Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

Wednesday, November 9, 2011

Executive Management, Administration & Finance

Office of Emergency Medical Services

Report to The
State EMS Advisory Board
November 9, 2011

MISSION STATEMENT:

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

a) Office of EMS Staff Member Publishes Book on ICS for EMS

After two years of research and work, Karen Owens, Office of EMS Emergency Operations Assistant Manager will have her book, "Incident Command for EMS," published. This book is written for EMS leadership and looks in detail at the overall ICS structure, specifically the positions that apply to the EMS provider and uses scenarios to ensure understanding and application of ICS principles for every response, from the single patient to the mass casualty incident. Some of the features of the book include in-depth explanations of the basic ICS structure and the functions of various positions, thorough understanding of the relationship of the EMS responder in the ICS structure and scenario-based application of ICS principles in the EMS setting. This is a great accomplishment for Karen and this book will be a valuable resource for the EMS system.

b) German EMS Providers Visit VDH

On September 28, 2011 Winnie Pennington, OEMS Emergency Operations Planner assisted in escorting four German Paramedics visiting Virginia on a tour to the Virginia Emergency Operations Center (VEOC). The paramedics work for the German Red Cross and are currently visiting with an exchange program through the Virginia Association of Volunteer Rescue Squads (VAVRS). The visitors were briefed by Patrick Cox, a VEOC operations officer, and were given a tour of the facility which included a walk through and explanation of the communication center. Other stops included planning, the Governor's press room, and the Joint information Center (JIC) as well as the operations area which houses the Emergency Support Functions during Virginia Emergency Response Team (VERT) augmentation. The visitors were impressed with the facility and questions included "How do I get to work here?"
When asked about their emergency management structure they replied that their organizational structure during emergencies is much like ours and most emergencies are handled locally or with mutual aid of surrounding localities. They have an over arching emergency management structure for the country, usually only activated during large

scale emergencies or disasters. Once the paramedics had completed their tour they were off to the Madison Building to meet and talk with Commissioner Remley.

c) OEMS Providing Information & Education on New Durable Do Not Resuscitate Regulations

The revised Durable Do Not Resuscitate (DDNR) regulations became effective on July 20, 2011 and the Office of EMS Division of Trauma and Critical Care has been working to provide updated information and education resources for EMS providers, physicians and others who administer or enact a DDNR. This education is especially important for EMS providers who have been trained on honoring DDNRs, and need to have the latest information from the new regulations so that they can effectively perform their jobs and honor the last wishes of those who have a DDNR. Paul Sharpe, Manager of the Division of Trauma and Critical Care and Russ Stamm, the Office of EMS administrator for the DDNR program have been working with EMS agencies, partner organizations and physicians to provide the new downloadable form (which eliminates the costly yellow carbon copy forms) and create educational resources on the Office of EMS website and more. Physicians or providers who may have patients with a DDNR should read the updated information at www.vdh.virginia.gov/OEMS/DDNR/index.htm.

d) 32nd Annual Virginia EMS Symposium

This year there are over 250 classes offered for emergency medical personnel to get continuing education credits. This program allows providers, nurses and physicians from around Virginia to take courses on the latest and most innovative technologies and processes in EMS. There are 17 tracks for classes that include:

1. Administration
2. ALS Academy
3. BLS Academy
4. Cardiac
5. Critical Incident Stress Management
6. Communications
7. Critical Care
8. Educator
9. Medevac
10. Health and Safety
11. Leadership and Management
12. Medical
13. Operations
14. Preconference
15. Preparatory
16. Special Considerations
17. Trauma

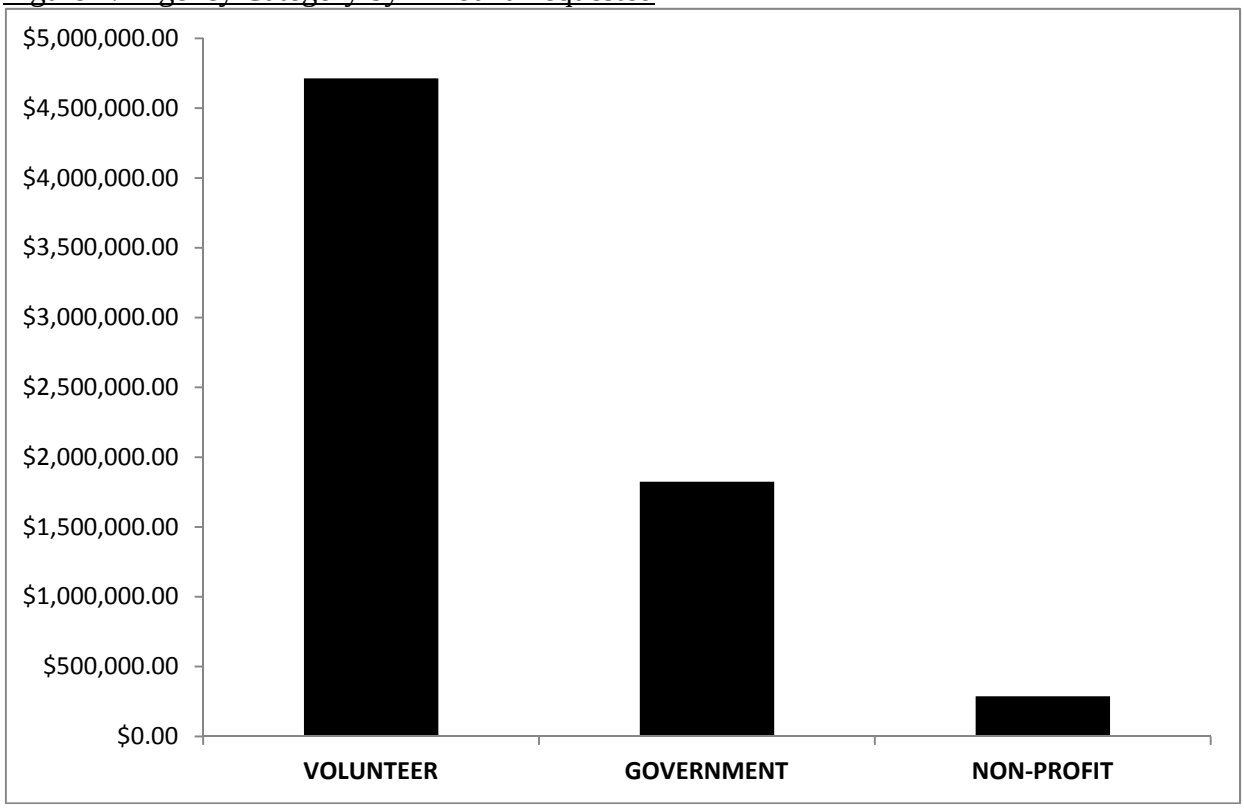
As of the publication of this Quarterly Report there were **1,692** registered attendees. To learn more about this program visit the OEMS section of the website at www.vdh.virginia.gov/oems.

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

The RSAF grant deadline for the Fall 2011 cycle was September 15, 2011, OEMS received 108 grant applications requesting $6,824,868.00 in funding. The following agency categories are requesting funding for the Fall 2011 grant cycle:

- 75 Volunteer Agencies requesting $4,713,881.00
- 26 Government Agencies requesting $1,823,838.00
- 7 Non-Profit Agencies requesting $287,149.00

Figure 1: Agency Category by Amount Requested

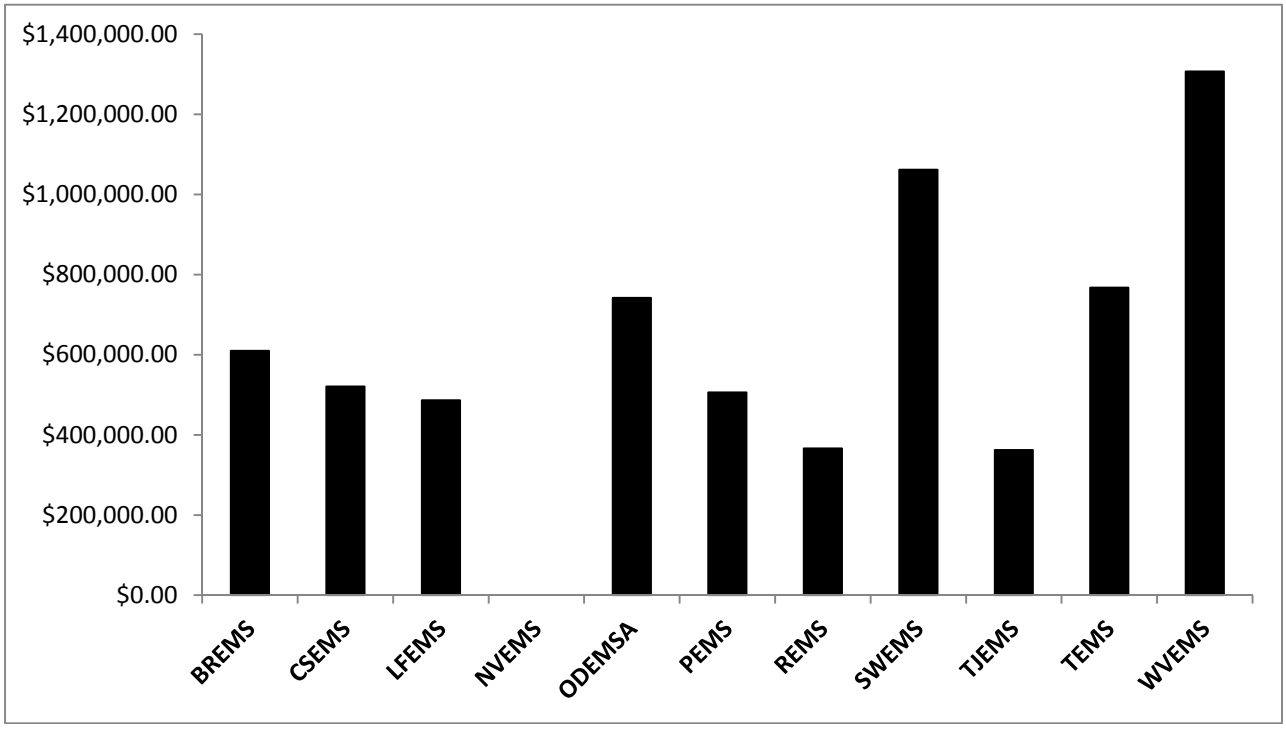


The following regional areas are requesting funding in the following amounts:

- Blue Ridge EMS Council – 6 agencies requesting funding of $609,998.00
- Central Shenandoah EMS Council – 13 agencies requesting funding of $520,956.00

- Lord Fairfax EMS Council – 7 agencies requesting funding of $486,431.00
- Northern Virginia EMS Council – 0 agencies requesting funding of $0.00
- Old Dominion EMS Alliance – 13 agencies requesting funding of $741,896.00
- Peninsulas EMS Council – 7 agencies requesting funding of $506,063.00
- Rappahannock EMS Council – 8 agencies requesting funding of $366,354.00
- Southwestern Virginia EMS Council – 16 agencies requesting funding of $1,061,949.00
- Thomas Jefferson EMS Council – 5 agencies requesting funding of $362,139.00
- Tidewater EMS Council – 11 agencies requesting funding of $767,714.00
- Western Virginia EMS Council – 19 agencies requesting funding of $1,307,182.00
- Non-Affiliated Agencies – 3 agencies requesting funding of $94,184.00

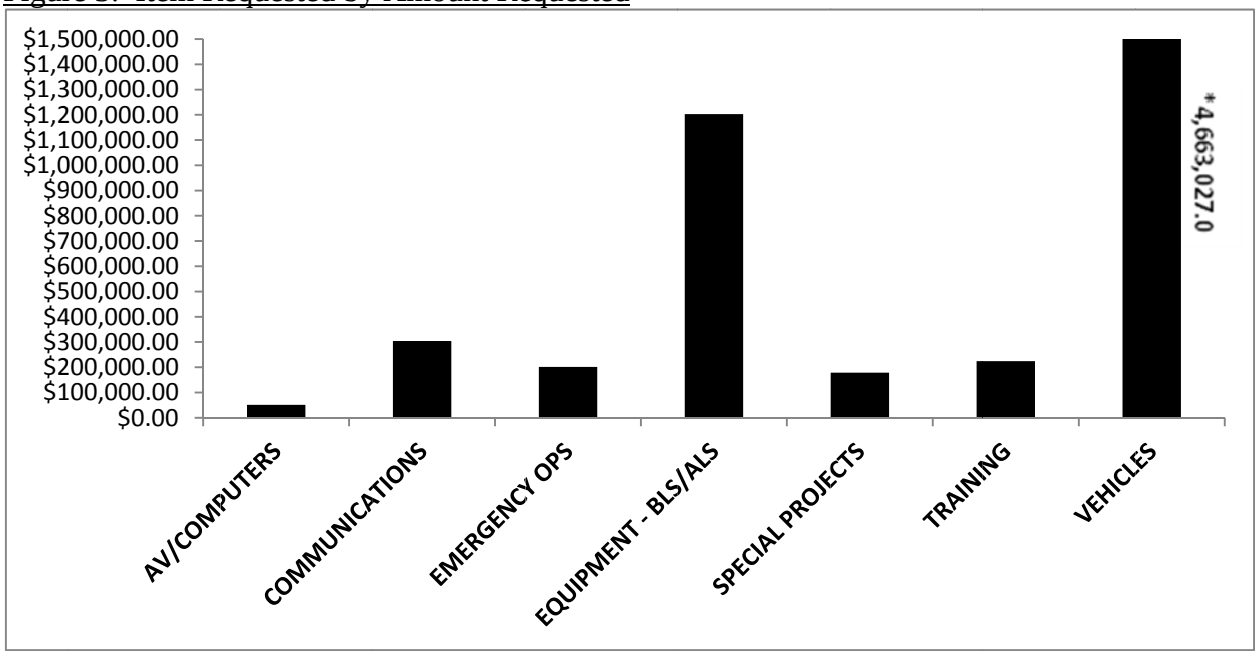
Figure 2: Regional Area by Amount Requested



The following item categories were requested for funding:

