).

EMSC State Partnership Grant Notes: Now that two major EMSC assessments (hospital *and* EMS agency) have been completed, EMS for Children grantees will be renewing their perspective and direction at the *Annual EMSC Program Meeting* (July 28-August 1) in Arlington, VA. The Virginia EMSC Medical Director, FAN (Family Advisory Network) representative and EMSC Program Manager will be attending this required gathering on Virginia's behalf. The existing list of ten EMSC Performance Measures that guide EMSC programs nationally are undergoing re-evaluation by HRSA work groups, and these (among many other items) will very likely be presented and discussed.

Due to completion of the recent EMS for Children assessments, State Program Managers were required to attend a technical workshop presented by the National EMSC Data Analysis Resource Center (NEDARC) titled *"Communicating Your Performance Measures Results"*.

NASEMSO Pediatric Emergency Care Council (PECC) Bullets: The PEC Council is a standing council of the National Association of State EMS Officials (NASEMSO), and is chaired by Virginia's EMS for Children Coordinator. A snapshot of current activities would include:

- Facilitating the beginning of legitimate crash testing of pediatric EMS equipment (working with NHTSA and several other agencies).
- Promoting the use of proper child restraints when transporting children in ambulances. More than 600,000 children are transported by ground ambulance each year and there are more than 1,000 ambulance crashes. Many of these children are NOT restrained appropriately, if at all.
- Developing a *Pediatric Disaster Preparedness Checklist Tool* for State EMS Offices to use in identifying preparedness gaps—this is a "deliverable" to HRSA from the PECC as part of the cooperative agreements currently in place for NASEMSO. This effort is being spearheaded by Virginia.
- Working with the emergency preparedness community to include the needs of children in disaster planning and mitigation.
- Promoting the use of easily obtainable pediatric patient videos as a educational tool for EMS providers.
- Participating in the process of developing model evidence-based pediatric protocols.
- Promoting and facilitating the creation of pediatric facility recognition programs by the states and U.S. territories.
- Participating in implementation of the EMS Education Agenda for the Future.
- Working to develop specific pediatric quality improvement indicators.
- Providing a structured mentoring function for new State EMSC Managers.

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 (direct line).

Virginia Poison Control Network

This will be the final report from the Division of Trauma and Critical Care on the Virginia Poison Control Network (VPCN). OEMS has served as the State's contract administrator for the VPCN since it as formalized in the 1990's. As of the contract renewal on July 1st contract administration for the VPCN was transferred to another area of VDH. VDH was making an effort to centralize contracts that are essentially "pass though" funding. The VPCN falls into this area.

Durable Do Not Resuscitate (DDNR)

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

Respectfully Submitted

Office of EMS Staff

Appendix A

ATTACHMENT 1
State EMS Advisory Board
Motion Submission Form

☒ **Committee Motion:**	**Name:**	TCC-RN to Paramedic Bridge Program Overview and Documentation
☐ **Individual Motion:**	**Name:**	

Motion:

TCC moves to accept the proposed RN to Paramedic competencies document.

Discussion: This becomes part of the Virginia EMS Education Standards and will take effect immediately. This document taking effect immediately will not impose hardships to educational programs as there are relatively few enrollees and programs are already using the previous passage of general competencies from EMS last year.

EMS Plan Reference (include section number):

2.2.1 - Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia.

4.2.2 Assure adequate and appropriate education of EMS students.

Committee Minority Opinion (as needed):

None given.

For Board's secretary Use only:

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

Board's Minority Opinion:

RN to Paramedic Bridge Program Overview and Documentation

The following document contains a description of the RN to Paramedic Bridge program and program specific documentation.

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

Contents

Registered Nurse to Paramedic Bridge Program (3 year certification)

The Registered Nurse to Paramedic Bridge Program is designed to certify the Virginia Licensed registered nurse to the highest level of pre-hospital advanced life support care available in Virginia. This program fulfills all the requirements of the Virginia EMS Education Standards for the Paramedic.