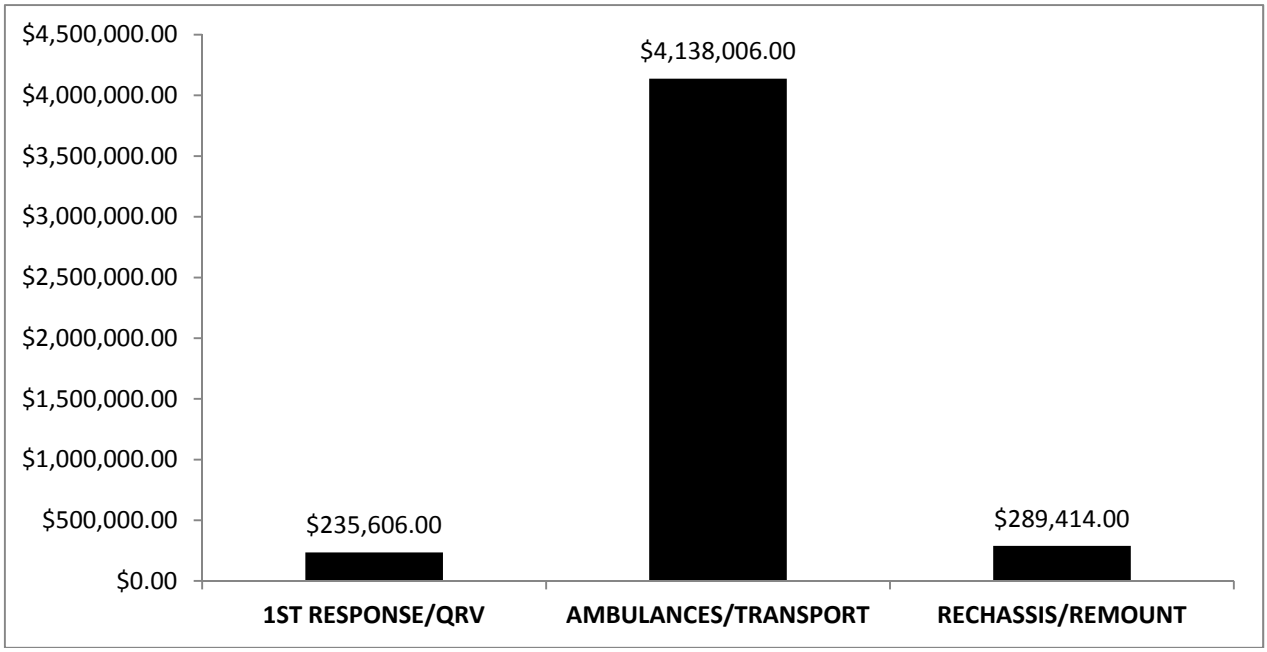
- Audio Visual and Computers - $ 51,431.00
    - Includes projectors, computers, toughbooks, and other audio visual equipment.
- Communications - $ 303,942.00
    - Includes items for mobile/portable radios, pagers, towers, repeaters and other communications system technology.
- Emergency Operations - $ 201,599.00
    - Includes items such as Mass Casualty Incident (MCI) trailers and equipment, extrication equipment, personal protection equipment (PPE) and Health and Medical Emergency Response Team (HMERT) equipment. The Emergency Operations category also includes any other equipment or items needed in order to rapidly mobilize and dispatch help in emergency situations.
- Equipment - Basic and Advanced Life Support Equipment - $ 1,202,595.00
    - Includes any medical care equipment for sustaining life, including defibrillation, airway management, and supplies.
- Special Projects - $ 178,395.00
    - Includes projects such as Recruitment and Retention, Management and Leadership, Special Events Material, regional projects and Emergency Medical Dispatch (EMD) and other innovative programs.
- Training - $ 223,878.00
    - This category includes all training courses and training equipment such as manikins, simulators, skill-trainers and any other equipment or courses needed to teach EMS practices.
- Vehicles - $ 4,663,027.00
    - Includes ambulances, 1st Response/Quick Response Vehicles (QRV), rechassis/remount of ambulances and all-terrain vehicles.

Figure 3: Item Requested by Amount Requested



NOTE: The VEHICLES category request amount was $4,663,027.00, the graph only represents items requested up to $1,500,000.00 to visually display other items requested. A specific category list of vehicles is documented in Figure 4.

Figure 4: Vehicle Category by Amount Requested



The Fall 2011 grant cycle will be awarded on January 1, 2012. The next RSAF Grant cycle will open February 1, 201 and close September 15, 2011.

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

The OEMS Grants Manager will present the Virginia Emergency Medical Services Interoperable Communications (VEMSIC) Project for the 2011 DHS grant submission on November 1, 2011. Each project submitted for interoperability will present to the Office of Veterans Affairs & Homeland Security (OVAHS) to outline the project and answer any questions or concerns. OEMS has requested funding in the amount of $1,865,650.00 for this project which will provide radios, vehicle chargers, mounting kits for vehicular installation and speaker microphones for each licensed patient-transport vehicle for EMS agencies recognized by OEMS as a designated emergency response agency (DERA) as defined by the Virginia Administrative Code 12 VAC 5-31-370.

EMS on the National Scene

II. EMS On the National Scene

a) EMSCAP Focuses on EMS Cost Evaluation

The EMS Cost Analysis Project (EMSCAP) is a collaborative effort between the National Association of State EMS Officials (NASEMSO), E. Brooke Lerner, Graham Nichol, Daniel Spaite, Herbert Garrison, and Ronald Maio. It is a continuation of the Emergency Medical Services Outcomes Project (EMSOP), a recently completed, 5 year National Highway Safety Administration (NHTSA) project intended to support and facilitate emergency medical services (EMS) outcomes research and evaluation. The objective of the EMS Cost Analysis Project is to create a comprehensive framework that would allow users to determine the cost of providing pre-hospital emergency care from a societal prospective. The workbook was pilot-tested in Oshkosh, Wisconsin; Richmond, Virginia; and Livingston County, New York and is now available for download at http://nasemso.org/Projects/EMSCostAnalysis/.

b) New Senate Bill Addresses Air Ambulance Accreditation

Senate Bill 1407 (S 1407), introduced by Senators Snowe and Cantwell, would establish an accreditation process for air ambulances as a requirement for Medicare reimbursement. The bill is the result of efforts by the Association of Critical Care Transport (ACCT). NASEMSO is a non-voting member of their board.
If passed, the bill would

Establish a Medicare accreditation process for air ambulances that recognizes varying levels of accreditation and establishing a quality, capability and patient safety floor to protect all Medicare patients;

Structure a revised Medicare air ambulance fee schedule which will better reflect cost differences for providing services at higher levels of accreditation, promote high quality care, and preserve and enhance timely access to air ambulance services, particularly in rural areas;

Promote appropriate utilization and transport of air ambulance services of Medicare and Medicaid beneficiaries;

Require a study of the issues and challenges in ground critical care transport including potential barriers to effective use of ground critical care transport when medically appropriate.
Please note the clarification on page 18 that this bill is not intended to preempt state licensing authority or standards setting. For questions or more information, please contact NASEMSO Program Advisor Kevin McGinnis or the Air Medical Committee Chair, Dr. Robert Bass.

c) 9. S. 911 Companion Bill Introduced in the House of Representatives

Congressmen John Dingell (MI) and Gene Green (TX) have introduced H.R. 2482 the *Public Safety Spectrum and Wireless Innovation Act* as companion legislation to Senate Bill S.911. Dingell and Green's companion bill contained many key legislative principles, and top public safety priorities, including: Allocating the entire 10 MHz D Block within the 700 band to public safety and allow it to be combined with 10 MHz already allocated to public safety for broadband; and Reauthorizing the Federal Communications Commission to conduct spectrum auctions in the future to boost the economy and raise revenue to pay down the debt and fund other programs; and Authorizing voluntary incentive auctions to generate tens of billions in new revenue of up $10 billion for debt reduction and $11 billion to help fund the nationwide interoperable public safety broadband network. Like S.911, this legislation meets a still outstanding recommendation of the bipartisan 9/11 Commission. This bill is being supported by the Public Safety Alliance (PSA) and its member organizations, including NASEMSO, and does largely mirror S. 911 although it does have some differences.

d) FCC Strengthens Enhanced 911 Location Accuracy Requirements

The Federal Communications Commission (FCC) has taken action to enhance the public's ability to contact emergency services during times of crisis and to enable public safety personnel to obtain more accurate information regarding the location of the caller. Specifically, the Commission strengthened the Enhanced 911 (E911) location accuracy rules for wireless carriers and sought comment on improving both 911 availability and E911 location determination for Voice over Internet Protocol (VoIP) services. The Commission announced that after the conclusion of the eight-year implementation period in early 2019, it will sunset the existing network-based rule and require all wireless carriers to meet the more stringent location accuracy standards in the handset-based rule. The Commission will set a specific sunset date for the network-based standard at a later date, after further notice and comment. The Commission also required new wireless network carriers to meet the handset-based accuracy standard going forward and that all wireless carriers to test their E911 location accuracy results periodically and to share the results with PSAPs, state 911 offices, and the Commission, subject to confidentiality safeguards.

e) NEMSIS: Save the Date for Software Developer's Meeting

The National EMS Information System (EMSIS) Technical Assistance Center (TAC) conducted a Software Developer's Meeting in Salt Lake City on September 21st and 22nd. The purpose of this meeting was to familiarize attendees with the new NEMSIS V3 products, answer questions regarding implementation and to discuss general ideas regarding integration of national and local EMS data reporting.

f) DHS Provides Progress Report on Implementation of 9/11 Commission Recommendations

The United States has made significant progress in securing the nation from terrorism since the September 11, 2001 attacks. Following 9/11, the federal government moved quickly to develop a security framework to protect our country from large-scale attacks directed from abroad, while enhancing federal, state, and local capabilities to prepare for, respond to, and recover from threats and disasters at home. A key element of this framework included the creation of the Department of Homeland Security (DHS) in March, 2003, bringing together 22 separate agencies and offices into a single, Cabinet-level department. Many of the features of this new, more robust enterprise align with – and respond to – recommendations contained in the 9/11 Commission Report, released in July 2004 to assess the circumstances surrounding 9/11 and to identify ways to guard against future terrorist attacks. In recognition of the 9/11 Commission Report and the tenth anniversary of 9/11, a new report describes how DHS has addressed specific 9/11 Commission recommendations over the past ten years.

g) EMI Course Highlights Utilization of EMAC

he Emergency Management Institute in Emmitsburg, MD will offer *E431 Understanding the Emergency Management Assistance Compact (EMAC)* in October 2011 and again in April 2012. This course enables emergency management personnel and response and recovery personnel from all political jurisdictions including EMS to more effectively understand, activate, implement, and utilize the EMAC system. Emergency management personnel and response and recovery personnel who can be legally deployed through the EMAC system, persons officially responsible for requesting and providing EMAC assistance, and those individuals desiring a more comprehensive working knowledge of the EMAC system should consider this course.

h) HHS Toolkit of Public Health Emergency Text Messages Now Available

A new toolkit of prepared cell phone text messages advising people how to protect their health after a disaster is available now through the U.S. Department of Health and Human Services. These messages support state and local emergency managers in disaster response and are available online at http://emergency.cdc.gov/disasters/psa. Messages are limited to 115 characters or fewer including spaces. Emergency responders can use the messages as they are or tailor the messages based on specific local needs. The toolkit currently features text messages relevant to hurricanes, floods and earthquakes. Local and state agencies register their interest in using the toolkit by providing contact information to HHS, so they can receive alerts and updates as the content expands to include health tips for additional types of disasters. More than 400 agencies have registered so far. Agencies register by email: publichealthemergency@hhs.gov.

i) GAO Issues Letter Report on CBRN Interagency Collaboration

The anthrax attacks of 2001 and more recent national reports have raised concerns that the United States is vulnerable to attacks with chemical, biological, radiological, and nuclear (CBRN) agents. Because of the potential consequences of such attacks, members of Congress have expressed the need for the Departments of Homeland Security (DHS) and Health and Human Services (HHS) to coordinate in assessing risks posed by CBRN agents. GAO was asked to examine how DHS and HHS coordinate on the development of CBRN risk assessments and the extent to which they have institutionalized such efforts. GAO examined relevant laws, presidential directives, collaboration best practices, and internal control standards; analyzed DHS and HHS CBRN risk assessments; and interviewed DHS and HHS officials. *National Preparedness: DHS and HHS Can Further Strengthen Coordination for Chemical, Biological, Radiological, and Nuclear Risk Assessments*, GAO-11-606, is now available.

j) Bipartisan House Bill Aims at Bioterrorism and Support for First Responders

Rep. Bill Pascrell, Jr. (NJ) and Rep. Peter T. King (NY), Chairman of the House Committee on Homeland Security (CHS), introduced legislation that will begin implementing the recommendations of the Weapons of Mass Destruction Commission. "*The Weapons of Mass Destruction Prevention and Preparedness Act of 2011*" (H.R. 2356) would improve U.S. efforts to prevent, protect, respond, and recover from a weapon of mass destruction (WMD) attack in the United States. The legislation addresses the nation's readiness for a biological weapons attack by calling for the appointment of a special assistant to the President for biodefense to coordinate federal biodefense policy, the development of a national biodefense plan and a coordinated budget that assess capability gaps and spending inefficiencies, a national biosurveillance strategy, provisions for first responders including voluntary vaccinations and response guidance for chemical, biological, radiological, and nuclear incidents, and authorization of the Securing the Cities program to allow for interdiction of a radiological device in high-risk cities.

k) DHS Communities of Practice Network Connects Homeland Security Disciplines

The First Responder Communities of Practice is a professional networking, collaboration and communication platform created by the Department of Homeland Security Science & Technology Directorate to support improved collaboration and information sharing amongst the nation's First Responders and other Federal, State, Tribal, Territorial, and local governments supporting homeland security efforts. This vetted community of members focuses on emergency preparedness, response, recovery and other homeland security issues. The Emergency Medical Services (EMS) Community provides a platform for those in the EMS field to find and share EMS-related information, resources, best

practices, lessons learned, and policies. Focus areas include rural and urban EMS issues and EMS advocacy.

l) CDC Public Health Emergency Response Guide Version 2.0 Now Available

State, local, and tribal health departments play an extremely important role in all-hazards emergency preparedness and response. Public health professionals within these departments should have immediate access to guidance and information that will assist them in rapidly establishing priorities and undertaking necessary actions during the response to an emergency or disaster. The National Center for Environmental Health (NCEH), Division of Emergency and Environmental Health Services (EEHS) has developed an all-hazards public health emergency response guide to address this need. The *Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors* is an all-hazards reference tool for health professionals who are responsible for initiating the public health response during the first 24 hours (i.e., the acute phase) of an emergency or disaster.
The Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors – Version 2.0 is now available on the Centers for Disease Control and Prevention (CDC) Emergency Preparedness and Response Web site. Updates included in this version of the guide primarily reflect changes in national level plans, programs, guidance, incident management systems, and terminology since its original release in November 2004.

m) CoAEMSP Announces Revision to Policy Manual

A new policy on Personnel Changes in "Key Personnel" (i.e., Program Director and Medical Director) has been incorporated into the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) Policies & Procedures Manual, which is available on the website. It is Policy XII and defines such things as vacancies, absences, and replacements (temporary, acting) as well as timetables for reporting changes to CoAEMSP. The policies are effective as of July 11, 2011.

n) NAEMSE Offers Implementing National EMS Education Standards Workshop for Educators

The National Association of EMS Educators (NAEMSE) workshop for the Implementation of the National EMS Education Standards is designed to provide a framework upon which EMS Educators will build curricula and assessment based on the National EMS Education Standards. The transition to standards based education is a process that begins with a clear understanding of what education standards are and how to develop benchmarks upon which curricula is designed and competency assessment measures are performed. The workshop is designed to examine the standards themselves for clarity and understanding. Interactive sessions will review ways to develop curriculum, classroom activities and lessons that address the content of the standards in ways that enhance student learning. Lastly, the workshop will address the manner in

which student learning is assessed and measured from an outcome-based approach. This is essential for the accurate measurement of student proficiency according to the standards; and will present strategies through which an instructor will maintain accountability for student learning, and a system for continuous quality improvement. For any questions, please contact NAEMSE, 250 Mt. Lebanon Blvd., Suite 209, Pittsburgh, PA 15234. E-mail: naemse@naemse.org.

o) NHTSA Efforts Culminate in Release of EMS Workforce Agenda

The National Highway Traffic Safety Administration (NHTSA) Office of Emergency Medical Services (OEMS) has released the EMS Workforce Agenda for the Future (EMS Workforce Agenda). The EMS Workforce Agenda was prepared by the University of California San Francisco with funding from NHTSA and the Emergency Medical Services for Children program at the Health Resources and Services Administration. Download the EMS Workforce Agenda here or online at www.ems.gov under the workforce tab.

p) HHS Office of Women's Health Focuses on Women and Heart Attacks

The ***Make the Call. Don't Miss a Beat*** is a national public education campaign that aims to educate, engage, and empower women and their families to learn the seven most common symptoms of a heart attack and encourage them to call 9-1-1 as soon as those symptoms arise. A woman suffers a heart attack every 90 seconds in the United States. Yet according to a 2009 American Heart Association survey only half of women indicated they would call 9-1-1 if they thought they were having a heart attack and few were aware of the most common heart attack symptoms. The campaign, developed by the U.S. Department of Health and Human Services' Office on Women's Health, encourages woman to make the call to 9-1-1 immediately if they experience one or more of the heart attack symptoms. For more information http://www.womenshealth.gov/heartattack/

q) CMS Seeks Comment on Ambulance Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) recently posted proposed revisions to the Ambulance Fee Schedule via the Federal Register. This proposed rule would revise the ambulance fee schedule regulations to conform to statutory changes, specifically extending the payment add-ons (implemented in 2008) for another year. In addition, air ambulance areas that were designated as rural on December 31, 2006, and were subsequently re-designated as urban, CMS proposes re-establishing the ``rural'' indicator on the ZIP Code file for air ambulance services through December 31, 2011. Finally, the proposal addresses the extension of the "rural bonus" payment. Please visit the CMS Website at: http://www.cms.gov/AmbulanceFeeSchedule/02_afspuf.asp.

r) New EMS Research Course at the National Fire Academy

The United States Fire Administration (USFA), Department of Homeland Security, is conducting a pilot course at the National Emergency Training Center (NETC) in

Emmitsburg, Maryland for the newly developed 6-day course *Hot Topics Research for Emergency Medical Services (P-139)*. The National Fire Academy (NFA) will be delivering two pilot offerings. The first pilot was conducted October 30 – November 4, 2011. The second pilot offering will be January 29 – February 3, 2012. This 6-day course provides the knowledge and skills to identify and research hot topics in Emergency Medical Services to ultimately identify, promote and embrace system or service improvements.

In related news, the NFA is seeking Subject Matter Experts for National Fire Academy Course Developments. The USFA's National Fire Academy wishes to increase its pool of subject matter experts for potential course developments. Subject matter experts are compensated for their work. NFA is seeking experts in the following areas: Arson, Fire and Explosion Investigation; Fire Prevention: Public Education; Fire Prevention Technology and Codes; Fire Prevention: Management; Hazardous Materials; Training and Education Program Management; Planning and Information Management; Emergency Medical Services; First Responders Health, Wellness and Safety; Incident Command and Control; and Management Science. If you are interested, please submit your resume and areas of interest to Deputy Superintendent Robert A. Neale at robert.neale@dhs.gov.

s) Association Between Ambulance Diversion And Survival Among Patients with Acute Myocardial Infarction (JAMA. Published Online June 2011)

For a patient suffering from an acute myocardial infarction (AMI), the best choice for care is the nearest hospital emergency department (ED). That care, however, is not available when ambulances are diverted from an ED—either because of shortages of staff or inpatient beds, or major equipment failures. Patients then have to travel further to an ED and possibly wait longer for care. To find the effect of ambulance diversion on patient outcomes, researchers looked at Medicare data for four California counties that account for 63 percent of the state's population. They obtained daily diversion logs from local agencies and excluded diversions that would not affect the admission of AMI patients. Conclusion: Among Medicare patients with AMI in 4 populous California counties, exposure to at least 12 hours of diversion by the nearest ED was associated with increased 30-day, 90-day, 9-month, and 1-year mortality. Free abstract…

t) Out-of-Hospital Cardiac Arrest Surveillance — Cardiac Arrest Registry to Enhance Survival (CARES), United States, October 1, 2005–December 31, 2010 (Centers for Disease Control and Prevention. 2011)

This report provides surveillance data on out-of-hospital cardiac arrest events that occurred in the United States during October 1, 2005–December 31, 2010. This is the first report to provide summary data from an OHCA surveillance registry in the United States. Each year, approximately 300,000 persons in the United States experience an OHCA; approximately 92% of persons who experience an OHCA event die. The majority of persons who experience an OHCA event do not receive bystander-assisted cardiopulmonary resuscitation or other timely interventions that improve the likelihood of

survival to hospital discharge (e.g., defibrillation). Efforts to increase survival rates should focus on timely and effective delivery of interventions by bystanders and emergency medical services (EMS) personnel.

u) Prehospital Notification by Emergency Medical Services Reduces Delays in Stroke Evaluation.

Findings from the North Carolina Stroke Care Collaborative, *Stroke* 2011 Jun 9, concluded that individuals with stroke-like symptoms are recommended to receive rapid diagnostic evaluation and emergency medical services (EMS) transport, compared with private modes, and hospital notification before arrival may reduce delays in evaluation. This study estimated associations between hospital arrival modes (EMS or private and with or without EMS pre-notification) and times for completion and interpretation of initial brain imaging in patients with presumed stroke. Conclusion: Patients with presumed stroke arriving to the hospital by EMS were more likely to receive brain imaging and have it interpreted by a physician in a timely manner than those arriving by private transport. Moreover, EMS arrivals with hospital pre-notification experienced the most rapid evaluation.

National Association of State EMS Officials (NASEMSO)

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

v) NASEMSO Supports Funding for US Poison Control Centers

NASEMSO has signed onto a letter with the American Academy of Pediatrics and 21 other stakeholder organizations to the leaders of the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and the U.S. House Appropriations Subcommittee on Labor, Health and Human Services, and Education. The letter supports funding for U.S. poison control centers. As organizations committed to the health and well-being of our nation's children and families, the signers encouraged restoration of funding for the network of highly effective, cost-efficient poison control centers to $29.3 million in the FY 2012 Labor-HHS-Education Appropriations legislation. Since initially authorized by Congress in 2000, federal funding for poison control centers has received significant bipartisan support. In FY 2010, Congress allocated $29.3 million in funding to supplement local and state support for the 57 poison control centers that serve our nation every day. Unfortunately, Congress reduced funding for poison control centers almost 25 percent in FY 2011 to $22 million. It is necessary for Congress to restore poison control center funding and reject the fiscally unwise and illogical cuts to this very successful national public health program. All advocacy letters supported by NASEMSO are posted on the Association's web site at www.nasemso.org.

w) NASEMSO Congratulates Dr. Carol Cunningham on NPLI Achievement

NASEMSO Medical Director Council Chair Carol Cunningham, MD, FACEP, FAAEM, recently completed the Harvard Kennedy School's National Preparedness Leadership Initiative (NPLI). As the State Medical Director for the Ohio Department of Public Safety, Division of Emergency Medical Services, Dr. Cunningham was one of 50 government leaders with homeland security responsibility selected to complete the national leadership program. The NPLI, a joint program of the Harvard School of Public Health and Kennedy School of Government, began with one week on the Cambridge campus followed by a five-month period during which leadership projects were completed. Dr. Cunningham was the lead writer and presenter of her group project at the concluding seminar at Harvard University.

x) OEMS Director elected to NASEMSO Executive Committee

Gary R. Brown, Director, Office of Emergency Medical Services, Virginia Department of Health was elected by his peers to the Executive Committee of the National Association of State EMS Officials at their annual meeting held in Madison, Wisconsin October 3-7, 2011.

Educational Development

III. Educational Development

Committees

A. **The Training and Certification Committee** (TCC): The committee did not meet in October as there were no action items to consider.

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

B. **The Medical Direction Committee (MDC)** The Medical Direction Committee meeting was held at the Office of EMS, 1041 Technology Park Dr, Glen Allen, Virginia on October 6, 2011.

1. **White Paper: Termination of Resuscitation** is forwarded as an action item for endorsement by the state EMS Advisory Board. Please refer to **Attachment A.**

2. **White Paper: Cervical Spine Clearance** is also forwarded as an action item for endorsement by the state EMS Advisory Board. Please refer to **Attachment B.**

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

National Registry of EMTs Certification Test Proposal

The National Registry of EMTs Certification Test Proposal endorsed at the August 2011 state EMS Advisory Board meeting was forwarded to Virginia Department of Health for consideration. The Health Department supports the proposal except for the recommendation to fund initial certification attempts by EMR and EMT. Due to current economic conditions, there is concern about the sustainability of the funding stream. The Department is reluctant to establish a process without the ability to dedicate funds for this purpose. The Office has been requested to identify alternative funding sources and recommend a process to consider funding examination fees in cases of genuine need.

As indicated above, all other components of the certification test proposal are fully supported. The Office will continue to move toward the implementation of this proposal with an anticipated implementation date of July 1, 2012. OEMS welcomes any suggestions for funding this initiative.

Advanced Life Support Program

A. Deborah Akers, has been hired to fill the position of ALS Training Specialist. Debbie comes to us from the Western Virginia EMS Council where she functioned as the "Regional Education Coordinator." Debbie has a vast amount experience in various components of the EMS system which includes volunteer provider, director for an accredited EMS educational program, active involvement on the national EMS scene, EMT Instructor and an ALS Coordinator. The office is excited that Debbie accepted the position and looks forward to working with her.

Basic Life Support Program

A. Instructor Institutes

1. The Office held an EMT Instructor Institute in October at the Office of EMS in Glen Allen, VA. 13 Candidates attended, 11 were certified as EMT-Instructors and two received Conditional Status.
2. The next EMT Instructor Practical is scheduled for Saturday, December 17, 2011.
3. The next Instructor Institute will be held in Richmond, VA , in January/February 2012.
4. EMS Providers interested in becoming an Instructor or learning about the process of becoming an EMS Education Coordinator please contact Greg Neiman, BLS Training Specialist by e-mail at Gregory.Neiman@vdh.virginia.gov

B. Virginia EMS Education Standards (VEMSES) Exam

1. There have been 135 initial and 18 retest attempts at the exam. The current initial pass rate is 57.78% and the retest pass rate is 72.22%.
2. Current EMT-Instructors/ALS-Coordinators may schedule to take the exam at Regional Consolidated Test Sites (CTS) or at specified locations with the Training Staff.
3. The Office is also offering the exam after in-person updates and ALS-C meetings. Fifteen took the exam after the update at the VAVRS Convention in Virginia Beach on September 24, 2011 and 15 more took it after the EMS Instructor Update held at Henrico Fire on October 8, 2011.

C. EMS Instructor Updates:

1. The Division of Educational Development continues to hold both online and in-person Instructor Updates.

2. Online Updates were held on the first Thursday evening in September. In-person updates were held on Saturday, September 24, 2011 in conjunction with the VAVRS Rescue College in Virginia Beach, VA and at Henrico Fire Training on Saturday, October 8, 2011. Pre-registration is not required to attend.

3. The schedule of future updates can be found on the Web at http://www.vdh.virginia.gov/OEMS/Training/EMS_InstructorSchedule.htm . The 2012 schedule will be posted soon.

EMS Training Funds

Financial Update on FY09, FY10, FY11 and FY12 as of October 18, 2011

FY09

	Commit $	***Payment $***	***Balance $***
BLS Initial Course Funding	$814,237.00	$554,290.52	$259,946.48
BLS CE Course Funding	$113,400.00	$61,976.27	$51,423.73
ALS CE Course Funding	$304,920.00	$102,606.50	$202,313.50
BLS Auxiliary Program	$76,000.00	$19,520.00	$56,480.00
ALS Auxiliary Program	$840,000.00	$184,222.25	$655,777.75
ALS Initial Course Funding	$1,028,861.50	$691,397.59	$337,463.91
Totals	**$3,177,418.50**	**$1,614,013.13**	**$1,563,405.37**

FY10

	Commit $	***Payment $***	***Balance $***
BLS Initial Course Funding	$442,119.00	$281,079.57	$161,039.43
BLS CE Course Funding	$66,360.00	$37,108.00	$29,252.00
ALS CE Course Funding	$194,880.00	$83,437.50	$111,442.50
BLS Auxiliary Program	$128,000.00	$13,280.00	$114,720.00
ALS Auxiliary Program	$476,000.00	$97,480.00	$378,520.00
ALS Initial Course Funding	$844,815.00	$455,611.54	$389,203.46
Totals	**$2,152,174.00**	**$967,996.61**	**$1,184,177.39**

FY11

	Commit $	***Payment $***	***Balance $***
BLS Initial Course Funding	$787,116.00	$471,172.81	$315,943.19
BLS CE Course Funding	$84,000.00	$34,842.50	$49,157.50
ALS CE Course Funding	$235,200.00	$100,642.50	$134,557.50
BLS Auxiliary Program	$98,000.00	$11,800.00	$86,200.00
ALS Auxiliary Program	$391,680.00	$121,080.00	$270,600.00
ALS Initial Course Funding	$1,057,536.00	$468,257.32	$589,278.68
Totals	**$2,653,532.00**	**$1,208,293.53**	**$1,445,238.47**

FY12

	Commit $	*Payment $*	*Balance $*
BLS Initial Course Funding	$578,967.00	$105,079.62	$473,887.38
BLS CE Course Funding	$86,520.00	$5,057.50	$81,462.50
ALS CE Course Funding	$221,760.00	$7,402.50	$214,357.50
BLS Auxiliary Program	$66,000.00	$0.00	$66,000.00
ALS Auxiliary Program	$244,000.00	$23,680.00	$220,320.00
ALS Initial Course Funding	$1,071,000.00	$323,850.00	$747,150.00
Totals	**$2,280,487.00**	**$465,069.62**	**$1,815,417.38**

EMS Education Program Accreditation

A. EMT accreditation program.
    1. Emergency Medical Technician (EMT)
        a) No applications on file.
    2. Advanced Emergency Medical Technician (AEMT)
        a) No applications on file.
    3. Intermediate – Reaccreditation
        a) John Tyler Community College
            (1) Incomplete application received and on file
        b) Rappahannock Community College
            (1) Application received and on file
            (2) Site Visit Team Assigned
            (3) Site Visit Scheduled and Conducted on July 11 and 12, 2011.
            (4) Conditional grant of accreditation awarded.
        c) Norfolk Fire-Rescue
            (1) Application received and on file
            (2) Site Visit Team Assigned
            (3) Site Visit Scheduled for August 11 and 12, 2011.
            (4) Full accreditation granted for 5 years.
    2. Intermediate – Initial
        a) City of Hampton Fire
            (1) Application received and on file
            (2) Site Visit Team Assigned
            (3) Site Visit Scheduled for December 8/9, 2011.
    3. Paramedic – Initial
        a) No applications on file.

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

C. Beginning January 1, 2013, paramedic students who are candidates for certification testing through the National Registry of EMT's (NREMT – www.nremt.org) are required to have graduated from a nationally accredited paramedic program—national accreditation is offered through the *Committee on Accreditation of Educational Programs for the EMS Professions* (CoAEMSP – www.coaemsp.org).