The Registered Nurse to Paramedic Bridge Program reviews the skills and subjects contained in the Virginia EMS Education Standards for Paramedic over approximately of 120 hours of instruction. A minimum of 120 hours are devoted to extensive clinical rotations requiring specific competencies. Additional hours may be required to complete all the required competencies. Clinical rotations of this type are not usually available for lower level providers to attend. These additional clinical rotations include time spent in OR/Recovery Units, Critical Care Units, Labor & Delivery Units, Pediatrics, Emergency Department, and may include Family Practice, Mental Health Clinics, Dialysis Clinics, Neurovascular Rehabilitation Clinics, Detoxification Units, and Extended Care Facilities.

The Registered Nurse to Paramedic Bridge Program is designed to educate the technician in all areas of pre-hospital patient care. These areas include instruction in: pre-hospital environments, preparatory skills, airway management and ventilation, patient assessment, trauma care, medical patient management, obstetrical/gynecological conditions, pediatric patients, neonatal care, psychiatric and behavioral emergencies, special considerations, and assessment based management.

In Virginia, all initial Paramedic Programs are required to satisfy the testing guidelines established by the National Registry of Emergency Medical Technicians. Upon successful course completion and National Registry Paramedic certification, the technician will receive automatic reciprocity for Virginia Paramedic certification which is required before being allowed to practice at this level. After receiving Virginia credentials, the Paramedic has the option to maintain National Registry Paramedic certification without affecting their Virginia certification. However, Virginia certification must be maintained in order to provide patient care at this level in this state.

PREREQUISITES FOR ADVANCED LEVEL PROGRAMS

To be eligible to attend an Advanced Level EMT course in Virginia you must:

A. Be proficient in reading, writing and speaking the English language.
B. Be a minimum of 18 years of age at the beginning date of the certification course.

C. Hold a current certification as an EMT-Basic or higher.
D. Hold, at a minimum, a High School or General Equivalency Diploma.
E. Have no physical or mental impairment that would render them unable to perform all practical skills required for that level of certification
F. Not have been convicted of or found guilty of any crime, offense or regulatory violation, or participated in any other prohibited conduct identified in state EMS regulations as follows:
    1. Have never been convicted or found guilty of any crime involving sexual misconduct where lack of affirmative consent by the victim is an element of the crime.
    2. Have never been convicted of a felony involving the sexual or physical abuse of children, the elderly or the infirm.
    3. Have never been convicted or found guilty of any crime (including abuse, neglect, theft from, or financial exploration) of a person entrusted to their care or protection in which the victim is a patient or is a resident of a health care facility.
    4. Have never been convicted or found guilty of any crime involving the use, possession, or distribution of illegal drugs except that the person is eligible for affiliation or enrollment five years after the date of final release if no additional crimes of this type have been committed during that time.
    5. Have never been convicted or found guilty of any other act that is a felony except that the felon is eligible for affiliation or enrollment five years after the date of final release if no additional felonies have been committed during that time
    6. Are not currently under any disciplinary or enforcement action from another state EMS office or other recognized state or national healthcare provider licensing or certifying body. Personnel subject to these disciplinary or enforcement actions may be eligible for certification provided there have been no further disciplinary or enforcement actions for five years prior to application for certification in Virginia
    7. Have never been subject to a permanent revocation of license or certification by another state EMS office or recognized state or national healthcare provider licensing or certifying body.
G. All references to criminal acts or convictions under this section refer to substantially similar laws or regulations of any other state or the United States. Convictions include prior adult convictions, juvenile convictions, and adjudications of delinquency based on an offense that would have been, at the time of conviction, a felony conviction if committed by an adult within or outside Virginia.

H. Be clean and neat in appearance.

I. May not be under the influence of any drugs or intoxicating substances that impairs your ability to provide patient care or operate a motor vehicle while in class or clinicals, while on duty or when responding or assisting in the care of a patient.

J. If in an ALS Bridge certification Program, must have completed the eligibility requirements for certification at the lower ALS level prior to the beginning date of the ALS Bridge Certification program.