1. Virginia is well positioned to ensure that students completing paramedic training programs in the Commonwealth will be eligible to test NREMT beginning January 1, 2013.
2. Of 16 accredited paramedic training programs, there are only a handful of programs which still need to obtain national accreditation through CoAEMSP/CAAHEP.
    a) Lord Fairfax Community College
        (1) Has submitted their self-study to CoAEMSP and is awaiting a site visit from the national accrediting body.
    b) Patrick Henry Community College
    c) Rappahannock EMS Council Paramedic Program
    d) Southside Community College
        (1) Has submitted their self-study to CoAEMSP..
        (2) CoAEMSP site visit scheduled for December 1/2, 2011.
    e) Prince William County Paramedic Program

On Line EMS Continuing Education

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

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

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

EMSAT

A. The Virginia Office of EMS is looking for a few good men (and women) to teach EMSAT programs with a potential audience of 35,000 EMS and Fire personnel. If you know an instructor who not only can "walk the

walk" but can also "talk the talk", contact EMSAT producer Mr. Terry Coy at OEMS. A good instructor should have public speaking skills, come up with interesting and believable simulations and possess excellent teaching resources such as pictures, graphics, CDs and case studies. Each EMSAT program is viewed by thousands of your peers here in Virginia.

B. EMSAT programs for the next three months include:
   1. Nov. 16, Head Injuries
   2. Dec. 21, Communicable Diseases on the Rise
   3. Jan. 18, Behavioral Emergencies

The EMS Provider Portal

The Office extends an appreciation to all EMS constituents who are assisting in promoting the EMS Provider Portal. As of October 14, 2011, provider compliance is at 57%--a 3% increase from July 2011. The Office is hoping for full compliance before the end of the year. We will keep this as part of the report as a reminder to encourage your EMS peers that have not logged into the portal, to do so. As the portal expands to EMS agencies, it will be most important that all providers have an active and up to date portal.

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

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

NEW!!

For the past year, the Office of EMS has been developing an improved system for tracking EMS provider agency affiliation as well as expanding agency administrative access to affiliated provider data/records. We are aiming to launch these new features on the evening of December 5, 2011—please note, this date is subject to change.

These new agency specific features have been built into the existing EMS Portal—utilized by EMS Providers and Instructors alike—which will enable EMS agency administrators to delegate authority and access to their affiliated personnel.

This new system will implement 'real-time' access to records and increase the security surrounding access to EMS provider and agency data. We will be moving away from a 'single login and password' shared by numerous EMS agency personnel to unique user logins where transactions can be more easily tracked.

In order to ensure a smooth transition to this new system, the office will be conducting training for EMS agency administrators during the Virginia EMS Symposium and online via webinar from November 14-19, 2011.

Other Activities

A. The office welcomes Mr. Peter Brown as the new OEMS Certification Examiner Supervisor. Pete will organize, train and improve standardization of EMS certification testing. Pete is working with the program representatives as the office transitions testing from Regulation and Compliance to the Division of Educational Development. This process will take some time, so we ask for your patience. Additional information about future changes in the EMS certification process will be forthcoming.
B. The office would also like to welcome new ALS Test representatives. Although not new to most of you, they are part of the wage positions the office has created to address the certification examiners position. The new wage employees are:
    1. Larry Oliver
    2. Michael Staats
    3. Bradley Ayers
    4. Mark Cromer

Emergency Operations

IV. Emergency Operations

Operations

- **Virginia 1 DMAT**

At the August Va-1 DMAT training session the team practices their skills in response to a political convention disaster. Triage and treatment along with additional hands on training with the electronic medical records system was practiced. Our September Leadership meeting reviewed some of the additional training that team member have received to be part of DMAT specialty teams. Va-1 DMAT has increased their roster activity necessary for the new team concepts. October's meeting provided orientation for new members and also the opportunity o go through the fingerprinting requirement for those new members that were eligible. Va-1 DMAT will celebrate "DMAT day" at the Virginia EMS Symposium on November 11, 2011.

Jim Nogle, Emergency Operations Manager, Frank Cheatham, HMERT Coordinator, and Gary Brown, OEMS Director continues to attend the meetings.

- **Hurricane Irene**

With the landfall of Hurricane Irene and projected path expected to impact Virginia, several Health and Medical Emergency Response Teams were placed on alert throughout the weekend. After impact the Office of EMS received a request for EMS assets to be deployed to New Kent County, as that locality received a significant hit from the effects of the Hurricane. Thomas Jefferson 2 was deployed for a period of two days and, at the request of New Kent, a second task force, Western 14 was sent for another two day period to assist in continued recovery operations. Office of EMS staff also assisted in staffing the state Emergency Operations Center during the event.

- **HMERT Operations**

Frank Cheatham, The HMERT coordinator also continued working with Harrisonburg in setting up a new Task Force, Harrisonburg 16. The HMERT Coordinator conducted training with Western 14 Task Force as a part of their continuing effort in keeping their members up to date.

- **VDH Statewide Exercise**

Winnie Pennington, Emergency Planner, participated in the VDH Statewide Exercise on June 22, 2011. She served as a liaison to provide EMS information during the exercise. Winnie also participated in the After Action Meeting to review the activities and lessons learned during the exercise.

- **Hosting VEOC Tour for German Paramedics**

Planner set up and assisted with tour for German EMS exchange students hosted by VAVRS to the Virginia Emergency Operations Center on September 28. Students were employees of the German Red Cross and were very impressed with Virginia's emergency management organization.

- **VAVRS Convention**

Ken Crumpler, Communications Coordinator, attended the Virginia Association of Volunteer Rescue Squads Annual Convention in Virginia Beach from September 22-25, 2011. During the event, Ken staffed the OEMS booth and answered questions of attendees.

Planning and Preparedness

- **VERT Staff Handbook Update**

Winnie Pennington, Emergency Planner, reviewed and updated OEMS VERT staff handbook and posted updates

- **OEMS BEEP**

Winnie Pennington, Emergency Planner, updated the office building emergency and evacuation plan to include instructions for earthquakes

Committees/Meetings

- **Hurricane Evacuation**

Frank Cheatham, HMERT Coordinator, continues to participate in the Hampton Roads Hurricane Evacuation Committee meetings. Frank, along with Jim Nogle and Karen Owens, attended a meeting with Bob Mauskapf and Lt. Col. Shelton of VSP in reference to Hurricane Evacuation held at VSP Headquarters.

- **EP&R Team Meetings**

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

- **COOP Committee**

Winnie Pennington, Emergency Planner convened the COOP Committee on October 25. Committee will be addressing issues from 2011 COOP EX which include; standardizing information sheets for employees, referencing policy in the plan, listing vendors, capturing seasonal tasks, storage of records, just-in-time training and training aids, inclusion of an Organizational Chart in the plan, and a check list of operational authorities.

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

A meeting of the CISM Committee was held October 20, 2011. The meeting focused on the finalizing the accreditation process for CISM teams and discussing the new Health and Safety focus within the OEMS.

- **Virginia Strategic Highway Safety Plan Committee**

Frank Cheatham began attending the Strategic Highway Safety Plan meetings held at the Virginia Department of Transportation facility, as a representative of the OEMS.

- **Traffic Incident Management (TIM)**

Frank Cheatham, HMERT Coordinator, continues to work on a Traffic Incident Management Program with VDOT and other agencies. There was a video shoot in Blacksburg that Frank attended. Frank also began participating in another TIM Committee with various heads of State Agencies held at VSP Headquarters chaired by Col Flaherty.

- **ChemPack**

Karen Owens, Emergency Operations Assistant Manager, continues to participate in teleconferences discussing the development and implementation of Chem Pack Training for EMS personnel.

- **EMS Communications Committee**

The EMS Communications Committee held its quarterly meeting on August 12, 2011 in Richmond at the Office of Emergency Medical Services. Discussion included OEMS PSAP reaccreditation standards being modified to require PSAP's to maintain an 85% or greater score for compliance with EMD protocols through quality assurance/quality improvement review. Additional documentation was reviewed regarding a White Paper to be compiled by the committee for presentation to varied groups promoting the employment of EMD protocols to agencies and jurisdiction not yet providing that service to its citizens. Committee member Richard Rubino was tasked with preparing a one sheet informational flyer to educate responders on the upcoming FCC Narrowbanding mandate. OEMS PSAP Accreditation and updates were also discussed.

Training

- **Vehicle Rescue Training Course**

The Division of Emergency Operations hosted a Vehicle Rescue Training Course in South Boston October 22-23, 2011. The course, attended by 30 students, provides training in extricating patients from vehicles after a motor vehicle crash. Frank Cheatham, HMERT Coordinator, attended the training to serve as Logistics support for the program

- **VDH COOP Checklist Review**

Winnie Pennington, Emergency Planner, developed and presented one session of training for staff in completion of VDH Employee COOP Checklist. This is a check list that must be completed by every VDH employee by the calendar close of each year. Employees who missed the first training will attend the make-up on November 30.

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

Winnie Pennington continues to develop bi-annual training for the VERT staff to assist in their readiness to respond.

- **Governor's Cabinet Exercise**

On October 24, 2011 Jim Nogle, Emergency Operations Manager attended a Cabinet level exercise at the Virginia Emergency Operations Center. The exercise focused on a potential radiological event with patient exposure.

Communications

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

Ken Crumpler visited Culpeper County 9-1-1 center, Prince William Co. 9-1-1 center and Nelson County 9-1-1 center for biannual OEMS PSAP reaccreditation. All training and certifications were in order, assistance will be provided with documentation for quality assurance/quality improvement.

- **EMS Communications Directory**

Through the Virginia chapters of APCO and NENA listserves, updated information was gathered to edit the EMS Communications Directory on the OEMS website. This information has been entered into the directory and submitted to DGS Office of Graphic Communications.

Planning and Regional Coordination

V. Planning and Regional Coordination

Regional EMS Councils

The Regional EMS Councils submitted First Quarter contract reports throughout the month of October. Submitted deliverable items are under review by OEMS. The EMS Systems Planner provided the Regional EMS Council Executive Directors with a revised reporting template, in order to streamline the deliverables reporting process.

The EMS Systems Planner attended regional award programs for the Southwest Virginia EMS Council, and attended the regular meeting of the Peninsulas EMS Council Board of Directors.

Medevac Program

The Medevac Committee met on November 9, 2011. The minutes were not available at the time of the submission of the state EMS Advisory Board quarterly report. At a prior meeting, Dr. Remley tasked the State Medevac committee to examine the future condition of air medical medicine in Virginia. Dr. Remley's directive also tasks the committee to partner with other stakeholders to propose a comprehensive voluntary statewide network committed to safety, access and quality. This project continues to evolve with the additional input of the Medical Direction Committee.

There have been several updates to the Medevac WeatherSafe application. Over the past few months, the EMS Systems Planner has been working with medevac system stakeholders, as well as representatives of the VHHA to build in an online landing zone directory. The directory includes essential information on landing zones for each medical facility in Virginia, including latitude and longitude, dimensions and weight capacity, radio frequencies, and photos of the landing zone site. Also, a hazard notification has also been built in to the application, so that medevac services can be notified if there is a hazard (or potential hazard) near any landing zone, such as a construction crane. There is also a module built in for agencies to report their air transport status (number of units in service, patient capacity, and if a unit is out of service, the reason) this could be essential in mass casualty situations.

In terms of weather turndowns, there have been over 1,400 turndowns due to weather since January 1…not only does this show dedication to the program itself, but also to maintaining safety of medevac personnel and equipment.

OEMS and Medevac stakeholders continue to monitor developments regarding federal legislation and other documents related to Medevac safety and regulation. These documents can be found on the Medevac page of the OEMS web site.

State EMS Plan

The Virginia Office of EMS Strategic and Operational Plan is mandated through *The Code of Virginia* to be reviewed and revised on a triennial basis. The current version of the plan was approved by the State Board of Health in March of 2011. There have been no changes to the plan since that approval.

Public Information & Education

VI. Public Information and Education

Symposium

Registration for the symposium closed on Sept. 30, but we kept it open for an extra week to allow for additional registrations. The final registration number is 1671 participants, faculty and staff.

PI&E produced and sent out a promotional brochure to all affiliated EMS providers to increase visibility of the program and boost registrations. PI&E also worked to promote the career fair by sending information to EMS Agencies, accredited training sites and more.

We also have been working on many of the planning and logistics aspects for symposium like registration, signage, producing the on-site guide more. We are also coordinating with VDH Emergency Preparedness and the Norfolk Health Department to provide flu and Tdap vaccines to the symposium participants.

We are also involved with the planning for the 2012 symposium and have sent out the request for the call for presentations to previous faculty, EMS instructors and more.

Governors Awards

The awards committee met on August 19th to discuss the nominees and select the winners. The winners will be announced during the Governor's EMS Awards Reception at symposium.

PI&E has been working on the logistics and the details for the awards reception. We coordinated with the Governor's Office to get the certificate and ordered the pyramids. We sent the invitations to all the nominees.

PI&E is also working with the awards committee to create new awards nomination packets and questions to better ensure that the nominees are in the best category and are deserving of this honor. We will are also working on a new strategic marketing plan to promote the program for next year.

Marketing & Promotion

Pertussis

With the increase in the cases of pertussis in Virginia, PI&E has been working to provide information to EMS providers about the importance of getting the Tdap vaccine, as healthcare providers, they may come into contact with infected patients or may be around

children who are susceptible. Information has been provided through the EMS Bulletin, social media and the website.

National Preparedness Month

National Preparedness Month was recognized during September and PI&E posted the official web banner on the OEMS page, we tweeted messages about preparedness and focused on EMS providers and their role in emergencies and being prepared.

Hurricane and Earthquake Response

PI&E staff provided updates and information for EMS providers on the earthquake and Hurricane Irene. PI&E Coordinator responded to the Joint Information Center to support VDEM and VDH Communications during Hurricane Irene. As a result of the messages shared via social media on the hurricane, the number of followers on the OEMS twitter site increased.

Emergency Medical Dispatch

PI&E added a page to the website that highlights EMD accredited programs in Virginia, especially the Dispatchers and tells the stories of lives that they have saved through implementing this program. This information was also shared in the EMS Bulletin, and as we continue to get stories and information of successes with this program and lives saved, we will continue to post them on the website and share through our social media.

Summer EMS Bulletin

The Summer EMS Bulletin was distributed electronically and included a variety of articles and information for EMS agencies, providers and other members of the EMS system. The bulletin averages over 20 thousand unique downloads from the OEMS website.

OEMS Media

The PI&E Coordinator worked with Division of Regulations and Compliance on a media request for information about the proposed regulations and their status in the regulatory process and information on changes to the regulations.

VDH Communications

Office of Licensure and Certification –The OEMS PI&E Coordinator provides media coverage and guidance for the Office of Licensure and Certification and continues to

manage media inquiries for the office on a variety of topics like COPN, medical facility complaints and more.

Abortion Clinic Regulations – The PI&E Coordinator has been working with VDH leadership to manage media inquiries about the new legislation that has required abortion clinics to become licensed facilities.

VDH Media Coverage – The OEMS PI&E Coordinator provided support for a variety of media requests for VDH programs. For the month of October, the PI&E Coordinator submits the media alert/contact information to VDH executive management, the Secretary's Office and Governor's Office.

VDH Website and Twitter – The OEMS PI&E Coordinator managed the content for the VDH homepage and Twitter site for September, but still continues to update and monitor the VDH Twitter feed via Tweetdeck.

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

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

Regulation & Compliance

VII. Regulation and Compliance

Compliance

The EMS Program Representatives continue to complete ongoing investigations pertaining to EMS agencies and providers. These investigations relate to issues concerning failure to submit prehospital patient care data (VPHIB), violation of EMS vehicle equipment and supply requirements, failure to secure drugs and drug kits, failure to staff the ambulance with minimum personnel and individuals with criminal convictions. The following is a summary of the Division's activities for the second quarter of 2011:

Enforcement

Citations Issued: 10
Providers: 5
EMS Agencies: 5

Compliance Cases

New Cases:	10	Cases closed:	7
Suspensions:	2	Temporary Suspensions:	2
Revocations:	1		
Consent Order:	0		

EMS Agency Inspections

Licensed EMS agencies:	680 Active				
Permitted EMS Vehicles:	4,283 (Active, Reserve, Temporary)				
Recertification:	Agencies:	90	Vehicles:	514	
New EMS agencies:	2				
Spot Inspections:	47				

Hearings (Formal, IFFC)

July 6, 2011: Byrd

September 9, 2011: Lynchburg Life Saving and First Aid Crew, Priority Patient Transport

Variances

Approved: 14 Disapproved: 3

Consolidated Test Sites
Scheduled: 36 Cancelled: 1

OMD/PCD Endorsements

As of October, 2011: 211 Endorsed

Regulations

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

2. Regulations amending the variance process from HB 1675 to become effective November 1, 2011 (legislation effective July 1, 2011).

Notable Information

"Effective July 1, 2011, an amendment to the *Code of Virginia* requires the issuance of specifically designated licenses plates to all persons providing non-emergency medical transportation for passengers whose trips are arranged through the Department of Medical Assistance Services, or a broker contracted by that agency. Beginning September 1, 2011, law enforcement will issue summons for failure to display the new licenses plates. In addition, the *Code of Virginia* gives DMV the authority to impose civil penalties in an amount up to $1000.00 for non-emergency medical transportation carriers that have failed to comply with this requirement." This notice was sent to all commercial agencies with a September 2011 date. Additional questions can be directed to the Motor Carrier Services, at 1-804-249-5130 or through the website, www.dmvNOW.com.

According to Motor Carrier representatives, there are only four (4) types of vehicle tags for EMS vehicles: locality tags, EV tags (911 services), non-emergency medical transportation tags, and For-Hire tags.

Division Work Activity

1. Regulation and Compliance staff represented the Office of EMS in Fire/EMS studies conducted by the Virginia Fire Service Board for the following jurisdictions: Northampton County (presentation to Board of Supervisors on September 26, 2011), Washington County (presentation scheduled for December 2011) and King George County and Amelia County (study to begin November, 2011).

2. Staff continues to offer technical assistance to EMS agencies, entities and local governments as requested. Staff met with the Board of Supervisors for Brunswick County, Fire Rescue for Campbell County and representatives for Greene County Rescue Squad.

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

4. Compliance staff replacement vehicles have been approved by the VDH administration.

5. The Quarterly staff meeting was held on South Hill, Virginia August 24-26, 2011.

Technical Assistance

VIII. Technical Assistance

EMS Workforce Development Committee

The Workforce Development Committee met on October 19, 2011

The committee was given an update on the Volunteer Rescue Squad Assistance Work Group (VRSAWG) Objectives, Action Plans and Strategies – please refer to **Appendix C.**

The committee identified and discussed the similar goals of the WDC's Standards of Excellence (SoE) program and the VRSAWG agenda;

STANDARDS OF EXCELLENCE ASSISTANCE WORK GROUP	**VOL. RESCUE SQUAD**
(7 Areas of Excellence)	(6 Objectives)
Clinical Care Measures/Standards	Improve Leadership Performance
Community Involvement	Increase and Maintain Membership
Leadership/Management	Implement Public Information Campaign
Life Safety	Implement Sound Financial Practices
Medical Direction	Identify Training and Delivery Gaps
Performance Improvement	Foster Squad and Local Government
Partnerships	
Recruitment & Retention	

The committee decided to postpone a pilot of Standards of Excellence until after January 1, 2012 in order to allow further discussions to be held with VRSAWG regarding a joint approach, collaboration and partnership to assisting Virginia EMS agencies struggling with issues in the areas of recruitment/retention and leadership/management.

The following motion was made as an informational item for the November 2011 State EMS Advisory Board meeting:

"The members of the Workforce Development Committee (WDC) agree that there should be only one Standards of Excellence (SoE) program in the Commonwealth (housed at the Virginia Office of EMS). However, we acknowledge that there are multiple ways to achieve improvement in Virginia EMS agencies. WDC supports the VRSAWG program in their journey to excellence."

Workforce Development Committee Sub-committee Reports:

a) Standards of Excellence

The sub-committee met on October 17, 2011 and discussed the possibility of doing a minimum of 1 regional pilot of the Standards of Excellence program using the Recruitment and Retention and the Leadership and Management Self-Evaluation Survey to assist identified EMS agencies determine opportunities for improvement in these two (2) areas of excellence.

The Office of EMS is planning to work with several participating regional EMS council to offer the opportunity for an EMS Agency (1 or 2 smaller EMS agencies) to improve their organization by participating in a Standard of Excellence (SoE) pilot project. This pilot project would concentrate on EMS agencies that have identified through a self assessment process a need to improve in one or both of the selected areas of excellence (Recruitment and Retention, EMS Leadership and Management) . EMS agencies could also be identified by one of the participating regional EMS Councils.

Each of the EMS agencies selected to participate in the SoE pilot would be paired with a local EMS agency for support and mentoring. In addition, subject matter experts would provide information, coaching and reference material for the EMS agency to use in the improvement process.

b) EMS Officer Standards

The draft of the competencies for EMS Officer I have been completed and include a multi-faceted approach to obtaining the required training for Virginia EMS Officer I. Each candidate will have the choice of using the following avenues (in whole or part) to complete the training requirements:

- Community College courses
- National Fire Academy course
- National Fire Protection Association (NFPA) residency programs
- Virginia Department of Fire Programs (VDFP) courses
- Virginia Office of Emergency Medical Services courses

The sub-committee has requested that the Officer I Standards be reviewed by interested parties for comments and submitted to the State EMS Advisory Board at the first meeting of 2012 for acceptance before the committee moves on to EMS Officer II.

Virginia 2011 EMS Career Fair

The Second Annual EMS Career Fair will be held on Thursday, November 10, 2011 at the EMS Symposium. The event will be held from 5:00 PM (right after classes end) and end at 7:00 PM. There are currently 16 organizations registered for this event.

1. Prince William County Fire
2. Rockingham County Fire
3. City of Fairfax Fire Dept.
4. City of Manassas Fire
5. Life Care Transport
6. Arlington County Fire Dept.
7. First Med/Eastern Ambulance Service
8. City of Alexandria Fire Dept.
9. Eagle Medical Transport
10. Albemarle County Fire
11. Fairfax County Fire and Rescue
12. Jefferson College of Health Science
13. Portsmouth Fire and Rescue
14. Valley Medical Transport
15. Chesapeake Fire Dept.
16. Chesterfield Fire and EMS

There are additional Career Fair spots available. Please contact Ms. Carol Morrow for additional information at carol.morrow@vdh.virginia.gov.

The Virginia Recruitment and Retention (R&R) Network

The Recruitment and Retention Network met on October 7, 2011 at the Culpeper Rescue Squad in Culpeper, Virginia. Gary Dalton and Karen Wagner gave a report on the Volunteer Rescue Squad Assistance Work Group (VRSAWG). There was support from the group to mentor EMS agencies experiencing organizational problems.

A discussion was also held related to alternative methods of delivering EMS courses (including retention classes). The Office of EMS is considering providing courses using a combination of methods to include, but not limited to, pre-course reading material, providing part/all of instructor overview by video streaming – coupled with a local discussion group, etc. This would eliminate some of the travel time to courses – but will require greater planning and coordination.

The next meeting of the Virginia R&R Network will be on Friday, December 2, 2011 in Hanover. Mr. Dave Tesh will give an overview of the Chesterfield Fire Department's Safer grant.

Trauma and Critical Care

IX. Trauma and Critical Care

This section includes:

- EMS for Children
  - Hospital Pediatric Emergency Department Designation
  - Site Visits for Small Rural Hospital EDs
  - Hospital and EMS Agency Survey Data Available
  - Transporting Children in Ambulances
  - PEC Council Look to Identify Pediatric Training/Education Competencies
  - PEPP Instructor Kits to be Updated
- Patient Care Information
  - NEMSIS Version 3 Preparation "Don't say you didn't know"
    - Be contractually prepared for NEMSIS version 3
    - What EMS Software vendors attended the NEMSIS Software Developers meeting
    - Why is Virginia Moving to Version 3 so soon after Version 2
  - VPHIB (Virginia Pre-Hospital Information Bridge)
    - What happened this quarter;
    - What is the rationale used to increase data quality standards
    - Compliance Rate
    - The focus for the upcoming quarter
  - On the technical side
- Trauma Registry (VSTR)
  - VSTR compliance
  - VSTR upgrade
- Trauma System
  - Trauma System Oversight and Management Committee
    - Committee Update
    - Trauma Center Fund
      - Disbursements
- Durable Do Not Resuscitate
  - New regulations took effect on July 20, 2011

Emergency Medical Services for Children (EMSC)

EMSC Committee

The EMS for Children (EMSC) Committee of the EMS Advisory Board had its quarterly meeting October 20, 2011. Meeting dates of the EMSC Committee are tentatively confirmed for 2012 as January 5, March 29, July 12 and October 4.

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

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

The draft criteria for three levels of PED designation were developed by the PED Designation Work Group and have been shared for comment with the EMSC and TSO&M Committees, as well as the Virginia Hospital and Healthcare Association, the VA chapter of the American Association of Pediatrics, the VA chapter of the American College of Emergency Physicians and others. Stakeholder input will shape any final changes to this *voluntary hospital PED designation program* before it is finalized. This project is being undertaken by Virginia's EMSC program to directly address national EMSC Performance Measure 74, which measures "*the percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies"*.

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

The EMSC program is continuing to visit small and rural Virginia hospitals (as dates allow) to assess their pediatric needs and capabilities versus recommended national guidelines. Grant-funded supplies are being distributed to the EDs agreeing to be assessed.

Hospital and EMS Agency Survey Data Available *(Performance Measures 71, 72, 73, 76, 77)*

During the first part of 2011 surveying of EMS agencies and hospitals was conducted in collaboration with the National EMSC Data Analysis Resource Center. EMS agencies were queried in relation to Performance Measures 71, 72 and 73, while hospitals were queried in relation to Performance Measures 76 and 77. The data have been compiled and are now available as handouts for the EMS Advisory Board and at the EMS for Children Symposium Booth; soon they will also be available on the OEMS website.

Broselow™ Tapes and Portable Pediatric Pulse Oximeters *(Performance Measure 73)*

Length-based pediatric resuscitation tapes (for ALS and BLS ambulances) and limited numbers of portable pediatric pulse oximeters (for BLS ambulances) will soon be available for agencies that need them through the EMSC program in the Office of EMS. Details will be soon distributed and will also be available on the OEMS website.

Transporting Children in Ambulances *(Performance Measure 80)*

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

Pediatric Emergency Care Council Looks to Identify Pediatric Training/Education Competencies

The PEC Council met October 3-4, 2011 at the annual meeting of the National Association of State EMS Officials (NASEMSO). The council, composed of EMSC managers from all 50 states and 6 US protectorates works on national issues concerning emergency care and children, providing input to NASEMSO and advising its federal partners and policymakers on pediatric issues. In addition to several ongoing projects, the Council is working to help identify appropriate minimum levels of pediatric education/training for EMS provider certification/license renewal in the future.

PEPP Instructor Resource Kits to be Updated

Updated PEPP (Pediatric Education for Prehospital Professionals) Instructor Resource Kits will be purchased and provided to the PEPP instructors trained two and a half years ago as part of the *Continuing Concepts for Prehospital Medicine Conference* hosted by the Tidewater EMS Council. 24 students were funded by the EMSC grant and about 16 others also attended (some from out of state). Utilizing federal EMSC funding, all of these instructors will be given the updated resources once Jones and Bartlett releases new versions of the materials, hopefully in early 2012.

EMSC Program Ideas Always Welcome

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

Patient Care Information System

Virginia Pre-Hospital Information Bridge (VPHIB)

NEMSIS Version 3: The next big step! **NOW** is the time that EMS agencies using third party software to collect EMS data should begin considering the impact of NEMSIS version 3 (v3.) V3 is very likely to take affect during your current contract period or next contract period with your vendor. NEMSIS has estimated that 2/3 of current EMS

software vendors will discontinue providing EMS software or merge with an existing company. This estimate is based on the significant maturity that EMS data collection will undergo with v3 and HL7 certification. EMS medical documentation is being driven to be equivalent to that of all other health care documentation. Protect yourself! Some things to consider:

- Will your vendor continue to provide an EMS product with v3?
- Will your product collect v2 and v3 simultaneously to allow for the transition of State data submission and billing services?
- Does your contract include a clause that your software will be capable of meeting the Virginia state requirements (not NEMSIS compliant, Virginia compliant) without additional costs or at least at a set rate so you know what to expect and can plan for?
- Has your vendor already begun developing a v3 product?
- When does your vendor plan to test its v3 product? Testing starts after October 2011.
- Has your vendor attended any of the NEMSIS software development meetings? These meetings have allowed vendors to express their needs and concerns and have input into the changes being implemented in v3.

NEMSIS hosted a two day software developers meeting in late September. Below is the list of participating vendors and number of persons they had at the software developers meeting:

- ACS Firehouse (1)
- Alert Tracking Systems (1)
- American Medical Response (2)
- Application Data Systems Inc. (2)
- Beyond Lucid Technologies Inc. (2)
- CogniTech Corp. (1)
- Consilience Software (1)
- Digital Innovations Inc. (3)
- Emergency Reporting (1)
- Emergency Technologies (2)
- EMS Charts (1)
- EMS Data System Inc. (1)
- EMSystems (1)
- ESO Solutions (3)
- Gold System (1)
- Golden Hour Data Systems Inc. (2)
- ImageTrend Inc. (4)
- Initium Systems (2)
- InspiringApps (1)
- Intermedix (2)
- New World Systems (2)
- OCI (2)
- Proper LLC (1)

- Sansio (1)
- TriTech Software Systems (2)
- UNC/EMSPIC (3)
- Zoll (4)

When will Virginia move to NEMSIS v3? Best guess will be that v3 will be implemented in the beginning of 2013. The final NEMSIS v3 products needed by states and vendors to begin testing and planning a v3 implementation have not yet been released and without these items it is impossible to plan. On October 31st. 2011 NEMSIS plans to release the following v3 documents/tools:

- V3 NEMSIS Data Dictionary
- NEMSIS XSD
- Business Logic (Schematron)
- Web Services Guide

Why is Virginia going to NEMSIS version 3 when we are just settling with version 2?

- Specific Points Asked of OEMS
    - The EMS Agencies and providers have invested a significant amount of time, effort, and resources to get to the current level of reporting.
    - The increased amount of elements increase out of service time at hospitals.
    - OEMS has stated that a majority of third party vendors will be unable to support NEMSIS version 3 and this will incur additional expense.

OEMS completely shares the feeling that Virginia EMS agencies, providers, and the OEMS have all invested a painfully significant amount of time establishing NEMSIS version 2 (v2.) So why are we going to move to NEMSIS version 3 (v3) already? OEMS staff was extremely vocal and resistant about moving to v3 on the national level making this exact same point. OEMS also felt that it was too soon for Virginia to move to v3 and that the result of pushing us towards v3 could result in Virginia deciding to no longer collect EMS data.

Through the Data Managers Council (DMC) of the National Association of EMS Officials (NASEMSO) we were able to voice our concerns collectively along with the State EMS Directors group and have made several adjustments to the v3 implementation that should make it less of a challenge; including widening the implementation window. This is not to say that it is not going to be a challenge still, but we have seen NEMSIS work better with the states so we can in turn implement v3 a little easier.