K. If in an ALS Bridge certification Program, must have become certified at the lower level prior to certification testing for the higher level of ALS certification.

Registered Nurse to Paramedic Curriculum

PREREQUISITES

1. The candidate must be a currently licensed in Virginia as a Registered Nurse or possess an RN License recognized through the Nursing Compact.
2. The candidate must be currently participating as an active EMS field provider or actively working as an RN.
    a. The term "active" as used above for both the field provider and
        i. RN is defined as a minimum average of eight (8) hours a week over the two previous years or a total of eight hundred thirty-two (832) hours within the previous two years (8 hours / week X 2 years = 832 hours).
3. The candidate must be currently certified as an EMT or posses higher EMS certification.

CURRICULA

Emphasis needs to be placed on the Airway Management Module with time to be spent with cricoidthyroidotomies and pleural decompression. Critical Decision Making must also be emphasized.

The RN Bridge to Paramedic Program will include:

1. Didactic (all knowledge objectives)
2. Psychomotor Skills Lab (critical decision making)
3. Competencies
4. Field Internship

The committee outlined the RN to Paramedic curricula and determined that each program would need to spend time in the following modules/topics marked with an *: The time spent on each topic will vary from program to program however the hours totals are the minimum for the module.

RN Bridge to Paramedic

Module	Topics	Minimum Contact Hours
Preparatory		4
*	EMS Systems/Roles and Responsibilities	
	The Well Being of the Paramedic	
	Illness and Injury Prevention	
	* Medical Legal Issues	
	Ethics	
	General Principles of Pathophysiology	
*	Pharmacology	
	* Venous Access and Medication	
	Therapeutic Communications	
	Life Span Development	
Airway Management and		8
	* Airway Management and Ventilation	
Patient Assessment		12
	History Taking	
	Techniques of Physical Examination	
	* Patient Assessment	
*	Clinical Decision Making	
	* Communications	
	Documentation	
Trauma		20
*	Trauma Systems/Mechanism of Injury	
	* Hemorrhage and Shock	
*	Soft Tissue Trauma	
	* Burns	
*	Head and Facial Trauma	
	* Spinal Trauma	
*	Thoracic Trauma	
	* Abdominal Trauma	
*	Musculoskeletal Trauma	
Medical		40
	Pulmonary	
	* Cardiology	

	Neurology	
Endocrinology		
*	Allergies and	
Gastroenterology		
	Renal/Urology	
* Toxicology		
	Hematology	
* Environmental Conditions		
	Infectious and	
Behavioral and Psychiatric Disorders		
	Gynecology	
Obstetrics		
Special		1
* Neonatology		
*	Pediatrics	
Geriatrics		
	Abuse and	
Patients with Special Challenges		
	Acute	
	Interventions	
Operations 20		
*	Ambulance	
* Medical Incident Command		
*	Rescue	
* Hazardous Materials Incidents		
*	Crime Scene	
Total		1

CLINICAL HOURS (MINIMUM) (See Appendix: A)

The RN to Paramedic Bridge candidate must complete a total of 72 hours in the Clinical Areas. The following are the minimum hours for each of the required areas: Emergency Department – 12 hours, Critical Care Area – 4 hours, Pediatrics – 4 hours, Labor and Delivery – 4 hours, OR/Recovery – 4 hours. The candidate has the flexibility to choose what areas to complete the remaining required hours.

COMPETENCIES

Candidates may utilize competencies while in their work setting while they are enrolled in the program as long as the competencies are documented in patient notes or through the use of the program competency log and signed off on by the nurse manager.

It was determined that the clinical requirements (competencies) could not be omitted but credit could be given for properly documented (logged) competencies that the candidate performs while in the work environment. Other competencies that are presented with appropriate documentation will be allowed by the program for past experience as outlined below

(Recommendations as Approved by Medical Direction Committee and Human Resources and Training Committee on October 18, 2001).

"The committee recommends that each program have a written policy defining how it will determine whether a student starting a program can apply past experience or proven competency for their current program. In cases where the previous experience or competency is recognized, credit can only be awarded up to the competency number required for the level of certification held. Any additional competency numbers described for the higher level of certification being sought must be completed during the higher certification's training course. In all cases where a program awards credit for past experience or competency, such recognition requires that all competency number allowances have documentation supporting each competency recognition. (Example: 1) If three field intubations are accepted, then documentation must be submitted reflecting each skill performance. 2) If using a previous training program, then documentation from that program reflecting each time the skill competency was performed is required.) Further, all recognized competencies must have occurred within one (1) year of the programs begin date. However, each skill must be documented as demonstrating competency during the current program. (If a program accepts previous competency documentation from a program and no more competency contacts are required based upon the curriculum, the current program must verify competency during its course of instruction. This process is described in a policy created by each program.)"

It should be emphasized that when the candidate is not in their normal work setting (department) being precepted by their nurse manager then they are to follow the policies and procedures established for approved preceptors. Programs should utilize a document such as the one in Appendix: B to assess and document previous experience that is being applied to the program.

EVALUATION

The RN to Paramedic Program must cover and evaluate all of the objectives in the Paramedic Curricula to properly prepare the candidate as a paramedic. All of the paramedic objectives must be met and documented for each of the candidates. Evaluation of the candidate must be performed throughout the program on the knowledge objectives and psychomotor skills as outlined in the objectives. The evaluation can be any combination of written and labs (psychomotor skills) to determine a thorough understanding of the objectives after each didactic section during the program. This module testing can occur in variety of methods.

PROGRAM MARKETING

The new curricula dictate that successful completion of the program will be determined by producing a competent field provider not by the arbitrary use of hours as a course determinant. Didactic material, competencies and field team leader activities will run this program to approximately three hundred (300) hours. There are several variables that may play a significant role in this number as documented previous experiences, aggressiveness of the candidate to complete their competencies and field leader activities will dictate the time frame for this program.

Appendix: A

Form TR-17D
RN to P Bridge
Clinical and Competency Hours

RN to Paramedic Bridge Program Clinical Hour and Competency Summary

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

804-888-9120

AREAS	RN to P Bridge
CLINICAL REQUIREMENTS:	
Emergency Department[1]	12 hrs
Critical Care Area[2]	4 hrs
Pediatrics[3]	4 hrs
Labor & Delivery[4]	4 hrs
OR/Recovery	4 hrs
Other Clinical Settings[5]	prn
TOTAL MINIMUM CLINICAL HOURS[6]	72 hrs
ALS Medic Unit (Field Internship)	48 hrs
TOTAL MINIMUM FIELD/CLINICAL	120 Hours
TOTAL PATIENT CONTACTS[6]	60
COMPETENCIES:	
Trauma Assessment, pediatric[7]	5
Trauma Assessment, adult	5
Trauma Assessment, geriatric	5
Medical Assessment, pediatric[7]	5
Medical Assessment, adult	5
Medical Assessment, geriatric	5
Cardiovascular distress[8]	10
Respiratory distress	10
Altered Mental Status	10
Obstetrics; delivery	2
Neonatal Assessment/care	2
Obstetrics Assessment	5
Med Administration	30
IV Access[9]	-
Airway Management[10]	25[10]
Ventilate Non-Intubated Patient [9, 11]	-
Endotracheal Intubation[12]	1 real Patient
Team Leader on EMS Unit[13]	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 for RN's who enroll in an RN to Paramedic Bridge Course as of May 10, 2014. Accredited Programs may set higher minimums or add to this list.

Appendix: B

RN to P Bridge Clinical and Competency Waiver

RN to Paramedic Program

Clinical and Field Internship Waiver Packet

The goal of this packet is to help guide you through the process by which credit may be granted for past medical experience. This past experience must be within the past 12 months prior to entering the program and must be documented and presented in a specific format. This information collected will be sent to the program medical director for review. The review process can take up to one month to be completed. It is imperative that all information contained in this packet be completely filled out prior to submitting for review to avoid any delays. Any incomplete packages will be returned to the student to be resubmitted. It is important to understand that the decision to grant credit for prior medical experience is solely at the disgression of the program's medical director.