OEMS staff also demanded from NEMSIS to know why we (the states) were being pushed so hard and so fast to v3. Ultimately, what we have learned over the past couple of months was helpful for us to better understand the push and to feel a little less like we were being forced to v3. The short answer is the great push is coming from the federal government and the need for justification for the cost of EMS medical care.

How does this relate to EMS? More and more news articles have been discussing the disparity in the cost of EMS care and in some cases the abuse occurring with EMS billing. The Centers for Medicare and Medicaid Services (CMS) which sets the costs associated with most other health care costs wants a valid source of EMS data collection. As an example, CMS sets all the reimbursement costs that hospitals charge for goods and services for Medicare and Medicaid patients. CMS does this through the collection patient, patient care, and patient care cost data submitted by hospitals to a single state entity, in Virginia the Virginia Health Information Inc. collects this, and then submits it to CMS. CMS decides the technical format and dataset that the hospitals will submit.

The National Highway Safety Transport Administrations' (NHTSA) Office of EMS is the home of NEMSIS and is working to convince CMS to allow NEMSIS v3 to be the data standard and the source of EMS data that will be used by CMS to set uniform ambulance billing costs in the near future. This commitment to CMS is the reason for an aggressive timeline. The alternative to states not moving to v3 would be for NEMSIS, which is developed by EMS for EMS, to be developed by CMS. OEMS staff and other state offices staffs have put in thousands of hours working together and in cooperation with NEMSIS and NASEMSO to assure v3 serves the needs of EMS providers, EMS agencies, state EMS data systems, the National EMS Database, and the federal medical databases at the same time.

Concerns about NEMSIS' v3 causing undue costs to Virginia EMS agencies can be mitigated. OEMS has already begun advising agencies through the VPHIB e-mail list serve and support site that NOW is the time to prepare for v3. When OEMS contracted with ImageTrend, the impact of v3 was not known to us. However, our contract language (available on the OEMS website) with ImageTrend states that ImageTrend will provide OEMS with the most current version available from NEMSIS and provide us with the ability to submit to the National EMS Database. Agency contract language should allow for the growth of technology and meet your needs such as billing and reporting to the state. This potentially could eliminate your costs, lower your costs, or at least allow you to have a predetermined cost if customization is required.

We have offered this same advice since February 2007. Throughout the project planning and implementation process VDH/OEMS utilized the following agency roles to communicate this with: The two persons listed in the EMS licensure database as the agency owners (owner1 and owner2) as requested by VAGEMSA, the person(s) that had previously submitted data to PPDR quarterly for the previous two years, known 3rd party software vendors, and known billing company contacts. Communication was given via e-mails, website postings, US Mail, OEMS quarterly report, quarterly verbal report and the EMS Advisory Board and others.

Please feel free at any time to contact VPHIB support and ask for advice related to the wording of your EMS data contracts.

Increased data elements are causing increased out of service times at hospitals. OEMS would be more than willing to address this and work to make improvements. To do so we would request that this claim be evidence driven and provided to OEMS to review. There are many factors that can influence longer report writing times that can be attributed to how the report is being written, has billing information being added, is the software you are using being maximized to make documenting as easy as possible etc. Our ePCR software has a built in timer and when we have checked the average time to complete a run form it has been 7 – 10 minutes.

"OEMS has stated that a majority of third party vendors will be unable to support NEMSIS version 3 and this will incur additional expense." This statement is not accurate. OEMS has indeed passed on that we have heard this statement with each NEMSIS v3 presentation we have heard given by NEMSIS and or its principle stakeholders. OEMS wants our agencies to know this because as we speak and over the next year agencies will be contemplating purchasing/entering in agreements with EMS software vendors and we want you to know what we know.

We have included in this report which vendors attended the recent NEMSIS software vendors meeting in an effort to give our agencies as much information as we can. We actually submitted a Freedom of Information Act request to get this for you. V3 will be a more mature software product and less forgiving of not submitting quality data. Because of this maturity it is expected that some of the current vendors may no longer find EMS data collection to be profitable or that they have only been willing to maintain their current product versus the cost of writing a new one.

Virginia OEMS moving to v3 is somewhat irrelevant to Virginia EMS agencies being forced to move to a new software program. OEMS was personally unable to attend the most recent NEMSIS software vendors meeting, which we have in the past, but the other state data managers that did attend unanimously agreed that the EMS software vendors present are eager to move to v3 and away from v2. OEMS anticipates that we will face more frustration from agencies because the agency will want to move to v3 while OEMS will attempt to go slow enough to accommodate as many vendors as possible.

Those agencies that currently own a software product that will not move to v3 or have not already begun to prepare for v3 will likely conclude for themselves that they have an outdated product. Remember EMS billing and a national effort is moving us to v3 not OEMS.

Is the end result of the data collected worth the total investment?

Simply, knowing what is occurring on the federal level with EMS fee for service, pay for performance, and the other issues surrounding health care reform; can we afford to not conform to the new and upcoming data requirements? These federal efforts are real and they are occurring now and they will shape EMS' future. If EMS data collection is not done the way we are currently moving, it is likely to occur another way.

We certainly hope the investment will be worth it. All those entities driving EMS data collection forward may explain it more eloquently than we can. To begin to prove the benefit of EMS care being provided and what resources it takes to provide that care can serve to increase the validity of what we do. We stand to be able to increase reimbursement, decrease costs by discovering treatments have no benefits, and develop education curriculum and treatment protocols based on science and evidence from our own area of health care.

Can we have more information on why the quality standards are going to increase is wanted?

OEMS can absolutely provide more information on why quality standards are being increased. OEMS commits to providing agencies with more information about how we are making decisions to increase a quality standard and in return we ask the EMS agencies commit to accepting this information by opening our e-mails and using the news and knowledgebase areas within the VPHIB support site. OEMS tries very hard to limit spam e-mail and when we send VPHIB information out and we do so based on what information we have been asked to provide and what we think is important for you to know to be prepared for upcoming changes. The last place we want agencies to learn about VPHIB is from our field program representative staff or from an adjudication officer. We often hear from people that they don't know something and that they also don't open our e-mail??
As mentioned in our July OEMS Quarterly Report, which we also post in the VPHIB support suite for those not involved with the EMS Advisory Board, we have begun focusing our resources to assessing the quality of data being submitted to VPHIB. The quality "is not so good" in some cases and that is another reason the nation is moving to v3. We will begin sending out data quality information on a system-wide level and individual agency level. Your willingness to improve data submission will help determine how much technology will be placed at the submission point and how much value we can all realize from our collective investment of EMS data collection.

Please read below to see some examples of why a data standard must be changed.

What happened this quarter?

The bulk of the efforts dedicated to VPHIB this quarter focused primarily on assessing data quality. We are assessing our ability to submit to the National EMS Database and for compliance with submitting the Virginia minimum dataset as prescribed. The goal of assessing and improving data quality is to assure that data output will reliably represent the system and the care being provided in the prehospital setting.

At the beginning of this quarter only approximately 51 percent of Virginia's EMS records had the ability to be uploaded to the National EMS Database. As of the week of October 17th we have this number up to approximately 75 percent and have a clear understanding have how to raise this by another 21 percent. With the implemented validation scoring rules and a planned XSD update, as well as some technical changes, we expect our first

NEMSIS submission to be at least 96 percent compliant with their minimum submission requirements (this is a very minimum.)

New tools are being developed to provide each individual agency with the ability to look for items that do not meet the Virginia standards through VPHIB's Report Writer 2 (RW2). Within RW2, under "All Reports", in the "Audit Reports" folder approximately 45 reports have been added that will help agencies to look for EMS records submitted to VPHIB that do not contain the information required in Virginia. The first nine reports will return different data element groups that agencies can look for patterns of missing data or the overuse of null answers (N/A, NR, etc.) The other reports are named for the single data elements that are required and will return all of the records that are poorly reporting a single element.

OEMS staff also worked with ImageTrend and four other states to help develop a detailed "data quality report card" that will be auto-generated from the VPHIB system to provide details about an agencies data submission quality. This tool will be available when VPHIB is updated to State Bridge version 5 (expected in November.) The report card will be reflective of VPHIB's validation rules.

XSD change: In an effort to improve our data quality and eliminate the overuse of null fields, e.g. not applicable, not recorded, not known etc, an XSD change will be implemented on January 31, 2011. Figure 1 below shows a simple example of a single element that will cause 148,609 records to not be able to be submitted to the National EMS Database because of the use of not available. Since the majority of the records missing from this element are from fire departments (Figure 2) so it is likely the type of service requested is 911 response and not truly not available. Under the NEMSIS standard "Type of Service Requested" cannot have a null value at any time.

Figure 1

Type Service Requested	No of Incidents
⊟ All Type Service Requested	1,745,532
911 Response (Scene)	1,402,287
Flagdown/Walk-in Emergent	2,573
Flagdown/Walk-in Non-emergent	2,211
Interfacility Transfer (Scheduled)	45,204
Interfacility Transfer (Unscheduled)	26,661
Medical Transport	98,918
Mutual Aid	7,409
Rendezvous	2,716
Standby	8,944
Not Available	148,609

Figure 2

Type Service Requested	Not Available
Organization Type	**No of Incidents**
⊟ All Services	148,609
Fire Department	143,152
Community, Non-Profit	3,196
Private, Non Hospital	501
Governmental, Non-Fire	1,547
Hospital	213

Some other examples of data quality issues that will be corrected with the January 31, 2012 XSD change are included below and are fairly core EMS items that should not create an undue burden:

- **E02_04/Type of Service Requested** - Not applicable (-25), Not Recorded (-20), Not Reported (-15), Not Known (-10), Not Available (-5) will no longer be accepted.

  Rational: Any record that contains a null value will cause the record to fail submission to the National EMS Database

  Exhibit:

Type Service Requested	No of Incidents
⊟ All Type Service Requested	1,750,225
911 Response (Scene)	1,406,551
Flagdown/Walk-in Emergent	2,580
Flagdown/Walk-in Non-emergent	2,212
Interfacility Transfer (Scheduled)	45,309
Interfacility Transfer (Unscheduled)	26,757
Medical Transport	99,105
Mutual Aid	7,416
Rendezvous	2,721
Standby	8,964
Not Available	148,610

  Source: VPHIB 2010 – 2011

- **E02_05/Primary Role of Unit** - Not applicable (-25), Non transport BLS (411014), Ground EMS (411007), Non-transport ALS (60), and Transport (75) will no longer be accepted.

Rational: Multi formats had previously been used. A deadline of July 31st was previously given to move to the Virginia standard of "primary role of the unit." Any record that contains a null value will cause the record to fail submission to the National EMS Database

Exhibit:

Primary Role of Unit	No of Incidents
⊟ All Primary Role of Unit	1,750,225
ALS First Responder	80,828
ALS Ground Transport	544,066
BLS First Responder	55,938
BLS Ground Transport	346,187
Critical Care Ground Transport	3,252
Medevac/HEMS	3,689
Other Transport	23,084
Rescue (Extrication etc.)	962
Supervisor	4,437
Not Available	687,782

Source: VPHIB 2010 – 2011

- **E02_12/EMS Unit Call Sign** - Not applicable (-25) will no longer be accepted.

Rational: Any record that contains a null value will cause the record to fail submission to the National EMS Database
Exhibit:

EMSUnitCallSign

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Missing (blank)	290222	16.4	16.4	16.4
	-5 (not available)	80062	4.5	4.5	21.0
	Not Available	23665	1.3	1.3	22.3
	Not Applicable	14293	.8	.8	23.1
	M1	13569	.8	.8	23.9
	Medic 1	11498	.7	.7	24.5
	Medic 3	11316	.6	.6	25.2
	M7	8676	.5	.5	25.6
	M4	8380	.5	.5	26.1
	M3	8102	.5	.5	26.6

Source: VPHIB 2010 - 2011

- **E02_20/Response mode to scene** - Not applicable (-25), Not Recorded (-20), Not Reported (-15), Not Known (-10), Not Available (-5) will no longer be accepted.

  Rational: Any record that contains a null value will cause the record to fail submission to the National EMS Database

  Exhibit:

Response Mode To Scene

	Frequency	Percent	Valid Percent	Cumulative Percent
Lights & Sirens	**917867**	**51.9**	**53.7**	**53.7**
Not Applicable	298797	16.9	17.5	71.1
No Lights or Sirens	**298722**	**16.9**	**17.5**	**88.6**
Invalid ImgTrnd Code	102546	5.8	6.0	94.6
Not Available	**80263**	**4.5**	**4.7**	**99.3**
Lights & Sirens Downgraded to No Lights or Sirens	8626	.5	.5	99.8
No Lights or Sirens Upgraded to Lights & Sirens	**3221**	**.2**	**.2**	**100.0**
Not recorded	128	.0	.0	100.0
Not Reported	**99**	**.0**	**.0**	**100.0**
Not Known	81	.0	.0	100.0
Total	**1710350**	**96.8**	**100.0**	
Missing (Blank)	57012	3.2		
Total	**1767362**	**100.0**		

Source: VPHIB 2010 - 2011

- **E03_01/Complaint Reported by Dispatch** - Not applicable (-25), Not Recorded (-20), Not Reported (-15), Not Known (-10), Not Available (-5) will no longer be accepted.

  Rational: Major filter for data use; is collected at the point of call origination, and Code 555/Unknown problem is available when the complaint cannot be obtained by 9-1-1 call taker.

Exhibit:

Complaint Reported By Dispatch	No of Incidents
⊟ All	1,750,225
Not Available	503,525
Illness	151,563
Breathing Problem	130,097
Chest Pain	107,144
Traffic/Transportation Accident	95,443
Fall Victim	95,342
Medical Transport	74,982
Other	66,985
Unconscious/Fainting	59,304

Source: VPHIB 2010 – 2011 (Top 10 complaints reported by dispatch)

- **E20_10/Incident/Patient Disposition** - Not Recorded (-20), Not Reported (-15), Not Known (-10), Not Available (-5) will no longer be accepted.