Please note: Credit will only be considered for work/ experience performed after being released, not while obtaining that level of certification - even if extra work was performed. Credit can only be given once.

The following information must be included in your package prior to submittal:

- Typed cover letter requesting waiver credit to be granted. (Based on prior Clinical and/ or Field Experience)
- Completed original of the Clinical and Field checklist (see attached) to document any and all skills performed within the past 12 consecutive months. This checklist should be annotated with the number of skills performed and time frame in which they were performed. This sheet must be endorsed by the agency's medical director or nurse manager's signature.
- Job description of clinical or field assignment. Employment specifics (place employed, length of time employed, number of hours per week, part-time, or full time). A resume can be used to satisfy this requirement provided it lists the above information
- Education and training pertinent to Medical Care in either the in-hospital, or pre- hospital environment. This information can be included on the resume.
- For military, please list length of time in service, training, duty stations, and any other specific information regarding education and training that may be beneficial in determining the amount of waiver credit the applicant may be eligible to receive.
- Students requesting field competency waiver must be a regionally released Cardiac Technician or Intermediate. Students must submit a copy of their regional councils, or agency letter of release.
- Must submit signature page along with documentation.
- Letter of endorsement from the student's medical director or nurse manager.

RN-P Competency Documentation

Student Name:_____ Student ID Number:_____
Date Range:_____ TCC Emp ID/ or SSN
(MM/DD/YYYY) – (MM/DD/YYYY)
Clinical:____ Field:____ Agency:

Students applying for both clinical and field credit must fill out a separate skills sheets for each area that is requested.

Skills /Competency Performed	Number Performed	Comments & Supervisor Signature
Cardiac Assessment		
Pediatric Respiratory		
Adult Respiratory		
Syncope		
Abdominal		
Altered LOC/ Neuro.		
Obstetrical		
Psychiatric/ Behavioral		
Trauma Assessment		
Pediatric Assessment		
Adult Assessment		
Geriatric Assessment		
IV Starts (Peds. <17)		
IV Start (Adult <65)		
IV Start (Geriatric >65)		

Skills /Competency Performed	Number Performed	Comments & Supervisor Signature
Med. Admin. (PO/SL)		
Med. Admin. (IM/SQ)		
Med. Admin. (IV)		
Med. Admin. (HHN)		
Med. Admin. (IV-Piggy Back)		
Med. Admin. (IO)		
12 Lead EKG (Placement)		
12 Lead EKG Interpretation		
Lead 2 EKG Interpretation		
Naso/ Orogastric Tube (Placement)		
Naso/ Orogastric Tube (Suctioning)		
Oral Suctioning		
Tracheal Suctioning		
Ventilation/ Non-intubated		
Endotracheal Intubation		
Defibrillation		
Cardio-version		
External Pacing		

Field Patient Type	Number of Patients	Comments/ Supervisor Signature
ALS Patients		
BLS Patients		
ALS Team Leader		
BLS Team Leader		

Other Skills Clinical/ Field		

Additional Information:

Signature:_____ Signature: _____

Medical Director/ Nurse Manager Student

Printed Name:_____ Date: _____

Medical Director/ Nurse Manager

Day Phone Contact Number: _____

RN to Paramedic
Program

Credit Waiver
Signature Page

I_____, understand that all information submitted in the packet is complete and true. I, also understand that any misinformation given is a direct violation of the college honor code, and is considered to be academic misconduct, and can be subject to disciplinary action, and or dismissal from the college. I am aware that the Emergency Medical Director has the final determination as to how much waiver credit may or may not be granted.

_____ _____
Signature Date

Appendix B

☒ **Committee Motion:**	**Name:**	TCC – CE Revision Proposal
☐ **Individual Motion:**	**Name:**	

Motion:

TCC moves to accept the proposed continuing education hours for providers to recertify in Virginia when the Registry implements their new hours in 2016 and that Virginia Providers wishing to maintain their National Registry must meet the minimum hours as set by the National Registry.

EMS Plan Reference (include section number):

2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia.

4.2.2 Assure adequate and appropriate education of EMS students.

Committee Minority Opinion (as needed):

None given.

For Board's secretary Use only:

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

Board's Minority Opinion:

CE Revision Workgroup CE Proposal

NR					Virginia			
Provider Level	NCCR	LCCR	ICCR	Total	NCCR	LCCR +ICCR		Total
EMR	8	4	4	16	8	4	4	16
EMT	20	10	10	40	20	10	6	36
AEMT	25	12.5	12.5	50	25	6	5	36
Intermediate					28	10	10	48
Paramedic	30	15	15	60	30	15	15	60

The workgroup has forwarded the following recommendation for feedback from TCC. They are proposing to mirror the NR at the EMR and Paramedic Levels, but reducing the hours required to recertify EMT and AEMT in Virginia to match current requirements. Virginia Providers wishing to maintain their NR EMT or AEMT would be required to complete the additional hours. At this point the focus is on the total hours required to recertify and that the NCCR's would most likely mirror Registry. What the LCCR and ICCR's hours look like in Virginia is still being decided, but the workgroup wanted to get feedback and direction from TCC.

Appendix C

☒ **Committee Motion:**		**Name:**	TCC – Experiential I-99 Allowed Competencies	
☐ **Individual Motion:**		**Name:**		
Motion:				
TCC moves to accept the Experiential Learning Document.				
EMS Plan Reference (include section number):				
2.2.1 Ensure adequate, accessible, and quality EMS provider training and continuing education exists in Virginia. 4.2.2 Assure adequate and appropriate education of EMS students.				
Committee Minority Opinion (as needed):				
None Given				
For Board's secretary Use only:				
Motion Seconded by:				
Vote:	**By Acclamation:**	☐ **Approved**	☐ **Not Approved**	
	By Count	**Yea:** ☐	**Nay:** ☐	**Abstain:** ☐
Board's Minority Opinion:				

Competencies	Current I to P Bridge Course Requirements	Maximum number of competencies allowed under experiential credit	Required Competencies for experienced I's bridging to P
Skills			
Med Admin	30	15	15
IV access	0	0*	0
Intubations	1 Live Patient	1 Live Patient	0
Ventilate non-intubated Pt.	0	0*	0
Airway Management	25 (10)	0	25 (10)
Patient Contacts (total)	60	30	30
Pediatric Trauma	5	3	2
Adult Trauma	5	3	2
Geriatric Trauma	5	3	2
Pediatric Medical	5	3	2
Adult Medical	5	3	2
Geriatric Medical	5	3	2
Cardiovascular distress	10	5	5
Respiratory Distress	10	5	5
Altered Mental Status	10	5	5
Obstetrics delivery	2	1	1
Neonatal Assessment/care	2	1	1
Obstetrics Assessment	5	3	2
Team Leader on EMS Unit	25 (15)	0	25 (15)

* Or up to ½ of the program's requirement.
Verification of completion within last 2 years must be presented to the program (Agency summary reports, QA/QI, Copies of run reports with patient information redacted, etc.)

Appendix D

Virginia EMS Officer I Draft Syllabus

Course Description

Objective: To provide students with entry-level training in company/departmental emergency medical services operations and administration at the first-line supervisory level.

Learning Outcome: Upon successful completion of this course, the student will be able to effectively manage human resources, community/public relations, EMS company/departmental organization and administration, including budgets, reports, incident pre-planning, public EMS education, safety, and emergency services delivery.

Course Content: Major topics covered in this course are the role of the EMS officer, facing compliance and accountability issues of the 21st century, recognizing and managing cultural diversity, safety/wellness, TQM, interfacing with the community and media at large, functional leadership, supervising EMS company/departmental operations, effective communications, introduction to EMS operations, incident management system(s) and managing multiple casualty incidents.