  Rational: Any record that contains a null value will cause the record to fail submission to the National EMS Database

  Exhibit:

Patient Disposition	No of Incidents
⊟ All Patient Disposition	1,750,225
Treated, Transported by EMS	973,138
Cancelled	197,603
Not Available	194,459
Patient Refused Care	144,013
Treated, Transferred Care	67,848
No Treatment Required	55,458
No Patient Found	44,196
Standby Only - No Patient Contacts	29,152
Treated and Released	24,968

Source: VPHIB 2010 – 2011

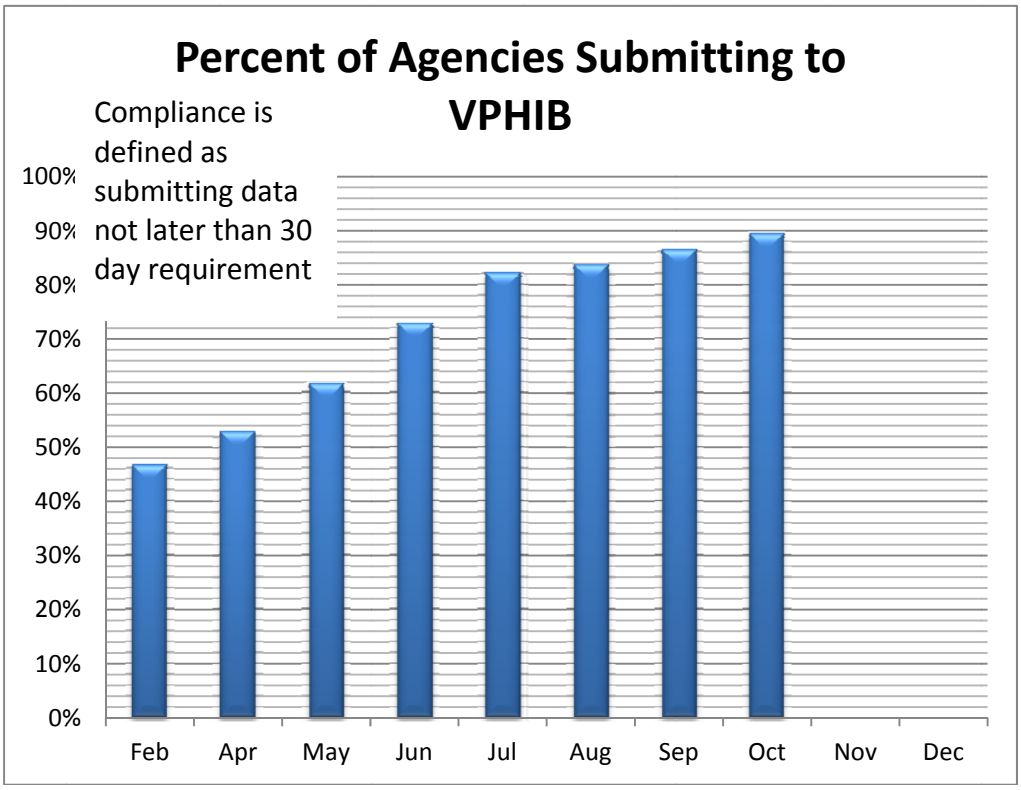
Other elements known to be problematic are below and will be addressed in the future. We recommend utilizing the reports in the "audit" folder in VPHIBs Report Writer 2 to see how your agency is doing with reporting these.

- **E06_05/Patient's City –** may be better reported as E06_06/Patient's County. VPHIB is attempting to collect the patient's county or when it is a city noted as "Richmond (city)." In the few instances where a town is incorporated the county name should be reported to be consistent with similar state databases. It is not the program's intent to collect town names that are not incorporated.
- **E06_11/Gender** - Since January 1, 2010 where there was a disposition that included a disposition that included treatment and in 26,482 times (2%) that gender could not be determined.
- **E06_12/Race** – is missing from 50,000 of 1.07 million records.
- **E06_15/Age Time Units** (see your agencies data in Report Writer 2)
- **E09_07/Time Units of Duration of Chief Complaint**
- **E09_11/Chief Complaint Anatomic Location** – is missing in over 50% of cases were the disposition included treatment.
- **E09_12/Chief Complaint Organ System** - is missing in over 50% of cases were the disposition included treatment.
- **E09_13/Primary Symptom** (see your agencies data in Report Writer 2)
- **E09_15/Provider Primary Impression** – In 2010 and 2011 there were 219,282 cases where the provider impression was "not available.
- **E09_16/Provider Secondary Impression** – 576,043 incidences of patients treated in 2010 and 2011 the provider's secondary impression is "not available." It is expected that either a secondary diagnosis or not applicable be submitted.
- **E10_04/Vehicle Injury** (see your agencies data in Report Writer 2)
- **E10_05/Area of Vehicle Impact** (see your agencies data in Report Writer 2)
- **E10_08/Use of Occupant Safety Equipment** (see your agencies data in Report Writer 2)
- **E10_09/Airbag Deployment** (see your agencies data in Report Writer 2)
- **E12_19/Alcohol/Drug Use Indicators** (see your agencies data in Report Writer 2)
- **IT5_6/Motor Vehicle Type** (see your agencies data in Report Writer 2)

VPHIB Submission Compliance: The VPHIB program routinely sends a monthly submission reminder out via the VPHIB list serve (an e-mail address is required in the minimum dataset) five to seven days prior to the monthly compliance report being developed. OEMS posts this report to the VPHIB Support Suite knowledgebase and the VPHIB program's knowledgebase, so agencies will not be caught unaware. The system does not currently identify agencies that have not submitted and send them an automated

individual notice. Figure 3 below shows the rate of submission since OEMS re-established monitoring compliance.

Figure 3



Our Focus for the Upcoming Quarter

VPHIB staffs will continue to focus on data quality and taking the needed steps to assure that VPHIB can produce high quality and reliable data. An XSD update will have been announced and some additional validation rules built that will better reflect the VPHIB Data Dictionary.
During the upcoming quarter VPHIB will begin to offer the availability of Web services to agencies using Zoll or EMSCharts as their data collection/reporting program. Web services will allow data to be automatically loaded into VPHIB from Zoll and EMSCharts databases so agencies using these products will not have to upload a file to OEMS. When the requirements for this service are available details will be sent to Zoll and EMSCharts users. At this time, the Alabama model of requiring uploading every two hours at a minimum in order to establish a Web services connection is very likely. This would be a significantly powerful public health surveillance system.

The "Technical Side" of VPHIB

Additional database space was added to the VPHIB database servers to accommodate the most recent State Bridge version 4.5 update. Enough space was also added to

accommodate expected upgrade needs for the next 1 – 2 years. Once the additional space was added to the servers, State Bridge version 4.6 was loaded. Version 4.6 added the new validation tool that ImageTrend will be releasing in version 5. This validation tool will allow staffs to better match validation scoring to the Virginia data dictionary. Loading this tool in advance will allow agencies to immediately begin utilizing the "data quality report card" being released in version 5.

OEMS and ImageTrend are currently assessing the VPHIB servers to see what the maximum amount of RAM is that can be installed on the server that supports Report Writer 2. OEMS is exploring developing more permission levels to provide a wider scope of access to appropriate levels of data. In order to do this the system needs to have the capability of managing the increased size of queries (statewide vs. agency level) and a higher volume of queries.

Virginia Statewide Trauma Registry (VSTR)

The second quarter's official audit for 2011 data submissions disclosed 99% compliance. Only one facility was non-compliant and we are currently working with them. This facility was also non-compliant during the last quarter of 2010 due to staff turnover and no one was performing that task. They have since completed submissions for all 2010 data and have begun to work on getting the data in for 2011.

Our next official audit will be conducted on November 15, 2011.

Trauma Registry Upgrade

TCC is exploring the best approach to upgrading the Virginia Statewide Trauma Registry (VSTR). Currently we are exploring the upgrade of the existing homegrown program with the Office of Information Management and having discussion with ImageTrend related to upgrading the VPHIB program to include an integrated Patient Registry.

ImageTrend provided a demonstration of their "Patient Registry" program to OEMS staffs on Monday, October 17. This demonstration focused on a high level look at how the end users would use the ImageTrend product and how OEMS would administer the program. Time was also spent on how this product can be integrated with the VPHIB system. An additional technical level meeting is being planned to look at the benefit and potential cost savings of sharing the technology that supports the two systems.
The need to upgrade the trauma registry has moved from a desired task to an essential task. According to the Centers for Medicare & Medicaid Services (CMS) the cut over date from ICD9 to ICD10 is October 1, 2013. This is a hard date. CMS will require that any patient treated by health systems on or after this date will be required to be submitted in ICD10 format. The volume of codes will be expanded from 13,600 to 69,000 and a two year period will be necessary to continue to collect ICD9 coded data being mapped into ICD10.

CMS has multiple resource materials available including the code set, mappings, code tables etc. at

http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage. The use of ICD10 will apply to all HIPAA related data.

OIM was previously asked to provide some cursory information on the resources and capabilities that OIM will require to perform this upgrade. TCC would like to start to formulate a business case for purchasing an upgrade of the VPHIB system versus the upgrade of the existing trauma registry. Items being considered outside of just the ICD10 code change are:

- Transition from ICD9 to ICD 10 code set
- Legacy data conversion
- Ability to collect ICD9 data for a period of 2 years and have it mapped into the ICD10 Codes automatically on import
- The ability to store/link/cube data so it can be linked to EMS data (JLARC recommendation) short-term plan with traffic data link.
- Addition of 5-10 additional elements missing from the national trauma dataset
- Ability to expand integration with hospital medical records to help hospitals eliminate manual data entry
- Import tools that do not require manual data loads (users should be able to independently upload date and receive detailed enough information on data structure and validation information to mange uploading independently.)

Trauma System

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

The TSO&MC last met on September 1, 2011 and the draft minutes to this meeting can be found posted on the Virginia Town Hall website as required. The key item for this meeting included the approval of the most recent revision of the Trauma Center Fund Distribution Policy and discussion on committee composition. The next meeting is scheduled for December 1st and planned topics are the establishment of a work group(s) to perform a review of the entire Trauma Designation Manual and a presentation by the OEMS orienting the committee to its role, Code Requirements, and place within the EMS Advisory Board structure.

A revision of the Trauma Designation Manual remains pending and is hoped to be presented at the December State Board of Health meeting.

b) Trauma Center Fund

Table 1 below is the most recent distributions to designated Trauma Centers from the Trauma Center Fund.

Table 1

Trauma Center & Level	Percent Distribution	Previous Quarterly Distribution	May 2011 FY11	Total Funds Received Since FY06
I				
Roanoke Memorial Hospital	14.67%	$197,397.63	$480,658.62	$5,405,943.84
Inova Fairfax Hospital	13.65%	$183,672.64	$447,238.60	$10,089,284.75
Norfolk General Hospital	12.69%	$170,755.01	$415,784.45	$5,991,363.78
UVA Health System	13.91%	$187,171.17	$455,757.43	$6,180,771.08
VCU Health Systems	25.96%	$349,314.42	$850,572.45	$10,369,655.78
II				$0.00
Lynchburg General Hospital	3.28%	$44,135.26	$107,468.32	$1,211,354.29
Mary Washington Hospital	4.33%	$58,263.92	$141,871.29	$381,994.32
Riverside Regional Medical Ctr.	2.96%	$39,829.38	$96,983.61	$1,129,304.16
Winchester Medical Ctr.	3.61%	$48,575.70	$118,280.68	$1,570,121.86
III				$0.00
New River Valley Medical Ctr.	0.15%	$2,072.20	$5,045.77	$112,793.72
CJW Medical Ctr.	1.03%	$13,859.55	$33,747.67	$457,215.51
Montgomery Regional Hospital	0.25%	$3,417.79	$8,322.24	$137,172.20
Southside Regional Medical Ctr.	0.62%	$8,369.55	$20,379.66	$238,446.94
Virginia Beach Gen'l Hospital	2.88%	$38,752.91	$94,362.43	$1,639,217.68
Total		$1,345,587.13	$3,276,473.22	$44,914,639.91

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

Durable Do Not Resuscitate (DDNR)

The DDNR regulations were approved by the Governor and went into effect in July 2011. The OEMS web site has been updated with a new multi-copy DDNR Order form available for download and printing, an updated Fact Sheet, applicable Regulations, and other related documents. All requests for forms are being answered personally via email correspondence or telephone call. Doctors and health care providers are individually directed to the OEMS DDNR home page where the information and new procedure is explained.

We have received over 95% positive feedback. The only reoccurring complaint is having physicians and patients sign three forms.

Information for Virginia Certified Emergency Medical Service (EMS) Providers:

- Do EMS Providers need to see an original Durable DNR or Other DNR Order?

  NO; as of July 21, 2011 legible copies of a DDNR order may be accepted by qualified health care providers

- What types of DDNR forms or orders can be honored by EMS providers?
  - The VDH/OEMS "State" DDNR form (old or new) can be honored at any time;
  - Authorized "Alternate DDNR Jewelry" can be honored at any time, but it must contain equivalent information to the State form;
  - A verbal order from a physician can be honored by a certified EMS provider. The verbal order may be by a physician who is physically present and willing to assume responsibility or from on-line medical control.
  - "Other" DNR Orders: this is the term used to define a physician's written DNR order when it is in a format other than the State form. "Other" DNR Orders should be honored by EMS providers' when the patient is within a license health care facility or being transported between health care facilities. Examples of "Other" DNR orders include facility developed DNR forms, POST forms, or other documents that contain the equivalent information as the State form.

Information and Responsibilities for Health Care Provider's Issuing (DNR) orders:

- The use of the State's DDNR form is encouraged for uniformity throughout the health care continuum.
- The State's DDNR form can be honored by qualified health care providers in any setting.
- Patient's that will not be within a qualified health care facility must have a State DDNR form in order for the DDNR to be honored.
- "Other DNR" orders can be honored anytime that a person is within a qualified health care facility or during transport between health care facilities when attended by a qualified health care provider (i.e. by ambulance.)
- If the option of a DDNR is agreed upon, the physician shall have the following responsibilities:
  - Explain when the DDNR order is valid;
  - Explain how to and who may revoke the DDNR;
  - Document the patient's full legal name;
  - Document the date the DDNR was executed;

- Obtain the patient's signature or the person who is authorized to consent on behalf of the patient;
- The physician's printed name and signature must be included;
- Note a valid contact number for the physician signing the DDNR order.

How to Download the DDNR and Find Additional Information on the DDNR program:
As of July 21, 2011 the State DDNR form has been changed to a downloadable document that will soon be made available on-line on the VDH/OEMS website at http://www.vdh.virginia.gov/oems/ddnr/ddnr.asp.

- The new downloadable DDNR form:
  - The revised DDNR form can be printed on any color paper (white paper printed on a color printer is the recommended.)
  - Health care providers may honor a legible copy of any of the three paged revised DDNR form. The patient copy, medical record copy, or DDNR jewelry copy all may be honored.
  - It is recommended that all photocopies of DDNR forms, of any type, be of actual size
- The previous golden rod colored State DDNR form:
  - May still be honored no matter when it was dated;
  - Physicians may still complete the golden rod State DDNR forms until supplies are exhausted;
  - Photocopies of completed golden rod colored State DDNR form may be honored indefinitely.

This Web site includes:

- DDNR Fact Sheet
- How to Fill Out the Durable Do Not Resuscitate Form
- How to download the authorized Durable Do Not Resuscitate form
- How to Purchase DDNR Bracelets and Necklaces
- The applicable Virginia laws (Code of Virginia) related to DDNR
- Virginia Durable DNR Regulations

For technical assistance downloading the form you may contact Mr. Russ Stamm at the Office of Emergency Medical Services at (804)888-9146 or Russ.Stamm@vdh.virginia.gov or write 1041 Technology Park Drive, Glen Allen, Virginia 23059.

Respectfully Submitted

Office of EMS Staff

Appendix A

☒ Committee Motion: Name: Medical Direction Committee

☐ Individual Motion: Name: _____

Motion:
The Medical Direction Committee moves the EMS Advisory Board endorse the "Termination of Resuscitation" White Paper.

EMS Plan Reference (include section number):

Initiative 3.1 - EMS Regulations, Protocols, Policies and Standards.
3.1.8 - Through a consensus process, develop a standard set of evidence-based patient care guidelines and standard formulary

Committee Minority Opinion (as needed):

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

Vote: By Acclamation: ☐ Approved ☐ Not Approved

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

Board Minority Opinion:

Meeting Date:

Out of Hospital Termination of Resuscitation in Adult Non-traumatic Cardiac Arrest

In all cases of sudden cardiac arrest, the healthcare provider is being challenged with two main questions: when to start and when to stop resuscitation attempts? In the individual case, the decision to start, continue or to terminate resuscitation attempts, is based on the difficult balance between the benefits, risks and cost these interventions will place on patient, family members and healthcare providers[1]. The majority of cardiac arrest patients transported to hospitals without a pulse do not result in survival to hospital discharge. With the inherent dangers of transporting patients under lights and siren conditions, it is prudent to examine the literature around termination of resuscitation.