Methods of Instruction: Lecture, discussions, classroom exercises, case studies, audio/visual modules, observations, tests, examinations and completion of required skills.

Course Participation:
- come to course prepared to actively participate in discussions,
- read the text prior to the next class session,
- complete all homework assignments,
- respect the beliefs, opinions, and values of other students,
- and have an open mind about the issues being discussed.

Attendance Policy

100% attendance of the course and 100% of completion of online modules is required

Prerequisites

- Certification as a Virginia EMT, Advanced EMT, Intermediate, or Paramedic.
- Be a minimum of 18 years of age at the beginning date of the program.
- No corrective action from OEMS or OMD
- IS 700, IS 800, IS 100, IS 200, or equivalent

Course Text

Ward, Michael. Fire Officer Principles and Practice 3rd edition. Burlington, MA, 2015.

Evaluation

- Must pass each with a 70% and maintain a test average of 80%
- Assignments and Activities -50%
- Tests - 25%
- Exam - 25%

Academic Honesty

We expect the highest standards of academic honesty. Academic misconduct includes cheating, plagiarism, falsification of records, unauthorized possession of examinations, intimidation, and any and all other actions that may improperly affect the evaluation of a student's academic performance or achievement; assisting others in any such act; or attempts to engage in such acts. Any incident of academic misconduct will result in the student being dropped from the course and the student's sponsoring agency being notified of the incident.

Appendix E

Virginia Office of EMS

Officer I Certification Course

Schedule and Reading Assignment(s)

Note: 100% attendance required

Date	Location	Time	Sessions #	Chapter	Homework Assignment
	Classroom	4 hours	**Orientation**	**1S**	**Turn in homework assignments 1-1, 1-2,**
	ONLINE		**Mod 1**	**3, 4, 6**	
	Classroom	4 Hours	**Review home work Test**		**Turn in homework assignments, 3-1, 3-2, 4-1, 4-2, 4-3,**
	ONLINE		**Mod 2**	**7, 8, 9, 10S**	
	Classroom	4 hours	**Review home work Test**		
	ONLINE		**Mod 3**	**11, 12, 5, 19**	
	Classroom	4 hours	**Review home work Test**		**Turn in homework assignments: 5-1, 5-2, 8-1,12-1, 12-2**
	ONLINE		**Mod 4**	**13, 14, 15, EMS Trends**	
	Classroom	8 hours	**Final Discussion, Tabletop Exam**		**Turn in homework assignment: 14-1**

Appendix F

State EMS Advisory Board
Motion Submission Form

☐ **Committee Motion:** Name: _Trauma System Oversight & Management Committee

☐ **Individual Motion**: Name: _____

Motion:

The TSO&MC moves that the EMS Advisory Board approve the following TSO&MC committee membership:

14 Voting Members and a Chair (exceeding 10)

- Level I Representatives (5) – (1 shall be a burn surgeon and at least 1 a trauma program director/manager)
- Level II & III Representatives (5) – (2 Level II Reps, 2 Level III Reps, and 1 non-designated hospital rep.)
- Emergency Medicine Representative (1)
- EMS Representative (1)
- Pediatric Surgeon (1)
- Citizen Representative (1)
- Chair

AND that there is a two year term limit and that no member shall serve more than two consecutive terms; and that some initial terms may, at the discretion of the Chair, be set at three years in order to facilitate staggered rotation of the committee's membership.

EMS Plan Reference (include section number):

3.1.5 Maintain and Enhance Trauma Center Designation Process.

4.1.2 Maintain Statewide Per-hospital and Inter-hospital Trauma Triage Plan.

Committee Minority Opinion (as needed):

The past 1 – 2 years meeting minutes can best reflect the ongoing dialogue that has occurred.

The committee member composition vote was Y: 11, N: 2, A: 2

The term limits vote was unanimous.

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

Vote: _____ YEA _____ NAY _____ ABSTAIN

Board Minority Opinion:
_____
_____
_____

Meeting Date: _____