Prehospital termination of resuscitation guidelines have been developed by the Ontario Prehospital Life Support (OPALS) study group[2] [3]. In their BLS prediction rule, EMT-B with defibrillation capabilities could consider patients with the following for termination of resuscitation:

1. No return of spontaneous circulation prior to transport
2. No shock was given
3. The arrest was not witnessed by EMS personnel

In applying the BLS rule 37.4% of the cardiac arrest cases would have been transported. There were a very small number of cases of survival to hospital discharge in patients who the BLS rule would have recommended termination of resuscitation.

The OPALS group developed a more conservative ALS prediction rule in which providers could consider patients with the following for termination of resuscitation:

1. No return of spontaneous circulation prior to transport
2. No shock was given
3. The arrest was not witnessed by EMS personnel
4. The arrest was not witnessed by bystander
5. No bystander CPR

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[1] Freddy et al. European Resuscitation Council Guidelines for Resuscitation 2010. Section 10. The ethics of resuscitation and end-of-life decisions; Published online 19 October 2010, pages 1445 – 1451

[2] Verbeek PR, Vermeulen MJ, Ali FH, Messenger DW, Summers J, Morrison LJ. Derivation of a termination-of-resuscitation guideline for emergency medical technicians using automated external defibrillators. Acad Emerg Med. 2002; 9(7):671-678.

[3] Morrison LJ et al. Derivation and evaluation of a termination of resuscitation clinical prediction rule for advanced life support providers. Resuscitation.2007; 74 (2):266-275.

In applying the ALS rule about 70% of the cardiac arrest cases would have been transported. There were no cases of survival to hospital discharge in patients who the ALS rule would have recommended termination of resuscitation.

The researchers from University of Toronto have validated the BLS and ALS guidelines for termination of resuscitation[4]. The researchers reviewed a total of 4854 cases of out of hospital cardiac arrest. Of these, 2439 were excluded due to various reasons including DNR orders, pediatric cardiac arrest cases (less than 18 years of age), signs of "obvious" death, and lack of records for outcomes (19 patients). The sensitivity of the rules was 100% for both BLS and ALS prediction rules. The positive predictive value of the BLS and ALS rules to predict those who will have unsuccessful resuscitation was 100%. Using the CARES registry data, other investigators studied the rule[5]. A total of 5505 cardiac arrest cases met the inclusion criteria for the study. The BLS prediction rule would have recommended termination of 2592 of these cases. Of these cases, 5 patients (0.2%) survived to hospital discharge. Using the ALS rule, 1192 cases would have met criteria for termination of resuscitation. None of these patients survived to hospital discharge. Of concern is how the patient's family will react to termination of efforts in the out of hospital environment. Two studies have demonstrated that families are satisfied with paramedics notifying family of the unsuccessful resuscitative efforts[6] [7].

Before implementation of a termination of resuscitation guideline, agencies and their medical directors should:

1. review current literature and determine which rule best suits the local EMS system
2. coordinate development of guidelines with stakeholders including hospitals, law enforcement, and local medical examiner
3. provide appropriate initial and continuing education to field providers and hospital partners
4. develop systems of feedback with hospitals to determine patient outcomes
5. devote appropriate efforts to reviewing PPCRs for compliance and process improvement

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[4] Morrison et al. Validation of a universal termination of resuscitation clinical prediction rule for advanced and basic life support providers; Resuscitation 80 (2009) 324-328

[5] Sasson et al. Prehospital termination of resuscitation in cases of refractory out of hospital cardiac arrest. JAMA. 2008; 300(12) 1432-1438

[6] SchmidtTA, Harrahill MA . Family response to out-of-hospital death. Acad Emerg Med 1995;2:513–8.

[7] DelbridgeTR, Fosnocht DE, Garrison HG,AubleTE. Field termination of unsuccessful out-of-hospital cardiac arrest resuscitation: acceptance by family members. Ann Emerg Med 1996;27:649–54.

Appendix B

☒ Committee Motion: Name: Medical Direction Committee

☐ Individual Motion: Name: _____

Motion:
The Medical Direction Committee moves the EMS Advisory Board endorse the "Cervical Spine Clearance" White Paper.

EMS Plan Reference (include section number):

Initiative 3.1 - EMS Regulations, Protocols, Policies and Standards.
3.1.8 - Through a consensus process, develop a standard set of evidence-based patient care guidelines and standard formulary

Committee Minority Opinion (as needed):

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

Vote: By Acclamation: ☐ Approved ☐ Not Approved

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

Board Minority Opinion:

Meeting Date:

Adult Clinical C-spine Clearance by EMS personnel

Medical Direction Sub-Committee
Virginia EMS Advisory Board

Background:

Approximately 10,000 people suffer spinal cord injury each year in North America. In 2000 there were 8 million evaluations for neck injury in North American ED's[8]. Thus, approximately 800 neck injuries are evaluated for each spinal cord injury detected. Widely accepted clinical-decision-rules exist that permit a trained provider to clinically clear a person with a potential neck injury[9]. These rules are widely used in emergency departments and in many EMS systems as well.

Spinal Immobilization is a treatment with untoward effects. It is painful, can cause soft tissue damage, restricts respiration[10], prolongs ED stay and may lead to unnecessary radiographs. Moreover, a responsible ED will prioritizes immobilized patients, thus unnecessarily backboarded patients create ED disruption. Not all EMS systems have adopted protocols that permit EMS providers to forgo spinal immobilization in patients where a neck injury is highly unlikely.

Clinical Decision Rules:

National Emergency X-Radiography Utilization Study (NEXUS)[2] criteria were used and widely studied in the 90s and form the basis for most clinical clearance protocols used in ED's. More recently, the Canadian C-Spine Rules (CCR) have been developed and studied[11]. The CCR's do not include exclusions for intoxication or distracting injury. A *New England Journal of Medicine* article nicely compares the two decision rules[12] and finds the CCR both more sensitive and specific than NEXUS criteria.

In 2009 Vallancourt published a validation of the Canadian Rules by Paramedics[13]. They showed that trained paramedics could apply the decision rule with good outcome. They included 1,949 patients of whom 12 had important injuries; paramedics correctly classified all the significantly injured patients for a sensitivity of 100% [CI 74-100]. Of the 1,949 patients 731 (38%) could have avoided immobilization.

Conclusion:

Paramedics can, with proper training and appropriate protocols, clinically clear the cervical spines of selected trauma patients. EMS systems should consider developing c-spine clearance protocols that will safely prevent unnecessary spine immobilization in patients with minor or no injuries. The Canadian C-Spine rules and the NEXUS Rules should be considered in the development of pre-hospital c-spine clearance protocols for adults.

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[8] McCaig, LF: **National Hospital Ambulatory Care Survey: 2000 Emergency Department Summary.** *Advance Data from Viral and Health Statistics 2004, 340.*
[9] Hoffman JR: **Low-risk criteria for cervical-spine radiography in blunt trauma: a prospective study.** *Ann Emerg Med 1988, 17: 792-6.*
[10] Bauer SJ: **Effect of spinal Immobilization devices on pulmonary function in healthy, nonsmoking man.** *Ann Emerg Med 1988; 17: 915-8.*
[11] Stiell IG: **The Canadian Cervical Spine Radiography Rule for stable trauma patients.** JAMA 2001, 286:1841-8.
[12] Stiell IG**: The Canadian C-Spine Rule versus the NEXUS Low-Risk Criteria in Patients with Trauma.** *NEJM 2003, 349(26): 2510-18.*
[13] Vallancourt C: **The Out-of-Hospital Validation of the Canadian C-Spine Rule by Paramedics.** Annals of Emer Med 2009, 54(5): 663-672.

http://www.sciencedirect.com/science/article/pii/S0196064498701763

Selective Cervical Spine Radiography in Blunt Trauma: Methodology of the National Emergency X-Radiography Utilization Study (NEXUS)☆☆☆★★★

Jerome R Hoffman MA, MD[*], Allan B Wolfson MD[‡], Knox Todd MD, MPH[§], William R Mower MD, PhD[*] and For the NEXUS Group

Received 22 September 1997; revised 3 April 1998; Accepted 6 April 1998. Available online 4 November 2005.

Abstract

Fear of failure to identify cervical spine injury has led to extremely liberal use of radiography in patients with blunt trauma and remotely possible neck injury. A number of previous retrospective and small prospective studies have tried to address the question of whether any clinical criteria can identify patients, from among this group, at sufficiently low risk that cervical spine radiography is unnecessary. The National Emergency X-Radiography Utilization Study (NEXUS) is a very large, federally supported, multicenter, prospective study designed to define the sensitivity, for detecting significant cervical spine injury, of criteria previously shown to have high negative predictive value. Done at 23 different emergency departments across the United States and projected to enroll more than 20 times as many patients with cervical spine injury than any previous study, NEXUS should be able to answer definitively questions about the validity and reliability of clinical criteria used as a preliminary screen for cervical spine injury. [Hoffman JR, Wolfson AB, Todd K, Mower WR, for the NEXUS Group: Selective cervical spine radiography in blunt trauma: Methodology of the National Emergency X-Radiography Utilization Study (NEXUS). *Ann Emerg Med* October 1998;32:461-469.]

Ann Emerg Med. 1998 Oct;32(4):461-9.

Selective cervical spine radiography in blunt trauma: methodology of the National Emergency X-Radiography Utilization Study (NEXUS).

Hoffman JR, Wolfson AB, Todd K, Mower WR.

Source

UCLA Emergency Medicine Center, USA.

Abstract

Fear of failure to identify cervical spine injury has led to extremely liberal use of radiography in patients with blunt trauma and remotely possible neck injury. A number of previous retrospective and small prospective studies have tried to address the question of whether any clinical criteria can identify patients, from among this group, at sufficiently low risk that cervical spine radiography is unnecessary. The National Emergency X-Radiography Utilization Study (NEXUS) is a very large, federally supported, multicenter, prospective study designed to define the sensitivity, for detecting significant cervical spine injury, of criteria previously shown to have high negative predictive value. Done at 23 different emergency departments across the United States and projected to enroll more than 20 times as many patients with cervical spine injury than any previous study, NEXUS should be able to answer definitively questions about the validity and reliability of clinical criteria used as a preliminary screen for cervical spine injury.

Comment in

- Ann Emerg Med. 2001 Feb;37(2):237-8.

PMID:

9774931

[PubMed - indexed for MEDLINE]

Appendix C

Volunteer Rescue Squad Assistance Work Group
2011 - 2012

By the end of 2012, VRSAWG will screen at least 50% of volunteer rescue squads, then assess and assist at least 10. We will provide tailored programs for rescue squads to better serve their communities with a standard of excellence.

We help volunteer rescue squads succeed by making them more . . .

(More Community and Member Oriented, more Influential, and more Financially Stable)

Objectives	Action Plans	Strategies
1. Improve leadership performance in at least 10 VRS by 12/15/2012 as measured by VRSAWG scorecard assessment for VRS. (O=Karen, AP=Kevin)	i. Create & complete at least 10 assessments of target rescue squads by 12/31/2011. ii. Conduct EMS Leadership Challenge for 24 leaders by 12/15/2011. iii. Conduct EMS Leadership Challenge for 48 leaders by 12/15/2012. iv. Host six, one day agency management training (OEMS) workshops by 12/15/2012. v. Establish written job descriptions for each operations and administrative position by 9/30/2012. vi. Develop written, standard pre-requisite criteria for any leadership candidates by 12/15/2012. vii. Create network/post EMS Leadership Challenge "lessons learned" from project completions by 12/15/2012.	A. Conduct becoming (Role-Model) B. Focus on needs of squad members. C. Listen & be open to diverse population & new ideas/generations. D. Proactively develop leaders by conducting leadership training to ensure excellent squad performance. E. Develop leaders that create a strong culture. F. Promote VRS relationships & partnerships with community & local government. G. VRSAWG owns rescue squad performance by developing "Fix It Now" (FIN) teams.
2. Increase and retain membership in at least 10 VRS by 25% by 12/15/2012 by teaching them recruiting and retention strategies. (O=Walter, AP=Carol)	i. Complete VRS screening survey questions (In support of objective #1.) by 9/20/2011. ii. Completion of screening/assessment and analysis of results by 12/1/2011. iii. Define and gain approval to finance two VRSWAG representatives to conduct on site assessments for at least 10 VRS between 4/1/2012 and 12/15/2012. iv. Create, market and distribute: Template Retention, Diversity and Recruitment program that is customizable for VRS's execution by 4/1/2012. Leverage existing Recruiting & Retention tools.	
3. Teach or assist at least 10 VRS to develop and implement a public information campaign in their community by 12/15/2012. (O=Dreama, AP=Paula)	i. Seek VRS input to name and train their PIO by 2/1/2012. ii. Schedule and market monthly Community Education programs (i.e. CPR) for every month in 2012. iii. Develop local radio messaging/advertisements (PSA) for delivery 4/1/2012 – 12/15/2012. iv. Designated squads deliver six informational presentations to community organizations from 2/1/2012 – 10/31/2012. v. Assist designated squads in activating face book & twitter account by 1/1/2012. vi. Assist designated squads in hosting an Open House in spring 2012.	
4. Educate at least 10 VRS to implement	i. Identify funding and resource availability for designated squads by 1/31/2012. (grants, fee for service, fund drives, etc.) ii. Partner with key General Assembly members to	

sound and auditable financial practices by 9/30/2012. (O=JC, AP=Steve)	implement a funding solution for LODD by 2/28/2012. iii. Develop and distribute a FAQ on pros and cons of revenue recovery by 1/31/2012. iv. Assist at least 5 VRS in implementing a revenue recovery solution by 12/15/2012. v. Educate the designated squads about the existing OEMS Budget Curriculum by 12/15/2011 & again by 3/31/2012.	H. Offer value added services & solutions to VRS. I. Build VRS awareness of VAVRS & OEMS services. J. Hold biweekly progress meetings with Objective Owners and VRSAWG Chairman to review progress.
5. Identify training and delivery gaps and create/deliver tailor made solutions to at least 10 VRS by 4/30/2012. (O=Gary, AP=Page)	i. Create & distribute a survey to all squads inquiring about availability and costs of CPR, EVOC & EMT certification by 9/30/2011 with survey completion deadline of 11/20/2011. ii. Analyze survey data by 12/15/2011 and communicate training data findings to members by 1/15/2012. iii. Use survey data to create tailor-made solutions to address and solve availability and cost issues associated with training delivery by 2/1/2012. iv. Deliver and assist in implementation of training programs to designated squads by 12/15/2012.	
6. Help at least 10 squads foster partnerships with their local government through a targeted communication and relationship strategy by 12/15/2012. (O=William, AP=Fred)	i. Create a local resolution that formalizes the government and VRS relationship by 12/15/2012. ii. Appoint a government liaison to work with VRS to solidify partnership by 4/30/2012. iii. Invite & involve government representatives to at least two squad activities, open houses and annual awards ceremonies in 2012 at designated squads. iv. Define and present (propose solutions) VRS legislative issues to external VAVRS stakeholders requiring governmental partnership by 8/30/2012.	

O = Owner AP = Accountability Partner

Focus! Action! Results!